Board of Directors - Open Meeting (Thursday 3 October 2024)

Thu 03 October 2024, 01:00 PM - 05:20 PM

Webinar teleconference

East Kent Hospitals University NHS Foundation Trust

Agenda

OPENING/STANDING ITEMS

01:00 PM - 01:05 PM
5 min

24/55
Welcome and Apologies for Absence

To Note *Acting Chairman*

Verbal

01:05 PM - 01:05 PM
0 min

24/56
Confirmation of Quoracy

To Note *Acting Chairman*

Verbal

01:05 PM - 01:05 PM
0 min

24/57
Declaration of Interests

To Note *Acting Chairman*

24-57 - BoD register of interests Sept 2024.pdf (3 pages)

01:05 PM - 01:35 PM
30 min

24/58
Patient Story

Discussion *Chief Nursing and Midwifery Officer (CNMO)*

24-58.1 - Front sheet Patient Story Board Oct 2024 FINAL.pdf (4 pages)
24-58.2 - Appendix 1 Patient Experience Story Board Oct 2024 FINAL.pdf (6 pages)

01:35 PM - 01:40 PM
5 min

24/59
Minutes of Previous Meeting held on 25 July 2024

Approval *Acting Chairman*

24-59 - Unconfirmed BoD 25.07.24 Open Minutes.pdf (13 pages)

01:40 PM - 01:45 PM
5 min

24/60
Matters Arising from the Minutes on 25 July 2024

Approval *Acting Chairman*

24-60 - Front Sheet Open BoD Action Log.pdf (6 pages)
24-60.1 - App 12 Action B-02-24 QEQM WHH ED Expansion AAR v2.pdf (9 pages)

REGULATORY AND GOVERNANCE

01:45 PM - 01:50 PM
5 min

24/61
Acting Chairman's Report

Information *Acting Chairman*

24-61 - Acting Chairman BoD Report Oct 2024.pdf (2 pages)

01:50 PM - 02:00 PM
10 min

24/62
Chief Executive's (CE's) Report

Discussion *Chief Executive*

24-62 - CEO Report Board October 2024.pdf (6 pages)

02:00 PM - 02:10 PM
10 min

24/63
Integrated Care Board (ICB) Strategy

Discussion *Chief Strategy and Partnerships Officer (CSPO)*

Verbal

02:10 PM - 02:40 PM
30 min

24/64
Integrated Performance Report (IPR)

Discussion *Chief Executive / Executive Directors*

24.64.1 - Front Sheet Aug IPR.pdf (3 pages)
24-64.2 - App 1 Board IPR Aug 24 FINAL.pdf (53 pages)

24/64.1
Month 5 Finance Report

Information *Interim Chief Finance Officer (CFO)*

24-64.1.1 - Front Sheet Finance Report M5 Board.pdf (2 pages)
24-64.1.2 - Appendix 1 M5 Board Finance Report SHORT.pdf (6 pages)

02:40 PM - 02:50 PM
10 min

24/65
Report on Journey to Exit NHS Oversight Framework 4 (NOF4) and Integrated Improvement Plan (IIP)

Discussion *Chief Strategy & Partnerships Officer (CSPO)*

24-65.1 - Front Sheet IIP Progress Report 23.09.24.pdf (2 pages)
24-65.2 - Appendix 1 Board IIP Report FINAL 23.09.24.pdf (8 pages)

02:50 PM - 03:00 PM
10 min

24/66
Risk Register Report

Assurance *CNMO*

24-66 - Risk Report BoD Public Oct 2024 FINAL.pdf (27 pages)

03:00 PM - 03:10 PM
10 min

24/67
Women's Care Group Maternity and Neonatal Assurance Group (MNAG) Chair's Report

Assurance *CNMO / Director of Midwifery (DoM)*

24-67 - BoD Overarching report MNAG Sept 2024.pdf (13 pages)

03:10 PM - 03:20 PM
10 min

TEA/COFFEE BREAK 3:10 - 3:20 (10 MINS)

Patients - Quality and Safety - Partnerships - Sustainability

03:20 PM - 03:30 PM
10 min

24/68
Complaints, Patient Advice and Liaison Service (PALS) and Compliments Annual Report 2023-2024

Approval *CNMO*

24-68.1 - Front Sheet PALS Annual Report.pdf (3 pages)
24-68.2 - App 1 PALS Annual Report 2023-2024.pdf (19 pages)

03:30 PM - 03:40 PM
10 min

24/69
Winter Planning and Capacity

Discussion *Chief Operating Officer (COO)*

Verbal

03:40 PM - 03:40 PM
0 min

Patients - Quality and Safety - Partnerships - Sustainability - People

03:40 PM - 04:30 PM
50 min

24/70
Board Committee - Chair Assurance Reports:

Board Committee Chairs

24/70.1
Nominations and Remuneration Committee (NRC) - Chair Assurance Report (3.40 pm to 3.45 pm)

Assurance *Chair NRC - Dr Andrew Catto*

24-70.1 - NRC Board Chair Report 01.10.24 FINAL.pdf (2 pages)

24/70.2
Quality and Safety Committee (Q&SC) - Chair Assurance Report (3.45 pm to 3.55 pm)

Assurance *Chair Q&SC - Dr Andrew Catto*

24-70.2 - QSC Chair's Report July 2024 Open Board Oct 2024.pdf (7 pages)

24/70.3
Finance and Performance Committee (FPC) - Chair Assurance Report (3.55 pm to 4.05 pm)

Assurance *Chair FPC - Richard Oirschot*

24-70.3.1 - FPC Board Report 29 August FINAL.pdf (5 pages)
24-70.3.2 - FPC Board Report 23 Sept FINAL.pdf (4 pages)

24/70.4
People and Culture Committee (P&CC) - Chair Assurance Report (4.05 pm to 4.15 pm)

Assurance *Chair P&CC - Claudia Sykes*

- Equality, Diversity and Inclusion (EDI) (EDI is now a standing item on this committee/board meeting as part of NHSE Equality Delivery System and so EDI can be considered in all meetings and key decisions. Please discuss and consider how this meeting/decision may impact EDI and record this e.g. have an adverse or positive impact on staff or patients with protected characteristics e.g. race, age, disability etc.)

24-70.4 - PCC Board report 25.9.24.pdf (4 pages)

24/70.5
Charitable Funds Committee (CFC) - Chair Assurance Report (4.15 pm to 4.20 pm)

Assurance *Chair CFC - Claudia Sykes*

Verbal

24/70.6
Integrated Audit and Governance Committee (IAGC) - Chair Assurance Report

Assurance *IAGC Member*

24-70.6 - IAGC Board Chair Assurance Report June July 2024 FINAL.pdf (6 pages)

Patients - Quality and Safety - People

04:30 PM - 04:40 PM
10 min

24/71
Infection Prevention and Control (IPC) Annual Report

Approval *CNMO*

24-71.1 - Front Sheet Board IPC annual report 2023-24.pdf (2 pages)
24-71.2 - Appendix 1 DIPC annual report 2023-24.pdf (22 pages)

04:40 PM - 04:50 PM
10 min

24/72
Medical Appraisal and Revalidation

Approval *Chief Medical Officer (CMO)*

24-72.1 - Medical Revalidation BoD paper Sept 24.pdf (4 pages)
24-72.2 - Appendix 1 SoC Sept 24.pdf (13 pages)

04:50 PM - 05:00 PM
10 min

24/73
Paediatric Audiology Services

Assurance *CMO*

24-73 - Paediatric Audiology Services Board Report 03.10.24.pdf (4 pages)

CLOSING MATTERS

05:00 PM - 05:05 PM
5 min

24/74
Any Other Business

Discussion *All*

Verbal

05:05 PM - 05:20 PM
15 min

24/75
Questions from the Public

Discussion *All*

Verbal

- **Questions from the public to be submitted in advance of meeting by 12.00 noon the day before meeting is held**

Date of Next Meeting: Thursday 5 December 2024

REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM SEPTEMBER 2024

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
BAIRD, STEWART	Acting Chairman	Stone Venture Partners Ltd (started 23 September 2010) **(1)** Stone VP (No 1) Ltd (started 15 August 2017) **(1)** Stone VP (No 2) Ltd (started 1 December 2015) **(1)** Hidden Travel Holdings Ltd (started 16 May 2014) **(1)** Hidden Travel Group Ltd (started 15 October 2015) **(1)** Trustee of Kent Search and Rescue (Lowland) (started 2013) **(4)** Director of SJB Securities Limited (started 30 October 2013) **(1)** Non-Executive Director of Continuity of Care Services Ltd (started 1 October 2022) **(1)**	1 June 2021 (First term)
CATTO, ANDREW	Non-Executive Director	Group Chief Executive Officer, Integrated Care 24 (IC24) **(1)** (including Director of Cleo Systems 24 Ltd, Brightdoc 24 Limited, Idental Care 24 Ltd.) Board Member of east Kent Health and Care Partnership (HCP) **(1)** Director of Transforming Primary Care **(1)**	1 November 2022 (First term)
CORBEN, SIMON	Non-Executive Director	Director and Head of Profession, NHS Estates and Facilities, NHS England **(1)** School Governor, Twyford School (Winchester) **(4)**	1 October 2022 (First term)
DESAI, KHALEEL	Director of Corporate Governance	Non-Executive Director/Trustee of The Mines Advisory Group (MAG) Charity **(4)**	29 April 2024
FLETCHER, TRACEY	Chief Executive	None	Appointed 4 April 2022
GLENN, TIM	Interim Chief Finance Officer	Chief Finance Officer and Deputy Chief Executive, Royal Papworth Hospital NHS Foundation Trust (substantive role – on secondment to East Kent Hospitals) **(1)**	6 November 2023
HAYES, SARAH	Chief Nursing and Midwifery Officer	Charity Trustee, The 1930 Fund for Nurses (Charity) **(4)**	18 September 2023
HODGKISS, ROB	Interim Chief Operating Officer	None	2 January 2024

REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM SEPTEMBER 2024

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
HOLDEN, DES	Chief Medical Officer	International Advisor, Public Intelligence (Denmark) **(5)** (2018) Advisor/Non-Executive Director, South East Health Technology Alliance **(4)** (2017) Visiting Professor, Clinical and Experimental Medicine, University of Surrey **(5)** (2023 to 2026)	2 January 2024
HOLLAND, CHRISTOPHER	Associate Non-Executive Director	Director of South London Critical Care Ltd **(1)** Shareholder in South London Critical Care Ltd **(2)** Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University and the University of Kent **(4)** South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services **(5)**	Appointed 13 December 2019 (Second term)
OIRSCHOT, RICHARD	Non-Executive Director	Non-Executive Director, Puma Alpha VCT plc (July 2019) **(1)** Director, R Oirschot Limited (August 2010) **(3)** Trustee, Camber Memorial Hall (June 2016) **(4)**	1 March 2023 (First term)
OLASODE, OLU	Senior Independent Director (SID)/Non-Executive Director	Executive Chairman, TL First Group (started 9 May 2020) **(3)** Chairman, Governance and Leadership Academy UK (started 11 September 2018) **(1)** Non-Executive Director, Priory Care Group (started 1 June 2022) **(1)** Independent Chair of Audit and Governance, London Borough of Croydon (started 1 October 2021) **(4)**	1 April 2021 (Second term)
STEVENS, BEN	Chief Strategy and Partnerships Officer	None	1 June 2023 (substantive) (20 March 2023 interim)
SYKES, CLAUDIA	Non-Executive Director	Director, Cloudier Skies Ltd **(1)** (started 21 December 2022) Chair, East Kent Health and Care Partnership (HCP) (**1**) (1 January 2024) Chair, Kent and Medway VCSE Alliance **(5)** (September 2022)	1 March 2023 (First term)

REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM SEPTEMBER 2024

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
VINER, DEBORAH	Interim Chief People Officer	None	2 September 2024
YOST, NATALIE	Executive Director of Communications and Engagement	None	31 May 2016

Footnote: All members of the Board of Directors are Trustees of East Kent Hospitals Charity

The Trust has a number of subsidiaries and has nominated individuals as their 'Directors' in line with the subsidiary and associated companies articles of association and shareholder agreements

2gether Support Solutions Limited:
Simon Corben – Non-Executive Director in common

Categories:

1 Directorships
2 Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS
3 Majority or controlling shareholding
4 Position(s) of authority in a charity or voluntary body
5 Any connection with a voluntary or other body contracting for NHS services
6 Membership of a political party

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Patient Story for the Board**

Meeting date: **3 October 2024**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO)**

Paper Author: **Associate Director of Patient Experience**

Appendices:

Appendix 1: Patient stories

Executive summary:

Action required:	**Information**
Purpose of the Report:	The patient story this time is slightly different as it does not relate to one person, but rather a community of migrant women who live in Thanet who are part of Beyond the Page's United Mothers group. The women have been involved in a project to hear the voices of migrant women about access to services including health services and some of the barriers they experience. Using peer researchers, they gathered feedback, and this is summarised in the short video that will be shared at the Board and a report which is referenced in the attached report. There will be attendance at the Board from the Co-Chief Executive Officer at Beyond the Page and one or two members of United Mothers.
Summary of key issues:	Reducing the health inequalities experienced by the local community must be a key priority for healthcare organisations in East Kent. There are high levels of deprivation which can make it harder for people to live healthier lives or attend important hospital appointments and this results in poorer health outcomes. As a large acute hospital trust and an anchor institution in the wider health economy we must play our part in reducing barriers to accessing healthcare. This includes offering flexible appointment times in out-patient clinics, providing patient information that people can understand, reliable interpreting services and staff who are culturally competent. Hearing the voices of local communities who don't always get their voices heard is important at a time when the Trust faces significant challenges, both culturally and financially, and our staff are working very hard to reduce waiting lists and provide high quality care. The voices of underserved communities must be heard so that we avoid building in inequalities to new care pathways and service re-design. The Trust's new Equality and Health inequalities Impact Assessment (EHIA) template and guidance will support services to identify potential negative impacts on health inclusion groups and people with protected characteristics and enable us to make adjustments that will mitigate or remove the negative impact.

	For patients and their families who are from other countries where there are cultural differences related to healthcare and when people don't speak English as their primary language, we need to provide interpreting services so that people can fully understand what tests are needed, what their diagnosis is, what the treatment options and risks are, so they can make an informed decision and give consent. Beyond the Page is a non-profit migrant women's group providing weekly English for Speakers of other Languages (ESOL) sessions, wellbeing, digital inclusion, and creative activities in Thanet under their United Mothers (UM) programme. Their aims are to: • engage and support women born outside the UK to develop speaking confidence in English and become active citizens; • work with partner organisations to develop and improve services for minority ethnic families; • build a positive, active multicultural and multilingual local community. Since 2015, Beyond the Page has offered safe, creative and fun women-only spaces for English language-learning, belonging and inter-cultural friendship. The project being shared at the Board was originally set up as Beyond the Page heard from migrant women the difficulties that they had in accessing services. This has ranged from women feeling discriminated against when talking to staff in health services or in schools and nurseries and women feeling unable to fully participate in their children's lives due to language barriers. Interviews were carried out with five women and the two researchers were interviewed themselves. They also carried out a survey for those women they had not managed to interview with seven women taking part. The nationalities represented were Afghani, Turkish, Nigerian, Brazilian, Czech, Mauritian, Vietnamese, and Iraqi. Positive experiences of health services: • In the survey all the women said that they had been able to book appointments for their children across the midwifery, health visitor, doctor and dentist services and said they had been friendly and welcoming. • Positive feedback from the interviews; one woman said she was very happy with the health visitor service as her baby was a low weight and they had been helpful. Another said she had been offered an interpreter at the hospital and they had said it couldn't be her husband, which was a good thing for her. Negative experiences of healthcare services: • Overall, women had experienced quite a few negative things with struggling to get the health support they needed, not accessing health visitor appointments, and not always getting translation support to understand consultations or medical procedures. • One said she had very long waiting times at Accident & Emergency (A&E) when she had a miscarriage and was in a lot of pain. They were disappointed that they were only given paracetamol, and they found that ongoing health issues were not listened to by the GP.

	• Women reported that they had made appointments with midwives and health visitors, but they had not attended, and their baby did not have the checks they needed. • The lowest result in the survey for understanding what was said to them by health services with three out of seven women reporting this. • A woman reported finding it challenging to make appointments and her husband did this. She also spoke about being directed to websites but that this was challenging as she struggled to read which was another issue raised by a woman. • One woman said that she did not think health services were very good. She had experienced rudeness over the phone and difficulty making appointments. She experienced the GP telling her to make another appointment when she talked about more than one thing and that she would have to come back. She also said she found it difficult to understand and no translation was provided for her. • There was feedback around the health visiting service and information provided particularly around co sleeping which was common practice for some women but also why they needed to change nappies after feeding. They reported not having health visitors in their country but were happy to take advice but needed more information and explanation as much of this was new information for them. Changes to health services wanted/needed: • Information provided to families about the NHS services available and what to expect from services; • Translation of information and recognition of language and literacy barriers; • Explanation of the information provided; • Patience and awareness of giving information and communication by staff members. The Patient Voice and Involvement team has an approach of seeking out the voices of underserved communities to get feedback on their experiences of healthcare. The Patient Involvement Officer based at Queen Elizabeth the Queen Mother Hospital (QEQM) made the initial contact with Beyond the Page in Thanet, and her contact with them has helped in getting the voices of their United Mothers heard at the Trust Board for this patient story. The Patient Voice and Involvement team has developed a set of slides to be used in staff training related to examples of people who experience significant health inequalities, including homeless people, carers and veterans. The team will be working on some slides related to migrant women and people next.
Key recommendations:	The Board of Directors is asked to discuss this story of migrant women's experiences and support actions being taken to improve the involvement of patients, carers and families in our local communities. The Board of Directors is also asked to inquire of Care Groups how they are delivering and developing services to provide equity of access, excellent patient experience and optimal outcomes for all our local communities in East Kent.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients
Link to the Trust Risk Register:	**CRR 159**: Detriment to patients with a disability as we are non-compliant with the mandatory Accessible Information Standards.
Resource:	No
Legal and regulatory:	The Trust must comply with the Care Quality Commission Regulations. The Equality Act 2010 and the public sector equality duty under the Act require NHS organisations to demonstrate due regard to people with protected characteristics in the provision of healthcare. The NHS Health Inequalities Leadership Framework Board Assurance Tool supports NHS Trust Boards to deliver exceptional healthcare quality for all through equitable access, excellent experience and optimal outcomes.
Subsidiary:	No

Assurance route:

Previously considered by: Not applicable - Patient/family stories come direct to the Board.

East Kent Hospitals University NHS Foundation Trust

PATIENT STORY

1. Purpose of the report

1.1 The patient story this time is slightly different as it does not relate to one person, but rather a community of migrant women who live in Thanet who are part of Beyond the Page's United Mothers group. The women have been involved in a project to hear the voices of migrant women about access to services including health services and some of the barriers they experience. Using peer researchers, they gathered feedback, and this is summarised in the short video that will be shared at the Board and in the report below.

1.2 There will also be attendance at the Board from the Co-Chief Executive Officer at Beyond the Page and one or two members of United Mothers.

2. Background

2.1 Reducing the health inequalities experienced by the local community must be a key priority for healthcare organisations in East Kent. There are high levels of deprivation which can make it harder for people to live healthier lives or attend important hospital appointments and this results in poorer health outcomes. As a large acute hospital trust and an anchor institution in the wider health economy we must play our part in reducing barriers to healthcare. This includes offering flexible appointment times in out-patient clinics, providing patient information that people can understand, reliable interpreting services and staff who are culturally competent.

2.2 Hearing the voices of local communities who do not always get their voices heard is important at a time when the Trust faces significant challenges, both culturally and financially, and our staff are working very hard to reduce waiting list and provide high quality care. The voices of underserved communities must be heard so that we avoid building in inequalities to new care pathways and service re-design. The Trust's new Equality and Health inequalities Impact Assessment (EHIA) template and guidance will support services to identify potential negative impacts on health inclusion groups and people with protected characteristics and enable us to make adjustments that will mitigate or remove the negative impact.

2.3 For patients and their families who are from other countries where there are cultural differences related to healthcare and when people do not speak English as their primary language, we need to provide interpreting services so that people can fully understand what tests are needed, what their diagnosis is, what the treatment options and risks are to make an informed decision and give consent. One example is that when some people hear "Do you have any questions?" they take this to mean it is the end of the conversation and they should go. Many people in our communities are not used to being asked their opinion or whether they have any questions, and this can mean they agree to a course of treatment that they don't fully understand, including the risks and side effects.

3. Beyond the Page and United Mothers

3.1 Beyond the Page is a non-profit migrant women's group providing weekly English for Speakers of other Languages (ESOL) sessions, wellbeing, digital inclusion, and creative activities in Thanet under their United Mothers (UM) programme.

3.2 Their aims are to:

- engage and support women born outside the UK to develop speaking confidence in English and become active citizens;
- work with partner organisations to develop and improve services for minority ethnic families;
- build a positive, active multicultural and multilingual local community.

Since 2015, Beyond the Page has offered safe, creative and fun women-only spaces for English language-learning, belonging and inter-cultural friendship.

3.3 Beyond the Page provide nine sessions a week to around 50+ women. In 2022-2023 they supported women from 20 different countries of origin. For many of the women they support, their provision is the only access to ESOL classes they receive. Many are on spousal visas, meaning they do not receive funding to be able to access ESOL in mainstream education. Some of the women do have access to ESOL classes through adult education which needs to be paid for, but these are only open to EU citizens and those who have been in the UK for three years. The end goal of these classes is a qualification in ESOL.

3.4 By offering a women's only space, women can share and learn from each other. Some women may not have experience of being in a formal classroom setting and do not have experience of taking exams. Many of the women do not have access to nursery and preschool until their children are eligible for free places. Without local family networks, they are often isolated. Beyond the Page provides a creche alongside the ESOL provision which means that both mothers and children have an opportunity for development. It also provides a break for the women from childcare responsibilities and supports their wellbeing.

3.5 They do not work to a set curriculum which means they are driven by the needs of the women rather than a set of specific outcomes. This can often be through peer-to-peer support and by signposting and information given by the organisation and other professionals we invite into the space. Their trained volunteers offer one to one conversation/befriending support which is held online and face to face. They work with local agencies in health, housing, the police, and early years to encourage better practices suited to the women's needs and signpost to services to support the women. They support women on a range of issues including employment, housing, poverty, immigration, schools, registering pregnancies and providing emotional support. They are now embedding lived experience into the organisation through a peer-led steering group and through a Community Champion's project.

3.6 Beyond the Page is a partner of the Margate Early Learning Community, a project which works to improve early learning outcomes for children growing up in Margate. The project is supported by Save the Children UK. Beyond the Page received funding in 2022 to pay for the delivery of their Wednesday group, held in Margate, which is aimed at women with young families so they can access the creche facility. Without this support many migrant women would be alone and unable to access services in the area. They currently work with women from a variety of nationalities.

3.7 The project was originally set up as they heard from migrant women the difficulties that they had in accessing services. This has ranged from women feeling discriminated against when talking to staff in health services or in schools and nurseries and women feeling unable to fully participate in their children's lives due to language barriers. They carried out a focus group in October 2022 with five migrant mothers which provided us with the following themes:

- Women felt extremely isolated and had low levels of confidence.
- Women were unable to access early years spaces and did not feel welcome.
- They wanted to attend classes for new mums not only for young parents

- Women reported feeling unable to attend school parents' evenings due to not being able to speak English and so did not go.

3.8 The original scope was for a small number of women from United Mothers to receive training from Save the Children to be peer/community researchers. Three women trained as peer researchers with two going on to carry out the interviews. Interviews were carried out with five women and the two researchers were interviewed themselves. They also carried out a survey for those women we had not managed to interview with seven women taking part. The nationalities represented were Afghani, Turkish, Nigerian, Brazilian, Czech, Mauritian, Vietnamese, and Iraqi.

3.9 The peer researchers also conducted interviews with professionals in relevant services. The peer researchers shared some of the early findings from the research and asked them about their services and how they met the needs of migrant mothers in the community. They spoke to the following professionals:

- Health Visitor, Kent Community Health NHS Foundation Trust
- Learning Producer, Turner Contemporary
- Senior Early Help Worker, Kent County Council (KCC) (Thanet children's centres team)

They contacted primary care health services and maternity services at East Kent Hospitals University Foundation Trust but were unable to arrange an appointment.

3.10 Findings were mixed across the interviews and surveys with the women. The services looked at were children's centres, schools and nurseries, health services and local activities. Some reported positive experiences, particularly those who filled out the online survey, with the majority saying they found staff to be helpful and welcoming. This was not the case when interviews were carried out nor within the focus group. We also found that, without translation being provided, it could be challenging to communicate the questions adequately.

3.11 They recorded all the sessions which were then transcribed. With peer researchers, Beyond the Page and Save the Children then looked at the positive and negative experiences for each service from the perspective of migrant families based on the information received. Satisfaction with health services remained quite low, with GP and dentist appointments challenging to get and complaints of waiting a long time to see someone in Accident & Emergency (A&E). Women reported feeling unwelcome in spaces and women did not seem to access services and activities other than midwifery or health visiting appointments when in the Children's Centres. Women reported feeling discriminated against in all the settings and cited language difficulties as a barrier to getting their family's needs addressed. There were also issues raised regarding support for children with additional needs.

3.12 Professionals clearly demonstrated a desire to engage with migrant communities, but some services did not provide any additional support needed to engage families. One professional interviewed had been involved in a community engagement project which engaged the local Roma community by herself being extremely visible in the community. They were very proactive in finding ways to engage and advocating on behalf of migrant families, for example with the GP and hospital. For other professionals the onus was on families to come to them, and they acknowledged that there were barriers to families being able to do this such as the cost-of-living crisis and the space being intimidating. One professional said that their services were open to all but didn't recognise the barriers that might be faced by migrant communities in accessing their space. Others had tried to engage with the community by putting on ESOL classes and were very keen to work with Beyond the Page as they had not had much success on their own.

3.13 Positive experiences of health services:

- In the survey all the women said that they had been able to book appointments for their children across the midwifery, health visitor, doctor and dentist services and said they had been friendly and welcoming.

- Positive feedback from the interviews; one woman said she was very happy with the health visitor service as her baby was a low weight and they had been helpful. Another said she had been offered an interpreter at the hospital and they had said it could not be her husband, which was a good thing for her.

3.14 Negative experiences of healthcare services:

- Overall, women had experienced quite a few negative things with struggling to get the health support they needed, not accessing health visitor appointments, and not always getting translation support to understand consultations or medical procedures.

- Women reported having problems booking an appointment with a GP. One said she had very long waiting times at A&E when she had a miscarriage and was in a lot of pain. They were disappointed that they were only given paracetamol, and they found that ongoing health issues were not listened to by the GP.

- There were reports of women being unable to access dentists for their children and themselves. Women reported that they had made appointments with midwives and health visitors, but they had not attended, and their baby did not have the checks they needed.

- The lowest result in the survey for understanding what was said to them by health services with three out of seven women reporting this. A woman reported finding it challenging to make appointments and her husband did this. She also spoke about being directed to websites but that this was challenging as she struggled to read which was another issue raised by a woman. One woman said that she did not think health services were very good. She had experienced rudeness over the phone and difficulty making appointments. She experienced the GP telling her to make another appointment when she talked about more than one thing and that she would have to come back. She also said she found it difficult to understand and no translation was provided for her. There was feedback around the health visiting service and information provided particularly around co sleeping which was common practice for some women but also why they needed to change nappies after feeding. They reported not having health visitors in their country but were happy to take advice but needed more information and explanation as much of this was new information for them.

3.15 Changes to health services wanted/needed:

- Information provided to families about the NHS services available and what to expect from services;
- Translation of information and recognition of language/literacy barriers;
- Explanation of the information provided;
- Patience and awareness of giving information and communication by staff members.

4. Actions taken to date

4.1 The Patient Voice and Involvement team has an approach of seeking out the voices of underserved communities to get feedback on their experiences of healthcare. The Patient Involvement Officer based at Queen Elizabeth the Queen Mother Hospital (QEQM) made the initial contact with Beyond the Page in Thanet, and her contact with them has helped in getting the voices of their United Mothers heard at the Trust Board for this patient story.

4.2 The Patient Voice and Involvement team has developed a set of slides to be used in staff training related to examples of people who experience significant health inequalities, including homeless people, carers and veterans. The team will be working on slides related to migrant women and people next.

4.3 The interpreting and translation service contract is managed by the Associate Director of Patient Experience. The provider has experienced challenges in fulfilling bookings for face-to-face interpreting for patients requiring an endoscopy or MRI. Some patients have experienced three cancelled tests in a row as no face-to-face interpreter could be sourced. We have actively managed the contract and as a result the provider has recruited two local Nepali interpreters and is now actively seeking additional Slovak interpreters.

5. Action planned for the next three to nine months

5.1 We will be rolling out Video Relay Interpreting on demand for a wide range of spoken languages, starting with the patient tablet devices available on most wards and some departments. Once this has been successfully implemented, we will be looking to expand this to diagnostics, emergency departments, maternity, urgent treatment centres and other services across the Trust. This will involve services purchasing additional tablets and providing webcams for desktop computers in outpatient clinics.

5.2 The Patient Voice and Involvement Team will continue to engage with underserved communities to get feedback, including talking to care leavers and looked after children, delivering co-designed training based on homeless people's experiences in healthcare, and launching a forum for patients who veterans and family members of veterans. Beyond the Page has a standing invitation to attend the Patient Participation and Action Group.

6. Conclusion

6.1 Hearing the voices of local communities who do not always get their voices heard is important at a time when the Trust faces significant challenges, both culturally and financially, and our staff are working very hard to reduce waiting list and provide high quality care. The voices of underserved communities must be heard so that we avoid building in inequalities to new care pathways and service re-design. The Trust's new EHIA template and guidance will support services to identify potential negative impacts on health inclusion groups and people with protected characteristics to enable us to make adjustments that will mitigate or remove the negative impact.

6.2 For patients and their families who are from other countries where there are cultural differences related to healthcare and people don't speak English as their primary language, we need to provide interpreting services so that people can fully understand what tests are needed, what their diagnosis is, what the treatment options and risks are, and to make an informed decision and give consent.

6.3 Reducing the health inequalities experienced by the local community must be a key priority for healthcare organisations in East Kent. There are high levels of deprivation which can make it harder for people to live healthier lives or attend important hospital appointments and this results in poorer health outcomes. As a large acute hospital trust and an anchor institution in the wider health economy we must play our part in reducing barriers to healthcare. This includes offering flexible appointment times in out-patient clinics, providing patient information that people can understand, reliable interpreting services and staff who are culturally competent.

6.4 The Patient Voice and Involvement team's engagement with Beyond the Page has enable us to hear the voices of some of the migrant community in Thanet. Listening to people and involving them is a continuous process and feeding back to people telling them what changes we've made because of their feedback is important. In this case the women's feedback is being used as part of the "Seeing the person" sessions the teams deliver to colleagues across the Trust.

7. Recommendations

7.1 The Board of Directors are asked to discuss this story of migrant women's experiences and support actions being taken to improve the involvement of patients, carers and families in our local communities.

7.2 The Board of Directors are also asked to inquire of Care Groups how they are delivering and developing services to provide equity of access, excellent patient experience and optimal outcomes for all our local communities in East Kent.

UNCONFIRMED MINUTES OF THE ONE HUNDRED AND THIRTY NINTH MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 25 JULY 2024 1.00 PM HELD IN THE CORPORATE MEETING ROOM, TRUST OFFICES, KENT AND CANTERBURY HOSPITAL & WEBINAR TELECONFERENCE

PRESENT:

Mr S Baird	Acting Chairman (Chair)	SB
Ms A Ashman	Chief People Officer (CPO)	AA
Dr A Catto	NED/Quality and Safety Committee (Q&SC) Chair/Nominations and Remuneration Committee (NRC) Chair	AC
Ms T Fletcher	Chief Executive (CE)	TF
Mr R Hodgkiss	Chief Operating Officer (COO)	RH
Dr D Holden	Chief Medical Officer (CMO) (by Webinar)	DH
Ms K Perry	Deputy Chief Nurse (CN) (on behalf of Chief Nursing & Midwifery Officer)	KP
Mr B Stevens	Chief Strategy and Partnerships Officer (CSPO)	BS
Ms M Stevens	Director of Finance (DoF) (on behalf of Interim Chief Finance Officer)	MS
Ms C Sykes	NED/Charitable Funds Committee (CFC) Chair/*Reading the Signals Oversight Group* Chair/People & Culture Committee (P&CC) Chair	CS

ATTENDEES:

Mr K Desai	Director of Corporate Governance (DCG)	KD
Ms C Doran	Quality Lead for East Kent locality, NHS Kent & Medway Integrated Care Board (ICB) (by Webinar)	CD
Professor C Holland	Associate NED	CH
Ms P Kumi	Head of Equality, Diversity and Inclusion (EDI) (minute number 24/042)	PK
Ms T Stewart	Staff Story (minute number 24/042)	TS
Mrs N Yost	Executive Director of Communications and Engagement (EDC&E)	NY

IN ATTENDANCE:

Miss S Robson	Board Support Secretary (Minutes)	SR

MEMBERS OF THE PUBLIC AND STAFF OBSERVING (BY WEBINAR):

Dr O Akinnawonu	Member of Staff
Mr R Barker	Member of the Public
Ms A Beales	Member of the Public
Ms R Clover	Member of the Public
Mr N Daw	Member of Staff
Mr I Child	Member of the Public
Mr J Hall	Member of Staff
Ms C Heggie	Member of the Public
Mr C Kerr	Member of the Public
Ms B Mayall	Lead Governor
Mr D Richford	Member of the Public
Mrs L Williams	Member of Staff

MINUTE NO.		ACTION
24/037	**CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE** The Acting Chairman opened the meeting, welcomed everyone present, and noted apologies received from Mr S Corben (SC), NED/2gether Support Solutions (2gether) NED In-Common; Mr T Glenn (TG), Interim Chief Finance Officer (CFO);	

Ms S Hayes (SH), Chief Nursing and Midwifery Officer; Mr R Oirschot (RO), NED/Finance and Performance Committee (FPC) Chair; and Dr O Olasode (OO), NED/Senior Independent Director (SID)/Integrated Audit and Governance Committee (IAGC) Chair.

The Chairman thanked Andrea Ashman, CPO, for all her hard work and commitment over the last seven years since she joined the Trust, this would be her last Board meeting. He wished her the very best in her new role as CPO commencing in September with Dartford and Gravesham NHS Trust.

24/038 **CONFIRMATION OF QUORACY**

The Acting Chairman **NOTED** and confirmed the meeting was quorate.

24/039 **DECLARATION OF INTERESTS**

There were no new interests declared.

24/040 **MINUTES OF THE PREVIOUS MEETING HELD ON 6 JUNE 2024**

DECISION: The Board of Directors **APPROVED** the minutes of the previous meeting held on 6 June 2024 as an accurate record.

24/041 **MATTERS ARISING FROM THE MINUTES ON 6 JUNE 2024**

B/06/23 – Redesigning Patient Pathways in the Emergency Departments (EDs)
The COO suggested presenting a report at the next meeting around the Trust's revised approach in respect of managing patients at the front door (e.g. Same Day Emergency Care (SDEC) and Clinical Decision Unit (CDU)), in advance of the upcoming winter period.

B/01/24 - Staff Survey 2024
It was noted a report had been presented to the Closed BoD meeting held earlier that morning about delivering improvements with this survey. The Board of Directors **APPROVED** the closure of this action.

B/02/24 – Lessons learnt review on EDs expansion builds at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM)
The CSPO confirmed the WHH review had been concluded, QEQM would be completed that week, and agreed to present a report at the next meeting.

B/05/24 – NHS Kent & Medway (K&M) Integrated Care Board (ICB) Strategy 2024/25 – 2029/30
It was noted a verbal update would be provided by the CE later on in the agenda.

B/06/24 – Update on progress of the Provider Board Collaborative
The CE provided a verbal update stating discussions and work continued to be progressed by the Provider Board Collaborative, focussing on the areas required, noting the Collaborative would be involved in the discussions developing the K&M ICB Strategy and around the various elements of this being picked up by each organisation across the healthcare system. The Board of Directors **APPROVED** the closure of this action.

B/07/24 – Culture and Leadership Programme (CLP) progress update and action plan

It was noted a CLP progress report was presented at this meeting. The Board of Directors **APPROVED** the closure of this action.

B/08/24 – Update on timeframe date when maternity minor estates works to be completed by
The CSPO provided a verbal update confirming out of the 48 items in progress, four were due for completion shortly, 19 to be completed by the end of August, 11 due to be completed within the wider estate works within the 2024/25 capital programme, and ongoing close monitoring of progress against remaining 14. The Board of Directors **APPROVED** the closure of this action.

B/10/24 – Update on action to address incidents of assaults on staff ensuring staff protected and supported
The CSPO commented there was a wider review being undertaken of the security service provision, and the Trust's requirements around the specification of this service as well as staff training provision. This was around mitigating actions to keep staff safe, with the Health & Safety team working closely with the Nursing team. A report to be presented towards the end of the year following this review.

B/11/24 – Trust's staff fire safety training covering evacuation procedures for patients receiving corridor care treatment
The CSPO confirmed generic fire safety training covered generic evacuation procedures. To specifically address the concerns raised about WHH changes had been put in place, with local risk based assessments being carried out around the use of corridors for care, along with localised training. The Board of Directors **APPROVED** the closure of this action.

The Board of Directors **NOTED** the action log, **NOTED** the updates on the actions, **NOTED** the actions for future Board meetings, and **APPROVED** the five actions above for closure.

24/042 **STAFF STORY**

The Head of EDI explained the staff story about neurodiversity and the staff member managing their neurodiversity and anxiety at work.

The staff member highlighted the following elements from their story:

- Had worked with the Trust since 2001 and in 2022 was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), dyspraxia and autistic traits at the age of 49. Once diagnosed the clinical support ceased and continued with her own research as this impacted every aspect of her life, had poor muscle tone, and was committed to help everyone understand neurodiversity. If had been diagnosed much earlier in life would have been able to develop coping strategies and understand her behaviours at a younger age;
- Joined the Trust's Neurodiversity Staff Network (currently approximately 75 members), who accepted her and provided significant support to her and other colleagues as well as guidance. The importance of this network that provided a safe space for staff to share their experiences, as well as the opportunity to discuss and share individual coping mechanisms to support individuals in raising with their line managers when they needed to take time out to manage their neurodiversity. Emphasised the day to day challenges for individuals in managing their neurodiversity;

- Network was extending its reach to managers who wished to understand neurodiversity and how they could support their staff;
- Highlighted Albert Einstein who was autistic, and opportunities and great creativity those who were autistic and neurodiversity could provide, whilst the need to understand that it took time to think about and process how to respond to questions;
- Received great support from her line manager and members of staff in her team, and the importance of all staff with Neurodiversity in having this similar support;
- No provision of free counselling support.

The Deputy CN asked how leaders could be supported to ensure discussions with staff with neurodiversity within a safe environment, that they felt comfortable and received the necessary support. The staff member commented on the staff health passport implemented by the Trust's Occupational Health team, and the ADHD UK guidance and action plan available to facilitate these conversations, to enable individuals to share their challenges and changes that could be made to support them.

The CSPO asked whether there were any changes or improvements that the Trust could make to support staff with neurodiversity within the workplace. The staff member highlighted it was important to bridge the gap and provide a safe space where staff felt comfortable, there would be no repercussions, and they would not be treated any differently, to be able to share their diagnosis, challenges, and how they could be supported. It was suggested the inclusion in the Trust's Leadership Development Programme introducing mechanisms around empowering employees to have open and honest discussions with leaders.

The CPO noted it was vital for all leaders to understand neurodiversity, acknowledging staff who had not shared their diagnosis, and encouraging staff to come forward and also be part of the Network. Also recognising when treating and engaging with patients this could be those with neurodiversity, and them having a positive experience receiving Trust's services.

The Board of Directors discussed and **NOTED** the Staff Story, and ongoing Trust wide support from the Board of Directors was key to helping that realisation be achieved.

24/043 **CHAIRMAN'S REPORT**

The Acting Chairman highlighted the following key elements:

- Trust's performance metrics were improving, recognising its continued journey of improvement and more work still to be done. It was acknowledged the really good work of staff and teams throughout the Trust to support the improvements, with a focus on exiting NHS Oversight Framework 4 (NOF4);
- Continued focus on the culture improvement programme with changes being seen and an improved position;
- Thanks to all staff for their hard work and continued support in making the needed changes happen, whilst working under immense pressure.

The Board of Directors **NOTED** the contents of the Chairman's report.

24/044 **CHIEF EXECUTIVE'S (CE's) REPORT**

The CE reported on the following key points:

- The NHS K&M ICB Strategy 2024/25 – 2029/30 was expected to be presented at the next meeting, there had been a collaborative approach in developing this strategy. Once available this would be circulated to Board members for review ahead of a Board discussion;
- Medical Education Awards held a few weeks ago, which was an uplifting event, good attendance, celebrating medical staff, congratulating the QEQM maternity team on their success and positive feedback from the junior doctors survey.

ACTION: Circulate the NHS K&M ICB Strategy 2024/25 – 2029/30 once available to Board members for review ahead of a Board discussion. CE

The Board of Directors **NOTED** the Chief Executive's report.

24/045 **INTEGRATED PERFORMANCE REPORT (IPR)**

The CSPO highlighted the changes made to how the IPR was presented now within a critical statistical process control (SPC) reporting framework. This provided improved assurance whether the Trust was consistently meeting its set targets, whether was consistently improving or if there was deterioration. This was against revised colour codes (blue – significant improving, orange – significant variation of concern, and grey – no significant change). The IPR now included a summary highlighting progress against the Integrated Improvement Plan (IIP) metrics.

The COO highlighted the following key elements in respect of operational performance metrics:

- ED performance continued to improve, continued challenges, pressures and demand on these services, increase of 5.8% in attendances that quarter compared to the same period the previous year. Length of stay (LoS) reducing. To support improved performance and ease operational pressure at the front door, implementation of SDEC and CDU at WHH and QEQM;
- Corridor care continued to be in place currently at both WHH and QEQM, with ongoing work to minimise this care with the aim to eliminate this;
- Elective activity: currently no patients awaiting over 104 weeks, 82 patients waiting over 78 weeks to be reduced to 39 by the end of July, with a focus now on reducing 65 weeks and 52 weeks;
- Thanks to all the teams and staff for their hard work in supporting the improvements in operational performance;
- Support from Maidstone and Tunbridge Wells NHS Trust, transferring 1,100 patients for treatment from the 90,000 patients on the Trust's waiting lists;
- Cancer: improved performance against 62 days and 28 days (currently compliant for the first time in a number of years), with provision of additional funding to secure staff resources to address capacity issues;
- Significant progress by the Endoscopy team in reducing the endoscopy backlog (surveillance), from 14,000 in January 2024 to 7,000 currently.

The Acting Chairman highlighted a discussion earlier at the Closed BoD meeting where the COO confirmed the growth activity in the EDs equated to 45 extra patients every day. It had been agreed the provision of regular future reporting to

Board members about operational pressures, activity, managing demand and patient experience within the EDs. It was noted the Acting Chairman and NED/P&CC Chair would continue to regularly visit the EDs.

The Deputy CN highlighted the following key elements in respect of Quality & Safety and Maternity metrics:

- Incidents of falls and pressure ulcers (PUs) had stabilised, with ongoing monitoring;
- Duty of Candour (DoC) data currently unavailble due to changes within the system, with a secondary process in place to ensure this information for moderate and above incidents was appropriately recorded;
- Complaints continued on an improved trajectory, with a focus on timely responses, with resolution meetings put in place with patients and families and good feedback about these;
- Trajectory for the closure of overdue incidents by October 2024, current reduction from 3,500 to 1,300;
- Never event in June 2024 being investigated through the Serious Incident (SI) framework, expected to be completed by the end of August 2024, with immediate review undertaken;
- Maternity: extended perinatal rate remained consistently below the threshold of 5.87 per 1,000 births (June 12 month rolling rate at 3.47 per 1,000 births). Friends and Family Test (FFT) response rate remained below average for six consecutive months and below the 15% threshold. Quarterly staff engagement score remained below the threshold and below the lower threshold at 6.07 in April to June.

The CMO highlighted the following key elements in respect of mortality metrics:

- Seeking clarification on the Hospital Standardised Mortality Ratio (HSMR) reporting now 114, noting reporting was always in arrears, and had consistently been reporting better than expected. It was noted there was ongoing data submission issues and whether this was the reason for the increase. The definitions of the groups reviewed and reported was changing and had sought clarification whether this change had already been implemented.

ACTION: Provide an update on the Hospital Standardised Mortality Ratio (HSMR) reporting numbers in response to seeking clarification about the increase in numbers. To confirm whether this was due to ongoing data submission issues, whether the definitions of the groups reviewed and reported that were changing had already been implemented, or whether action to review the reasons for the increase was needed. CMO

The CPO highlighted the following key elements in respect of people metrics:

- Vacancy rate risen to 9.2%, just below the threshold that was being maintained;
- Staff turnover continued to remain stable at 9.1% with premature turnover being sustained at 15%;
- Reduction in sickness absence remained below the alerting threshold for the fifth month, WHH Care Group the lowest clinical area at 3.79%, whilst some areas were high with focussed work to support these areas and staff to enable return to work;

- Staff engagement levels was a key area of concern remaining below the threshold, with continued focussed work to engage and encourage staff to provide their feedback;
- Improvements in staff appraisal rates and training compliance.

The Board of Directors discussed and **NOTED** the metrics reported in the IPR.

24/045.1 **MONTH 3 FINANCE REPORT**

The DoF reported on the following key points:

- On plan against the planned deficit of £23,128k with risk mitigations in place in respect of shortfall in consultant pay awards (circa £400k) and industrial action (£600k);
- Cost Improvement Programme (CIP) was slightly above plan;
- Capital expenditure slightly behind plan of £1.8m against planned £2.5m;
- Trust successfully improved its creditor management, returning to 30 day creditor terms for non-NHS suppliers, which had been 34 days in early July.

The Acting Chairman acknowledged and thanked all staff across the organisation for their hard work and commitment in achieving the improved position against its finance performance.

The Board of Directors reviewed and **NOTED** the financial performance of Month 3.

24/046 **REPORT ON JOURNEY TO EXIT NHS OVERSIGHT FRAMEWORK (NOF4) AND INTEGRATED IMPROVEMENT PLAN (IIP)**

The CSPO highlighted the following key points:

- Error in report in respect of Leadership, Governance & Culture, reported green that should be amber and would be corrected. This rating was due to not achieving recruitment to Manager Director roles and interviews to be held that week, expected to get back on track in quarter 2;
- Urgent & Emergency Care (UEC) and Planned Care both rated amber;
- Finance rated green, recognising a great deal of work still to be done;
- Internal review had been undertaken on progress against the key milestones and quarterly metrics;
- Positive recognition externally of the progress made to date, and on track to achieve the year end position at quarter 4.

The Acting Chairman highlighted the risk with the upcoming winter period and pressures as a result, potential impact in not achieving the exit criteria.

The Board of Directors discussed and **NOTED** the report on Journey to Exit NOF4 and IIP.

24/047 **NHS KENT AND MEDWAY (K&M) INTEGRATED CARE BOARD (ICB) STRATEGY**

The CE reiterated this had been covered under the CE's report, noting a K&M Integrated Care System (ICS) Strategy in place incorporating all partners, and the NHS K&M ICB Strategy was the NHS component focussing on sustainability. Plan

to present the Strategy at the September 2024 BoD Development Strategy Session and then the October BoD meeting.

The Board of Directors **NOTED** the verbal update on the K&M ICB Strategy.

24/048 **RISK REGISTER REPORT**

The DQG highlighted the following key elements:

- Report detailed risks scored above 15, a total of 34 risks on risk register (reduction from original 82), 14 risks with overdue actions with a focus from risk owners to close these;
- New reporting format clearly indicating by arrows the movement up or down of progress to reduce risks;
- De-escalation of five risks;
- Reasonable assurance reported from the Internal Auditors following audit review of the Trust's risk management, improvement from the previous year.

The Acting Chairman acknowledged the significantly improved position.

The Board of Directors:

- **SUPPORTED** the recommendations made within the Risk Register report;
- **RECEIVED** and **NOTED** the Significant Risk Report for assurance purposes and for visibility of key risks facing the organisation.

24/049 **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS:**

24/049.1 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

The Q&SC Chair reported on the following key issues:

- Venous Thromboemolism (VTE) had been a key area of focus with an improved performance of assessment compliance, as identified in the IPR;
- Focussed review of complaints that was a concern for the Trust, patients and families, in respect of responses, and this would continue to be an ongoing area to monitor progress;
- Overdue incidents were improving, recognising there was still more work to do to ensure this continued and was sustained;
- Trust identified as an outlier in respect of paediatrics diabetes audit, actions implemented and would be monitored to review improvements in the following year's audit results;
- Continued close monitoring of risks;
- Screening and quality assurance report on cervical screening and assurance received the majority of necessary actions had been put in place;
- Front line clinicians and nurses invited to Committee meetings to receive first hand feedback from staff.

The Associate NED raised an issue that he had been made aware of during his site visit at K&C that morning, in respect of holes in the equipment wraps, noting in the report that this was not a contributing link to Surgical Site Infections (SSIs), and around basic hand hygiene standards. This continued to be an issue in the numbers discarded as a result of these holes and also an associated time element when having to repeat the preparation of this equipment. The COO commented

this remained an ongoing issue, a meeting would be held at the beginning of August with the orthopaedic and theatre teams, clinicians, COO and CNMO, to ensure a resolution, minimise any potential cancellation of operations, and possibly undertake a further review of the procedures by the outsourced provider to understand the reasons for the holes. The Q&SC Chair reported assurance received of the detailed review of the outsourced provider's procedures by the Trust's Infection, Prevention and Control (IPC) team.

ACTION: Provide an update at the next meeting on the outcome of the meeting in August to discuss the issues about the holes in equipment wraps, review of the procedures by the outsourced provider, and agreed actions to address and resolve this and minimise any potential cancellation of operations. — COO

The Board of Directors **NOTED** the 28 May and 25 June 2024 Q&SC Chair Assurance Report.

24/049.2 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The NED/P&CC Chair/FPC member reported on the following key issues:

- Trust submitted its annual accounts on time that year, thanks to the Finance team and all staff in achieving this;
- Support from PricewaterhouseCoopers (PwC) in identifying efficiency savings and the work around financial grip and control, now within transition to ensure processes were embedded and continued to be taken forward by the Trust's staff;
- Important for the Trust to have in place a long term financial plan on how it would achieve financial stability in the future, and working towards achieving breakeven position in future years.

The Board of Directors **NOTED** the 31 May and 25 June 2024 FPC Chair Assurance Reports.

24/049.3 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

The P&CC Chair reported on the following key points:

- Positive improvement with recruitment of staff, especially ED consultants (increased from four to ten at QEQM);
- Continued focus on compliance against appraisal rates and training, a further report on progress to be provided in a few months;
- Verbal update received on Equality, Diversity and Inclusion (EDI) and written report to be presented in October covering visibility of the work being embedded throughout the organisation;
- At the meeting held the previous day a deep dive into the people plans within the Care Groups, with the development of dashboard metrics for leads to monitor progress of staff engagement and delivery to improve the staff survey response rate;
- Generally seeing improvements whilst recognising the work ongoing and still much more work to be done that would take time to embed.

The Board of Directors **NOTED** the 26 June 2024 P&CC Chair Assurance Report, and the verbal update from the 24 June 2024 P&CC meeting.

24/049.4 **CHARITABLE FUNDS COMMITTEE (CFC) CHAIR ASSURANCE REPORT**

The CFC Chair reported on the following key points:

- Charity team continued to do a great job with a very small team resource, working closely with the individual hospital League of Friends;
- Charity on track against its plan to achieve its £1m income target that year.

The Associate NED raised the really good news in approval to fund dialysis machines and enquired how many the £90k would fund. The CFC Chair confirmed funding for a total of six machines, with the aim to combine funding with that from the Trust's capital programme to utilise purchasing opportunities and purchase a total of 12 machines.

The Board of Directors **NOTED** the 11 July 2024 CFC Chair Assurance Report.

24/050 **CARE QUALITY COMMISSION (CQC) UPDATE REPORT**

The DQG highlighted the following key elements:

- Anticipated the historical Must and Should Do requirements would be completed by the end of December 2024;
- The maternity Should Do requirement relating to the estate/environment including a second obstetrics theatre at QEQM remained open. It was not expected to be able to close this until April 2025;
- A clear plan in place to address the medical and nursing staff having access to resus training needed for their roles;
- Third check and challenge meeting held that week (Kent and Canterbury Hospital site) around embedding the new CQC self-assessment programme, well received and good preparation for staff.

The Acting Chairman asked why it had taken so long to resolve and close the Must and Should do improvement requirements following the inspection. The DQG stated was confident these would be resolved and that quarterly update reports would continue to be presented to the BoD. The Acting Chairman requested more frequent reports be presented to ensure oversight of progress and to receive reports at each of the bi-monthly meetings. It was noted more regular updates were provided to the Clinical Executive Management Group (CEMG) and Q&SC.

ACTION: Present progress update CQC reports to the BoD at each of the bi-monthly meetings (increasing frequency from quarterly) to ensure oversight of progress to close the Must and Should do requirements. DQG

The Acting Chairman asked for a summary briefing to be produced and circulated to Board members detailing the overdue Must and Should Do requirements, with a timeframe of when these would be resolved, along with an explanation of any associated challenges that could impact delay with these being completed.

ACTION: Produce and circulate to Board members a summary briefing detailing overdue Must and Should Do requirements, with a timeframe of when these would be resolved, along with an explanation of any associated challenges potentially impacting delay with these being completed. DQG

The Associate NED enquired whether the Trust was being sufficiently innovative in respect of looking at how it could recruit to hard to recruit consultant roles, ensured

it recruited talented staff, and what other routes had been explored. The CMO reported the Trust was exploring opportunities for staff within the Trust as well as internationally, and recognised it needed to be more innovative to address vacancies particularly at WHH.

The Board of Directors received and **NOTED** the CQC update report and the assurance provided in relation to progress with inspection action plans, query management, surgery quality visits, and the self-assessment and Check and Challenge meeting programme.

24/051 **CULTURE AND LEADERSHIP PROGRAMME (CLP) UPDATE**

The CSPO highlighted the following key points:

- CLP and action plan provided a clear vision for all staff working towards this, work aligned to that being taking forward with the staff survey to support improving the response rate and score;
- Following feedback from staff, having rapid actions against a timeframe for the next six, 12 and 18 months. It had also been raised inconsistencies across the organisation in respect of how leaders approached management of staff, with work underway developing a management induction programme for all leaders, with the expectation of piloting rollout of training sessions in September;
- Taking forward the formation of a new Staff Council, providing an additional avenue for staff voices to be heard, ensuring continued staff engagement and involvement, being supported by the DCG and CLP team;
- New annual staff awards event organised to be held September/October 2024, with currently around 129 nominations received across a range of categories for staff and teams.

The CSPO emphasised it was important to ensure staff received feedback, particularly providing an explanation of the reasons why action was not able to be taken for any issues raised.

The NEDs highlighted the need to ensure consistency in respect of all areas having regular team meetings (providing another mechanism for feedback) as staff had reported this was not happening across all areas, and enquired how this would be monitored. The CSPO confirmed this was incorporated within the management programme being developed as part of getting back to basics, leaders would be challenged that they were living the values of the programme, with an evaluation to be undertaken following its implementation. There was also an element of empowering staff to speak up and raise any concern around leadership if not meeting the programme.

The Acting Chairman reiterated the commitment of all Board members in supporting and being part of the CLP, and what more the NEDs could do to restore trust, and what in practical terms they could do in taking this programme forward. It was suggested a method for feedback be created for NEDs to provide issues raised by staff during site visits that require to be considered and addressed, for dissemination to the appropriate leadership within the organisation for action, and to provide feedback to the staff.

ACTION: Develop a method for feedback for NEDs to provide issues raised by staff during site visits that require to be addressed, for dissemination to the — DCG

appropriate leadership within the organisation for action, and to provide feedback to staff on the issues they had raised.

The COO raised the two red rated areas in the action plan related to Admin & Clerical listening actions, the new local induction implementation, and when these ratings would be improved. The CPO commented that immediate improvements could not be delivered and agreed to confirm an expected improvement timeline.

ACTION: Confirm the timeline for an improved rating for the two red rated areas in the action plan for Admin & Clerical listening actions, and the new local induction implementation. CPO

The Board of Directors **NOTED** the CLP update report, the progress to date and continued to support the programme.

24/052 **WOMEN'S CARE GROUP MATERNITY AND NEONATAL ASSURANCE GROUP (MNAG) CHAIR'S REPORT**

The DoM highlighted the following key points:

- Restorative care being progressed as well as co-design, with external support. Feedback from the Maternity Safety Support Programme (MSSP) visit that day acknowledged the good work of the Trust, which had not been as far progressed at a national level and the work of the Trust would be shown as a positive example;
- Trust had developed a scorecard allowing it to look at and analyse ethnicity and deprivation data;
- Initiatives supporting recruitment, included staff career cafes around opportunities for career development and training, as well as recruitment video;
- Clinical Negligence Scheme for Trusts (CNST) compliance, with 100% of qualifying cases reported to Maternity and Newborn Safety Investigations (MNSI);
- Midwifery workforce: midwifery co-ordinators had maintained supernumerary status and provision of 1:1 care in labour;
- PRactical Obstetric Multi-Professional Training (PROMPT) compliance was at 97.5% for all staff groups and 100% for anaesthetic doctors. Compliance for Newborn Life Support (NLS) training had fallen below 90% overall, obstetric doctors currently at 78.8% and would be meeting with clinicians to obtain assurance that the revised trajectory of 91% would be achieved by the end of July 2024;
- Maternity claims: reporting now demonstrated linking with the Maternity Patient Safety Incident Response Framework (PSIRF) plan around learning and alignment with the Maternity and Neonatal Improvement Programme (MNIP). Claims were low value and main area covered mental health/psychiatric injury and stress;
- Trust undertaking a neonatal deaths (NND) review for the period 1 April 2023 to 31 March 2024, that also included three in May 2024. Trust reporting lower than the national comparator, although nationally had seen an increase in deaths, locally there had been an increase and an independent review would be undertaken. The ICB, Region and CQC had been informed of this review. Expectation review to be completed within about 12 weeks, the findings, learning, and any recommendations would be shared with the BoD hopefully at its October meeting;

- Continued focus encouraging staff to speak up, that feedback and any concerns raised were acted upon;
- Trust was looking at an interim solution in respect of the 2nd theatre at QEQM.

The NEDs commented it had been almost two years since publication of the Independent Investigation into East Kent Maternity Services (IIEKMS) report and enquired whether the restorative work with families could be done more at pace. The DoM commented this work needed to be right and was working with and listening to families, who had fedback their request that the process was right and was progressing at the appropriate pace.

The Associate NED congratulated the team on achieving 100% PROMPT compliance, and enquired whether staff received ongoing simulation training. The DoM reported PROMPT was an annual requirement, with additional simulation training provision across each of the hospital sites, as well as weekly and monthly ad-hoc drills undertaken, with attendance logs recorded.

The Board of Directors discussed and **NOTED** the MNAG Chair Assurance Report.

24/053 **PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) FOR 2024/2025**

The Board of Directors **NOTED** the updated PSIRF Policy and Plan presented for information, noting this had been approved by the K&M ICB, ratified through the Policy Authorisation Group (PAG), and previously approved by the BoD.

24/054 **ANY OTHER BUSINESS**

There were no other items of business raised.

24/055 **QUESTIONS FROM THE PUBLIC**

The Chairman reported no questions had been received in advance of the meeting.

The Chair closed the meeting at 3.45 pm.

Date of next meeting: Thursday 3 October 2024.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Matters Arising from the Minutes on 25 July 2024**

Meeting date: **3 October 2024**

Board sponsor: **Acting Chairman**

Paper Author: **Board Support Secretary**

Appendices:

Appendix: Queen Elizabeth the Queen Mother Hospital (QEQM) & William Harvey Hospital (WHH) Emergency Department (ED) Expansion After-Action Review executive summary report

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The Board is required to be updated on progress of open actions and to approve the closing of implemented actions.
Summary of key issues:	An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales. The Board is asked to note the updates on the action log.
Key recommendations:	The Board of Directors is asked to **NOTE** the action log, **NOTE** the updates on actions, **NOTE** the actions for future Board meetings, and **APPROVE** the four actions recommended for closure.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	None
Link to the Corporate Risk Register (CRR):	None
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: None

MATTERS ARISING FROM THE MINUTES ON 25 JULY 2024

1. Purpose of the report

1.1. The Board is required to be updated on progress of open actions and to approve the closing of implemented actions.

2. Background

2.1. An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales.

2.2. The Board is asked to note the updates on the action log as noted below:

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/17/22	Amend the IAGC Terms of Reference (ToR) reflecting the substitute Board Committee member attendance if Committee Chair was unable to attend an IAGC meeting. The ToR will be re-reviewed following completion of the Good Governance Institute (GGI) Governance Review.	~~Oct-23~~/ ~~Jun-24~~/ ~~Jul-24~~/ Oct-24	Integrated Audit and Governance Committee (IAGC) Chair/ Director of Corporate Governance (DCG)	Open	Board Committee ToR will be reviewed by the DCG following the recommendations of the GGI Governance Review. Item for future Board meeting.
B/06/23	01.06.23 - On completion of the ED works review the UEC services, front door patient pathways, management of patients, and patient flow to develop a sustainable Trust strategy. 05.10.23 - Provide a progress update in December 2023 on progress in respect of redesigning patient pathways at the front door, management of these patients, and patient flow.	~~Dec-23~~/ ~~Feb-24~~/ ~~Jun-24~~/ ~~Jul-24~~/ Oct-24	Chief Operating Officer (COO)	Open	**01.02.24 -** Trust would be looking at and reviewing the front door services to redesign patient pathways through ED, ensuring these were simplified and less complicated to benefit the care and experience of patients, as well as supporting staff to manage demand. A further update would be provided at a future Board meeting. **04.04.24 –** The Trust is reviewing and resetting patient pathways across the Trust. An update will come to Board when available.
B/33/23	Present an update to the Board on progress monitoring the gap	~~Jun-24~~/ ~~Jul-24~~/ ~~Oct-24~~/ Dec-24	Chief People Officer (CPO)	Open	**06.06.24 -** Initial principles implemented with training sessions provided, information available for staff on the Trust's

	analysis, action plan, work needed and any additional support to enable implementation of the ten Sexual Safety in Healthcare - Organisational Charter commitments.				staff intranet, liaising with other Trusts in respect of training best practice. Development of a specific policy around sexual safety and speaking up, and accessing support. Lead Freedom to Speak Up Guardian working on a paper to be presented to the July 2024 Board meeting. **July 2024 -** Update on Sexual Safety will be included in the regular six monthly Freedom to Speak Up (FTSU) report due to be presented to the October 2024 Board meeting, deferred to December 2024. **September 2024 -** The FTSU Team is experiencing a high number of absences. As a result, interim measures have been put in place to maintain the service by the Executive Team acting through the CPO as a priority. There is also a project to consider partnership working to ensure resilience and reliability of the service. This is being considered with the involvement of all key stakeholders. In the interim, the CPO will continue to report to the P&CC and to the Chair recognising this is a priority for the Board. This is also now a Significant Risk for the Trust.
B/02/24	Share lessons learnt review on the WHH and QEQM EDs expansion builds for information.	~~Jun-24~~/ ~~Jul-24~~/ Oct-24	Chief Strategy and Partnerships Officer (CSPO)	To Close	**06.06.24 -** Review not yet concluded and report to be presented once completed. **25.07.24 -** Review concluded for WHH, QEQM to be completed by the end of July, report to be presented to the October 2024 BoD meeting. **03.10.24 –** QEQM & WHH ED Expansion After-Action Review executive summary report presented to 03.10.24 Board meeting (attached to matters arising report - Appendix 12). **Action for agreement for closure at 03.10.24 Board meeting.**
B/03/24	Present the Annual PALS report to the ~~June/~~July 2024 Board of Directors meeting.	~~Jun-24~~/ ~~Jul-24~~/ Oct-24	Chief Nursing & Midwifery Officer (CNMO)	To Close	**July 2024 -** Report being presented through internal governance process to the Patient Experience Committee, Quality & Safety Committee, then to the BoD. **03.10.24** - Complaints, PALS and Compliments Annual Report 2023 - 2024 presented to 03.10.24 Board meeting. **Action for agreement for closure at 03.10.24 Board meeting.**

B/09/24	Next PV&I Annual Report for 2024-25 to include statistics and data on how feedback from patients was being provided shown as a pie chart.	Jun-25	CNMO	Open	Item for future Board meeting.
B/10/24	Provide an update on the action and what was being done to address incidents of assaults on staff ensuring staff were protected and supported.	~~Jul-24~~/ ~~Oct-24~~/ Dec-24	CSPO	Open	**25.07.24 -** Wider review being undertaken of the security service provision, and the Trust's requirements around the specification of this service as well as staff training provision. This is around mitigating actions to keep staff safe. Report to be presented following this review towards the end of the year.
B/12/24	Circulate the NHS K&M ICB Strategy 2024/25 – 2029/30 once available to Board members for review ahead of a Board discussion.	Aug-24	CE	To Close	2024/25 - 2029/30 Strategy presented and discussed at 05.09.24 Board Development Strategy Session. **Action for agreement for closure at 03.10.24 Board meeting.**
B/13/24	Provide an update on the Hospital Standardised Mortality Ratio (HSMR) reporting numbers in response to seeking clarification about the increase in numbers. To confirm whether this was due to ongoing data submission issues, whether the definitions of the groups reviewed and reported that were changing had already been implemented, or whether action to review the reasons for the increase was needed.	Oct-24	CMO	Open	Assurance briefing on changes to HSMR circulated to Board members (Appendix 11). **Action for agreement for closure at 03.10.24 Board meeting.**
B/14/24	Provide an update at the next meeting on the outcome of the meeting in August to discuss the issues about the holes in equipment wraps, review of the procedures by the outsourced provider, and agreed actions to address and	Oct-24	COO	Open	Verbal update to be presented at 03.10.24 Board meeting.

	resolve this and minimise any potential cancellation of operations.				
B/15/24	Present progress update CQC reports to the BoD at each of the bi-monthly meetings (increasing frequency from quarterly) to ensure oversight of progress to close the Must and Should do requirements.	Oct-24	Director of Quality Governance (DQG)	Open	The Quality and Safety Committee received a full update report on 24 September. In summary there are 12 Must Do (out of 28) and 7 Should Do (out of 25) requirements that remain open (some requirements feature on multiple action plans). The number of open actions related to each Must and Should Do is shown in the table below. There is a total of 32 out of 206 actions open across all action plans. Of these 32 open actions, 28 are expected to close by 30 October and 4 are expected to close by 31 December 2024.
B/16/24	Produce and circulate to Board members a summary briefing detailing overdue Must and Should Do requirements, with a timeframe of when these would be resolved, along with an explanation of any associated challenges potentially impacting delay with these being completed.	Oct-24	DQG	Open	As update noted above in action B/15/24. The number of open actions related to each Must and Should Do is shown in the table below.

OPEN REQUIREMENTS AND ACTIONS

Action plan	Open Must Do Requirements	Open Should Do Requirements	Total number of actions on plan (29/01/24)	Number of open actions (09/07/24)	Number of open actions (03/09/24)
Well led	0 of 4 (0%)	4 of 8 (50%)	56	15	
2gether	0 of 4 (0%)	N/A	7	3	
QEQM UEAM	3 of 6 (50%)	0 of 3 (0%)	26	14	
QEQM GM	4 of 7 (57%)	1 of 5 (20%)	26	14	
WHH GM	2 of 8 (25%)	0 of 4 (0%)	33	16	
WHH UEAM	2 of 4 (50%)	0 of 2 (0%)	13	2	

East Kent Hospitals University NHS Foundation Trust

WCYP	1 of 11 (9%)	1 of 9 (11%)	28	12	
DCB	1 of 11 (9%)	1 of 1 (100%)	12	4	
Corporate	3 of 4 (75%)	1 of 1 (100%)	5	5	
TOTAL			**206**	**79 (38%)**	**32 (15%)**

B/17/24	Develop a method for feedback for NEDs to provide issues raised by staff during site visits that require to be addressed, for dissemination to the appropriate leadership within the organisation for action, and to provide feedback to staff on the issues they had raised.	Oct-24	DCG	Open	Verbal update to be presented at 03.10.24 Board meeting.
B/18/24	Confirm the timeline for an improved rating for the two red rated areas in the action plan for Admin & Clerical listening actions, and the new local induction implementation.	Oct-24	CPO	Open	We have not yet seen a list of actions but know that the group is now meeting on a quarterly basis. The Chief Operating Officer (COO) is scheduled to come to the next CLP steering group for an update and clarity on this point. The local induction remains red with a new date for delivery for end of October 2024.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL (QEQM) & WILLIAM HARVEY HOSPITAL (WHH) EMERGENCY DEPARTMENT (ED) EXPANSION AFTER-ACTION REVIEW

Meeting date: 3 October 2024

Board sponsor: Chief Strategy and Partnerships Officer (CSPO)

Paper Author: Senior Strategic Development Manager

Appendices:

None

Executive summary:

Action required:	**For Information**
Purpose of the Report:	This report summarises the findings and recommendations from an extensive after-action review that was conducted following the identification of a number of issues, both perceived and real, relating to the QEQM & WHH ED expansions. The report aims to investigated both good practice and areas that need improvement, to ensure that the processes and working practices improve all future large capital projects.
Summary of key issues:	• There was good practice that needs to be continued and embedded into future projects. • The elements for improvement are often areas where there are multiple stakeholders and where engagement needs to be improved. • Appropriate resource needs to be dedicated to the project from a clinical and operational end-user perspective. • Internal communication between different functions within 2gether Support Solutions (2gether) have not improved and in some cases, deteriorated. • Large capital projects need consistent and engaged Senior Responsible Owners (SROs)/Executive Sponsors to give appropriate oversight, governance and support to overcome complex problems. • Overall, the end-users are extremely pleased with the end products and the environments that have been created for patients and staff.
Key recommendations:	The report contains a number of recommendations that the Trust should ensure are adopted. An overarching group will be established that will track the progress and implementation of these recommendations, and ensure that they are embedded into all future build processes.

We care

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Implications:

Links to Strategic Theme:	This report aims to support: • Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	N/A
Resource:	Y
Legal and regulatory:	N
Subsidiary:	Y – The Trust and 2gether need to work together to implement the recommendations.

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

QEQM & WHH ED EXPANSION AFTER-ACTION REVIEW

1. Purpose of the report

1.1 This extensive after-action review was conducted following the identification of a number of issues, both perceived and real, were raised relating to the QEQM & WHH ED expansions. The report aims to investigated both good practice and areas that need improvement, to ensure that the processes and working practices improve all future large capital projects.

2. Background

2.1 The primary driver of the risks and issues across the ED expansions across the QEQM and WHH was the central expectation and what the Trust signed-up to deliver to secure the funding. An additional factor, which given more time could have been mitigated, is that all the design and the vast majority of the build took place during the COVID-19 pandemic, which restricted the teams in previously unexperienced ways.

2.2 However, feedback from subsequent NHS England (NHSE) visits has highlighted how they have been impressed by the scope and final product of the build, especially highlighting how much was delivered for the money given. NHSE has already changed how it allocates money, to set more realistic expectations, following a review of the 28 ED projects across the country that were given emergency funding during COVID-19. The two EKHUFT schemes were part of this and form the basis of a case study for the review.

2.3 Towards the end of the project, in March 2023, an initial information gathering exercise for the after-action review was performed to ensure that due to the length of the project certain things we would want to learn would not get lost. This after-action review met with every function across the two sites and within the project team, totalling fifteen workshops across six months. Notes of these workshops were taken and returned back to the participants for agreement. These notes were amalgamated and then summarised for this after-action review. In addition to this, a document was created to show what each ED used to look like, what facilities it had and what the footprint used to be, compared to what was created as part of the project.

2.4 When attending these sessions, and subsequently reviewing the notes, it was clear that the 2gether functions did not share a vision, take joint organisational responsibility or engage adequately in the capital project, across all the different 2gether functions. Part of this will be down to the complexity and accelerated timelines of the project, however, there are long-standing challenges between the functions which seem to have deteriorated and have not been addressed.

2.5 Generally speaking, the Care Groups are extremely pleased with the outcome of the project, particularly at the QEQM. The environment for patients and staff has improved dramatically. However, the teams felt that the support across the project from the site management and executive team was not sufficient and that certain decisions on the function and layout of the

departments were imposed upon them. There was a general and consistent theme throughout the sessions that the many changes in senior management across the three-year period at both site management and executive level, contributed towards a lack of consistency and effective decision-making. Only one executive regularly attended governance meetings or was visible at handovers across the three-year period on what was, and still is, the largest capital project the Trust has undertaken. The perception of all the above was particularly demonstrated by there being no celebration at the end of the project by the Trust for all the extra work and hardship the teams endured over a period of years.

2.6 While some of these recommendations will be implemented naturally as certain functions always look to make improvements, not all of them will and some are long-standing issues. The recommendations within this paper are not the sole solution to meet the goals set out, and therefore flexibility should be given to people to find alternatives and improve on the recommendations. As a result of this report, an overarching group will be established that will track the progress and implementation of these recommendations, and ensure that they are embedded into all future build processes.

3. Recommendation Summary:

3.1 The recommendations highlighted here are a mixture of things that the project did well, did not do so well and did not do at all. The aim of this after-action review is not just to focus on the processes that did not work but to also point out good practice and to highlight this as something that needs to continue.

3.2 NHSE Collaboration

3.2.1 The following key impacts were a direct result of the unrealistic central expectation of what could be delivered within the required timescales and what the Trust signed-up to:

- **Project Planning and Design**: The lack of time for adequate planning and design resulted in unrealistic initial programs, a lack of clarity regarding scope and risks, and an inadequate assessment of existing infrastructure.
- **Contractual Agreements**: The accelerated timeline forced the projects to enter into contracts that placed the majority of the financial risk onto the Trust.

This could be addressed by:

- **Explicitly Articulate the Risks of Accelerated Timelines**: Business cases should explicitly detail the risks associated with accelerated timelines and set realistic expectations with funding bodies regarding potential cost overruns and program delays.
- **Develop a Costed Risk Register**: A costed risk register should be created to illustrate the potential financial impact of project uncertainties.
- **Transparency and Early Warnings**: Concerns should be raised early and transparently with funding bodies, to demonstrate that there is understanding and control over projects.

3.2.2 However, there are long-standing issues and improvements that fall outside of the main drivers which need to be addressed. There is also good practice that needs to be taken forward to other projects. These recommendations have been themed to different areas and different points along the lifecycle of a project.

3.2.3 Finally, the recommendations listed below were followed during the project in some cases, but are listed below as good practice regardless of whether it was achieved in the project or not. The main body of the report explains which areas were better or worse at achieving them, which should be reviewed when trying to ensure the recommendations are being met on future projects.

3.3 Project Planning, Scope, and Risk Management

3.3.1 The likely difficulty and relative success of a project can be determined right from the outset. How a project is planned, as well as the scope and approach to risk management, is instrumental for the rest of the scheme.

3.3.2 The Trust and 2gether need to adhere to set principles and avoid common pitfalls to large capital projects:

- **Feasibility**: The physical location, refurbishment or new build, construction method, existing services and estate are all important factors to consider when deciding the preferred option of a project. All of these will dictate the difficulty and likely pitfalls for the rest of the scheme.
- **Early and Two-Way Engagement**: All relevant functions such as Estates, IT, Facilities and clinical leads should be actively involved from project inception to ensure comprehensive input and minimize downstream issues. There should also be clearly defined clinical leadership time and end user project management resource allocated to the project.
- **Produce a Project Estates Risk Register**: A design risk register should be created and actively maintained with input from various departments, to highlight existing issues in areas where new capital projects interact with, or refurbish, existing estates.
- **Define Scope Explicitly**: Project scope, including backlog maintenance and critical infrastructure addressed, should be clearly defined and agreed upon by all parties at the outset.
- **Develop an Equipment Strategy**: Early in the project lifecycle, an equipment strategy should be formulated that itemizes large medical devices and allocates a provisional sum for furniture and other miscellaneous items. This strategy should be reviewed and signed off by Procurement. If procuring equipment in advance in order to meet capital expenditure targets is unavoidable, additional funds should be allocated or the equipment budget should be adjusted, to cover suitable storage costs.
- **Contractor Performance and Procurement**: There was inconsistent performance, site management, and quality of work between contractors. When procuring contractors, the contractors past performance should be considered in an appropriate way.

3.4 Project Governance and Structure

3.4.1. While elements of the project were audited and deemed to be well documented, there are some areas which could have been improved. The Trust did not fund dedicated roles to support a

£30m project across two sites, and therefore did not have a full-time end-user project manager or clinical lead for the duration of the project. The Trust either needs to fund these posts centrally outside of the care group structure through revenue or find a way of capitalising these roles into the project in line with all the build project management structure.

- **Adhere to Capital Project Governance Guidance**: Strictly follow established guidance on capital project governance with appointed dedicated roles, such as the end-user project manager and clinical lead, ensuring the project team understands the reporting structure and escalation routes for raising concerns.
- **Define Clinical Lead Responsibilities**: Clearly define the roles and responsibilities of the clinical lead, emphasising design input over build process involvement, and provide dedicated time for them to contribute effectively.
- **Consider a Dedicated Digital Lead**: For projects with significant technical and digital components, appoint a digital lead with broader responsibility for all technical aspects beyond IT.
- **Clearly Defined Roles & Responsibilities:** Large capital projects are complex and can involve several different types of project managers, which can be confusing for people not experienced in build work.
- **Create and Distribute a Project Structure Chart**: Develop and circulate a clear one-page structure chart outlining project roles, responsibilities, and contact information to all stakeholders, including those not directly involved in governance meetings.
- **Record and Document Agreements**: Formalise all agreements, requests, and decisions made during the project lifecycle through written documentation and signatures.
- **Utilise a Centralized Communication Plan**: Implement a centralized and regularly updated communication plan, accessible to all stakeholders, outlining communication channels, frequency, and responsible parties for disseminating information.
- **Wider Access to Design Drawings**: Provide broader access to the most up-to-date design drawings for all stakeholders affected by the capital project.
- **Value Engineering Sign-Off**: Any proposed value engineering changes, once an initial design is agreed upon, must be reviewed and signed off by all stakeholders who would be impacted, ensuring awareness of the proposal and potential consequences.
- **Clearly State Derogations**: When a project involves "light" or "medium" touch refurbishment areas with minimal changes, the project team must explicitly state any derogations from national and local standards (technical or clinical).
- **Secure Sign-Off on Derogations**: Ensure all derogations from standards are formally signed off by the Senior Responsible Owner (SRO) in conjunction with 2gether and relevant functions.
- **Contract Variation:** Towards the end of the scheme, a committee was created to sign-off any changes that would cost above and beyond what was budgeted. This process was useful to get fast and effective decisions, even if the majority of the decisions had little scope for declining – the process still provided clear visibility.
- **Sign-off and Recorded Signatures:** In every capital project it is a requirement to have the end-users physically sign the agreed drawings. This was followed for the ED expansion but it would be beneficial to include all end-user representatives and not just the clinical team.

- **Regular Catch-up Meetings**: Throughout the scheme, both sites had a weekly catch-up meeting involving representatives from the various different functions needed, to agree and work around a large build in a complex area.
- **Warranties & Extended Warranties:** Some warranties are purchased through the project and some are not. These items under warranty often need to be maintained in specific ways to ensure the warranty is valid. There should be greater ownership in advance of the warranties by the appropriate parties.

3.5 Design Process and Engagement

3.5.1 The design of a scheme is really important because any changes made further into the process take longer and are likely to cost more. This can be time consuming and create a lot of work for various functions within the project, when maintenance of the programme timeline is already challenging. While this particular scheme was under pressure to deliver quickly, which impaired the design process, there are things that worked well, as well as things that can be put in place which would make future projects quicker and easier.

- **Comprehensive Design Manual**: Updated design manuals should include standards for various elements such as doors, equipment, and technical specifications to ensure consistency and maintainability.
- **Have Design Workshops for Each Function**: Ensure functions attend design workshops and require them to sign-off the drawings and contribute to standardising these spaces in the design manual.
- **Share Door Schedules with Estates Locksmith**: Share finalised door schedules with the Estates locksmith to ensure that they have the necessary access and reduce the number of keys required.
- **Early Authorising Engineer Involvement**: Embed authorising engineers early in the design process to advise on interactions with existing systems, ensure compliance, and prevent issues arising from inaccurate record drawings.
- **Review and Approve Designs for Existing System Integration**: Mandate that designs involving connections to existing systems, such as steam lines, undergo verification by professionals familiar with the site and its systems, to ensure accuracy and prevent potential problems.
- **Designate a Server Room Location**: Establish a policy to locate all future server rooms in secure internal areas, avoiding roof installations (even with additional security protocols), to mitigate risks and ensure long-term viability.
- **Security & Access Control**: While the camera locations on the ED build were based on expert security input, the access control was decided by the clinical and operational team.

3.6 Build Process and Site Management

3.6.1 This is what happens during the build and on the construction site. Overall, this project had an excellent health and safety record. This is particularly impressive given that the project lasted for three years and involved consistent building works in areas adjacent to patients, lots of interaction with existing areas and shut-off periods, and joint access corridors to building sites that were deep inside departments.

- **Develop a Comprehensive Construction Manual**: Create a detailed construction manual outlining the standards and expectations for contractors, including site security protocols, dust control measures, noise monitoring requirements and minimum timescales for submitting risk assessments and method statements (RAMS).
- **Specify Approved Sub-Contractors**: In the construction manual or design manual, either specify a list of approved sub-contractors or outline stringent criteria and quality standards for sub-contractor selection, to ensure satisfactory workmanship and minimize reliance on unreliable or banned companies.
- **Account for Building Condition in Contractor Entrances**: When planning contractor access points, thoroughly assess the existing building's condition to anticipate potential damage from heavy equipment and allocate contingency funds for restoration if necessary.
- **Formalise Out-of-Hours Contact Procedures**: Establish a formal on-call system for project-related emergencies outside of regular working hours, clearly outlining the contractor's responsibilities and contact information in the project contract.
- **Design Co-ordinator or M&E Co-ordinator:** Every contractor works differently and has a different working culture. What proved very useful was having some sort of design co-ordinator on site to ensure complex designs are brought together in the correct way.

3.7 Implementation and Handover

3.7.1 This is the transition period where a project area stops becoming a building site and becomes a clinical area. Moving from one to the other relies on certain activities happening in a specific order and is therefore prone to delays. This is hard to plan for and requires longer transition periods to be set in future programmes, to account for any unforeseen problems.

- **Thorough Handover Processes**: Formal handover procedures with clear and unambiguous language and meaning, including sign-offs from all relevant stakeholders, are necessary to guarantee a smooth transition to operational use and identify any outstanding issues.
- **Timely Provision of Asset Lists and OEM Manuals**: Ensure timely provision of comprehensive asset lists, including 2gether tags on all equipment, and original equipment manufacturer (OEM) manuals to Estates before clinical occupation, to facilitate asset management and maintenance.
- **Address Delays in Equipment & Furniture Deliveries**: Improve the procurement delivery process for equipment and furniture stored off-site, minimising delays, itemised storage and delivery receipts, and reducing the number of lost items.
- **Provide Adequate Notice for Facilities Cleaning**: Provide the Facilities team with sufficient notice of handover dates for cleaning and ensure that areas are completely finished, including snag resolution, before cleaning commences to avoid redundant work and resource allocation as well as duplication.
- **Develop End-User Handbooks**: Create user-friendly handbooks or digital guides for staff occupying new areas that provide information on equipment operation, maintenance procedures, and safety protocols, minimising misuse and potential damage.
- **Regular Catch-up Meetings**: Throughout the scheme both sites had a weekly catch-up meeting involving representatives from the various different functions needed, to agree and work around a large build in a complex area. For refurbishments and complex builds this

was helpful to ensure that as many stakeholders as possible were involved and knew what was planned for the week. Regardless of complexity, these types of meetings will be useful and could be flexible on the frequency as needed.

4 Conclusion

4.1 There are pockets of good practice throughout the scheme, but also long-standing issues between functions that have not been addressed. These functions were particularly within 2gether, but the problems also preceded the creation of 2gether. There is limited consistent structure and good practice from the Trust that is applied from project to project. Previously this was provided by the capital projects team being within the Trust, but since the creation of 2gether this does not work in the same way. All of these relationship and cultural issues would have been picked up if there was an appropriate, engaged and consistent SRO for the project.

4.2 As a result of this report, an overarching group will be established that will track the progress and implementation of these recommendations, and ensure that they are embedded into all future build processes. While some of these recommendations will be implemented naturally as certain functions always look to make improvements, not all of them will and some are long-standing issues. The recommendations within this paper are not the sole solution to meet the goals set out and therefore flexibility should be given to people to find alternatives and improve on the recommendations.

East Kent Hospitals University NHS Foundation Trust

CHAIRMAN'S REPORT October 2024

My report should be read alongside Tracey's Chief Executive Officer (CEO) report providing an overall assessment of the Trust's operational performance and the Committee Chairs' reports providing assurance.

Opening remarks

I want to start by thanking East Kent's members for joining our Annual Members' Meeting at the Queen Elizabeth the Queen Mother Hospital (QEQM) on 5 September. Members of the public successfully found their way to the depths of our Education Centre from where we streamed the meeting online. Tracey, Tim Glenn (Interim Chief Finance Officer (CFO)) and Bernie Mayall (our Lead Governor) joined me on the platform and we presented our Annual Report and Accounts and gave a snapshot from the Trust over the last year. As always it was a good discussion and our members asked probing, helpful questions. This is a vital part of our engagement with members of our community and we are grateful to you for taking the time to show interest in the work of our Trust and our continuing journey to improve. It was important for us to highlight the range of activity of all of our colleagues and I was particularly taken by these numbers which demonstrate the scale of our services delivered in 2023/2024:

One of the privileges of my position is my responsibility as the Trust's Maternity Safety Champion. I wore this hat on extended visits to QEQM and William Harvey Hospital (WHH). First of all, my thanks to staff and patients who spoke to me. I once again saw close-up the commitment of all those involved in our maternity services to ensure we are expert, inclusive and compassionate in our work. I was also hugely encouraged by the clear recognition by staff that there is still work to do. Whilst staff were extremely proud of the fact that during the last year they have carried out more than 4,000 follow-up calls to discuss people's experiences six

weeks after giving birth (under 'Your Voice is Heard' scheme launched in 2022), they also made the point that there was work to do to follow-up on feedback and make changes.

The summer months also saw a General Election and the start of a new Parliament with new MPs for East Kent. As our hospitals form a central part of the East Kent community I am pleased that the Trust initiated both a welcome to our MPs and briefings to inform them of the Trust's experiences and challenges.

Board changes
The Trust is well underway in its search for a new Chief People Officer (CPO) and Chief Operating Officer (COO) – both positions becoming vacant in the New Year. These are critical roles on the Board and great care is being taken to secure candidates with the skillset and values required by the Trust.

In other recruitment developments, I am delighted to say the Council of Governors has approved the appointment of a new Non-Executive Director to the Board. Details will be made public soon. In the interim, I want to thank the interview and stakeholder panels who participated in a very robust and thorough process resulting in an excellent new appointment to the Trust Board.

Board Governance
Our improvement journey in the key areas of Finance, Emergency Department Performance, Elective Waiting Lists and Cancer Treatment continues. I will defer to the information shared by Tracey and my Executive colleagues who will report on our operational and financial performance, save to say the trajectory continues to be an improving one.

The Board received a fascinating and extremely illuminating presentation from Kent County Council's Director of Public Health, Dr Anjan Ghosh, at our last Board Development session. Focused on 'Health Disparities in Coastal Communities of East Kent', Anjan described how our coastal communities have higher needs compared to non-coastal communities. In particular, adjusting for age, sex and deprivation, the prevalence of long-term conditions is higher in coastal communities. This speaks to the very particular pressures faced by a Trust such as East Kent where we have 350 miles of coastline. Such data and insight will be critical in the Trust formulating its strategy in the next six months.

We also heard from representatives of Kent's Health Care Partnership (HCP). A vitally important discussion recognising the need for a cross-sectoral and region-wide solutions.

Finally, as we are in Autumn, the work on the Trust's winter preparedness plans have progressed in earnest. They will form part of our next meeting but we are building on the experience and insight of previous years to have a sustainable and robust plan that flexes to the uncertainties of winter pressures we will inevitably face. We are working with regional and national partners to ensure a coordinated approach. With that in mind, it is important I close recognising the dedication and commitment of all of our staff as they build up to what will undoubtedly be a uncertain few months.

Acting Chairman
Stewart Baird

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Chief Executive's Report**

Meeting date: **3 October 2024**

Board sponsor: **Chief Executive**

Paper Author: **Chief Executive**

Appendices:

None

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	The Chief Executive provides a monthly report to the Board of Directors providing key updates from within the organisation, NHS England (NHSE), Department of Health and other key stakeholders.
Summary of key issues:	This report will include a summary of the Clinical Executive Management Group (CEMG) as well as other key activities.
Key recommendations:	The Board of Directors is requested to **DISCUSS** and **NOTE** the Chief Executive's report.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	The report links to the corporate and strategic risk registers.
Link to the Corporate Risk Register (CRR):	The report links to the corporate and strategic risk registers.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT

1. Purpose of the Report

The Chief Executive provides a monthly report to the Board of Directors providing key updates from within the organisation, NHS England (NHSE), Department of Health and other key stakeholders.

2. Background

This report will include a summary of the Clinical Executive Management Group (CEMG) as well as other key activities.

3. Clinical Executive Management Group (CEMG)

At meetings of the CEMG in August and September, the group approved a streamlined approach to the management of non-renal Reverse Osmosis (ROs) equipment across the Trust, with the effective management and oversight of the RO systems through a single point of contact and also ratified a pre-operative surgical skin preparation protocol for patients undergoing surgical procedures.

4. Operational update

The length of time patients are waiting to be seen continues to improve, however, as previously reported, we still have a long way to go.

Across all areas within the Trust, improvements are being made. At the end of August our Accident & Emergency (A&E) position was 77.4% with our Type 1 performance (for our sickest patients) 56.2%, the best reported position since June 2021.

At the end of August 2024, the Trust had 244 patients awaiting cancer treatment over 62 days. We have seen continued improvement with both the 28-day Faster Diagnostic and 62-day performance standards; the best reported position since December 2021.

The focus on reducing the number of patients waiting for an endoscopy across our surveillance, urgent and routine waiting lists continues. We have seen the backlog reduce from 13,350 at the start of January to 5,300 patients currently. Across all our other diagnostic areas, comprehensive recovery plans are in place and we are reporting our best compliance since July 2022. As with all areas, whilst this improvement is extremely positive, there is still as long way to go.

Efforts to mitigate long waiting times for planned treatments have also seen marked improvements. In January 2024, over 2,000 patients were at risk of exceeding the 78-week wait threshold; however, this number has now reduced to 32 at the end of August with the teams actively working on reducing those patients at risk of breaching 65-week waits in line with National expectations.

5. Continuation of tier 1 status for Elective, Cancer and Diagnostics

Following the latest review of elective and cancer performance and in agreement with the regional team, it was confirmed that the Trust will remain in Tier 1 for Elective, Cancer and Diagnostics from week commencing 29 July 2024.

This Tier 1 status will require the Trust to attend regular meetings with the NHSE team, focussed on progress and delivery of the national elective delivery ambitions and any actions associated with recovery.

Performance progress for Trusts in Tier 1 is reviewed regularly between relevant National and Regional NHS England (NHSE) teams, which includes a formal review on a quarterly basis, the outcome of which is formally ratified at the sub-board Quality and Performance Committee of NHSE.

6. National NHS Annual Staff Survey

The 2024 National NHS Annual Staff Survey launched on Monday 16 September at 09:30 am. This launch date maximised the survey window, giving the Trust the longest survey fieldwork duration of any NHS organisation in the country. A comprehensive delivery plan, approved by Board in July and fully resourced, is currently being enacted. This has been developed to maximise the opportunity for staff to share their feedback, whilst minimising the impact on service delivery.

Spanning an 11-week period, the timetable includes more activity than ever before. An example of this being ‘polling stations’, which will be taking place on every site, every week – with a total of 32 planned throughout the next 11 weeks. These polling stations will provide staff with access to the space and facilities they need to complete their survey, along with the support staff to enable them to do so, answering questions and attending to concerns.

At the end of the first week of fieldwork, 2,025 staff had responded to the survey, giving a 20% response rate, which is currently higher than all other NHS organisations in the country.

7. NHS Kent and Medway Integrated Care Board (ICB) health strategy

The Integrated Care Board has been leading a piece of work bringing together Primary Care, NHS Providers, and the ICB to develop a strategy for the population of Kent & Medway that will guide the way to equitable, sustainable and responsive healthcare. Using data from across the system, feedback form our patients, the public and stakeholders four strategic themes have been identified as the key areas of focus within healthcare. The four strategic themes are: (1) Patient experience, access and outcomes, (2) People, (3) Sustainable services and (4) Financial Sustainability.

Over the last three months all organisations in Kent and Medway have been working together to develop the areas of focus within each of the four strategic themes

including describing the vision, goals and plans for delivery across each area. These are in the process of being finalised following the extensive joint work that has been undertaken and it is expected that these will come to Board for final ratification and approval between November 2024 and January 2025.

8. EKHUFT Celebration Awards

To recognise the many great examples of staff improving how we deliver services to our patients, and support for each other, we have re-introduced an annual celebration of colleagues across the Trust.

More than 260 nominations were received for our EKHUFT Celebration Awards, launched in June this year. The judging panel has had the very difficult task of shortlisting the teams and individuals to attend a final awards event in October.

Members of the Executive team have delivered certificates of recognition to colleagues who were nominated. The nominations spanned a wide range of roles at different levels and in different services, both clinical and non-clinical, with fantastic examples of great care, compassion and innovation from our colleagues.

It is important that we find different ways to acknowledge this and having a Celebration Awards event provides another way for us to recognise each other and reward excellence.

We continue to share examples of great practice highlighted as a result of the nominations.

There are a host of other ways to appreciate our colleagues who go the extra mile all year round, including our Golden Hearts, Encouraging Praise in Colleagues (EPiC) awards, and recognition e-cards themed around the NHS People Promise.

9. Specialist Adult Allergy Clinic

A new specialist adult allergy clinic, the first of its like in Kent, was opened to primary care referrals on 10 September 2024 at the Kent and Canterbury hospital. Adults with a range of allergic conditions, including airborne, drug, venom and food allergies, will have access to local specialist care, having previously often had to travel for services in London, Surrey or Sussex.

The new clinic will offer a range of services including advanced diagnostic testing, individualised treatment plans, ongoing allergy management and will also focus on patient education and support, helping individuals understand and manage their allergies more effectively.

10. Dedicated unit for respiratory patients

A new day unit at the William Harvey Hospital is helping support patients with respiratory conditions. The Respiratory Assessment Day Unit (RADU) is a dedicated area for people to receive care and treatment for urgent lung conditions such as

asthma, chest infections or Chronic Obstructive Pulmonary Disease (COPD) and pleural diseases such as pleural effusion and pneumothorax, or collapsed lung.

It is the first time the Trust has had a specific unit for respiratory patients and allows people to be transferred from the hospital's emergency department or referred from other services for urgent care.

11. New MRI at Buckland Hospital, Community Diagnostics Centre (CDC)

As part of the Community Diagnostic Centre, Buckland Hospital in Dover welcomed the delivery of a state-of-the art MRI unit this month.

This unit represents the final phase of NHSE CDC Capital project funding for the Buckland site and supports realisation of the local Community Diagnostic vision through the delivery of a new static MRI.

12. National Inclusion Week

The Equality, Diversity & Inclusion (EDI) team and members of our staff networks held a series of events to showcase the initiatives and services that are available to staff and to highlight the importance of inclusion in the workplace and beyond as part of National Inclusion Week, which began on 23 September.

13. Annual Members Meeting

The Trust's 2023/24 Annual Members' Meeting, which brings together Board members, our lead governor, chair and members of the Board of Directors, was held at the Queen Elizabeth the Queen Mother Hospital (QEQM) on 5 September 2024, with patients, staff and members of the public invited to find out more about our work, the Trust's performance and our future plans.

I would like to thank all those who took the time to attend this meeting either face to face or online.

14. Executive Team update

I am pleased to announce that Angela Van Der Lem will be joining the Trust on 21 October 2024 as our substantive Chief Finance Officer. Angela's career has seen her lead a wide range of strategy, policy, finance and delivery teams, most recently at the Ministry of Defence where she held the opposition of Director of Finance for Defence Digital.

Angela will take over from Tim Glenn who joined the Trust in January on a one-year secondment from the Royal Papworth Hospital NHS Foundation Trust, to where he will return.

Rob Hodgkiss, the Trust's Chief Operating Officer, will also be leaving the Trust in the early 2025, having served just over one year in post. Recruitment is underway for both the Chief Operating Officer and Chief People Officer positions, with significant interest received.

I would like to take this opportunity to thank Tim and Rob for their commitment to East Kent throughout their time here.

15. Conclusion

The Board of Directors is requested to **DISCUSS** and **NOTE** the Chief Executive's report.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Integrated Performance Report (IPR)**

Meeting date: **3 October 2024**

Board sponsor: **Chief Strategy & Partnerships Officer (CSPO)/Interim Chief Finance Officer (CFO)**

Paper Author: **Chief Strategy & Partnerships Officer**

Appendices:

APPENDIX 1: August 2024 IPR

Executive summary:

Action required:	Discussion
Purpose of the Report:	The report provides the monthly update on the Integrated Improvement Plan (IIP), Operational Performance, Quality & Safety, Workforce, Financial & Maternity organisational metrics. The metrics are directly linked to the Strategic and Annual objectives. The reported metrics are derived from: 1. The Trust Integrated Improvement Plan 2. Other Statutory reporting 3. Other agreed key metrics.
Summary of key issues:	The IPR has been subject to a review and refresh and a revised format is being presented from May 2024 onwards. The reported metrics have been grouped to give a detailed view of progress against the quarterly milestones for the Integrated improvement plan alongside a summary view of metrics falling within each strategic theme. The attached IPR is now ordered into the following strategic themes: • **Integrated Improvement Plan (IIP).** • **Patients,** incorporating operational performance metrics. • **Quality and Safety (Q&S),** incorporating Q&S metrics. • **People,** incorporating people, leadership & culture metrics. • **Sustainability,** Incorporating finance and efficiency metrics. • **Maternity,** incorporating maternity specific metrics for quality and safety, Friends and Family Test (FFT) and engagement. Key performance points (July Reported Month): **Integrated Improvement Plan**

	• The number of patients with an in-hospital stay of more than 14 days remains below the Recovery Support Programme (RSP) trajectory for a fourth consecutive month. • 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 four months. • The financial efficiency programme, elective care long waiters and Type 1 four-hour Emergency Department (ED) 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. **Patients** • 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 Recovery, Treatment and Support (RTS) Team caseload >7 days not being delivered. • Overall a consistent reduction in 104 & 78 week breaches is in place with remaining challenges to demand seen in Gastroenterology & Otology. • Type 1 Compliance continues to exceed the tier 1 milestones in each month moving into quarter 2. **Quality & Safety** • Zero Serious Incidents (SIs) declared in the month. • Two never events reported in August. • FFT Satisfaction levels for Outpatients, Overdue Incidents, Adult Safeguarding and Venous thromboembolism (VTE) Screening Compliance are all demonstrating a statistical improvement. **People** • Sickness absence improved in August, reducing to 4.52%. Sickness absence related to stress, anxiety and depression continues to improve, although it remains the highest cause of sickness absence across the Trust. • Vacancy rate has increased back up to 9.6%, the highest it has been across the last 12 months. The primary reason for this increasing trajectory over the past few months is the holding of Band 2 Healthcare Support Worker (HCSW) vacancies. • Statutory training compliance continues on a positive trajectory, with a subtle, month-on-month improvement to 92.4%. **Finance** • The Group has delivered the Year to Date (YTD) plan of £37,753k to Month 5. The continued achievement of the plan is a significant strategic achievement for EKHUFT.

East Kent Hospitals University NHS Foundation Trust

	• Trust pay expenditure has increased in month predominantly due to the Specialty and Specialist (SAS) Doctor pay award paid in August and an increase in junior doctor appointments. • The Trust has delivered £17.2m of efficiencies in the first five months, £0.3m above the YTD plan, consisting of recurrent savings of £13.0m and non-recurrent savings of £4.2m. **Maternity** • The extended perinatal rate remains consistently below the threshold of 5.42 per 1,000 births, with the August 12 month rolling rate at 3.98 per 1,000 births. • The FFT maternity response rate, calculated using the national methodology based on delivery episodes, has remained below average for seven consecutive months.
Summary recommendations:	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the metrics reported in the Integrated Performance Report.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	**CRR 77:** Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 78:** There is a risk that patients do not receive timely access to emergency care within the Emergency Department (ED).
Resource:	N
Legal and regulatory:	N
Subsidiary:	Y - Working through with the subsidiaries their involvement and impact on We Care.

Assurance route:

Previously considered by: N/A

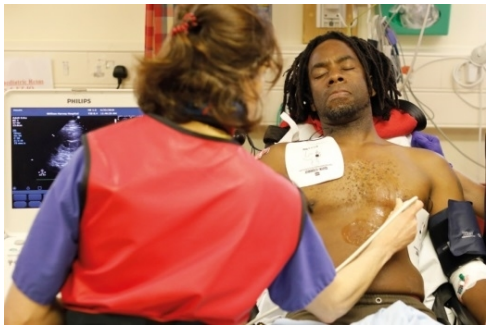
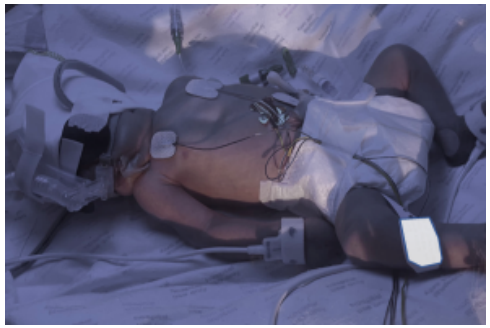
Integrated Performance Report

AUGUST 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

August Highlights:

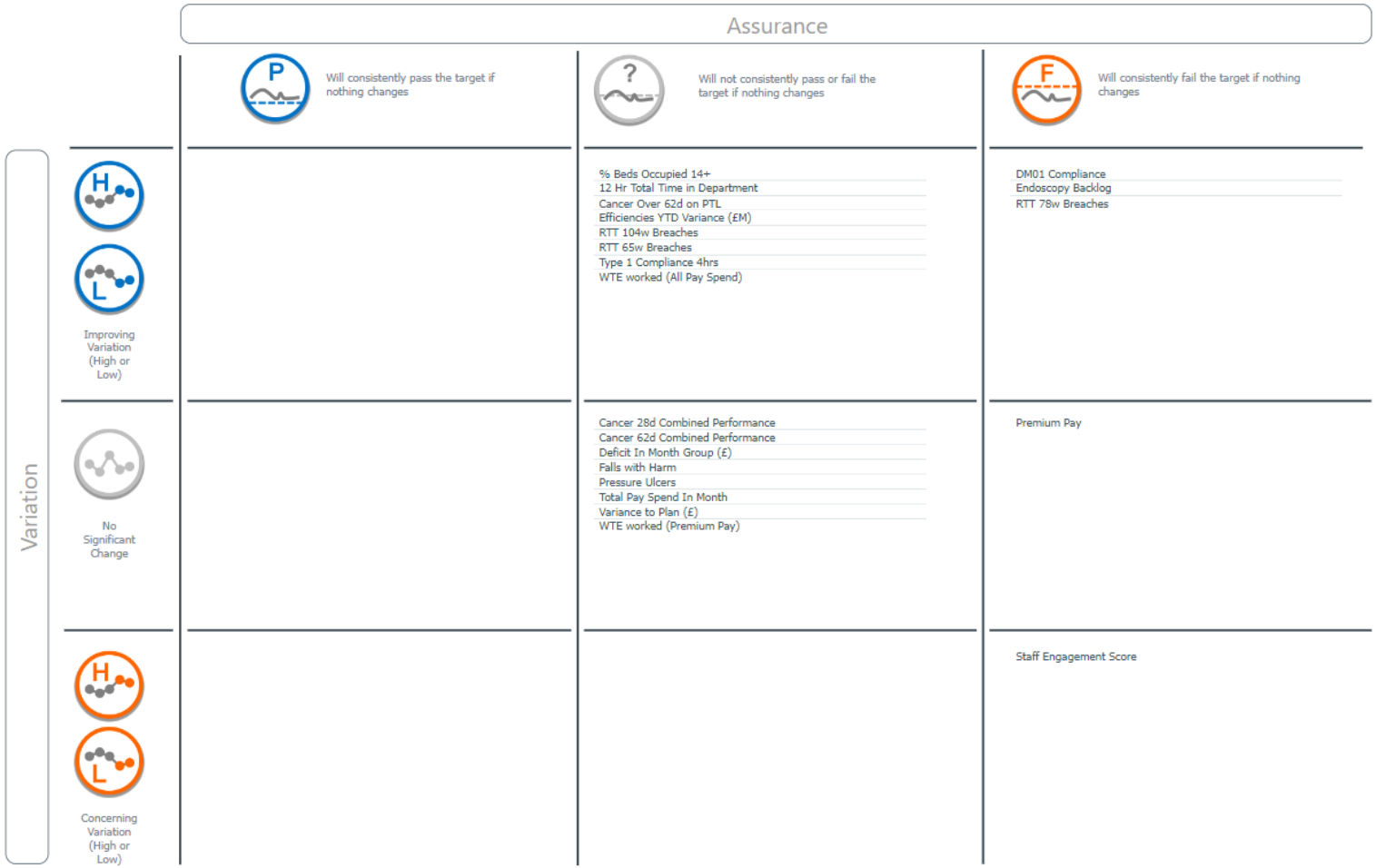
The number of patients with an in-hospital stay of more than 14 days remain below the RSP trajectory for a fourth consecutive month.

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 four 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

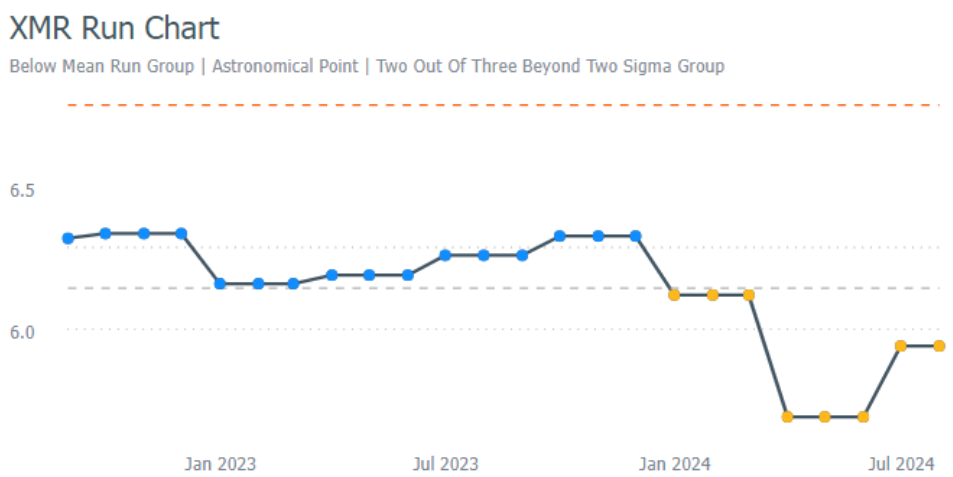
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
People	IIP		Staff Engagement Score			6.80	6.27	6.34	6.34	6.34	6.13	6.13	6.13	5.70	5.70	5.70	5.95	5.95
Patients	IIP		Type 1 Compliance 4hrs			48.0%	45.5%	45.8%	45.2%	43.5%	42.9%	45.1%	50.3%	47.4%	53.2%	52.0%	54.7%	56.2%
	IIP		12 Hr Total Time in Department			9.0%	10.3%	10.7%	10.4%	11.5%	11.1%	10.3%	9.4%	10.0%	9.5%	9.6%	9.4%	9.2%
	IIP		% Beds Occupied 14+			31.0%	34.3%	33.4%	36.2%	33.6%	34.3%	32.5%	30.6%	32.5%	30.8%	29.6%	30.0%	30.8%
	IIP		Cancer 28d Combined Performance			75.0%	59.7%	63.6%	62.5%	68.7%	57.8%	66.9%	68.3%	64.9%	70.2%	70.4%	72.6%	71.6%
	IIP		Cancer 62d Combined Performance			70.0%	59.3%	63.9%	61.8%	63.5%	56.1%	55.6%	69.1%	66.2%	64.1%	63.0%	71.6%	73.9%
	IIP		Cancer Over 62d on PTL			200	405	367	308	407	419	244	188	236	237	233	203	244
	IIP		RTT 65w Breaches			1,151	1,499	1,900	1,942	2,360	2,698	2,695	2,301	2,203	1,802	1,656	1,360	1,269
	IIP		RTT 78w Breaches			0	233	325	435	643	752	653	485	465	272	82	35	32
	IIP		RTT 104w Breaches			0	9	8	12	12	6	13	24	15	1	1	0	1
	IIP		Endoscopy Backlog			3,527	9,212	9,367	9,408	9,572	9,116	8,005	7,238	6,153	5,170	4,108	3,018	1,997
	IIP		DM01 Compliance			70.0%	54.1%	60.7%	59.1%	55.8%	54.2%	61.6%	61.2%	62.5%	63.4%	60.9%	61.3%	63.9%
Quality	IIP		Falls with Harm			11	8	6	2	3	2	10	4	6	3	4	2	7
	IIP		Pressure Ulcers			112	62	103	82	84	113	91	76	84	84	82	79	71
Sustainability	IIP		Deficit In Month Group (£)			6.3M	9.0M	8.9M	6.5M	9.3M	11.0M	10.2M	12.2M	8.8M	7.3M	7.1M	8.3M	6.3M
	IIP		Variance to Plan (£)			0K	-3,981K	-4,350K	-1,861K	-3,115K	-5,381K	-5,721K	-6,718K	-5K	5K	-28K	20K	53K

Integrated Improvement Plan (IIP)

Staff Engagement Score

Staff Engagement Score

Timescale	Value	SPC
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	
Aug-24	5.95	



Understanding the Latest Performance

Concern flag alerting for more than 4 periods

For the month beginning 01/08/2024 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).

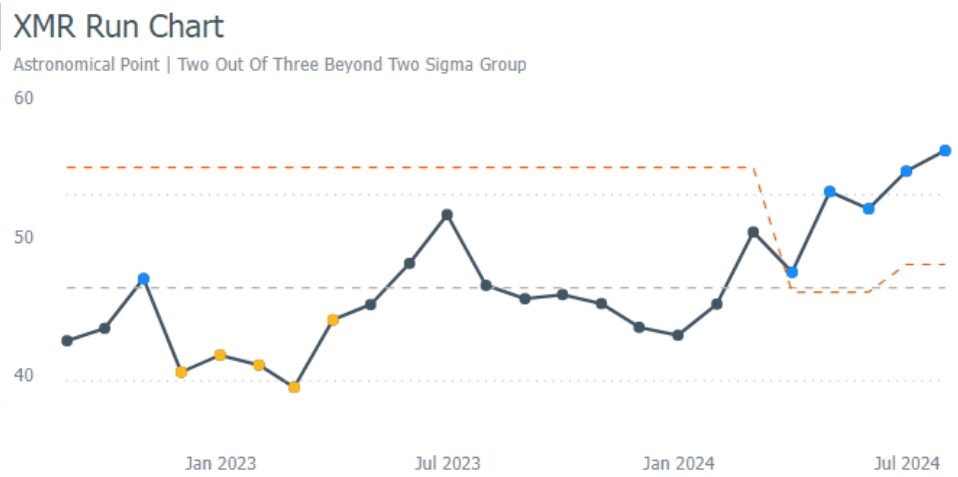
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
		Head of Staff Experience	End Mar 25	• Staff engagement recovered slightly in July (by 25 points, to 5.95) but remains a long way from the 6.80 target. Staff advocacy recovered the most over this time (35 points) but continues to anchor overall 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.
	• 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 Staff Survey launched on Monday 16th September. There are 11 weeks of fieldwork and a comprehensive timetable of activity and interventions has been resourced to drive response rates. A managers engagement pack has been developed alongside other key assets, and pre-engagement has taken place both at Team Brief (12/09) and through Executive communications. The staff survey briefing was delivered on 16/09 and response rates will be shared through a dynamic dashboard, from w/c 23/09.

Integrated Improvement Plan (IIP)

Type 1 Emergency Department; Four Hour Compliance

Type 1 Compliance 4hrs

Timescale	Value	SPC
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%	
Aug-24	56.2%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/08/2024 the latest Type 1 Compliance 4hrs performance is 56.2% against a Trajectory target of 48.0% (higher is better).

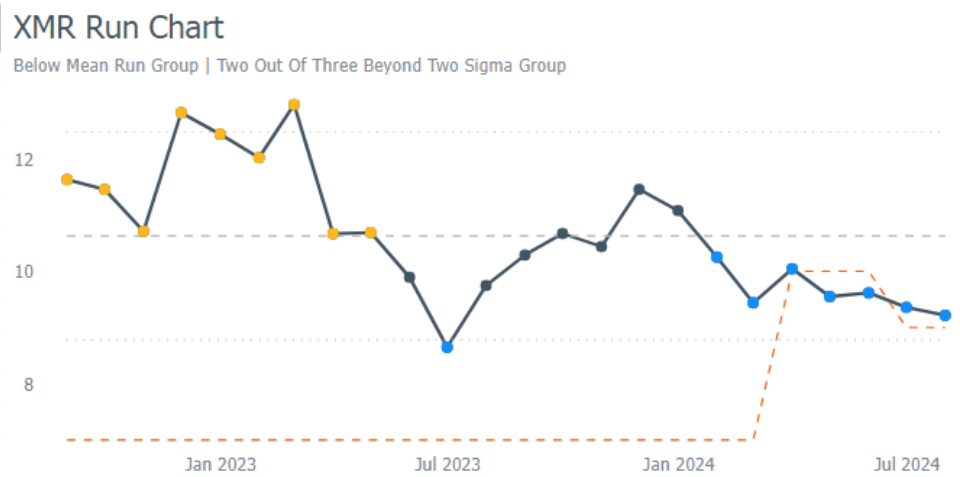
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Attendance Avoidance	• Extension of the SPOA model developed during 2024/5 to incorporate functions of an 'emergency portal' – advice and guidance, same day emergency care access – primary and secondary care; acute GP referral management; ambulance '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 56.2% 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 started 11/9 • 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
Sep-23	10.3%	
Oct-23	10.7%	
Nov-23	10.4%	
Dec-23	11.5%	
Jan-24	11.1%	
Feb-24	10.3%	
Mar-24	9.4%	
Apr-24	10.0%	
May-24	9.5%	
Jun-24	9.6%	
Jul-24	9.4%	
Aug-24	9.2%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/08/2024 the latest 12 Hr Total Time in Department performance is 9.2% against a Trajectory target of 9.0% (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).

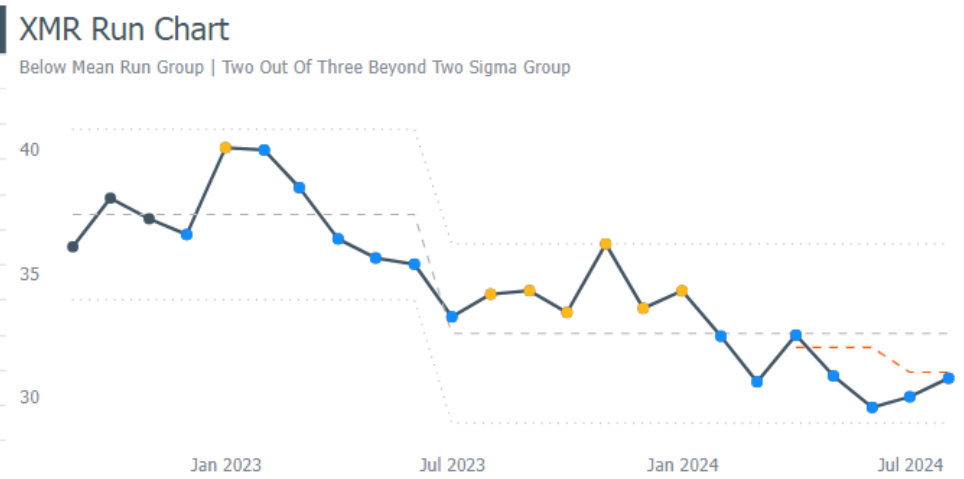
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Demand outstrips capacity (admitted patients) 103% attendances at WHH against contract	• Improve timeliness for decision to admit • Direct pathways to assessments units following decision to admit • Increase senior decision maker time on assessment 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 – further reduction 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;
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. Plan for Safe Haven at WHH in development • Focus for 24/25 on escalation and capacity to manage long stayers- SOP for escalation 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
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%	
Aug-24	30.8%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/08/2024 the latest % Beds Occupied 14+ performance is 30.8% 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).

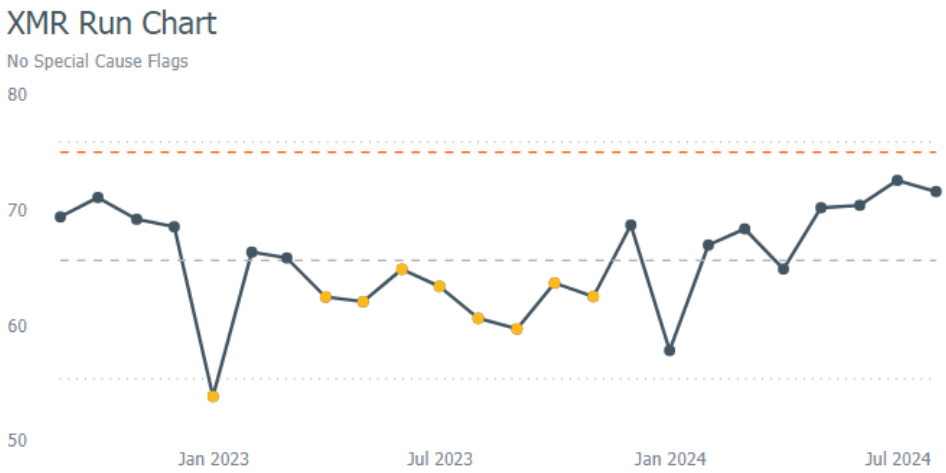
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patients meeting the criteria to reside >14 days	• Revisit criteria to reside and develop training plan to improve data completeness and quality • Consider out of hospital alternatives to patients residing – virtual ward expansion, ESD, hospital 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 – impact assessment Q2 • 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
Sep-23	59.7%	
Oct-23	63.6%	
Nov-23	62.5%	
Dec-23	68.7%	
Jan-24	57.8%	
Feb-24	66.9%	
Mar-24	68.3%	
Apr-24	64.9%	
May-24	70.2%	
Jun-24	70.4%	
Jul-24	72.6%	
Aug-24	71.6%	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/08/2024 the latest Cancer 28d Combined Performance performance is 71.6% against a static target of 75.0% (higher is better).

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

The biggest contributing factors are: 07 - Lower GI (44.0% , 298*), 09 - Gynaecological (61.9% , 162*), 08 - Skin (87.5% , 118*). *Breaches

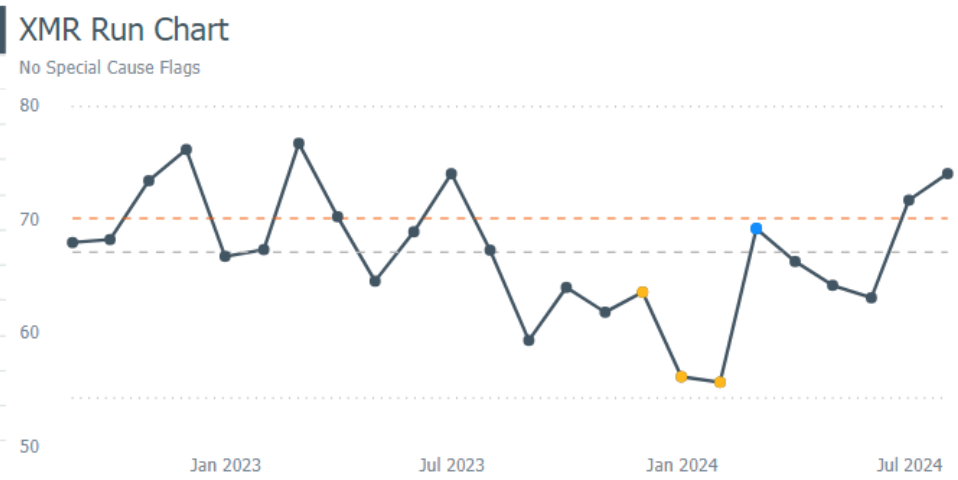
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
		• Radiology • Endoscopy	• Funding – July 24 • Working groups – Q3	• Amended escalation process with weekly radiology touchpoint focused on booking • Funding to support insourcing CT and US guided biopsy. US capacity to come online September 24, CT capacity in October 24 • Further increased in Endoscopy capacity to support Cancer pathways due to mobilise in the first week in September – target to bring down Endoscopy booking out times to <7days by end October. • Additional US insourcing capacity comes online from 21st September.
Letter backlog	• Timely consultant dictation of cancer outcome letters to patients • Timely administrative support to process dictated letters	• Cancer compliance • Admin • Consultants	• Ongoing	• 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
2ww	• Recovery from non-compliant August position	• 2ww Team • UGI Ops • LGI Ops • MaxFax Ops	• September 24	• Allocating additional clinic capacity to address the backlog of breached 2ww appointments. UGI, LGI and Maxfax the most affected specialties due to clinical capacity constraints • Instruction to the teams to maintain increased capacity to bring down the booking out days to <7 days. 2ww team outlining the extra capacity required to meet this target. • Cancer services engagement with key operational teams to re-establish 2ww touchpoints and capacity planning

Integrated Improvement Plan (IIP)

Cancer 62 Day Performance

Cancer 62d Combined Performance

Timescale	Value	SPC
Sep-23	59.3%	
Oct-23	63.9%	
Nov-23	61.8%	
Dec-23	63.5%	
Jan-24	56.1%	
Feb-24	55.6%	
Mar-24	69.1%	
Apr-24	66.2%	
May-24	64.1%	
Jun-24	63.0%	
Jul-24	71.6%	
Aug-24	73.9%	



Understanding the Latest Performance

No Special Cause Variation

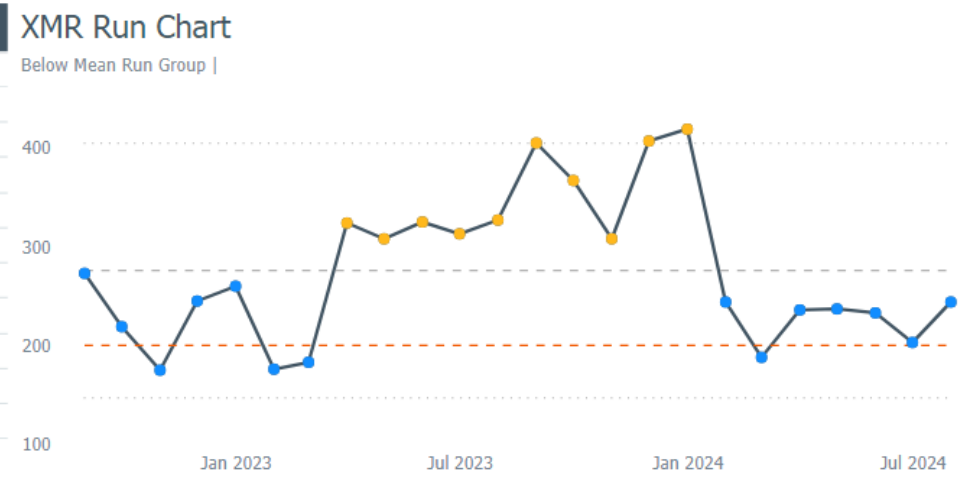
For the month beginning 01/08/2024 the latest Cancer 62d Combined Performance performance is 73.9% against a static target of 70.0% (higher is better).

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

The biggest contributing factors are: 11 - Urological (69.7% , 27*), 07 - Lower GI (60.3% , 16*), 01 - Breast (69.1% , 15*). *Breaches

Cancer Over 62d on PTL

Timescale	Value	SPC
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	
Aug-24	244	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/08/2024 the latest Cancer Over 62d on PTL performance is 244 against a static target of 200 (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: 07 - Lower GI (74*), 11 - Urological (40*), 13 - Head & Neck (37*). *Number

Integrated Improvement Plan (IIP)

Cancer 62 Day Performance; Action Plan

Cancer 62d Performance & >62d PTL Patient Actions

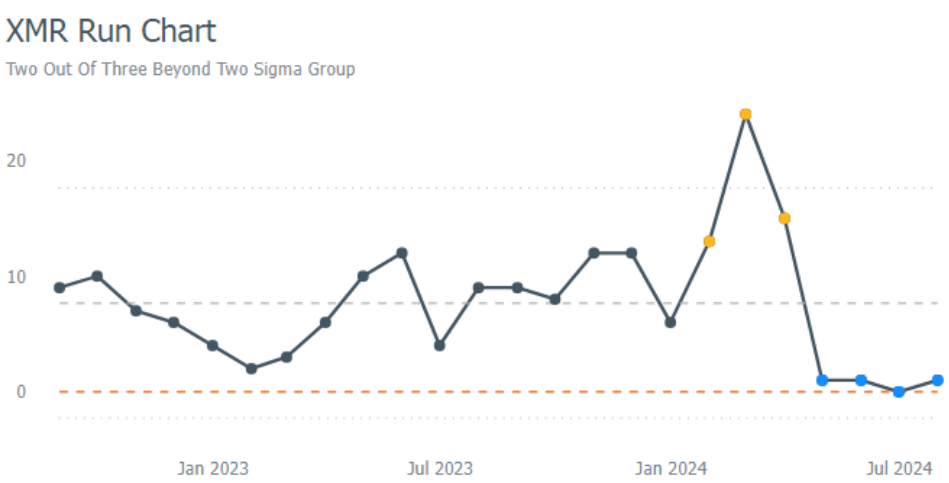
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Grip and control of backlog position	• Clear actions outlined in PTL to progress patients. • Close monitoring of treatment booking times • Escalation through operational access meetings for areas of concern • Patient level review of those 50+ 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. Focussing on recovery workstreams for 2ww. • Targeted escalation for patients against agreed thresholds for Histopathology, Radiology. Endoscopy escalation meeting established September 24. • Breach reviews for all patients • Close monitoring of PTL changes. Notably, Lower GI is now the key contributing specialty to the backlog driven by elongated times on the pathway pre-diagnosis. Recovery plan being developed with a focus on further FDS improvements • Head and Neck surgical capacity remains constrained. Recruitment in progress and decision to divert tiered funding to support a locum post for 6 months.
Capacity for diagnostics	• Staff vacancies contributing to reduced radiological diagnostics	• Radiology	• Q3	• Tiering funding provided to support insourcing for US, Guided CT and US biopsy, endoscopy • Reporting timelines were significantly reduced supported by an increase in histopathology workforce and access to outsourcing reporting for radiology
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 supported by tiered funding – a successful applicant has been employed who will increase the available robotic surgical capacity from October onwards
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 • Cancer services reviewing the time from MDM to Decision to Treat discussions due to the impact on the 62d compliance standard
Effective implementation of Tiered Funding	• Ensuring all funding streams are implemented to maximise impact on FDS and 62 compliance	• All specialties	• Year end 24/25	• 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. Update of planned reallocation of funding issued to NHSE
Impact of patient holidays on suspected cancer pathways	• Patients being referred from GP with holidays booked. • For STT pathways the initial patient interaction starts the cancer pathway clock with no holiday pauses permittable and risk to the patient for delayed urgent diagnostic	• All specialties with STT pathways	• Q3	• Working with primary care partners to provide updated communication to GPs outlining the impact diagnostic pathways and risks to patients when referred with known holiday causing delay to urgent suspected cancer diagnostic • Following comms to primary care due in October, the STT teams will be providing feedback to GPs where patients are referred inappropriately

Integrated Improvement Plan (IIP)

Referral to Treatment Waiting Times; 104 & 78 week waits

RTT 104w Breaches

Timescale	Value	SPC
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	
Aug-24	1	



Understanding the Latest Performance

Improvement flag alerting for 4 periods

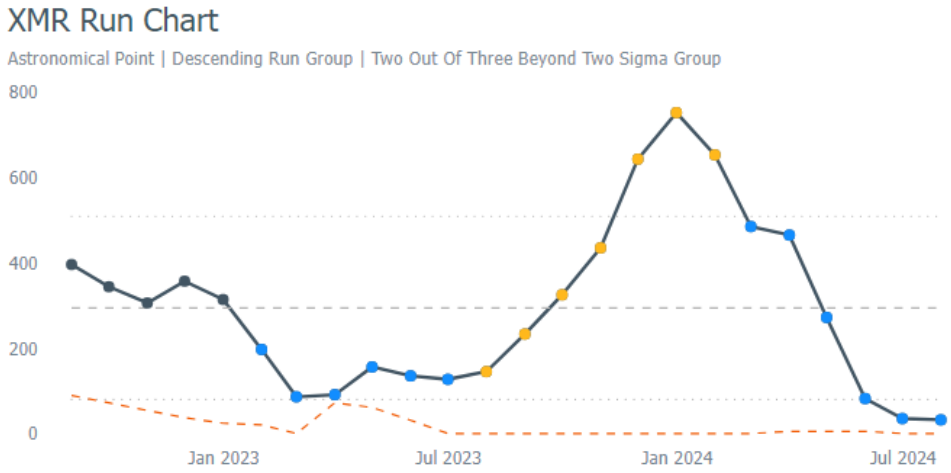
For the month beginning 01/08/2024 the latest RTT 104w Breaches performance is 1 against a static target of 0 (lower is better).

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).

The biggest contributing factors are: 100 - GENERAL SURGERY (1*). *Breaches

RTT 78w Breaches

Timescale	Value	SPC
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	
Aug-24	32	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/08/2024 the latest RTT 78w Breaches performance is 32 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).

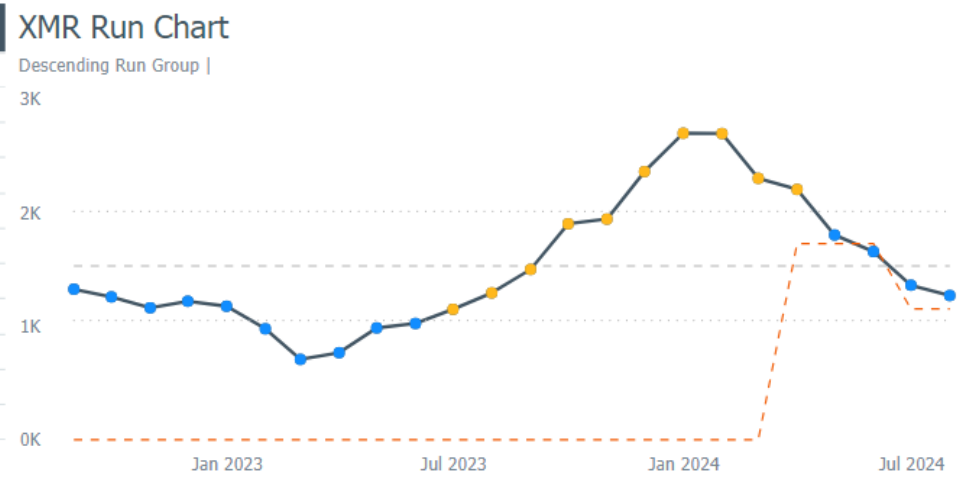
The biggest contributing factors are: 215 - PAEDIATRIC EAR NOSE AND THROAT (16*), 100 - GENERAL SURGERY (5*), 171 - PAEDIATRIC SURGERY (3*). *Breaches

Integrated Improvement Plan (IIP)

Referral to Treatment Waiting Times; 65 week waits

RTT 65w Breaches

Timescale	Value	SPC
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	
Aug-24	1,269	



Understanding the Latest Performance

Improvement flag alerting for 4 periods

For the month beginning 01/08/2024 the latest RTT 65w Breaches performance is 1,269 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 (322*), 301 - GASTROENTEROLOGY (194*), 104 - COLORECTAL SURGERY (186*). *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. • All internal capacity being directed to key risk cohorts from dropped sessions • Two additional Ophthalmic Consultants to commence. • Independent Sector capacity aligned to support risk cohorts	• COO • Dep COO • COO • MD – CCAS • MD - CCAS • MD – CCAS • Dep COO	• Ongoing • Ongoing • Ongoing • Jul-Sep • Ongoing • Aug-Oct • Ongoing	• 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 • Commenced • Appointed, one commenced and one planned start date middle October • Commenced

Integrated Improvement Plan (IIP)

Referral to Treatment Waiting Times; Long Waiter Actions

RTT Long Waiter Actions

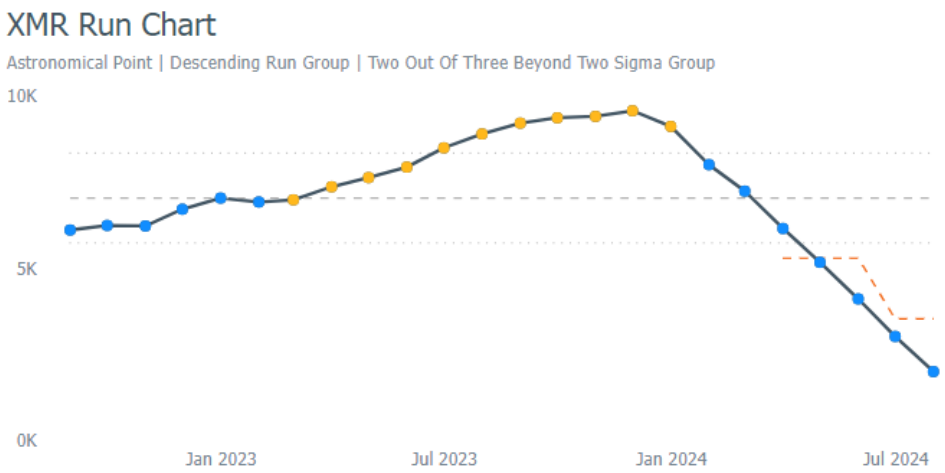
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Drive to clear all 78 week risks.	• GiRFT team secured 20 pts for Otology Capacity from BHR. • Development of Choice Application SOP to manage non-admitted choice in line with revised Access Policy • Additional Gastroenterology 1st OPA's Commissioned to support current backlog via Insourcing • Deep dive into Upper & Lower GI and H&N inc. Paediatric ENT with respective teams daily focus and review of position, inc. 'super validation' process in place with key admin/Ops staff • Swap out of theatre capacity to accommodate longest waits in H&N and Paediatric ENT inc. Paediatric ward capacity • MTW support for ENT, Chronic Pain and Gastro patients • Paediatric ENT reviewing immediate capacity plans • Additional adult and paediatric ENT capacity secured with I.S.	COO Dep COO COO Dep COO Dep COO COO CCAS/WYCP I.S. Lead	• August • Ongoing • September • Ongoing • September -December • Ongoing • 21st August • Ongoing	• Capacity fully utilised. • Commenced • Commenced • Commenced • Commenced • Regular weekly transfer process in place and all of this cohort is now fully transferred. • Additional capacity on line from end September • Commenced

Integrated Improvement Plan (IIP)

Endoscopy Backlog; Overdue Surveillance and Routine Waits

Endoscopy Backlog

Timescale	Value	SPC
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	
Aug-24	1,997	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/08/2024 the latest Endoscopy Backlog performance is 1,997 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: Colon (681*), Dual (554*), OGD (532*). *Overdue Waiters

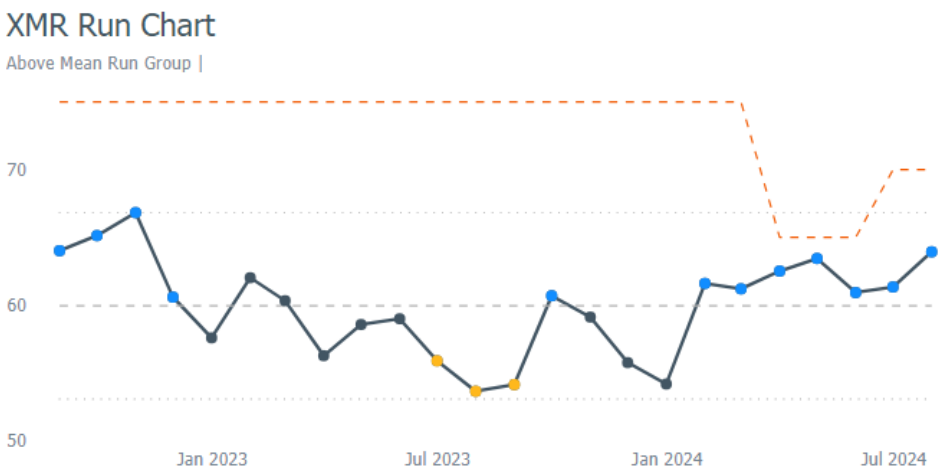
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
		• Endoscopy recovery lead	• Ongoing	• Activity now sustained at 550 procedures a month. • Forward booking now sustained at 1300 -1500 patients. • Trajectory to be compliant with JAG waiting lists standards on cause for the of October. • Patients requiring a date to be booked across all pathways now down to 710.
Demand management	• Implementing a Triage system to demand management the service.	• Endoscopy recovery lead • Clinical lead	• May 2024	• Process designed, sunrise chances made, SOP written. • New Triage process started – currently rejecting around 40 patients a week. • Engagement with Colorectal surgeons starting.
Waiting list accuracy	• A program of staged validation against new clinical standards.	• Endoscopy recovery lead • Clinical lead	• Ongoing	• validation program – Complete • Program of BAU waiting maintenance now in place.

Integrated Improvement Plan (IIP)

Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

DM01 Compliance

Timescale	Value	SPC
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%	
Aug-24	63.9%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/08/2024 the latest DM01 Compliance performance is 63.9% against a Trajectory target of 70.0% (higher 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: MRI (67.1% , 3,097*), Non Obstetric Ultrasound (55.3% , 2,077*), Echocardiography (24.0% , 667*). *Breaches

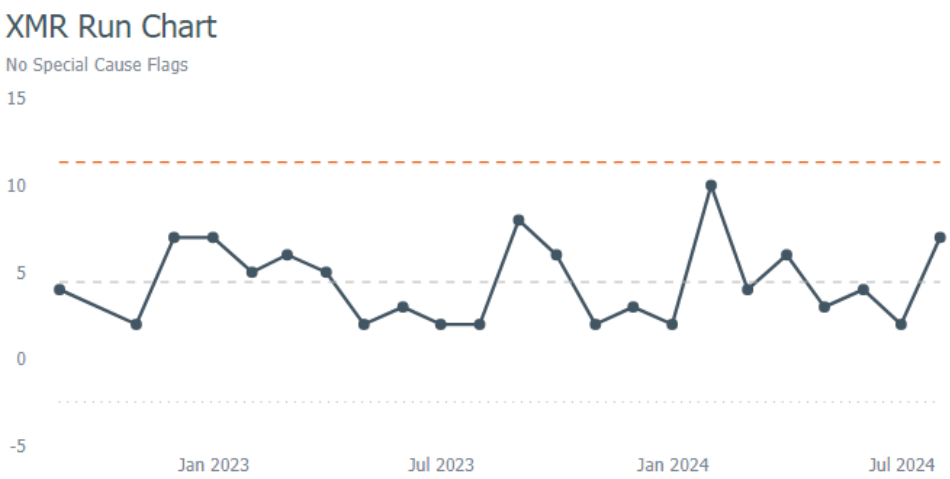
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
		• DM01 recovery lead / HOO for Imaging	• Sept 24	• Initial referral standards circulated with ICB GP`s. • Insourcing provider agreed to do 42 extra scans within existing contract. • V1 of a New booking visualisation tool being evaluated. • New booking team leader and process in place.
NOUS back log	• Review underutilised capacity • Booking team and process review.	• DM01 recovery lead / HOO for Imaging	• Sept 24	• Lack of chaperones identified as a cause of underutilised capacity. Plan to address being drafted. • V1 of a New booking visualisation tool being evaluated. • New booking team leader and process in place.
Echocardiography Back log	• Capacity gap	• Cardiology GM	• Sept 24	• Recovery plan in place • Insourcing and Enhanced echo rate for substantive physiologist matching rate from insourcing agreed
Dexa back log	• DM01 recovery lead High cancelations	• Dexa Service manager	• Sept 24	• Recovery plan in place. • DNA plan being implemented.
Cardiac MRI Back log	• Validation, review outsourcing process	• Cardio GM	• Sept 24	• Validation resource required quantified.

Integrated Improvement Plan (IIP)

Patient Falls with Moderate or Above Harm Recorded

Falls with Harm

Timescale	Value	SPC
Sep-23	8	
Oct-23	6	
Nov-23	2	
Dec-23	3	
Jan-24	2	
Feb-24	10	
Mar-24	4	
Apr-24	6	
May-24	3	
Jun-24	4	
Jul-24	2	
Aug-24	7	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/08/2024 the latest Falls with Harm performance is 7 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 July 2024.	• Escalation sighting care group ownership, Falls Steering Group. • Hot Spot areas identified, Care Groups to share improvements at quarterly Falls Steering Group. • Trust Wide Improvement Plan (TWIP) to be reviewed to align with Patient Safety Incident Review Framework.	Falls Lead ADON FOC Care Groups Falls Lead	• Ongoing through out the year • 3 monthly reviews • November 2024	• Work will remain ongoing across the year. • Care Groups developing action plans to drive local improvements, links with falls team to address learning to patient safety events. • TWIP to be reviewed. Themes to be addressed to ensure they align with patient Safety Incident Review Framework.
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.	Falls Lead People and Culture Team	• July 31st 2024	• Completed July 2024. • Completed July 2024. • Position report for staff mapping completed and returned to Lead for People and Culture Systems Team awaiting delayed response.

Integrated Improvement Plan (IIP)

Falls with Harm; Actions Table

Falls with Harm (con't)

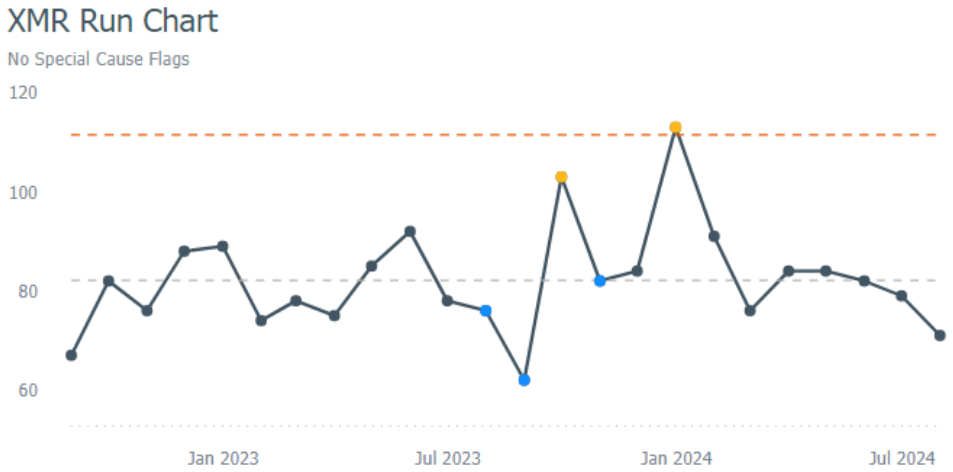
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Unwitnessed falls remain high In the most vulnerable patients. Enhanced observational care need identified not always able to put in place.		Associate Director of Nursing QEQMH	• September 2024	• The EKHUFT Enhanced Care Tool is now Currently on Sunrise at the QEQMH, additional areas at the QEQMH added September 2024. • Awaiting for date to be agreed for Trust wide launch. • EKHUFT working group with other Trusts and the community ICB led by Associate Director of the Fundamentals of Care.
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 & falls team developed EOB risk assessment module for ESR. • Workforce planning to present to the Statutory Mandatory and Essential Training Steering Group for ESR access on completion. • 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 assessment to Sunrise, strengthening the process and assessment.	Falls Lead Consultant Falls Lead EKHUFT Audit team Major Trauma Director Lead for Falls Deteriorating Patient lead Resus Lead	• October 2024 • November 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 October 2024. Action plan formulised actions include stand alone document for lying and standing blood pressures. • Action completed, 4AT implemented on the 4th September on sunrise for 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 for simulation education for medical clinicians and Critical Care Out reach team (CCOT). Working Group to be set up. • Post fall medical assessment to go live on Sunrise.

Integrated Improvement Plan (IIP)

Pressure Ulcers; Hospital Associated

Pressure Ulcers

Timescale	Value	SPC
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	79	
Aug-24	71	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/08/2024 the latest Pressure Ulcers performance is 71 against a (6 Sigma Threshold) target of 112 (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 to a line with ward based PURPOSE T training. • Presented to Statutory Mandatory and Essential Training Steering Group to develop a mandatory training module. To resubmit Training Needs Analysis following panel feedback. Moodle training being developed regarding PURPOSE T risk assessment and pressure ulcer prevention and categorisation. Aiming to be available on ESR. • Liaising with Sunrise regarding simplifying the risk assessment process.	DCN for FOC TV Lead TV lead/ Steering Group ADN for FOC	August 2024 August 2024 December 2024 November 2024 January 2025	• Action complete • Action complete • Positive feedback from ward managers- staff are feeling supported, training is having an impact & areas that have been taught are seeing an improvement in risk assessment completion. • Lead TVN presented at Statutory Mandatory and Essential Training Steering Group TNA resubmitted following feedback at August meeting on 29th August 2024. Awaiting further feedback. Learning and development team to present the ESR module separately. • Associate Director of Fundamentals of Care is working with Chief Nursing Information Officer on an overarching review of all risk assessments on Sunrise to simplify the whole risk assessment process.

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. With an increase in shear being noted.	• Working with high reporting areas to improve repositioning techniques • SKINS and repositioning regimes have been separated on Sunrise for ease of completion. • 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. • To develop guidance on the repositioning of patients with unstable spinal issues. • TVNs to attend ward meetings to discuss barriers to repositioning and gain feedback from clinical staff. To inform Trust wide improvements	• TV Lead	October 2024 September 2024 August 2024 March 2025 November 2024	• Provide a targeted approach based on learning from incidents involving face to face training in the appropriate clinical areas. • Action Complete • Action Complete • Liaising with national TVNs and spinal specialists regarding the guidance. National guidance is being developed. • TVNS are attending the ward managers meetings this is generating good discussion that will be taken to clinical staff and fed back at Tissue Viability Steering Group. Also information the Trust wide Improvement plan.
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 to improve the treatment of MASD • Identify suitable incontinence products with colleagues from the Procurement Team, 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 January 2025 December 2024	• Barrier cream trial completed on one ward to be expanded to other clinical areas • Education to be rolled out alongside trial. Local representative attending link champion day on 8th October. First ward based training days planned for September to continue throughout the year. • Moisture associated skin damage pathway shared in the recent Tissue Viability Publication and now available on the Trust Intranet. Need to embed this further trust wide through training and communication.
Delay in obtaining appropriate support surface for the most vulnerable patients starting within the Emergency Departments..	• ED trolley project to improve support surface in ED. Trial date in October 2024. To commence at WHH then to move to QEQM. • Training on accurate risk assessment will improve the compliance with pressure ulcer prevention strategies	• TV Lead	December 2024 March 2025	• Lead Manual Handling advisor has sourced funding from charities for 10 ED trollies initially trial to commenced firstly at WHH ED then will move to QEQM. • Modules being developed for pressure ulcer risk assessment and correct interventions on ESR.

Integrated Improvement Plan (IIP)

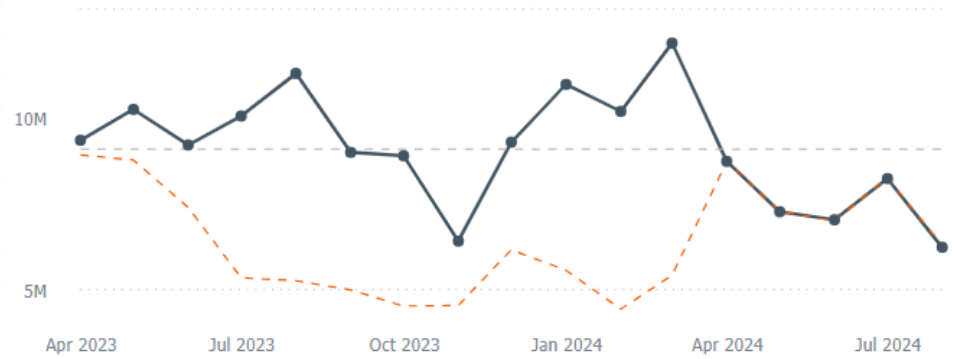
Income & Expenditure Monthly Deficit (Group)

Deficit In Month Group (£)

Timescale	Value	SPC
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	
Aug-24	6.3M	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/08/2024 the latest Deficit In Month Group (£) performance is 6.3M against a Trajectory target of 6.3M (lower is better).

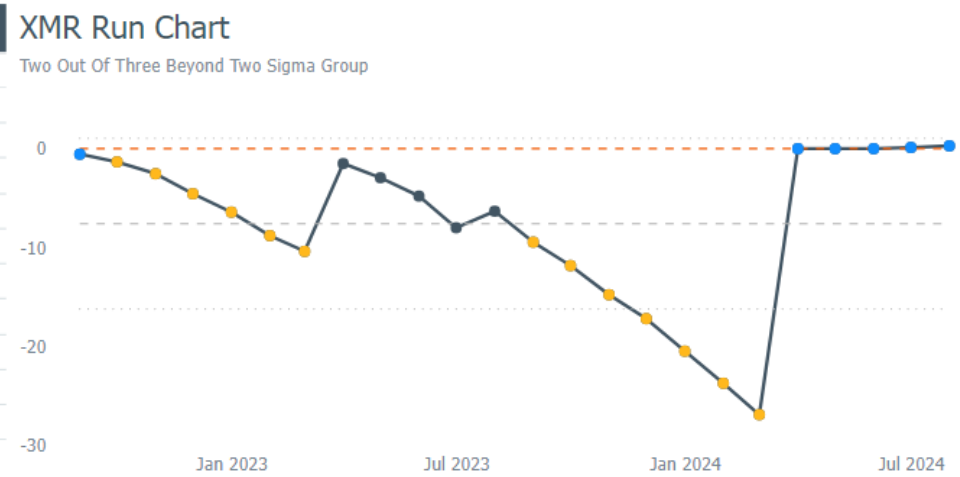
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining achievement of financial plan through Quarters two to four	• Increase level of CIP plan being developed to mitigate any potential slippage against efficiency schemes • Embedded bi-weekly FIPB with full Care Group representation and Theme lead presentations on a rotation basis	• Theme leads • PMO	• July 2024	• £53.4m risk-adjusted schemes (in-year effect) identified as at 9/9/24 against £49m CIP target, 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
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	
Aug-24	0.3	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/08/2024 the latest Efficiencies YTD Variance (£M) performance is 0.3 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 £0.3m above plan with CIP delivery at Month 5 of £17.2m of which £4.2m is non-recurrent. • £53.4m risk-adjusted recurrent schemes (in-year effect) identified as at 9/9/24, 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 continuing to work with Director of Finance to streamline the CIP reporting process • Informal forecasting of CIP developed in month 4, and in process of validation with Theme leads and Finance business partners. Formal forecasting from Month 6.
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 proposed and approved by Execs. Trust to proceed with securing the necessary resources to bolster the PMO and support the CIP programme effectively. • 2 Band 7 posts have been appointed to following internal expressions of interest for secondment opportunities. Band 7 external advert closed and in shortlisting stage. Recruitment to progress for other vacancies.

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)		% Beds Occupied 14+ 12 Hr Total Time in Department Cancer Over 62d on PTL ED Compliance RTT 104w Breaches RTT 52w Breaches RTT 65w Breaches Type 1 Compliance 4hrs	DM01 Compliance Endoscopy Backlog Not Fit to Reside (pats/day) RTT 78w Breaches Super Stranded >21D
No Significant Change		Cancer 28d Combined Performance Cancer 31d Combined Performance Cancer 62d Combined Performance DNA Rate OP New	12Hr Trolley Waits Ambulance Handovers within 30m Cancer Over 104d on PTL Theatre Session Opp. Theatre Uncapped Utilisation
Concerning Variation (High or Low)		Cancer 2ww Performance RTT Incomplete Performance RTT Total Incomplete Pathways	

Patients

August Highlights:

Unplanned Care
Attendances were on contract at Trust level for August 2024 for Type 1 and 2 (WHH 103% and QEQM 97%) although admissions were below plan (WHH 77% for +1 LOS and 21% for zero LOS; QEQM (90% for +1 LOS and 44% for zero LOS) 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 August (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 August 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
Robust plans in place to manage 78 weeks in September to single figures, noting challenges with capacity within paediatric ENT.

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

Endoscopy backlogs down to 1,997 at the end of August, sustainable position to be achieved by October.

Theatre utilisation improvement plan developed and agreed to commence focussed programme 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	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Patients	NAT		ED Compliance			73.0%	70.7%	70.6%	70.3%	69.0%	68.8%	70.8%	73.1%	71.8%	76.0%	75.2%	76.3%	77.4%
	IIP		Type 1 Compliance 4hrs			48.0%	45.5%	45.8%	45.2%	43.5%	42.9%	45.1%	50.3%	47.4%	53.2%	52.0%	54.7%	56.2%
	IIP		12 Hr Total Time in Department			9.0%	10.3%	10.7%	10.4%	11.5%	11.1%	10.3%	9.4%	10.0%	9.5%	9.6%	9.4%	9.2%
	NAT		12Hr Trolley Waits			0	867	1,079	1,168	1,260	1,368	1,111	1,131	1,207	1,227	1,189	1,085	1,033
	NAT		Ambulance Handovers within 30m			95.0%	90.0%	90.3%	88.7%	89.4%	89.4%	88.0%	87.9%	88.3%	92.6%	88.1%	87.7%	89.8%
	IIP		% Beds Occupied 14+			31.0%	34.3%	33.4%	36.2%	33.6%	34.3%	32.5%	30.6%	32.5%	30.8%	29.6%	30.0%	30.8%
	KEY		Super Stranded >21D			107	245	235	260	244	243	229	208	224	213	205	202	212
	NAT		Not Fit to Reside (pats/day)			100.0	199.8	193.5	207.0	176.7	184.6	166.5	168.9	172.2	174.4	192.0	181.2	189.6
	IIP		Cancer 28d Combined Performance			75.0%	59.7%	63.6%	62.5%	68.7%	57.8%	66.9%	68.3%	64.9%	70.2%	70.4%	72.6%	71.6%
	NAT		Cancer 31d Combined Performance			96.0%	92.7%	92.4%	92.7%	94.0%	92.5%	95.3%	91.5%	93.5%	96.2%	95.0%	96.3%	95.3%
	IIP		Cancer 62d Combined Performance			70.0%	59.3%	63.9%	61.8%	63.5%	56.1%	55.6%	69.1%	66.2%	64.1%	63.0%	71.6%	73.9%
	IIP		Cancer Over 62d on PTL			200	405	367	308	407	419	244	188	236	237	233	203	244
	KEY		Cancer Over 104d on PTL			0	77	83	67	65	84	62	43	38	36	42	39	54
	KEY		Cancer 2ww Performance			93.0%	96.3%	95.5%	96.2%	96.0%	93.0%	97.1%	95.9%	94.5%	94.6%	96.1%	94.7%	90.6%
	NAT		RTT Incomplete Performance			51.2%	51.5%	49.2%	49.1%	48.7%	49.0%	50.1%	50.8%	51.9%	52.0%	51.0%	50.3%	50.8%
	NAT		RTT Total Incomplete Pathways			86.3K	88.9K	89.9K	89.2K	90.0K	90.0K	87.2K	85.4K	86.9K	87.5K	85.8K	85.6K	88.1K
	NAT		RTT 52w Breaches			5,489	5,113	5,966	6,194	6,459	6,912	6,691	6,613	6,356	5,700	5,186	4,773	4,657
	IIP		RTT 65w Breaches			1,151	1,499	1,900	1,942	2,360	2,698	2,695	2,301	2,203	1,802	1,656	1,360	1,269
	IIP		RTT 78w Breaches			0	233	325	435	643	752	653	485	465	272	82	35	32
	IIP		RTT 104w Breaches			0	9	8	12	12	6	13	24	15	1	1	0	1

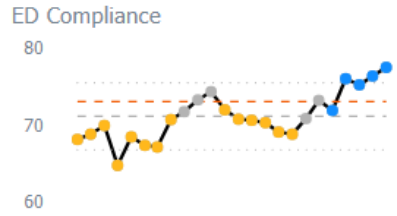
Patients

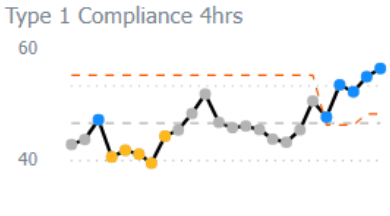
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
	IIP		Endoscopy Backlog			3,527	9,212	9,367	9,408	9,572	9,116	8,005	7,238	6,153	5,170	4,108	3,018	1,997
	IIP		DM01 Compliance			70.0%	54.1%	60.7%	59.1%	55.8%	54.2%	61.6%	61.2%	62.5%	63.4%	60.9%	61.3%	63.9%
	KEY		Theatre Session Opp.			25	54	52	41	46	45	42	33	40	40	33	41	51
	NAT		DNA Rate OP New			7.0%	7.3%	7.6%	7.6%	8.2%	7.8%	7.0%	6.7%	6.8%	6.9%	6.8%	7.3%	7.7%
	NAT		Theatre Uncapped Utilisation			85.0%	79.1%	79.9%	79.4%	77.2%	76.7%	78.1%	79.4%	80.7%	78.5%	79.9%	77.9%	79.2%

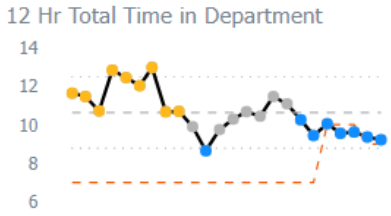
Patients

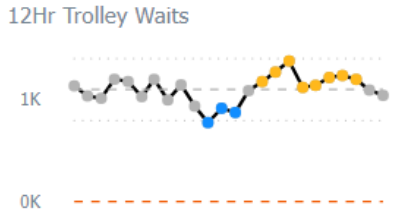
KEY ISSUE(S)	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
	• Robust programme in place to ensure clear deliverables in utilisation with a sustainable plan post Prisms departure in August 24	• MD - CCAS	• Ongoing	• 8-6-4-2 process commenced in June. • Ophthalmic utilisation review ongoing and progress being made. • 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

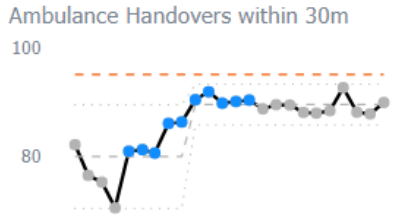
Patients

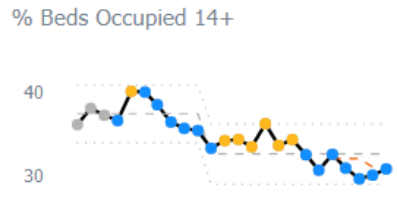

ED Compliance
80
70
60

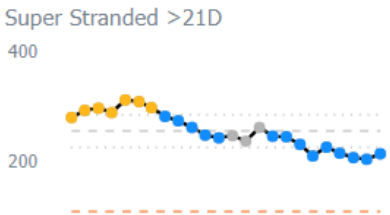

Type 1 Compliance 4hrs
60
40

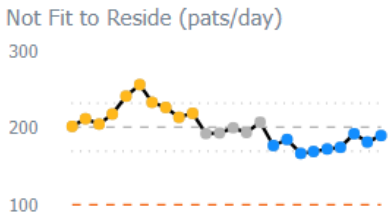

12 Hr Total Time in Department
14
12
10
8
6

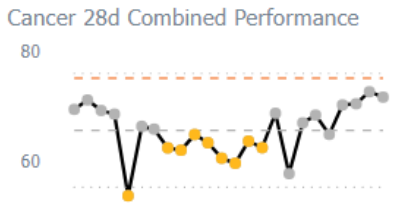

12Hr Trolley Waits
1K
0K

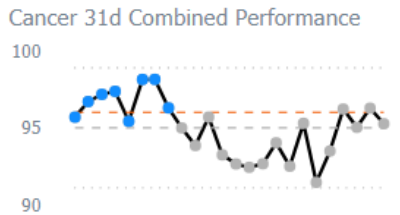

Ambulance Handovers within 30m
100
80

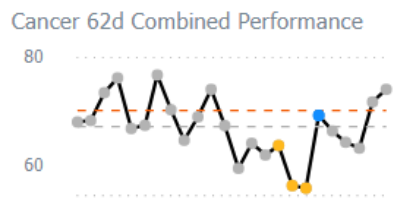

% Beds Occupied 14+
40
30

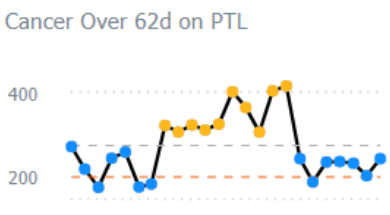

Super Stranded >21D
400
200

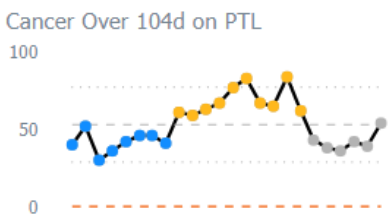

Not Fit to Reside (pats/day)
300
200
100

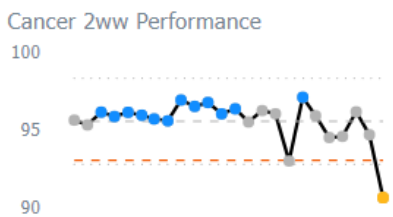

Cancer 28d Combined Performance
80
60

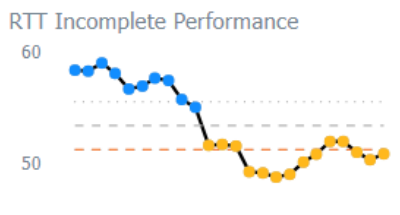

Cancer 31d Combined Performance
100
95
90

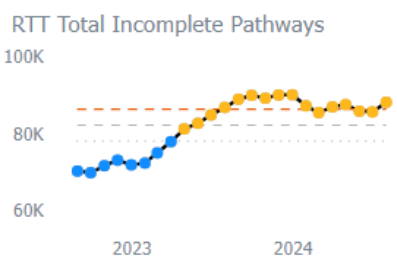

Cancer 62d Combined Performance
80
60

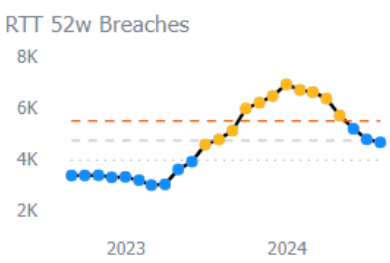

Cancer Over 62d on PTL
400
200

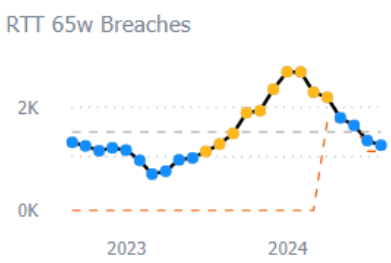

Cancer Over 104d on PTL
100
50
0

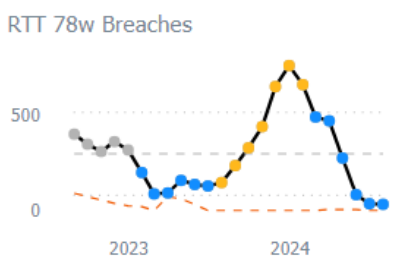

Cancer 2ww Performance
100
95
90

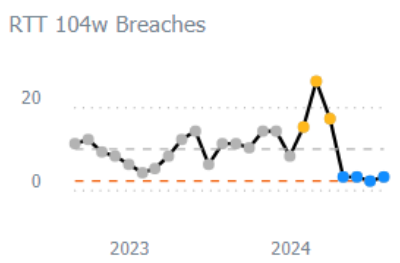

RTT Incomplete Performance
60
50


RTT Total Incomplete Pathways
100K
80K
60K
2023
2024


RTT 52w Breaches
8K
6K
4K
2K
2023
2024

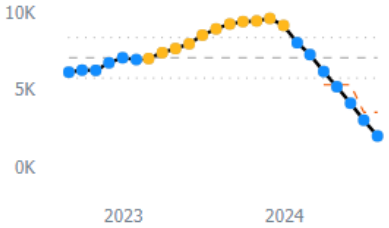

RTT 65w Breaches
2K
0K
2023
2024


RTT 78w Breaches
500
0
2023
2024

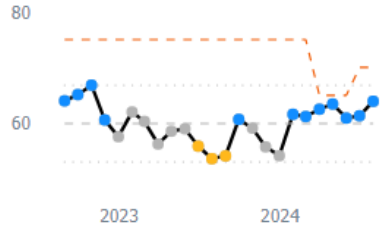

RTT 104w Breaches
20
0
2023
2024

Patients

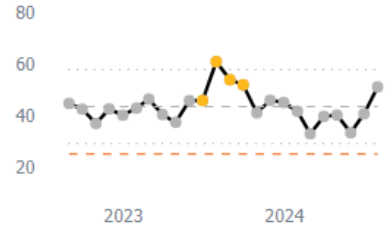
Endoscopy Backlog



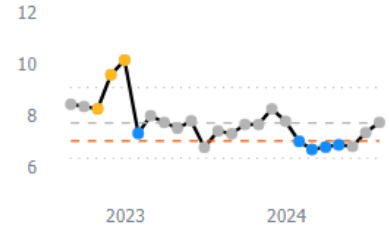
DM01 Compliance



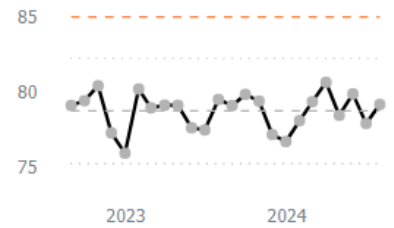
Theatre Session Opp.



DNA Rate OP New



Theatre Uncapped Utilisation



Quality and safety

Assurance

Variation

	P — Will consistently pass the target if nothing changes	? — Will not consistently pass or fail the target if nothing changes	F — Will consistently fail the target if nothing changes
H / L — Improving Variation (High or Low)		Clinical Incidents Duty of Candour - Written 15wd Safeguarding Children Training Serious Incidents Serious Incidents Breached exceed 60-day deadline	FFT Satisfaction Level - ED Overdue Incidents Safeguarding Adults Training VTE Assessment Compliance
No Significant Change	FFT Satisfaction Level - Outpatient	Complaints Number Duty of Candour - Findings Duty of Candour - Verbal 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	
H / L — Concerning Variation (High or Low)			Complaint Response

Quality and safety

August Highlights:

Safeguarding Incidents:
The safeguarding individual team members are assigned specific areas they support. Face to face supervision has returned in the children's areas following an August pause. Additional safeguarding supervisors have been trained which will increase capacity to support supervision. Care groups ensure they recognise safeguarding when reviewing an incident. Quality assurance of the reports being undertaken demonstrates confidence is building in ward areas. Next month we have the Safeguarding conference which will provide additional capacity for training.

Duty of Candour:
Duty of Candour data has now been validated and has been made available on the scorecard. Due to the identified issues with how the data was being pulled since Learning from Patient Safety Events (LfPSE) was implemented on the Datix IT system in February 2024, there were a number of patient safety incidents requiring DoC. Now this has been corrected, actions are being taken to address historical non-compliance this will be completed by November 2024.

Complaint Response:
August 2024 has seen a slight increase in performance of response, a trajectory has been set and will mean the Key Performance Indicator(KPI) of 85% compliance is on track to be met by December 2024.

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. Some good progress has been made and we are on target to clear the open incidents by 31st October.

Never Events:
In August, there were 2 never events reported. One wrong site block and one wrong route administration of medication. See slide 13 for details.

Infection Prevention and Control:
New thresholds released in line with national antimicrobial resistance action plan, most reportable HCAI's now under threshold, C-dif cases remain well below both current and previous thresholds. Pseudomonas blood stream infections, which previously were under threshold, are now breaching, and Klebsiella continues to be above threshold, focus remains on reducing these through the CLEAN campaign.

Quality and safety

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Quality	NAT		Clinical Incidents			2,876	2,286	2,519	2,134	2,061	2,377	1,147						
	NAT		Patient Incidents			2,541						762	1,950	1,938	1,979	1,846	2,040	1,865
	NAT		Never Events			0	0	1	0	0	1	0	1	0	0	1	0	2

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Quality	KEY		Incidents - Moderate / Severe			59	33	41	27	29	40	23						
	NAT		Patient Incidents - Moderate / Severe			67						12	39	37	28	47	41	48
	KEY		Overdue Incidents			0	2,980	3,353	3,293	3,614	2,986	1,663	1,358	822	1,406	1,557	1,164	724
	NAT		Serious Incidents Breached exceed ...			0	3	1	2	3	4	1	0	1	1	0	1	3
	IIP		Falls with Harm			11	8	6	2	3	2	10	4	6	3	4	2	7
	NAT		Safeguarding Incidents			53	40	36	48	34	42	34	53	33	50	32	29	28
	NAT		Safeguarding Children Training			90.0%	90.0%	90.1%	91.2%	91.4%	91.9%	93.6%	93.5%	94.3%	93.6%	93.3%	92.3%	91.8%
	NAT		Safeguarding Adults Training			90.0%	86.5%	87.2%	88.6%	89.1%	89.8%	91.7%	92.1%	93.2%	93.5%	93.6%	93.0%	93.4%
	NAT		Duty of Candour - Findings			100%	87.5%	85.7%	81.3%	100%	92.9%	100%	100%	100%	76.5%	80.0%	87.1%	72.2%
	NAT		Duty of Candour - Written 15wd			100%	94.1%	91.4%	96.6%	85.0%	88.5%	95.5%	89.5%	61.9%	66.7%	64.3%	50.0%	86.7%
	NAT		Duty of Candour - Verbal			100%	100%	97.1%	96.2%	95.7%	90.9%	91.3%	94.7%	76.2%	78.3%	78.4%	87.0%	90.9%
	NAT		IPC: EColi Infections			13	7	11	5	15	13	14	17	10	11	16	14	13
	NAT		IPC: CDiff Infections			12	11	9	13	11	11	8	14	4	4	6	9	8
	NAT		IPC: Klebsiella Infections			7	7	4	9	9	5	4	5	10	7	7	9	7
	NAT		IPC: Pseudomonas Infections			2	1	3	1	2	3	4	3	2	2	4	5	2
	NAT		IPC: MRSA Infections			0	0	1	1	2	1	0	1	0	0	0	0	1
	NAT		IPC: MSSA Infections			6	3	6	7	6	8	7	2	6	7	5	8	6

Quality and safety

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
	NAT		IPC: MSSA Infections			6	3	6	7	6	8	7	2	6	7	5	8	6
	IIP		Pressure Ulcers			112	62	103	82	84	113	91	76	84	84	82	79	71
	NAT		Mixed Sex Breaches			162	62	26	49	63	132	134	132	120	24	36	76	56
	KEY		Complaint Response			90.0%	32.3%	7.1%	5.0%	7.8%	10.4%	15.5%	19.7%	0.0%	4.5%	7.8%	16.9%	20.5%
	KEY		Complaints Number			120	82	82	86	61	98	82	80	106	106	83	102	99
	NAT		FFT Satisfaction Level - ED			90.0%	81.3%	81.3%	81.5%	81.7%	80.9%	83.9%	82.9%	85.3%	87.0%	84.1%	83.6%	87.6%
	NAT		FFT Satisfaction Level - Outpatient			90.0%	95.2%	95.0%	95.1%	95.5%	95.5%	95.4%	95.2%	95.9%	95.7%	95.6%	95.4%	95.7%
	NAT		FFT Satisfaction Level - Inpatient			90.0%	88.8%	89.7%	87.7%	89.6%	90.1%	92.0%	90.0%	89.4%	91.1%	90.5%	92.3%	91.3%
	NAT		VTE Assessment Compliance			95.0%	91.2%	92.1%	92.1%	90.4%	91.6%	92.4%	92.5%	92.3%	93.2%	93.4%	92.7%	93.2%
			NICE Compliance			33.0%								4.3%	8.6%	16.5%	25.2%	34.4%

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	• 5 SI reports remain outstanding for closure by the ICB. • The plan is to submit all remaining open SI's before the end of September. • 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	30/09/2024	• ICB closure panels scheduled to review and approve existing SI's • An ICB closure panel is booked for 18/09/2024 to review the submitted SI's and approve closure • A further closure panel can be agreed if required with the ICB.
Overdue incidents	• Care groups have been provided with trajectories for the closure of overdue incidents by October 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	31/10/2024	• Care group governance meetings set up weekly to discuss progress with trajectories • The number of incidents becoming overdue has reduced from 20per day to 18 per day. The Triumvirates have been informed that this must reduce to 0. • The number of overdue incidents has reduced since end of August.
Complaint Performance is below the standard we would expect	• Resources within central team focussed on response reviewing, • 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	• Head of CPBS	• Ongoing in line with agreed trajectory for clearing the complaint breaches	• Trajectory set from 1 August, with progress planned, within current resource, to meet target of 85% within timescales by end of December 2024. • Meetings with care group specialties to discuss progress with trajectories and aged complaints. • Escalation process ongoing with support from triumvirates. • The number of complaints over 60 working days has significantly reduced since the end of August. to 148 as at 16.09.2024 compared to 239.

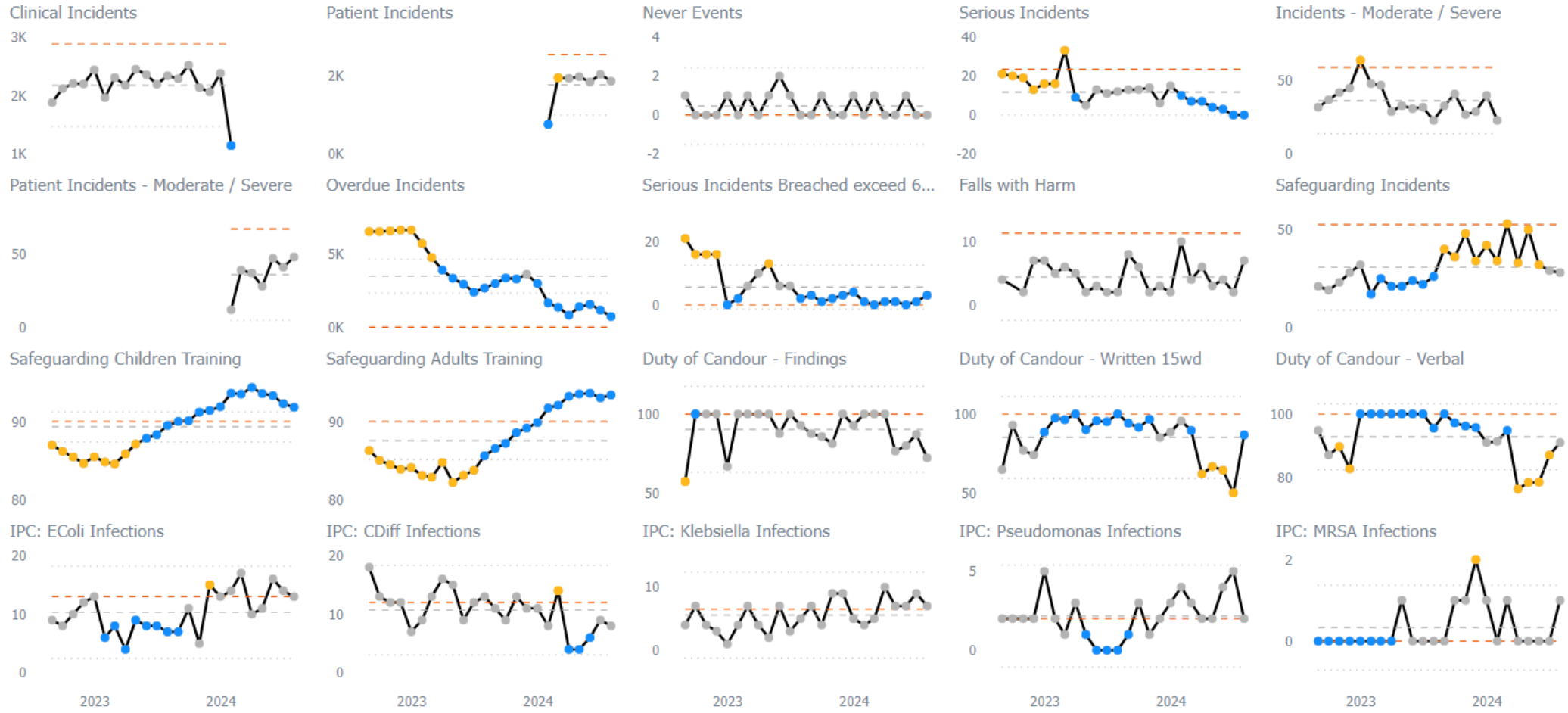
Quality and safety

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
There were 2 Never Events in August 2024 Wrong site Block Wrong route medication	• Appropriate action taken by clinical staff • DOC undertaken • Clinical Staff Supported • Immediate learning shared across the organisation			• To be presented at the anaesthetic M&M • Pre-Stop-Block training in as a matter of urgency for all new trainees. • Checklist being sent out to all anaesthetists. • For PSII investigation • An immediate review was requested in relation to the current processes for medication safety and IV training. • The incident was shared with Clinical Executive Management Group members to ensure wider immediate organisational learning. • For PSII investigation
IPC Measures: Due to changes in thresholds, Klebsiella and Pseudomonas Blood stream infections are now over the threshold, and without intervention will breach	• Targeted training focus on Lines completed, targeted focus now on environmental and equipment cleanliness as part of CLEAN campaign.	• IPR Team	Aug 2024	• Targeted training on all sites completed in relation to line care, whole Trust 'line forum' completed. • Trustwide review of FR cleaning ratings and additional protocols commenced • Training from Tristel team completed Trustwide

Quality and safety

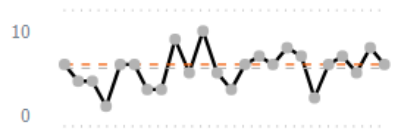
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT Inpatient: satisfaction levels remain around the Trust target of 90% satisfaction. There are significant disparities between satisfaction levels at the three sites, with K&CH scoring much higher than WHH and QEQM. Patient flow through EDs 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
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

Quality and safety

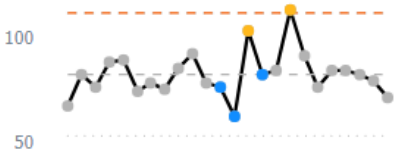


Quality and safety

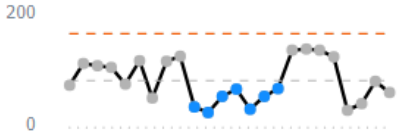
IPC: MSSA Infections



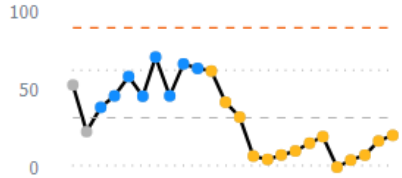
Pressure Ulcers



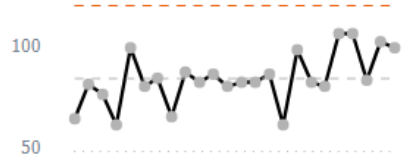
Mixed Sex Breaches



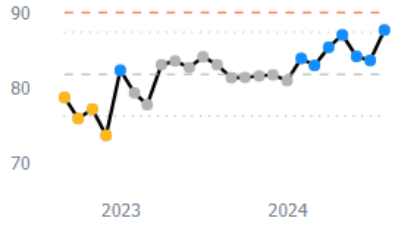
Complaint Response



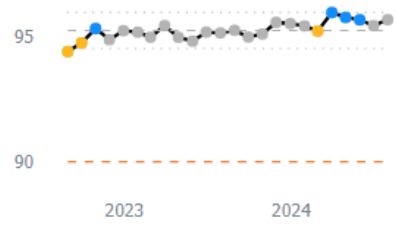
Complaints Number



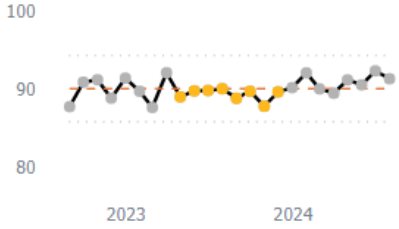
FFT Satisfaction Level - ED



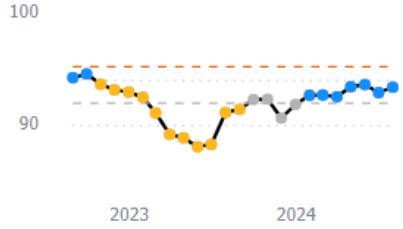
FFT Satisfaction Level - Outpatient



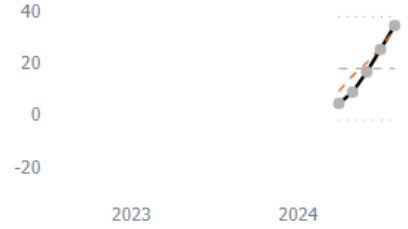
FFT Satisfaction Level - Inpatient



VTE Assessment Compliance



NICE 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	Sickness Statutory Training	Appraisals Compliance Hand Hygiene Training
No Significant Change	Premature Turnover Rate	Vacancy Rate	Medical Job Planning Rate
Concerning Variation (High or Low)			Staff Advocacy Score Staff Engagement Score

People

August Highlights:

Sickness absence improved in August, reducing to 4.52%. This remains below the alerting threshold and has now done for seven consecutive months following the introduction of face-face counselling in February. The Kent & Canterbury and Royal Victoria Hospitals Care Group has the lowest sickness absence of any Care Group at 3.98%, following closely by the William Harvey at 4.19%. The top 3 reasons for sickness are; stress, anxiety and depression, surgical procedures and MSK problems.

Sickness absence related to stress, anxiety and depression continues to improve, although it remains the highest cause of sickness absence across the Trust. The improvement appears to be a result of targeted support by the People & Culture Care Group Teams along with the re-introduction of on-site clinical psychology. 234 staff have accessed 724 face-to-face counselling sessions across the last 6-months, with a clinically reliable change in 77% of staff, and a measurable improvement using a well-validated (CORE-10) instrument. Across the 6 months, there has been an estimated saving of £195,194.03 due to this delivery of service. Stress, anxiety and depression does however remain the highest cause of sickness absence across the Trust.

Vacancy rate has increased back up to 9.6%, the highest it has been across the last 12 months. The primary reason for this increasing trajectory over the past few months is the holding of Band 2 HCSW vacancies

Staff turnover remains at 8.9% for August, continuing to exceed the desired industry 'gold' standard (≤10%). Turnover is the lowest it has been in over 18 months, and continues on an improving trajectory. Nursing turnover continues to improve and is now at 7.8% - also the lowest it has been in 18 months. In fact, there has been a continuous and positive reduction in nurse turnover since February 2023. Health Care Support Worker turnover has reduced from a height of 24% in May '23 and currently stands at 10.3%. This is the result of 14 successive months of improvement. Premature turnover had been increasing and recently breached the alerting threshold, although it has returned below 15% in August.

Statutory training compliance continues on a positive trajectory, with a subtle, month-on-month improvement to 92.4%. Compliance for medical staff is below the expected threshold, but has responded positively in-month and improved to 80.2%.

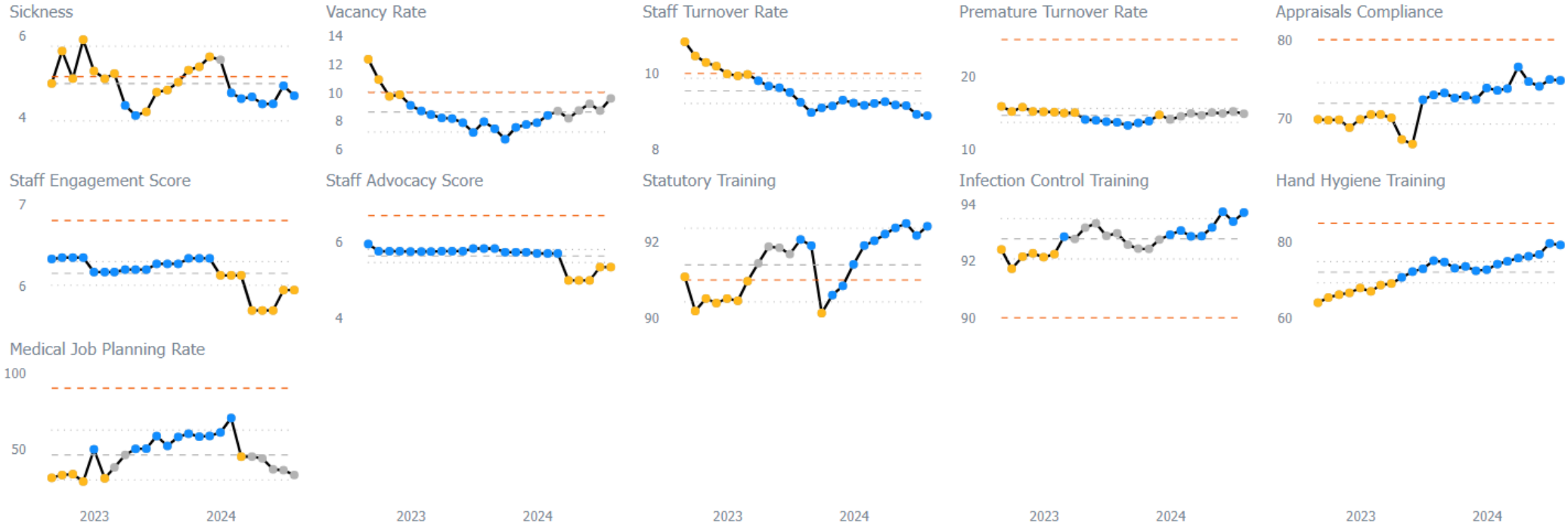
People

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
People	NAT		Sickness			5.0%	4.9%	5.2%	5.2%	5.5%	5.4%	4.6%	4.5%	4.5%	4.3%	4.3%	4.8%	4.5%
	NAT		Vacancy Rate			10.0%	7.4%	6.7%	7.5%	7.7%	7.9%	8.4%	8.7%	8.2%	8.7%	9.2%	8.7%	9.6%
	NAT		Staff Turnover Rate			10.0%	9.0%	9.1%	9.1%	9.3%	9.2%	9.2%	9.2%	9.3%	9.2%	9.2%	8.9%	8.9%
	NAT		Premature Turnover Rate			25.0%	13.3%	13.6%	13.9%	14.7%	14.1%	14.5%	14.9%	14.6%	15.0%	14.9%	15.2%	14.9%
	KEY		Appraisals Compliance			80.0%	73.3%	72.6%	72.9%	72.4%	73.9%	73.6%	73.8%	76.6%	74.7%	74.1%	75.0%	74.8%
	IIP		Staff Engagement Score			6.80	6.27	6.34	6.34	6.34	6.13	6.13	6.13	5.70	5.70	5.70	5.95	5.95
	KEY		Staff Advocacy Score			6.70	5.83	5.73	5.73	5.73	5.70	5.70	5.70	4.99	4.99	4.99	5.34	5.34
	NAT		Statutory Training			91.0%	91.9%	90.1%	90.6%	90.8%	91.4%	91.9%	92.0%	92.2%	92.4%	92.5%	92.2%	92.4%
	KEY		Infection Control Training			90.0%	92.6%	92.4%	92.4%	92.8%	92.9%	93.1%	92.9%	92.9%	93.2%	93.7%	93.4%	93.7%
	KEY		Hand Hygiene Training			85.0%	74.7%	73.1%	73.6%	72.4%	72.7%	74.2%	74.9%	75.8%	76.3%	76.8%	79.7%	79.2%
	KEY		Medical Job Planning Rate			90.0%	58.1%	60.3%	58.3%	58.8%	61.1%	70.5%	45.3%	45.3%	44.1%	37.0%	36.5%	33.3%

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 (**14.9%**) 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
Staff Advocacy Score
6
4
Statutory Training
92
90
Infection Control Training
94
92
90
Hand Hygiene Training
80
60
Medical Job Planning Rate
100
50
2023
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Sustainability

Assurance

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

Sustainability

August Highlights:

The Group has delivered the YTD plan of £37,753k to Month 5. The continued achievement of the plan is a significant strategic achievement for EKHUFT.

Trust pay expenditure has increased in month predominantly due to the SAS Doctor pay award paid in August (backdated to April and offset by additional income) and an increase in junior doctor appointments (in addition to expected rotation levels). YTD the Trust is favourable to plan in pay by £0.3m 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.

Trust non pay run rate decreased in month, mainly in rechargeable drugs and devices. YTD the Trust is £0.4m favourable to plan for non pay. Rechargeable drugs and devices are overspent by £3m YTD, which is offset against an increased level of income; underspends in clinical supplies and other non pay are linked to the reduction in NLF2R patients and a non-recurrent prior year rates rebate.

There are emerging risks to the submitted 2024/25 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, they could be a risk to our year-end position.

The Trust has delivered £17.2m of efficiencies in the first five months, £0.3m above the YTD plan, consisting of recurrent savings of £13.0m and non-recurrent savings of £4.2m. £53.4m in-year effect of risk-adjusted schemes identified as at 9/9/24, of which £52.9m are green schemes.

Sustainability

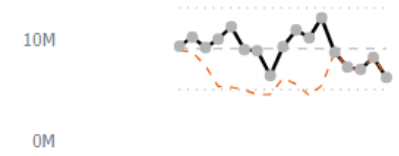
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Sustainability	IIP		Deficit In Month Group (£)			6.3M	9.0M	8.9M	6.5M	9.3M	11.0M	10.2M	12.2M	8.8M	7.3M	7.1M	8.3M	6.3M
	IIP		Variance to Plan (£)			0K	-3,98...	-4,3...	-1,86...	-3,11...	-5,381K	-5,721K	-6,718K	-5K	5K	-28K	20K	53K
	IIP		Premium Pay			11M	8.8M	8.2M	8.4M	8.3M	8.7M	8.7M	10M	8.1M	8.4M	7.9M	8.8M	8.9M
	IIP		WTE worked (Premium Pay)			1,290	1,060	1,230	1,065	981	959	1,041	1,131	963	1,019	968	1,031	1,049
	IIP		Total Pay Spend In Month			58M	52M	50M	51M	50M	52M	51M	60M	51M	51M	51M	51M	52M
	IIP		WTE worked (All Pay Spend)			10,406	10,254	10,1...	10,294	10,255	10,210	10,274	10,286	10,1...	10,103	9,984	10,0...	10,048
	KEY		Efficiencies Green Schemes (£M)			40	9	9	11	11	13	13	13	3	5	4	11	15
	IIP		Efficiencies YTD Variance (£M)			0.0	-9.5	-11.8	-14.8	-17.2	-20.5	-23.7	-26.9	0.0	0.0	0.0	0.1	0.3

Sustainability

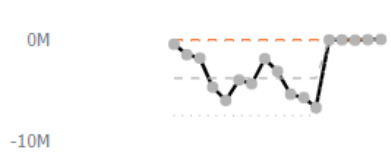
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
ID Medical finding it challenging to swap out high pay premium medical workers and/or negotiate alternative terms, such as becoming Direct Engagement (DE). Many of the high cost agency have been working with the Trust long term and embedded in 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

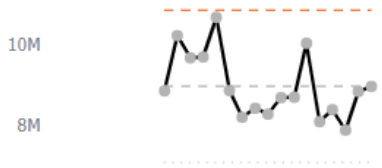
Deficit In Month Group (£)



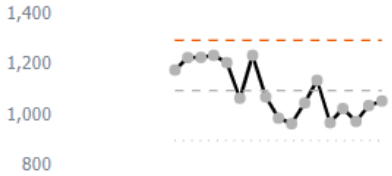
Variance to Plan (£)



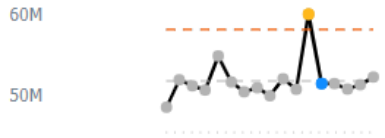
Premium Pay



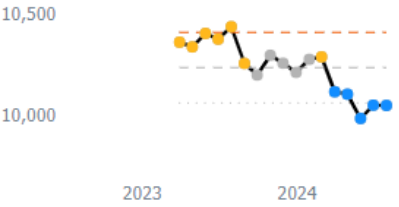
WTE worked (Premium Pay)



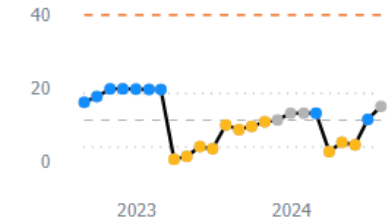
Total Pay Spend In Month



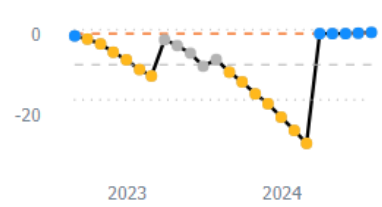
WTE worked (All Pay Spend)



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
Improving Variation (High or Low)		Serious Incidents Maternity	
No Significant Change		FFT Maternity (IP) Recommended FFT Maternity Recommended Maternity Complaint Response Maternity Complaints Maternity Incidents Moderate / Severe Maternity Patient Incidents Moderate / Severe	
Concerning Variation (High or Low)	Extended Perinatal Mortality	FFT Maternity Response Rate	WH Engagement Score

Maternity

August Highlights:
The extended perinatal rate remains consistently below the threshold of 5.42 per 1,000 births, with the August 12 month rolling rate at 3.98 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. EKHUFT data indicates an increasing trend in extremely premature babies (<28 weeks) being born, who then have a 30-80% chance of survival according to BAPM stats The rate of livebirths born under 28 weeks is 5.9 per 1000 births so far in 2024, compared to an average of 4.2per 1000.births during 2016-2020.

Whilst the number of babies born this early is small, this equates to a 34% increase of the neonatal deaths which occurred during the period of 1st April 2023 to 31st March 2024, 86.7% were born extremely premature The review will also examine the medical, social, and system-level factors that may have contributed to the neonatal deaths. (Equity and Equality)

The families have been contacted individually and followed up with a letter informing them of the review highlighting this is not because new information has come to light about their baby's care , but because we want to make sure our care is as good as it can be.
The external team consist of a Senior midwife, Consultant neonatologist and Senior Neonatal Nurse who will have monthly engagement with the DDOM and the aim to have a final report early December.

The Friends and Family Test (FFT) maternity response rate, calculated using the national methodology based on delivery episodes, has remained below average for seven consecutive months. However, the rate at William Harvey Hospital (WHH) increased in August to 12.8%, while the rate at Queen Elizabeth The Queen Mother Hospital (QEQM) declined to 7.7%. The Patient Experience team continues to collaborate with the Maternity Voices Partnership (MNVP) and ward managers to promote and enhance the response rate, aiming to capture feedback from a broader demographic of service users. At the ward level, discussions have emphasised the importance of promoting FFT at the point of discharge. Additionally, efforts are underway, in partnership with Patient Experience midwives and postnatal ward managers, to explore alternative formats that may encourage higher engagement.
Of those who responded to the antenatal FFT question in August, 89.5% would recommend EKHUFT Antenatal Maternity Services, and 91.5% would recommend EKHUFT for delivery services—exceeding the 90% target for eight consecutive months.
Historically, the Trust sent FFT text messages after all maternity-related contacts, which resulted in a low response rate of 5%, attributed to "feedback fatigue." In early 2022, a methodological change was implemented, shifting to sending a single text after delivery. This text asks for feedback on key areas, including antenatal care, delivery/birth, postnatal ward experience, and newborn hearing screening. This adjustment has led to an overall improvement in response rates, though additional efforts are needed to meet the Local Maternity and Neonatal System (LMNS) target of 15%.

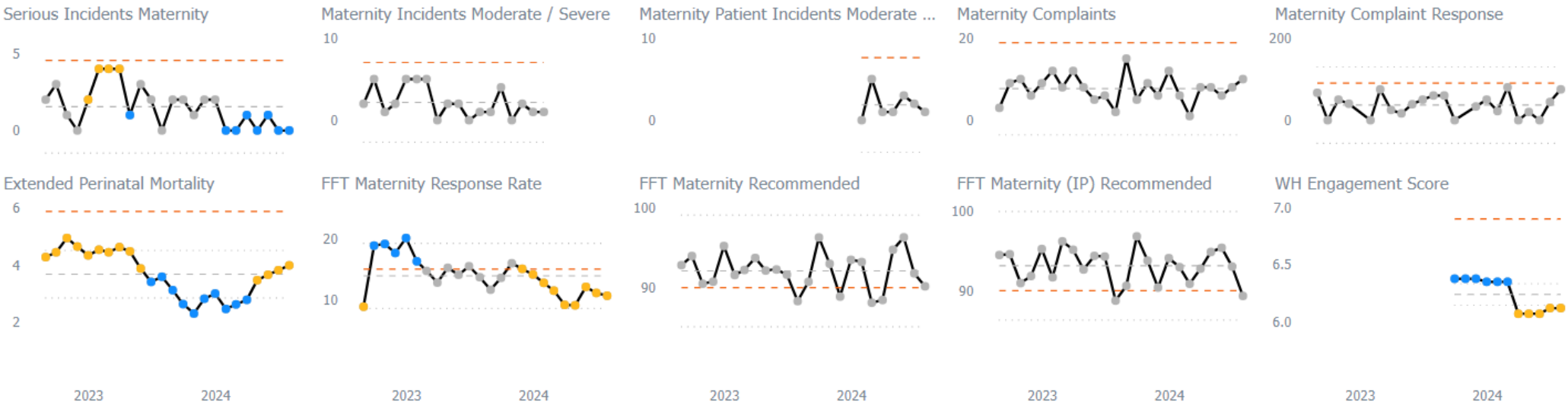
Maternity: Metric Dashboard

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Maternity	NAT		Serious Incidents Maternity			5	2	2	1	2	2	0	0	1	0	1	0	0
	KEY		Maternity Incidents Moderate / Sev...			7	1	4	0	2	1	1						
	KEY		Maternity Patient Incidents Moderat...			8						0	5	1	1	3	2	1
	KEY		Maternity Complaints			19	15	5	9	6	12	6	1	8	8	6	8	10
	KEY		Maternity Complaint Response			90.0%	60.0%	0.0%		33.3%	50.0%	22.2%	80.0%	0.0%	20.0%	0.0%	44.4%	75.0%
	KEY		Extended Perinatal Mortality			5.87	3.11	2.62	2.29	2.81	2.99	2.45	2.61	2.77	3.46	3.65	3.81	3.98
	NAT		FFT Maternity Response Rate			15.0%	11.7%	13.6%	16.0%	15.0%	14.1%	12.8%	11.5%	9.2%	9.1%	12.1%	11.1%	10.7%
	NAT		FFT Maternity Recommended			90.0%	90.7%	96.3%	93.0%	88.9%	93.5%	93.2%	88.1%	88.5%	94.7%	96.3%	91.8%	90.2%
	NAT		FFT Maternity (IP) Recommended			90.0%	90.6%	96.8%	93.8%	90.4%	94.1%	92.9%	90.9%	92.7%	94.8%	95.3%	93.0%	89.3%
	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	6.12

Maternity: Actions

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
	• 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 • Agreed with corporate team an understanding that some maternity incidents will remain open for longer than 6 weeks, given the complex nature of some investigations.	• 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 17/09/2024) is 98**, of which 55 are maternity, and 43 are gynaecology. This has halved since July.
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 early December • 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
Complaints	• Current vacancy for complaints manager within Governance Team	• Denise Newman, Head of Governance		• Vacancy out to advert. • Interim local action plan developed with DDOM for maintenance of service provision within governance team. • 41 current open complaints at various stages of completion. 3 currently breaching care group deadlines.

Maternity: Metric Run Charts



East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Month 5 (M5) Finance Report**

Meeting date: **3 October 2024**

Board sponsor: **Interim Chief Finance Officer (CFO)**

Paper Author: **Interim Deputy CFO**

Appendices:

APPENDIX 1: M5 Finance Report

Executive summary:

Action required:	Information
Purpose of the Report:	The report is to update the Board on the financial performance to August (Month 5).
Summary of key issues:	In August (Month 5), the Group delivered a deficit position of £6,278k, against a deficit plan of £6,335k, an in-month favourable variance of £57k. The deficit plan to Month 5 (£37,752k) was achieved by the Group, as detailed below.

	Month 5 - YTD		
£000	**YTD Plan**	**YTD Actual**	**YTD Variance**
Patient care income	£373,087	£372,105	(£982)
Other income	£28,029	£26,543	(£1,486)
Employee expenses	(£279,012)	(£278,166)	£846
Other operating expenses	(£156,221)	(£155,079)	£1,142
Non-operating expenses	(£3,891)	(£3,534)	£357
Technical Adjustments	£255	£423	£168
TECHNICALLY ADJUSTED SURPLUS / (DEFICIT)	**(£37,752)**	**(£37,708)**	**£45**

Patient care income has underperformed year-to-date (YTD) by £1.0m predominantly due to two reasons. Firstly, within Spencer Private Hospitals (SPH) due to consultant availability impacting on activity levels and secondly due to the successful reduction in patients residing in our hospital past the RTS < 7 days date, the Trust has seen a (£1.8m) reduction in planned income from the risk share agreement it holds with the Integrated Care Board (ICB). This has been offset by the reduction in pay costs delivered as a result of not opening those beds.

We care

East Kent Hospitals University NHS Foundation Trust

	Other income is underachieving by £1.5m YTD, predominantly within 2gether Support Solutions (2gether) where income underperformance is offset by non-pay underspends. Within employee expenses the shortfall in funding for the consultant pay award is £1.6m YTD. This is partly offset in income (£1.0m), however, a shortfall in funding remains and although currently offset by non-recurrent benefits in the YTD position, if additional funding is not agreed, it could be a risk to our year end position (£1.0m). The Specialty and Specialist (SAS) doctor pay award, including back-pay to April, was paid in August at an estimated cost of £0.5m. This has been matched in full with additional income. A £49m in-year cost improvement programme (CIP) target has been set for 2024/25, as part of the £85.8m deficit plan. CIP delivery is £0.3m ahead of plan YTD to Month 5. The Trust has recognised recurrent savings of £13.0m YTD to August and non-recurrent savings of £4.2m. The Group cash balance (including subsidiaries) at the end of August was £34.4m. The Trust drew £10.5m of working capital (Public Dividend Capital (PDC)) in the month (£38.9m YTD). Total capital expenditure at the end of August was £3.5m spend against a plan of £7.1m. All key scheme leads have been asked to reforecast the phasing of expenditure for their schemes, by month, to the end of the financial year to present to the Capital Investment Group (CIG) in October.
Key recommendations:	The Board is asked to review and **NOTE** the financial performance of Month 5.

Implications:

Links to Strategic Theme:	• Partnerships • Sustainability Having Healthy Finances by providing better, more effective patient care that makes resources go further.
Link to the Trust Risk Register:	**SRR 3664**: Failure to deliver the Trust financial plan for 2024/25.
Resource:	N - Key financial decisions and actions may be taken on the basis of this report.
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: Finance and Performance Committee - 23 September 2024

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2024/25

August 2024

Chief Finance Officer
Tim Glenn

Group Summary
Month 05 (August) 2024/25

	Trust			2gether Support Solutions			Spencer Private Hospitals			Consolidation Adjustments			Group		
	Year to Date			Year to Date			Year to Date			Year to Date			Year to Date		
(£'m)	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
NHS Income From Commissioners - exc. D&D	341.874	338.514	(3.360)	0.000	0.000	0.000	8.876	7.225	(1.651)	(2.961)	(1.109)	1.852	347.789	344.630	(3.159)
NHS Income From Commissioners - Drugs	20.113	22.678	2.565	0.000	0.000	0.000	1.595	1.241	(0.354)	0.070	0.000	(0.070)	21.778	23.919	2.141
NHS Income From Commissioners - Devices	3.500	3.556	0.056	0.000	0.000	0.000	0.000	0.000	0.000	0.020	0.000	(0.020)	3.520	3.556	0.036
Other Income	26.848	26.994	0.146	66.445	61.104	(5.341)	0.006	0.018	0.012	(65.270)	(61.573)	3.697	28.029	26.543	(1.486)
Total Income	**392.335**	**391.742**	**(0.594)**	**66.445**	**61.104**	**(5.341)**	**10.477**	**8.484**	**(1.993)**	**(68.141)**	**(62.682)**	**5.460**	**401.116**	**398.648**	**(2.468)**
Substantive Staff (inc. Apprenticeship Levy)	(224.530)	(223.774)	0.756	(17.138)	(17.112)	0.026	(3.576)	(3.086)	0.490	(0.262)	0.322	0.584	(245.506)	(243.650)	1.856
Bank Staff	(18.513)	(19.746)	(1.233)	0.000	0.000	0.000	0.000	0.000	0.000	0.081	0.000	(0.081)	(18.432)	(19.746)	(1.314)
Agency/Contract	(14.283)	(13.472)	0.811	(1.068)	(0.907)	0.161	(0.303)	(0.371)	(0.068)	0.580	(0.020)	(0.600)	(15.074)	(14.770)	0.304
Total Employee Expenses	**(257.327)**	**(256.993)**	**0.334**	**(18.206)**	**(18.019)**	**0.187**	**(3.879)**	**(3.457)**	**0.422**	**0.400**	**0.303**	**(0.097)**	**(279.012)**	**(278.166)**	**0.846**
Drugs	(19.176)	(18.935)	0.241	0.000	0.000	0.000	(1.675)	(1.241)	0.434	1.442	1.085	(0.356)	(19.409)	(19.091)	0.318
Rechargeable Drugs	(20.100)	(23.048)	(2.948)	0.000	0.000	0.000	0.000	0.000	0.000	(0.251)	0.000	0.251	(20.351)	(23.048)	(2.697)
Rechargeable Devices	(3.500)	(3.556)	(0.056)	0.000	0.000	0.000	0.000	0.000	0.000	(0.020)	0.000	0.020	(3.520)	(3.556)	(0.036)
Supplies and Services - Clinical	(20.601)	(19.277)	1.324	(17.530)	(23.990)	(6.460)	(0.744)	(0.919)	(0.175)	1.353	0.610	(0.743)	(37.522)	(43.576)	(6.054)
Supplies and Services - General	(60.707)	(62.030)	(1.322)	(12.405)	(6.813)	5.592	(0.129)	(0.097)	0.032	61.186	57.001	(4.186)	(12.055)	(11.939)	0.116
Clinical negligence	(14.608)	(14.608)	(0.000)	0.000	0.000	0.000	0.000	0.000	0.000	(0.306)	(0.000)	0.306	(14.914)	(14.608)	0.306
Depreciation and Amortisation	(9.505)	(9.505)	0.000	0.000	(0.384)	(0.384)	(0.089)	(0.138)	(0.049)	(1.638)	(0.001)	1.637	(11.232)	(10.028)	1.204
Other non pay	(22.038)	(19.031)	3.008	(17.469)	(11.316)	6.153	(3.641)	(2.569)	1.072	5.930	3.682	(2.248)	(37.218)	(29.233)	7.985
Total Other Operating Expenses	**(170.235)**	**(169.990)**	**0.246**	**(47.404)**	**(42.503)**	**4.901**	**(6.278)**	**(4.964)**	**1.314**	**67.696**	**62.377**	**(5.319)**	**(156.221)**	**(155.079)**	**1.142**
Non Operating Expenses	(3.957)	(3.777)	0.180	0.108	0.270	0.162	(0.091)	(0.025)	0.066	0.049	(0.002)	(0.051)	(3.891)	(3.534)	0.357
Profit/Loss	**(39.184)**	**(39.018)**	**0.166**	**0.943**	**0.852**	**(0.091)**	**0.229**	**0.038**	**(0.191)**	**0.004**	**(0.003)**	**(0.007)**	**(38.008)**	**(38.131)**	**(0.123)**
Less Technical Adjustments	0.255	0.423	0.168	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.255	0.423	0.168
Technically Adjusted Profit/Loss	**(38.929)**	**(38.595)**	**0.334** 1	**0.943**	**0.852**	**(0.091)** 2	**0.229**	**0.038**	**(0.191)** 3	**0.004**	**(0.003)**	**(0.007)** 4	**(37.753)**	**(37.708)**	**0.045** 5

1. Trust:
The Trust year-to-date deficit is £38.6m against a plan deficit of £38.9m; a £0.3m favourable variance YTD . The key drivers include:

- Income from patient care activity is adverse to plan by £0.7m YTD. The key factors are drugs and devices over performance YTD £2.6m, accrued income for the Consultant pay award £1.0m and SAS Doctors £0.5m (all offset by additional expenditure) and £1.8m underperformance against ICB discharge funding due to the success of the joint project to lowering the number of not fit to reside inpatients in our beds. In-month there was also ICB contract reductions relating to discharge schemes of £2.7m, offset by £2.6m mediation settlement. There is £1.7m of prior year income in the YTD position from NHS Specialist Commissioning income relating to ERF and Drugs.
- Other operating income is favourable to plan by £0.1m YTD, driven mainly by above plan income for GP trainee salaries and car parking income, offset by below plan cash donations.
- Employee expenses are £0.3m favourable to plan YTD, mainly driven by substantive and agency staff underspends (£1.5m in total) offset by a £1.2m overspend on bank staff.
- Other operating expenses are £0.2m favourable to plan YTD, primarily due to a prior year rates rebate for Kent and Canterbury Hospital backdated to the 2017/18 financial year, received in August.

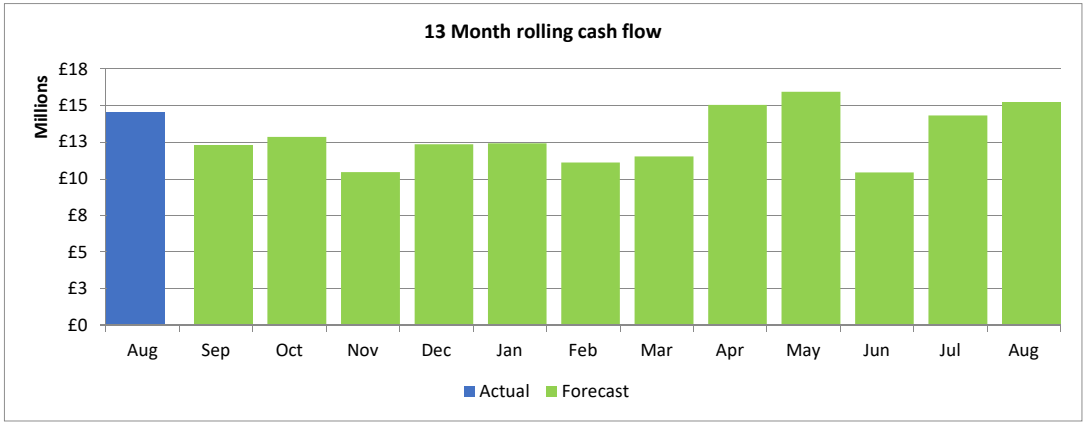
2. 2gether Support Solutions
2gether Support Solutions reported a YTD surplus of £0.8m; £0.1m adverse to plan. Income underperformance for catering retail is offset by non pay underspends.

3. Spencer Private Hospitals
Spencer Private Hospitals operating profit and profit after tax level is a YTD surplus of £0.04m; adverse to plan by £0.2m, mainly due to surgical activity being below budgeted levels which is partly offset by underspends on substantive staff cost and other operating expenses.

4. Consolidation Adjustments
Consolidation adjustments remove all inter-company transactions for income and expenditure.

5. Group
The Group reported a year to date deficit of £37.7m, which is in line with the planned year to date deficit.

Cash Flow
Month 05 (August) 2024/25



Unconsolidated Cash balance was £14.5m at the end of August 2024, £5.0m above plan.

Cash receipts in month totalled £91.0m (£7.6m above plan):

- K&M ICB paid £60.1m in August (£2.9m above plan - £1.8m contract value and £1.1m invoices cleared)
- NHS England paid £13.0m in August (£0.2m above plan)
- VAT received was of £3.9m in August (£0.4m above plan. related to July VAT reclaimed)
- Other Receipts totalled £3.5m (£1.0m above plan)
- Revenue Support received in month was £10.5m (£3.1m above plan)

Cash payments in month totalled £96.7m (£8.5m above plan)

- Creditor payment runs including Capital payments were £31.5m (£5.3m above plan).
- £20.6m payments to 2gether were £6.6m above plan.
- Total payroll was £44.5m, £3.4m below plan (inc PAYE, NI and Pensions)

2024/25 Cash Plan

The revised plan submitted to NHSE/I in June 2024 shows a Trust deficit position at the end of 2024/25 of £88.5m. Revenue support PDC for the full deficit amount is forecast in the year.

Revenue Support

In Q1 2024/25 the Trust requested £25.6m and received £21.5m . The impact of receiving less than requested, resulted in prioritising Non-NHS creditor payments and delaying payments to NHS creditors and in addition, risk suppliers relationship and non-compliance of BPPC.

So far In Q2 2024/25 the Trust has requested a total of £25m, including the shortfall in Quarter 1. In July 2024, the Trust requested £10.9m in line with our cash flow forecast and received £7.0m revenue support, a reduction of £3.9m, which also further impacted our BPPC compliance. Subsequently the Trust requested a further £10.5m in August (which included the Shortfall of £3.9m). This was received on the 19th August.

A further Revenue support of £7.5m has been requested for September in line with our Month 6 Year to date deficit of £46.4m awaiting NHS England approval.

The deadline for Q3 revenue support submission is 19th September 2024. The Trust will be submitting a request of £22.8m (£7.7m October, £10.0m November and £5.1m December).

Creditor Management

The Trust paid to 30 day creditor terms for Non NHS suppliers in Month 5.

At the end of August 2024, the Trust was recording 42 creditor days (Calculated as invoiced creditors at 31st August/Forecast non-pay expenditure x 365).

Statement of Financial Position

Month 05 (August) 2024/25

	Trust			2gether Support Solutions			Spencer Private Hospitals			Consolidation Adjustments			Group		
(£'m)	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**
Non Current Assets	**379.770**	**372.383**	**(7.387)**	**67.469**	**67.202**	**(0.267)**	**4.408**	**4.427**	**0.019**	**(145.701)**	**(144.964)**	**0.737**	**305.946**	**299.048**	**(6.898)**
Inventories	7.878	8.423	0.545	5.245	5.245	0.000	0.047	(0.001)	(0.048)	0.000	0.000	0.000	13.170	13.667	0.497
Trade Receivables	37.592	33.202	(4.390)	25.520	7.388	(18.132)	5.397	5.949	0.552	(31.706)	(14.436)	17.270	36.803	32.103	(4.700)
Accrued Income and Other Receivables	(3.504)	(3.098)	0.406	(0.127)	(0.179)	(0.052)	(0.134)	(0.069)	0.065	0.000	0.000	0.000	(3.765)	(3.346)	0.419
Assets Held For Sale	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Cash and Cash Equivalents	17.955	14.544	(3.411)	12.413	21.779	9.366	2.049	2.117	0.068	0.000	0.000	0.000	32.417	38.440	6.023
Current Assets	**59.921**	**53.071**	**(6.850)**	**43.051**	**34.233**	**(8.818)**	**7.359**	**7.996**	**0.637**	**(31.706)**	**(14.436)**	**17.270**	**78.625**	**80.864**	**2.239**
Payables and Accruals	94.290	80.647	(13.643)	23.247	13.413	(9.834)	5.103	5.772	0.669	(27.854)	(10.789)	17.065	94.786	89.043	(5.743)
Deferred Income and Other Liabilities	8.100	8.893	0.793	0.000	0.000	0.000	0.000	0.000	0.000	(0.006)	(0.034)	(0.028)	8.094	8.859	0.765
Provisions	10.035	10.653	0.618	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	10.035	10.653	0.618
Borrowing	4.270	3.597	(0.673)	2.524	2.509	(0.015)	0.105	0.095	(0.010)	(4.334)	(4.396)	(0.062)	2.565	1.805	(0.760)
Current Liabilities	**116.695**	**103.790**	**(12.905)**	**25.771**	**15.922**	**(9.849)**	**5.208**	**5.867**	**0.659**	**(32.194)**	**(15.219)**	**16.975**	**115.480**	**110.360**	**(5.120)**
Provisions	3.423	3.373	(0.050)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	3.423	3.373	(0.050)
Borrowing	71.611	70.425	(1.186)	50.475	49.449	(1.026)	1.964	1.923	(0.041)	(115.804)	(113.864)	1.940	8.246	7.933	(0.313)
Non Current Liabilities	**75.034**	**73.798**	**(1.236)**	**50.475**	**49.449**	**(1.026)**	**1.964**	**1.923**	**(0.041)**	**(115.804)**	**(113.864)**	**1.940**	**11.669**	**11.306**	**(0.363)**
Net Assets	**247.962**	**247.866**	**(0.096)**	**34.274**	**36.064**	**1.790**	**4.595**	**4.633**	**0.038**	**(29.409)**	**(30.317)**	**(0.908)**	**257.422**	**258.246**	**0.824**
Public Dividend Capital	559.544	598.468	38.924	30.267	30.267	0.000	0.048	0.048	0.000	(30.315)	(30.315)	0.000	559.544	598.468	38.924
Retained Earnings	(373.566)	(412.587)	(39.021)	5.085	5.794	0.709	1.736	1.773	0.037	0.363	0.535	0.172	(366.382)	(404.485)	(38.103)
Revaluation Reserve	61.983	61.981	(0.002)	0.000	0.000	0.000	2.812	2.812	0.000	(0.535)	(0.535)	0.000	64.260	64.258	(0.002)
Taxpayers Equity	**247.961**	**247.862**	**(0.099) 1**	**35.352**	**36.061**	**0.709 2**	**4.596**	**4.633**	**0.037 3**	**(30.487)**	**(30.315)**	**0.172 4**	**257.422**	**258.241**	**0.819**

1. Trust:

Non-Current Assets - values reflect in-year additions less depreciation charges. Non-Current assets also includes the loan and equity that finances 2gether Support Solutions.

Current Assets - Current assets have decreased from the 2023/24 opening position by £7m due to reduction in trade receivables and cash. Please see Cash and Working capital pages for additional details.

Current Liabilities - Current liabilities has decreased by £13m due to reduction in payables (See Working Capital sheet for more detail) slightly offset by increase in Deferred income.

Non current liabilities - The long-term debt entry relates to the long-term finance lease debtor with 2gether.

Public Dividend Capital - Decreased to date by £10.5m reflecting PDC revenue support received up to August 2024.

2. 2gether Support Solutions:

Non-current assets - reflects movement in depreciation to date.

Current assets - This has increased from opening position by £2m due to increase in receivables.

Current liabilities - have increased by £2.3m from the opening position, primarily due to increase in payables

3. Spencer Private Hospitals:

Current Assets - decreased mainly due to invoice receivables

Current Liabilities - decreased mainly due to payment of creditors.

4. Consolidation Adjustments - Removal of inter-company transactions and loans.

Capital Expenditure
Month 05 (August) 2024/25

Capital Programme	Annual	Annual	Year to Date		
£000	**Plan**	**Forecast**	**Plan**	**Actual**	**Variance**
Critical Priorities (PEIC)	4,000	4,000	1,529	547	982
MDG - Medical Devices Replacement	2,249	2,249	685	177	508
Diagnostics Clinical Equipment Replacement Programme (ERP)	3,618	3,618	1,229	417	812
IDG - IT Systems Replacement	700	700	158	3	155
Electronic Medical Records (EMR)	800	800	278	68	210
Subsidiaries - 2Gether Suport Solutions (2SS)	618	618	97	31	66
Subsidiaries - Spencer Private Hospitals (SPH)	150	150	45	157	(112)
Mechanical Thrombectomy	2,028	2,028	1,230	1,009	221
Renal – Expansion of dialysis services (Phase 2)	964	0	80	0	80
Stroke HASU	1,118	1,118	87	15	72
Pathology S8 - GP and Community Order Comms (LIMS)	140	140	140	140	0
Maternity Estates Review	1,594	0	90	2	88
Diagnostics Imaging (QEQM MRI)	2,100	2,100	0	0	0
Community Diagnostics Centre (CDC) - Buckland (EKHUFT)	1,033	1,033	600	416	184
Fire Compartmentation Strategy	4,000	4,000	299	47	252
Digital Histhopathology - 2024/25 (Year 2)	407	407	337	307	30
QEQM MRI Power Upgrade	45	45	0	0	0
Donated Assets	900	900	270	177	93
Vacuum Assisted Biopsy and Excision System (VAB/VAE)	0	70	0	0	0
Trust IFRS16 Acquisitions	242	242	0	0	0
All Other	0	(14)	0	(60)	60
	26,706	**24,204**	**7,154**	**3,453**	**3,701**

Funded By:	**Plan**	**Forecast**	**Change**
Operational Capital	21,887	21,887	0
Donations	900	900	0
PDC	1,347	1,417	70
	24,134	**24,204**	**70**

Under/(Over) Commitment	**(2,572)**	**0**

The Group's gross capital year-to-date expenditure to the end of Month 5 2024/25 was £3.45m. This represents a £3.7m underspend against the YTD Plan of £7.15m.

The £3.7m underspend is driven by slippage across all major schemes, most notably the critical infrastructure programme (PEIC - £0.98m), the equipment replacement programmes (ERP – £0.81m and MDG - £0.5m) and other major estates schemes, including the Fire Compartmentation Strategy (£0.25m), Mechanical Thrombectomy (£.022m) and the Community Diagnostics Centre (CDC - £0.18m). Some of the major IT programmes are also behind the YTD plan: Electronic Medical Records (EMR - £0.2m) and the IT hardware & software replacement programme (IDG - £0.16m). All key scheme leads have been asked to reforecast their schemes, by month, to the end of the financial year to enable the Capital Investment Group (CIG) in October to consider implementing a planned slippage management approach from Month 6/7 onwards if required.

Other key areas to highlight:
Additional Capital Funding has been approved as follows:

• The MOU for the **£0.07m PDC funding approved** by NHSE to support the **Vacuum Assisted Biopsy (VAB) and the Vacuum Assisted Excision (VAE)** Business Case has now been received. The scheme has been included within the Trust's 2024/25 Capital Programme and forecast.

• A letter of approval has also been received from NHSE in respect of **£0.45m awarded** for the procurement of equipment and establishment of a **Transnasal Endoscopy service (TNE)** at EKUHFT. The business case needs to go through internal Trust governance for approval.

• Confirmation has been received from the DHSC in support of **£25m capital funding to deliver critical improvements to the maternity estate at QEQM**, subject to a subsequent Full Business Case being approved by the national team. The proposed timeline and phasing to deliver the improvements will be confirmed in the coming months, although the following indicative allocation has been proposed:
2024/25: £1.536m
2025/26: £3.217m
2026/27: £16.520m
2027/28: £3.677m
Total £24.950m

The latter two schemes referenced are yet to be reflected within the 2024/25 Capital Programme's Forecast, pending the receipt of the associated MOUs (Memorandums of Understanding between the Trust and NHSE) and full internal Business Case approval.

Cost Improvement Summary
Month 05 (August) 2024/25

Delivery Summary	This Month		Year to Date	
Programme Themes £000	**Plan**	**Actual**	**Plan**	**Actual**
0.01 Estate Utilisation & Rationalisation	38	11	114	64
0.02 Procurement	681	622	2,539	2,697
0.03 Digital Utilisation & Rationalisation	8	8	27	13
0.04 Income – Capture, Coding and Pricing	633	633	1,567	1,567
0.05 Financial Control & Governance	341	22	2,711	108
0.06 Low Value Interventions	-	-	-	-
0.07 Drugs & Devices	67	118	562	743
0.08 Length of Stay	223	319	1,114	1,219
0.09 Medically Optimised for Discharge Pathway	-	-	-	-
0.10 Theatre Utilisation	369	298	1,795	1,239
0.11 Admission Avoidance	-	-	-	-
0.12 Outpatients	284	55	1,420	1,717
0.13 Diagnostics	179	292	883	1,229
0.14 Medical Staffing	580	500	1,876	1,012
0.15 Nursing and Midwifery	236	130	724	702
0.16 Allied Health Professionals	88	65	326	365
0.17 Other Workforce	200	20	792	718
Care group Led Schemes **	132	1,128	508	3,850
Grand Total	**4,057**	**4,221**	**16,956**	**17,242**

Delivered £000		
Month	**Target**	**Actual**
April	2,786	2,786
May	2,957	2,957
June	3,440	3,440
July	3,715	3,837
August	4,057	4,221
September	4,247	
October	4,501	
November	4,597	
December	4,517	
January	4,630	
February	4,636	
March	4,915	
	49,000	**17,242**
		35.2%

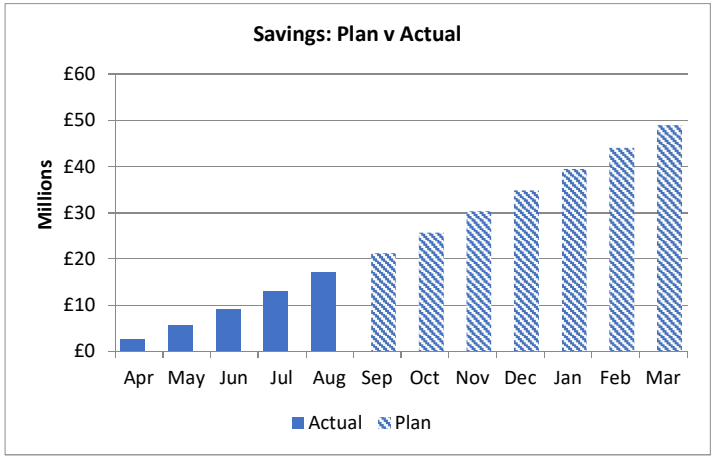
Efficiencies

The agreed Efficiencies plan for 2024/25 is £49.0m. CIP delivery is above plan to Month 5 by £0.3m. Recurrent savings of £2.3m have been delivered in August, and £13.0m on a YTD basis.

As the financial control & governance schemes are defined by care group they are being allocated to the relevant care group.

PwC support to the PMO and Theme Leads continues. The PMO is working closely with Finance Business Partners and Theme Leads, focussing on delivery of CIPs for the current financial year.

The PMO is collaborating effectively with the Financial Recovery Director, concentrating efforts on advancing projects at various stages - Amber, Red, and Pipeline - towards Green status. This will put the trust in a strong position for action and ensure delivery in FY24/25.



East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Report on Journey to Exit NHS Oversight Framework 4 (NOF4) and Integrated Improvement Plan (IIP)**

Meeting date: **3 October 2024**

Board sponsor: **Chief Executive (CE)**

Paper Author: **Chief Strategy and Partnerships Officer (CSPO)**

Appendices:

Appendix 1: IIP Progress Report (September 2024)

Executive summary:

Action required:	Discussion
Purpose of the Report:	This report has been provided to update the Board of Directors at EKHUFT on delivery progress of the IIP during August 2024 and offers assurance based on evidence gathered for how this is influencing the transition criteria set within the NHS England Recovery Support Programme NOF4 as at Q1.
Summary of key issues:	The report includes an update by programme and project. The Finance Programme continues to be rated as green this month, achieving the Q1 metrics, remaining on track for M5. The Leadership, Governance & Culture programme has been rated as amber, and has now achieved the outstanding metrics from Q1. The Urgent and Emergency Care (UEC) and Planned Care programmes have been rated as amber, working towards the achievement of the Q1 metrics, whilst continuing to focus on Q2. The Programme Management Office (PMO) continue to work to align IIP associated risks with the Trust significant risk register. 80 pieces of evidence were received in Q1. These were presented as part of the Q1 external review took place on 23 July with the Integrated Care Board (ICB) and South East (SE) Region colleagues, who confirmed both the performance and evidence positions against the Q1 metrics. These are reflected in the highlight reports. Evidence continues to be gathered ahead of the Q2 review in October.
Key recommendations:	The Board of Directors is invited to **DISCUSS** the report.

We care

East Kent Hospitals University NHS Foundation Trust

Implications:

Links to Strategic Theme:	This report aims to support: • Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	N/A
Resource:	No
Legal and regulatory:	Yes – regulatory impact.
Subsidiary:	Yes – in the overall provision of services within the resources available to the Trust.

Assurance route:

Previously considered by: Clinical Executive Management Group (CEMG)

East Kent Hospitals University Foundation Trust
Report on Integrated Improvement Plan (IIP)

Journey to Exit NHS Oversight Framework 4 (NOF4) – IIP Progress Report - September 2024

Purpose of Report

East Kent Hospitals University NHS Foundation Trust

This report has been provided to update the Board of Directors at EKHUFT on delivery progress of the Integrated Improvement Plan and offers assurance based on evidence gathered for how this is influencing the transition criteria set within the NHS England Recovery Support Programme National Oversight Framework Segment 4 (NOF4). The report also acknowledges the key risks to delivery of the IIP, highlighting current mitigations in place.

Delivery of the Integrated Improvement Plan is overseen by the EKHUFT Clinical Executive Management Group (CEMG) which is chaired by the Chief Executive. Programmes continue to ensure the level of evidence meets EKHUFT and other stakeholder requirements i.e., system partners and region.

The Board of Directors receive a monthly update on delivery of the Integrated Improvement Plan focusing on successes, challenges and actions to mitigate any key risks to delivery which may affect NOF4 transition criteria with a programme RAG self-assessment. Impact and demonstrable progress against the overall programme objectives set by the National Team are provided on a quarterly basis through a deep dive presentation.

High-level Programme Summary

Agreed Programme RAG	Summary
Leadership, Governance & Culture	• A substantive Chief Finance Officer (CFO) has been recruited and will take up post in mid October. The advert for the Chair closed on 2 August and the shortlisting process is underway. • A board development day took place earlier this month and the next is scheduled for November, following the approval of the Board Development programme. • Following the interim arrangement of Managing Director (MD) cover at Queen Elizabeth the Queen Mother Hospital (QEQM) until end of March 2025, the Q1 metrics have now been met. • Conversations continue to agree scope of the plan. It is agreed the plans need to include topics such as communication, leadership/leadership choices and resilience. The team identified that a broader tri programme would be worth designing with a view to support professional specific action learning or development spaces - so a space for MDs a space for medical leaders etc. • There is clear evidence of increased and effective engagement: Over 200 colleagues joined August staff forum, compared to approx. 80 when forums started. Record 266 nominations received for EKHUFT celebration awards and during August all nominees received a hand delivered letter and certificate from members of the Exec team. Weekly examples of staff engagement in Quality Improvement (QI) projects included in internal comms. Partnership and voluntary organisations represented at Annual General Meeting (AGM). • 45 meetings have been arranged and nine of these have taken place. Remainder planed for September and October. In process of procuring external partner to support wider organisational strategy, linking with partners across the system. • There is an ongoing dedicated estates work programme. Detailed work ongoing focusing on critical infrastructure remediation. Work has commenced on site opportunities.
Finance	• The formal re-audit of financial controls forms part of final tranche of PriceWaterhouseCoopers (PWC) support and will commence in three weeks time. • Cost Improvement Programme (CIP) delivered above plan for M5. • Year to Date (YTD) deficit plan to Month 5 achieved by the Group. • Emerging risks relate to the recent junior doctor industrial action at the end of June, and shortfall in funding to cover the consultant pay award. The trust is working both internally and with Integrated Care Board (ICB), regional and national partners to mitigate these risks. • PWC continue to work with the Trust to develop the first draft for discussion at the end of Q2. • Interdependence with ICB recovery plan is both a key risk and opportunity. The Trust is actively engaged in the system process, supporting the leadership of a system wide workshop with Miles Scott (Chief Executive Officer (CEO) at Maidstone and Tunbridge Wells NHS Trust (MTW)) who is CEO Senior Responsible Officer (SRO) at a system level for the plan production.
Urgent Care	• The trajectory for Length of Stay (LOS) for NEL >14 days was met in Month 5 with performance at 30.8% against a trajectory of <31%. The delivery of this trajectory is at risk due to the changes in contract provider of the P1 pathways and the increase in patients not meeting the criteria to reside – a mitigation plan has been requested of the system partners to address this and internally a change in the referral management of complex discharges will support a reduction in delays associated with the referral and assessment process – this launched in September 2024. • The Type 1 trajectory at Month 5 was achieved with a performance of 56.2% against a Q2 target of 48% and is the highest performance for the past two years. The number of patients >12 hours is slightly off track at 9.2% of patients waiting in the department >12 hours against a quarter average of 9% to be delivered - this remains an area of focus by the care groups but does reflect the pressure in the system with an increase in attendances above contract levels. Targeted interventions to improve this position include the opening of the Clinical Decision Unit (CDU) at William Harvey Hospital (WHH) in September as well as the launch of the new acute medicine model. • Standard Operating Procedure (SOP) has now been finalised and shared with the ICB. It was piloted at QEQM and rolled out to WHH w/c 23/09. Harm reviews are being undertaken and baseline data agreed. • The Critical Care team are now starting to review any patients that waited over 12 hours in Emergency Department (ED) and were transferred into Critical Care, with any omissions of care are shared with specialties as part of learning.

High-level Programme Summary

Agreed Programme RAG	Summary
Planned Care	**Referral to Treatment (RTT)** • As at the end of August, the Trust had 35 78 week breaches. The trust has also completed a detailed review around their 65 week clearance plan which has been reviewed at Access, ratified by the Chief Operating Officer (COO) and now forms the core plan for delivery against the IIP. This plan currently forecasts a worst case of 574 65 week risks at the end of September (ahead of 1,125 IIP plan) alongside an expectation of zero 78 week risks in September. • Key current challenges/actions relate to ongoing Otology demand (reviewing CV's from insourcing provider), Paediatric ENT demand (contact programme underway, validation of cohort against EBICS criteria, additional weekend lists in place, insourcing being sourced to mobilise ASAP). Also full mobilisation of insourcing for Gastro 65 week cohort commenced with ID medical additional clinics starting from 14 September. • Core focus is on the full use of all available trust capacity for longer waiters and meetings are in place to swap out capacity for shorter waiting specialities where feasible to support the reduction plan. **Cancer** • In August, clinician availability and outpatient capacity constraints in 2ww clinics, particularly in LGI, UGI, and MFU, impacted the early stages of the cancer pathway, leading to the 2ww target being missed for the first time in three years. In response, Cancer Services collaborated with specialty teams to implement a recovery action plan. • There has been an in-month increase in the backlog, driven by extended histopathology reporting times and diagnostic delays due to patient rescheduling and staff leave. Recovery efforts are being monitored through escalation meetings, with additional capacity diagnostic supported by tiered-funded schemes starting in September, including expanded US, US and CT biopsy, and endoscopy diagnostic services. • Successes include an unvalidated August performance of 71.4% for the 28-day target and 75.6% for the 65-day target – the first time both standards have been above 70% in nearly three years. Specialty teams are focusing on maintaining these standards above 70% as they work to recover the 2ww performance. Additionally, the total PTL size has improved, stabilizing around the low 3,000s, down from over 3,600 previously. • 62d backlog: June – 233, July – 203, August - 244 28d compliance: June – 70.4%, July – 72.3%, August – 71.4% (unvalidated) 62d compliance: June – 63.0%, July – 71.9%, August – 75.6% (unvalidated) **Diagnostics** • As of the end of August, the Trust Endoscopy backlog was at 5675 ahead of trajectory (6327) with a clear plan to achieve 4,395 by the end of October. The Endoscopy team are now halfway through collecting evidence to apply for JAG accreditation. • Additional funding support to deliver further improvement has been secured as part of Tiering and National Cancer monies. • Echo's and Cardiac MRI both looking to insourcing solutions as temporary measures and being worked through procurement. Additional validation funding has been secured with Cardiac MRI being one of the target areas for this support. • New DM01 recovery lead appointed to provide focused support, with the overall Trust DM01 position at the end August is now up to 64.1%.

Impact to NOF4 Transition Criteria – Leadership, Governance & Culture - Q1

Transition Criteria RAG agreed at Q1 External Review meeting 23 July 2024

NHS
East Kent Hospitals University
NHS Foundation Trust

Transition Criteria 1	Transition Criteria 2	Transition Criteria 3
A Stable Executive team with clear and robust organisation wide governance in place supported by an agreed board development programme.	Demonstrable improvement in the culture of the whole organisation in particular the safeguarding and the safety culture, and effective engagement with the workforce.	Development of organisation strategy for clinical pathways.

Suggested Evidence

- All Board and sub-board leadership and development programmes in place
- Evidence of Board oversight of regulatory actions with clear improvement plans, and use of Board Assurance Framework (BAF)
- Evidence of progress against action plan for Well Led domains and Good Governance Institute (GGI) recommendations and delivery of Care Quality Commission (CQC) must dos (within capital restrictions)

- No significant deterioration in quality
- Evidence of learning from statutory reviews
- Evidence of improved and effective engagement of staff, patients and wider stakeholders
- Evidence of ongoing delivery of maternity & neonatal improvement plan

- Trust organisation strategy for clinical pathways or equivalent developed with effective clinical and stakeholder engagement and plan for implementation developed

Impact to NOF4 Transition Criteria – Finance - Q1

Transition Criteria RAG agreed at Q1 External Review meeting 23 July 2024

NHS
East Kent Hospitals University
NHS Foundation Trust

Transition Criteria 1	Transition Criteria 2	Transition Criteria 3
Delivery of 2024/25 plan inclusive of the CIP, income and expenditure plans.	Robust financial oversight, governance, and a strong financial control environment in place.	Agreement of a Medium-Term Financial Recovery Plan (FRP) with system / region and national partners and demonstrable progress towards delivery.

Suggested Evidence

- Financial position actuals submitted in monthly NHS England (NHSE) returns in line with plan.
- 2024/25 outturn position in line with plan.
- Improved levels of agency usage; at or towards national agency ceiling target.
- Delivery CIP programme agreed as part of 2024/25 annual plan.
- Recurrent % of the 2024/25 CIP programme being greater than 67%.

- 6 monthly review of PWC Grip and Control Actions
- Evidence that recommendations from PWC report have been adhered to
- Independent review of financial governance
- Appropriate attendance at finance & investment committees
- Evidence of staff engagement (e.g.. Finance training attended by non-finance staff)
- Equality and Quality impact assessments developed for each cost improvement plan (CIP) linked to financial savings.
- Clear governance process for assessing and approving CIPs including clinical sign off
- Evidence of financial governance processes working in practice

- Development of Medium-Term Financial Recovery Plan (FRP) with financial trajectories agreed with ICB & NHSE.
- Evidence FRP addresses key drivers of deficit as identified in PWC reports including workforce realignment/resizing.
- Evidence of alignment with the Integrated Care System (ICS) financial plans and of engagement and support from stakeholders (e.g. finance committee papers/ minutes, documents used to engage Trust staff).
- Evidence Trust has internal capacity and capability in place to deliver FRP (e.g. substantive internal finance leadership & resource).
- Evidence timely progress is being made on 2025/26 efficiency plan.

Impact to NOF4 Transition Criteria – Urgent & Emergency Care - Q1

Transition Criteria RAG agreed at Q1 Internal Review meeting 9 July 2024

NHS
East Kent Hospitals University NHS Foundation Trust

Transition Criteria 1	Transition Criteria 2
Consistent improvement in performance to deliver UEC type 1 to >50% and 12 hour waits to below 8%.	Demonstrable quality, safety and operational improvements across the whole UEC pathway reducing the proportion of patients occupying beds with 14+length of stay.

Suggested Evidence

- Type 1 to exceed 50% sustainably
- 12 hours from arrival to be below 8%
- Sustainable removal of corridor care
- Compliance with NHSE Tiering requirements and governance

- Evidence of reduction of Length of Stay through improvements in simple and timely discharge
- Patients requiring emergency care or experiencing a deterioration in their condition receive timely, appropriate escalation and treatment
- Evidence of effective safety prioritisation and harm avoidance processes across UEC pathways that incorporates sustained learning from incidents

Impact to NOF4 Transition Criteria – Planned Care - Q1

Transition Criteria RAG agreed at Q1 Internal Review meeting 9 July 2024

East Kent Hospitals University NHS Foundation Trust

Transition Criteria 1	Transition Criteria 2	Transition Criteria 3
To deliver Zero 104 and 78 week waits with consistent reduction in overall Patient Tracking List (PTL) and 65 week waits in order to deliver zero by March 2025.	To deliver Cancer Faster Diagnosis Standard (FDS) c77% and 62d combined performance c70% with consistent reduction in 62d backlog.	Consistent trajectory towards DMO1 compliance c5% and endoscopy delivery plan agreed and delivered.

Suggested Evidence

- Evidence of sustainable improvement in elective performance and waiting list management with reduction in overall PTL 65w consistently reducing against % of PTL
- Reduction in incidents of harm relating to diagnostics and/or treatment delays for patients waiting longer than standard waiting times or a result of being lost to follow up
- Compliance with NHSE Tiering requirements and governance

- Evidence of sustainable improvement in cancer performance with effective multidisciplinary team (MDT) arrangements and improved validation position of surveillance waiting list
- Embedded streamline pathway, aligning diagnostic and MDT capacity
- Reduction in total diagnostic PTL
- Tiering process monitoring, feedback and delivery

- Endoscopy recovery delivery plan with agreed trajectories and milestones delivered against
- Reduction in total diagnostic PTL and >6ww
- Reduction in incidents of harm relating to diagnostics and/or treatment delays for patients waiting longer than standard waiting times or a result of being lost to follow up
- At least 90% of Community Diagnostic Centre (CDC) activity plans delivered.
- Trust delivering their portion of the Kent and Medway Integrated Care Board endoscopy plan

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

Report title: **Risk Register Report**

Meeting date: **3 October 2024**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO)**

Paper Author: **Associate Director Quality Governance (on behalf of Director of Quality Governance)**

Appendices:

None

Executive summary:

Action required:	Assurance
Purpose of the Report:	This paper presents the current Significant Risk Report to ensure Board oversight of those risks rated as high and above (15>). All have an assigned Executive Director and are required to be updated monthly and reported through Clinical Executive Management Group (CEMG) and the appropriate Board Sub Committees to Board. This paper shows movement in month, details those risks that have been de-escalated from the Significant Risk Register due to the mitigations in place and new risks. Escalations from the last Risk Review Group (at the time of writing) on Tuesday 27 August 2024 are provided. The next Risk Review Group meeting is on Tuesday 24 September 2024. Progress continues against the management actions recommended following the internal audit into risk management conducted on behalf of the Trust by RSM LLP (received in May 2024) as reported in the July 2024 report to the Board. An update will be received at the October CEMG and then upwards to Board via Integrated Audit and Governance Committee (IAGC).
Summary of key issues:	The majority of the risks contained in the significant risk report have had a review within the last four weeks. As of the 19 September 2024 when the Significant Risk Register was extracted there eight risks with associated overdue actions. These have been escalated with care group leadership teams and corporate leads. There have been significant improvements in ensuring records are reviewed and updates provided but it is essential that this process becomes embedded within strengthened business as usual governance arrangements.

	Monthly meetings with each accountable executive and the Associate Director of Quality Governance (in the absence of a Risk Manager) commenced in May to review the Significant Risk Report and any additional risks within the Corporate sections of the risk register. The Risk Review Group on 27 August received deep dive presentations from Strategic Development, Capital Planning and Estates (Corporate Cate Group) and Women's Health (WCYP Care Group). The following escalations were made from the Risk Review Group to CEMG: • It was identified in July that the digital risks on the Risk Register need to be reviewed and enhanced. 4Risk access has been provided to the Director of ICT and a series of reports pulled for discussion at the Digital Divisional Governance meeting. The risk related to cyber threats has been escalated to the Significant Risk Register. Director of ICT to report back on progress of wider work. Meeting planned 26 September 2024. • It was recognised that there was further work to be done to ensure that the Strategic Development, Capital Planning and Estates Risk Register is fit for purpose. This includes strengthening the process to ensure that 2gether Support Solutions (2gether) risks are represented, where appropriate. It was suggested that at present there are gaps on this Risk Register. This has been noted as well as part of the Strategy refresh and work continues to improve the position. • Following discussion at the July CEMG a proforma was distributed to the Care Group Leadership teams to enable equipment risks on the Risk Register to be validated (medical devices) and any gaps identified (medical devices and non-medical devices). This information will be collated, any gaps added to the Risk Register and urgent mitigations agreed based on Care Group prioritisation. Recent recruitment to the Head of Risk Management and Assurance was unsuccessful. The post has been re-advertised with interviews planned week commencing 30 September 2024. Essential cover is still being provided by the Associate Director of Quality Governance.
Key recommendations:	The Board of Directors is asked to **SUPPORT** the recommendations above made within the paper. The Board of Directors is asked to **RECEIVE** the Significant Risk Report for assurance purposes and for visibility of key risks facing the organisation.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships

	• Sustainability
Link to the Trust Risk Register:	This paper provides an update on the significant risks (to be known as the 'significant risk report') to the Trust which replaces the Corporate Risk Register (CRR).
Resource:	Yes. Additional resource will be required to mitigate some of the significant risks identified. There is one Risk Manager for the whole organisation who works within the Quality Governance directorate. This post is vacant as of the end of April 2024. The first round of recruitment was unsuccessful and as such the job description has been reviewed and subsequently the grading amended to ensure parity with other multi-site acute hospitals. The first round of recruitment with the revised job description was un successful. Shortlisting has just been finalised from the second round. Interviews will be held on 2 October 2024. If this is not successful interim support will be identified. Essential support is being provided by the Associate Director of Quality Governance.
Legal and regulatory:	Yes. The Trust is required to comply with the requirements of a number of legal and regulatory bodies including but not limited to: • NHS England • Care Quality Commission • Health and Safety Executive
Subsidiary:	2gether Support Solutions Spencer

Assurance route:

Previously considered by: Risk Review Group on 27 August. Clinical Executive Management Group on 4 September. The relevant subset of the Significant Risk Register will also be presented at Finance and Performance Committee on 23 September, Quality and Safety Committee on 24 September and People and Culture Committee on 25 September.

It should be noted that as the Risk Register is a live document the supporting information was extracted on 19 September. Whilst the Risk Register will contain updates since presentation at CEMG it will not include additional new risks as these require approval at the Risk Review Group ahead of CEMG.

East Kent Hospitals University NHS Foundation Trust

SIGNIFICANT RISK REPORT

1. Purpose of the report

1.1 This report is provided to ensure the Board are aware of all risks rated high (15) and above on the Trust risk register.

1.2 This paper presents movement in month and details those risks that have been de-escalated from the Significant Risk Register due to the mitigations in place.

1.3 Escalations are presented as discussed and agreed at the Risk Review Group on 27 August 2024.

2. Background

2.1 A comprehensive review and refresh of the Corporate, Care Group and Specialty level risk registers was launched in November 2023. This followed an initial review and recommendations made by an External Consultant on behalf of the Trust in October 2023. Phase 1 of this work was concluded at the end of March 2024. Phase 2 will involve embedding the processes and governance improvements introduced and continuing to develop the risk culture in the organisation.

2.2 One of the outputs of the Trust Risk Review was the creation of a Significant Risk Report. The latest is summarised with priority actions noted.

2.3 The Risk Review Group was established in early February 2024. The eighth meeting was held on 27 August 2024. There has been good attendance and six of the six Clinical Care Group have now presented deep dives in addition to several Corporate Care Groups (Corporate Medicine, Corporate Operations and Corporate Finance and Strategic Development Capital Planning and Estates). Children and Young Peoples Services are the only remaining area that have not presented a deep dive since the establishment of the Group (Women's Health presented in August). This will take place in September.

3. Current Significant Risk Register

3.1 There are currently 31 risks in total on the Significant Risk Report (down from 34 in the July report to the Board and 82 at the start of the review).

3.2 There are no changes to the residual risk scores of the risks which were also reported last month.

3.3 There are overdue actions associated with eight of the risks (marked in bold for clarity). These have been escalated for immediate attention with the Care Group Triumvirate leadership teams. Following the monthly executive risk reviews a number require re-writing. Risk Owners have been informed.

3.4 The Significant Risk Register is summarised below:

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to July 24 report	Target Risk Score	Actions summary
1891	Corporate Operations	Misalignment between Demand and Capacity across the Trust's urgent and emergency care (UEC) pathway	Extreme (20)	⟺	Low (6)	Conduct comprehensive review of current Emergency Department (ED) processes and identify areas for improvement - focus initially on opportunity to reduce the number of patients spending 12+ hour in ED Person Responsible: Kate Hannam Due: 31 Dec 2024 Given no investment from NHS England (NHSE) Bed Capacity Management System seek alternative options. Person Responsible: Kate Hannam Due: 31 Dec 2024 Demand and capacity modelling to be completed by NHSE for all P1 to P3 patients Person Responsible: Kate Hannam Due: 30 Sept 2024
3386	Care Group - Women's Health	Potential risk of inaccurate records due to Euroking back copying	Extreme (20)	⟺	Low (4)	IT to provide weekly updates to Maternity teams on progress actions from the queries review with Magentus following the daily meetings.

						Person Responsible: Sharon Gough Due: 06 Dec 2024
2406	Care Group - Diagnostics, Cancer and Buckland	Delay to patient diagnosis from potential loss of Nuclear Medicine service at William Harvey Hospital (WHH)	High (16)	⟺	Low (4)	ARSAC licence renewal to allow operational services to commence Person Responsible: Mark Dwyer Due: 31 Oct 2024
2934	Care Group - Women's Health	Inadequate theatre capacity at Queen Elizabeth the Queen Mother Hospital (QEQM) for maternity services	High (16)	⟺	Low (4)	Progress plans with strategic development with potential NHSE funding to support the needed maternity estate expansion (including obs theatre) at QEQM Person Responsible: Karen Costelloe Due: 30 Sept 2024 Pilot electronic booking of sections at QEQM first. Person Responsible: Zena Jacobs Due: 30 Sept 2024 Review and implement solutions with clinical teams for late theatre starts and overruns Person Responsible: Zena Jacobs Due: 30 Sept 2024 Review and design temporary theatre solutions with clinical teams with use of recovery room

						Person responsible: Cherrie Knight Due: 30 Sept 2024 Review and improve the efficiency of section lists Person Responsible: Zena Jacobs Due: 2 Dec 2024
3354	Queen Elizabeth Queen Mother Care Group	Clinical environment not fit for purpose in many areas	High (16)	⟺	Low (4)	Estates issues for all ward areas to be addressed with the Estates team to ensure an ongoing programme of maintenance and repair. List of estates issues from closed ward risks attached. Person Responsible: Susan Brassington Due: 30 Nov 2024
2682	Care Group - Diagnostics, Cancer and Buckland	Increased likelihood of potential radiation incidents and regulatory breaches leading to patient, staff and public harm, due to repeated postponement of TRAC meetings	High (16)	⟺	Low (4)	Radiation safety to be agenda item for all care group governance meetings and quarterly report to be submitted to TRAC. Person Responsible: Julie Childs Due: 18 Dec 2024 Schedule quarterly meetings and ensure required staff are invited. Person Responsible: Desmond Holden Due: 30 Sept 2024 Attendance at TRAC meetings to be ensured and

						supported by care groups. Person Responsible: Desmond Holden Due: 30 Sept 2024.
3553	William Harvey Hospital Care Group	Failure of Cardiac Catheter Suite equipment (Lab 1, 2 & 3) WHH	High (16)	⟺	Low (6)	Exploration of running of weekend lists. Paper for enhanced rate for physiologists still to be drafted. Wider conversation around weekend NSTEMI and elective lists ongoing. Person Responsible: Alexandra Mcvey Due: 2 Dec 2024 BCP to be updated following Sept 2023 failure of both PCI labs at WHH and agreed with region. Discussion to be had with radiology re role of IR suite in BCP given that they have the same equipment. New BCP template circulated and discussed with emergency planning. Person Responsible: Alexandra Mcvey Due: 31 Oct 2024 Development of COPEL levels to manage specialty response to pressures similar to MOPEL and POPEL Person Responsible: Alexandra Mcvey Due: 27 Sept 2024

2158	Care Group - Diagnostics, Cancer and Buckland	Risk of Patient harm and treatment due to unreported A&E chest x-rays	High (16)	⟺	Low (4)	External review by Regional Adviser commissioned. Meeting to be arranged with care group leaders to discuss outputs of report. Person Responsible: Desmond Holden Due: 30 Sept 2024
678	Care Group - Diagnostics, Cancer and Buckland	Insufficient Pharmacy support for the safe (and secure) use of medicines on wards	High (15)	⟺	Low (4)	Recruit to establishment for clinical pharmacy before starting Care Quality Commission (CQC) BC recruitment by considering innovative recruitment options. Person Responsible: Rebecca Morgan Due: 30 Sept 2024 Review current working models to release clinical pharmacy time e.g. late nights, dispensary commitments. Person Responsible: Rebecca Morgan Due: 30 Sept 2024 Recruit following BC approval for medical wards. Person Responsible: Rebecca Morgan Due: 1 Jan 2025 Consider Full 7-day service from Pharmacy following

						action from CQC Must Do. Person Responsible: Will Willson Due: 31 Dec 2024 BC for GSM medical wards for CQC Must Do to be amended in line with Chief Medical Officer (CMO) comments. Person Responsible: Rebecca Morgan Due: 30 Sept 2024 Work is happening within the Care Group (CG) to define the best leadership structure for the pharmacy service. This includes consideration of how staff can work differently to address issues such as medicines reconciliation. Person Responsible: Mark Eley Due: 31 Oct 2024
2796	Kent & Canterbury and Royal Victoria Care Group	There is a risk of delay in dialysis treatment due to high number of Renal Dialysis machines that are over 15 years old	High (15)	⟺	Low (6)	6 Dialog + machines have been ordered and these will replace 3x Medway dialysis unit and 3x Marlowe ward. These are not part of the tendering process for new trust standard machines Person Responsible: Nicky Bentley Due: 30 Sept 2024

						In the process of finalising the rolling replacement programme for dialysis machines across all dialysis units to ensure there is clearly shown sub-set within the MDG capital allocation that will be reviewed monthly at the Trust's Capital Investment Group. Person Responsible: Alexander Chapman Due: 30 Sept 2024 6 machines are being purchased as a matter of urgency – with procurement Person Responsible: Alexander Chapman Due: 30 Sept 2024
1831	Queen Elizabeth Queen Mother Care Group	Privacy and dignity will be adversely affected when patients are treated in non-care spaces	High (15)	⟺	Low (6)	**Monitoring of use of corridor areas as patient areas using DATIX reports and harm reviews as necessary as an ongoing process** **Person Responsible: Joanna Williams** **Due: 31 Jul 2024** **<u>Action</u> – to be reviewed across WHH and QEQM and merged risk.**
3556	William Harvey Hospital Care Group	Delays in delivery and personal care are resulting in an increased	High (15)	⟺	Low (6)	**Continued Implementation of the Emergency Floor Improvement plan which includes**

		risk of pressure ulcers and falls occurring				**direct pathways such as right sizing SDEC, SEAU and UTC** **Person Responsible: Rachel Perry** **Due: 30 Sept 2024** **<u>Action</u> - PU and Falls risks to be reviewed with Deputy CNMO.**
3367	Corporate Medical	Lack of timely review of diagnostic test results	High (15)	⟺	Low (6)	**To understand the issues and Trust processes across the specialties to identify the causes of this risk** **Person Responsible: Samantha Gradwell** **Due: 28 Jun 2024** **Developing a page on Sunrise for consultants to review all results that are allocated to them** **Person Responsible: Michael Bedford** **Due: 31 Jul 2024**
679	Care Group – Diagnostics, Cancer and Buckland	Failure to supply, from Pharmacy, scheduled chemotherapy treatments to patients	Extreme (20)	⟺	High (15)	Options regarding future plan for APU presented at CIG. Presentation will be by SD but support for options provided by APU staff. Actions will be generated following outcome of SIG Person Responsible: Will Willson Due: 31 Oct 2024

						Replacement of the unit with off-site licensed facility as part of the Integrated Care System (ICS) strategy and linked to the national aseptic review. Person Responsible: Will Willson Due: 30 Sep 2029 Commence £250k of remedial work required. Person Responsible: Desmond Holden Due: 31 Oct 2024
2696	Care Group – Critical Care, Anaesthetics and Specialist Surgery	There is a risk that staff will not be sufficiently trained in resuscitation due to the size of the resuscitation team	High (16)	⇔	Moderate (8)	**All HLS and pHLS have 'walk in' availability** **Person Responsible: Peter Samworth** **Due: 16 Aug 2024** **The resus team have agreed to increase their number of RO - candidates ratio from 1- 6, to 1-8 to accommodate more staff to receive training and as of now there are 3 new RO's who can all facilitate HLS at present** **Person Responsible: Peter Samworth** **Due: 16 Aug 2024** **Training dates released to be booked to until December 2024**

						Person Responsible: Peter Samworth **To be implemented** **Due: 16 Aug 2024** **Bespoke training for areas who request this to increase compliance** **Person Responsible: Peter Samworth** **Due: 16 Aug 2024** **<u>Action</u> – risk to be re-written as no longer due to capacity in resus team.**
3264	Care Group – Critical Care, Anaesthetics and Specialist Surgery	There is a risk that patients will breach the 52 week wait standard for a maxillofacial first outpatient appointment due to an inability to recruit specialty doctors	High (16)	⟺	Moderate (8)	**Recruitment into vacancies and reduce outpatient first appointment wait time.** **Person Responsible: Nicola Lindsey** **Due: 31 Aug 2024** **<u>Action</u> - Care Group leads reviewing data and considering downgrade (Chief Operating Officer (COO)).**
3557	Care Group – William Harvey	Increased length of stay for mental health patients awaiting inpatient community beds	High (16)	⟺	Moderate (9)	The UEAM team are working to identify and provide assessment facilities for patients awaiting inpatient beds. Person Responsible: Benjamin Hearnden Due: 31 Oct 2024 Recruit mental health nurses.

						New mental health lead appointed and will start on 3/12. Person Responsible: Tomislav Canzek Due: 01 Nov 2024 Work with external partners/commissioners to ensure provision of service meets the needs of mental health patients in a timely way. Ongoing meetings with Kent and Medway NHS and Social Care Partnership Trust (KMPT) Ongoing consultation and recent Integrated Care Board (ICB) visit and actions unidentified. This is still in progress - date amended Person Responsible: Benjamin Hearnden Due: by: 30 Sept 2024 Ensure safeguarding vulnerable adults and paediatric training compliance. Compliance is monitored on an ongoing basis and also reinforced at Team Days. Person Responsible: Benjamin Hearnden To be implemented Due: 30 Sept 2024
3642	Care Group – Queen Elizabeth,	There is a demand and capacity gap in	High (16)	⇔	Moderate (9)	New procurement award for devices across two companies

	The Queen Mother	respiratory sleep and diagnostic services which risks patients breaching Referral to Treatment (RTT), DMO1 and Cancer targets	Care Group to consider whether can be downgraded (COO)			to mitigate lone company FSNs Person Responsible: David Boyson Due: 31 Oct 2024 Establish fully remote CPAP monitoring service to achieve discharge profile of 50% current WL. Funding for modems for home monitoring being explored. Person Responsible: David Boyson Due: 31 Oct 2024 Programme Management Office (PMO) support for business case completion through efficiencies programme. It is primarily focused on the Respiratory Diagnostic services; Sleep Disordered Breathing- 'sleep service/ CPAP service', and Respiratory Physiology testing - 'lung function'. It also encompasses the domiciliary NIV service - 'NIV', which is not a diagnostic service but a large (separate) outpatient service that runs alongside the sleep service as there is much overlap of work, equipment and staffing.

						Person Responsible: David Boyson Due: 31 Oct 2024 Review options for localised LFT service at WHH with associated income and financial/performance trajectory-- staff, equipment and Consultant support Person Responsible: David Boyson Due: 31 Oct 2024 Establish revised training programme for existing and new staff including tertiary colleague support to improve recruitment and retention. Apprenticeships have started Person Responsible: David Boyson Due: 31 Oct 2024
1895	Care Group – Diagnostics, Cancer and Buckland	Current CT and MRI reporting backlog presents a clinical risk due to potential delays in diagnosis and treatment	High (16)	⟺	Moderate (9)	External review to be undertaken by Regional Advisor (Tony Newman-Saunders). Person Responsible: Desmond Holden Due: 30 Sept 2024 Four additional posts to be recruited to as part of vacancy factor. Interviewing on 3/9. Person Responsible: Beverley Saunders

						Due: 30 Sept 2024 Waiting for four Radiologist to come into post following successful recruitment CDC business case. Person Responsible: Beverley Saunders Due: 31 Oct 2024
2979	Care Group – Critical Care, Anaesthetics and Specialist Surgery	Delays to patient care and poor patient experience due fragile YAG Laser machine at QEQM Eye Clinic	High (15)	⟺	Very Low (3)	Replacement YAG Laser to be funded and purchased Person Responsible: Howard Ford Due: 30 Sept 2024
1628	Care Group – William Harvey	Staffing mix and experience impact on the ability of the Care Group to provide services to paediatric patients in line with the RCPH standards	High (16)	⟺	Low (4)	Advertise and recruit into Matron post. Interim in place in meantime. Person Responsible: Benjamin Hearnden Due: 2 Dec 2024 **Medical staff to attend advanced training (PILS then APLS). Paediatric ED Consultant Leads in place for WHH and QEQM. All new doctors are booked for PILS and Registrars are expected to undertake APLs but this has been impacted due to Covid-19. April 2023 PILS training impacted by training staff shortages and lack of spaces to book.**

East Kent Hospitals University NHS Foundation Trust

						Person Responsible: Thomas Boon **Due: 30 June 2024** **<u>Action</u> – Risk to be re-written. Risk around PEM cover and training not nursing.**
2234	Care Group – Diagnostics, Cancer and Buckland	Failure to meet national histopathology TAT's to support cancer pathway	High (16)	⟺	Moderate (8)	1.0 WTE histopathologist vacancies are being advertised on a rolling basis but are currently unsuccessful in recruitment. Alternative solutions being explored such as fixed term consultant staff on NHS pay rates via an agency and finders fee. Person Responsible: Stuart Turner Due: 30 Nov 2024 Trust involved in discussions regarding a Kent & Medway Joint Venture. Trust to ensure areas of pressure are highlighted and worked up. Person Responsible: Desmond Holden Due: 6 Jan 2025 Review a workforce/ workload points-based manager system to manage workload in line with RC Path Guidance.

						Person Responsible: Stuart Turner Due: 31 Mar 2025 KMPN Digital Histopathology & AI project to improve performance & resilience. Person Responsible: Stuart Turner Due: 30 Apr 2025
2899	Care Group – Women's Health	Consultant obstetric vacancies at QEQM may result in an inability to deliver the service	High (16)	⟺	Moderate (9)	Re-advertise for the 3 vacancies at QEQM. Post held off until after April so that the cohort who get their CCT in October could apply Person Responsible: Zoe Woodward Due: 28 Mar 2025
3384	Corporate – Strategic Development & Capital Planning	The ability to deliver safe and effective services & implement improvements across Trust estate is compromised due to financial constraints for capital funding and assets replacement	High (16)	⟺	Moderate (12)	Deliver the 24/25 Capital programme as per the signed off plan Person Responsible: Nicky Bentley Due: 30 Apr 2025 Progress to full business case for the replacement of maternity facilities at QEQM Person Responsible: Nicky Bentley Due: 30 Sept 2024 Engage a partner through Procure 23 to undertake the production of an "estates master plan and development

						opportunities" document Person Responsible: Nicky Bentley Due: 30 Sept 2024
2599	Corporate – Medical	There is a risk of inadequate medical staffing levels and skills mix to meet patients' needs	High (15)	⟺	Low (6)	**Programmes to support career progression and attraction of consultant posts for long term locums becoming substantive (i.e. CESR)** **Person Responsible: Kelly Martella** **Due: 2 Sept 2024** Review the consultant medical recruitment process – focussing on specialities (HCOOP first tranche) Person Responsible: Twyla Mart Due: 30 Sept 2024
3700	Corporate – Finance & Performance Management	Failure to agree a Medium-term Financial Recovery Plan with System / Region and National Partners	Extreme (20)	NEW	Moderate (12)	Development of the MTFP Person Responsible: Tim Glenn Due: 31 Oct 2024 Agreement of the MTFP with Board, ICB & NHSE Person Responsible: Tim Glenn Due: 31 Dec 2024
3701	Corporate – Nursing	Staff may experience physical and psychological harm as they are frequently	High (16)	NEW	Low (6)	Review of security arrangements in the Trust as currently the SLA with the third party provider does

		subjected to verbal and physical abuse from patients exhibiting challenging behaviours				not permit hands on restraint Person Responsible: Stuart Hammerton Due: 30 Sept 2024 TNA is being undertaken to understand the training requirements of all staff groups across the Trusts Person Responsible: Julie Yanni Due: 30 Sept 2024
3702	Care Group – Critical Care, Anaesthetics and Specialist Surgery	Delayed discharge of patients from Critical Care when medically fit to be transferred to the ward	High (16)	NEW	Moderate (8)	**Work with site triumvirate on priority for critical care wardable patients to be discharged from Critical Care** **Person Responsible: Gemma Oliver** **Due: 31 Aug 2024**
3699	Care Group – Diagnostics, Cancer and Buckland	Loss of blood and blood products impacting patient safety and significant financial loss, due to staff not being alerted to a temperature control failure following failure of the trust wide blood transfusion laboratory remote temperature alert system	High (15)	NEW	Very Low (1)	Payments team to pay provider and once complete product will be delivered for installation and verification Person Responsible: Marcus Coales Due: 30 Sept 2024
1814	Corporate – Strategic	Loss of access to key	High (15)	NEW	(10)	No Actions

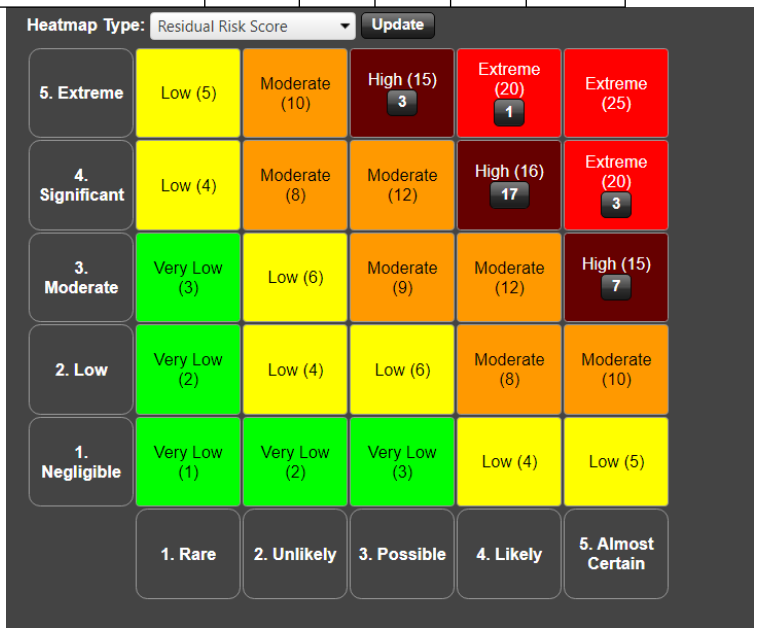
	Development & Capital Planning	operational / clinical systems from threats (cyber, air con, break of external circuits, fire, floods etc) for a protracted period				
1350	Care Group – Diagnostics, Cancer and Buckland	Failure to provide ward stock medicines in a timely fashion due to obsolescence of Pharmacy TWS Distribution robot	High (15)	NEW	Very Low (3)	Run a table top exercise (with Emergency, Prevention, Preparedness and Response (EPPR) team) to simulate robot failure and subsequent actions to inform contingency plans Person Responsible: Sophie Magee Due: 30 Nov 2024 Replace robot. Present case for replacement to DCB finance and Performance meeting to get the case approved in advance of business planning and should capital become available in the interim Person Responsible: Sophie Magee Due: 1 Jul 2025

3.5 The below table shows the risk register entries by clinical or corporate care group and residual risk score. All Significant Risks have been allocated an Accountable Executive. A heat map is also presented to show the position of all of the Significant Risks.

	Residual Risk Score				
Care Group	**15**	**16**	**20**	**25**	**Total**
CCASS CG	1	3			4

East Kent Hospitals University NHS Foundation Trust

DCB CG	3	5	1		9
K&C CG	1				1
QEQM CG	1	2			3
WHH CG	1	3			4
WCYP CG		2	1		3
Corporate Medical	2				2
Corporate Nursing		1			1
Corporate Operations			1		1
Corporate Strategic Development	1	1			2
Corporate Finance			1		1
TOTAL	**10**	**17**	**4**	**0**	**31**
CHANGE SINCE JULY BOARD REPORT	**0**	**-4**	**+1**	**0**	**-3**



4. Changes since the last report

4.1 New risks or escalations to the Significant Risk Report since last report

- Failure to agree a Medium-term Financial Recovery Plan with System / Region and National Partners (risk ref: 3700). Corporate Finance. Residual risk extreme (20). Added 25/07/24.

- Staff may experience physical and psychological harm as they are frequently subjected to verbal and physical abuse from patients exhibiting challenging behaviours (risk ref: 3701). Corporate Nursing. Residual risk high (16). Added 25/07/24.

- Delayed discharge of patients from Critical Care when medically fit to be transferred to the ward (risk ref: 3702). CCAS CG. Residual risk high (16). Added 25/07/24.

- Loss of blood and blood products impacting patient safety and significant financial loss, due to staff not being alerted to a temperature control failure following failure of the trust wide blood transfusion laboratory remote temperature alert system (risk ref: 3699). DCB CG. Residual risk high (15). Added 24/07/24.

- Loss of access to key operational / clinical systems from threats (cyber, air con, break of external circuits, fire, floods etc) for a protracted period (risk ref: 1814). This risk has been open since October 2019 but was escalated from moderate (8) to high (15) on 23/07/24 to reflect recent cyber threats.

- Failure to provide ward stock medicines in a timely fashion due to obsolescence of Pharmacy TWS Distribution robot (risk ref: 1350). This risk has been open since March 2018. On 01/08/24 the residual risk was escalated from moderate (12) to high (15).

4.2 De-escalations from the Significant Risk Report

- Exposure of staff to levels of nitrous oxide from the use of Entonox in the maternity unit (risk ref: 2999). WCYP Care Group. This risk was de-escalated on 01/08/24 from 16 (high) to 12 (moderate) due to the mitigations in place.

- There is a risk of patient harm occurring due to delays in recognising and escalating deteriorating patients in ED due to capacity (risk ref: 2808) QEQM Care Group (UEC). De-escalated from 16 (high) to 12 (moderate) on 9/09/24.

- Failure to comply with the NHS standard contract for infection prevention and control (risk ref: 3210). Corporate Nursing. De-escalated from 16 (high) to 4 (low) on 2/09/24.

- There is a risk that patients are cancelled and theatres starts are delayed due to a lack of surgical admissions lounge at WHH, this impacts on patient's experience and dignity (risk ref: 2766). CCAS Care Group. Previous residual risk 15 (high). De-escalated to 9 (moderate) on 19/09/24.

- Due to large volumes of recruitment, risk of poor skill mix, junior nursing workforce (risk ref: 2195) QEQM Care Group. Previous residual risk 16 (high). De-escalated to 12 (moderate) on 09/09/24.

- There is a risk of inadequate midwifery staffing levels and skills to meet the needs of women and their families (risk ref: 2565) WCYP Care Group. Previous residual risk 16 (high). De-escalated to 12 (moderate) on 12/07/24.

- Inability to recruit Emergency Department Consultants and Acute Consultants at QEQM (risk ref: 3309). QEQM Care Group. Previous residual risk 16 (high). De-escalated to 9 (moderate) on 16/08/24.

- Delayed diagnoses for patients awaiting endoscopy (risk ref: 3566). QEQM Care Group. Previous residual risk 16 (high). De-escalated to 8 (moderate) on 23/09/24.

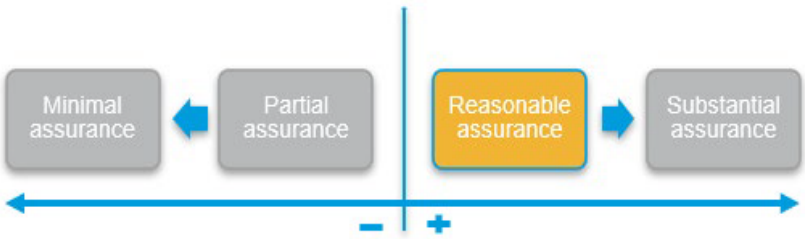
4.3 Closure of risks

- Capacity and demand for ED care resulting in corridor care (risk ref: 3625) WHH Care Group. Previous residual risks 15 (high). This risk was closed on 29/08/24 and subsumed within risk ref: 1891 (Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway) Corporate Operations Care Group, current residual risk 20 (extreme) to reflect this being a Trust wide risk.

5. Risk Audit 23/24

5.1 On 22 May 2024 the final report was received following the internal risk audit undertaken on behalf of the Trust by RSM UK Risk Assurance Services LLP as part of the internal audit plan 2023/24. The review aimed to determine whether the Trust has continued to develop its risk management framework to assist with managing its strategic risks.

5.2 The auditors have suggested the Board can take **reasonable assurance** that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.



5.3 There were 4 Management Actions contained within the report. An update against actions will be reported at the October CEMG and upwards to Board via IAGC. There has been some slippage on the original dates proposed due to the vacant position of Head of Risk Management & Assurance since April. Progress is being made however and the actions will be closed down with ongoing monitoring as part of Business as Usual governance arrangements by November 2024.

5.4 The Director of Quality Governance has been invited to a meeting with the Auditors week commencing 16 September 2024 to discuss planning for the 2425 audit. This will take place in February 2025.

6. Escalations from Risk Review Group

6.1 It was identified in July that the digital risks on the Risk Register need to be reviewed and enhanced. 4Risk access has been provided to the Director of ICT and a series of reports pulled for discussion at the Digital Divisional Governance meeting. The risk related to cyber threats has been escalated to the Significant Risk Register. Director of ICT to report back on progress of wider work. A meeting is to be held on 26 September 24.

6.2 It was recognised that there was further work to be done to ensure that the Strategic Development, Capital Planning and Estates Risk Register is fit for purpose. This includes strengthening the process to ensure that 2gether risks are represented, where appropriate. It was suggested that at present there are gaps on this Risk Register. This has been noted as well as part of the Strategy refresh and work continues to improve the position.

6.3 Following discussion at the July CEMG a proforma has been distributed to the Care Group Leadership teams to enable equipment risks on the Risk Register to be validated (medical devices) and any gaps identified (medical devices and non-medical devices). This information will be collated, any gaps added to the Risk Register and urgent mitigations agreed based on Care Group prioritisation.

6.4 Progress against the actions agreed following the Internal Risk Audit will be reported to the September Risk Review Group with reporting at the subsequent CEMG meeting. It is recognised that there is some slippage due to the Head of Risk Management and Assurance vacancy but plans are in place to recover the position during September.

6.5 Recent recruitment to the Head of Risk Management and Assurance was unsuccessful. The post has been re-advertised with interviews due to take place on 2 October 2024. Interim support may be required due to the imminent rollout of InPhase (due before 31/12/24 due to current contract expiry).

7. Conclusion

7.1 The Board is asked to receive the Significant Risk Report for assurance purposes and for visibility of the key risks facing the organisation.

7.2 Board members are asked to receive the escalations from the Risk Review Group.

East Kent Hospitals University NHS Foundation Trust

BOARD OF DIRECTORS (BoD) ASSURANCE REPORT

Committee: **Women's Care Group Maternity and Neonatal Assurance Group (MNAG) Chair's Report**

Meeting dates: **13 August 2024 and 10 September 2024**

Chair: **Chief Nursing and Midwifery Officer (CNMO)**

Paper Author: **Director of Midwifery (DoM)**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

None

Assurances received at the Committee meeting:

Papers for discussion /approval	Summary
Maternity and Neonatal Improvement Programme (MNIP) Update	In addition to workstream reviews at MNAG, programme Board meetings have now started with executive Senior Responsible Officers (SROs) holding workstream leads to account. At each MNAG meeting a detailed report was presented for each workstream highlighting progress made in month and any milestones that were off track against the year one trajectory. The reports and exceptions were approved by MNAG. **Workstream1: Developing a positive culture.** There are **five** high level milestones (recommendations) within Workstream 1 – Developing a positive culture. Two of these were due to, and did, complete in Year one, and three are due to complete in Year two. There were no matters for escalation linked to programme delivery. **Workstream 2: Developing and sustaining a culture of safety learning and support.** There are **ten** high level milestones (recommendations) within Workstream 2 Matters for escalation include the need to clear backlogs linked to overdue policies**;** 15/106 Guidelines are expired. In addition, 5/59 Patient Information Leaflets (PILs) have expired. Plans have been delayed owing to the volume of improvement work and the service now aims to clear these backlogs by October 2024.

East Kent Hospitals University NHS Foundation Trust

	'Good' rating; there is one requirement that needs continued Executive support to achieve this rating - the second obstetric theatre at Queen Elizabeth the Queen Mother Hospital (QEQM) (for which a business plan has been submitted and all funding options are being explored). Other requirements are the relocation of the bereavement suite at William Harvey Hospital (WHH) which is anticipated to commence by the end of Autumn 2024. In relation to safe staffing a business case has been developed for middle grade doctors. **Workstream 3: Clinical Pathways that underpin safe care.** There are six high level milestones with 20 sub-milestones. Two of these are off track with revised trajectories. These have been re prioritised for year two. **Workstream 4: Listening to and working with women and families with compassion.** There are seven high level milestones within workstream 4 all of these are due to be completed in Year one. Two milestones have been superseded by other work and two revised to be brought in line with Trust or regional timescales. **Workstream 5: Growing retaining and supporting our workforce. There are seven high level milestones in this workstream with four of these due to be completed in Year one.** Two milestones were superseded by other actions that were implemented, two were moved to year two as linked to work which can only be undertaken once local students qualify. One action was off track in relation to requirements within a Health Education England (HEE) action plan which is centrally managed by the Medical Education Team. Some of these link to estates work such as dedicated training spaces. **Workstream 6: Infrastructure and Digital.** There are four high level milestones within this workstream with one of these due to be completed in year one. This milestone has been achieved – no escalations required.
Clinical Negligence Scheme for Trusts (CNST) Compliance	The Maternity Incentive Scheme (MIS) Year six data collection period commenced on 2 April 2024. The service continues to work towards achieving full compliance with the Year six requirements. At the August MNAG the following papers were discussed in compliance with CNST reporting: **Avoiding Term Admissions into Neonatal Units (ATAIN) – CNST Safety Action 3**

We care

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	The papers confirmed that pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 36+6 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice. In line with CNST requirements the paper identified that weekly cross-site meetings are attended by members of the Multi-Disciplinary Team (MDT) to review each admission to Special Care Baby Unit (SCBU)/Neonatal Intensive Care Unit (NICU) for necessity and learning. Babies that are ≥37 weeks admitted to SCBU/NICU are reported on the maternity dashboard with that data having being pulled from Badgernet. Learning identified at the ATAIN meetings is shared across the Trust with maternity and neonatal teams. Drawing on insights from themes identified from any term admissions to the neonatal unit, a quality improvement initiative has been identified to further decrease admissions and/or length of stay. Progress on this initiative will be shared with the Safety Champions and Local Maternity and Neonatal System (LMNS). **Obstetric Medical Workforce CNST Safety Action 4 (SA 4)** A review of the sustainable model for the obstetric workforce has taken place. This has resulted in a number of actions including: • A review of the 24-hour consultant on call rota at the WHH. This has led to a change to the 24 hours on call rota at WHH which started in January 2024. • A Business case for four additional middle grades (trainees) has been submitted in August. This will facilitate the development of a 2 tier on call rota for the WHH. • Recruited to a new 'Portfolio pathway to specialist register (CESR) post as part of the 'growing our own' initiative. • To be compliant with CNST SA 4 the Board is asked to approve the action plan in relation to the middle grades. A report on induction of locums and obstetric consultant attendance at emergencies will also be brought back to the board within the reporting period. **Neonatal Medical workforce** Medical: • There is gap on Tier 1 rota for six months due to maternity leave mitigated by agency and internal locum cover.

	• BAPM recommends eight Whole Time Equivalent (WTE) Tier 2 posts. The service is currently non-compliant (seven WTE) due to the inequity in allocation of trainees at deanery level. This has been escalated across the network to Training Programme Directors (TPDs), Medical education and Head of School of paediatrics. • Consultant rota non-compliant currently1:5.5 WTE (1:8 WTE). - New consultants appointed, commence in October 2024 which will make rota 1:7.5 WTE compliant. **Neonatal Nursing Workforce:** • Qualified in Specialty (QIS) standard (70% of workforce) ○ WHH NICU non-compliant at 68.6% of registered workforce holding the qualified in specialty. ○ QEQM SCBU non-compliant at 56.4% of registered workforce holding qualification in specialty. ○ Compliance with qualification in speciality is impacted upon by both vacancies and maternity leave. At QEQM SCU 1.0 Whole Time Equivalent (WTE) band 5 vacancy, with 56.4% of registered workforce qualified in specialty (against a target of 70%). ○ At WHH 3.56 WTE QIS staff are on maternity leave and 2wte vacancies at band 6 – currently on Trac and active recruitment underway. ○ QEQM SCBU there is 1.0 WTE band 5 vacancy which has been successfully recruited. The Board is asked to note and approve the action plan. **Anaesthetic Workforce** The CNST requirements includes the need for a duty anaesthetist to be immediately available for the obstetric unit 24 hours per day/seven days per week. The maternity unit collects data in relation to anaesthetic attendance in the form of a monthly scorecard. Non attendance is also reviewed as a clinical incident. To support compliance the service is required to review rotas for a one month period. A paper will be brought to the October MNAG in relation to CNST compliance. **CNST Standard 6 – Q1 Saving Babies Lives** LMNS validated results for Q4 of the Saving Babies Lives care bundle was received on 16/07/2024.

	An action plan has been created for each outstanding element and intervention to ensure compliance: • Element 1: Self-assessment showed 80% implementation. There are two outstanding interventions relating to the expansion of an in-house smoking cessation service. • Element 2: Self-assessment showed 100% implementation. • Element 3: Self-assessment showed 100% compliance. • Element 4: Self-assessment showed 80% compliance. There is one outstanding intervention relating to fetal monitoring risk assessment. • Element 5: Self-assessment showed 100% compliance. • Element 6: Self-assessment showed 83% compliance. There is one outstanding intervention relating to the completion of annual e-learning for continuous glucose monitoring. Being progressed with the support of the Medical Director. Moving into CNST year six the focus of submissions is now: progression, trajectories, and meeting LMNS targets. Evidence of sustained improvement. Local themes and trends. Continuous learning: • Weekly meetings with the LMNS are ongoing for support to meet each intervention. **CNST Standard 8 – Q1 Training** This paper provided the MNAG with an update on Newborn and Infant Physical Examination (NIPE) with regards to annual training and governance of NIPE practitioners within the Trust. In the previous reporting period, the DoM reported that a 'stop the line' had been put in place whilst training was progressed. The paper also provides information regarding Newborn Life Support (NLS) training figures for the relevant staff groups to ensure that compliance is met for CNST. • NIPE practitioners require a robust process to ensure that they retain the required Continuing Professional Development (CPD) to maintain NIPE practitioner status. A NIPE register has now been developed and all NIPE practitioner including Nurses, Midwives and Advanced Neonatal Nurse Practitioners have been identified. NIPE update training has now been secured and three sessions are being facilitated with a total capacity of 25 candidates per session. The first cohort of staff have now attended the commissioned NIPE update training for all identified NIPE Practitioners in EKHUFT. Verbal feedback from staff has

	been very positive and they have found the course beneficial. Compliance for staff attending the NIPE annual update, including those who were compliant is currently at 28%, with a trajectory of 82% on the 27 September 2024 when the last course is completed. Training compliance for the obstetric and midwifery teams is currently ≥90% for NLS annual update training. The neonatal teams training data currently falls below the 90% threshold and this is due to a number of factors: • Issues with data collection from the medical teams. • A change in the requirement for NICU and SCBU nursing teams to move from Paediatric Life Support (PLS) to NLS even when they do not attend births at the recommendation of the Resus Council UK 4 NIPE and NLS Update August 2024. • No differentiation between nursing staff that attend births (QIS / ANNP) and those staff who do not on the dashboard. However, the trajectory for Nursing Staff is reported to be 90% by October 2024. The training data will be reviewed weekly to ensure that the training compliance is meeting the planned trajectory. The DSA's have been contacted to ensure that the data for the Neonatal and Paediatric teams is accurate as in December the compliance was at or nearly at 100%.
Antenatal and Newborn Screening Update	**Fetal Anomaly Screening Programme (FASP) update** Further to the transfer of Ultrasound Scan (USS) services to the Women's Care Group the DoM and CNMO commissioned an external review of systems and processes within Obstetric Sonography. The aim of the review being to provide an opportunity of fresh eyes on current pathways and further support the Sonographers. A visit to WHH commenced on 26 July 2024, where the senior Operational team and Principle Sonographer welcomed the Senior Ultrasound Services manager undertaking the review. Feedback from the July 2024 visit recognised the vast work undertaken following the transfer of services and acknowledged the challenges the service has around geography of service and estates constraints. • Location of the scan rooms at WHH are across different areas of the hospital site and long distance away from each other, which impacts on the team being able to have peer support for second opinions. This can be seen in the high recall rates.

	• Due to the geography of the service, the Sonography team are unable to discuss cases between women and birthing persons, lone working despite having colleagues on the same site, limited opportunity to debrief after giving sensitive information, which can often be quite traumatic for staff. • Due to geography of the ultrasound department women and birthing persons wait in four different areas in mixed waiting rooms and has had an impact of patients attending their appointment on time. It was acknowledged that despite challenges there are opportunities to improve service delivery and celebrate success. A visit to QEQM has been scheduled for 4 October 2024 and a full QI plan will be developed on completion of invited review. In the interim some immediate actions are being progressed particularly in relation to team working.
Perinatal Quality Surveillance Tool (PQST) June and July 2024	This covers the minimum dataset required for Trust Board review as recommended by the Ockenden review. This relates to the months of June and July 2024. During the month of June 459 babies were born at EKHUFT and 510 in the month of July 2024. • There was one moderate, one severe and one maternal death incident reported during the month of June and two moderate incidents in the month of July 2024. • One Serious Incident (SI) was reported in June. • Supernumerary status compliance reported at 100% at WHH, 100% at QEQM for both months. • Compliance of 1:1 in Labour was reported as 100% QEQM 100% at WHH in both months. • Level 3 Safeguarding compliance as of the end of July has remained above the threshold of 90%. • Child protection level 3 compliance as of the end of July has remained compliant at 95%. • Three Maternity & Newborn Safety Investigations (MNSI) referral in June (two babies requiring cooling and one maternal death) and one in July of a baby requiring cooling.

- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) neonatal deaths – there were no new deaths in June or July but the rolling rate remains high due to the previous 11 months.
- No unit closures.

One new risk added to the risk Register:

3703	Lack of compliance with annual NIPE training to maintain competencies has resulted in a reduction of available clinical resource to undertake NIPE.

Neonatal Deaths

EKHUFT data indicates an increasing trend in extremely premature babies (<28 weeks) being born, who then have a 30-80% chance of survival (according to BAPM).

The rate of livebirths born under 28 weeks is 5.9 per 1000 births so far in 2024, compared to an average of 4.2 per 1000 births during 2016-2020.

Whilst the number of babies born this early is small, this equates to a 34% increase.

Of the neonatal deaths which occurred during the period of 1 April 2023 to 31 March 2024, 86.7% were born extremely premature.

Weeks Gestation at Birth	Neonatal deaths 2023/24
Below 22 weeks	5
22 weeks	5
23 weeks	1
25 weeks	1
26 weeks	1
33 weeks	1 (born at another Trust)
35 weeks	1

As a result of the noted increased, an external review from an independent team was commissioned.

East Kent Hospitals University NHS Foundation Trust

	The terms of reference include: • To conduct a comprehensive review of all neonatal deaths (deaths within the first 28 days of life) that occurred within the defined review period. • To identify any common factors, themes or care that contributed to the neonatal deaths. • To make recommendations to improve neonatal care and reduce preventable neonatal mortality. The review will also examine the medical, social, and system-level factors that may have contributed to the neonatal deaths (Equity and Equality). The families have been called individually and followed up with a letter informing them of the review, highlighting that this is not because new information has come to light about their baby's care, but so we can ensure our care is as good as it can be. The external team consist of a Senior midwife, Consultant neonatologist and Senior Neonatal Nurse who will have monthly engagement with the DDoM. The aim is to have a final report by December 2024.
Care Quality Commission (CQC) Update: Estates and minor work Maternity Staffing	There have not been many changes to the current position of two outstanding Must Do requirements out of 20. The two remaining Must Do requirements relate to: • ***Regulation 15 - Environment and facilities:*** Improvements to the estate through minor works across the maternity units are ongoing. The business case for the £25m includes the new proposed designs for two new obstetric theatres and consultant led delivery suite at QEQM by extending out the back of the current labour ward is progressing. The bid for funding has progressed to RIBA4 (design phase) and £1.6 million awarded for initial works. A temporary solution of reconfiguration of the recovery area with the labour ward to a treatment room with the ability to be used a theatre in an emergency scenario if a 2nd section is required is being scoped with support from theatres, anaesthetics and clinical teams. The plans for the dedicated bereavement suite within the labour ward are complete. Specialist support from Mechanical and Engineering are going forward with a view of a contractor to be

awarded in due course. Tendering has been slightly delayed due to confusion of availability of charitable funds, however, the Trust will be underwriting the costs Capital 2024/25 allocation to progress the works to commence this financial year.

The CQC raised concerns that the current triage and day care facilities at WHH were poor, and women were cared for in a chaotic environment. The initial review of triage red flags at WHH identified constraints to the physical space. Where possible utilisation of alternative maternity out-patient space for day care activity has been explored. There is still scope for fetal medicine to be relocated. A working group has been established to review this and re-review design plans in order to make the area less cramped and provide a better experience for women and birthing people. It is anticipated that the works will be implemented 2025/26.

The table below provides an overview of outstanding work that is currently driving non-compliance with monthly audits:

WHH:

Concern	Area	Funding stream	Timeframe
Sink splashbacks	across delivery, triage and Folkestone ward.	Capital costs - part of Phase 1 works	By end of financial year March 2025
Full refurbishments of bathrooms	Delivery Suite and Folkestone Ward	Capital costs - part of Phase 1 works	By end of financial year March 2025
Triage / Day care	examination lights to be installed on the walls by beds	Minor works (revenue)	Purchase Order (PO) raised early July. Chased estates 13.09.24 as contractor has issued invoice however works not complete
Room 7 scan room	Triage	Minor works (revenue)	PO raised early July. Chased estates 13.09.24 as contractor has issued invoice however works not complete

QEQM:

Concern	Area	Funding stream	Timeframe
Sink splashbacks	across delivery, triage and Folkestone ward.	Capital costs - part of Phase 1 works	By end of financial year March 2025
Midwifery Led Unit (MLU) office carpet	MLU	Minor works (revenue)	Quote approved and PO raised. Chased estates today for works to be completed by end of September 2024
Flooring to Kingsgate Kitchen requires repair. Scorching in front of dishwasher	Kingsgate Ward kitchen	Minor works (revenue)	Quote approved 28.08.28. Works due to be completed be end of September

- ***Regulation 18 - enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.***

This requirement is an overdue status due to the impact in the cessation of the midwifery programme of education at Canterbury and Christchurch university last year. The requirement will remain in an overdue status as the student midwives are not due to qualify until December 2024. All of the current students have expressed an interest in staying at the Trust and have been offered midwifery positions.

Entonox Risk Assessment and Update	A low-level extraction unit which provides a minimum of 10 air changes an hour is in place. The units are checked Monday to Friday by the estates teams to ensure working conditions, however, three MLU rooms at QEQM do not have the pure air systems that exist in other birth rooms. This may have been an oversight when the Pure Air systems were installed back in 2022. Staff working in the environment were tested using personal monitors to assess the exposure levels which were reported within normal parameters.

East Kent Hospitals University NHS Foundation Trust

	Action Control of Substances Hazardous to Health (COSHH) Risk assessment undertaken by Health and Safety team. Paper to presented to Medical gases committee on 19.9.24. Installation of an Anaesthetic Gas Scavenging System (AGSS) in each room where the gas is used. Staff to be re-tested using personal monitors. Installation of a permanent monitoring system.
Feedback from Board Level Safety Champions	Together with the Chief Executive Officer (CEO) both the Non-Executive Director (NED) for Maternity and the Executive Director (ED) for Maternity undertake regular walkabouts and listening events across the service. Feedback from the June and July listening events was generally positive. The following issues were raised and have been/are being addressed: • Hydration and access to cold water in the work place. A water cooler was fitted in the staff room but a station has now been identified in the clinical area for storage of water bottles. • There were also concerns relating to the ability of having Huddles on the post-natal ward owing to the size of the existing room. Changes were made to utilise a room that is of an adequate size for the handover as a key safety initiative. • The understanding of the team on Folkestone ward in relation to the role of the operational midwife at night time. Clarity was provided in relation to the support and oversight that can be expected from the operational lead at night. • Frustration in relation to duplication of effort linked to the lack of an end to end Maternity IT system. A business case is being written and the service is exploring joint procurement with the LMNS. • Reported lack of pace in relation to some minor works.
Matters to escalate to Quality & Safety Committee (Q&SC) and Board	1. Neonatal Death review (update included). 2. Workforce issues: Anaesthetic rotas, neonatal nursing and medical workforce action plan. 3. NIPE ‘stop the line’ (update provided). 4. Estates issues linked to CQC must dos – (Table provided above with trajectory). 5. Entonox monitoring at QEQM.

East Kent Hospitals University NHS Foundation Trust

	6. Limited access to Freedom to Speak Up Guardian (FTSUG) owing to staffing constraints.

Other items of business: None

Items to come back to the Committee outside its routine business cycle:

There was no specific item over those planned within its cycle that it asked to return.

Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
MNAG asks the BoD to discuss and **NOTE** this MNAG Chair Assurance Report.	Assurance	3 October 2024
MNAG asks the BoD to approve the Obstetric Medical Workforce (CNST Safety Action 4) action plan in relation to the middle grades.	Approval	3 October 2024
MNAG asks the BoD to note and approve the Neonatal Nursing Workforce (CNST) action plan.	Approval	3 October 2024

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Complaints, Patient Advice and Liaison Service (PALS) and Compliments Annual Report 2023-2024**

Meeting date: **3 October 2024**

Board sponsor: **Chief Nursing and Midwifery Officer**

Paper Author: **Head of Complaints, PALS and Bereavement Services**

Appendices:

Appendix 1: Complaints, PALS and Compliments Annual Report 2023-2024

Executive summary:

Action required:	**Approval**
Purpose of the Report:	An annual review of complaints, compliments and PALS received by the Trust. To meet the requirements of the Local Authority Social Services and National Heath Service Complaints (England) Regulations 2009.
Summary of key issues:	A performance review of complaints and PALS, along with the themes related to complaints and PALS. Details of the actions and learning from complaints and PALS, including any actions from complaints reviewed by the Parliamentary and Health Services Ombudsman.
Key recommendations:	The Board of Directors is asked to **APPROVE** the report to be published on the Trust website, for public review.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	Y – complaint performance within timeframes.
Resource:	N

We care

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Legal and regulatory:	Y – this report meets the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
Subsidiary:	N

Assurance route:

Previously considered by:

Patient Experience Committee
Quality and Safety Committee

East Kent Hospitals University NHS Foundation Trust

Complaints, PALS and Compliments Annual Report 2023-2024

1. Purpose of the report

1.1 This attached Annual Report provides an overview of the activity of complaints, PALS and compliments during 01 April 2023 to 31 March 2024 (2023-2024).

2. Background

2.1 This report is to meet the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the East Kent Hospitals University NHS Foundation Trust Complaints Management Policy.

2.2 It is considered good practice and was recommended by the 2020 Healthwatch report Shifting the Mind-Set, to be good practice for NHS trusts to publish their annual performance report on the organisation's website.

3. Summary

3.1 This report is for approval to be added to the Trust's website.

3.2 The report meets the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. The regulation and the Complaints Management Policy stipulate the following information forms the basis of the report:

3.2.1 Specify the number of complaints received;
3.2.2 The number of complaints that were upheld, partially upheld or not upheld;
3.2.3 The number of complaints referred to the Parliamentary and Health Services Ombudsman (PHSO);
3.2.4 The subject matter of complaints;
3.2.5 Any matters of general importance arising out of those complaints or the way in which they were handled;
3.2.6 Lessons learnt from complaints, including any actions or service improvements made.
3.2.7 The number of complaints acknowledged within three working days;
3.2.8 The timescale complaints were acknowledged within.

4. Conclusion

4.1 This report is provided for approval and then for publication on the Trust's public website and staff intranet websites.

East Kent Hospitals University NHS Foundation Trust

Complaints, PALS and Bereavement Services

Annual Report 2023-2024

1. Introduction

Our teams continue to provide care across a variety of services spectrum, as an acute and community provider. To ensure we meet the needs of our diverse and growing health population, we encourage people to provide feedback, both critical and complimentary. This information will help shape how we provide our services and make changes to ensure we are able to meet our patient's need.

The complaints, PALS and compliments are a part of the feedback information the Trust receives. The feedback gives important insight about how, as a Trust we are performing, and how people feel about our: services, facilities, and staff. As well as learning from when things do not go well, when our services receive compliments, we can share great working practices, or initiatives with other teams and departments.

To ensure clients (patients, friends, families, advocates or person representatives) feel able to talk to us about any concerns, we want to reassure clients that any negative feedback will not affect any future care or treatment they may need.

This Annual Report provides an overview of the activity of complaints, PALS and compliments during 01 April 2023 to 31 March 2024 (2023-2024).

2. Summary

- 2023-2024 there has been a 10.4% increase in new complaints. There were 1034 new complaints received in 2023-2024, compared to 937 in 2022-2023.
- Complaints were acknowledged within three working days, on average, 94%, Key Performance Indicator (KPI) is 90%.
- There has a decrease in performance of complaint responses within timescales. The new Chief Nursing and Midwifery Officer, is driving improvement of the quality of responses. The changes and staff development has impacted on performance, agreed actions are in place for medium term improvement.
- 2023-2024 there has been a 26% decrease in new PALS. There were 5566 new PALS received in 2023-2024, compared to 7522 in 2022-2023.
- 2023-2024 PALS responded to within timescales, on average, was 84%
- 2023-2024 there has been a 10.4% increase in compliments. There were 1034 new compliments received in 2023-2024, compared to 937 in 2022-2023.

3. The process for giving feedback

The Trust's process for managing the complaints, compliments and PALS is patient-focused and based on the Parliamentary Health Service Ombudsman (PHSO) six principles for good complaint handling:

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

The main role of the complaints and PALS teams are to assist clients in obtaining information, a resolution, or supporting them with information.

PALS provide advice, information and support to help resolve concerns a client may have, as well as providing information on all Trust services, and signposting people to other NHS trusts or healthcare providers. The PALS Officers works closely with services to resolve concerns quickly and effectively; they also ensure themes/trends are identified and shared.

If we are unable to resolve a PALS or the PALS team feel a more in-depth investigation is required, a PALS may be escalated to a formal complaint, for resolution.

For complaints we ensure an appropriate investigation is carried out and a written response is provided. The Trust will also offer meetings to help explain and/or resolve concerns.

The PALS team also managed the reporting of compliments. Wards and services record compliments as they are received, in order that information can be shared, this information is themed. Areas of high compliments are encouraged to share great working practices, or initiatives.

Protected Characteristics

As a Trust EKHUFT meets the legal requirements under UK equalities legislation. We do so by sending an equality monitoring form with every formal complaint acknowledgement. This helps us provide an effective and fair service by asking our clients to spend some time completing the equalities monitoring form - the information requested includes age, sex, gender identity/reassignment etc. EKHUFT strive to ensure that we are reaching all sections of the community and aims to reduce health inequalities. Completing this form is voluntary and the information is kept in the strictest of confidence as anonymous data. At EKHUFT the completing and returning of this information is poor.

4. Care groups

The Trust's services were reorganised, which was finalised in August 2023. The care groups are now:

Corporate (Corp)
Diagnostics, Cancer and Buckland Hospital (DCB CG)
Critical Care, Anaesthetics and Surgical Services (CCASS CG)
Kent and Canterbury Hospital and Royal Victoria Hospital (KCH&RV CG)
Queen Elizabeth the Queen Mother Hospital (QEQM CG)
Women's, Children and Young People's Health (WCYPH CG)
William Harvey Hospital (WHH CG).

Each care group has a senior leadership structure, to ensure that services meet requirements, provide improvement work, and meet the Trust objectives and business plan. Each care group leadership team comprises of a Managing Director, Director of Nursing and Medical Director.

The complaints and PALS teams are part of the Corporate care group. The teams liaise closely with the care groups to ensure appropriate investigations and learning from complaints and PALS, along with sharing of compliments. The complaints and PALS teams liaise with clients, monitor performance within the organisation and adherence to the complaints and PALS policy.

5. Overall Themes for Complaints, PALS and Compliments

The top 5 primary subject themes recorded across the Trust received in 2023-2024 are:

Complaints		PALS		Compliments	
Clinical Management	352	General Enquiries	1601	Nursing care	15,178
Communication	91	Delays	853	Attitude	2632

Delays	78	Communication	628	Clinical Management	2190
Surgical Management	75	Appointments	437	Communication	2185
Attitude	71	Patient Experience	335	Food	1640

In comparison, the top 5 primary subject themes received in 2022-2023 were:

Complaints		PALS		Compliments	
Clinical Management	207	General Enquiries	2456	Nursing care	15,741
Diagnosis	102	Communication	895	Clinical Management	2622
Delays	96	Delays	660	Attitude	2234
Communication	85	Clinical Management	574	Communication	2081
Nursing Care	80	Appointments	413	Food	1493

There has been no change in the top theme for each feedback source and for compliments there has been no change in the themes, although they are in a different order.

For complaints, diagnosis and nursing care, which featured in 2022-2023 is replaced in 2023-2024 by surgical management and attitude.

For PALS the top three remain the same, in a different order: communication has received fewer PALS, however delays has received more. Clinical management has been replaced by patient experience and appointment has received a slight increase of PALS, which has moved it further up the theme list.

6. Performance:

Below is a record of the numbers received between April 2023 and March 2024 and is colour coded where there is a KPI (red - target not met, amber – target partially met and green – fully met)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of contacts to PALS and complaint teams	1051	1008	1027	1037	1046	1046	1057	1162	914	1272	1128	1122
New complaints received	65	93	88	93	83	89	87	91	65	107	88	85
% difference in nos. of new complaints from 2022-2023	10% ↑	43% ↑	24% ↑	6% ↑	12% ↑	17% ↑	1% ↓	10% ↑	2% ↓	5% ↑	7% ↑	4% ↓
Complaints acknowledged within 3 working days	100%	88%	97%	88%	96%	95%	93%	96%	92%	94%	94%	99%
Complaints responded to within agreed timescales	45%	73%	62%	64%	42%	35%	4%	5%	4%	8%	15%	19%
New PALS received	420	450	481	437	451	471	444	507	365	538	505	497
% difference in nos. of new PALS from 2022	1.2% ↓	14.2% ↓	1.6% ↓	30.1% ↓	26.1% ↓	14.2% ↓	31.3% ↓	15.7% ↓	27.7% ↓	8.1% ↓	0.1% ↓	20.9% ↓
No of telephone calls into PALS	566	465	458	507	512	486	526	564	484	627	535	540
Responded to within agreed timescales	72%	90%	92%	91%	75%	91%	72%	91%	87%	87%	81%	83%
Compliments received	2275 ↑	2667 ↑	2512 ↑	2406 ↓	2723 ↑	2095 ↓	2587 ↑	3051 ↑	2897 ↓	2473 ↓	1938 ↓	2829 ↓

- Over the period from April 2023 to March 2024 there has been a total of 12870 contacts with the team, which resulted in 1033 complaints and 5566 PALS.
- 8% of the contacts with the team resulted in a formal complaint,
- PALS numbers have decreased, particularly during the year. Between October 2022 to April 2023, the PALS team set up the Waiting Patient Service with temporary staff. The service dealt with enquiries about delays to surgery and waiting times, part of the work coming out of the pandemic. Early April 2023 this service was closed and the resource withdrawn from PALS. During the seven-month period the Waiting Patient contacts were recorded as PALS.
- Compliments have decreased by 0.8%.

7. Complaints

There has been a consistent increase in complaints, which has been the case since the start of the pandemic. During 2022- 2023 there were 937 complaints, in 2023-2024 complaints totalled 1034, this equates to a 10% increase.

It should also be noted that the complexity of issues raised has meant that more complaints were identified during the initial triaging of phone calls, emails and letters received. The complexity of concerns has also added to the time taken for governance teams within the care groups to be able to investigate and provide a response. More complaints cover several care group services and also external services.

There has been ongoing work to improve the quality of complaint responses and timescales for responding. A project has been started by the Chief Nursing and Maternity Officer (CNMO) to review the quality of complaint responses, with the medium term aim of reducing the number of returned complaints due to incorrect or answers, and also providing more responses within agreed timescales.

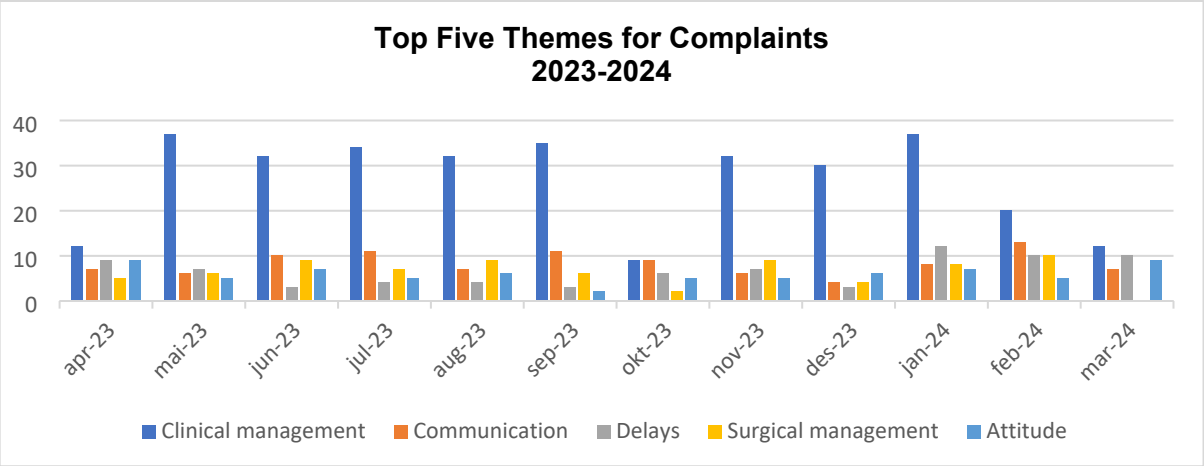
Themes:

The top five themes for complaints have been reasonably stable over the 12-month period. For this period the top five complaints themes are detailed below, with the themes broken down into the specific issues. It should be noted that one complaint can have several concerns, which may relate to several themes and then sub-subjects.

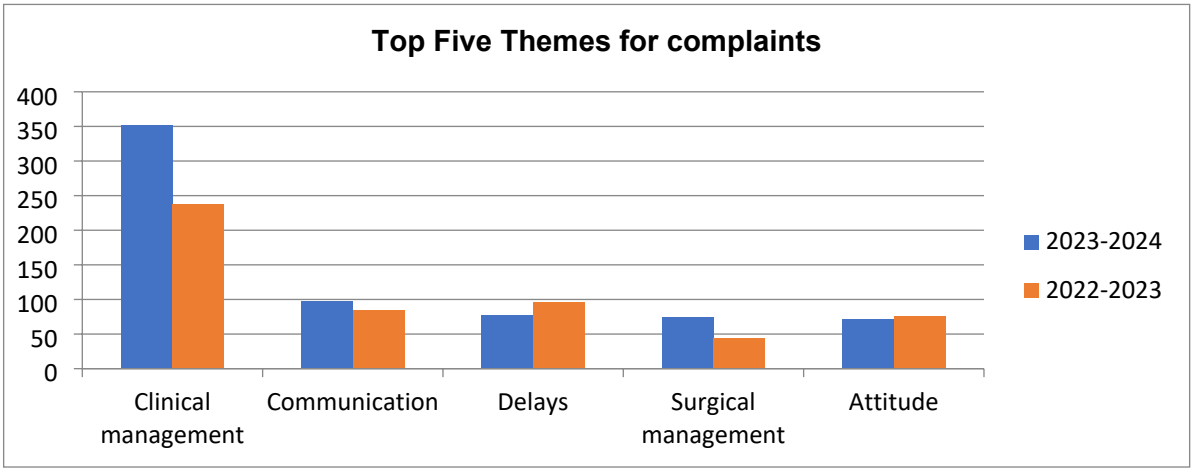
Clinical Management	**352**
Blood tests not carried out	4
Inappropriate ward	3
Incomplete examination carried out	8
Lack of / inappropriate pain management	9
Referral issues	14
Scans / X-rays not taken	9
Unhappy with treatment	305
Communication	**99**
Misleading or contradictory information given	21
A&C staff communication issues	1
Doctor communication issues	41
Other communication issues (i.e. old literature, phones not working	3
Catering and porters	1
Unhappy with info on medical records	6
Nursing communication issues	11
Other staff communication issues	6
Unable to contact department / ward	2
Lack of information / explanation of how procedure went	7
Delays	**78**
Delay in allocation of outpatient appointment	7
Delays in being seen in A&E	19
Delay in referral	4
Delay with elective admission	2
Delay with emergency admission	1
Delay in being see in outpatient department	1
Delay in going to theatre	2
Delays in receiving treatment	35

Delay in sending / receiving copies of medical records	3
Delay in receiving x-ray results	4
Surgical Management	**75**
Consent issues	5
Difficulties during procedure	19
Preassessment issues	5
Unexpected outcome / post op complications	46
Attitude	**71**
Problems with doctor's attitude	42
Problems with nurse's attitude	20
Problems with other staff attitude	9

Clinical management has remained the top theme for complaints during the year. Communication and delays feature in the PALS top five themes. Clinical management, communication and attitude, also feature in the top five themes for compliments.



Top five themes of complaints received in 2022 compared to 2023



Clinical management remains the top five concern for complaints.

Complaint Outcomes and Actions from 2023-2024:

The following are some of the actions and learning identified from complaints:

Care group	Action
DCB CG - Cancer	A project was in place to increase the number of consultant posts in the department.
DCB CG - Health Records	A new database is now in place which is more effective in tracking patient requests.
QEQM CG - Emergency Department (ED – A&E)	Clear signage has been introduced to inform patients they are able to discuss their care in private, during the triage process, which is undertaken at the front door area. The Trust has employed three additional substantive enhanced observation support workers to assist with any patients who need mental health support.
QEQM CG - Surgical	"We care" improvements are being implemented on Quex ward, with a focus on nutrition and mouthcare. A mouthcare chart has been devised and a hydration station introduced, to ensure nutritional needs are being met and monitored for all patients. Laminated signs have been implemented on wards above patient beds, to ensure staff are aware of any special instructions. The surgical teams worked with their colleagues in primary care, to help reduce the demand on scoping services, by using alternative diagnostics and pathways, reducing overall waiting lists.
WHH CG - ED	Patient Liaison Officers are now in place to improve the communication between patients, relatives and the care team. Patient journey booklets have been introduced in the ED, given to every patient who attends and completed by each clinician treating the patient so the patient, relatives and staff are aware of the patient's plan, outstanding treatments and the care given. The ED team have reintroduced written instructions to patients with fractures, so they are aware of what they need to do when they are discharged. The ED team are exploring the use of both written information and QR codes that can be scanned onto a phone, to help patients with their aftercare, when they are discharged. A specific pharmacy team has been allocated to the ED, part of their role is to ensure compliance with critical medication.
WHH CG - Surgical	The surgical teams are working with colleagues in primary care, to help reduce the demand on scoping services by alternative diagnostics and pathways, reducing overall waiting lists. A specific Do Not Attempt Resuscitation (DNAR) checklist has been put in place, to assist with correct completion and ensure patients/families are involved in any discussion, as appropriate.
WYCP CG - Child Health and Young Persons (CYPH)	Practices have been reviewed and a toolbox talk implemented. A training session designed to refresh standards and practices and update where these may have been changed, to ensure patients, relatives and employees are supported at all times. Work has started to improve the integration of care between local and specialist teams. The CYPH team are engaged with the South Thames Paediatric Network to improve collaborative working. A plan has been implemented to ensure urgent slots are made available in consultant clinics and to only book clinics eight weeks in advance. This is to reduce the number of

	cancellations and ensure more appointments will be available to be offered in a timelier manner.
WYCPH CG - Maternity	Cross working with paediatrics has been developed to ensure greater compliance with the Polyhydramnios (build-up of increased amniotic fluid) protocol. A protocol has been developed for medical teams caring for babies in Special Care Baby Unit (SCBU) or when they are transferred to our hospitals, from another hospital. This includes ensuring routine liaison with the team caring for the mother, when the mother is also in recovery or experiencing health problems and is unable to be with her baby. New posters have been put up around the maternity areas to advertise the 24-hour translation telephone service better. A new patient information leaflet is being produced, that is tailored to helping women antenatally, who are found to have low lying placentas and placenta praevia at scans, especially in understanding the recommended management and explaining the risks. Community Midwifery leads are exploring the possibility of including a Transcutaneous Bilirubinometer device in community midwife postnatal packs, in order to detect jaundice, during check-ups.
Trust wide	An Electronic Prescription and Medication Administration (EPMA) system is now in place across the Trust: • EPMA allows staff to flag up any allergies more effectively and provides much more clarity in the prescription process. • EPMA highlights when patients are waiting for medication and assist in preventing delays in administering medication. As part of the new Mental Health Policy due to be ratified in a few months, and in partnership with the Mental Health Providers (Kent and Medway NHS and Social Care Partnership Trust), all ED staff will receive mental health training, on an annual basis.

Outcome of complaints closed in 2023-2024:

It is deemed good practice, particularly by the Parliamentary and Health Services Ombudsman (PHSO), to record outcomes of complaints under one of the categories in the table below. This is also contained within the NHS and Local Authority Complaint Regulations 2009 and was reinforced by the 2020 Healthwatch report 'Shifting the Mind-set'.

Period	Upheld	Partly Upheld	Not Upheld	Withdrawn	On Hold
2022-2023	206	427	164	139	2
2023-2024	95	387	204	169	18

8. PHSO Investigations

The complaints team closely monitor the number of cases that become formal investigations. There has been an increase in the number of cases the PHSO has asked for information, this is to consider if they should undertake an investigation. We have seen a significant increase in the number of cases being investigated; the PHSO wound down their actions during the Covid-19 pandemic and fully returned during 2023.

PHSO Cases Received	Enquiries	Formal Investigations
2022-2023	9	4
2023-2024	25	13

PHSO outcomes

The following are outcomes from cases that were reviewed and investigated by the PHSO. The outcome of their investigation is included for reference.

WHH CG Surgery **Upheld**	• The PHSO agree, the failure to identify diverticulitis led to the patient developing sepsis and dying. • The PHSO have seen from the CT imaging, the patient was very unwell and this should have been identified by the radiologist, on or very shortly after, the CT scan took place. • All this considered, the PHSO believe it more likely than not that, had the CT scan been correctly reported on, to enable the surgical team to act appropriately in contacting the patient for admission, assessment and treatment, the patient would not have died. ACTIONS: The Trust should therefore recognise what went wrong. Write to the family to acknowledge the failings identified and apologise to them for the impact of the failings and the anguish caused.
DCB CG Pathology **Partially Upheld**	• Staff did not do a malnutrition risk assessment when they admitted the patient to hospital, to consider what nutritional support they needed. • Staff did not repeat these assessments weekly while they were an inpatient. ACTIONS: The PHSO asked that the Trust considers changes or improvements, so the mistakes are not repeated in the future. The Trust makes an action plan about improvements and when to devise these changes and put them in place.
QEQM CG Surgery **Not Upheld**	• The PHSO understands the patient's concerns relating to the treatment provided. Taking into consideration the medical records and the input from the PHSO adviser, the Ombudsman's decision is the Trust provided appropriate treatment to the patient, in line with GMC guidance. • It adequately assessed the patient and took account of their history of bowel obstruction, including what had previously been successful. • Based on that assessment, it provided suitable treatment for the patient's symptoms. Additionally, surgical treatment was discussed with the patient, which they were undecided about, given the significant risks. The PHSO decision was that there were no failings in relation to the treatment provided to the patient during their admission in June 2020. The PHSO therefore do not uphold the complaint.
QEQM CG ED **Upheld**	• Based on the evidence, the PHSO have found the Trust should not have discharged the patient on 10 May 2021. Had the Trust arranged for a CT scan or review by the surgical team, the patient would not have been discharged. • The PHSO advise the Trust should also have waited for the patient's results to come back and ruled out sepsis before discharging.

	• The PHSO have found the patient was discharged prematurely on 10.05.21 and the Trust should have arranged for a CT scan or review from the surgical team. • The PHSO are unable to confirm to what extent the patient's life may have been prolonged due to other factors. They believe the patient may have died prematurely. ACTIONS The PHSO asked that the Trust consider what changes or improvements, to avoid a repeat of the mistakes. An action plan should be devised to plan changes.
QEQM CG ED **Withdrawn**	The patient decided to pursue a legal claim against the Trust, which prevents the PHSO from continuing their investigation.
WCYPH CG Obstetrics **Upheld**	The PHSO identified failings in the way the complaint was handled, specifically identifying potential failings of care within the complaints process. This has caused the patient and family significant distress and upset, which could have been avoided. ACTIONS: An apology letter from the Trust to the patient within four weeks of the report, in recognition on the failings and in acknowledgement of the impact, additional emotional upset and distress this caused. An action plan to be compiled within eight weeks; detailing the actions the Trust has, or will be taking, to avoid any similar future occurrence.
WHH CG Surgery **Not Upheld**	Based on the records the PHSO have seen, the delay in arranging corrective surgery for the patient, was in line with NHS guidance. The delay decision was due to the risks involved. Based on the evidence available, the PHSO have not seen that anything went wrong in how the Trust delayed the patient's referral for surgery. The PHSO recognises and sympathises with the pain the patient experienced with their hernia and the distress they faced when experiencing complications, and delays with their surgery. These delays were necessary, in line with NICE and NHS guidance, to ensure the patient received the best possible outcome to their treatment.
WHH CG Surgery **Partially Upheld**	• The Trust had failed to properly look after the patient's lost records and required an action plan to identify the cause of the lost record, as well as action the Trust will take to prevent a similar occurrence from happening in the future (with regard to lost records). • The PHSO also found the Trust did not appropriately manage the stock of dressings used for the patient's wound, causing additional unnecessary pain, humiliation and distress. ACTION: A payment of £500 was therefore requested for reparation of distress caused.

Currently for 2024-2025 there are 11 cases being formally investigated by the PHSO and 29 enquiries from the PHSO are under review.

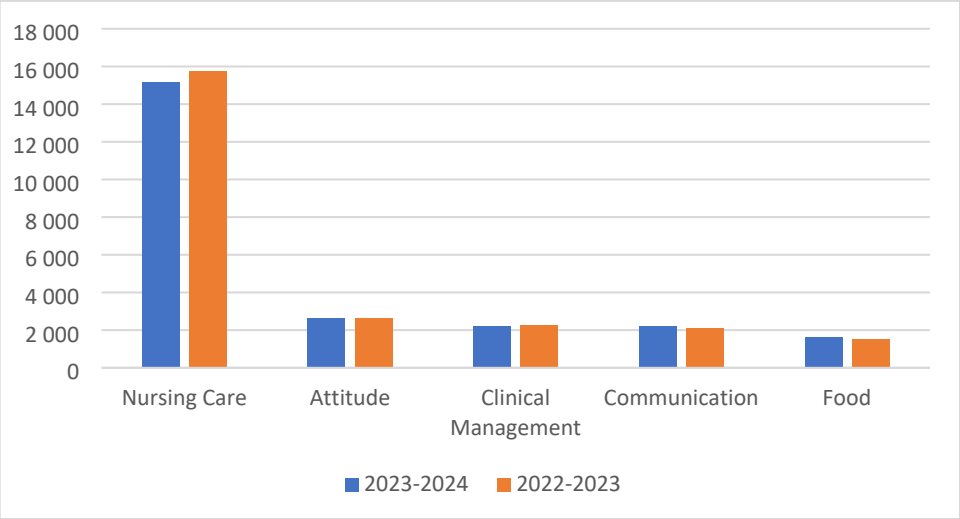
9. Compliments

The Trust received 30,601 compliments in 2023-2024, compared to 30,846 in 2022-2023, a minimal decrease of 0.8%. Compliments are entered, in the main, by wards and services to the Trust's compliments database. This information is added retrospectively, so is a constantly changing picture.

Themes and trends

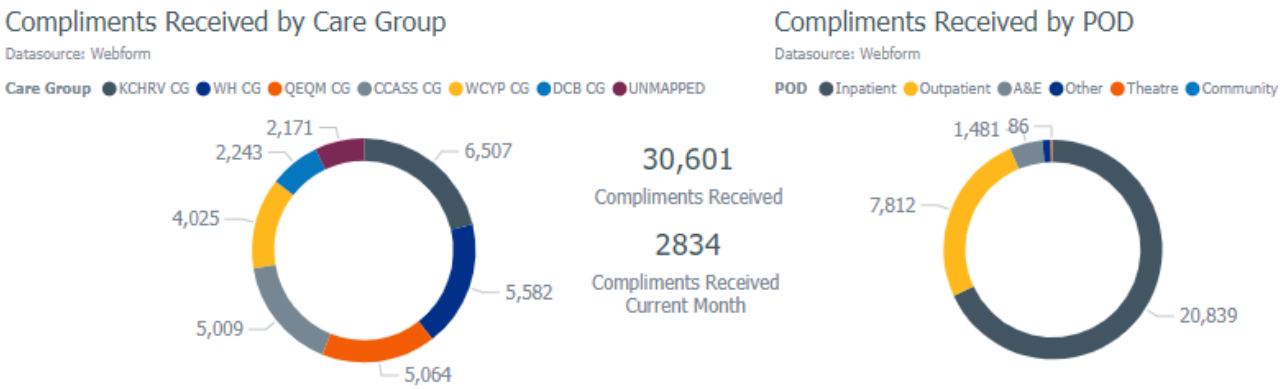
The top five themes identified from compliments during 2022-2023 and 2023-2024 are both nursing care, clinical management, attitude, communication and food. It is pleasing to see the majority of compliments received in both 2022-2023 and 2023-2024 relate to nursing care.

Top five themes of compliments in 2023-2024 compared to 2022-2023

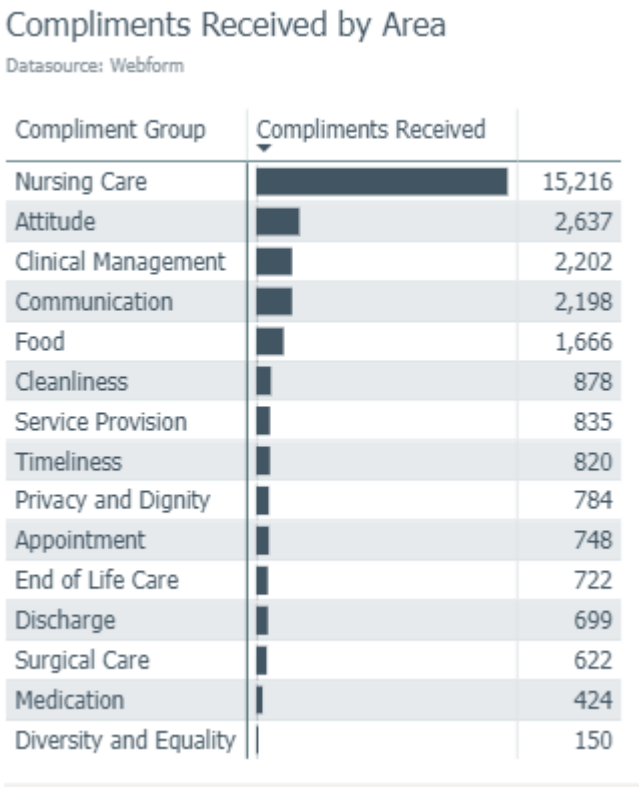


Communication also features in both complaints and PALS top five themes.

Compliments can be broken down by care group and also by place of delivery. We can see that CCASS CG received the most compliments in 2023-2024 and the majority of the compliments came from inpatient admissions (POD – place of delivery).



The breakdown of compliments received, in the top 15 areas are:



Nursing care receives the majority of compliments. Also, mirrored within the top complaints and PALS themes are the compliments: attitude, clinical management, communication, appointment and surgical care. There is also a PALS theme of patient experience, which some of the compliment themes would follow: privacy and dignity, food, and cleanliness.

10. PALS

The top five themes for PALS, like complaints, have been reasonably stable over the 12-month period. For this period the top five PALS themes are detailed below, with the themes broken down into the specific issues. It should be noted that PALS may have several concerns, which may relate to several themes and then sub-themes.

The complexity of PALS has, like complaints, generally increased. The team work to resolve as many issues as possible, to avoid the longer formal complaint process.

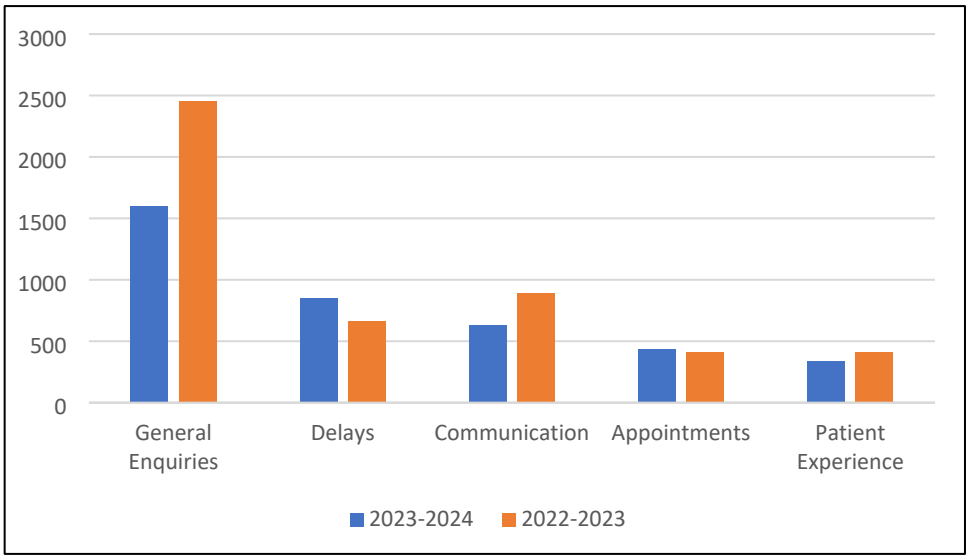
Between October 2022 to April 2023, the PALS team set up the Waiting Patient Service with temporary staff. The service dealt with enquiries about delays to surgery and waiting times, part of the work in relation to recover following the pandemic. During the seven-month period the Waiting Patient contacts were recorded as general enquiry PALS. Early April 2023 this service was closed and the resource withdrawn from PALS.

PALS Themes

General enquiries	**1601**
Question / query asked	707
Chasing outpatient appointment	307
Chasing referral	214
Chasing elective admission	145
Chasing radiology results	80

Chasing other results	77
Forms completed	35
Medical literature / information provided	14
Chasing emergency admission	10
Equipment enquiry	7
Help for patient via volunteer / or staff	3
Freedom of Information Request	2
Delays	**853**
Delays in receiving treatment	202
Delay in referral	190
Delay in allocation of outpatient appointment	153
Delay in receiving x-ray results	118
Delay with elective admission	79
Delay in sending / receiving copies of medical records	41
Delays in being seen in A&E	29
Delay in being see in outpatient department	21
Delay with emergency admission	10
Delay in going to theatre	7
Delay in receiving hearing aid / repair or surgical fittings	3
Communication	**628**
Unable to contact department / ward	263
Doctor communication issues	114
Misleading or contradictory information given	62
Other staff communication issues	58
Nursing communication issues	36
Lack of information / explanation of how procedure went	35
A&C staff communication issues	25
Other communication issues (i.e. old literature, phones not working	18
Unhappy with info on medical records	9
Issues with interpreter service	5
Therapist communication issues	3
Appointments	**437**
Problems with department appointment	201
Problems with outpatient appointments	114
Change of appointment date	77
Problems with administration	44
Insufficient time to book transport	1
Patient Experience	**335**
Signposting	199
Complaint referred to complaint department	61
Raise complaint / comment	59
Shoulder to cry on / talk through issues / comfort and support	11
Delays with complaint response / process	2
Explain complaint process	2
Message to a loved one	1

Top five themes of PALS received in 2023-2024 compared to 2022-2023



The top four themes in 2023-2024 are the same as though received in 2022-2023. However, patient experience has displaced clinical management in the top five themes.

Outcomes and Actions from PALS 2023-2024:

The following are a sample of the actions and learning identified from the PALS contacts received in 2023-2024:

Care Group	Learning and Actions
CCASS CG - Day Surgery	Theatre and ENT Clinical Lead developing a protocol to inform the waiting list team of any last-minute cancellations, so patients are informed.
DCB CG - Radiology	Wait times for investigations and reporting to be included in the telephone system message, to save patients time waiting in the queue. Radiology are working hard to direct their resources appropriately and in order of clinical priority (2ww, urgent, routine) to improve turnaround times as much as possible. The Radiography department are reviewing how they can improve the service for small children regarding: length of appointment time, needs for sedation, involving parents/carers in all aspects. The issue of abandoned and cancelled exams has been identified as lacking process across all imaging, the service leads are working on aa action plan to resolve and audit the communication shortfall.
DCB CG - Outpatients	The Outpatients Matron reminded staff of the need to keep patients informed of any delays in clinics.
DCB CG - QEQM Phlebotomy	QEQM have an appointment only service. Staff reminded to refresh their screens regularly, to ensure all appointments seen immediately.
QEQM CG - Surgical	The ward have implemented a communication/ handover book about NG tube replacement fitting and reinstatement of fluids and solids. The ward have implemented laminated signs above patient beds to ensure staff are away of any special instructions.

QEQM CG - ED	Reviewing how can adapt triage area to ensure privacy and dignity collecting patient information. Acute Medical Unit (AMU) staff being provided with fundamentals of care sessions by the education team. Paediatric team reminded to share name with patient and carer present. Paediatric team reminded to provide an explanation of what to expect during the patient admission. Paediatric team introduced each patient to have a 'named nurse'.
QEQM CG	Additional training around enhanced skills and techniques is to be given for bedside nurses in hot wards, to support the care of patients who have a cognitive impairment.
QEQM CG – Healthcare of the Older Person (HCOOP)	Matron has discussed with the ward manager who will ensure effective communication with patients and their families about discharge for patients to their home, or to a rehabilitation unit.
WHCYPH CG – ED and Early Pregnancy Unit (EPU)	For women experiencing pregnancy losses in the ED, the understanding of the process and any cremation/burial is inconsistent. Training was been arranged by the Bereavement Midwives.
WCYPH CG - Obstetrics scanning	Delays in obstetric scans were experienced during June 2023, when obstetric scans moved to Women's Health: • Delays recorded as a serious incident for investigation. • Ensured all scans were on the system and the booking team contacted patients. • The Communications Team put a notice on the Trust's social media accounts to reassure women the Trust was working on the delays. • A dedicated phone line was available for women to contact the team with any queries or concerns.
WCYPH CG - Obstetrics	Reinforced with the booking team the importance of verbally agreeing all appointments, changes to appointments or cancellations with the patients directly and documenting this on the system. Regular auditing is being undertaken to ensure this process is being followed.
WHH CG - ED	Recognised that the ED need more robust vascular access cover and a review is in place to look at nursing cover/development.
WHH CG - SDEC	Team have developed a leaflet, to outline the services that are provided. The leaflet will be distributed to patients, alongside the use of QR codes to give patients the information regarding their follow up care and treatment.
WHH CG - Day Surgery	Patients are to be asked about regular medications, if they stay in longer than the expected timeframe.
WHH CG - Rheumatology	Delay in booking 6-monthly appointments. Service is looking at improvements in the way follow-up appointments are booked.

11. Risks for the Complaints and PALS services: 2024-2025

The identified risks to services, which should be highlighted are:

- PALS offices across sites are not visible to the public and all sites do not have meeting areas for people wanting to use the PALS service.
- Response quality is continually challenged, which pushes against the response timeframe. Training is planned for the complaints team to support their skill and competence levels.
- The PALS team have supported the bereavement team, due to vacancies, sickness, and the volume of work. This has impacted on the Trust's ability to respond to answer 'live' telephone calls and also respond to PALS within the ten working day timeframe. Resource during the winter months in bereavement continues to be a concern.
- The PALS team are using Datix Client, which is no longer supported by Datix. A business plan has been approved for the implementation of a new system, InPhase, which will be rolled out in 2024.
- The complaints are recorded on Datix Web, which was originally set up to meet the needs of patient Safety/incidents. The system has been adjusted over time, however reporting remains an onerous task. Complaints will be moved to the InPhase system in 2024.

12. Achievements for Complaints and PALS

2023-2024 has overall been a challenging year for the Complaints and PALS teams. The teams have not been fully resourced. In light of the resource levels, the performance of the team and their resilience to cope with the volume of work, should be commended.

- Ten out of the 12 months KPI has been exceeded for acknowledging complaints in three working days.
- Nine out of the 12 months, the PALS team, have resolved and closed over 80% of PALS within ten working days.
- Training on complaints and PALS has been carried out for various staffing groups: new consultants, matrons, new nurses and QEQM ED nurses.
- External training for PALS and Bereavement took place, on resilience and dealing with distressing behaviours and an understanding of the grief process.
- There is a project looking at the entrance way for St Peter's Road, QEQM, which will involve a meeting POD for PALS, this has been funded by the charity. Further work will start for improving the PALS visibility on the other sites.

13. The future – plans for 2024-2025

Alongside the care group re-organisation mentioned earlier, the staff working on complaints, within care groups, have merged into a central complaints team. A newly formed team now exists within the corporate care group and this team holds the management of all complaints, working closely with care group colleagues to ensure quality response reviews and resolutions. The identified staff moved to the new team in March 2024.

The new complaints team have also reviewed the complaints service and have identified specific areas for development and improvement, some work towards these changes has already been started. Some of the reviews and improvements include:

- The complaints process has been mapped, all complaints are managed and coordinated by one case manager from start to finish.
- An escalation process has been formulated to ensure that care groups are aware of timescales for responding, along with providing a framework for requesting more senior input, when this response is not provided.
- All complaints are to be reviewed by a clinical, nursing and an operational lead, a member of staff not directly involved in the care of the patient.

- A training and development programme has been devised for complaints and PALS – twice weekly, one-hour sessions have been planned and implemented.
- To continue to work on improving our performance on achieving the deadlines agreed to respond to complaints and PALS.
- To work with care groups to better capture outcomes and learning from complaints and PALS to implement sustainable improvements.
- The embed the implementation of the Patient Safety Incident Response Framework (PSIRF). PSIRF, which creates opportunities for improved triangulation between the patient safety incidents and complaints, along with learning and improvements.
- To implement InPhase and to ensure the robust systems of reporting for complaints and PALS for the Trust.
- To actively support sites to be able to have a PALS office in a visible and accessible location for our patients and their families.
- To work with the volunteer service to boost the PALS experience and provide more accessibility.
- To continue to work with the Patient Voice team, ensuring full accessibility for the public to make a complaint, compliment or PALS. To finalise other means of communication with the teams, to ensure accessibility for all. This includes all of the information provided on the Trust's web pages for this service, written complaint responses and any interaction with users of the service.
- To continue to work on the quality of written responses from PALS and the complaints team, to ensure they meet the needs of the recipient.
- New PHSO NHS Complaint Standards were introduced in Spring 2024. Expectations from the Ombudsman are to align all NHS providers to deliver the same service, enabling a better experience for the complainant and better learning from Trusts. We are continuing the work to implement changes, which will include work with the care groups.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KCH
Advocacy
Patient-focussed
Listening
Patient
Complaints
Compliments
continuous
critical
formal
Getting
Comments

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Nominations and Remuneration Committee (NRC)**

Meeting date: **1 October 2024**

Chair: **Andrew Catto, Non-Executive Director (NED)**

Paper Author: **Board Support Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

No new interests declared

Assurances received at the Committee meeting:

Agenda item	Summary

NRC Decisions outside the Committee
• **Changes within the Executive Team – Chief People Officer (CPO)**
• **Chief Finance Officer (CFO) Appointment**
	• The Committee ratified the decisions taken outside the NRC business cycle and approved the following:
	  • Departure of the CPO;
	  • Current Interim Deputy CPO to act up into the CPO post.
	  • Appointment of Angela van der Lem as CFO;
	  • CFO salary.

Executive Directors Pay Arrangements and Executive Recruitment	• The Committee received a report on Executive Directors pay along with an update on Executive recruitment, and approved:
	  • to apply the annual award (cost of living pay uplift) of 5% in line with the recommendations of the Senior Salary Review Body (SSPRB) for all Very Senior Managers (VSMs);
	  • agreed this annual award to be backdated to 1 April 2024;
	  • the tendering and appointment of Executive search agency to support the Executive recruitment at pace for a CPO and Chief Operating Officer (COO);
	  • noted progress update on the CPO and COO recruitment.

Non-Executive Directors (NEDs) Commitments Board Skills, Experience and Competencies	• The Committee received a report on the NED commitments, Board skills, experience and competencies: • noted NED appointed by the Council of Governors expected to commence with the Trust mid-October 2024;

East Kent Hospitals University NHS Foundation Trust

	• approved the proposal for the appointed NED to join identified Board Committees as a member, noting the NEDs commitments will be further reviewed again in six months; • noted and agreed the skill-set of the NEDs on the Trust's Board for consideration for the vacant NED role for recommendation to the Council of Governors.
Fit and Proper Persons Requirements Policy	• The Committee received and approved the amended Fit and Proper Persons Requirements Policy.

Other items of business

- The Committee noted the 2024 Annual NRC Work Programme.
- The Committee noted the Board Register of Interests.

Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
The NRC asks the BoD to receive and **NOTE** this assurance report.	Assurance	To Board on 3 October 2024

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: Quality and Safety Committee (Q&SC)

Meeting date: 23 July 2024

Chair: Dr Andrew Catto, Non-Executive Director (NED)

Paper Author: Dr Andrew Catto, Non-Executive Director (NED)

Quorate: Yes

Appendices:

None

Declarations of interest made:

No declaration of interest was made outside the current Board Register of Interest.

Assurances received at the Committee meeting - focus on assurance:

Agenda item	Summary
INTEGRATED PERFORMANCE REPORT (IPR) - INCIDENT CLOSURE FOCUS	The Committee received the report and **NOTED** the following key updates: • Over the last two years the number of open incidents had reduced from 16,000 to around 1,300. • 28 incidents 'tip' into being overdue each day, so the issue required continual management, and the team were working with the Care Groups to ensure it was part of their business as usual, and that the clinical teams managed their own incidents daily. • Daily trajectories had been set (which required 131 incidents to be closed each day). All Care Groups had agreed to meet their trajectories; however, site pressures could impact targets being achieved. • There was no additional resource for this work, as it was considered as business-as-usual. • There would be monthly updates to Q&SC, and performance was also monitored through the Clinical Executive Management Group (CEMG) and the Care Group governance meetings. • Care Group leads lead on dealing with complaints from their areas and are held to account for meeting compliance with the agreed trajectories. The Committee commented that: • We should celebrate progress that had been made increasing the number incident closures. • Outputs from incidents and the learning achieved, would be a useful deep dive for a future meeting of Q&SC. • The Trust appeared to have a good reporting culture. • Further work was required to increase Trust-wide learning from incidents.

East Kent Hospitals University NHS Foundation Trust

Quality Governance Report (Patient Experience, Inquests, Claims, Incidents, Central Alerting System (CAS) and Patient Safety Incident Response Framework (PSIRF) Update)	The Committee received the report and **NOTED** the following key updates: • An issue had been identified regarding the Duty of Candour (DoC) Data was being addressed by the Information Team. • The PSIRF transition process was going well. Training sessions for staff were taking place on all sites. • There had been an increase in the number of complaints and Patient Advice and Liaison Service (PALS) request being received. • National Institute for Health and Care Excellence (NICE) guidance compliance had not progressed as expected but an improvement plan was in place. This would be reviewed at the September 2024 meeting. • All specialties had been reminded about compliance with the Structure Judgement Review (SJR) and Mortality and Morbidity (M&M) processes, asking them to provide an update on their progress to a future Mortality Surveillance and Steering Group Meeting, and identifying if they needed any further support. • A trajectory to improve complaint response times was being developed. • There had been the positive step of clinical teams having phone calls with the family, once the complaint comes in, and working with families to resolve their concerns. • The Committee noted that NICE Guidance compliance target was a challenging trajectory but an improvement plan was in place.
Care Quality Commission (CQC) update report	The Committee received the report and **NOTED** the following key updates: The Trust had established a self-assessment programme and check and session with Critical Care, Anaesthetics and Specialist Surgery (CCASS) and Women, Children and Young People had now taken place, and were very helpful exercises. Quality visits had also taken place at William Harvey Hospital (WHH), Kent & Canterbury Hospital (K&C) and Queen Elizabeth the Queen Mother Hospital (QEQM), and action plans were in the process of being developed. The closure of the 2023 actions was being progressed, many of which linked to statutory and mandatory training compliance. September 2024 was the target to have improved the compliance of medical and nursing staff. Work was also taking place to complete the overdue must and should do actions. The team had seen an increase in CQC enquiries, continued work was taking place to address those. The CQC assurance group continued to meet, and meetings had been moved to bi-monthly.

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	The Committee commented that: There were overdue policies, which presented a risk. A Standard Operating Procedure (SOP) for reviewing patients who had been in our Emergency Departments (EDs) for over 24 hours was discussed. Nursing training compliance was on track to meet the September trajectory. There was an issue with the compliance data being updated on the Electronic Record System (ERS), however, the Chief Medical Officer (CMO) confirmed that all consultants had time allocated in their job plans for training. The amount of statutory and mandatory training had increased significantly, and the CMO would be happy to explore the frequency that some training was required.
Monthly Significant Risk Register Report	The Committee received the report and **NOTED** the following key updates. There were currently 26 open quality risks, which was a reduction of three since the previous report. The residual risk scores had remained unchanged. There were overdue actions related to 12 of the quality risks and the Care Group leadership teams were working to address these. Three quality risks have been removed from the register, delay in diagnosis and treatments due to delays in vetting referrals (ref: 3666), Insufficient Tympanometers (ref: 3617) and Risk to storage room at QEQM (ref: 3665). The Committee commented that: The risk report had progressed over the last 12 months, and we were now seeing that a process was in place to address our risks.
Committee Board Assurance Framework (BAF) Review	The Committee received the report and **NOTED** the following key updates. It was advised that the BAF would be discussed at each Q&SC meeting and structured to the meeting agenda (with a substantive review of the BAF risks taking place on a quarterly basis). Work was well underway to link the significant risk register with BAF risks, (and this was evident in the additional papers circulated with the July meeting pack). It was confirmed that how the BAF linked into this Committee would be discussed in further detail at the Q&SC planning meeting between the Q&SC Chair, Director of Corporate Governance and the Chief Nursing & Midwifery Officer (CNMO)/CMO scheduled for 6 August 2024.
Maternity & Neonatal Assurance Group (MNAG)	The Committee received the report and **NOTED** the following key updates. A Maternity and Neonatal Improvement Programme visit was taking place on the 24 and 25 July 2024, to review the Trust's progress. **Clinical pathways** - enhanced maternal care is a priority workstream.

	Listening to Women and families - focus on equality, diversity and inclusion (EDI) and a scorecard had been developed to ensure there was targeted care for the women and families from those demographics, and senior staff had received training. **Workforce** – focus on both recruitment and retention and a recruitment video had been developed with the Integrated Care Board (ICB) and the team had attended career cafes. **Governance** – the team had been working hard to drive down the backlog of overdue incidents and the maternity PSIRF plan was now being implemented. Key updates from the Clinical Negligence Scheme for Trusts (CNST) work programme: **Perinatal Mortality Review Tool (PMRT) Report** - the report confirmed that all deaths were reviewed using the national tool, within the required timeframes. **Workforce** - the team were compliant with the required staffing levels and a full staffing review had recently been completed. **Training** – the Team were compliant with the PRactical Obstetric Multi-Professional Training (PROMPT), Emergency and foetal care training. However, due to a change in the national standards further staff were required to attend neonatal staff support training. **Claims** - it was ensured that claims were being reviewed to identify learning and linked with PSIRF. There was a higher number of claims, but they were of lower value and were related to psychiatric injury following birth trauma. Any recommendation had been fed back into the improvement programme. Four Serious Incidents (SIs) had been reported to Maternity and Newborn Safety Investigation (MNSI) and the Early Notification scheme (ENS) and any learning had been linked back into PSIRF. The Committee noted the following key points from the Neonatal Death Review report: There had been an increase in the neonatal death rate, however, it had remained below that of the national comparator. An external review had now been arranged to review the cases for learning. **Feedback from NED Board Safety Champion** – the safety champion completed departmental walk rounds, and any issues identified were addressed.
Infection Prevention and Control (IPC) Annual Report	The Committee received the report and **NOTED** the following key updates. For the first quarter of this year *Clostridium difficile* infections were below the threshold and at the lowest rates that had been seen. It was felt to be the result of the work completed by the antimicrobial stewardship.

	The Surgical Site Infections surveillance review highlighted that we had a significantly higher than average number of infections, following fracture neck of femur surgery. Considerable work had taken place Trust-wide to address this and we had seen a notable improvement, the Trust was now only just above the national average. NHS England (NHSE) and ICB infection control teams visited the Trust on 23 July 2024 and were content with improvements made. All IPC Audits had been completed. There were on going challenges with our environment and our estate. Focused improvement had been made in surgery, maternity and in our EDs, to improve our environmental audit results. The Gram-negative blood stream infections remained above the national threshold. Following the adoption of PSIRF, a review of all our infections highlighted 75% of our E-coli infections originated from the community. As a result, we were engaging with partners regarding public health messaging. Line care and the clean campaign continued to be a key focus for the team. The team participated in the national point prevalence survey for infections and antimicrobial stewardship. Trust rates were slightly above the national rates. The Infection Control Gap analysis against the hygiene code showed there were no areas of non-compliance. The infection control improvement plan which had been developed following the implementation of PSIRF, recently had its quarterly review which identified further areas for improvement. The IPC Annual Report would be presented to the October 2024 Trust Board.
Safe Systems for Controlled Drugs	The Committee received the report and **NOTED** the following key updates. The low rate of audit completion related to staff availability. Improvements needed to be made in relation to drug disposal and tracking the drugs to the patient. This report should come to Q&SC regularly and actions needed to flow out to the Care Group. Controlled drugs were an area of concern for the reasons given above, and we needed to be assured that improvements were being made. It was agreed that it would be useful to carry out a deep dive at a future meeting of this Committee and invite wards to explain what the controlled drugs audits mean for them and to identify how improvement could be made in their areas.

	Controlled drugs (CDs) deep dive to be added to the Committee work plan and CDs were a focus of the CQC quality visits, and would pick out the most challenged areas.
Complaints Annual Report	The Committee received the report and **NOTED** the following key updates. There had been an increase in new complaints of 10.4%, however, we had also seen an increase in compliments. We were 94% compliant with acknowledging complaints within the agreed timescales. The key themes identified had remained static. Improving PALS team visibility was being worked on. Complaint response times remained a risk With the centralisation of the complaints team, further training had been identified for staff. The focus for the rest of the year was to clear the complaints back log, continued focus on communication and making those calls to families with the aim to resolve their issues and concerns and identify learning from complaints. The complaints tended to relate to patients and relatives feeling they were not listened to sufficiently or responded to and delays in treatment. The Committee commented that: We needed to understand how the complaint themes were allocated. It would be useful to understand the Trust's increase in complaints, in comparison to other trusts and it would be useful for further scrutiny to take place. It would also be useful to see further assurance regarding how the Trust responded to patient feedback and from the friends and family test. Tracking the percentages of complaints not being responded to within the agreed timescales would also be helpful.

Referrals from other Board Committees

No referrals from other Board Committees were considered at this meeting.

East Kent Hospitals University NHS Foundation Trust

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this Q&SC Chair Assurance Report.	The Board are asked to note the Q&SC focus on assurance: CQC outstanding actions Safe systems of controlled drugs scrutiny. Management of complaints deep dive.	3 October 2024

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Finance and Performance Committee (FPC)**

Meeting date: **29 August 2024**

Chair: **Richard Oirschot, Non-Executive Director (NED)**

Paper Author: **Executive Assistant**

Quorate: **Yes**

Appendices: **None**

Declarations of interest made:

No declaration of interest was made outside the current Board Register of Interest.

Assurances received at the Committee meeting:

Agenda item	Summary
Significant Risk Register	The Chief Nursing & Midwifery Officer (CNMO) presented the Significant Risk Report associated with the Trust's finance and performance risks. The Committee received confirmation that there were no additional risks added since the last report. The Committee also heard there remains one risk with overdue actions and this is around demand and capacity gap in respiratory, sleep and diagnostic services in the Queen Elizabeth the Queen Mother Hospital (QEQM) Care Group. This risk was escalated via the Risk Review Group (RRG) and with the Care Group and risk owners and is now being actively managed. The Committee received assurance on the management of the Trust's financial and performance risks.
We Care Integrated Performance Report (IPR) (M11): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee received an update and noted the following key points: – Staff engagement score improved in July 2024 although it is not at the desired level yet. – Four-hour Emergency Department (ED) compliance was 54.7% against the target 48% in July 2024 and continues to improve in August 2024. – 65-week wait for treatment is improving and the number of patients waiting for treatment for 78 weeks is close to zero. The aim to eliminate 78 weeks wait completely by August 2024 proved difficult due to challenges in Paediatric ENT and Otology. The system-wide support was sought and secured to address these challenges.

	– Cancer 28 Days Faster Diagnosis Standard has been over 70% for two consecutive months, which is for the first time over the past two years, and the Trust is very close to achieving the 75% target. – DMO1 compliance was at 61.3% in July 2024 against a trajectory target of 70%. – Endoscopy backlog performance was slightly below trajectory in July 2024 but plans are in place to clear the surveillance backlog by the end of September 2024. The Committee received assurance that all the positive changes had been embedded and had become part of business as usual. The Chief Operating Officer (COO) confirmed robust processes had been put in place and key posts had now been substantively recruited into. However, there are still gaps that may present risks and the Committee agreed that maintaining focus on those gaps was crucial. The Committee discussed and reiterated the importance of the Trust becoming an operationally sustainable organisation and building on the trajectory of improvements seen this year.
Patients No Longer Fitting the Criteria to Reside (RTS POST 7 DAYS) Length of Stay (LoS) and Bed Plan Update (Including Internal and NFC2R) – BAFFPC002	The Committee received an update and noted the report and focused on the following elements: – The Trust has a target length of stay reduction of 10.6 days by the end of 2024. – Although the length of stay in July 2024 did not reduce, the level of activity the Trust had in July 2024 would have required 67 additional beds. – No Longer Fit to Reside target was 102 patients but the actual figure was 137 patients over seven days. However, there was no financial recompense for the Trust. – The Trust requires at least 10 discharges to the Community per day and over the last three days there were between one and three discharges per day meaning a significant cumulative effect. – The Committee received an update on plans to address elective length of stay. The Committee had a detailed discussion around difficulties with discharges in view of approaching winter including challenges in the social sector and possibility of involving independent providers such as Home Link, the company providing “bridging” care.
Theatre Utilisation	The Committee received an update on Theatre Utilisation and noted the following key points in the report:

	– Two phases of theatre transformation have now been completed. These two phases focussed on establishing central processes to better utilise resources, treating more patients and generating income. The staff embraced the changes once they began to see value of them. – Theatre booking process was reviewed with staff involved to ensure that lists are appropriate with staffing level and skills required for these lists. This in turn reduced cancellations and dropped sessions. – Focused work has been undertaken with regards to high volume low complexity lists (HVLC) especially in Orthopaedics and Ophthalmology in terms of pooling patients to be ready to list for procedures. – The next phase is around lists utilisation to achieve the 85% target and beyond across all specialities in the Trust. The Committee was informed that the Head of Operations for Theatres would be leaving the Trust at the end of September 2024 and as yet, the replacement had not been recruited. The Committee discussed the importance of digitalisation of the theatres, which is part of the phase 3 of the theatre transformation.
BAFFPC003 Update on the 2024/25 Capital Programme (CIP)	The Committee received an update and noted the report. The Financial Recovery Director highlighted that the Trust had achieved its cost improvement plan in Month 4 and delivered the year to date (YTD) of £13.0m against the YTD plan of £12.9m. The Committee was made aware that additional opportunities to protect against slippage on the existing delivery plans were being considered. The Committee received assurance that the overall forecast to deliver the £49m CIPs was on track with the risks being managed on a scheme by scheme basis. The Committee was made aware the Model Hospital, the Estate Return Information Collection (ERIC) and Workforce Productivity benchmarking indicated that workforce, service productivity and estates were the key outliers. However, there are areas where the Trust performed better than peers, for example, outpatient attendance per Consultant and ED Type 1 admission rate. The Committee also received updates on the planned structure and next steps.
Month 4 Finance Report	The Interim Chief Finance Officer (CFO) confirmed to the Committee that since the last Committee meeting three weeks ago there had been no material change to the NHS macro-economic position.

	The Finance Director made the following observations on the financial report for the month of July 2024 (Month 4): – The planned deficit of £8.3m was delivered in July 2024 bringing the total deficit to £31.4m, which is in line with the plan. – Patient care income overperformed the YTD due to increase in rechargeable drugs and income accrual relating to the Consultant pay award. – Other income was underachieving the YTD in Month 4 by £2m predominately within 2gether Support Solutions where income underperformance is offset by non-pay underspends. – Employee expenses – the Consultant pay award is outside of plan £1.3m YTD but is partly offset against the income accrual £0.8m). – The cash balance was £40.1m the end of July 2024. The payment of £10.5m was received on the 19 August 2024. – There was a capital underspend of £1.8 against YTD in July 2024. – Allocation of the remaining three CIP schemes into Care Groups is ongoing and is expected to conclude in Month 5. The Committee discussed the possibility of gaining central support to manage Consultant pay award shortfall.
Finance Team Structure	The Interim CFO presented his analysis to the Committee of the size and appropriateness of the Trust's Finance Team following the Corporate staffing reviews. It was highlighted that the size of the Trust's Finance team was relatively small compared to peers and this posed a question as to whether the team was able to provide a full and adequate service to the Trust. Benchmarking data had been obtained and the Trust's internal auditors were engaged to determine what elements were missing from the structure and what support was missing . A new structure will be presented to the Executives and then brought to the Committee for further assurance.
BUSINESS CASES: OVER £1.75M REQUIRING INVESTMENT £2.5M FOR SELF-FUNDING. CAPITAL BUSINESS CASES OVER £1M	There were no business cases to discuss.
Capital Investment Group (CIG) Assurance Report	The Following key points were noted by the Committee:

	– YTD capital underspend is predominately around medical devices and equipment replacement programme. The Group is working closely with colleagues from 2gether to understand the detail of it and received assurance that this will come back to plan. – £4m were allocated to the Fire Compartmentalisation Programme and the works will begin week commencing 2 September 2024. Assurance was received from 2gether that allocated funds will be spent. Due to this programme being operationally challenging, detailed oversight arrangements were put into place. The progress will be reported to the Committee. The Committee considered the impact of the fire compartmentalisation work would require temporary closure of some wards/areas and asked what impact this would have in the run-up to winter. The COO outlined the plans including not backfilling vacant beds and said that he anticipated there would be few or no issues at QEQM and Kent & Canterbury Hospital (K&C) but the William Harvey Hospital (WHH) site would be challenging due to increasing activity. The Committee received assurance that the fire compartmentalisation work at WHH would not be delayed and the corridor care would be adequately managed during these works.
Business Case Scrutiny Group (BCSG) Assurance Report	There were no Business Cases to report.
Board Assurance Framework (BAF) And Principal Mitigated Financial and Performance Risks	This item was not discussed.

Referrals from other Board Committees

No referrals from other Board Committees were considered at this meeting.

Item	Purpose	Date
FPC asks the BoD to discuss and **NOTE** this FPC Chair Assurance Report.	Assurance	3 October 2024

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Finance and Performance Committee (FPC)**

Meeting date: **23 September 2024**

Chair: **Richard Oirschot, Non-Executive Director (NED)**

Paper Author: **Executive Assistant**

Quorate: **Yes**

Appendices: **None**

Declarations of interest made:

No declaration of interest was made outside the current Board Register of Interest.

Assurances received at the Committee meeting:

Agenda item	Summary
Significant Risk Register	The Chief Nursing & Midwifery Officer (CNMO) presented the report. Important progress has and continues to be made in the Trust's risk management processes. The Committee received assurance that the updating of risks was being actively managed and overseen. The Committee received assurance the Significant Risk Register is being kept up to date and any corrective/mitigating actions are being monitored. The risk manager position remains vacant and has been for some time although the role is being performed. However, the job description has been further refined and the CNMO is hopeful the position would now be successfully recruit to. A request was made by the Committee to include a trajectory between the target scores and their current position and to show a timeline of how we will get between the two. The CNMO agreed to address this and make it clearer in future reports to the Committee.
Review of FPC Board Assurance Framework (BAF) Risks	The Committee reviewed its BAF Risks as it does at each Committee recognising the agenda had been framed with reference to the BAF. The Committee discussed the wording of FPC BAF Risk 001 relating to the impact of Covid. The revised wording needed further refining, which would be discussed by the Executive. It was also noted by the Committee that the linked Significant Risks to the FPC's BAF risks were not entirely aligned with the risks highlighted in the

	Risk Report. This would be picked up by the Director of Corporate Governance (DoCG) and CNMO.
Financial Sustainability Plan (FSP)	The Committee undertook a detailed discussion of an emerging Financial Sustainability Plan presented by the Interim Chief Finance Officer (CFO). The FSP was discussed in the context of what had been achieved and what the Plan required of the Trust over the next three years – and the challenges that created. There was a wide-ranging discussion of the achievements, challenges and next steps recognising this was a first outline which would continue to be developed. The Committee welcomed the opportunity to hear with specificity the sources of the income and savings to drive towards break even. Recognising that there were inherent challenges which require external support and recalibration. The Committee also acknowledged the savings targeted in-year of £49 million were on track and the Trust's delivery in this area was ahead of trends in the wider sector. The Committee noted that a first complete draft of the FSP will be presented to the Board and discussed further at the Committee.
We Care Integrated Performance Report (IPR) (M11): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee noted the IPR operational metrics and in particular noted the following key points: – Continued improvement in Accident & Emergency (A&E) for type one compliance which has continued into September and currently stands at around 57%. – All types are at 77% for 12 hours in the department on a reduction to 9.2%, currently on 9% for September. – 62-day cancer has seen some of the best performance for a number of years and that's continued as well into September with over 77 % currently. – 78-week breaches continued reduction. The aim is to eradicate those in September. – Diagnostics is the biggest challenge currently at 63.9 % for August which has continued to improve and currently for the month of September is at 66.3% with a range of schemes in place. – Cancer 28 Days Faster Diagnosis Standard has been over 70% for two consecutive months. – Endoscopy backlog is getting to a sustainable position.
Winter Plan	The Committee noted this is being prepared and will be available to the Committee at its October meeting.
BAFFPC003	The Committee noted that the Trust is at £17.24million against £16.96million on plan YTD, 0.3million better than plan at Month 5.

East Kent Hospitals University NHS Foundation Trust

Update on the 2024/25 Capital Programme (CIP)	Length of Stay (LoS) continues to be successful and Outpatients is overperforming.
TRUST Programme Management Office (PMO) Transition Plan	The Committee received assurance in relation to the Trust's transition plan from the support being provided by PricewaterhouseCoopers (PwC) towards creating internal capacity in its PMO department to deliver the FSP including overseeing the Cost Improvement Programme (CIP). The combined approach of establishing internal capacity – including recruitment – ; the phased winding down of involvement of PwC; and the approach taken to formulate the FSP in collaboration with colleagues would mitigate the risks of a gap in delivery of the CIP or FSP following the end of PwC's engagement with the Trust. It was noted that a period of Handover applied equally to the transition between the current and new CFOs in October/November.
Month 5 Finance Report	The Trust is on track for month 5 and indications are good for run-rate and year end. The Interim CFO informed the Committee that the Integrated Care Board (ICB) – in-step with communication from NHS England (NHSE) - is concerned that there are increased financial pressures in the system as we all head into our the second-half of the financial year but we will all be keeping a close eye on his over the next few months. The Committee observed that there were some of the Care Groups which have a larger adverse variance this month than others. This was acknowledged and would be updated on at the next meeting.
Business Planning Principles	The Committee received a report from the Director of Strategy on the approach and principles adopted for business planning endorsed by the Executives. Building on the process and the governance which has been put in place for this financial year and taken lessons learnt from last year. On that basis, the team have devised the principles which will define the approach for business planning this year and it will launch in the coming weeks.
Capital Investment Group (CIG) Assurance Report	The Committee received an update and noted the following in the report: – £2.9m year-to-date spend against plan of £4.7m. – Additional capital funding received from NHSE: £1.56m for procurement of Mobile CT Scanner for targeted lung health check activity and £70k for VAE/VAB Business Case.

East Kent Hospitals University NHS Foundation Trust

Business Case Scrutiny Group (BCSG) Assurance Report	The Committee noted the following recent business cases presented at BCSG : • Transfer of service from Kent Community DSN's (Diabetes Specialist Nurses) to EKHUFT DSN's for Women in Pregnancy. • Smoking Cessation Maternity (Tobacco Control Service). • Fidaxomicin for over 60-year-old patients as first line treatment in Clostridioides difficile infections.
Financial Improvement Programme Board (FIPB) Assurance Report	The Committee noted FIPB met with Clinical Executive Management Group (CEMG) last week in what was described as a positive meeting with good engagement.
Referrals from other Board Committees	There was one referral to the Board recommending the Business assumptions for the business plan.

Item	Purpose	Date
FPC asks the BoD to discuss and **NOTE** this FPC Chair Assurance Report.	Assurance	3 October 2024

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East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: People & Culture Committee (P&CC)

Meeting date: 25 September 2024

Chair: Claudia Sykes, Non-Executive Director (NED)

Paper Author: Claudia Sykes

Quorate: No

Appendices: None

Declarations of interest made: None

Assurances received at the Committee meeting: see below

Agenda item	Summary
Board Assurance Framework (BAF) risk: recruitment and retention **Recruitment update**	The overall Trust vacancy rate is 9.6% at 31/8, better than the alerting threshold of 10%. However, this includes a number of high-risk areas: Consultants: Successful recruitment has been seen in the Emergency Department (ED) with 2.6 Whole Time Equivalent (WTE) vacancies outstanding from 20 WTE total establishment. Gastroenterology has reduced the vacancy level to 4.92 WTE out of their 18.79 WTE establishment. The other hard to recruit areas remain consistent, with the largest vacancy gap being Health Care of Older people (HCOOP), with a 47.6% vacancy rate, holding 9.95 WTE against the 20.9 WTE establishment. Work continues to try to reduce the vacancies within these hard to fill areas, but many are shortages across the NHS nationally. The Chief Medical Officer (CMO) noted that his main area of concern was at Queen Elizabeth the Queen Mother Hospital (QEQM). The vacancy rate for Healthcare Support Workers has been increasing, to 204 WTE (14%). There is a review underway after which the Trust will resume recruitment on these positions. The midwife vacancy rate has also been increasing for the last year and is now at 35 Full Time Equivalent (FTE). The Trust is expecting c27 FTE newly-qualified midwives to join in January.
BAF risk: recruitment and retention **Staff retention**	Staff engagement is measured through the Trust Quarterly Pulse survey, with results at July 2024 showing 5.95%, from a response rate of 24%. This remains well below the target of 6.8%. The Trust has been working on a number of different engagement activities, leading up to the annual Staff Survey launch, with a comprehensive plan covering every week and involving all members of the executive team at different sites. The Staff Survey launched on 16 September and will close on 29 November, with results

	published in March 2025. The Staff Survey response rate as at 25 September was 22.6%. The premature vacancy rate has been rising and now stands at 14.9%. The Committee discussed better use of exit interviews and processes to determine the reason why people are leaving the Trust within 12 months of joining. This was high in certain groups, e.g. health care support workers and nurses. The Committee also discussed how to ensure staff were supported more within their first year. The Committee was **NOT ASSURED** over appraisal completion, which remain below the target of 80%, at 74.8%. The Committee requested a further deep dive into this area for the November meeting. The Corporate area remains low at 52% completion, and the Chief Nursing & Midwifery Officer (CNMO) and Chief Executive Officer (CEO) will drive this area for improvement.
BAF risk: culture and values **Culture and Leadership Programme (CLP)**	The Committee received an update on the Trust's CLP. The Trust has been rolling out a 2-day leadership essentials training programme, which covers areas including managing sickness absence, resolving conflict and giving feedback. 794 staff have attended this training, with more booked on. The feedback has been excellent. The Trust has also commenced Management Induction training for all new managers, feedback has been very positive. The Staff Council is in the process of being established, with 29 representative roles scoped out.
BAF risk: culture and values **Freedom to Speak Up (FTSU)**	The Committee received a report from the Lead FTSU Guardian, which raised a number of concerns: - There has been continued absence within the FTSU team for over a year which has reduced the effectiveness and resilience of the team; - The report stated that data for FTSU cases was inaccurate and currently unavailable, and so could not be reported. No reports on FTSU activities and cases has been received by the Committee for eight months, with the last report covering the period up to December 2023. The Committee was **NOT ASSURED** over the effectiveness of the FTSU service at the Trust. The Interim Chief People Officer (CPO) is working on emergency measures to monitor FTSU e-mails and ensure current cases are being responded to, although due to the confidential nature of this work, she is having to do much of this herself. Due to workload, it would not be possible to provide any further assurance on FTSU at the next Committee in November. The Committee supported the emergency measures proposed, but also raised concerns about the impact on the Interim CPO's workload, and the

	need for the Committee and Board to receive assurance on the FTSU service as quickly as possible. The Chair noted that the Trust needed to ensure staff were confident in the FTSU service; that this service provided additional pathways to highlight issues on patient care and safety; and it was also a Care Quality Commission (CQC) requirement from recent inspections. The Committee and Board needed assurance as quickly as possible that this service was effective. The Chair will refer this to the Board.
BAF risk: culture and values **Equality, Diversity and Inclusion (EDI)**	The annual reports for Workforce Disability Equality Standard (WRES) and Workforce Race Equality Standard (WDES) were deferred to the November meeting as the deadline has been extended and these need to be reviewed by Clinical Executive Management Group (CEMG) first.
BAF risk: culture and values **Occupational Health**	The Committee received the bi-annual report from the Occupational Health (OH) team. This highlighted that the main reasons for referrals to OH were for musculoskeletal issues (back and neck, lower limb), followed by mental health concerns and stress. There were a total of 840 referrals for January-June 2024. The Committee discussed the high rates of referrals from some care groups compared with others, and the need to ensure managers were trained on supporting staff with reasonable adjustments and the right equipment.
BAF risk: culture and values **Employee Grievances and disciplinaries**	The Committee reviewed the report from the Employee Relations team on grievances, disciplinaries and Tribunal activity. Further information was requested on the protected characteristics of people involved in each, and with more data on trends and themes rather than stand-alone numbers.
BAF risk: organisational development and resilience **Workforce planning**	The Committee reviewed an update on workforce strategy. It was noted that the Trust's existing People Plans covered to 2025, and needed to be refreshed. The Interim CPO reported that she was putting in place outline strategy actions which would be reported to the November Committee. The Committee discussed the need for workforce planning to be addressed alongside the Financial Plan, Clinical and Estates strategies. These needed to address demographic changes, recruitment and retention challenges, and provide a robust forward view on the staffing needs for the future. This needed to be developed using input from system partners, the Kent and Medway Medical School (KMMS), Integrated Care Board (ICB) and others. This also needed to be considered in the context of the Darzi report, which reiterated the need for more care to be provided within the community, a greater use of digital and self-care support. There was also work needed on organisational development, career pathways and succession planning at all levels of the Trust. The Committee was **Not assured** on this work to date, and there were concerns around the capacity of the People and Culture team

East Kent Hospitals University NHS Foundation Trust

	to deliver this within the timeframes needed alongside the other Trust strategies. It was noted that out of the three BAF risks within the People and Culture responsibility, this was the area with the most limited evidence and assurance so far. The Committee requested that this be added to the Risk Register.

Other items of business: None

Actions taken by the Committee within its Terms of Reference: None

Items to come back to the Committee outside its routine business cycle: None

There was no specific item over those planned within its cycle that it asked to return

Items referred to the BoD or another Committee for approval, decision or action:

The Committee referred the lack of an effective Freedom to Speak up Service to the Trust Board for discussion and action.

Item	Purpose	Date
P&CC asks the BoD to discuss and **NOTE** this P&CC Chair Assurance Report.	Assurance	3 October 2024

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: Integrated Audit and Governance Committee (IAGC)

Meeting dates: 26 June and 26 July 2024

Chair: Dr Olu Olasode, Non-Executive Director

Paper Author: Board Support Secretary

Quorate: Yes

Appendices:

None

Declarations of interest made:

No additional declarations of interest made

Assurances received at the Committee meeting:

Agenda item	Summary
Audited Group Accounts 2023/24 • **Management Representation Letter** • **Informing the Audit Risk Assessment for EKHUFT 2023/24 document** • **External Audit – Audit Findings Report (ISA260 Report) 2023/24 and Auditors Annual Report (Value for Money (V4M))** • **Head of Internal Audit (HoIA) Opinion 2023/24**	• The Committee received **Assurance** and recommended to the Board of Directors (BoD) approval of the audited 2023/24 annual group accounts. • The Committee recognised the improvements in the annual audit process. The Finance, External Audit and all staff involved in the production of the accounts were commended for their hard work ensuring these were available for submission within the required deadline, that had not been achieved the last two years. • The Committee sought assurance that the lessons learnt will be embedded to ensure the deadline for submission was met the next year. This was important given the high level of risks associated with changes in the finance team. • An area of focus for the 2024/25 audit is to reduce the number of disclosure amendments. • The Committee requested a report at a future meeting on the medium term financial plan along with an updated action plan on achieving a breakeven financial position with clear timescale targets. • The Committee also requested further assurance embedding the ongoing grip and control work and the governance of the Trust's cost improvement programme. • The Committee reviewed and approved the Trust a Going Concern, and noted the Trust was Unqualified. • The Committee reviewed and recommended to the BoD approval of the Management Representation letter. • The Committee reviewed and confirmed the Informing the Audit Risk Assessment for EKHUFT 2023/24 document. • The Committee discussed and noted the External Audit – Audit Findings Report (ISA260 Report) 2023/24 and Auditors Annual Report.

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	• The Committee reviewed and noted the HoIA Opinion 2023/24, recognising the improvements made with recommendations for embedding further improvements.
Quality Accounts for 2023/24	• The Committee received **Assurance**, signed off and recommended to the BoD approval of the 2023/24 Quality Accounts. • The Committee noted a different process to be followed the next year in producing this document, in respect of design and focus, with the aim to identify at key points in the year the progress of key elements through the Quality and Safety Committee (Q&SC). • The Committee thanked the Deputy Director of Quality Governance and all staff involved in producing this document, recognising the improved governance review process that had been followed. • The Committee, however, noted that sufficient time should be given in future for input from Q&SC, fact verification, and proof-reading of the draft versions prior to presentation to the IAGC for approval and recommendation to the Board.
Annual Report 2023/24 • **Compliance Against FT Code of Governance** • **Annual Governance Statement**	• The Committee received **Assurance** and recommended to the BoD approval of the audited 2023/24 Annual Report, noting the content was in line with the NHS Foundation Trust Annual Reporting Manual.

Internal Audit Progress Report	• The Committee received **Assurance** and noted the Internal Audit progress report:
	  • Five final audit reports issued since the last IAGC meeting:
	  • Cashflow Monitoring (Reasonable Assurance), good processes and control in place with opportunities for improvements;
	  • Risk Management (Reasonable Assurance), improved management of risks, all risks reviewed and updated, good controls and framework in place with oversight across the Trust of its risks from Board to ward. Recommendation for further improvement in respect of timely completion of actions;
	  • Data Security Protection Toolkit (Substantial Assurance), Trust rated green and positive position with training compliance;
	  • Doctor Payments (Advisory), no issues identified, recommendations to improve process for locum background checking, monitoring doctors working hours, and actions in place. The Committee requested assurance and evidence of embedded, sustained compliance against the required processes for locum doctors background checking, and that this was being regularly monitored to ensure compliance;
	  • Theatre Utilisation (Reasonable Assurance), good work and robust arrangements in place, recommendation to update Standard Operating Procedures (SOPs) to ensure sustained embedding of processes and procedures.
	• The Committee noted continued good progress in respect of the management of follow up of actions, that overdue actions are being

	progressed and completed (currently four actions overdue and outstanding with one high priority).
Internal Audit Plan 2024/25	• The Committee received **Assurance** and approved the 2024/25 Internal Audit Plan linked with the Trust's risks. • The Committee noted the need to align internal audit work with the maturity of ongoing improvement programmes and the need for flexibility in its delivery. • The Committee noted the Trust's award of the Internal Audit contract to RSM to be presented to IAGC for approval.
Local Counter Fraud Specialist (LCFS) RSM Risk Assurance Services LLP – LCFS Progress Report	• The Committee received **Assurance** and noted the LCFS progress report and detailed activity. • The Committee noted the 2024/25 LCFS Plan being produced and once completed will be presented to IAGC for approval. • Local proactive exercises and training to raise staff awareness of fraud, as well as increased risks associated with cyber security and social media, with good engagement from staff and teams. • LCFS working closely with the Trust around prompt implementation and completion of actions. • Ten new referrals received.
External Audit Grant Thornton (GT): External Audit Progress Report and Sector Update	• The Committee received **Assurance** from a verbal progress update. • The Committee noted an internal annual review of lessons learnt from the 2023/24 annual accounts audit to be undertaken to identify any areas for further improvements building on the successful achievement of meeting the 2023/24 annual accounts submission deadline this year.
Governance Improvement Framework: Programme of Work	• The Committee received **Assurance** from the report and noted the work being undertaken. • The Committee acknowledged the review and improvements to the governance framework, with further assurance to be provided with an updated governance map. • Board Committee work forward plans will be reviewed, as well as the frequency of meetings to ensure these Committees continued to work effectively and received the assurance needed. • The Clinical Executive Management Group (CEMG) is operating within a robust, structured governance framework, with assurance at Executive level from operational areas across the organisation. • The Good Governance Institute (GGI) will be undertaking a review to assess the progress and embedding of the governance improvements. • The Committee requested a further progress update report to be presented at the next IAGC meeting to evaluate the improvements and how Board Committees are working. • The Committee noted a review of the Trust's refreshed maturity matrix and risk appetite to be discussed at the BoD Development Strategy Session in September. • The Committee requested for ongoing update and assurance across the various programmes in its action log as part of a holistic

East Kent Hospitals University NHS Foundation Trust

	and integrated governance improvement programme, with timelines, milestones and expected impact.
Board Assurance Framework (BAF)	• The Committee received **Assurance** from the BAF, noting the responsibility of the IAGC for reviewing the BAF framework and the Board Committees responsible for reviewing the sections of the BAF that related to their area of accountability. • The Committee received assurance that the BAF shapes Board Committee agendas feeding into the Trust's strategic risks. This process was working effectively with the Finance and Performance Committee (FPC) reflecting areas of its accountability, this was being reviewed for implementation with Q&SC and the People & Culture Committee (P&CC). • The Committee also requested further work to be done to ensure that the BAF is aligned to the Significant Risk Register (SRR) and the Integrated Performance Report (IPR). • The Board Committee NED Chairs will provide regular verbal progress updates at future IAGC meetings on aligning Committee agenda items to the BAF risks.
Risk Register Report	• The Committee received **Assurance** and noted the Significant Risk Register and the IAGC's visibility of the key risks facing the organisation. • The Committee noted continued robust management of risks, with a current total of 34 risks, reduced from 40 in June, and 82 at the start of the risks review. • Escalation of overdue actions against 14 risks with the Care Group Triumvirate leadership teams to immediately address. • The current 4Risk system was not user friendly and the new system InPhase will support production of improved reports, and provide the evidence and assurance around robust risk management. • Five risks de-escalated. • Risk Review Group having mature, in-depth and challenging discussions about risks and progress of actions, identifying whether any should be de-escalated, with senior leadership and Executive oversight from CEMG.
Annual Risk Maturity Self-Assessment	• The Committee received **Assurance** and Approved the findings of the internal audit assurance around the detailed management actions and to undertake a repeat survey in Quarter 1 of 2025/26. • The Committee noted controls in place to manage risks, good response rate to survey, outcome confirmed the Trust's improved risk management and risk culture journey, with risk information sharing across the organisation, and opportunities for further improvements.
Single Tender Waiver (STW) Report	• The Committee received **Assurance** and noted the STW report. • The Committee Approved the recommendation that Care Groups and Corporate Departments remind budget holders of the need to engage with Procurement Services at an early stage to ensure competitive tenders are completed in line with the Trust's Standing Financial Instructions (SFI)s and Public Contract Regulations (2015) to avoid breaches.

	• The Committee noted the roll out of Procurement Policy Training on a monthly basis during 2024/25, and encouraging Care Group and Corporate Departments to release key staff for these half day training sessions. • Reduction in the number of STWs (decreased by 14% (14) compared to 2022/23), although a 91% (£4.28m) increase in value mainly due to one high cost STW. • During quarter 4 2023/24 approval of 26 STWs at a total value of £3.78m, 16 STWs totalling £2.35m had been rejected, no retrospective approvals, and no declarations of interest.
Freedom of Information (FoI) Annual Report 2023/24	• The Committee received **Assurance** and noted the 2023/24 FoI Annual Report and that staff at all levels needed to understand the need to respond to requests and approve FoI responses promptly in order that the Trust improved compliance with FOIA and achieved the Information Commissioner's Office (ICO's) targets. • During 2023/24 increase in FoI requests received of 888 (up by 17.9% on previous year of 753), compliance increased to 84.1% (by 5.6% within the same resources). • Challenges continued with the management of FoIs within the small team resource available and the Trust was looking at a digital system to support the FoI management process. • Broad and varied requests received with some complex responses required.
Freedom to Speak Up (FTSU) Report	• The Committee received **Partial Assurance** and noted the FTSU report. • The Committee expressed concerns on the high level of improvement actions, including Care Quality Commission (CQC) actions, that remain outstanding. • The Committee noted the plan to review and revise the FTSU arrangements, the team and service delivery, looking at a site by site service. • Increased activity of staff speaking up resulting in ongoing challenges in delivering the service. • Looking at an effective electronic management system to record cases, actions and changes, to support efficient feedback to staff that speak up. This system will also enable the team to provide reports and dashboards. • The Committee requested an update on progress made to address the outstanding actions, emerging risks, and the governance arrangement of the Trust's FTSU arrangements.
National NHS WTE Education Financial Return Submission	• The Committee received **Partial Assurance** from a verbal report on this return submission. • The Committee noted a report will be presented to the next IAGC meeting, and it requested this include Equality, Diversity and Inclusion (EDI) data.
Business Case Investment Policy	• The Committee received **Assurance** and endorsed the Business Case Investment Policy following a review and update. • The Committee noted the following key changes made: • two new Groups;

East Kent Hospitals University NHS Foundation Trust

	• reflected the Trust's Governance; • reflected working within the wider healthcare economy with the Kent & Medway Integrated Care Board (K&M ICB) and the K&M Integrated Care System (K&M ICS); • flow chart detailing delegated limits of business case approval process; • Sign-off attained from every Executive Director before proceeding and presentation to the Capital Investment Group (CIG) for recommendatory and oversight, and Business Case Scrutiny Group (BCSG) for consideration for approval.
Policy Compliance	• The Committee received **Assurance** from the Policy Compliance report. • The Committee noted currently 27 of 228 policies (12.5%) past their review dates (compared with 16.7% at the end of the last reporting period), majority were medical/clinical policies, and 90% of these will be in date by the end of July 2024. Oversight from Executive Directors, with weekly updates provided. • Staff training and awareness around how to complete an Equality Impact Assessment (EIA) to support improving the quality of submission of policies and ensure these are timely signed off by the Policy Authorisation Group (PAG). • The current system was a manual process and ineffective, and with the implementation of the InPhase system this will provide improvements and enable an integrated report to be provided.

Other items of business
The Committee noted the 2024/25 IAGC Annual Work Programme, there will be a future discussion of this with the Trust's DCG in liaison with the Chief Executive and Interim Chief Finance Officer. This will be to ensure the programme reflects the recommendations of the governance review and the Trust's governance mapping structure.

Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this assurance report from IAGC.	Assurance	To Board on 3 October 2024.

East Kent Hospitals University NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (BoD)

Report title: **Infection Prevention and Control (IPC) Annual Report 2023-2024**

Meeting date: **3 October 2024**

Board sponsor: **Director of Infection Prevention and Control (DIPC)**

Paper Author: **Deputy Director of Infection Prevention and Control**

Appendices:

Appendix 1: IPC Annual Report (April 2023 - March 2024)

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The Director of Infection Prevention and Control (DIPC) is required to produce an Annual Report on the state of healthcare associated infection (HCAI) in the organisation for which s/he is responsible and release it publicly according to the *Code of Practice on the prevention and control of infections and related guidance* (The Health and Social Care Act 2008).
Summary of key issues:	The Annual Report is produced for the Chief Executive and Board of Directors and describes IPC activity during the year. • The Trust breached most external thresholds for reportable infections; • The IPC team is now fully recruited to, and implementing actions; • The Trust now has robust surgical site infection surveillance for trauma and orthopaedics; • The Trust compliance with IPC training was 92%; • All IPC planned audits were completed in this year; • The Trust has an Antimicrobial stewardship strategy; • Antimicrobial prescribing audits were completed during the year; • The Trust participated in the National Point prevalence survey.
Key recommendations:	The Board of Directors is asked to discuss and **APPROVE** the IPC Annual Report 2023-2024.

Implications:

Links to Strategic Theme:	• Quality and Safety
Link to the Trust Risk Register:	N/A
Resource:	No

East Kent Hospitals University NHS Foundation Trust

Legal and regulatory:	Y- Supports compliance with The Code of Practice on the Prevention and Control of Infections (Health and Social Care Act).
Subsidiary:	Y – 2gether Support Solutions activities are included in the reporting.

Assurance route:

Previously considered by: IPC and Antimicrobial Stewardship Committee - July 2024, and Quality and Safety Committee - July 2024

24/71 – APPENDIX 1

East Kent Hospitals University NHS Foundation Trust

INFECTION PREVENTION AND CONTROL ANNUAL REPORT

APRIL 2023 – MARCH 2024

Contents

East Kent Hospitals University NHS Foundation Trust

INFECTION PREVENTION AND CONTROL ANNUAL REPORT

April 2023 – March 2024

1. Introduction

The Director of Infection Prevention and Control (DIPC) is required to produce an Annual Report on the state of healthcare associated infection (HCAI) in the organisation for which s/he is responsible and release it publicly according to the *Code of Practice on the prevention and control of infections and related guidance* (The Health and Social Care Act 2008). The Annual Report is produced for the Chief Executive and Trust Board of Directors and describes Infection Prevention and Control activity during the year, including progress made against the work plan and objectives identified in the Infection Prevention and Control Annual Programme and against any external objectives.

2. The Year 2023 – 2024

This report covers the period from April 2023 to the end of March 2024. This year was characterised by progression back to business as usual in infection prevention and control. Covid-19 national guidance developed throughout the year with' Living with COVID-19' guidance released in April 2022, which no longer required asymptomatic staff testing and reduced patient testing, to August 2022 when the national requirement for any asymptomatic testing ceased. All COVID-19 guidance was subsumed and incorporated into viral respiratory infection guidance, enabling a full return to the new ' business as usual' and the Trust provide information as requested to the national COVID -19 enquiry.

The decreasing cases of COVID-19 and re-implementation of routine 'standard and transmission-based precautions became challenging, as staff had to 're-learn' these, and identify all IPC risks, not just COVID-19. This year also saw the re-emergence of Flu cases, and patients co-infected with Flu and COVID-19, alongside cases of diptheria associated with the immigration centres, and national measles outbreaks. This Trust also saw a unique outbreak of a new strain of *Clostridioides difficile* (c-dif) Ribotype 181- affecting five patients across different sites over a three month period, and further C-dif cases, meaning the Trust breached the threshold.

Within this year the Trust implemented effective Surgical site infection surveillance in Trauma and orthopaedics, which identified significantly higher than national rates of infection. The Trust responded accordingly and implemented actions, and the Integrated Care Board (ICB) and NHS England (NHSE) Infection prevention and control teams visited to review and support.

The Director of Infection Prevention and Control continued to report to the Quality and Safety Committee and periodically to the Trust Board on the status of infection prevention and control throughout this reporting year, and presented the update 'Infection prevention and Control Board Assurance framework and workstreams.

3. The Infection Prevention and Control Team (IPCT)

By March 2024 the IPC team were fully recruited to. The Fulltime 'Expert' exec DIPC role was disbanded when the previous DIPC retired in July 2023, and the role became part of the portfolio of the Chief Nurse, who has previously been a Board level DIPC.

There is a Deputy DIPC, and each of the three Hospital Sites has a Lead Nurse, a clinical nurse specialist, a Charge Nurse and a support practitioner. These teams also support Buckland, Royal Victoria hospital, and all offsite renal services, as well as Spencer, and hospital at home teams. All are supported by two team administrators – who also lead on, and manage Fit testing in the organisation, (this was a new role for the IPC team from October 2023) and a support officer who manages the surveillance and data. The part time fit testing role was completed by an external company between October 2023 and March 2024, and now recruitment to the post is underway.

A band 6 Infection surveillance nurse was also recruited to in May 2023 to support the Trust compliance with Surgical site infection surveillance.

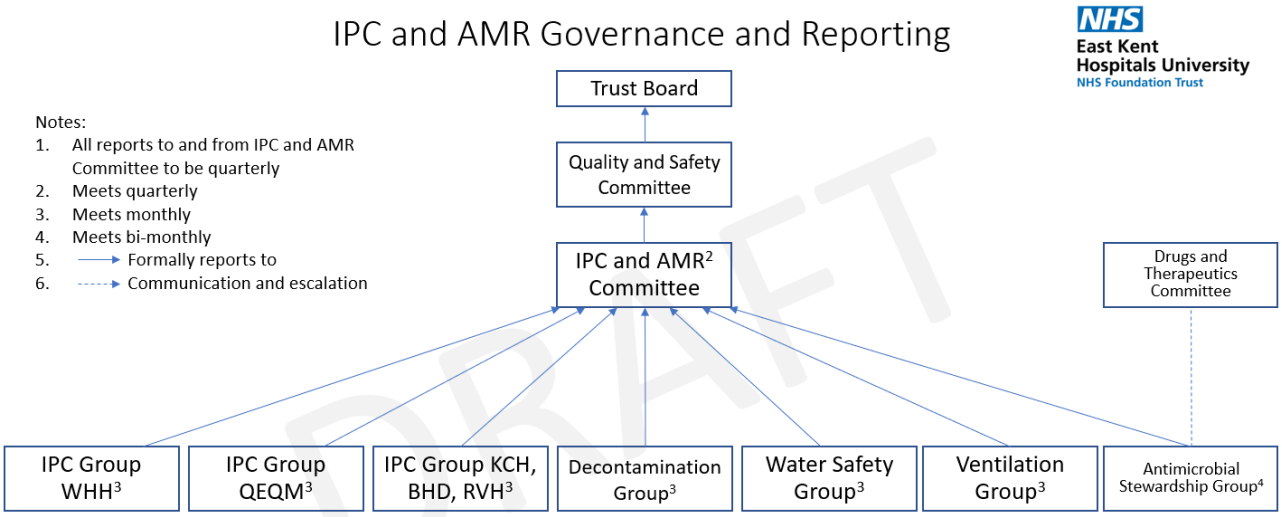
Alongside the IPC team are medical microbiology and virology consultants. There is no specific named IPC lead microbiologist, but all share support of the team. There is also a Trust consultant pharmacist leading on antimicrobial stewardship three days a week, with two part time antimicrobial stewardship pharmacists supporting – (one post vacant currently) one consultant microbiologist has this as part his portfolio also.

4. Infection Prevention and Control Committee and Reporting Structure

The structure includes site-based Infection Control Groups on each inpatient hospital site, with links to the two smaller ambulatory facilities in Dover and Folkstone. These site groups are operationally focused and bring together clinical and non-clinical colleagues on each site to discuss challenges and successes and share the learning from investigations. Each of these groups along with groups for decontamination, water safety, ventilation safety and antimicrobial stewardship report to a new quarterly Infection Prevention and Control and Antimicrobial Stewardship Committee (IPCAS).

The IPCAS Committee takes a strategic perspective and gathers themes and learning from across the Trust and is a vehicle for wider sharing, including with colleagues from external bodies such as the Kent and Medway Integrated Care Board (ICB) and the United Kingdom Health Security Agency (UKHSA). The IPCAS Committee reports to the Board via the Quality and Safety Committee and directly through the DIPC as required by the Code of Practice on the Prevention and Control of Infections (Health and Social Care Act 2008). The structure is shown below:

IPC Reporting Structure



5. The Care Quality Commission (CQC)

There were no IPC specific focussed CQC inspections during 2023-2024, however, IPC should and must do's were identified in the maternity CQC visit in relation to Personal Protective Equipment (PPE) usage, environmental and equipment decontamination and the aging estate. Actions have been completed in many areas, and the IPC team continue to offer support to maternity for ongoing improvements and innovation in IPC. Within the new care groups throughout this year, the Trust has also implemented a self-assessment process for CQC, and the IPC aspects are incorporated within that.

6. Education and Training

The *Code of Practice* requires that all staff undertake mandatory infection prevention and control training on a regular basis. The specific requirement is:

> 'that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patients care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection'.

The IPC team worked continuously to review and update the trust IPC training, which remained a combination of face to face and virtual learning as well as practical hand hygiene training.

At the end of this reporting period (March 2023) compliance with IPC mandatory training requirements was 92.9%.

7. Audit

The audit programme was reviewed during this year and the hand hygiene audits revised to reflect the return to pre-pandemic PPE use. These audits were also moved to the new Trust audit platform 'Tendable'. Hand hygiene audit results at the end of March 2023 were 97% overall.

For the reporting year 2023-2024 the following audits continued:

Audit	Completed	Achievement
Antimicrobial prescribing		Please see Antimicrobial Stewardship Report.
Infection Prevention and Control Audits of Environmental and Clinical Practice	Yearly	Regular audits (every 12 months) of the clinical environments have continued. The completed audit reports were sent to the Ward/Department Manager, who is responsible for both formulating and implementing an action plan. **2023-24 environmental audit results:** **Queen Elizabeth the Queen Mother Hospital (QEQM):** Highest 92%, Lowest 49% Average 80% **William Harvey Hospital (WHH)** Highest 95%, Lowest 57% Average 72% **Kent & Canterbury Hospital (K&C)** Highest 89%, Lowest 52% Average 68% The results of these Audits are reported via the Site Infection Prevention and Control Group and escalated as required through Trust Infection Control and Antimicrobial Stewardship Committee.
Regular Infection prevention and control audits	Monthly	Monitoring of compliance with the management of invasive devices, e.g. peripheral cannula, central vascular catheter and urinary catheter, insertion and continuing care and commode cleanliness audits. The results of these Audits are reported via the Site Infection Prevention and Control Group and escalated as required.

The Trust also participated in the National point prevalence survey for antimicrobial prescribing and Health care associated infections.

8. Hospital Hygiene and the Healthcare Environment

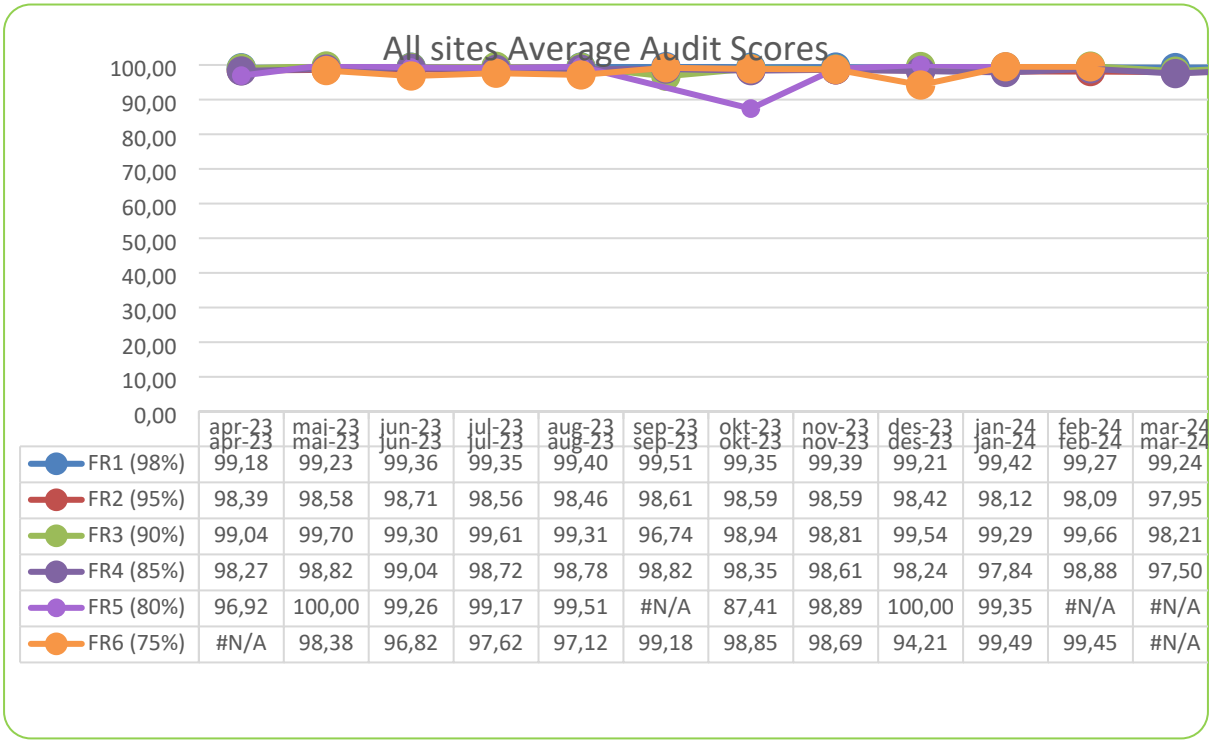
The IPC Team have continued to monitor standards of cleanliness within the Trust and promote good practice in conjunction with the Hospital and Facilities Managers through participation in the following activities:

- Patient-led Assessment of the Care Environment (PLACE).
- Environmental audits of cleanliness and the healthcare environment.
- Advising contractors/contract management on cleaning and domestic issues.
- Day to day advice/intervention/escalation to facilities management as appropriate, with regard to cleaning issues.
- Advising, with engineering colleagues from 2gether Support Solutions, through the site based and trust wide Water Safety Groups on the safe management of water supplies, to prevent risks associated with Legionella and, in augmented care settings, *Pseudomonas aeruginosa*.
- Advising, with engineering colleagues from 2gether Support Solutions (2gether), through the Trust wide Ventilation Safety Groups

During 2023-24 the IPC team has continued to work with 2gether colleagues to review and manage cleanliness standards across the organisation. The Trust has, with a small number

of exceptions, a very old estate and a very significant backlog of maintenance and need for refurbishment of clinical environments. This creates a major challenge to effective cleanliness and does not support good IPC practice or a good patient experience. The DIPC and DDIPC work with the trust and 2gether to prioritise the very limited capital investment available, taking into consideration the range of patient and safety risks, not limited to IPC risks. These challenges are reflected in the Trust's corporate risk register.

The clinical areas are audited in accordance with the national standards. All staff are BICS trained auditors, and the average scores highlighted below.



	apr-23	mai-23	jun-23	jul-23	aug-23	sep-23	okt-23	nov-23	des-23	jan-24	feb-24	mar-24
FR1 (98%)	99,18	99,23	99,36	99,35	99,40	99,51	99,35	99,39	99,21	99,42	99,27	99,24
FR2 (95%)	98,39	98,58	98,71	98,56	98,46	98,61	98,59	98,59	98,42	98,12	98,09	97,95
FR3 (90%)	99,04	99,70	99,30	99,61	99,31	96,74	98,94	98,81	99,54	99,29	99,66	98,21
FR4 (85%)	98,27	98,82	99,04	98,72	98,78	98,82	98,35	98,61	98,24	97,84	98,88	97,50
FR5 (80%)	96,92	100,00	99,26	99,17	99,51	#N/A	87,41	98,89	100,00	99,35	#N/A	#N/A
FR6 (75%)	#N/A	98,38	96,82	97,62	97,12	99,18	98,85	98,69	94,21	99,49	99,45	#N/A

Throughout the year, as issues are identified, action plans are put in place, and due to some ongoing issues relating to the functional risk ratings, some areas are being reviewed and will potentially implement hybrid ratings - this is ongoing work.

9. Incidents/Outbreaks of Healthcare-Associated Infection

National Covid-19 'outbreak' reporting was stood down during 2023-2024, with a return to internal reporting of COVID-19 outbreaks, aligned to the internal Outbreaks and incident policy.

There have been very few confirmed outbreaks of healthcare associated infections during 2023-2024. Small outbreaks of seasonal viral infections – including Influenza, COVID-19 and norovirus, were managed according to policy and protocols. Individual contact tracing exercises for exposures to infectious diseases such as measles, Chicken Pox and Tuberculosis have been managed in collaboration with clinical teams and colleagues from Occupational Health, the ICB and UKHSA as required. There was one outbreak of a rare ribotype of C-dif (181) where 5 patients tested positive over a 6 week period, and the Trust implemented routine c-dif control measures – cleaning, isolation and treatment – and there were no further cases since August 2023.

10. Surveillance and Epidemiology

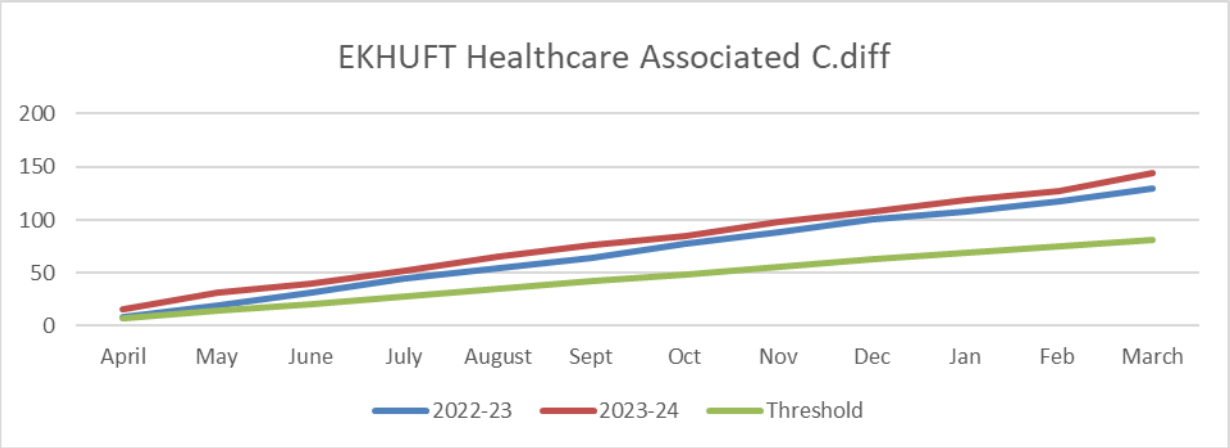
Reportable Infections

Thresholds for *Clostridioides difficile* and Gram negative bloodstream infections (see below for details) were published for the year 2023-2024, Trust performance against these thresholds and data for those infections where no threshold has been set are given below.

10.1 Clostridioides difficile (previously known as *Clostridium difficile*)

All cases of *C. difficile* identified from samples taken on day 2 of admission (where the day of admission is day 0) are hospital attributable.

These cases are described as Hospital Onset Healthcare Associated (HOHA). In addition, any patient discharged from hospital in the 28 days prior to a positive test for *C. difficile* are also hospital attributable. These cases are described as Community Onset Healthcare Associated (COHA). These two categories are combined in figure 4 showing performance compared with 2023-2024 and a linear trajectory to the externally set threshold.



For the full year 2023-2024 the Trust was significantly above the external threshold. This reflects a regional trend with all of the acute trusts in Kent and Medway, leading to a systemwide collaboration to implement strategies to reduce cases. This change in C-diff epidemiology is still not fully understood locally or nationally however internal review of cases identified the following themes:

- 51% of all cases were community onset community acquired
- 11% relapse / re-infection
- 26% deemed to be potentially avoidable
- 63% antibiotic associated (of which)
- 26% were not in accordance with antimicrobial guidelines
- 10% cases confirmed cross infection (181 outbreak 5 of these cases –all others 1 case of same ribotypes)
- 9% cases community acquired, however samples not taken in urgent pathway (none since August 2023)
- 52% cases were deemed to have been a delay in recognising symptoms and sending samples

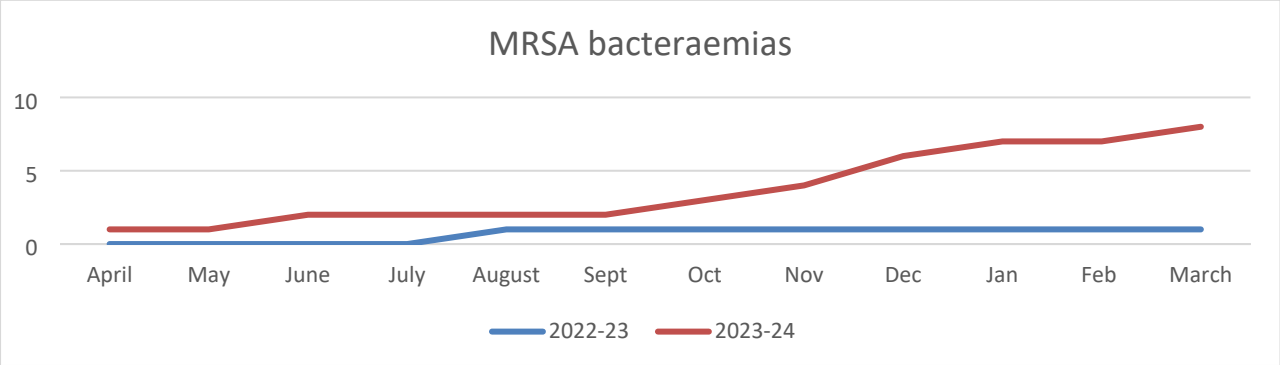
Actions focussed predominantly around antimicrobial stewardship (see section 11), environmental cleaning, and hand hygiene.

10.2 *Staphylococcus aureus* Infections (MRSA and MSSA) bloodstream infections

10.2.1 MRSA

MRSA bloodstream infections should be extremely rare events and avoidable healthcare onset cases should be regarded with zero tolerance.

In 2023/2024 the Trust have reported five MRSA bacteraemia HOHA's and three COHA's. All cases were reviewed for learning. One case identified significant learning, and was deemed avoidable, two cases were deemed to have been associated with lines, however, in both cases the lines were inserted correctly, and managed correctly daily, all other cases were deemed to be unavoidable. Main learning from these cases identifies a delay in swabbing wounds on admission, in accordance with the MRSA policies, documentation of insertion of lines and ongoing line care, which will be included in the IPC plan for 2024/25 and incorporated into the CLEAN campaign – which is a 'back to basic's focus on **C**-clean hands and correct PPE, **L** – Line care, **E**-environmental and equipment cleaning, **A**-antimicrobial stewardship, **N** -Needles and sharp safety.

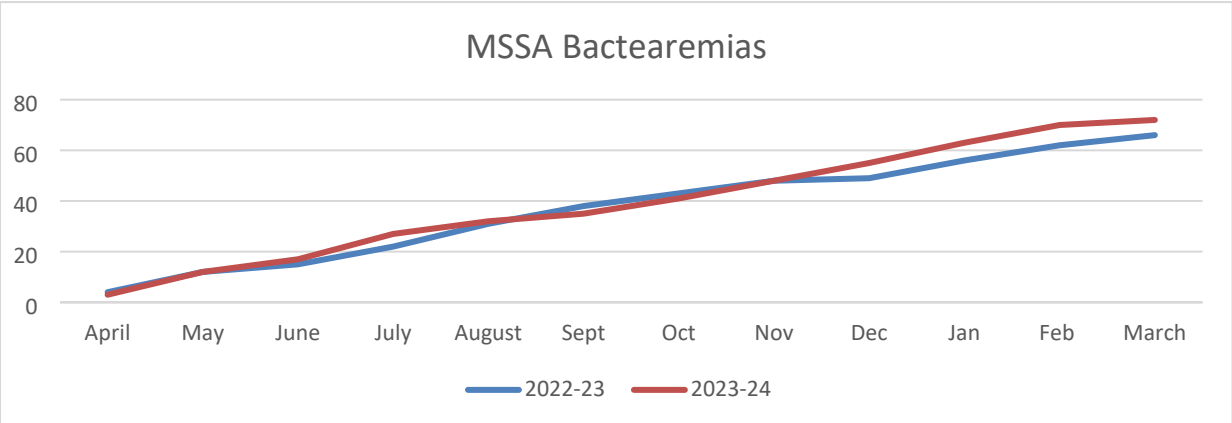


10.2.2 MSSA

Meticillin sensitive *Staphylococcus aureus* (MSSA) bloodstream infections are common in both community and hospital settings. Healthcare associated infections are commonly related to vascular access catheters or surgical site infection. There is no externally set objective for MSSA bloodstream infections.

The number of hospital attributed bacteraemias is 9% higher for 2023/24 compared to the previous year - reporting 72 cases to the end of March 2024.

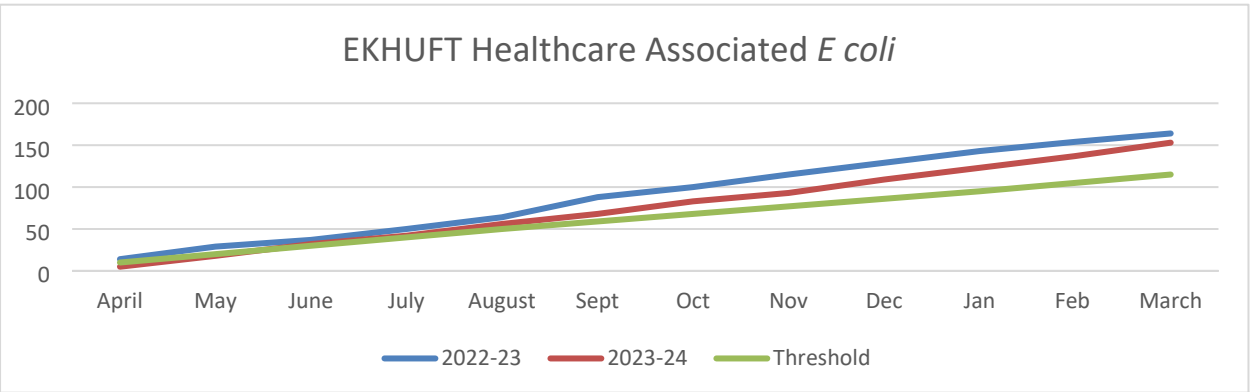
All HOHA and COHA cases are investigated by the IPC team with associated action plan where learning is identified – the learning for MSSA's is similar to MRSA – predominantly wound care and line care focus.

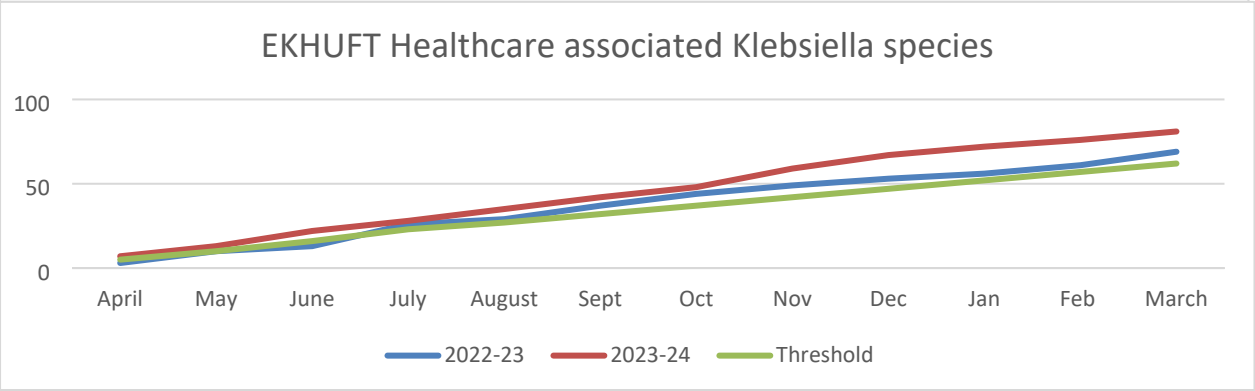


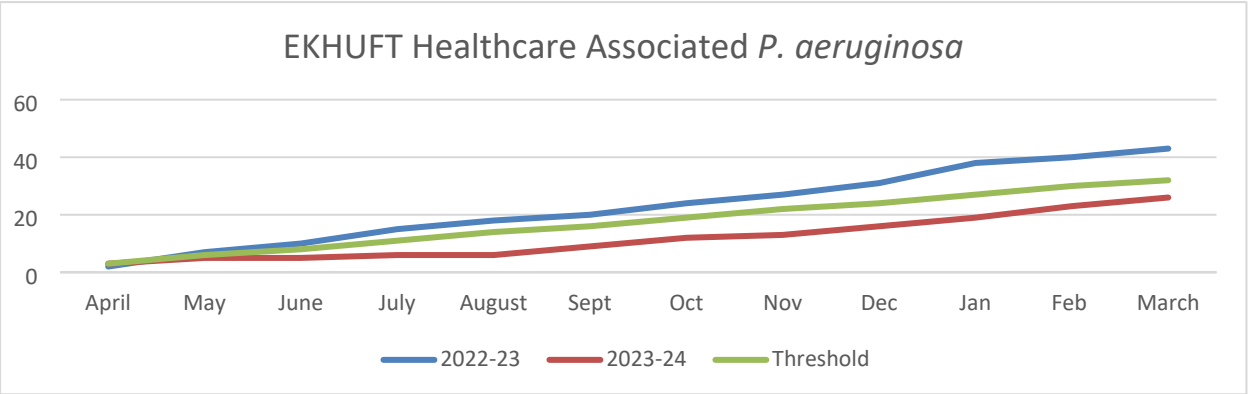
10.3 Gram Negative Bloodstream Infections

The data for the three nationally reportable Gram negative bloodstream infections are given below:

The Trust were over trajectory for both E-coli (154 cases against threshold of 115) and Klebsiella (81 cases against threshold of 62). For E-coli, the Trust made a 7% reduction in cases compared to 2022/23, whereas for Klebsiella there was a 15% increase in cases. The main focus of actions for these remains predominantly urinary catheter and UTI reduction – (such as improving hydration) however the targeted interventions for both of these gram negative infections are similar, therefore hard to understand why one is decreasing, whilst the other increasing.







Year-end cases 26, against threshold of 32, and a reduction compared to last year of 40%
The 'Device Related Infection Prevention Practice' resources are being utilised in areas in wards on some wards as part of quality improvement initiatives, and has seen improvements in urinary catheter care and line care -as reported through monthly IPC audits.

10.4 Carbapenemase Producing Organisms (CPO)

CPO are of concern as organisms producing Carbapenamases (enzymes that confer antimicrobial resistance) are resistant to many of the antimicrobials of last resort. In some areas of the UK, CPO have become endemic and once established in a healthcare facility, they can be extremely difficult to eradicate. Management of CPO follows published guidance from UKHSA. For EKHUFT where CPO are not endemic this is based on targeted screening of certain patient groups. Although this screening has identified sporadic cases, no cluster or outbreaks have been identified. Vigilance remains high.

11. Antimicrobial Stewardship (AMS)

11.1 Current Antimicrobial Stewardship Team

Consultant Medical Microbiologist (Lead Consultant for AMS) – in post
Consultant Pharmacist (AMS) – 0.6 Whole Time Equivalent (WTE) – in post
Advanced Pharmacist (AMS) based at WHH – 0.64 WTE – in post
Advanced Pharmacist (AMS) based at QEQM – 0.6 WTE - vacant for most of 2023-24 (maternity leave and promoted after returning from maternity leave to new job in the Trust), new starter in September 2024.
Other Consultant Medical Microbiologists and Clinical Fellows are available for advice/ward rounds if needed.
Prescribers are asked to refer any patients they are concerned about to the Consultant Microbiologists/Clinical Fellows via the Careflow app. A response can be added to the referral recommending a treatment plan and duration.
A Multi Disciplinary Meeting (MDM) was established for Covid-19 treatment options as National Institute for Health and Care Excellence (NICE) guidelines have been in constant review during this year.
Clinical ward pharmacists are asked to review all antibiotic prescriptions and ensure that:

- there is an accurate indication and stop/review date on the Sunrise chart
- they are prescribed as per guidelines, microbiology advice or as per culture and sensitivity results. They are asked to challenge anything that does not fit these criteria and document in Sunrise notes

- prompt clinical teams to refer patients to Microbiology via Careflow if duration of treatment is at 10 days or more or if the antibiotic choice is a restricted antibiotic, not as per guidelines or microbiology advice

Junior doctors were asked to participate in the IVTOS quality improvement project as an element of embedding AMS to their practice.

11.2 Aims of the AMS Team

- Reduce inappropriate antimicrobial prescribing; total consumption, broad spectrum and high *Clostridioides difficile* risk antibiotics (in particular: co-amoxiclav, piperacillin/tazobactam, fluoroquinolones, clindamycin, carbapenems and 3rd generation cephalosporins).
- Work pro-actively to prevent increasing antimicrobial resistance and healthcare associated infections e.g. *C. difficile*.
- Provide education and training to prescribers, nurses and pharmacists where needed
- Reduce allergy and other antimicrobial related incidents by 50% by 2025.

The pharmacy AMS team produces a highlight report summarising activities conducted monthly.

11.3 Data

Unless stated otherwise, the graphs and tables presented in this report uses data collected from the RxInfo database. In order to compare data across different timeframes, the data is presented as Defined Daily Doses (DDDs/1000 admissions).

It should be noted that since April 2020, admissions for the Emergency Department (ED) is not complete. The effect this has on the data presented, is not known.

FP10s have been included in the usage data. ED use a lot of FP10 prescriptions to facilitate discharge. To not include them would potentially skew the data and not give a true representation of the prescribing patterns within ED.

11.4 Standard Contract 2023/24

The consumption of antibiotics in the Watch and Reserve categories of the AWaRe list is monitored under the NHS Standard Contract. All the 'High *C. difficile* risk antibiotics' monitored by the AMS team in the list above fall under the Watch and Reserve categories.

To clarify an aspect that has created queries: the NHS Standard Contract for 2019/20 and 2021/22 included a requirement for acute providers to reduce total per-patient antibiotic consumption by 1% and 2% respectively. For 2022/23 the contract requirement was changed to focus on the UK AMR National Action Plan commitment by requiring a 4.5% reduction in use of Watch and Reserve antibiotics from a 2018 baseline and indicating that a further 2% reduction would be required for 2023/24 (to continue on a trajectory towards meeting the National Action Plan commitment). Data became available prior March 23, for the National Action Plan baseline year of 2017, and there was a national decision to align the Contract requirement for 2023/24 with the UK AMR National Action Plan commitment to reduce use of Watch and Reserve antibiotics in hospitals by 10% from 2017, in order to minimise the risk that this National Action Plan commitment was not going to be met.

The data are reported as Defined Daily Dose (DDD)/1000 admissions (using the dictionary of medicines and devices nomenclature to allow benchmarking). As per above clarification and for consistency with the UK 5-year AMR National Action Plan target, trusts are required to show a 10% cumulative reduction from calendar year 2017 baseline data.

Results for 2023/24 are shown below (Table 1). Final admission figures for March 2023 may vary so this figure will be subject to change.

Table 1.

	Baseline 2017 data	Target Watch + Reserve DDDs per 1000 admissions for 2023/24	Actual Watch + Reserve DDDs per 1000 admissions for 23/24 so far
DDDs / 1000 admissions	**2278**	2050	3474
% difference in Watch + Reserve DDDs per 1000 admissions from 2017 baseline			**+ 69%**

Co-amoxiclav is the most used Watch and Reserve antibiotic in the trust, followed by clarithromycin, ciprofloxacin, Tazocin® (Piperacillin/Tazobactam) (figure 1)
There has been approximately 140% increase in the use of co-amoxiclav across the trust between 2014 and 2023.

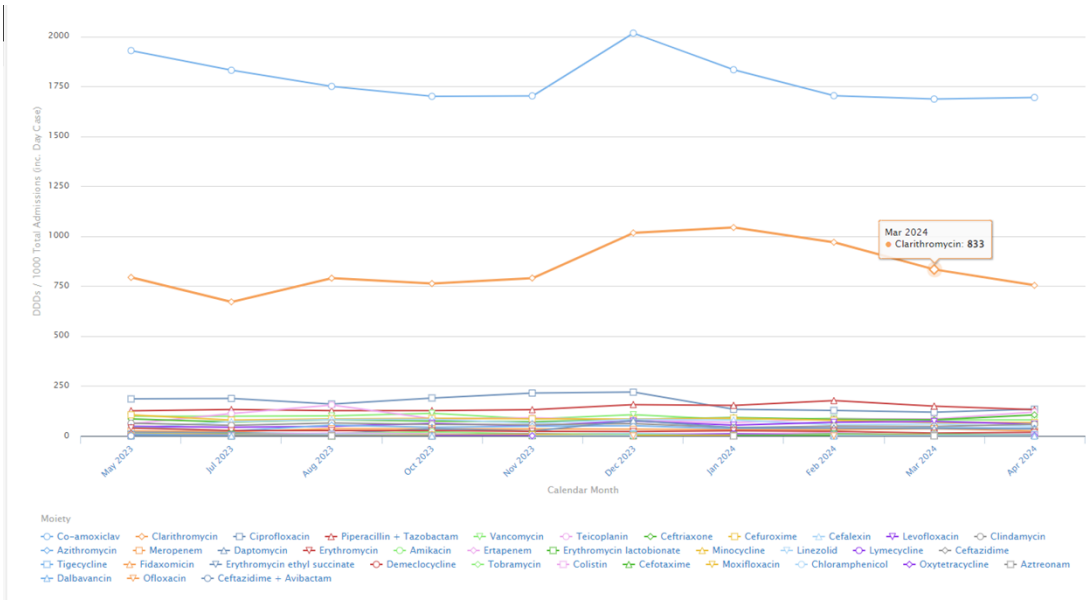


Figure 1: Consumption of Top 10 Watch and Reserve Antibiotics by drug in Defined Daily Dose (DDDs)/1000 total admissions for Financial Year (FY) 2023-24 (including FP10s)

Emergency Medicine is the biggest user of Watch and Reserve antibiotics (figure 2). ED uses approximately three times as many antibiotics as the second highest user (Specialty Medicine) and more than the rest of the Top five combined.

Antibiotic usage has been steadily increasing in ED and across the Trust since 2014, with co-amoxiclav and clarithromycin forming the largest portion.

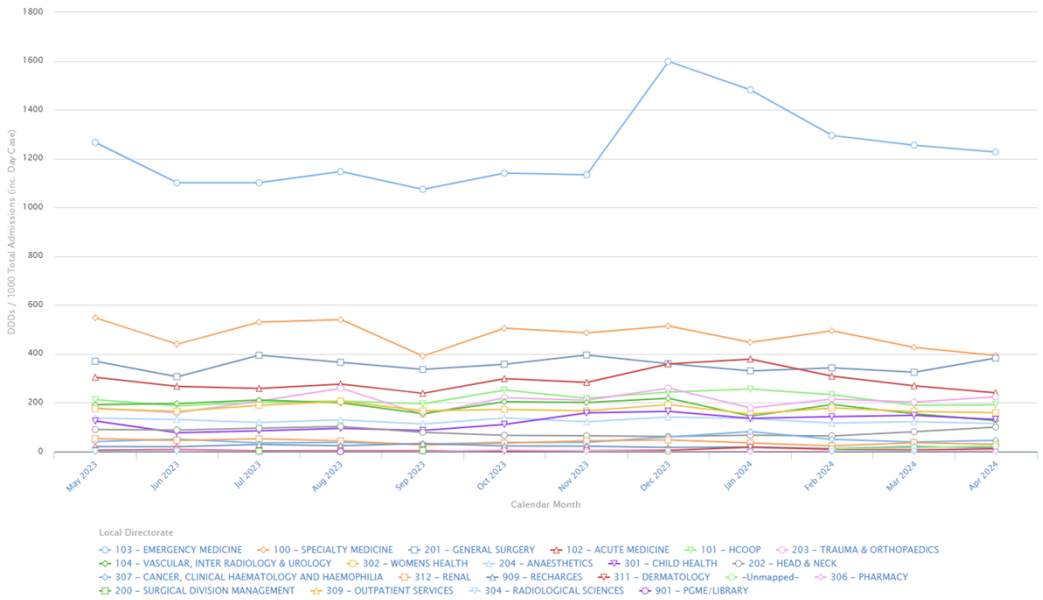


Figure 2: Consumption of Watch and Reserve Antibiotics by Top five local directorates in DDDs/1000 total admissions for 2023-2024 (including FP10s)

Figure 3 and 4: Co-amoxiclav use in Emergency Medicine by formulation (2023-24) in DDD / 1000 admissions including FP10s

Majority of co-amoxiclav usage occurs in ED in the form of to take out/home (TTO) prepacks, with usage doubling between 2014 and 2023.

11.5 AMS Team audits/projects conducted

A variation of audits have been conducted during 2023-24. This has helped assessing current situation of engagement amongst various HCP. The following are important to highlight:

- ED team was shown results of an AMS audit and asked to provide an action plan to discuss at ASG in June 23, but the ED consultants advised that this was not an ED issue and was the responsibility of General and Specialist Medicine and Surgical care groups. This point was discussed further with the Chief Medical Officer in June 2023, and with other CMOs appointed.
- IVTOS CQUIN/ quality improvement plan conducted as MDT mainly by junior doctors, with good engagement initially and AMS being more embedded in doctors practice, creating awareness of IVTOS in the Trust with nurses and pharmacists as well.
- CURB65 score audit in AMU for patients diagnosed with CAP, results were presented to AMU clinical governance and engagement with a consultant from WHH at AMU has occurred since then.
- Point prevalence survey audit results were shared to clinical directors with a message from the CMO in November 2023
- EPMA validation of the mandatory aspect of reason for antibiotics, the indication- how accurate is this being picked up from the dropdown system when compared with clinical notes. The accuracy of EPMA with Clinical notes showed around 75%. These results were discussed and shared with clinical pharmacists and at DVG.
- Compliance of antibiotic prophylaxis in surgical orthopaedic theatres at KCH was also an audit conducted. The results of this audit were presented to anaesthetics and IPC.
- Ad hoc audits conducted by the AMS Team when a *C. difficile* Period of Increased Incidence has occurred. Results are then fed back to the IPC team.
- TTA prepacks use in ED
- Antibiotics prescribed and used under PGD in Urgent Treatment Centre (UTC)

The last two points need further observation and results presenting to the team in a more strategic way, one audit was conducted by pharmacy and the UTC one by nurse in UTC, there have been some questions raised on the data collection that pharmacy is still waiting to hear from UTC team.

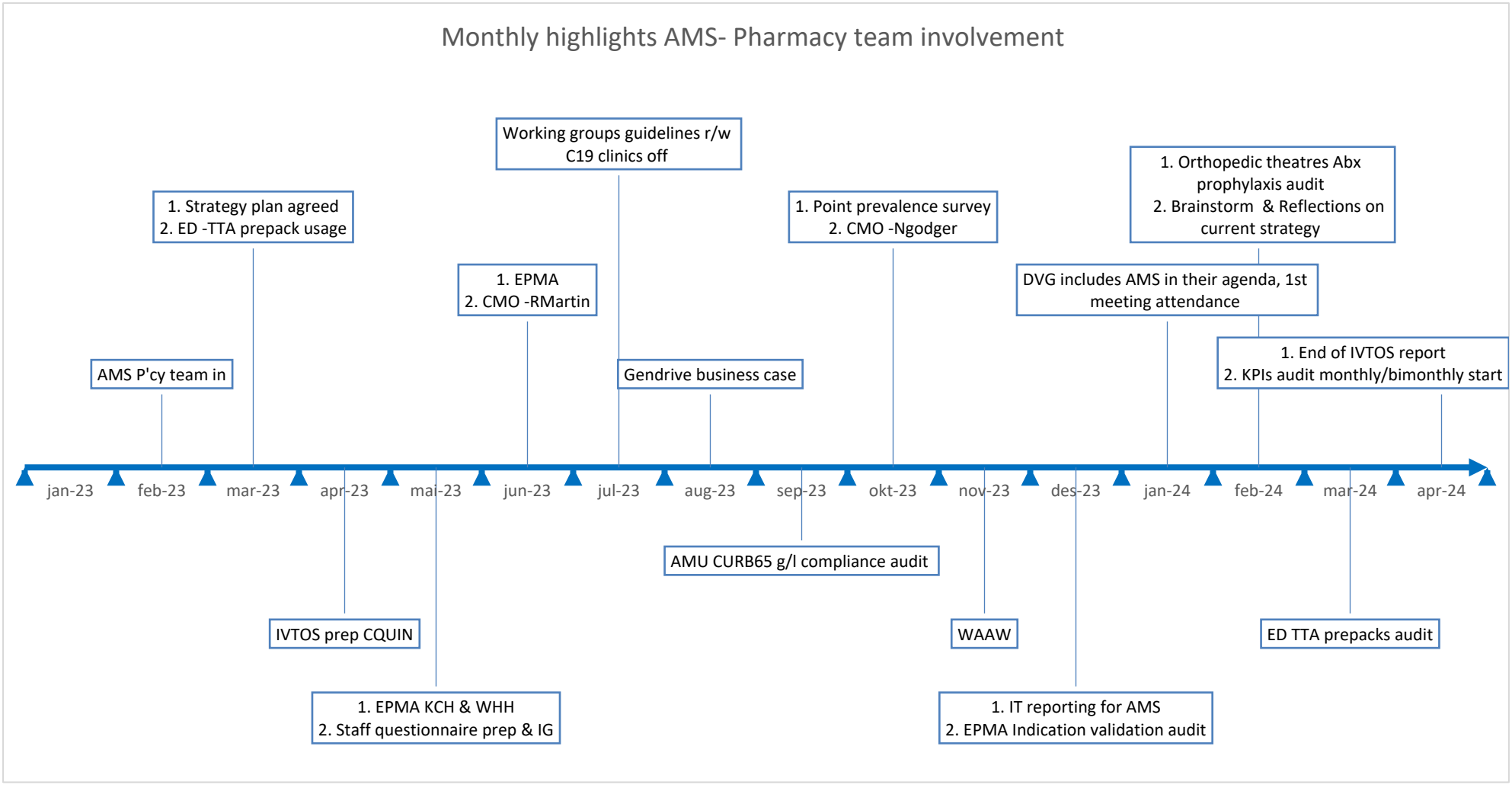
The pharmacy AMS team are also working with IT and quality improvement teams to discuss how data from Sunrise EPMA can be used to guide both audits and reporting of antimicrobial usage. Good and positive information has been extracted that aids AMS audits.

11.6 Next audits

There is a focus on AMS audits connecting with potential CDI. The plan is to monitor monthly areas that are high users of broad-spectrum antibiotics monthly and other areas every two months. These audits are to start and to run from April 24 with a minimal data collection of 6 months and maximum of 12 months. By the time of this report was written, the analysis for April's AMS audit was done and results shared with teams. There is a potential clash of data results that need to be presented/shared with time approaching where new audit days approach.

11.7 Highlights

Next figure shows the highlights for AMS team during the establishing of the team post pandemic.


Monthly highlights AMS- Pharmacy team involvement
Working groups guidelines r/w C19 clinics off
1. Strategy plan agreed
2. ED -TTA prepack usage
1. Point prevalence survey
2. CMO -Ngodger
1. Orthopedic theatres Abx prophylaxis audit
2. Brainstorm & Reflections on current strategy
1. EPMA
2. CMO -RMartin
DVG includes AMS in their agenda, 1st meeting attendance
AMS P'cy team in
Gendrive business case
1. End of IVTOS report
2. KPIs audit monthly/bimonthly start
jan-23
feb-23
mar-23
apr-23
mai-23
jun-23
jul-23
aug-23
sep-23
okt-23
nov-23
des-23
jan-24
feb-24
mar-24
apr-24
AMU CURB65 g/l compliance audit
IVTOS prep CQUIN
WAAW
ED TTA prepacks audit
1. EPMA KCH & WHH
2. Staff questionnaire prep & IG
1. IT reporting for AMS
2. EPMA Indication validation audit

12. Decontamination

12.1 Sterile Supplies (CSSD)

Instrument reprocessing is outsourced to In House Sterile Services (IHSS) The Trust Deputy DIPC undertook a formal visit following ongoing issues relating to 'holes' in wraps in 2023 and a second visit with the Trust authorising engineer to review processes. The DDIPC found that IHSS processes met requirements for systems and processes, however there have been ongoing issues with both holes in wraps and contaminants, which continue to be investigated, and IHSS continue to implement training and education with their staff.

The MD of IHSS has also visited EKHUFT and the DDIPC and service created joint action plans to potentially reduce holes and onward potential cancellation / delay in surgery related to the additional checks on sets required. The actions included a review of all processes, transportations, storage , shelving and use of tins for larger orthopaedic instruments. The holes are reducing and a trial of Tins for heavier sets is in planned.. The contract with IHSS is managed by the service, and decontamination aspects reported through the Decontamination committee, there was one major failure of decontamination issue identified this year – where a bored instrument was found to have not been effectively decontaminated during surgery, duty of candour was followed and the patient informed, and there was no onward infection identified.

12.2 Endoscope reprocessing

Endoscope reprocessing is undertaken and managed locally, all sites where processing is undertaken were audited by the Trust Authorised Engineer for decontamination. All sites were deemed to be compliant with essential requirements, with some aspects of flow and training requiring some actions, and evidence of estates interventions in relation to ventilation and water ongoing maintenance required. No service met the 'best practice' standards.

12. Surgical Site Surveillance

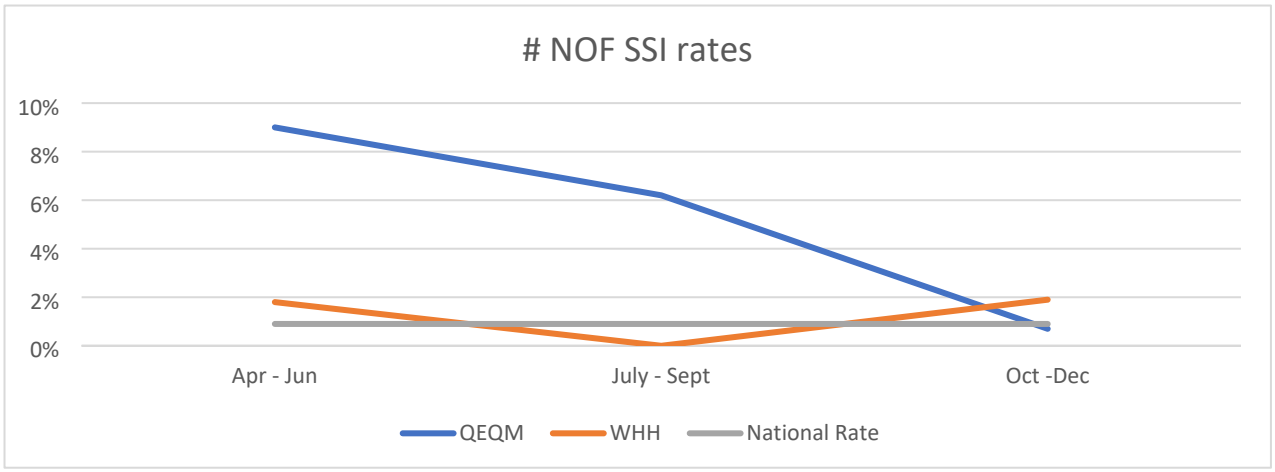
Surveillance of surgical site infection (SSI) following orthopaedic surgery is included in the mandatory healthcare-associated infection surveillance system.

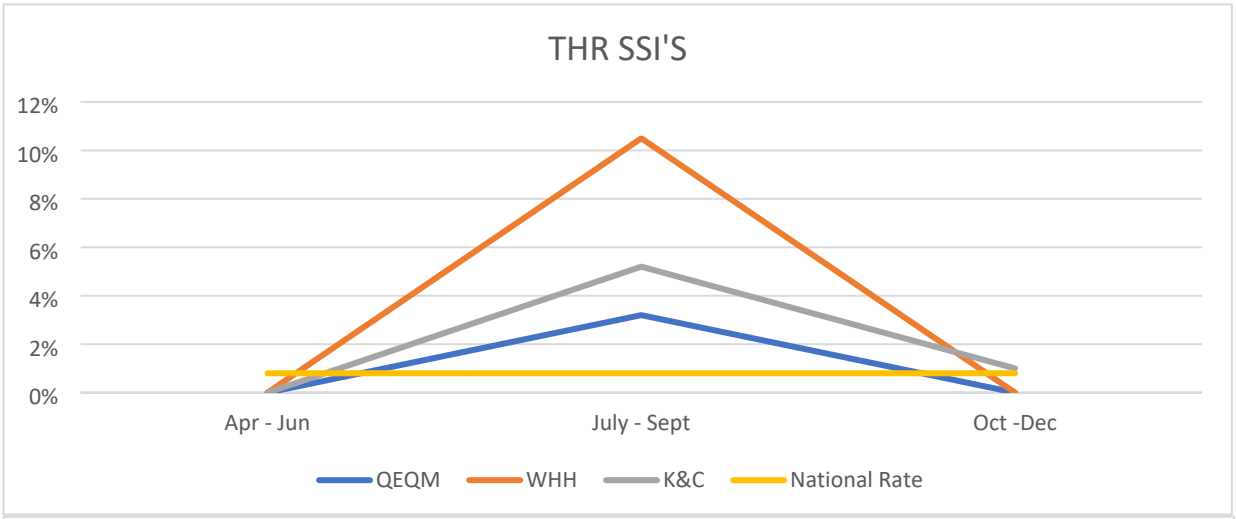
All NHS Trusts where orthopaedic surgical procedures are performed are expected to carry out a minimum of three months surveillance in at least one of the three orthopaedic categories:

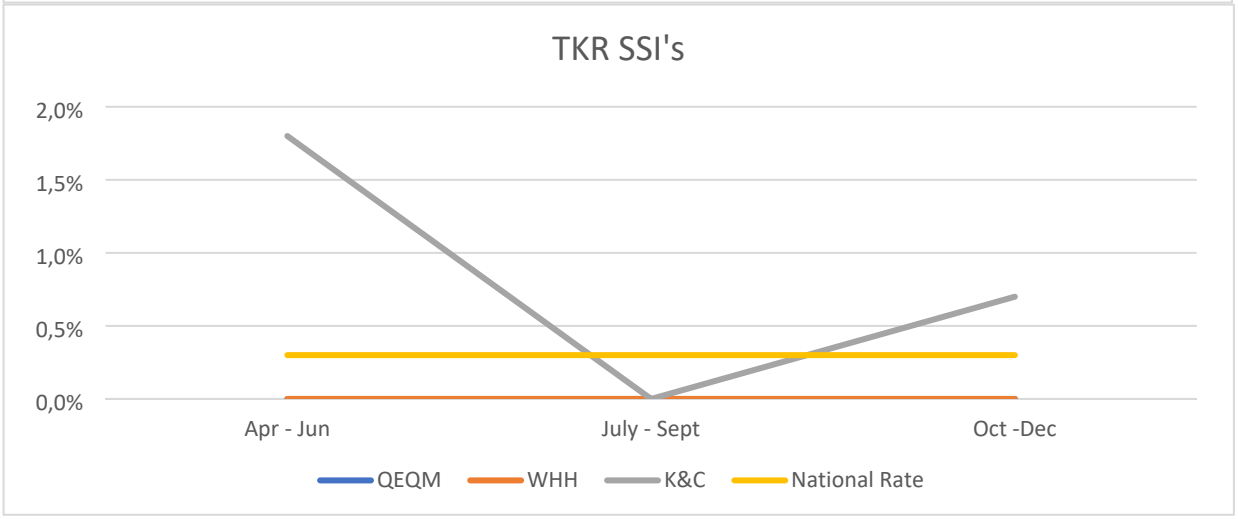
- Total hip replacements
- Knee replacements
- Hip hemiarthroplasties

EKHUFT undertake continuous surveillance in all three categories (rather than limiting participation to the mandatory single quarter per year). Prior to 2023 the process was not deemed to be robust, and the IPC team employed an infection surveillance nurse. This identified a high rate of infections, across all categories. The Trust immediately implemented a task group to highlight and complete actions to reduce these rates, and a gap analysis was undertaken against both the NICE prevention of surgical site infections guidance and the National Neck of femur pathway was completed. The ICB and NHS England (NHSE) infection prevention and control teams also visited to support and help identify actions, all of which have implemented.

The Trust continues to hold fortnightly action update meetings and rates have significantly reduced since the implementation of the group.







It should be noted that the peak in rates for WHH in the middle report, relates to a single infection, rather than a spike in infections.

Focus will continue on reducing surgical site infections, with a hope to increase to other specialties.

13. Conclusions

There has been a strong and sustained focus on IPC and antimicrobial stewardship during the last twelve months and there has been progress, despite the context of extreme operational pressures,

and a continuing challenge from Covid-19, Influenza and norovirus. The Trusts aging estate causes the most significant impact on the ability of the staff to be able to effectively clean, and manage care in a safe environment, and this remains a key focus going forward. The IPC and antimicrobial stewardship teams are established and work continuously to improve practice and outcomes for patients and staff.

In the last year we have:

- Fully recruited to all IPC team roles, including employment of an infection surveillance nurse for Surgical site infection surveillance. The consultant Pharmacist for AMS is In post, but there have been ongoing gaps in the team due to maternity leave and vacancy.
- Reviewed the training needs and education for IPC for all trust staff.
- Recommenced the IPC Link Practitioner programme
- Reviewed the IPC environmental and clinical practice audit programme into the new 'MEG' audit platform.
- Contributed to ongoing reviews of the National Infection Prevention and Control Manual (NIPCM)
- Implemented a new governance structure for IPC including AMS and decontamination.
- Revised the IPC Business Continuity Plans.
- Reviewed the scope and quality of the surveillance of HCAI and started a programme of improvement work.
- Worked collaboratively with system partners to develop a Kent and Medway IPC Strategy.

We have achieved success in the following areas:

- The IPC team is fully recruited to
- The Trust was below the external threshold for *Pseudomonas aeruginosa* bloodstream infections (BSI)
- The Trust was below the previous year's reported MSSA blood stream infections
- Implemented robust processes for surgical site infection surveillance in Trauma and orthopaedics – Total hip, total knee replacements and fractured neck of femur repairs.
- Reduced SSI's relating to fracture neck of femur repairs in QEQM to the national average

The remaining challenges and areas of focus include:

- The Trust exceeded thresholds for all other gram negative blood stream infections (E-Coli and Klebsiella) .
- The Trust reported 8 cases of attributable Meticillin Resistant Staphylococcus aureus (MRSA) Blood Stream Infections (BSI)
- In common with the majority of acute trusts locally, regionally and nationally we have seen a significant increase in Cdiff infections compared with the previous year. This has led to us exceeding the external trajectory.
- maternity services highlighted the need for further work related to cleanliness, the quality of the inanimate environment and some aspects of routine IPC practice.
- Overall the state of our estate and physical infrastructure remains very challenging and does not support good IPC practice.
- The identified rates of surgical site infections in the current surveillance programme identifies rates which are higher than the national average.

Focus for coming year:

- Utilising PSIRF methodology implement IPC reporting matrix for rapid reviews and learning
- CLEAN campaign implementation to focus IPC methodology for

‘C’ Clean hands and correct PPE

‘L’ Line care – urinary catheter and vascular line insertion and care

‘E’ -Environmental and equipment cleaning

‘A’ Antimicrobial Stewardship

‘N’ needle and sharp safety

- Focussed improvement plan on learning identified from last year – Sampling, isolation, and aspects of CLEAN campaign.

East Kent Hospitals University NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (BoD)

Report title: **Medical Appraisal and Revalidation**

Meeting date: **3 October 2024**

Board sponsor: **Chief Medical Officer (CMO)**

Paper Author: **Senior Business and Operations Manager to the CMO**

Appendices:

Appendix 1: Statement of Compliance (SoC)

Executive summary:

Action required:	**Approval**
Purpose of the Report:	As part of the Trust's duty as a Designated Body, the Trust is required to ensure it is able to execute the responsibilities of the Medical Profession (Responsible Officers) Regulations 2010 (and its amendments). The purpose of the report is to provide updates and assurance that the responsibilities are being met and improvements are being delivered as agreed by the Statement of Compliance (SoC) report submitted to the Board of Directors in November 2023.
Summary of key issues:	• Appraisal compliance has remained steady at 83% amongst implementation of a new medical appraisal system. • The rate of positive revalidation recommendations continues to improve.
Key recommendations:	The Board of Directors is asked to **NOTE** this report and: • **REVIEW** and **AGREE** the Statement of Compliance linked to this report. • Recommendations are to **REVIEW** this report and provide any comments or feedback that will help continue to realise the improvements being sought.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People
Link to the Trust Risk Register:	CRR 123 - Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate medical staffing levels and skill mix to meet patients' needs.
Resource:	N

East Kent Hospitals University NHS Foundation Trust

Legal and regulatory:	Y: Impacts our functions regulated by the Higher-Level Responsible Officer (NHS England).
Subsidiary:	N

Assurance route:

Previously considered by: The contents of this paper have been subject to ongoing review and monitoring by the Responsible Officers Advisory Group (ROAG).

East Kent Hospitals University NHS Foundation Trust

Medical Appraisal and Revalidation

1. Purpose of the report

1.1 To provide assurance that the Trust is meeting its requirements to deliver the Medical Profession (Responsible Officers) Regulations (2010).

2. Background

2.1 Revalidation and appraisal are carried out in the NHS to ensure doctors are licensed to practice medicine and supported to develop so care continuously improves. This report summarises the Trust's position in respect to its performance as a Designated Body.

3. Appraisal Compliance

3.1 The Trust currently has 950 connected doctors, with 789 (83%) with appraisal completed/within guidelines.

3.2 In April 2024 the Trust started the transfer of the Trusts e-portfolio system to a new provider. With the full implementation of the new e-portfolio system from 1 August 2024. During the transition period appraisals were asked to pause. The aim within the Annual Organisational Audit (AOA) report was to return to pre-transfer compliance rates within three months of implementation. This has been achieved within two months of implementation.

3.3 Actions agreed by the Board of Directors following the previous Statement of Compliance report (November 2023) were updated and presented to the Board of Directors through the AOA report in May 2024. The latest Statement of Compliance has been updated and is attached to this report.

4. Revalidation

4.1 All recommendations for revalidation are discussed at the monthly Responsible Officers Advisory Group (ROAG).

4.2 Since February 2024, 157 doctors have required revalidation recommendations. 131 (83%) have received a positive recommendation; 26 (16%) have had recommendations deferred due to insufficient evidence; and one (1%) had recommendations deferred as they are subject to an ongoing process. The most common cause for deferring a recommendation due to insufficient evidence continues to be lack of 360 Multi-Source Feedback. The number of positive recommendations has continued to improve from a position of 72% of all revalidations due since the last report (66 positive recommendations out of 92).

4.3 Portfolios are now as standard reviewed two to three months prior to the revalidation due date at ROAG for example those due in November are reviewed in September. Depending upon when the revalidation due date falls in the month this provides eight to twelve weeks to complete any outstanding recommendations. This has helped to improve positive revalidation recommendations.

4.4 We are confident that the Trust's new e-portfolio system will further improve positive revalidation rates with the increased transparency of any overdue actions for doctors.

5. Maintaining Accurate Records

5.1 Connection check is performed twice a month to maintain an accurate list of our prescribed connections with medical practitioners.

5.2 The connection checking process is now cross checked monthly with the job planning records to ensure accuracy.

6. Job Planning

6.1 As of September 2024, there were 673 doctors that required a job plan and 236 had completed/had a job plan reviewed in the previous 12 months. This makes the current position on job planning compliance 35%.

6.2 In the sign-off stages of the job planning process there is currently: 5% in third sign-off, 5% in second sign-off, and 4% in first sign-off. The remainder is currently in discussion.

6.3 From 1 April 2024 job planning rounds were introduced in the Trust. The Trust is entering quarter three in which it is expected that doctors will start to sign off job plans and thus increase the compliance rate. We aim that we will achieve the 90% job planning compliance by 1 April 2025. Achieving 90% will mean we have met the requirements of level 1 of the Levels of Attainment and Meaningful Use Standards.

7. Levels of Attainment and Meaningful Use Standards

7.1 There are 17 standards to meet across five levels (level 0 – level 4), each standard/level is sequential and must fully met before the next level can be obtained.

7.2 Our current position against these standards are as follows: 5/17 standards met, 6/17 partially met, 5/17 not met.

7.3 Level 0 (e-job planning): 1/1 standards met.

7.4 Level 1 (basic individual job planning): 3/4 standards met (remaining standard: achieve 90% job planning compliance).

7.5 Level 2 (advanced individual job planning): 1/3 standards met.

7.6 Level 3 (team job planning): 0/5 standards met.

7.7 Level 4 (organisational job planning): 1/4 standards met.

8. Conclusion

8.1 The Trust's medical appraisal position has continued to maintain a steady compliance rate.

8.2 Revalidation recommendations continue to be reviewed and provided by the Responsible Officers Advisory Group (ROAG) and the group continue to review and improve processes in response to data and feedback from the General Medical Council (GMC).

8.3 The governance around maintaining accurate data relating to medical practitioners continues to meet the expectations of the Higher-Level Responsible Officer and the Trust is continually seeking ways to improve and respond to local and national changes.

8.4 Actions developed to improve appraisal and revalidation are impacting other workstreams within the Chief Medical Officer portfolio, such as job planning and the Levels of Attainment.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 6 June 2024 Action from last year: See comments Comments: Actions and comments captured in the AOA board report and summarised throughout this SoC Action for next year: AOA to continue

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None Comments: Dr Jonathan Purday continues in appointment as Responsible Officer as per last year. Action for next year: None

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year: Continue to review resources and ensure RO services are being met in response to workforce changes. Comments: New Deputy Chief Medical Officer appointed to post to support CMO functions. Action for next year: Continue to review resources and ensure RO services are being met in response to workforce changes

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Continue to maintain accurate records Comments: Connection checks performed twice a month and are utilised to cross-check the processes in place to capture incoming and outgoing connections. Action for next year: Continue to maintain accurate records

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Confirm publication of updated policy

Comments: Draft policy ongoing due to implementation of new system. Draft written and being reviewed by CMO team and JLNC.

Action for next year: Confirm publication of updated policy

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: Confirm completion of all recommendations and actions following peer-review

Comments: Completion of all recommendations of peer review undertaken in 2022

Action for next year: Continue to undertake regular reviews on quality appraisals

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Confirm completion of actions to ensure temporary medical workforce is supported in appraisal and revalidation requirements.

Comments: temporary workforce is supported by ensuring connection of temporary workers through the connection check. An induction is completed monthly for all new starters and drop in clinics run to allow for doctors to attend for further advice.

Action for next year: continue to undertake reviews of temporary workforce compliance

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Continue to monitor delayed appraisals and improve governance around revalidation recommendations.

Comments: A delayed appraisal escalation process has been implemented. Doctors with perceived non-engagement, the use of the Rev6 process has been implemented with agreement from the RO. All doctors who are under the Rev6 process are reviewed monthly at ROAG. Once suitable engagement has been seen ROAG members approve the Rev6 process to be

stood down. The Trust have not yet had to escalate further beyond this process.

Action for next year: Continue to monitor delayed appraisals and improve governance around revalidation recommendations.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Continue to monitor delayed appraisals and improve governance around revalidation recommendations.

Comments: The actions taken in question 1 have sufficiently worked to improve appraisal governance.

Action for next year: Continue to review effectiveness of process monitoring delayed appraisals.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Publish new appraisal policy

Comments: The appraisal and revalidation policy publication has been delayed due to the implementation of a new medical appraisal software. It has been updates and is with the CMO team for review. To later be shared with JLNC for comment

Action for next year: Publish new appraisal policy

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Confirm appointment of senior appraisers

Comments: Refresher training for appraisers continues to be delivered. Upon review for "senior appraisers" it was noted that there is a wide discrepancy in numbers of appraisals completed by appraisers. This has taken focus. A request has been made for those under the required number of appraisals to increase number of appraisals or be at risk of being removed from the appraiser role.

Action for next year: Continue to review appraisers completion rates and establish a pool of senior appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development

events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Continue to review QA process. Comments: ASPAT score reported and reviewed every 6 months. The latest scores have improved further since 2023. To help improve QA further, a team needs to be established to review and champion improvement to further assist the Trust Appraisal Lead. Action for next year: Continue to review QA process and establish a team to champion QA

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: None Comments: QA report continues to be generated every 6 months and presented to the Board. Action for next year: None

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Continue to work with the ROAG members to provide challenge and strengthen the governance process of providing recommendations. Comments: ROAG continues and is now part of business as usual. The membership meets monthly and reviews doctors with two months' notice. This has helped to improve revalidation rates. Action for next year: Continue to work with the ROAG members to provide challenge and strengthen the governance process of providing recommendations.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Continue to monitor and uphold this practice.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: The year prior to revalidation doctors are informed of the ROAG process and the requirements to be ready for revalidation. A further update is provided in the lead up to each ROAG meeting if information is missing. Once the decisions in the ROAG have been made, the outcomes are recorded and communicated to the doctors. If information is missing, or requested by the RO, the doctor is chased for the information and normally has 2-3 months to provide the information to the RO. They are then re-reviewed by the RO before a final decision.

Action for next year: Continue to monitor and uphold this practice.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Continue to complete the remaining outstanding actions.

Comments: The HLRO comments continue to be implemented. They have taken pause during the implementation of the new e-portfolio system.

Action for next year: Complete the remaining outstanding actions.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Improvements to complaint/incidents governance expected January 2024. The expectation is that this new system will improve how we capture individuals named in complaints/incidents or named in actions in response to complaints/incidents.

Comments: The implementation for the new complaint/incidents governance system has been delayed to January 2025. Currently Datix is reviewed monthly and reports are communicated to doctors due for their appraisal the following month. Following work with the complaints team, the CMO team are also notified at point of complaint. The new e-portfolio system provides greater transparency with complaints with the use of a 'notes' function. At point of notification of complaint the CMO team update the notes function to remind doctor (and/or appraiser) to reflect upon complaint.

Action for next year: Continue to embed the reporting of complaints/incidents governance following the implementation of the new system.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Confirm new structure and review MHPS policy in line with new structure.

Comments: Review of the MHPS policy has been actioned and submitted to the Local Negotiating Group (LNC) for comment. Programme to develop new structure of medical leaders underway

Action for next year: Continue to develop skills of new medical leaders to support the process

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year: None

Comments: Reports to the Board continue to be submitted in line with the reporting timescales

Action for next year: None

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: Continue to share relevant information

Comments: MPIT process is standard within the team. For each new connection an MPIT review is undertaken and requested where appropriate.

Action for next year: None

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: As per question 1

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Comments: As per question 1

Action for next year: As per question 1

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Continue to reduce reliance on long-term temporary workers.

Comments: Temporary Workforce team have contracted ID Medical as a managed service to reduce contracted temporary workforce. Tender is currently out for another agency for hard to recruit posts for long term high cost agency workers. Temporary Workforce are now also working to NHS Employers pre-employment standards in line with Resourcing.

Action for next year: Continue to reduce reliance on long-term temporary workers.

Section 6 – Summary of comments, and overall conclusion

The last statement of compliance was completed in 2023. The outstanding actions from the previous report are:

- **The update of the Appraisal and Revalidation policy: this was not progressed due to the implementation of the new medical appraisal software;**
- **The implementation of a team of 'senior appraisers' to help support the Quality Assurance function.**
- **Delivery of the actions following the gap analysis of the effective clinical governance guidance from the GMC. All actions relating to the RO function are now embedded as standard practice. However, there are a number of outstanding actions that have commenced but not complete.**

For the outstanding actions, there are plans in place to achieve them within the next 12 months. Delay to the previous outstanding actions has occurred due to the implementation of a new e-portfolio system. The new e-portfolio system, whilst being the same cost as the previous system, allows for greater functionality with transparency and communication.

The Trusts Responsible Officer Advisory Group (ROAG) continues to strengthen decision making by early review of portfolios. The ROAG have steadily improved revalidation rates over the past 12 months.

Overall, the Trust continues to deliver the statutory RO function and is committed to providing this service according to best practice guidance.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Paediatric Audiology Services**

Meeting date: **3 October 2024**

Board sponsor: **Chief Medical Officer (CMO)**

Paper Author: **Head of Community Child Health & CYP Therapy Service (W&CYP) and Head of Audiology (DCB)**

Appendices:

None

Executive summary:

Action required:	Assurance
Purpose of the Report:	The Care Quality Commission (CQC) have requested the Trust Board considers the assurance in relation to the safety, quality and accessibility of paediatric hearing services within the organisation
Summary of key issues:	NHS England (NHSE) have raised significant risk in relation to Auditory Brainstem Response (ABR) testing including the quality of external peer review and testing within an adult service. Solutions are being considered, however, there are complex issues related to staffing, demand and historic service delivery that need to be considered.
Key recommendations:	The Board of Directors is asked to receive this report and **NOTE** the issues that the service is working to address.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients
Link to the Trust Risk Register:	3660 Failure to complete Improving Quality in Physiological Services (IQIPS) accreditation by April 2025.
Resource:	Yes – invoice in process for IQIPs accreditation. Bench marking to be arranged .
Legal and regulatory:	Yes - NHSE/CQC requirement for Paediatric Audiology Services to be IQIPS accredited or to have had an external evidence-based assessment.
Subsidiary:	No

Assurance route:

Previously considered by: Paper presented to Trust Board on 6 June 2024

We care

East Kent Hospitals University NHS Foundation Trust

PAEDIATRIC AUDIOLOGY SERVICES

1. Purpose of the report

1.1 CQC require EKHUFT to provide an update in relation to the safety, quality and accessibility of children's hearing services following NHSE review and progress in relation to IQIPS accreditation.

2. Background

2.1 NHSE have completed a national review of all paediatric audiology. The review involved three stages:
Stage 1: Review of Integrated Care Board (ICB) submission in line with PRN006122_i (October 2023);
Stage 2: Review of national New born hearing screening S4H data;
Stage 3: Review of ABR and Quality and Governance Documentation submitted in line with Paediatric Audiology Services Quality Assessment tool (February 2024).

2.2 Following the last report to the Board (6 June 2024) NHSE/CQC have requested further assurance in relation to the progress made toward IQIPS accreditation.

3. NHSE Review

3.1 NHSE reports following desk top review have now been received. Two separate reports were provided, however, it was recommended both reports were read in conjunction.

3.2 East Kent Children's Hearing Service (EKCHS) obtained a 92% score with an overall quality rating of A-Good and a risk level which could be considered to be B-Low Risk for the governance and quality documentation review. Stage 3 was not completed for EKCHS as ABR testing is not currently undertaken the service.

3.3 Acute Audiology obtained a 66% score with an overall quality rating of C-Poor and a risk level considered to be D-Serious Risk. Particular concerns were raised in relation to ABR testing.

3.4 Kent Community Health NHS Foundation Trust (KCHFT) have also been identified as risk level considered to be D-Serious Risk. Particular concerns were raised in relation to ABR testing. KCHFT and EKHUFT ABR Peer Review with each other which was raised as a concern.

4. NHSE Key Recommendations

4.1 Below are the recommendations within the NHSE report. No specific concerns were raised with the ABR results that we submitted as part of the stage 3 review. However, there were concerns regarding testing of paediatric cases within an adult service and also in relation to the peer review relationship with KCHFT. KCHFT's report identified significant concerns in relation to the test results that was submitted from their department.

- Based on available evidence, further assurance is required with an independent service review visit to ascertain whether current paediatric hearing service provision across both teams are safe to continue, immediate mitigations or mutual aid are required, or full closure.

- Furthermore, given the overall risk of an adult service undertaking new born ABR assessments coupled quality concerns raised by the review panel on the ABR cases submitted, further assurance through an external five-year sample ABR look back is required.
- A low permanent childhood hearing impairment (PCHI) yield for children who have passed their new born hearing screen has been identified. The data related to PCHI yield following screen pass was 0.00 (0.11). We understand that whilst East Kent Hospitals University Trust's Adult hearing service undertakes new born hearing screening (NHSP) ABR assessments, screen pass referrals are seen by East Kent Children's Hearing Service. It is quite possible that East Kent Children's Hearing Service is not uploading their screen pass data onto S4H therefore indicating no yield. It is important that the service ensures timely updating of S4H for all metrics. It should be noted given the interdependencies between the two services it is difficult to extrapolate the NHSP data for each service and therefore should be interpreted jointly.
- It is expected that all audiology sites will work towards and maintain IQIPS accreditation through United Kingdom Accreditation Service (UKAS) and fully engage with ABR peer review as measures of quality. As a starting point, and if not already done so the service may wish to utilise the British Academy of Audiology self-assessment audit tool.
- The ICB and the Trust should consider what resources and expertise are required to support the service to work toward accreditation with UKAS under the IQIPS programme and engage in regional peer review with agreed appropriate timescales.
- Our NHS workforce are the most valuable commodity, and we must protect them during this difficult period of recovery. We would like all systems to ensure audiology services are aware of and signposted to the varied health and wellbeing support offers within the NHS, System, and their Trusts. We strongly recommend all Trusts identify a named health and wellbeing professional to work directly with the audiology team to develop bespoke wellbeing offers. In addition, we encourage Freedom To Speak Up team to connect with all audiology staff feel their voice is being heard.

5. IQIPS Accreditation

5.1 An application form has been submitted and currently awaiting further contact from United Kingdom Accreditation Schemes (UKAS) in order to plan bench marking exercise. Submission of the application took longer than anticipated due to internal processes in signing off the funding.

5.2 The next step is to arrange bench marking of the service by UKAS – it has not been possible to arrange this until the IQIPS accreditation was submitted. This will have an impact on the time scale for arranging the bench-marking. It is still hoped to arrange this before the end of 2024.

5.3 In the meantime, East Kent Children's Hearing Service and Acute Audiology are in the process of completing the gap analysis.

5.4 IQIPS have advised it a minimum of 16 months to complete the accreditation process so it is unlikely to be completed by April 2025.

6. Actions (including updates from last Board Report)

6.1 Having reviewed the NHSE reports and recommendations, we believe the issues related to the safety of the service are around peer review and testing in the adult service.

- Urgent action is being taken to identify an alternative source of external peer review.
- We are exploring options of testing within a paediatric area. This is a complex issue linked to staff resources, service demands and historic service delivery.
- The issue re: S4H data submission has been identified and actions put in place to resolve.
- Funding for bench marking has been identified.
- As much as possible of the Gap Analysis has been completed but will need to form part of the bench marking exercise to gain clarity from UKAS as to specific requirements.
- EKCHS and Acute Audiology Service will be working closely together to develop and action plan based on meeting the above recommendations.
- EKCHS are continuing to explore options for accessing support from an external in-sourcing/ agency to support staffing shortages.

7. Conclusion

7.1 NHSE have raised significant risk in relation to ABR testing including the quality of external peer review and testing within an adult service. Solutions are being considered however there are complex issues related to staffing, demand and historic service delivery that need to be considered.