Board of Directors - Open Meeting (Thursday 5 October 2023)

Thu 05 October 2023, 10:30 AM - 01:20 PM

WebEx Webinar teleconference

East Kent Hospitals University NHS Foundation Trust

Agenda

OPENING/STANDING ITEMS

10:30 AM - 10:40 AM
10 min

23/86
Welcome and Apologies for Absence

To Note *Vice-Chairman*

Verbal

10:40 AM - 10:40 AM
0 min

23/87
Confirmation of Quoracy

To Note *Vice-Chairman*

Verbal

10:40 AM - 10:40 AM
0 min

23/88
Declaration of Interests

To Note *Vice-Chairman*

23-88 - Board of Directors register of interests - September 2023.pdf (4 pages)

10:40 AM - 10:40 AM
0 min

23/89
Minutes of Previous Meeting held on 7 September 2023

Approval *Vice-Chairman*

23-89 - Unconfirmed BoD 07.09.23 Open Minutes.pdf (16 pages)

10:40 AM - 10:40 AM
0 min

23/90
Matters Arising from the Minutes on 7 September 2023

Approval *Vice-Chairman*

23-90 - Front Sheet Open BoD Action Log.pdf (5 pages)

REGULATORY AND GOVERNANCE

10:40 AM - 10:45 AM
5 min

23/91
Vice-Chairman's Report

Approval *Vice-Chairman*

23-91 - FINAL Vice-Chairman BoD Report 05.10.23 v3.pdf (5 pages)

10:45 AM - 10:55 AM
10 min

23/92
Chief Executive's (CE's) Report

Discussion *Chief Executive*

23-92 - CEO Report to Board - October 2023.pdf (6 pages)

10:55 AM - 11:20 AM
25 min

23/93
Board Committee - Chair Assurance Reports:

Assurance *Board Committee Chairs*

Patients - Quality and Safety

23/93.1
Quality and Safety Committee (Q&SC) - Chair Assurance Report (10 mins)

Assurance *Chair Q&SC - Andrew Catto / Chief Nursing & Midwifery Officer (CNMO)*

23-93.1 - QSC Assurance Report 260923.pdf (3 pages)

Partnerships - Sustainability

23/93.2
Finance and Performance (FPC) – Chair Assurance Report (10 mins)

Approval *Chair FPC - Richard Oirschot / Interim Chief Finance Officer (CFO)*

23-93.2 - FPC Committee Assurance Report 051023.pdf (5 pages)

Patients - Partnerships - Sustainability

23/93.3
Charitable Funds Committee (CFC) (Exception Report) (5 mins)

Assurance *Chair CFC - Claudia Sykes*

Verbal

11:20 AM - 11:30 AM
10 min

23/94
Assurance Paper on Board Actions Following Letby Verdict

Assurance *Chief Executive*

23-94.1 - Assurance Paper on Board Actions Following Letby Verdict.pdf (8 pages)
23-94.2 - Appendix 1 - PSIRF Road Map.pdf (11 pages)

11:30 AM - 11:40 AM
10 min

23/95
Maternity Incentive Scheme Year 5 Submissions

Discussion *CNMO*

- **Summary of Maternity Papers**
- **Maternity Dashboard Performance Report**
- **Perinatal Quality Surveillance Tool (PQST)**
- **Anaesthetic Maternity Workforce Update**
- **Neonatal Maternity Workforce Update and Action Plan**

23-95.1 - Maternity BoD Oct Overaching.pdf (3 pages)

11:40 AM - 11:50 AM
10 min

23/96
Reading the Signals Oversight Group: One year on from Reading the Signals

Discussion *Chief Executive*

23-96 - Reading the Signals one year on.pdf (22 pages)

11:50 AM - 12:00 PM
10 min

TEA/COFFEE BREAK 11:50 - 12:00

12:00 PM - 12:00 PM
0 min

Patients - Quality and Safety - People

12:00 PM - 12:10 PM
10 min

23/97
2023/24 Winter Planning and Capacity - Delivering Operational Resilience

To Note *Acting Chief Operating Officer*

Verbal

12:10 PM - 12:20 PM
10 min

23/98
Serious Incidents and Safe Staffing

CNMO

23/98.1
Serious Incident (SI) Report

Assurance *CNMO*

23-98.1.1 - EKHUFT BoD SI Report Front Sheet Oct 2023 V4.pdf (2 pages)
23-98.1.2 - Appendix 1 EKHUFT SI Report Sept 2023 V4.pdf (10 pages)

23/98.2
Safe Staffing Report

Assurance *CNMO*

23-98.2.1 - Safer Staffing Board Report - Sept.pdf (2 pages)
23-98.2.2 - Appendix EKHUFT Safer Staffing Aug 2023.pdf (5 pages)

12:20 PM - 12:20 PM
0 min

Partnerships - Sustainability

12:20 PM - 12:50 PM
30 min

23/99
Integrated Performance Report (IPR)

Discussion *Chief Executive / Executive Directors*

- 23-99.1 - Front Sheet Oct 23 IPR (002).pdf (3 pages)
- 23-99.2 - Appendix 1 Board IPR v5.0 Aug 23 FINAL.pdf (60 pages)

23/99.1
Month 5 Finance Report

Information *Interim Chief Finance Officer*

- 23-99.1.1 - Front Sheet M5 Finance Report Board 051023.pdf (3 pages)
- 23-99.1.2 - Appendix 1 M5 Finance Report short.pdf (8 pages)

12:50 PM - 01:00 PM
10 min

23/100
Integrated Improvement Plan (IIP) Report Including Metrics

Information *Chief Strategy and Partnerships Officer*

- 23-100.1 - Front Sheet Integrated Improvement Plan Report Final.pdf (2 pages)
- 23-100.2 - Appendix 1 EKHUFT IIP October Board Report 26.09.23.pdf (15 pages)
- 23-100.3 - Appendix 2 Updated IIP September 2023 FINAL 25.09.23.pdf (20 pages)
- 23-100.4 - Appendix 3 IIP Programme Risk Register FINAL 25.09.23.pdf (6 pages)

CLOSING MATTERS

01:00 PM - 01:05 PM
5 min

23/101
Any Other Business

Discussion *All*

Verbal

01:05 PM - 01:20 PM
15 min

23/102
Questions from the Public

Discussion *All*

Verbal

Date of Next Meeting: Thursday 2 November 2023

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM SEPTEMBER 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ANAKWE, RAYMOND	Non-Executive Director	Medical Director and Consultant Trauma and Orthopaedic Surgeon at Imperial College Healthcare NHS Trust **(1)**	1 June 2021 (First term)
ASHMAN, ANDREA	Chief People Officer	None	Appointed 1 September 2019
BAIRD, STEWART	Vice Chair/Non-Executive Director	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)** Non-Executive Director of Spencer Private Hospitals (started 1 November 2021) **(1)** 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	Chief Executive Officer, Integrated Care 24 (IC24) **(1)** Member of east Kent Health and Care Partnership (HCP) **(1)**	1 November 2022 (First term)
CORBEN, SIMON	Non-Executive Director	Director and Head of Profession, NHS Estates and Facilities, NHS England **(1)**	1 October 2022 (First term)
DICKSON, JANE	Acting Chief Operating Officer	Director, Holiday Letting, Scotland (Ltd company) **(1)**	18 September 2023
DICKSON, NIALL	Chair	Senior Counsel, Ovid Consulting Ltd (trading as OVID Health Company) (started November 2020) **(1)** Chair of the East Kent Health and Care Partnership (HCP) Board **(1)**	5 April 2021

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM SEPTEMBER 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
FLETCHER, TRACEY	Chief Executive	None	Appointed 4 April 2022
FULCI, LUISA	Non-Executive Director	Director of Digital, Customer and Commercial Services, Dudley Council (started 6 April 2021) **(1)** Director of Dudley & Kent Commercial Services Ltd. (started 11 May 2022) **(1)**	1 April 2021 (First term)
GOODGER, NIC	Interim Chief Medical Officer	Surgeon, Chaucer Hospital **(5)**	7 August 2023
HAYES, SARAH	Chief Nursing and Midwifery Officer	Charity Trustee, The 1930 Fund for Nurses (Charity) **(4)**	18 September 2023
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)
JONES, DYLAN	Chief Operating Officer	None	Appointed 12 April 2023
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)

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM SEPTEMBER 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
OLASODE, OLU	Senior Independent Director (SID)/Non-Executive Director	Chief Executive Officer, TL First Consulting Group (started 9 May 2000) **(1)** Chairman, ICE Innovation Hub UK (started 11 September 2018) **(1)** Independent Chair, Audit and Governance Committee, London Borough of Croydon (started 1 October 2021) **(1)** Independent Non-Executive Director (Adult Care), Priory Group (Adult Social Care and Mental Health Division) (started 1 June 2022) **(1)**	1 April 2021 (First term)
STEVENS, BEN	Chief Strategy and Partnerships Officer	None	1 June 2023 (substantive) (20 March 2023 interim)
STEVENS, MICHELLE	Interim Chief Finance Officer	None	1 April 2023
SYKES, CLAUDIA	Non-Executive Director	Director, Cloudier Skies Ltd **(1)** (started 21 December 2022)	1 March 2023 (First term)
WOOD, MICHAEL	Interim Group Company Secretary	None	April 2023
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

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM SEPTEMBER 2023

Spencer Private Hospitals:
Stewart Baird – 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

UNCONFIRMED MINUTES OF THE ONE HUNDRED AND THIRTY SECOND MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 7 SEPTEMBER 2023 AT 12.35 PM IN THE HARRIS ROOM (COWDREY BUILDING – SECOND FLOOR) AT THE SPITFIRE GROUND – CANTERBURY CRICKET GROUND, ST LAWRENCE, OLD DOVER ROAD, CANTERBURY, KENT CT1 3NZ AND BY WEBEX TELECONFERENCE

PRESENT:

Mr N Dickson	Chairman	ND
Ms A Ashman	Chief People Officer (CPO)	AA
Mr S Baird	Non-Executive Director (NED)/People and Quality Committee (P&CC) Chair/Nominations and Remuneration Committee (NRC) Chair	SB
Dr A Catto	NED/Quality and Safety Committee (Q&SC) Chair	AC
Mr S Corben	NED/2gether Support Solutions (2gether) NED In-Common (left meeting at 4.00 pm)	SC
Ms J Dickson	Interim Chief Nursing and Midwifery Officer (CNMO)	JD
Ms T Fletcher	Chief Executive (CE)	TF
Ms L Fulci	NED	LF
Mr N Goodger	Interim Chief Medical Officer (CMO)	NG
Mr R Oirschot	NED/Finance and Performance Committee (FPC) Chair	RO
Dr O Olasode	NED/Senior Independent Director (SID)/Integrated Audit and Governance Committee (IAGC) Chair (WebEx)	OO
Mr B Stevens	Chief Strategy and Partnerships Officer (CSPO)	BS
Mrs M Stevens	Interim Chief Finance Officer (CFO)	MS
Ms C Sykes	NED/Charitable Funds Committee (CFC) Chair/*Reading the Signals* Oversight Group Chair	CS

ATTENDEES:

Ms M Cudjoe	Director of Midwifery (DoM) (minute number 23/078)	MC
Ms C Todd	Lead Freedom to Speak Up Guardian (minute number 23/079)	CT
Ms M Durbridge	Improvement Director, NHS England (NHSE)	MD
Prof C Holland	Associate NED/Dean, Kent & Medway Medical School (KMMS)	CH
Mr A Littlefield	Lead for Patient Voice and Involvement (minute number 23/072)	AL
Mr P Ryder	Managing Director, 2gether Support Solutions (WebEx) (minute number 23/083)	PR
Ms A Smith	Deputy DoM	AS
Mr M Wood	Interim Group Company Secretary (GCS) (WebEx)	MW
Mrs N Yost	Executive Director of Communications and Engagement (EDC&E)	NY

IN ATTENDANCE:

Miss L Coglan	Council of Governors (CoG) Support Secretary	LC
Mr T Cook	Special Adviser to the Chairman and Deputy GCS	TC
Miss S Robson	Board Support Secretary (Minutes)	SR

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Ms R Adey	Member of Staff (WebEx)
Mrs M Bonney	Governor (WebEx and in person)
Mr N Daw	Member of Staff
Ms N Elllis Webb	Member of the Public
Mr S Emerton	Member of the Public
Mr D Esson	Kent Online
Ms C Heggie	Member of the Public
Mr D Hibbert	Member of the Public
Ms C Irwin	Member of the Public (WebEx)

Ms L Judd	Governor (WebEx)
Mr N Kalli	Member of the Public
Ms S Mahmood	Governor (WebEx)
Mrs B Mayall	Lead Governor (WebEx)
Ms A Moore	Journalist (HSJ) (WebEx)
Dr K Premchand	Member of Staff
Mr B Rylands	Governor (WebEx)
Mr P Schofield	Governor
Mr C Shorter	Governor (WebEx)

MINUTE NO.		ACTION
23/067	**CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE** The Chairman opened the meeting, welcomed everyone present, and introduced Mr N Goodger, Interim CMO. Apologies for absence were received from Mr R Anakwe, NED; and Mr D Jones, Chief Operating Officer (COO). The Chairman stated a Closed BoD meeting had been held that morning that included discussions about the Trust's current financial position and recovery plan, development of longer term strategy, state of the estate, capital investment requirements, and progress of the Integrated Improvement Plan (IIP). It was also noted there had been a Board Development Strategy session held in August 2023. The Chairman reported following the review of Board meeting papers, was reflected in the reduced volume presented at this meeting, with ongoing work to continue to ensure the volume was further reduced, papers were concise and highlighted key issues. A wider governance review would be undertaken that would also incorporate a review of Board meeting papers, as well as papers presented to Board Committees. The Chairman stated at the end of the meeting when inviting questions from the public, he would take verbal questions from those in attendance in the meeting room, and written questions from those joining online.	
23/068	**CONFIRMATION OF QUORACY** The Chairman **NOTED** and confirmed the meeting was quorate.	
23/069	**DECLARATION OF INTERESTS** There were no new interests declared.	
23/070	**MINUTES OF THE PREVIOUS MEETING HELD ON 6 JULY 2023** **DECISION:** The Board of Directors **APPROVED** the minutes of the previous meeting held on 6 July 2023 as an accurate record.	
23/071	**MATTERS ARISING FROM THE MINUTES ON 6 JULY 2023** **B/02/23 - Number of women took decision and went elsewhere to other NHS organisations to access maternity services and not East Kent Hospitals (their local NHS Trust)** The Interim CNMO reported as commented at the last meeting, this information had been requested from local colleagues within the Local Maternity and Neonatal	

System (LMNS). She stated the number of women that had booked to give birth at East Kent Hospitals had reduced by 80 (out of approximately 6,000), with the assumption these women had chosen to give birth elsewhere. **It was agreed to close this action.**

B/03/23 - Review and reassess the current Board Assurance Framework (BAF), its contents and the risks, assessing the risks against achievement of the strategic annual objectives and the IIP over the next 12 month period
The CE reported the BAF needed readjusting to align it with the Strategic Objectives influenced by the IIP, and would be further reassessed aligning it with the long term strategy once developed. This was ongoing work over the next six to 12 months. **It was agreed to close this action.**

B/12/23 - Provide in the report presented to the September 2023 Board meeting an update following the review of feedback from staff exit interviews and the reasons for staff turnover, particularly the reasons for the higher turnover rate at William Harvey Hospital (WHH)
The Interim CNMO reported this related to the higher staff turnover in maternity services at WHH, which had significantly reduced with only two midwives that had left over the last two month period. Online exit interviews were being evaluated and face to face exit interviews were being implemented. It was noted the engagement score for these staff was increasing and this was a positive indication of staff engagement. The CPO stated since the introduction across the organisation in March 2022 of online exit interviews, 769 responses had been received (36% response rate), which was filtered by specialty to enable detailed analysis. She confirmed 50% of staff that had left had moved to the Community. **It was agreed to close this action.**

B/19/23 - Liaise with the NHSE Lead following July Making Data Count session and discuss how improvements could be made to the presentation of maternity data
The Interim CNMO confirmed this work had been undertaken and the women's health leadership team had spoken with NHSE who had confirmed the current maternity data reporting was in line with what they suggest. It had also been confirmed they were happy with the Trust's Statistical Process Control (SPC) and how data was presented. **It was agreed to close this action.**

DECISION: The Board of Directors **NOTED** the action log and updates from the actions from the previous meeting, **NOTED** the actions for future Board meetings and **APPROVED** the two actions recommended for closure and the four actions agreed for closure as noted above.

23/072 **PATIENT STORY**

The Interim CNMO thanked Barbara, a local deaf person, for allowing the Trust to tell her story and experience by a deaf actor, Nicole. She emphasised it was vital that Trust services were accessible to everyone, and thanked the teams for their work in supporting this patient and the actions taken. The video of Barbara's story was shared at the Board meeting.

The Lead for Patient Voice and Involvement reported the Trust was working collaboratively with deaf services, Kent County Council (KCC) and local partners, as well as staff around better awareness and staff attitudes of the needs of deaf patients and the services available to access. It was noted the poor experience at the start of the patient's treatment pathway and the actions addressed to improve

this, and improve access for deaf people using Trust's services. He thanked the IT team for all their work and support in updating the systems, enabling staff to record and flag patients so that their communication needs were met when accessing services. He emphasised the need for staff to ensure patients understood what they had been told about their care and treatment.

The NEDs commented that some interpreters would not wish to access hospital settings and to look at online solutions. The Lead for Patient Voice and Involvement stated that face to face interpreter service was felt to be the best service provision.

The Board of Directors **NOTED** the patient story report and supported the actions being taken to support deaf people accessing Trust services.

23/073 **CHAIRMAN'S REPORT**

The Chairman noted the case of the nurse Lucy Letby, the crimes committed were very rare, and the importance of being vigilant and having strong and effective clinical governance to ensure patient safety. He reported the Trust continued to remain and operate under significant operational and financial pressures.

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

23/074 **CHIEF EXECUTIVE'S (CE's) REPORT**

The CE reported key points:

- Trust's commitment to addressing the omitted key areas identified by Council of Governors in the 2022/23 Quality Accounts, including learning disability, autism and neurodiversity; maternity, culture and lack of staff engagement; people and culture, poor compliance with appraisals and supervision; ensuring achieved level of benefits planned in the Emergency Departments (EDs), and staffing and engagement overseeing staff issues around accommodation and embedding health and safety standards and practices;
- Annual Members Meeting being held in the evening of 28 September where the Trust's 2022/23 Annual Report and Accounts would be presented;
- Trust awarded NHS Pastoral Care Quality Award, in recognition of its work in international recruitment and commitment to providing high-quality care to internationally educated nurses and midwives during the recruitment process and throughout their employment.

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

23/075 **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS:**

23/075.1 **NOMINATIONS AND REMUNERATION COMMITTEE (NRC) – CHAIR ASSURANCE REPORT**

The NRC Chair highlighted key points:

- Focussed discussions on Executive Director recruitment and ensuring any gaps were filled in the interim until substantive appointments were made:
  - Interim CFO covered by Michelle Stevens;

  - New CNMO, Sarah Hayes, starting in September;
  - Interviews held for substantive CMO hoped to be in a position to announce appointment shortly;
- Executive Directors' end of year appraisals and 2023/24 objectives discussed that would include objective covering Culture and Leadership Programme (CLP);
- Continued ongoing work in respect of succession planning in alignment with new appointments and the organisational restructure;
- Agreement of a one year extension to existing NED contract for Spencer Private Hospitals.

The Board of Directors **NOTED** the 11 July 2023 NRC Chair Assurance Report.

23/075.2 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

The P&CC Chair highlighted key points:

- Continued to see green shoots and positive movements particularly in respect of vacancy rate fallen from 9.8% to 7.2%, staff turnover remained below the 10% national standard at 9.5%, and staff recruited were being retained. Statutory training compliance remained stable and above 91% threshold at 91.2%. Sickness absence increased to 4.9%, remaining below the 5% threshold, with increased stress and anxiety recorded, and a focus for P&CC to monitor;
- Not assured on appraisal compliance at 72.4%, that remained below the threshold of 80%, work ongoing to identify areas that needed support to improve compliance;
- Increased gap in Band 6 midwifery staff due to internal promotions.

The CPO reported the annual NHS staff survey to be launched in September and encouraging staff to take a break and complete this, Board members were encouraged to complete the survey. The Chairman emphasised the importance of Executive Directors being visible across all the hospital sites and engaging with staff, whilst recognising the difficulties in achieving this being a large organisation.

The NEDs raised the upcoming consultant and junior doctors strike and what impact there would be as a result for patients. The EDC&E assured rolling communications to patients about strike action and that they would be contacted if they were impacted. The CPO stated operational and corporate teams had been meeting to discuss and understand any potential risks, ensuring forward planning of any changes required to ensure continuity of service provision during industrial action.

The NEDs commented on the Innovation Showcase event held earlier that morning, and that it was really good to have seen the innovative initiatives, projects and positive stories to improve patient care and treatment being implemented across the Trust, and the importance of publicising this. The EDC&E confirmed external communications would be published about the examples of work in the Innovation Showcase.

The Board of Directors **NOTED** the 30 August 2023 P&CC Chair Assurance Report.

23/075.3 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

The Q&SC Chair highlighted key points:

- Welcomed presentation of the new style Integrated Performance Report (IPR) providing more granularity and understanding of the various metrics;
- Received and discussed a deep dive report in respect of the action plan to address C. difficile infections, that provided assurance of the actions that aligned with best practice guidance;
- Received assurance of improved surgical site infection surveillance measures in place that were effective;
- Positive update on Ward Accreditation, of which 29 had been rated Gold; 21 Silver and 80 Bronze;
- Endoscopy backlog was associated with increased demand and staff shortages, mitigations put in place, and this would continue to be monitored by Q&SC that patients waiting were kept safe;
- In alignment with good practice recommended the Board of Directors in future receive regular reports on safe staffing and Serious Incident (SI) review in respect of the management of SIs, and any themes;
- In respect of the case of Lucy Letby, going forward the Q&SC would have a focus on themes in respect of Board governance, mortality review process, issue of data flow through the organisation to ensure identification signalling of any areas of real concern and the escalation of these. Review and evaluation of unexpected abnormal results, and seeking explanation.

The Associate NED commented he had raised a question at Q&SC about whether the Trust was fully utilising the Kent & Medway endoscopy training hub at Maidstone and Tunbridge Wells NHS Trust and assurance that it was. The Interim CMO reported the business case for qFIT endoscopy testing had recently been approved and would be implemented, this would identify patients requiring an endoscopy and would significantly reduce unnecessary demand and the waiting list. The Trust would ensure staff accessed the training available and that the workforce were appropriately skilled.

The Board of Directors **NOTED** the 29 August 2023 Q&SC Chair Assurance Report.

23/075.4 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR ASSURANCE REPORT**

The NED/IAGC member, CS, highlighted key elements:

- Concern about the delay in submission of the 2022/23 Annual Accounts, which had since been presented, approved and submitted. The delay was due to a late technical issue that needed to be resolved, it was important to undertake a review and lessons learnt for the following year's annual audit;
- Progress update on the internal governance review, highlighted the external governance review needed to commence as soon as possible;
- Concern about lack of progress of efficiency savings on the Cost Improvement Programme (CIP).

The Board of Directors **NOTED** the 28 July 2023 IAGC Chair Assurance Report.

23/075.5 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The FPC Chair highlighted key points:

- Only £800k of CIP efficiencies had been recognised to date against a plan of £8.8m, and total £40m receiving limited assurance. Approximately £14.4m CIP savings identified, of which £11.3m would have an in-year impact;
- Patients no longer fitting the criteria to reside, with the change in reporting of occupancy at mid-night there was currently 192 patients, the lowest position since July 2022. There had also been a positive trend and decline in the numbers of patients staying for 7+ days and 21+ days since January 2023;
- Decline in ED 12 hour trolley waits, reduced from 929 in June to 769 in July;
- Escalation beds remained static at 70;
- Month 4 financial position showed a deficit of £39m, £8.4m adverse to the planned £30.6m deficit. As a result of the adverse performance and lack of efficiency savings the year-end £72m deficit target would be extremely challenging to achieve. Due to the current position and increased run rate the Trust might need to review further around drawing on working capital (Public Dividend Capital (PDC)) in November, unless a revised forecast was agreed with NHSE or a significant change in performance;
- Approval and recommendation to the Board for approval of the Ziopatch Contract Award and the 2023/24 Internationally Educated Nurse (IEN) Recruitment business case for 112 IENs. Noting concern that some 50 IENs had already been recruited prior to formal approval of this;
- Risks were discussed and the recommendation that four risk scores be increased from 16 to 20, which included financial annual plan not on target, CIP not on target, and insufficient capital investment allocation to ensure appropriate investment in the estate and equipment.

The NEDs raised concern about having in place appropriate patient flow and discharge plans, to ensure patient flow through the hospital and support for patients when discharged. The Interim CNMO commented the challenges for patients with complex needs and support requirements from the wider system partners, the need to have collaborative discussions and work together as a system to support these patients that was ongoing.

DECISION: The Board of Directors:

- **NOTED** the 25 July and 29 August 2023 FPC Chair Assurance Reports;
- **APPROVED** the**:**
  - 2023/24 Internationally Educated Nurse (IEN) Recruitment business case;
  - Ziopatch Contract Award.

23/076 **TRANSFORMING OUR TRUST: OUR RESPONSE TO *READING THE SIGNALS* – UPDATE REPORT**

The CSPO noted the fourth *Reading the Signals* Oversight Group meeting had been held, with discussions about maternity dashboard, metrics and independent case reviews.

The NED/Chair of *Reading the Signals* Oversight Group thanked families who continued to be engaged, attend meetings, and present challenges, with good discussions held at the meetings. It was noted the importance of hearing the patient voice and at the October Group meeting there would be a wider discussion about progress of the Group and whether meetings would continue to be held.

The Board of Directors acknowledged the progress of the Group and the benefits of hearing from the families engaged with the Group, the discussions and whether they felt progress had been achieved.

ACTION: Consider for a future Board of Directors meeting for the families engaged with the *Reading the Signals* Oversight Group being invited to present, as part of the Patient Experience Story, their feedback and comments about the Group, discussions, achievements, and whether they felt progress and improvements had been made. — CSPO

The Board of Directors **NOTED** the Transforming our Trust: Our Response to '*Reading the Signals*: Maternity and Neonatal Services in East Kent' - update report.

23/077 **PATIENT VOICE AND INVOLVEMENT QUARTERLY REPORT**

The Interim CNMO noted:

- Progress update on the work reaching out, engaging and involving patients obtaining feedback about Trust's services;
- Negative feedback received in respect of the inaccessibility of systems for deaf people who used British Sign Language (BSL), as well as lack of awareness of staff;
- Positive feedback included care given, quality of treatment and positive staff attitude considering the pressure staff were working under;
- Friends and Family Test (FFT) responses, overall satisfaction level of just over 93% from April to June 2023 against the national of 95%. Positive satisfaction level for Urgent and Emergency Care at 82%.
- Deep dive into FFT comments covering paediatric medicine, rheumatology, and ear, nose and throat (ENT) services, identifying care, kindness of staff and quality of treatment that were positive, and negative themes related to communication and information.

The NEDs raised issues identified by patients in being able make contact in respect of any queries about appointments and having sufficient staff resources available, and ensuring patient appointment letters issued. The Interim CNMO acknowledged the need to have dedicated accessible telephone lines for patients to ring with any appointment enquires. It was noted the need for the Board of Directors to receive on an annual basis a Patient Advice and Liaison Service (PALS) report, providing details about themes of complaints, timeline of responding to complaints and numbers of complaints and compliments received, lessons learnt, and any actions as a result of feedback received.

ACTION: Present annually a Patient Advice and Liaison Service (PALS) report (December 2023), providing details about themes of complaints, timeline of responding to complaints, numbers of complaints and compliments received, lessons learnt, and any actions as a result of feedback received. — Interim CNMO

The Board of Directors **NOTED** the Patient Voice and Involvement Quarterly Report.

23/078 **MATERNITY INCENTIVE SCHEME YEAR 5 SUBMISSIONS**

- **PERINATAL MORTALITY REVIEW TOOL (PMRT)**
- **TRANSITIONAL CARE**
- **SAVING BABIES LIVES**
- **PERINATAL QUALITY SURVEILLANCE TOOL (PQST) – JULY AND AUGUST 2023**

The Interim CNMO highlighted key elements:

- Overarching Maternity Incentive Scheme Year 5 Submission report presented in respect of delivering and maintaining safe maternity services against the Clinical Negligence Scheme for Trusts (CNST), which equated to a saving of £1m for the Trust. Individual specific CNST Safety Action evidence reports provided in the reading room for information;
- Safety Action 1, PMRT report noting a review of all eligible deaths, identified themes and actions taken;
- Safety Action 3, Avoiding Term Admissions into Neonatal Units (ATAIN) report, audit programme in place supervised by audit lead midwife, along with an action plan developed requiring Board Approval;
- Safety Action 6, Saving Babies Lives report demonstrating an initial gap analysis against this standard, compliance would be calculated using the national implementation tool published end of June 2023 by October 2023;
- Safety Action 9, PQST reports:
  - Anaesthetic training compliance for PRactical Obstetric Multi-Professional Training (PROMPT) improved to 83% but remained below the national standard of 90%;
  - 3 Healthcare Safety Investigation Branch (HSIB) referrals for the month of June, and one for July;
  - 2 SIs reported;
  - 1:1 care in labour 100% compliant;
  - FFT received 252 responses, 12.3% response rate – the national best was 18%, and responses showed 94.6% extremely likely or likely to recommend an increase from the previous month.

The NEDs raised the disappointing PROMPT percentage that remained below the national standard, the need to ensure this target was met, and concern if not compliant CNST would not be achieved for year 5. It was also raised the need to review the maternity digital plan and assurance that this was being progressed. The Interim CMO reported he would be looking at the PROMPT training compliance and what work was needed to further improve this and work towards achieving the national standard. It was stated there should not be any issues in not being able to achieve this standard, noting the challenges were around rotas and releasing staff to undertake this training whilst ensuring patient safety. The DoM reported she would be working with the Interim Director of IT in respect of progressing the next stage around the maternity digital programme work.

DECISION: The Board of Directors:

- Received assurance from Safety Action 1, Quarter 1 2023/24 PMRT report demonstrating full compliance in line with CNST standard requirements four areas of evidential requirement;

- Received Safety Action 3, ATAIN paper, **NOTED** an action plan developed that addressed the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks, and **APPROVED** the action plan and the Transitional Care and ATAIN reviews and action plan findings be shared with the LMNS, Integrated Care Board (ICB) and Integrated Care System (ICS) quality surveillance meeting;
- Received Safety Action 6, Saving Babies Lives report and **NOTED** an initial gap analysis against the revised Safety Action and care bundle, many of the required interventions had already been implemented, the substantial work required to achieve implementation of elements within the revised care bundle. To assess whether the service would achieve compliance, an assessment would be undertaken utilising the recently released national implementation tool, on completion of the gap analysis findings would be shared with the Board and the ICB;
- Received and **NOTED** Safety Action 9, PQST reports.

23/078.1 **MATERNITY AND NEONATAL IMPROVEMENT PROGRAMME (MNIP)**

The DoM highlighted key points:

- MNIP discussed at August Board Development Strategy session, and also shared with key stakeholders and the *Reading the Signals* Oversight Group;
- Engagement event held, feedback incorporated, including amending the six workstream charters that aligned with the single delivery plan and timelines. Delivery of maternity services would be measured against this three year plan;
- A full project plan sat underneath the workstreams, with an Executive Director lead for each.

The NEDs commented the MNIP included a lot of detailed information, and enquired how the Board of Directors could be assured about progress in receiving a summarised brief report. The DoM stated the development of a dashboard containing all metrics from each of the workstreams to support monitoring and oversight of the programme's implementation that would be shared.

The Interim CNMO thanked the DoM, Deputy DoM and all the staff in maternity services for their hard work, engagement and support in developing the MNIP, and commitment to continuing to make improvements.

The DoM stated the Nursing and Midwifery Council (NMC) had recently visited the Trust, and it was hoped midwifery students would be returning in October. The Trust had also been visited by the Regional Midwifery Officer and Regional Team, with positive feedback recognising the achievements made to date, and acknowledging there was still more work to be done. The Interim CNMO noted the need to ensure the public had confidence in the Trust's services provided, it had requested the Care Quality Commission (CQC) visit and undertake an re-inspection, unfortunately they already had a committed inspection timetable. The Trust Chairman stated the need to continue to request a further visit and inspection to see the improvements and changes that had been implemented.

DECISION: The Board of Directors **APPROVED** the MNIP, amended charters and programme for delivery.

23/079 **FREEDOM TO SPEAK UP (FTSU) QUARTERLY REPORT**

The Lead FTSU Guardian (FTSUG) reported:

- FTSU Team fully established and embedded, who continued to see steady rise in matters raised;
- Roll-out of mandatory e-learning modules, with support from face-to-face training, workshops and forums;
- Staff wanted to see changes and it was not clear to them the changes that had been made as a result of them speaking up, and the Team's next step was linking the changes and ensuring staff were made aware of these, which had been achieved as a direct result of them speaking up;
- Team pro-actively sought staff feedback.

The Associate NED commented whether it should be considered offering staff personal cameras for safety and security assurance against abuse from service users. The NEDs reported the provision of personal alarms. The Lead FTSUG stated staff would need to be asked whether they would want the provision of this equipment, noting the benefit of being a deterrent and a potential future option to explore. The Interim CNMO commented on the Red Card Sanctions Procedure Policy in place, and to review that this was being appropriately utilised to address and manage incidents of violence and aggression by service users to staff, before implementing additional equipment/procedures. It was noted it was important that staff felt safe at work, and the benefit of liaising with the Kent Community Health NHS Foundation Trust (KCHFT) in respect of their procedures in place for the safety of their lone worker community staff.

ACTION: Liaise with Kent Community Health NHS Foundation Trust (KCHFT) to discuss what procedures they had in place to keep their lone worker community staff safe. — Interim CNMO

In response to a question raised by the NEDs, the Lead FTSUG confirmed FTSU Team members had access to, as all Trust staff had to counselling services, and also in addition psychological support.

The CPO encouraged Board members if they had not already done so, to complete the FTSU mandatory training.

The Board of Directors **NOTED** the FTSU report and the benefits from pro-actively seeking feedback on workers' experiences of speaking up from numerous routes.

23/080 **INTEGRATED PERFORMANCE REPORT (IPR)**

The Board of Directors received the revised IPR format following a review and refresh presenting a wider view of metrics.

Patients

The CSPO highlighted key elements:

- All type ED performance ahead of plan at 74.3%, and Type 1 ED performance under plan at 50.5%;
- Ambulance handover compliance improved performance at 91.8%;
- New Cancer 28 Faster Diagnosis Standard (FDS) slightly improved, that would be a focussed standard to monitor performance. Deterioration in

diagnostics performance with key issues in CT and endoscopy (with actions in place around capacity to improve performance) and work to improve the cancer patients waiting 62 days or more.

The NEDs raised the importance of having sight of the direct access patient pathways, the direction of travel for patients, and patient flow, to ensure patients were accessing the care and treatment required. As well as ensuring measuring patient pathway data around effectiveness and if any changes were needed. Concern was raised about the overall dip in performance, and the collaborative work of the Trust with primary care. The CSPO reported the Trust was increasing working closely with primary care colleagues, working together to reduce unnecessary demand, and allowing focus on patients with immediate need.

Maternity

The Interim CNMO noted the incorporation of maternity specific metrics, there had been a reduction of stillbirths, and significant improvement in the timescale for closure of SIs.

The NEDs enquired about green performance areas, particularly in respect of community and ward maternity staff performance, how this was reported, and receiving assurance. The CSPO stated green performance areas needed to be covered within the narrative as well presenting deep dives at Board Committees to provide the necessary assurance.

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

23/080.1 **MONTH 4 FINANCE REPORT/FINANCIAL POSITION**

The Interim CFO reported:

- Main driver for being off plan was the non-delivery against CIP;
- Level four controls implemented to support reducing run rate, which included vacancy, workforce and administration reviews, deep dive of agency nursing to reduce utilisation of agency costs that was behind the planned target. Assurance of completion of Equality Impact Assessments (EIAs) before any controls were put in place.

The CE reported a detailed discussion was held at the Closed meeting that morning, around the need to reduce the run rate, and Executives were working closely with Care Groups and Corporate teams to reduce expenditure. It was also acknowledged the importance of commencing next year's business planning process as early as possible.

The Board of Directors **NOTED** the:

- Month 4 Finance Report;
- Financial performance and actions being taken to address issues of concern.

23/081 **INTEGRATED IMPROVEMENT PLAN (IIP) REPORT INCLUDING METRICS**

The CSPO reported:

- Revised concise reporting format, providing overview of delivery of IIP, and RAG rated progress against the quarterly milestones;
- Leadership and Governance RAG rated green. Quality and Safety; Maternity; and People and Culture RAG rated amber. Finance; and Operational Performance RAG rated red. Areas of challenge were Finance and Operational Performance, with ongoing work to address and take forward the actions required to provide assurance of delivery. As well as progressing actions to move areas of amber to green.

The NEDs raised concern about the limited assurance and progress in delivering the Finance programme and what action around governance was needed to move this from red to amber. The Interim CFO reported enhanced controls had been put in place, concern these were not having the required impact on the deteriorating financial performance, and sessions being held with Care Groups to review expenditure.

The Board of Directors **NOTED** the IIP report and progress of delivery of the IIP to date.

23/082 **BOARD ASSURANCE FRAMEWORK (BAF) RISK REGISTER**

The Interim CNMO reported:

- The BAF risk register and risk appetite discussed at August Board Development Strategy session;
- No new risks added to the BAF, proposed reduction of four risks;
- Further work to be undertaken linking the BAF to the Trust's Long Term Strategy, and the management of risk registers operationally and corporately throughout the organisation.

The NEDs raised discussions at the previous FPC meeting in respect of risk BAF 41 – Failure to deliver the financial plan of the Trust as requested by NHSE for 2023/24, and that it had been agreed this risk would be reduced to 20 (from (25)) and not 16 as noted in the report. The CE explained the Clinical Executive Management Group (CEMG) received the BAF risk register for discussion and agreement of any increases or reductions in risk scores. She noted risks and risk scores were discussed and challenged at Board Committees, and confirmed risk BAF 41 was agreed by CEMG that it should be reduced to 20 and not 16, and the BAF would be updated.

ACTION: Update the BAF reducing risk BAF 41 – Failure to deliver the financial plan of the Trust as requested by NHSE for 2023/24, to the risk score of 20 and not 16. — Interim CNMO

DECISION: The Board of Directors **APPROVED** the:

- latest update on the BAF Quarter 1;
- revised risk appetite statements.

23/083 **HEALTH AND SAFETY (H&S) AND STATUTORY COMPLIANCE UPDATE**

2gether's MD highlighted:

- Following completion of a full review of all fire doors, identified major investment required to ensure the Trust remained compliant to current fire legislation. Identified that c£2.1m of high-risk repairs and/or replacements were urgently required in the 2023/24 budget period due to wear and tear, all doors currently met requirements;
- Work continued on the upgrade of the fire alarm annunciation system at WHH due for completion at the end of the year;
- Continued good engagement with staff across the organisation;
- Overall compliance was good, whilst recognising there was still more work to do that was impacted by the lack of capital investment provision;
    - Cumulative Health and Safety Toolkit Audit (HASTA) score 91.8%, increase of c1.8% since May 2023;
    - Estate statutory compliance assurance level at c92.3%, with continued ongoing work to achieve c95% as soon as practicably possible.

The Interim CNMO raised the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) in the report, two assaults on staff by a patient, for these incidents to be reviewed in respect of the impact of harm to the staff and duration of time off work. 2gether's MD agreed to share the details of these incidents with the Interim CNMO.

ACTION: Share the details of the two assault incidents on staff by a patient with the Interim CNMO. — 2gether's MD

The NEDs enquired whether the five year plan for the works of the replacement of fire doors and whether this timeframe was realistic, whether the funding was available, and whether there was any risks. 2gether's MD confirmed the works would be undertaken over five years, the challenge was the provision of sufficient capital investment and currently insufficient allocation to meet the needs of maintaining and investing in the Trust's old estate. The NEDs emphasised concern about the Trust's estate and buildings that were old and required significant investment to make them fit for purpose.

The CSPO reported the Trust's capital programme requirements assessment included the fire doors within its prioritisation and utilisation of the capital investment available.

The Board of Directors **NOTED** the Trust's current position in relation to H&S, and statutory compliance, especially in respect to the prevailing risks.

23/084 **ANY OTHER BUSINESS**

There were no other items of business raised.

23/085 **QUESTIONS FROM THE PUBLIC**

The Chairman invited verbal questions from those in the meeting room, and written questions from those online.

Mrs Bonney commented on the *Reading the Signals* report and the recent Lucy Letby case, a theme in respect of the opportunity of staff to speak up, this feeding

into the Board, and the lessons learnt. Noting the FTSU Board lead Executive Director sponsor, CPO, and whether this should be the appropriate lead responsible or whether there was a conflict of interest. She enquired whether all the maternity staff had now received their annual appraisals, noting there had been improvements. It was stated following her recent experience, whether the Trust had a policy in place for patient discharge letters and whether these were given to patients at the time of discharge. In respect of summarising their treatment, ongoing care, and contact information if they had any queries or concerns following discharge, particularly in respect of elderly and stroke patients who could have communication difficulties. The Chairman emphasised the presentation earlier in the meeting from the FTSU lead guardian, noting the significant improvement in staff speaking up, the work and progress made by the FTSU team. The CE confirmed the appropriateness of the CPO having responsibility in leading the FTSU service, explaining the reasons that they had reduced line management of operational staff providing an unbiased view. She stated the Executive Directors, Board, and wider leadership team supported creating an improved and open cultural environment, encouraging staff to speak up and being curious about issues raised. It was noted the FTSU service presented reports to the P&CC and Board of Directors, the CE also met with the FTSU guardians quarterly, who had external supervision support. These reporting avenues provided various routes for the FTSU team to escalate and raise any issues. The Interim CNMO highlighted there were many other routes outside FTSU for staff to raise any issues or concerns. The P&CC/NED confirmed he was the NED Champion for FTSU and met with the FTSU guardians bi-monthly, that included site visits and talking to staff. The Chairman commented the FTSU service would continue to be reviewed, benchmarked against other trusts to ensure this continued to align with best practice. The DoM reported around 80% of maternity staff had received their appraisals, the remaining staff had been identified and discussed by the senior leadership team and dates for these to be held were being scheduled for completion. It was noted all midwives had a designated Professional Midwifery Advocate (PMA) with meetings held annually, with discussions around competency and any gaps in training or development. The Interim CMO confirmed patients discharged from wards were provided with a discharge letter, and that this was electronically sent to their GP. In respect of outpatient clinics patients would not receive a discharge letter, but possibly a summary that was also the case on discharge from ED. The CE acknowledged further work was needed to remind staff when providing GPs with patient clinic discharge summaries that these were also provided to the patient.

Mr Rylands asked ‘why did the Trust agree to a £72m deficit when this clearly appeared to be unreachable, and whether there was any linkage between the fact the NHS Counter Fraud Authority had reported the Trust to the NHS Financial Regulator and the growing significant deficit. Given the Trust had such a significant deficit, would there be job cuts’. The Interim CFO stated the initial 2023/24 financial plan had been a £93m deficit and were challenged nationally to review and reduce this expected deficit. The Trust was also required to provide a future projected breakeven plan against its submitted and agreed £72m deficit plan, recognising the challenges in achieving this annual plan. She reiterated reviews would be undertaken of the Trust’s workforce, emphasising its reliance on bank and agency staff that would be areas that would be reviewed in the first instance.

Mr Rylands asked ‘When he would receive the data promised as a Governor by a Board member two meetings previously’. The Chairman reported this would be addressed outside the meeting and followed up with Mr Rylands by his office, to confirm what had been requested.

The Chairman stated the Board was committed to holding these meetings on the hospital sites going forward, it was not possible for that day, and would be looking at these being held across the hospital sites on a rotational basis. This supported reducing costs and the Board's visibility across its sites. He noted due to the meeting room size required, these would be held in the Education Centres and that clinical educational meeting requirements would be a priority.

The Chairman thanked the staff involved in the Innovation Showcase event for their hard work, that was beneficial for Board members to see and the great innovation projects throughout the Trust.

The Chair closed the meeting at 4.25 pm.

Date of next meeting: Thursday 5 October 2023.

Signature _____

Date _____

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Matters Arising from the Minutes on 7 September 2023**

Meeting date: **5 October 2023**

Board sponsor: **Vice-Chair**

Paper Author: **Board Support Secretary**

Appendices:

NONE

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 three actions recommended for closure.

Implications:

Links to 'We Care' Strategic Objectives:	• 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 7 SEPTEMBER 2023

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/04/23	Present a report to the Board in November 2023 (12 months following the publication of the Kirkup report) providing a review and evaluation of the changes and improvements implemented, the impact and outcome of these on women, the service and its staff, along with feedback from staff about how they felt working in maternity services and what had changed and whether had made a real difference for them.	Nov-23	Interim Chief Nursing and Midwifery Officer (CNMO)	to Close	Report presented to 05.10.23 Board meeting. **Action for agreement for closure at 05.10.23 Board meeting.**
B/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.	Feb-24	Chief Operating Officer (COO)	Open	Item for future Board meeting.
B/08/23	Consider when reviewing the Oversight Group	Nov-23	Chief Strategy & Partnerships Officer (CSPO)	to Close	Action incorporated in new action B/21/23 from 07.09.23 Board meeting. **Action for**

	later in the year extending invitation to some patient and family representative members to present at a future Board on their experience of this Group and the progress that had been made.				**agreement for closure at 05.10.23 Board meeting.**
B/09/23	Look at including in future reports an additional column in the pillars of change update appendix providing a brief overview of the result of the actions detailing 'the what, impact and outcomes from these'. Consider and look at using Blue, Red, Amber and Green (BRAG) status definitions rather than RAG currently used.	~~Jul-23/ Sep-23~~/ Oct-23	Chief Strategy & Partnerships Officer (CSPO)	Open	Work in progress and will report at the September 2023 Board meeting.
B/13/23	Provide an update in the next report presented following discussion with the Patient Voice and Involvement team and wider CNMO teams about the triangulation of patients, families and communities feedback across the Trust, FFT responses, as well as complaints. This was around ensuring identification of any themes, what changes and improvement action was needed to address issues raised and that action was taken on the feedback received. Consider looking at producing a deep dive report on any themes identified.	~~Sep-23~~/ Oct-23	Interim Chief Nursing and Midwifery Officer (CNMO)	Open	Verbal update to be provided at 05.10.23 Board meeting.

B/14/23	Include section in the next report presented on feedback of the PLACE audits as well as any themes identified from complaints.	~~Sep-23~~/ Oct-23	Interim Chief Nursing and Midwifery Officer (CNMO)	Open	Verbal update to be provided at 05.10.23 Board meeting.
B/17/23	Present report to October 2023 Board meeting setting out the various urgent and emergency care (UEC) patient pathways to meet individual patient needs for ongoing treatment, covering the period over the next six to twelve months. To also incorporate the collaborative work with the out of hours service and support from the community.	Oct-23	Chief Operating Officer (COO)	Open	Verbal update to be provided at 05.10.23 Board meeting.
B/21/23	Consider for a future Board of Directors meeting for the families engaged with the Reading the Signals Oversight Group being invited to present, as part of the Patient Experience Story, their feedback and comments about the Group, discussions, achievements, and whether they felt progress and improvements had been made.	Feb-24	CSPO	Open	Item for future Board meeting.
B/22/23	Present annually a Patient Advice and Liaison Service (PALS) report (December 2023), providing details about themes of complaints, timeline of responding to complaints, numbers of complaints and compliments received, lessons learnt, and any	Dec-23	Interim CNMO	Open	Item for future Board meeting.

	actions as a result of feedback received.				
B/23/23	Liaise with Kent Community Health NHS Foundation Trust (KCHFT) to discuss what procedures they had in place to keep their lone worker community staff safe.	Oct-23	Interim CNMO	Open	Verbal update to be provided at 05.10.23 Board meeting.
B/24/23	Update the BAF reducing risk BAF 41 – Failure to deliver the financial plan of the Trust as requested by NHSE for 2023/24, to the risk score of 20 and not 16.	Oct-23	Interim CNMO	Open	Verbal update to be provided at 05.10.23 Board meeting.
B/25/23	Share the details of the two assault incidents on staff by a patient with the Interim CNMO.	Oct-23	2gether Support Solutions Managing Director	to Close	Details shared with Interim CNMO. **Action for agreement for closure at 05.10.23 Board meeting.**

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Vice-Chairman's Report**

Meeting date: **5 October 2023**

Board sponsor: **Vice-Chairman**

Paper Author: **Vice-Chairman**

Appendices:

Appendix 1: Non-Executive Director Commitments

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The purpose of this report is to: • Report any decisions taken by the BoD outside of its meeting cycle; • Update the Board on the activities of the Council of Governors (CoG); and • Bring any other significant items of note to the Board's attention.
Summary of key issues:	Update the Board on: • Current Updates/Introduction; • Activity of the CoG; • Visits/Meetings.

Key recommendations:	The Board of Directors is requested to:
	• **NOTE** the contents of this Vice-Chairman's report; and
	• **RATIFY** the decisions taken outside the BoD meeting business cycle:
	  • **APPROVE** the award of the contract for the Supply of Lot 4 - Orthopaedic Internal and External Fixation (Trauma);
	  • **APPROVE** the award of the contract for the Supply of Sleep and Respiratory Managed Services for 5 years.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients • People • Partnerships • Sustainability

East Kent Hospitals University NHS Foundation Trust

Link to the Board Assurance Framework (BAF):	N/A
Link to the Corporate Risk Register (CRR):	N/A
Resource:	No
Legal and regulatory:	No
Subsidiary:	No

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

VICE-CHAIRMAN'S REPORT

1. Purpose of the report

To report any decisions taken by the Board outside of its meeting cycle. Update the Board on the activities of the CoG and to bring any other significant items of note to the Board's attention.

2. Introduction

As we move into Winter, health and care services continue to struggle to meet demand across the entire country, East Kent being no exception. The demand for our services is ever growing, and although the Trust has continued to make sustained improvements to access our services, the flow of patients throughout our hospitals, and out of our Emergency Departments (EDs), continues to be an area of focus. In Jane Dickson's report, we will hear the Trust's plan to tackle Winter. As we have said previously at Board, our work with the Health and Care Partnership (HCP) and Integrated Care Partnership (ICP) continues to be vital as East Kent cannot tackle this problem alone.

In addition, the Trust's financial pressures continue to be a key area for the Board. As Tracey says in her report for this meeting, the Trust continues to have an unplanned deficit for this financial year. The external focus on all Trusts at the moment is considerable and well documented and we must do better to get control of our spending. The executive team continues to work on control measures including further scrutiny of budgets and controls within Care Groups, but we need to demonstrate we have a grip on this for the rest of the year.

Our staff continue to be a focus as we know all too well the dangers of staff not feeling safe to report concerns, and this was more than highlighted in the independent investigation into maternity and neonatal care from Dr Bill Kirkup. The Trust is one year on from the publication of Dr Kirkup's report, and we report at the Board some of the work that has been taking place to improve services. We still have a great deal of work to do to improve and start to see improved outcomes, however, I know all of the Board and our staff are committed to this change.

As our changes across the Trust continue to settle, with newly established Care Groups, I am pleased to welcome Sarah Hayes, Chief Nursing and Midwifery Officer (CNMO) to the Trust. Sarah has over 15 years' experience at senior management level in nursing, and I know her contribution to the Executive Team will be invaluable. I would also like to thank Jane Dickson for all of her work as our Interim CNMO. The work she has managed to achieve in a short span of time is remarkable, and we are pleased to continue to retain Jane, in the role of Acting Chief Operating Officer.

3. Council of Governors (CoG)

The Council of Governors held a development morning which was well received and covered numerous topics such as, the role of a Governor, how a Governor can be effective and Governor engagement with the Board in order to get the best out of the role of Governor and Board.

I know those in attendance valued this development session, and we are keen to host many more to come in the future to ensure our Council have full support in their role as Trust Governors.

4. Decisions taken by the Board of Directors (BoD)

The BoD decision taken outside its meeting cycle is noted below that requires formal noting and ratification by the BoD:

- Approved the award of the contract for the Supply of Lot 4 - Orthopaedic Internal and External Fixation (Trauma) to Johnson and Johnson.
- Approved the award of the contract for the Supply of Sleep and Respiratory Managed Services to Resmed for 5 years under the NHSSC Non Invasive Ventilation, Sleep Therapy and Sleep Monitoring Framework. Value of this 5-year agreement with Resmed of £3,672,295 ex VAT, with savings anticipated to be £84,733 over the first 12 months of the agreement.

East Kent Hospitals University NHS Foundation Trust

Appendix 1 – Non-Executive Director (NED) Commitments

NEDs September 2023 commitments have included:

Non-Executive Directors	NEDs meeting Extra-ordinary Closed Board of Directors (BoD) meeting Annual Members Meeting (AMM) Extra-ordinary Closed CoG meeting Finance and Performance Committee (FPC) meeting Quality and Safety Committee (Q&SC) meeting Reading the Signals Oversight Group meeting Meetings with Executive Directors Meeting with Spencer Private Hospitals (SPH) Chief Executive Officer SPH Board meeting Culture and Leadership Programme Interviews

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **5 October 2023**

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)

No Business Cases were approved or considered by the CEMG at meetings held in September 2023, the group did, however, approve a new Terms of Reference (TOR) reflective of the new Care Group structure and receive an update on the roadmap for implementation of the new Patient Safety Incident Response Framework (PSIRF), a plan for which will be shared with the Board in December 2023.

4. Operations update

4.1 Planned Care

The number of patients on the Trust's waiting list for Referral to Treatment (RTT) has been increasing by approximately 2000 - 3000 patients per month since the start of 2023. At the end of March 2023, the Trust reported 75,000 total incomplete pathways, whilst at the end of August this has increased to 86,800 and is anticipated to breach 90,000 in September. Furthermore, the Trust continues to report 104 and 78-week breaches which are increasing on a monthly basis and moving away from target trajectories. 65-week breaches have also breached the trajectory position from July 2023 and continue to increase monthly.

The growth of the waiting list has been driven by several key contributing factors; an increase in referrals, fewer clock stops, lower than planned elective activity and an accumulated loss of activity through industrial action since April 2023. The associated risk and growing concern with patients who are decompensated and at risk of harm whilst waiting for treatment is being monitored through administrative and clinical validation. This needs to be consistently applied in line with the national 12-week validation requirement so that it is robust enough to provide assurance that there is oversight of each patient waiting. To enhance the current frequency of contact with our patients, the Trust will be introducing a digital solution and adjusting communication with our patients who cannot engage with digital platforms.

Diagnostic waiting times are also significantly contributing to our 78-week breaches in Surgery and Gastroenterology and increasing endoscopy provision at pace will significantly improve this position for both cancer, routine and surveillance patients. Improving diagnostic access across Radiology and Cardiology will also yield a significant reduction in RTT waiting times.

Additionally, there is a risk associated with cancer recovery efforts, as the number of patients on the Patient Tracking List (PTL) increases. To support improvements in

the cancer pathways the teams are working in partnership with Radiology to review and refine the processes for booking and reporting to reduce the turnaround time for key diagnostics. Biopsy capacity and booking is also being reviewed to reduce the reporting wait times to allow our patients to have timely results from their biopsies.

4.2 Unplanned Care

Performance across the Trust's Emergency Departments (EDs) dipped in August after four consecutive months of improved Type 1 and 3 performance.

Trust-wide Type 1 performance deteriorated in the month, decreasing from 51.3% in July to 46.1% in August (Queen Elizabeth the Queen Mother Hospital (QEQM): 50.4% to 47.4%, William Harvey Hospital (WHH): 52.2% to 44.9%).

Trust-wide performance for all types also deteriorated in the month, decreasing from 74.0% in July to 71.6% in August (QEQM: 66.5% to 65.3%, WHH: 65.9% to 61.7%). This reflects the overall national trend for Urgent Emergency Care (UEC) performance.

The average number of patients with a decision to admit (DTA) in the emergency department at 08:00am increased from 51.7 to 64.6 in month but remains an improving trend over the past 12 months. This is reflected in the improving position for the number of 12 hour waits reporting 9.8% August 2023 v 11.7% September 2022.

Despite additional pressure at the front door, the Trust has successfully maintained ambulance offloads, with nearly 90% of all ambulance handovers taking place within half an hour. While this enables our South East Coast Ambulance Service (SECAmb) colleagues to have the fast turnaround required to attend to the next call out, it does transfer the pressure to the Trust's EDs and the number of patients being held in the department at any given time.

Progress continues to be made with our front door pathways in preparation for the anticipated increase in demand on the Trust's services as we head into winter.

Emergency escalation protocols are being reviewed and ratified to provide additional capacity when required for winter pressures. Front door pathways have been amended at both acute sites to ensure optimal patient flow through the Trust's Urgent Treatment Centres, dedicated Medical Assessment Units and Clinical Decision Unit and then onto short stay wards (Surgical Emergency Assessment Units, Gynaecology Assessment Units, Frailty, and Same Day Emergency Care). All pathway changes and expansion of service provision at the front door are aimed at reducing the time patients wait in the Trust's EDs and enabling patients to access the tailored care they require in a timely manner.

The WHH ED Build is nearing completion, with the final stage, the waiting room improvement works, expected to be finalised in the first week of October. This completes the near 3-year project to improve and expand the ED facilities at the WHH.

The QEQM build schedule is due to be completed at the end of the calendar year. The commencement of Phase 3B, the final stage of the build, results in the loss of space in the ambulance corridor, Rapid Assessment and Treatment (RAT+) room, and Aerosol Generating Procedure (AGP) room (used for mental health). The QEQM team continue to work through mitigations for the known loss of capacity, providing

space to support our mental health patients and operationalising amended front door pathways to maintain flow through the department.

5. Financial performance and NHSE control measures

At the end of M5 (August) 2023 the Trust has a year to date (YTD) deficit of £50.3m against the planned YTD deficit of £36m. Two elements of the deficit are strike action (£1.1m), unfunded pay award for agenda for change staff & Medical & Dental Staff (£1.8m) neither of which were part of the planned £72m deficit.

Key drivers of the YTD position include non-delivery of recurrent efficiency savings (£11.5m) and pay overspend including increased levels of staffing utilisation due to escalation areas, one to one care and the associated high cost of agency premium.

The Trust continues to work at pace on efficiency plans and further embedding the controls on spend which have been adopted in line with the national level 4 requirements.

At the September Board meeting in a question it was stated that the NHS Counter Fraud Authority had reported the Trust to the NHS Financial Regulator. I can confirm that the NHS Counter Fraud Authority do not believe there has been any issue of fraud and they have shared this with NHS England.

6. Care Quality Commission (CQC) Section 29a response

A full response to the warning notice served under Section 29A of the Health and Social Care Act 2008 was issued on time on 20 September 2023, with evidence uploaded to the CQC portal.

7. Charter for Sexual safety in Healthcare

On 4 September 2023 NHS England launched its first ever sexual safety charter in collaboration with partners across the healthcare system in light of survey results being published by the British Journal of Surgery which revealed that 63.3% of female surgeons and 23.7% of male surgeons had been the target of sexual harassment by colleagues.

The Trust has signed up and committed to the Charter for Sexual safety in Healthcare, making a public commitment to its workforce and patients to tackle unwanted, inappropriate and/or harmful sexual behaviour in the workplace.

The Trust will be required to commit to the following ten principles and actions to achieve a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce by July 2024:

1. We will actively work to eradicate sexual harassment and abuse in the workplace.
2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.

5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. We will ensure appropriate, specific, and clear training is in place.
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9. We will take all reports seriously and appropriate and timely action will be taken in all cases.
10. We will capture and share data on prevalence and staff experience transparently.

An analysis of the Trust's current state/compliance against each commitment is being undertaken and will be followed by a specific action plan to address each, which will be developed by the lead Freedom to Speak Up Guardian with support from the Chief People Officer and colleagues. Each commitment will be addressed systematically with input from staff to ensure that individual voices are heard and issues addressed.

A full report on the Sexual safety in Healthcare Charter will be presented to the Board of Directors in November 2023.

8. National Staff Survey

The annual NHS Staff Survey launched on Monday 18 September 2023, with all staff invited to confidentially and anonymously share their experience of working within the Trust, along with their views around how the Trust is performing as a provider of Healthcare for patients.

The Survey acts as a barometer of Trust health, providing an opportunity to measure progress against actions taken in light of the previous years' results and to benchmark against other comparable organisations nationwide.

Responses to the national Staff Survey allow the Executive Board, Care Group and Specialty leads to understand the experiences of our people and to support/ facilitate implementing the changes that we all want to see.

The current response rate, as at midday on 26 September 2023, is 13.6% (1,331 respondents).

9. National Reinforced Autoclaved Aerated Concrete (RAAC) concerns

Further to reports in May 2023 that some buildings in the NHS Estate across England and Scotland may have been constructed using Reinforced Autoclaved Aerated Concrete (RAAC), phased out in the 1990's and known to be weaker than other forms of concrete, a full review of the Trust owned estate has been undertaken. The review consisted of; a desktop review of record information, site based knowledge of the existing building infrastructure, along with a representable number of physical site inspections with no RAAC identified within the estate.

For completeness it should be recognised that whilst the Trust does not have any RAAC in its estate, a level of risk is held in respect to other non-RAAC concrete related issues, these being;

1. WHH Main Clinical Zone block & beam failure – report previously commissioned and shared between Boards.
2. WHH Water Towers Concrete Panels are failing.
3. Kent & Canterbury (K&C) 1937 concrete cancer on 2 elevations – remediation has taken place to date but remains in very poor state of repair.

Suitable mitigations remain in place against all instances i.e. protective netting and regular assurance inspections continue via a third-party specialist.

10. Trust Board update

I would like to take this opportunity to welcome Sarah Hayes, Chief Nursing and Midwifery Officer, to her first public Trust Board meeting. Sarah joined the Trust on 18 September 2023 with more than 18 year's senior management and leadership experience in the NHS, across both the hospital and community settings, most recently as Chief Nurse of the North Middlesex University Hospital NHS Trust.

11. Conclusion

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

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

Committee: **Quality and Safety Committee (Q&SC)**

Meeting date: **26 September 2023**

Chair: **Dr Andrew Catto, Non-Executive Director**

Paper Author: **Executive Assistant/Interim Group Company Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

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

In attendance: Moira Durbridge, NHS England (NHSE) Improvement Director.

Assurances received at the Committee meeting:

Agenda item	Summary
Infection Prevention and Control IPC) Report	The Committee received **partial assurance** of the current performance about nationally reportable infections noting the following: • Clostridioides difficile (C-diff) remains a challenge for the Trust with the current number of cases being at 80% of the annual threshold, which is a key area of focus for the Antimicrobial Stewardship Group. An outbreak of a very rare strain of C-diff was identified in the Trust and actions are being taken to contain it; • cases of Klebsiella and E-coli infections are over trajectory. Other reportable infections are within or below trajectory; • surgical site infection surveillance is ongoing and the gap analyses against the National Institute for Health and Care Excellence (NICE) guidelines was completed. The neck of femur care pathway is under review; • good uptake of COVID-19 and influenza vaccinations among the Trust's staff.
Care Quality Commission (CQC) Update Report	The Committee received the latest assurance report on the activities of the Journey to Outstanding Care Programme Steering Group (JTOCPSG). The Committee **noted** that the Trust had responded to CQC in respect of the Section 29a Notice on the 20 September 2023. Plans are in place to share the response with the Board and Integrated Care Board (ICB).

Corporate Principal Mitigated Quality Risks	The Committee was made aware that there had been no significant changes the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) during this reporting period. It was **noted** that the updated BAF and CRR would be presented to the Board for review on 5 October 2023, following which further revisions would be made.
Fundamentals of Care (FoC) Chair's Report	The Committee **considered** an assurance report on the activities of the Fundamentals of Care Committee, the following key points were noted: • the level of engagement work with external and internal stakeholders and examples of positive feedback received; • the Trust-wide inpatient feedback score was 94.4% with the threshold of 77% meaning that the highest number of patient responses per month was received across inpatient areas; • Volunteer Services successfully recruited 30 youth volunteers aged 16-18 to help with the ward activities and to collect patient feedback; • noise at night remains a concern for the wards but improvements were made.
Mortality Steering and Surveillance Group (MSSG) Chair's Report	The Committee **considered** an assurance report on the activities of the Mortality Steering and Surveillance Group noting the following: • Hospital Standardised Mortality Ratio (HSMR) remains lower than expected for the Trust as a whole (93.9%); • Structured Judgement Reviews (SJR) – there were 36 SJRs in July 2023, the majority of which were completed by medical specialties; • concerns were highlighted regarding the number of deaths occurring on Richard Stevens Ward and Cambridge K Ward at William Harvey Hospital (WHH).
Maternity and Neonatal Assurance Group (MNAG) Chair's Report	The Committee **received** an assurance report on the activities of the Maternity and Neonatal Assurance Group and noted the following key matters: • the rate of reportable neonatal and perinatal deaths remained lower than comparable peers; • improvements noted in relation to ultrasound screening which the Care Group would continue to monitor; • ten internationally-recruited midwifes had completed their Objective Structured Clinical Examination (OSCE) and an experienced Consultant Midwife was recruited; • inadequate theatre capacity at Queen Elizabeth the Queen Mother Hospital (QEQM) in terms of access to a second theatre and the distance between the Maternity Unit and main theatres in time-limited emergencies, which had been escalated to the Committee.

Integrated Incidents, Patient Experience, Claims and Learning from Serious incidents	The Committee **received** the quarterly report presenting the July 2023 data, and noted the following: • 11 serious incidents had been reported in July 2023; • there was a slight increase in number of complaints but the response rate also increased; • a review had been undertaken in relation to the Trust's compliance with NICE Guidelines between January 2021 and June 2023. The review concluded that the Trust had no evidence of compliance with 46% of the NICE Guidelines and work was on-going to plan how this would be addressed as a priority.
Dementia Strategy Update	The Committee **received** an update on the implementation and progress of the Trust Dementia Strategy 2023-26.
Endoscopy Capacity Update	The Committee **noted** that Endoscopy capacity remains a significant challenge for the Trust and the mitigations put in place to reduce the backlog.
Safe Staffing	The Committee **received** the Safe Staffing Report and noted that the Trust continued to monitor Nursing and Midwifery numbers and skill mix in response to clinical needs on a daily basis.

Referrals from other Board Committees

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

The Committee asks the BoD to discuss and **NOTE** this Q&SC Chair Assurance Report.	Assurance	5 October 2023

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: **25 September 2023**

Chair: **Richard Oirschot, Non-Executive Director**

Paper Author: **Interim Group Company Secretary**

Quorate: Yes

Declarations of interest made:

None

Agenda item	Summary
Cost Improvement Programme (CIP)	The Committee noted the following developments: • partner organisations were not being required to re-forecast; • EKHUFT was in line with other trusts in terms of focusing on areas that needed help and support; • some cost savings were achievable in nursing staffing, but it was important to balance these with quality standards; • more information was required with regard to detailing key themes and impact; • a workforce review was required; • the style of the CIP report was to be re-modelled to include actions and likely impact of actions. The Committee discussed and **NOTED** the M5 Savings and Efficiencies Update and **LIMITED ASSURANCE** was received in respect of the Trust's progress with regard to the CIP.
Patients no longer fitting the criteria to reside	The Committee discussed and **NOTED** the Patients No Longer Fitting the Criteria to Reside (NLFTR) report which centred on the following key areas: • the reported NLFTR position; • the reported position of related long stay metrics; • the reported position related to Emergency Department (ED) performance metrics (% 12 hour (hr) stay in ED, 12hr Trolley Waits, 4hr performance); • update on work in progress supporting operational improvement programmes; • update on the outcome and next steps for the Trust-wide bed audit reviewing the funding status for beds across the Trust. A report on the adverse movement in respect of Accident & Emergency (A&E) waiting time in August 2023 would be considered at the next meeting.

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Month 5: **• Finance Report** **Business Planning, 2024-26 Launch**	The Committee discussed the Trust's financial performance and actions being taken to address issues of concern, the following key points being noted: • the Group had reported an in-month position of £11.3m against a plan of £5.3m, resulting in a deficit variance of £6m; • the Year to Date (YTD) position is £50.3m against a plan of £35.9m, giving a YTD variance to plan of £14.4m; • the agreed financial plan for 2023/24 is a £72m deficit. Delivery of the 2023/24 financial plan is based upon some extremely challenging assumptions, including the delivery of £40m of efficiency savings on a cash releasing efficiency basis; a reduction in the number of not medically fit to reside patients and the elimination of 65-week breaches. Trust Income was above plan YTD by £5.1m mainly due to additional allocation from the Integrated Care Board (ICB) for Health and Care Partnership (HCP) East Kent projects. Pay was overspent by £12.6m YTD due to non-delivery of CIP, increased levels of staffing utilisation, mainly in nursing and Medical & Dental and high-cost of agency costs. Trust Non-Pay was overspent by £6.5m primarily driven by non-delivery of efficiencies, rechargeable drugs costs and IT systems contracts. As at Month 5, the Trust was behind its activity plan by £2.7m, predominantly due to cancelled elective activity as a result of the Doctors' strikes. At the end of August 2023, the Trust was broadly on plan in respect of capital expenditure with a £7.9m spend against a plan of £7.8m. The Trust has achieved very little efficiency savings so far this year, with £1.1m achievement against the £12.6m YTD plan. **Business Planning, 2024-26** On Thursday 20 September 2023, the Trust launched its 2024-26 Business Planning process with Care Groups. The start of the process is earlier in the cycle than recent years in order to ensure the Trust is best prepared to deliver a refreshed Financial Recovery Plan (FRP), underpinned by a robust Business Plan for 2024-26 and by the timescales outlined in the Integrated Improvement Plan (IIP). High-level planning principles and key expected deliverables were shared with Care Groups and Corporate Team leads, along with a clear timetable for delivery to March 2024. Detailed Business Planning assumptions that will also underpin the Business Plan are now being developed, encompassing the Capacity/ Performance, Financial, Workforce and Strategic aspects of the Trust's Business Plan.

	These will be shared with Care Groups in early October, but will be subject to updates following the publication of any national guidance on planning for forward years.
Board Assurance Framework (BAF) and Principal Mitigated Financial and Performance Risks	The Committee noted the following matters in relation to the BAF: **Headlines**: There were three BAF risks and eight risks on the Corporate Risk Register (CRR) relating to 'Our Future' and 'Our Sustainability'. **Changes to the BAF**: There have been no changes to the BAF during this reporting period. Following the approval of the revised risk appetite and tolerance statements at the Board of Directors on 7 September 2023, meetings will be undertaken with the individual Executive Directors to review and refine the risks on the BAF to ensure they are aligned with the current Strategic Objectives. **Changes to the CRR**: There has been one increase in risk rating following recommendation by the Finance and Performance Committee, CRR 145 – There is a risk that the Trust will not be able to meet its 2023/24 efficiencies target, and therefore miss the agreed control total deficit, potentially further losing financial autonomy, and jeopardising the Financial Recovery Plan has been increased from a high (16) to an extreme (20). Scores were increased for the following Risks: 145, 148, 149, 13 to 20. BAF Risk 41 also increased to 20. The Committee discussed and **APPROVED** the Board Assurance Framework and Corporate Risk Register.
PRISM Programmes Overview	The Committee discussed and **NOTED** the Prism overview paper, relating to an Inpatient Flow Improvement Programme and a Theatre Productivity Improvement Programme to be adopted Trust-wide.
Endoscopy Procurement Outcome and Award	The Committee discussed the report and **recommended approval** of the Endoscopy Procurement Outcome and Award to the Board.
We Care Integrated Performance Report (IPR) (M5): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee discussed and noted the 'We Care Integrated Performance Report' (IPR) with partial assurance being received with regard to performance against key metrics for 2023/24. The Committee noted, in particular, that Did Not Attends (DNAs) and theatre data seemed high and a follow up report on this areas was requested.

Capital Investment Requirements	The Committee discussed the capital infrastructure investment requirements for the Trust over the next 5-years and the gap between the capital investment currently allocated and the amount required. The Committee **CONSIDERED** the Trust's capital investment requirements.
Annual Committee Workplan	The Committee and discussed and **NOTED** the Annual Workplan update.
Enhanced Care Update	The Committee agreed to postpone this item until the next meeting.
Commissioning for Quality and Innovation Programme (CQUIN)	The Committee considered the Q1 report for the 2023/24 CQUINs Programme, it being noted that Q1 performance data and evidence had been submitted via the National CQUIN Portal on 24 August 2023 and to the Integrated Care Board (ICB) on 7 September 2023. Q1 evidence related to the Specialised CQUINS was submitted on 25 August 2023. It was noted that for 2023/24, the ICB had agreed that there would be no financial penalty for failure to meet the national CQUIN targets, but that evidence of improvement would be expected. The Committee discussed and **NOTED** the Commissioning for Quality and Innovation Programme (CQUIN).
Capital Investment Group	The Committee **received** the Minutes of the Capital Investment of 20 July 2023, for information.
Business Case Scrutiny Group	The Committee **received** a verbal assurance report from the Chief Finance Officer (CFO) in respect of the Business Case Scrutiny Group.
Financial Improvement Oversight Group (FIOG)	The Committee **received** an assurance report on the activities of the FIOG on 15 August 2023.
Policies	The Committed discussed and **APPROVED** the Overseas Patients policy, Cash Collection policy, Cash receipting policy, Financial Management of Fixed Assets and Stock Taking Policy.
Any Other Business	The Committee recommended that Keith Pringle should attend all future meetings. It was **agreed** that the Medical Director should have a standing agenda item for assurance purposes, and that a programme of financial training for wider staff should be developed.

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

Item	Purpose	Date
The BoD is asked to receive and **NOTE** this FPC Assurance Report.	Assurance	5 October 2023
The BoD is asked to **APPROVE** the Endoscopy Procurement Outcome and Award.	Approval	5 October 2023

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Assurance Paper on Board Actions Following Letby Verdict**

Meeting date: **5 October 2023**

Board sponsor: **Chief Nursing and Midwifery Officer, Chief People Officer, Chief Medical Officer**

Paper Author: **Deputy Chief Nursing Officer**

Appendices:

Appendix 1: Patient Safety Incident Response Framework (PSIRF) Road Map

Executive summary:

Action required:	Assurance
Purpose of the Report:	The purpose of the report is to provide assurance to the Board that key actions outlined in the letter received from NHS England (NHSE) 18 August 2023 following the verdict in the trial of Lucy Letby are in place or in progress at EKHUFT.
Summary of key issues:	On the 21 August 2023 former neonatal nurse Lucy Letby was found guilty of murdering seven infants and the attempted murder of six others at the Countess of Chester Hospital between 2015-2016. NHSE sent a letter to all Integrated Care Boards, NHS Trusts and Primary Care Networks outlining the decisive steps towards patient safety monitoring: • **Medical Examiners;** The Trust established a Medical Examiners service and currently reviews 90% of all non-coronal deaths that occur within the Trust. • **Patient Safety Incident Framework (PSIF);** The Trust is undertaking significant preparative work in relation to PSIRF. A road map for the implementation of PSIRF has been produced. • **Freedom to Speak Up;** The Trust adopted the new Freedom to Speak Up Policy in December 2022 and has a team of four Freedom to Speak up Guardians. • **Fit and Proper Persons;** the Trust's Fit and Proper Test is currently being amended to reflect the "Framework changes from the 30 September 2023 for new Board level appointments. • **Strengthening Governance;** The Trust has reviewed its quality governance structure which included a Quality Governance Framework to be implemented in the new care groups within the structural reorganisation. • **Neonatal Care Quality Commission (CQC) self-assessment;** has been undertaken by both neonatal units in the organisation, an action plan produced and continues to progress.

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Key recommendations:	The Board of Directors is asked to **NOTE** the Trust is addressing the key actions outlined in the letter received from NHS England following the verdict in the trial of Lucy Letby.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients • People
Link to the Board Assurance Framework (BAF):	**BAF 32**: There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered. **BAF 33:** There is a risk of failure to adequately resource, implement and embed effective governance processes throughout the Trust. **BAF 40**: There is a risk of failure to address inequality, lack of diversity and injustice for staff working at East Kent Hospitals.
Link to the Corporate Risk Register (CRR):	**CRR 107:** Inability to embed learning from incidents, complaints and claims across the Trust. **CRR 118:** There is a risk that the underlying organisational culture impacts on the improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace. **CRR 139:** Trust fails to adequately investigate clinical incident in a timely manner and I identify themes in order to action change and avoid future repetition.
Resource:	N
Legal and regulatory:	Y - Regulatory CQC Standards
Subsidiary:	N

Assurance route:

Previously considered by: None

East Kent Hospitals University NHS Foundation Trust

Assurance Paper on Board Actions Following Letby Verdict

1. Purpose of the report

1.1 The purpose of the report is to provide assurance to the Board that key actions outlined in the letter received from NHSE 18 August 2023 following the verdict in the trial of Lucy Letby are in place or in progress at EKHUFT.

2. Background

2.1 On the 21 August 2023 former neonatal nurse Lucy Letby was found guilty of murdering seven infants and the attempted murder of six others at the Countess of Chester Hospital between 2015-2016.

2.2 Senior management teams at the Countess of Chester Hospital were criticised for ignoring warnings about Lucy Letby that may have prevented some of the killings. This included an informal review conducted by a Consultant and Lead Neonatologist which looked at 4 unexplained collapses of infants that occurred in the same unit resulting in three deaths. Lucy Letby was on duty when all of these unexpected events happened. These deaths were promptly reported by the Consultants to the Trust's committee responsible for addressing serious incidents. The committee classified the deaths as "medication errors" rather than as a serious incident (SI) which would have resulted in a SI investigation.

2.3 The British Government has since announced that an independent statutory enquiry will be held into the circumstances surrounding the murders.

2.4 A letter was sent to all Integrated Care Boards, NHS Trusts and Primary Care Networks on 18 August 2023 following the verdict in the trial of Lucy Letby. The letter stated NHSE's commitment to doing everything possible to prevent anything else happening like this again and outlined the decisive steps towards patient safety monitoring.

3. Medical Examiners

3.1 There has been a national rollout of medical examiners since 2021 creating additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner, improving data and making it easier to spot potential problems. The Trust has established a Medical Examiner service consisting of 14 Consultants providing 23 sessions per week. The service has been set up to achieve the requirements of a statutory National Medical Examiner System due to be introduced from April 2024, which includes:

- Confirmation of the proposed cause of death by the medical doctor and the overall accuracy of the medial certificate of cause of death;
- Discussion of the proposed cause of death with bereaved people and establish if they have questions or any concerns relating to the death;
- Support appropriate referrals to senior coroners; and

- Identify cases for further review under local mortality arrangements and contribute to other clinical governance processes.

3.2 The service is achieved through the use of a Mortality Patient Tracking List (PTL) which is used to capture the elements required above. The aim is to review 100% of all non-coronal deaths that occur within the Trust, the service currently achieves 90% but as it is not currently a statutory requirement for all GP surgeries to refer cases to the Medical Examiners service it is difficult to determine how accurate this figure is.

3.3 The number of deaths reviewed by the Medical Examiners service at the Trust is between 8000 and 8200 per year.

4. Patient Safety Incident Framework

4.1 This autumn, the new Patient Safety Incident Response Framework (PSIRF) will be implemented across the NHS representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families and taking effective steps to improve and deliver safe care for patients. PSIRF requires organisations to transform rather than make adaptations to the current guidance on managing patient safety incidents. The changes are so significant that staff will be required to completely change their way of thinking and behaviour in all things related to Patient Safety. These changes include the way in which we work, removal of the serious incident status, methods of investigation how we record our investigations, the outcomes, the involvement of patients within the process, the way our investigations are signed off, the way in which the Board will gain assurance around patient safety and the way in which we monitor and measure ourselves within our quality governance processes.

4.2 The only items that will not change are our legal requirements within patient safety. This includes the Duty of Candour as well as certain legally required or mandated investigations for example Maternal Deaths, Child Deaths and Never events.

4.3 The Trust has undertaken significant preparative work in relation to PSIRF. Datix/Learning from Patient Safety Events (LFPSE) will meet the deadline set by NHSE for full compliance with the LFPSE fields on Datix by the end of September 2023. The “go live” date for LFPSE is 1 November 2023.

4.4 The PSIRF plan described in the PSIRF Road Map (Appendix 1) will be agreed at the Clinical Executive Management Group (CEMG) in October. The PSIRF policy will be developed in November and signed off by Board in January 2024.

4.5 EKHUFT’s “go live” date for transfer from our current incident reporting policy to the new PSIRF Policy will be 1 March 2024. It should be noted that PSIRF sits within the national patient safety strategy and there are additional initiatives to support patient safety to be implemented within this.

5. Freedom to Speak Up

5.1 In June 2022 NHSE rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations are expected to adopt the updated national policy by January 2024. The Trust

adopted the new policy in full in December 2022 ahead of the deadline. All NHS leaders and Boards must ensure proper implementation and oversight. Specifically:

5.2 All staff have easy access to information on how to speak up.

- The FTSU Up Policy can be found in the Policy Centre, alongside all other Trust policies.
- The Trust has 4 FTSU Guardians, available to give advice on how to speak up.
- There is a link on the Staff Zone homepage which signposts to the FTSU team, should concerns need to be raised.
- The FTSU Team raise awareness of speaking up to workers (i.e.: at every Trust Welcome Day, to each cohort of Internationally Educated nurses) to provide easy access to information on how to speak up.
- The three e-learning modules on speaking up have been made mandatory to provide opportunities to learn and consistency of understanding across the Trust. The FTSU Team compliments these modules by delivering face-to-face training, workshops and forums to provide a more inclusive learning environment and embed the knowledge.
- There are posters across the Trust highlighting the multiple routes for speaking up. These messages are replicated on screensavers and in Trust-wide communications.

5.3 Relevant departments, such as Human Resources, and Freedom to Speak up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.

- Updates from NHSE about the national Speak Up Support Scheme are shared with leads for Employee Relations and FTSU by the Chief People Officer. These updates are shared Trust-wide by the Communications Team. The latest update was shared in June 2023.

5.4 Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

- The Trust has a number of staff networks, supported by the Equality, Diversity and Inclusion (EDI) Team. The networks serve to support workers who are at a disadvantage and includes supporting those facing cultural barriers to speak up. The staff networks feed in to the EDI steering group where concerns can be escalated. The FTSU Team has a strong working relationship with the EDI Team and offer support to those facing barriers to speaking up.

- The FTSU Team works with the Pastoral Care Team to support Internationally Educated Nurses to recognise cultural barriers that they may face to speaking up and educate them on what speaking up means and expectations of them in the NHS.

- The Trust has a team of FTSU Guardians, with sole responsibility for supporting workers to speak up. This creates capacity to visit teams and wards, in person, and built and

maintain trusting relationships. The team can be contacted in a variety of ways to suit the person speaking up.

- The Trust delivers services with the support from colleagues at 2gether Support Solutions (2gether). The FTSU Team have a working relationship with the People and Culture function for 2gether so that appropriate signposting and support can be offered.

5.5 Boards seek assurance that staff can speak up with confidence and whistle-blowers are treated well**.**

- The FTSU team reports regularly to Board and to Board sub-committees on their activity to ensure staff can speak up with confidence and whistle-blowers are treated well. In addition, the annual staff survey and quarterly pulse surveys monitor staff views on speaking up and whistleblowing. Survey data is factored into the FTSU plan and culture changes programmes.

5.6 Boards are regularly reporting and acting upon available data**.**

- The FTSU Team reports quarterly to the People and Culture Committee, annually to the Integrated Audit and Governance Committee and bi-annually to the Board of Directors. Reports contain a summary of activity, key issues and recommendations for further action.

6. Fit and Proper Persons

6.1 NHSE have reminded all organisations of their obligations under the Fit and proper Person requirements. This has recently been strengthened the Fit and Proper Person Framework has identified additional checks, including a board member reference template which applies to board members and non-board members. This assessment will be refreshed annually and recorded on Electronic Staff Record (ESR) so that it is transferable to other NHS organisations as part of their recruitment processes. EKHUFT are adopting the additional checks which include:

- When the full Fit and Proper Persons Test (FPPT) assessment is needed, which includes self-attestations;
- New appointment considerations;
- Additional considerations in specific situations such as joint appointments, shared roles and temporary absences;
- The role of the chair in overseeing the FPPT;
- The FPPT core elements to be considered in evaluating Board members;
- The circumstances in which there will be breaches to the core elements of the FPPT;
- The requirements for a Board member reference check;
- The requirements for accurately maintaining FPPT information on each board member in the ESR record – for the purpose of the FPPT framework, 'ESR' refers to the FPPT data fields in ESR;
- The record retention requirements;
- Dispute resolution;
- Quality assurance over the Framework.

6.2 The Trust's Fit and Proper Person's Test is currently being amended to reflect the "Framework" changes from the 30 September 2023, for new Board level appointments or promotions.

6.3 At the point of recruitment, the NHS Employers Checking standards are completed with an additional two to include:

- Identity Checks Right to Work;
- Checks Employment History and Reference;
- Checks Professional Registration and Qualification Checks;
- Work Health Assessments;
- Criminal Record and Disclosure and Barring Service (DBS) checks;
- Insolvency Check;
- Disqualified Director Check.

6.4 From the 30 September 2023 any appointments to the Chair position will also include FPPT approval from the NHSE Appointments Team.

6.5 Trust's policy now requires that the Chief Executive (for Executive Directors) and the Chairman (for the Non-Executive Directors and the Chief Executive) assess on-going competence in the role as part of the "fit and proper persons' requirements".

6.6 As competence is discussed as part of appraisal, a positive appraisal will be evidence that this element of the requirement is met. In addition, as with previous years, each Board member provides an annual declaration that they remain compliant with the regulations.

6.7 The Chief Executive Office reviewed all Board FPPT tests in June 2023.

7. Strengthening Governance

7.1 In July 2022, NHSE have identified that all of the above are not enough on its own and good governance is essential. Following a formal consultation and to improve our capacity and capability to address our challenges in how our structures operate (how we lead, manage and govern our services and challenge ourselves to continually improve), a new organisational structure has been implemented which went live August 2023.

7.2 To strengthen the organisation, the Trust commissioned an external Consultant to review the Trust quality governance structure which included a Quality Governance Framework, a draft structure and implementation Timeline. The framework and supporting documents provide an approach to quality governance to be implemented by the new care groups. The timeline measures of success over two years to demonstrate how changes will be made and embedded into the Trust. Many aspects however will happen in the next few months and certainly before the end of 2023-2024.

8. Neonatal CQC Self-Assessment

8.1 In July 2022 the Neonatal Units of the William Harvey and Queen Elizabeth the Queen Mother Hospitals undertook a Neonatal CQC Quality 'We' Statements using a Care group self-assessment tool. An action plan was produced.

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9. Conclusion

9.1 In summary the Trust is addressing the key actions outlined in the letter received from NHS England following the verdict in the trial of Lucy Letby.

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Patient Safety Incident Response Framework (PSIRF) Road Map

Deputy Director of Quality Governance

August 2023
Presentation

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Introduction to PSIRF

- The PSIRF is a key part of the NHS Patient Safety Strategy published in July 2019.
- It replaces the 2015 Serious Incident (SI) Framework from April 2023.
- PSIRF is a whole system change to how we think and respond when an incident happens to prevent recurrence.
- It requires provider organisations to adopt the new national standards for declaring, investigating and responding to patient safety incidents.
- It supports the national strategy's aim to help the NHS to improve its understanding of patient safety by drawing insight from incidents using new and updated techniques.

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Outline of the changes that PSIRF brings

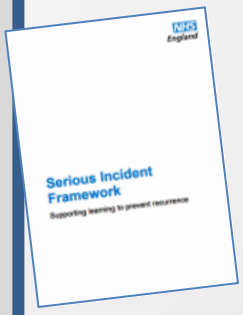
PSIRF VS. SI Framework

The Future

- Mandated patient involvement
- Systems and risk based approach to patient safety incident investigations to replace Root Cause Analysis (RCA)
- Sets clear expectations for engaging patients, families and carers in investigations
- Introduces local provider patient safety incident response plans (PSIRPs) to define what incidents will be investigated
- Providers select top patient safety priorities for incidents that need full investigations
- 3-6 months investigation timeframe determined by the provider.
- New mandated national investigation standards and report template
- A team of highly trained and independent investigators replaces singular investigator

Current

- Prescribed definitions of what meets the SI criteria for declaration and full investigation
- Uses root cause analysis methodology for investigations
- 60 working day timeframe for completion of investigations
- Investigation led by a single lead investigator
- Local report templates in use but guided by SI framework credibility checklist
- Integrated Care Boards (ICBs) provide ultimate sign off and closure
- Lack of family/patient engagement



Key Elements of Transformation

- The scope is broader by moving away from reactive thresholds for declaring an SI.
- The experience for those affected will improve.
- Decisions to investigate will no longer be based on levels of harm.
- Quality over Quantity – there must be fewer investigations with much greater levels of learning and improvement as an outcome.
- Frequently occurring incidents should not be investigated individually.
- There will be a greater level of patient engagement and involvement.
- Our data will drive the improvements we target on an annual basis.
- Quality Improvement will be at the heart of our response to Patient Safety Incident (PSI).

Mandated Investigations

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Mandated for internal full patient safety incident investigation

- Incidents that meet the criteria set in the Never Events list (February 2021)
- Incidents that meet the 'Learning from deaths criteria'
- Death or long-term severe injury of a person in state care or detained under the Mental Health Act

Mandated for external investigation

- Incidents which meet the 'Each Baby Counts' and maternal deaths criteria (Healthcare Safety Investigation Branch (HSIB) investigation)
- Mental health-related homicides by persons in receipt of mental health services or within six months of their discharge
- Child deaths (Child death review statutory and operational guidance)
- Deaths of persons with learning disabilities (Learning Disability Mortality Review (LeDeR) programme reporting and review)
- Safeguarding incidents (current safeguarding process)
- Incidents in national screening programmes (Public Health England (PHE) reportable and Screening Quality Assurance Service (SQAS)
- Deaths of patients in custody, in prison or on probation (PPO)

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Road Map to Successful Implementation

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PSIRF Road Map for Successful implementation 1

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PSIRF ROADMAP FOR EKHUFT		
	SEPTEMBER 23	Engage with Key internal and external stakeholders
		Confirm roles and responsibility within PSIRF
		Training designed for Datix/LFPSE and Key staff identified into training groups.
		Oversight training for the Board to be agree and booked.
		Complete role description and agree numbers and support model for Patient Safety Partners.
		Launch PSIRF Comms Strategy and the Website for the next year.
		Agree QI involvement in PSIRF.
Develop PSIRF Plan for the coming year and agree key areas of focus. Three for Maternity and three for the wider Trust and our processes for managing our incidents.	OCTOBER 23	
Recruit Patient Safety Partners.		
Delivery of Datix Training for relevant staff		
Complete all Testing for Datix LFPSE fields.		
Agree approach to improving PS culture, linking in with current culture programme.		
Agree Templates to be used within the PSIRF Plan		
Agree with the ICB how they will gain assurance and have oversight of our improvements.		
Start to develop expertise in the new investigation methodology across the PS Team.		
Set up engagement sessions/feedback methods from staff on the front line.		

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PSIRF Road Map for Successful Implementation 2

	NOVEMBER 23	1 November 'Go Live on Datix'
		PSIRF Plan to be signed off by Clinical Executive Management Group (CEMG) with Identified risks understood and documented
		Consider/develop training for Patient engagement within PSII.
		Source/Develop After Action Review Training.
		Developing the process for engaging our patients when responding to incidents.
PSIR Plan to be signed off by the Trust Board and shared with the ICB.	DECEMBER 23	
PSIR Policy to be signed of by CEMG.		
Pilot new methodology for PSII.		
Ongoing Training for Datix and Investigation process and method.		

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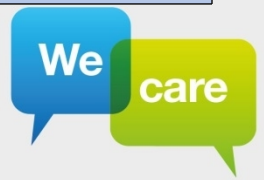
PSIRF Road Map for Successful Implementation 3

	JANUARY 24	PSIR Policy to be signed off by the Trust Board and shared with the ICB.
		Comms and further Training to Staff on the PSIR Plan and how to respond to incidents.
		HSIB training on Investigating for key staff.
Feedback from ICB on the PSIR Plan and Policy	FEBRUARY 24	
Comms and ongoing training for relevant staff on PSIR Plan.		
	MARCH 24	1 March 24 is our 'Go Live' date for transition to our PSIR plan.
		Training and support continues for the Governance Staff along with Comms and staff feedback.



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Questions

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REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Summary of Maternity Papers

Meeting date: 5 October 2023

Board sponsor: Chief Nursing & Midwifery Officer (CNMO)

Paper Author: Director of Midwifery (DoM)

Appendices:

APPENDICES PROVIDED IN READING ROOM (DOCUMENTS FOR INFORMATION)
APPENDIX 1: MATERNITY DASHBOARD FRONT SHEET AND MATERNITY DASHBOARD PERFORMANCE REPORT
APPENDIX 2: PERINATAL SURVEILLANCE TOOL (PQST) REPORT
APPENDIX 3: ANAESTHETIC MATERNITY WORKFORCE UPDATE
APPENDIX 4: NEONATAL MATERNITY WORKFORCE UPDATE AND ACTION PLAN

Executive summary:

Action required:	Information
Purpose of the Report:	• In accordance with the standards set out within the NHS Resolutions (NHSR) Maternity Incentive Scheme, and Ockenden recommendations the following reports are submitted to the Board for information and oversight. 1. PQST Report August 2023. 2. Maternity Dashboard August 2023. 3. Safety Action 4 - Medical Workforce Reviews (Anaesthetics, Neonatal including Neonatal Nurses and resultant action plans). • These reports have been presented to the Maternity and Neonatal Assurance Group (MNAG) for detailed review and discussion and a summary provided to the Quality & Safety Committee (Q&SC).
Summary of key issues:	**The Perinatal Quality Surveillance Tool August 2023** The metric contained in this paper is a sub-set of the maternity dashboard and provided detail on the Serious Incidents (SIs), lessons learnt and feedback from families. 1. No SIs were declared in the month of August. 2. The Friends and Family Test (FFT) response rate was good at 11%. The team discussed what the local threshold should be. It was agreed that the Integrated Care Board (ICB) Directory of Midwifery (DoM) will explore the Regional response rate, in the absence of a national average and this will be applied across the Local Maternity and Neonatal System (LMNS). On average 90% of women provided a positive response. 3. William Harvey Hospital (WHH) currently challenged with a high vacancy rate. 10 Internationally Educated Midwives (IEMs) have successfully

	completed their Objective Structured Clinical Examination (OSCEs) and will commence a 12-week bridging programme. 3 midwives have been recruited from the domestic pipeline. **Maternity Dashboard August 2023** DoM presented the paper to MNAG highlighting areas of positive performance and areas for improvement that the team were addressing: • The rate of reportable neonatal and perinatal deaths remains lower than the Trust comparator group average. The rolling 12 month Stillbirth rate remains at 2.56 per 1000 births compared to the comparator average of 3.92/1000. • The extended perinatal rate (Stillbirths and Neonatal deaths up to 28 days) remains at 3.58 per 1000 births compared to the comparator average of 5.87 per 1000 births. • There were no SIs or Healthcare Safety Investigation Branch (HSIB) referrals in August. • One:One care in labour and the supernumerary status of the coordinator were both achieved in month. • Safeguarding and Information Governance (IG) training remain non-compliant, however, the actual percentage of compliance is higher than that on Electronic Staff Record (ESR) as a number of staff have attended training in month. The team is still on track for compliance by November 2023. **Safety Action 4** : **Medical Workforce** **Anaesthetic Medical Workforce Paper**. To declare compliance it is a requirement that the service reviews its workforce against the Anaesthesia Clinical Services Accreditation (ACSA) Standard 1.7.21. This relates to the availability of a duty anaesthetist 24/7 who has clear lines of communication with a supervising anaesthetic consultant at all times. The Trust position is to be shared with the Trust Board no later than 7 December 2023. **Neonatal medical and nursing workforce paper.** The National Quality Board recommend that there is a strategic multi-professional neonatal staffing review at least annually and that a mid-year review should also provide assurance that neonatal services are safe and sustainable. To achieve compliance the service is required to benchmark its workforce against the BAPM standards for both Neonatal Medical and Nursing staffing and share this position with the Board no later than 7 December 2023.
Key recommendations:	**Safety Action 9: The Perinatal Quality Surveillance Tool (PQST) August 2023** The Board to receive **ASSURANCE** that a monthly PQST report demonstrating full compliance in line with the Ockenden and Clinical Negligence Scheme for Trusts (CNST) standard requirements has been discussed at MNAG.

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	Maternity Dashboard August 2023 • Anaesthetic training compliance for PRactical Obstetric Multi-Professional Training (PROMPT) has improved to 83% but remains below the national standard of 90%. The CNMO and Medical Director will be meeting with Care Group leads to explore the plan for achieving this safety action. • The Care Group has a revised trajectory to achieve compliance with Safeguarding and Management and Supervision Tool (MAST) training. This is also a Care Quality Commission (CQC) must do action. **Safety Action 4: Medical Workforce** • The Board to **NOTE** the action plan in relation to neonatal workforce. In line with CNST requirements this will also be shared with the LMNS. • The Board to **NOTE** the Anaesthetic workforce paper, the impact of shortages on attendance at training and the lack of an identified Obstetric Anaesthetic Lead at WHH . These issues are both being progressed by the Medical Director.

Implications:

Links to Strategic Theme:	• **Quality and Safety** • **Patients**
Link to the Board Assurance Framework (BAF):	N/A
Link to the Corporate Risk Register (CRR):	N/A
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: MNAG 12 September 2023, and Quality & Safety Committee (Q&SC) 28 September 2023

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: ***Reading the Signals*** **Oversight Group: One year on from** ***Reading the Signals***

Meeting date: **5 October 2023**

Board sponsor: **Chief Strategy and Partnerships Officer (CSPO)**

Paper Author: **Executive Director Communications and Engagement**

Appendices:
NONE

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	To update the Board on work undertaken by maternity and neonatal services and wider Trust initiatives one year on from the publication of *Reading the Signals*, the independent report into maternity and neonatal services in East Kent.
Summary of key issues:	We have taken each of Dr Kirkup's key areas for action and adopted them as five of our seven organisational objectives, we call these: • Patient, family and community voices • Reducing harm and delivering safe services • Care and compassion • Engagement, listening and leadership • Developing our organisation. Our maternity service is working to embed the changes that are needed with families and staff to make continued and sustained improvement in care and outcomes for women, babies and their families. The lessons from Reading the signals also apply to the whole of our Trust and some of the work we are doing Trust-wide is also included in this report. We recognise there is much more we need to do, this work is ongoing and we are grateful to the families and colleagues from external organisations who are helping us with this work.
Key recommendations:	The Board of Directors are asked to discuss and **NOTE** the report.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and safety • Patients • Our people • Partnerships • Sustainability

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Link to the Board Assurance Framework (BAF):	**BAF 39:** There is a risk that women and their families will not have confidence in East Kent maternity services if sufficient improvements cannot be evidenced following the outcome of the Independent Investigation into East Kent Maternity Services (IIEKMS). **BAF 32:** There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered.
Link to the Corporate Risk Register (CRR):	**CRR 118:** There is a risk of failure to address poor organisational culture.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:
Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

ONE YEAR ON FROM *READING THE SIGNALS*

On October 19 2022, Dr Bill Kirkup published his independent investigation into maternity and neonatal care provided from 2009 to 2020 in East Kent.

The report was deeply shocking, it found that women, babies and their families had suffered significant harm and the experience they endured was unacceptably and distressingly poor. This went on for more than a decade.

The report highlighted care that repeatedly lacked kindness and compassion, both while families were in our care and afterwards, when families were coping with injuries and deaths. We did not listen to women, their families and indeed at times, our own staff.

The investigation found at least eight opportunities where the Trust Board and other senior managers could and should have acted to tackle these problems effectively. This was simply not good enough.

The consequences were devastating. Of the 202 cases that agreed to be assessed by the panel, the outcome for babies, mothers and families could have been different in 97 cases, and the outcome could have been different in 45 of the 65 baby deaths, if the right standard of care had been given.

The Trust Board has apologised unreservedly for the pain and devastating loss endured by the families and for the failures of the Board to effectively act. Losing a baby has an immeasurable impact on women and their families and whilst the Trust Board has apologised, the impact of these outcomes can never be altered and for this we are truly sorry. These families came to us expecting that we would care for them safely and compassionately, but we failed to do that. We accept all that the report says.

We also apologise to those within our communities. We are aware of the anxiety that these failings have caused among those who rely on our services.

We remain determined to use the lessons in Reading the signals to put things right, to make improvements and make sure that we always listen to patients, their families and staff when they raise concerns.

One year on from the publication of Reading the signals, the importance of the report and its findings remains just as profound and significant.

We have embarked on a journey to fundamentally transform the way we work. Changing the culture of a large and complex organisation takes time and there is much work to do, but we are determined to succeed so that we are providing the right standard of care and compassion to everyone who touches our services, every day.

This report describes the work we are doing, the improvements we have made and where we still have work to do.

We are grateful to everyone who has been involved in this work, has given feedback and has provided both challenge and encouragement. We look forward to continuing this work with you.

East Kent Hospitals University NHS Foundation Trust

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Background

In February 2020 the government health minister, Nadine Dorries MP, announced that Dr Bill Kirkup would lead an independent investigation of maternity services in East Kent.

The *Reading the signals* report identified four key areas for action:

- Monitoring Safe Performance
- Standards of Clinical Behaviour
- Flawed Team Working
- Organisational behaviour

There was also a specific recommendation for the Trust to accept the reality of the report's findings, acknowledge in full the unnecessary harm that has been caused and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

On receiving *Reading the signals* on 19 October 2022 we apologised unreservedly, publicly accepted all of the findings and gave a firm commitment to use the lessons within it to make the improvements needed to consistently deliver the safe and compassionate care local communities should expect, not just in maternity and neonatal services but across the entire Trust.

On 21 October 2022, the Trust Board held an extra-ordinary Board meeting attended both virtually and in person by families, members of the public and the media, formally accepted the report in full and committed to addressing the areas for action in the report and the recommendation for the Trust. The Trust also discussed the report and its findings in public meetings of its Council of Governors, local Health Overview and Scrutiny Committee and all subsequent public Board meetings.

In February 2023, we set out an interim response to the report which was published alongside an open letter of apology to the public and shared with every member of staff. These immediate, short and long-term actions, include improving how we listen to and involve patients and families and specific, focused work in maternity to improve safety, as well as wider work being taken forward across the Trust.

We have taken each of Dr Kirkup's key areas for action and adopted them as five of our seven organisational objectives, we call these:

- Patient, family and community voices
- Reducing harm and delivering safe services
- Care and compassion
- Engagement, listening and leadership
- Developing our organisation.

Our maternity service is working to embed the changes that are needed with families and staff to make continued and sustained improvement in care and outcomes for women, babies and their families. We recognise there is much more we need to do. This work is ongoing and we need to involve more people as we continue our work to develop safer and more compassionate services.

Our Maternity and Neonatal Improvement Programme (MNIP) was developed throughout Spring and Summer 2023 and involved bringing together people who use the service, the

maternity leadership team, all grades of midwifery, obstetric and neonatal staff, Kent & Medway Local Maternity and Neonatal System (LMNS), Maternity and Neonatal Voices Partnership (MNVP) and members of NHS England's regional maternity team to ensure it was truly co-produced. The programme was also benchmarked against, and aligned to, requirements of the recently published Three Year Single Delivery Plan for Maternity and Neonatal Services.

We are grateful to the families, and colleagues, who are giving their time to the Reading the Signals Oversight Group and for their challenge and involvement. The purpose of the group is to ensure there is appropriate engagement with patients, their families and the community to oversee, challenge and advise on how the Trust embarks and embeds the restorative process required to address the problems identified in the report.

Patient, family and community voices

Dr Kirkup's investigation found that we did not listen to women, families and at times our own staff, and this contributed significantly to the poor experience of families and in some cases to clinical outcomes.

We are working hard to change this in both our maternity and neonatal services and as a Trust.

To help us achieve this we have recruited a patient experience team specifically to work with women, birthing partners and families and staff to improve patient and staff experience. The team is made up of a professional midwifery advocacy lead, one patient experience midwife and two non-clinical patient experience administrators.

This year the maternity Patient Experience team has focused on embedding 'Your Voice is Heard', which is a feedback service unique to East Kent. This service was co-produced with our local Maternity and Neonatal Voices Partnership, families and a Trust governor.

The Director and Deputy Director of Midwifery have introduced *Walk the patch*, regularly walking around the units to listen to women and birthing people and directly hear about their experiences of their maternity care. By doing this they are also assessing that the environment is safe and clean, are observing what staff are doing well and what needs improving. They bring their feedback to the heads of midwifery and the matrons so it can be acted on quickly and/or included in staff training. The Maternity and Neonatal Voices Partnership will continue to take this work forward.

The team has also launched *Leave your troubles at our door*, as an additional patient experience service to provide women and birthing people in hospital with direct access to a senior member of the midwifery team, as someone to speak to if they wish to talk about their care. This is promoted through posters displayed on the wards.

We are increasing the ways we involve people who use our services, working with the Maternity and Neonatal Voices Partnership. We have much more work to do in this area. We are involving families in investigations from the outset; have co-produced our maternity and neonatal improvement programme and new pathways of care; and we are working with families directly involved in Dr Kirkup's investigation.

We want our service to be welcoming, safe, clean, friendly, calm and well organised. This Autumn the Maternity and Neonatal Voices Partnership will lead a '15-Steps challenge', which sees the service through the eyes of people who use it and what they see and

experience within 15 steps of entering a department. We invite service users and will use the feedback to inform improvements.

The age and quality of our buildings, and a lack of funding for our maternity and neonatal estate is an ongoing challenge. We are working with the Kent and Medway Integrated Care Board, local MPs and NHS England regionally to identify sources of funding to enable us to deliver the much-needed expansion and refurbishment of both maternity units.

Your Voice is Heard

Introduced in May 2022, this initiative is more than just a survey. People who use our maternity service are contacted by phone six weeks after discharge to discuss all aspects of their and their baby's care. Feedback from these follow-up calls is used to recognise what works well and identify where we need to make changes to improve people's experience.

So far, we have heard from more than 5,000 women who have given birth in our hospitals, and from their partners, too. We want everyone to have a positive experience of all aspects of their care and to be 'happy to return', we have a lot of work to do to reach this point. We are committed to using the feedback we have from this initiative and other methods to make the necessary changes to achieve this.

Some of the changes we have made are small but practical and important to people using our services, such as introducing soft-close bins to reduce noise on the postnatal wards, offering snack boxes and hot drinks for birthing partners and are trialling new sleeper chairs for birthing partners. We need to make sure these are consistently available.

Feedback has also been used to create a pain management working group, to understand and consider how we respond to the pain relief needs and options of our women and birthing people, including providing these in a timelier way.

We have reinstated home visits on the first day home from hospital and we are working with our system partners and the Patient Voice and Involvement team to listen to families about developing improved and accessible antenatal education. We need to do much more to improve people's experiences of postnatal care, including support for infant feeding, discharge processes and partner experiences; choice of place of birth; and consent and communication.

It is important that we also know where things are going well so we can build on them. More than 2,000 compliments from families have also been shared directly with staff. We are extending Your Voice is Heard to include the neonatal service this autumn and later this year, we will extend it further to include bereaved families, in addition to the support in place for them.

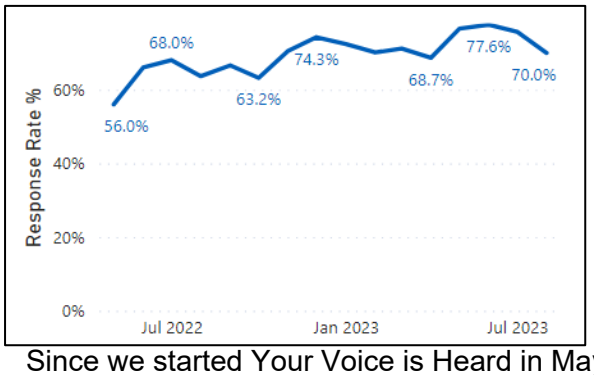
Your Voice is Heard is in addition to the Friends and Family Test surveys and is one of 12 ways we gather and use feedback in maternity. We review the feedback by ethnicity and deprivation to ensure we are hearing from people from a wide range of backgrounds.

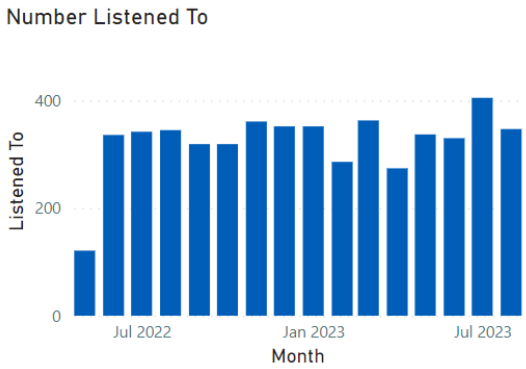
We also have feedback from other national surveys although the timeline for receiving the results is much longer. The latest annual CQC Maternity Services Survey, conducted in 2022 and published in January 2023, had a response rate of 51%. It showed East Kent maternity services as having lower than average scores for antenatal care and postnatal care and higher than average scores for patient experience during labour and birth.

We also work closely with and receive feedback from the Maternity and Neonatal Voices Partnership. We look at the themes coming from all the sources of patient feedback to understand what actions we need to take to co-produce improvements with our patients and families.

Your Voice is Heard data

We speak to between 300 and 400 people each month. In May 2022, our response rate was 56%, in August 2023 it was 70%.

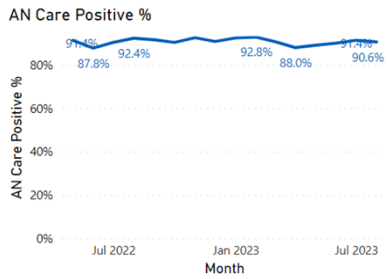


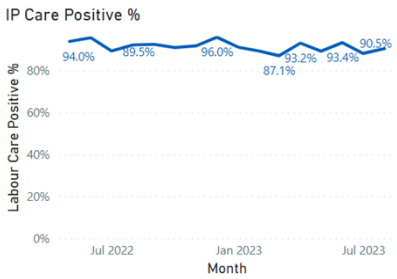


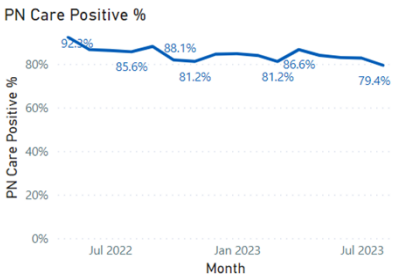
Since we started Your Voice is Heard in May 2022, the score for antenatal care was at its lowest at 87.8% in June 2022, it was 90.6% in August 2023.

Care on our labour wards was at its lowest at 87.1% in March 2023 and was 90.6% in August 2023.

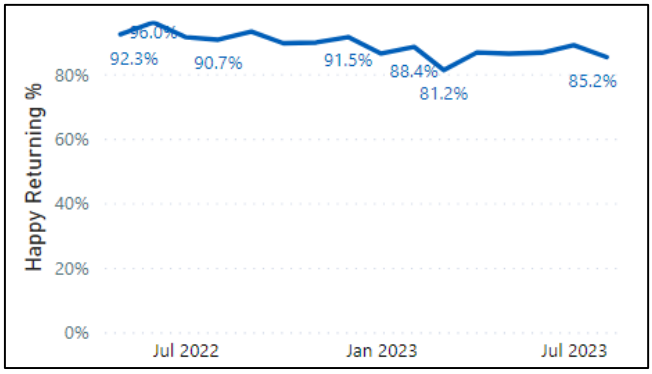
Postnatal care has declined from 92.3% in May 2022 and was at its lowest at 79.4% in August 2023.







The number of women ‘happy to return’ has declined from 92.3% to 85.2%.



East Kent Hospitals University NHS Foundation Trust

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Our framework for listening, involving and acting on feedback

NHS
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The Maternity Patient Voice Vision: *'To hear valuable feedback from women about their maternity care and use their experiences to support the continuous improvement of the quality of our maternity services'*

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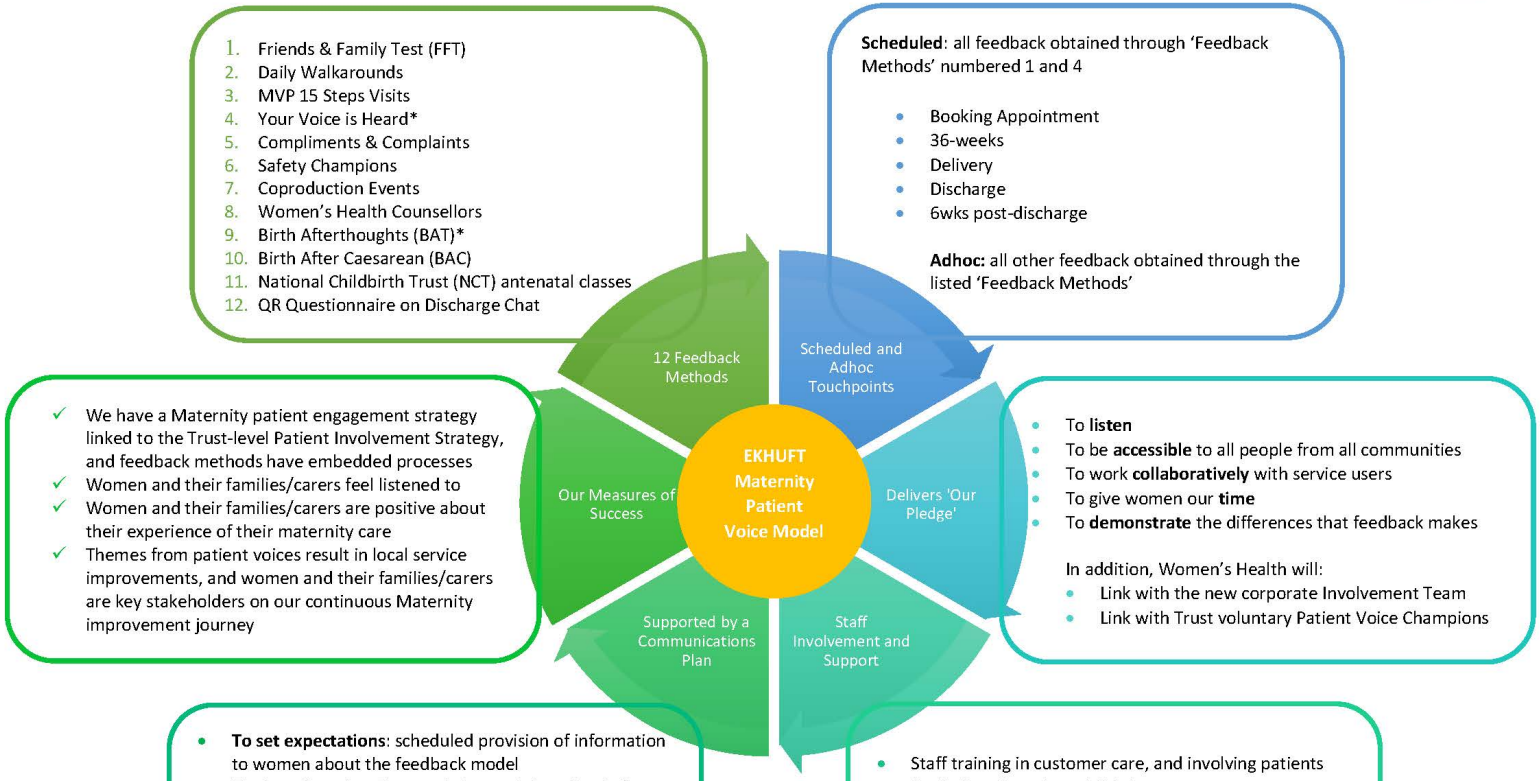

East Kent Hospitals University NHS Foundation Trust

Changes across our Trust: Patient Voice and Involvement

The lessons within *Reading the signals* apply as much to the rest of our Trust and all our services, as they do in maternity. Within the wider Trust, we have recruited a new patient voice and involvement team to help us involve patients and our communities in our services. The team has been in place for 12 months and we are at an early stage of this work.

There are patient involvement officers, based at our three acute hospitals in Ashford, Canterbury and Margate, who's role is to reach out to local communities and voluntary, community and social enterprise organisations to reach people who may not often get a chance to have their voice heard For example, the feedback from this team and their engagement activities is being used to improve equity and access to care, by addressing people's accessibility needs for example, translation and interpretation services, adapted reading levels for all published documents and alignment to the Accessible Information Standard.

People can get involved on a voluntary basis by becoming a Participation Partner. Participation Partners get involved in a range of activities – everything from being a member on a Trust group or committee, to being on an interview panel or supporting staff training.

The Patient Participation and Action Group (PPAG) holds us to account for implementing the Patient Voice and Involvement Strategy. The group is co-chaired by a Participation Partner and the Head of Patient Voice and Involvement, and a Non-Executive Director attends as the Board Champion for Patient Voice. Membership of the group is 50% people who use our services or are carers or family members, 30% voluntary community and social enterprise sector representatives and 20% EKHUFT staff.

Reducing harm and delivering safe services

Dr Kirkup's investigation identified unacceptable, poor clinical care in our maternity service. We are committed to providing the safe care that our communities need and deserve.

Despite the commitment and hard work of our staff, when the Care Quality Commission (CQC) inspected our maternity service in January 2023, they very disappointingly found that the Trust was not consistently providing the standards of maternity care women and families should expect.

We acted at once to respond to the CQC's concerns. For example, by increasing doctor cover in the triage service at William Harvey Hospital and introducing additional training and electronic alerts for staff when a fetal monitoring check is due.

Other immediate changes included improving access to and regular checking of emergency equipment and increased cleaning of the environment and the equipment. We continue to monitor these standards daily, alongside hand hygiene and PPE compliance. Data is collected on a weekly basis and presented on a scorecard that is monitored internally by the Director and Deputy Director of Midwifery and shared with the CQC on a monthly basis.

To improve the safety of our triage service, we have implemented the Birmingham Symptom Specific Obstetric Triage System. The system is designed to ensure women and birthing people are assessed promptly on arrival at either of our maternity units and triaged appropriately according to their clinical need. The aim is for everyone to be assessed within 15 minutes and given a clinical priority using a recognised colour coding system so that people with the most urgent need(s) are treated first.

The timeliness and assessment of the triage service is monitored, to ensure patients are being cared for appropriately. The number of women and birthing people being seen on time by a midwife has increased from 97.3% in October 2022 when the system was implemented to 99.1% in August 2023.

To improve the quality and safety of care we have invested to increase the numbers of midwives and doctors, including specialist roles. However, filling vacancies has remained challenging this year, particularly in midwifery at William Harvey Hospital. To support our recruitment drive, we have recently appointed ten internationally educated midwives. Once their training is completed they will be added to our rosters to increase our midwifery establishment and capacity.

We are also working on development opportunities to upskill our existing workforce, including the NHS Health Education England Maternity Support Worker Competency Framework to upskill the maternity support workforce and provide a clear pathway for career progression.

Midwifery staffing challenges have meant we have been unable to offer women and birthing people the Singleton Midwife-led Unit at William Harvey Hospital as a place of birth. This unit is due to re-open later in the Autumn 2023, offering more choice to women in relation to their preferred place of birth.

To ensure we have the right staff in the right places, we use a workforce acuity tool supported by a live tracker to make sure staff are where they are most needed. In September 2022, staffing met acuity needs 55.7% of the time. This figure fluctuated through to February 2023, after which we saw a steady increase up to 73.5% in July 2023.

When insufficient workforce numbers and skill mix cannot meet safe staffing requirements, there are escalation processes available, such as the divert of services to alternative unit(s) to safeguard women and their babies. Over December 2022 and January 2023 there were nine incidents of unit diverts and by August 2023 this had reduced to 0 for the second consecutive month.

In February 2023, student midwives were removed from their placements at William Harvey Hospital due to mounting concerns about how the safety issues identified by CQC and others, including concerns with fetal monitoring, escalation of concerns and checking of equipment, were impacting on the effectiveness of the learning environment. In May, the Nursing and Midwifery Council (NMC) withdrew its approval for the midwifery programme at Canterbury Christ Church University due to broader concerns and students were removed from all Kent and Medway placements.

We have been working closely with the University of Surrey to enable student midwives to return and we are delighted to be welcoming back midwifery students to the Trust in the autumn. We have increased the practice development team and systems for student support and supervision. We are increasing the ways students can raise concerns about their clinical placement.

We will continue to work with the NMC and the University of Surrey to ensure the standards students require in order to became safe and effective registered midwives are being met. Students on clinical placement with us are not counted in our staffing numbers, but they are an important part of our team and for our future workforce.

Regular staff training and reflection on clinical practice is a crucial part of delivering safe services. We have launched a staff Safety Summit to share key safety learning with staff,

twice a month. At this forum cases are discussed, themes and learning identified and solutions discussed and shared.

We have also introduced five key ways to regularly share learning across maternity:

- 'Hot Topics' that require immediate dissemination
- 'Safety Threads' used in safety huddles and handovers
- 'Lunch and Learn' sessions to share learning in a relaxed space
- Monthly 'Safety Summit' with Board maternity safety champions, Chief Nursing and Midwifery Officer and Non-Executive Director
- 'We Hear You' and twice-monthly consultant forums, which give staff direct access to the senior leadership team.

We are changing the way we monitor patient safety and our clinical performance, articulated in the *Reading the Signals* report as 'finding signals among noise'. We use statistical process charts which plot data over time to help us understand variation and to help us take the most appropriate action. The format of our data is based on best practice, has been externally reviewed and welcomed by NHS England.

Changes across our Trust: Call 4 concern

The national initiative 'Call 4 concern' is being piloted at William Harvey Hospital by our Critical Care Outreach Team (CCOT) who manage this service. It is a scheme where patients and relatives can call the team directly if they are concerned about a patient's condition.

Posters and leaflets are provided in and outside ward areas across the hospital giving information and the contact number for the service. Patients and/or carers and relatives can contact the team directly or ask a member of staff for the information. Since the pilot was introduced in July 2023 the service has received nine calls.

If a patient/relative has unresolved concerns, CCOT staff liaise between the patient and or carer/relative and the team/ward staff. The pilot will be evaluated before rolling out more widely.

Saving babies lives

Saving Babies Lives is a government ambition under to achieve a national 50% reduction in stillbirth and neonatal mortality by 2025, from 2010 figures. To achieve this the stillbirth rate in the UK would need to decrease to 2.6 stillbirths per 1000 total births and neonatal mortality to 1.2 neonatal deaths per 1,000 total births.

Stillbirths and neonatal deaths are measured by MBRRACE-UK. Every year MBRRACE-UK produces a "Perinatal Mortality Surveillance" report which provides rates for all stillbirths over 24 weeks and all neonatal deaths, when the baby was born alive after 24 weeks gestation, but died before 28 days of age.

Rates vary between hospitals, particularly if those hospitals care for larger numbers of babies or very sick babies. MBRRACE-UK use the number of babies born in an organisation, as well as whether they have a neonatal intensive care unit or facilities for surgery for new born babies, in order to group together similar Trusts.

The latest nationally-published MBRRACE data (for the year 2021) shows that in 2021, the rate of stillbirths and neonatal deaths in East Kent in 2021 was 5.99 per 1,000 births. The average for similar trusts was 5.87.

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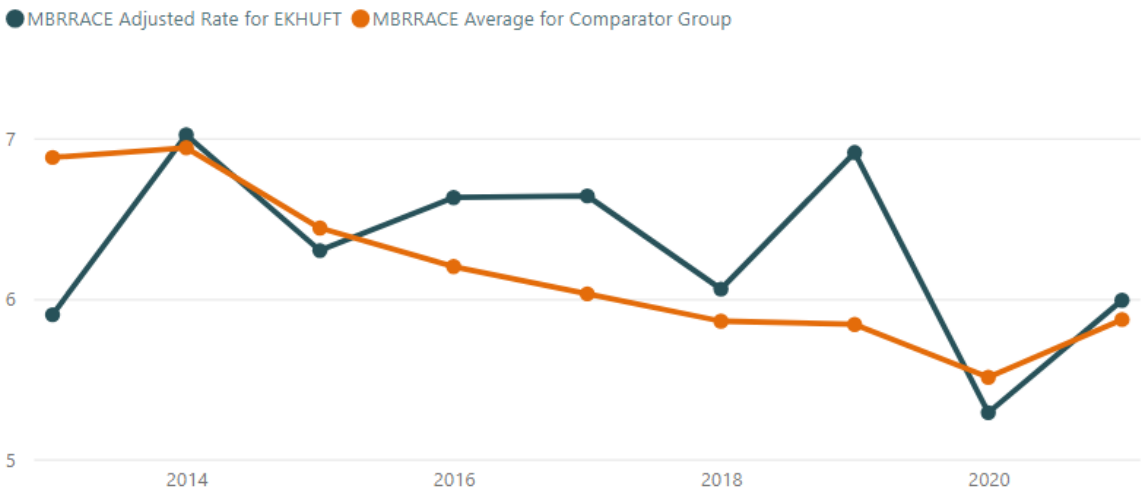
MBRRACE adjusted rate for East Kent and MBRRACE average for comparator group by birth year



The neonatal death rate in East Kent for 2021 was 1.88 per 1,000 births, compared with an average for similar trusts of 1.96.

The stillbirth rate for 2021 was 4.11 per births, compared with an average for similar trusts of 3.92.

The tables below show the number of stillbirths and neonatal deaths at our Trust since 2013, alongside the MBRRACE-UK rates.

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Birth Year	Stillbirths	Births	EKHUFT Crude Stillbirth Rate	MBRRACE Crude Rate for EKHUFT	MBRRACE Adjusted Rate for EKHUFT	MBRRACE Average for Comparator Group
2008	40	7,414	5.40			
2009	36	7,328	4.91			
2010	42	7,480	5.61			
2011	27	7,373	3.66			
2012	36	7,530	4.78			
2013	24	7,039	3.41	3.58	4.28	4.75
2014	31	7,000	4.43	4.85	5.01	4.98
2015	22	7,062	3.12	3.66	4.31	4.41
2016	27	6,953	3.88	3.70	4.12	4.11
2017	21	6,973	3.01	2.72	3.82	3.95
2018	27	6,571	4.11	3.80	4.00	3.95
2019	27	6,413	4.21	4.20	4.07	4.01
2020	20	6,127	3.26	3.60	3.84	3.81
2021	25	6,213	4.02	4.18	4.11	3.92
2022	25	6,246	4.00			

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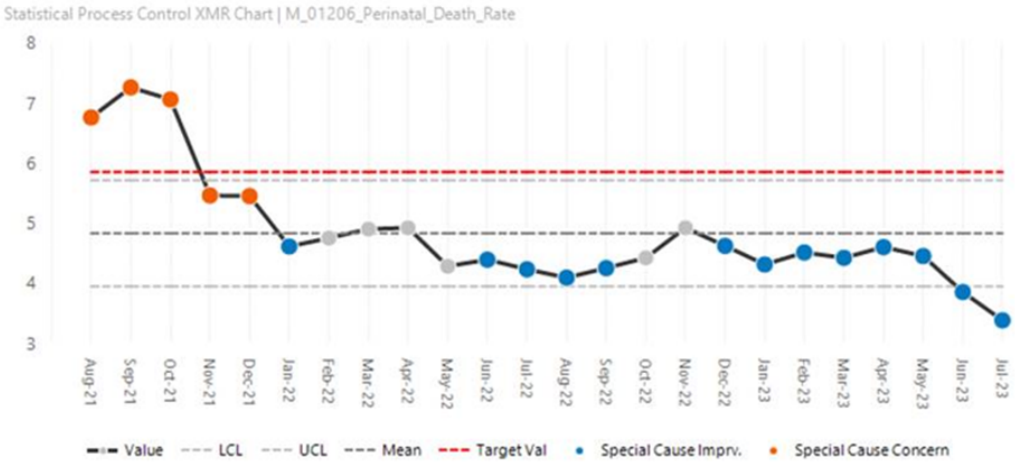
Birth Year	Neonatal Deaths <28 days	Livebirths	EKHUFT Crude Neonatal Death Rate	MBRRACE Crude Rate for EKHUFT	MBRRACE Adjusted Rate for EKHUFT	MBRRACE Average for Comparator Group
2008	19	7,374	2.58			
2009	14	7,292	1.92			
2010	13	7,438	1.75			
2011	12	7,346	1.63			
2012	12	7,494	1.60			
2013	10	7,015	1.43	1.29	1.95	2.09
2014	14	6,969	2.01	1.86	1.93	1.97
2015	14	7,040	1.99	1.62	2.01	2.04
2016	20	6,926	2.89	2.57	2.53	2.10
2017	21	6,952	3.02	3.01	2.84	2.09
2018	11	6,544	1.68	1.68	2.08	1.92
2019	19	6,386	2.98	2.97	2.99	1.84
2020	7	6,107	1.15	0.99	1.56	1.71
2021	9	6,188	1.45	1.45	1.88	1.96
2022	4	6,221	0.64			

Extended perinatal mortality

The chart below shows the number of all stillbirths and neonatal deaths recorded in East Kent in the last year (August 2022 to July 2023).

Month	Value
Aug-22	4.11
Sep-22	4.27
Oct-22	4.44
Nov-22	4.94
Dec-22	4.64
Jan-23	4.33
Feb-23	4.53
Mar-23	4.44
Apr-23	4.62
May-23	4.47
Jun-23	3.87
Jul-23	3.40



In August 2023, East Kent had 2.56 stillbirths per 1,000 and 1.03 neonatal deaths per 1,000. Our perinatal mortality cases are reviewed by expert panels, with independent expert review, using the national Perinatal Mortality Review Tool.

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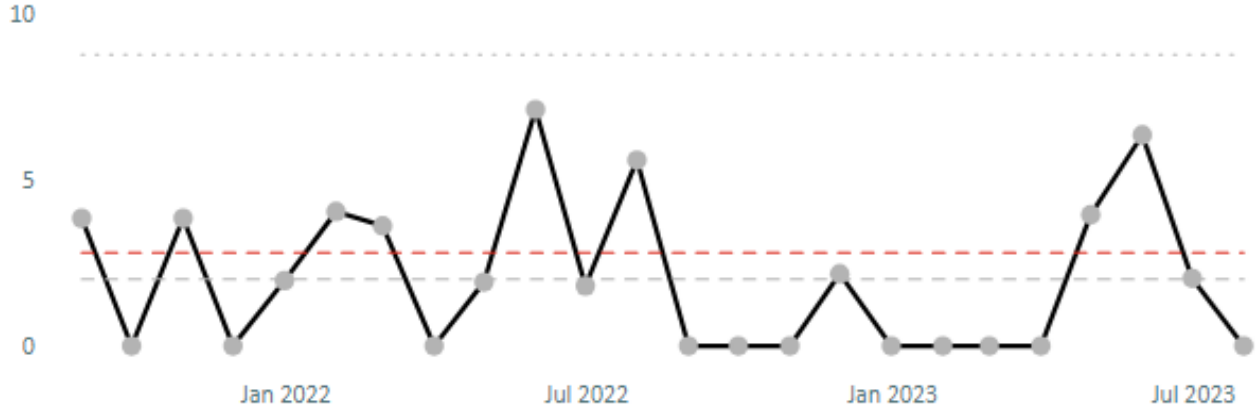
Hypoxic Ischemic Encephalopathy (HIE)

Hypoxic Ischemic Encephalopathy (HIE) - moderate or severe brain damage. The target range is 2.4- 2.8 per 1,000 live births. Between September 2022 and August 2023, the overall average for East Kent has been 2 cases per 1,000 live births. There were no cases In August 2023.



East Kent Hospitals University NHS Foundation Trust

Care and compassion

The importance of providing compassionate care, not just clinical care, was a theme running through the entire *Reading the signals* report. We had failed families by not being compassionate when they needed us most.

We have co-produced a new bereavement care model in our maternity and neonatal service with families who wanted to ensure other families did not experience a lack of care and compassion. Specialist bereavement midwives have worked with families and the Saving Babies Lives charity (SANDS) to improve and expand the emotional and practical support available to families who have tragically experienced baby death or severe injury or illness.

This seven-day service model includes continuity of carer for women and their families during a bereavement but also through any subsequent pregnancies, labour and delivery.

The next step in the remodelling of our bereavement service is the relocation of the Twinkling Stars bereavement suite (a dedicated area for families) at William Harvey Hospital to a location which provides improved privacy with its own access so that women, babies and their families can be cared for in a more considerate and suitable setting.

There is evidence that a positive working culture improves the safety and quality of care for service users. We have included caring with compassion and respect in routine staff training for maternity and neonatal staff. For example, we have adopted 'Civility Saves Lives', a national project aimed at promoting kindness and respect within teams, based on evidence about the impact this has on patient safety. Colleagues in different roles and from different departments come together to learn about how the way we behave impacts one another, and the way we make decisions.

As part of the work to improve the culture in maternity services, service leaders are enrolled onto the NHS Perinatal Culture and Leadership Programme. The next step for the programme will be a culture survey, which is to be issued across maternity and neonatal services in October 2023. Results of the survey will be shared back with care group senior leaders and, with support of an external culture coach for each acute hospital, an internal change team will be formed to identify and implement solutions for a culture that harnesses better outcomes and experience for service users and our workforce. This is independently facilitated and will involve service users in any areas for improvement, including working with the Maternity and Neonatal Voices Partnership.

Changes across our Trust: caring with compassion training

We recognise that the lessons within *Reading the signals* apply as much to the rest of our Trust and all our services as they do in maternity and we need to provide care that is more compassionate. We launched a caring with compassion video in May 2023, which is now part of mandatory training for all Trust staff. The video was developed by the Supportive and Palliative Care Team and was funded by the East Kent Hospitals charity. The film follows the experiences of 'Peter' and his family in the last days of his life, and is a powerful reminder of the importance of recognising and responding to the holistic needs of the people using our services.

From March, we have provided a monthly session for Health Care Support Workers focused on 'Seeing the Person'. Eighty Health Care Support Workers have participated to date, with feedback being very positive about how they can understand the vital role they play in every patient's experience.

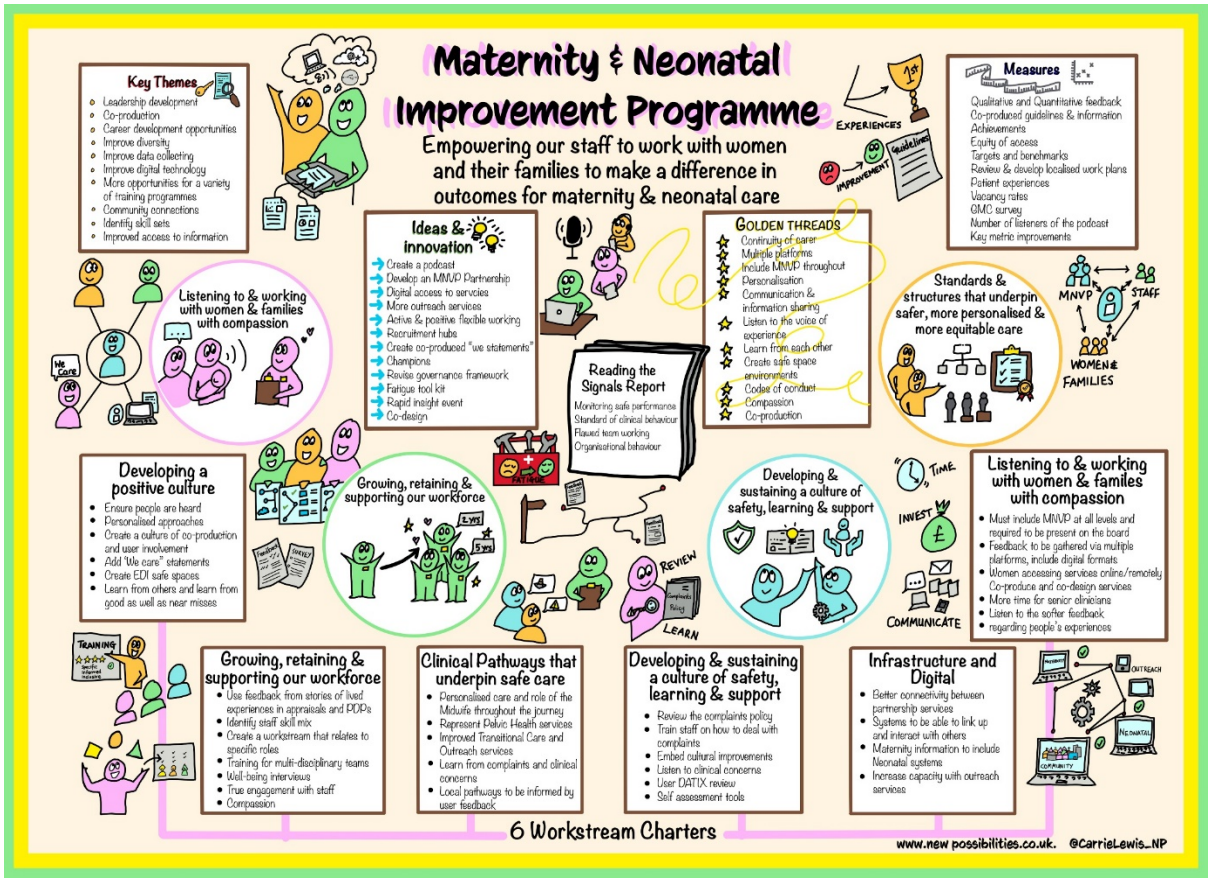
East Kent Hospitals University NHS Foundation Trust

Engagement, listening and leadership

We want to have effective, embedded ways of listening to and involving staff, patients and our partners in decisions about services.

We recruited a new experienced, substantive Director, and Deputy Director of Midwifery, who started in post in mid May 2023 to strengthen maternity leadership and support further improvements to the service across the Trust.

The new maternity and neonatal leadership team has worked with families, staff and partners to co-produce a Maternity and Neonatal Improvement Programme for East Kent. This included a 'We hear you' engagement day, held in June, which brought together people who use the service, the maternity leadership team, obstetrics, maternity and neonatal staff, the Kent and Medway Local Maternity and Neonatal Service, Maternity and Neonatal Voices Partnership and members of NHS England's regional maternity team to co-produce the vision for the programme. The next engagement day will take place later this year.



A visual synthesis of outputs from the event.

The programme has six priority areas, each with executive oversight, approved by Trust Board in September 2023:

1. Developing a positive culture
2. Developing and sustainable culture of safety, learning and support
3. Clinical pathways that underpin safe care

4. Listening to and working with women and families with compassion

5. Growing, retaining and supporting our workforce

6. Infrastructure and digital.

This programme incorporates work developed in March following the publication of the *Reading the Signals* report in October and the Care Quality Commission (CQC) inspection in January 2023. It also reflects the national Three-Year Single Delivery Plan for Maternity and Neonatal Services published in May 2023 – a plan that sets out how the NHS will make maternity and neonatal care safer, more personalised and more equitable.

We recognise the importance of staff feeling listened to, and having easy access to a senior leader if they have any concerns. The leadership team have introduced *We Hear You* which gives staff direct access to the Director and Deputy Director of Midwifery, and twice-monthly consultant meetings for colleagues to meet and discuss any concerns they have with the associate medical director for women's health as well as the clinical leads from each hospital site. These forums are in addition to regular multi-disciplinary patient safety meetings.

Across our Trust:

Strengthening our Freedom to Speak Up support

We want to create an organisational culture which feels psychologically safe enough to speak up, learn and improve in, to do this we have expanded our Freedom to Speak Up (FTSU) team by appointing four dedicated FTSU guardians across the Trust, one specifically for maternity.

It is important that where staff have concerns they are reporting it, so we can learn and take action. We have actively promoted access to this team and we have seen a threefold increase in people across the Trust contacting the FTSU guardians in 2022/23 compared with 2021/22. As well as resolving individual issues, feedback is being used in mandatory training and with other information to identify and support areas of risk. Freedom to Speak Up activity is confidentially reported into the Maternity and Neonatal Assurance Group, and directly into the Trust Board.

At the end of 2022, we launched ‘Connectors’ across the Trust – a growing network of staff who are trained on a voluntary basis to support their peers and colleagues with any concerns they have at work. Connectors are trained to listen and help staff identify their next steps, which can include raising concerns.

Implementing the culture and leadership programme

As part of the commitment to nurture compassionate leaders and effective teams that work well together, the Trust is adopting NHS England’s Culture and Leadership Programme developed by the Kings Fund. This programme has been introduced elsewhere in the NHS and there are proven links between compassion in healthcare and outcomes for patients. It is aimed at all levels in the Trust and recruited more than 100 change champions across the Trust in Summer 2023 who are supporting this work.

This national programme is currently in its diagnostic phase, with change team members organising staff forums and interviewing Board members as part of gathering feedback on culture and behaviours from staff across the organisation.

East Kent Hospitals University NHS Foundation Trust

Developing our organisation

We want to have effective governance processes which create link throughout the organisation, from frontline staff to the Board, where partnership working is embedded and effective, and leadership is open to challenge.

We established the Maternity and Neonatal Assurance group, chaired by the Chief Nursing and Midwifery Officer and attended by the non-executive director maternity champion (a senior clinician). The group reports monthly to the Quality and Safety Committee and directly to the Trust Board quarterly and is attended by multiple stakeholders, including the Maternity and Neonatal Voices Partnership. It provides specific oversight of maternity and neonatal services, including training compliance, the monthly maternity dashboard, maternity and neonatal improvement programme, progress against Clinical Negligence Scheme for Trusts (CNST), Ockenden and CQC actions.

We have implemented the nationally-required role of the Maternity and Neonatal Safety Champion. Our seven multi-disciplinary Maternity and Neonatal Safety Champions are promoted across the units, as a point of reference and contact for the workforce, our families and stakeholders.

We have reviewed governance in maternity and developed a maternity risk management strategy in 2022. To support improved governance systems of control across maternity, we appointed several specialist roles, including a head of governance, patient safety matron, a quality governance and education matron and a compliance midwife.

We are working with our partners across the health and social care system in Kent and Medway, to share our learning across the region and to learn from others.

Across our Trust: organisation restructure to enable delivery of safe, high quality and timely services

We have reviewed how our care groups (each responsible for the management of a number of clinical services) are structured and have implemented the first phase of a restructure to enable the delivery of safe, high quality and timely services. The new structure is organised around patient ‘pathways’ to improve our ability to provide seamless care across the Trust and improve governance across the Trust.

A new governance framework will be used at all levels of the organisation and sets out the Trust’s approach to ensuring that roles, responsibilities, reporting and escalation lines are clear and that there are robust systems of governance and accountability in place at all levels to safeguard patients and carers from harm, ensure the care provided by the Trust is in line with regulatory and statutory requirements and provide an effective line of sight from place of care to Board.

East Kent Hospitals University NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (BoD)

Report title: **Serious Incident (SI) Report**

Meeting date: **5 October 2023**

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

Paper Author: **Acting Joint Head of Patient Safety**

Appendices:

Appendix 1: SI Report

Executive summary:

Action required:	Assurance
Purpose of the Report:	This report is to enable the BoD to have greater oversight of all Patient Safety Incidents that have occurred in the Trust during the month of August 2023 and take assurance that these have been/are being managed in accordance with the NHS England (NHSE) Serious Incident Framework and that lessons have been learned and shared.
Summary of key issues:	Assurance of the efficacy of the overall incident management and Duty of Candour (DoC) compliance processes were previously reported to the Clinical Executive Management Group (CEMG) as part of the monthly Quality Governance Compliance Report (QGCR) and quarterly via the Quality and Safety Committee (Q&SC). Following a recommendation by the chair of the Q&SC and subsequent discussion at the BoD meeting held in private in September 2023, it was agreed that the BoD would receive this report every month. • In August 2023 the Trust declared 12 Serious Incidents (SIs). • None of these 12 incidents are being investigated by the Healthcare Safety Investigation Branch (HSIB). • In August the Trust held 18 SI Declaration Panels and four SI Investigation Approval Panels, the purpose of these panels is described in the body of the report. • As of the 31 August 2023 the Trust had 69 open SIs, 55 (80%) are under investigation and 14 have been submitted to the Integrated Care Board (ICB) for closure. Two of these SI breached the 60 day date or their extension date, one of which was declared prior to 1 April 2023. The one breach post April is the first SI breach since the new process was introduced on 3 April 2023.

We care

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	• A DoC update is now included in this report. During August there were 18 cases for which DoC applied with 100% compliance for the Verbal and follow up letter elements.
Key recommendations:	It is recommended that the Board of Directors **REVIEW** and **DISCUSS** the information contained within this report and takes assurance of the efficacy of the overall incident management and DoC compliance processes in place within the Trust.

Implications:

Links to 'We Care' Strategic Objectives:	• **Quality and Safety** • **People**
Link to the Board Assurance Framework (BAF):	BAF33: There is a risk of failure to adequately resource, implement and embed effective governance processes throughout the Trust.
Link to the Corporate Risk Register (CRR):	CRR 107: Inability to embed learning from incidents, complaints and claims across the Trust. CRR 118: There is a risk that the underlying organisational culture impacts on the improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace CRR133: Patients will not be informed of incidents where the Trust may have caused/contributed to harm (DoC). This risk has recently been deescalated and is now risk CRR 2799 on the Quality Governance Risk Register.
Resource:	N
Legal and regulatory:	Yes. The Trust is required to comply with NHSE Serious Incidents Framework.
Subsidiary:	N

Assurance route: Previously reported to Patient Safety Committee 02/10/2023 and the Clinical Executive Management Group on 04/10/2023

We care

East Kent Hospitals University NHS Foundation Trust

Serious Incident REPORT

September 2023 (August Data)

By
Acting Joint Head of Patient Safety and Improvement

Executive Sponsor
Chief Nursing and Midwifery Officer

CONTENTS

Patient Safety Incidents

The Trust is committed to ensuring the safety of everyone who uses its services and to improving the quality of care to patients. EKHUFT recognises the importance of reporting all incidents as an integral part of the risk management strategy, and follows the current national frameworks in understanding why an incident has occurred. Learning from reported incidents can improve patient experience and quality of care, lessons can be learnt and shared across the organisation to prevent recurrence and reduce the risk of harm. This report has maintained the Care Groups as they were prior to 14/08/2023 but will transition to the new Care Groups from 01/09/2023.

THE FIGURES

AUGUST 2023

2339 Patient Safety Incidents

85% of 2744 total incidents reported

THE HARM

	AUGUST 2023
No Harm	1428
Low Harm	877
Moderate	23
Severe	6
Death	3
Harm ungraded (under review)	2
TOTAL	2339

The figures for this report are collated on 01/09/2023 and at that time there were 3 deaths reported on Datix in August:

1. Death possibly related to the insertion of a Percutaneous Endoscopic Gastronomy (PEG) tube. Escalated to Serious Incident Declaration Panel (SIDP) for discussion.
2. Surgical site infection (SSI) possibly contributing to death (reported on Strategic Executive Information System (STEIS)).
3. Missed diagnosis of an historic case of delay in identifying lung cancer in 2017 as X-Ray was not reported on. Case discussed at SIDP and did not meet StEIS criteria due to changes in practice since 2017).

Serious Incidents Reported on the Strategic Executive Information System (StEIS) by Category

SIs declared in August 2023

CATEGORIES OF HARM on StEIS
01/08/23 – 31/08/23

	No harm	Low	Moderate	Severe	Death	Total
Diagnostic incident including delay	0	0	0	1	0	1
Healthcare Associated Infection (HCAI)/Infection control incident	0	1	0	0	4	5
Pressure ulcer	0	0	1	0	0	1
Slips/trips/falls	0	0	0	1	0	1
Sub-optimal care of deteriorating patient	0	0	1	0	1	2
Surgical/invasive procedure incident	0	0	1	1	0	2
Total	0	1	3	3	5	12

**Please note: Table above shows incidents reported on StEIS from 1 to 31 August 2023, hence death figures are not comparable with those from the table on page 3, which shows incidents reported on Datix in August 2023. Only 1 of the deaths reported on Datix has been reported on StEIS during the same month; the remaining 4 Serious Incidents were reported on Datix in March and July 2023.*

Serious Incident Investigations

(Process and Overview)

When an incident is identified that is significant in nature, significant in terms of potential learning and potentially reaches the threshold for declaring as a Serious Incident, it is presented by the Care Group Governance Team and the representing clinician at the SIDP which is chaired by either the Chief Nursing and Midwifery Officer (CNMO), Chief Medical Officer (CMO) or the Director of Quality Governance (DQG) on a daily basis Monday – Friday as required.

The Care Group Governance Team identify an Investigation Lead from senior medical, nursing or appropriate other senior professional, and facilitate a meeting to review the incident with the facts available using the current Root Cause Analysis templates. The investigation will identify a Root Cause, prepare an SI report and develop an Action Plan alongside any actions already commenced or completed since the incident occurred. The completed report is scheduled for the Serious Incident Investigation Approval Panel 2 weeks before it is due to the Integrated Care Board (ICB) at which the CNMO, CMO and Director of Quality Governance to quality assure the report, make recommendations for changes or approve the report for ICB submission. The Care Group Governance Team and Investigation Lead attend this meeting.

In August 2023 there were 18 SIDP (SI opening) meetings and 4 SIIAP (SI approval) meetings.

Six Serious Incident reports were submitted to the ICB in August of which 2 had extensions granted and were submitted before the new date breached, 1 breached the target date (but was reported on StEIS in January 2023).

INVESTIGATIONS Declared/Agreed

Activity and performance in August 2023

Non-SI investigations commenced during August 2023

(Investigations overview by type)

Investigation type	No.		Incident category
After Action Review (AAR)	6	1	Care / treatment
		1	Clinical assessment
		1	Communication / behaviour
		1	Delay / failure
		1	Patient fall
		1	2gether Support Solutions Service issues
Cancer 104-day Harm Review	0		
Clinical Case Review	1		
Infection Prevention and Control Root Cause Analysis (IPC RCA)	0		
Mortality and Morbidity (M&M) review, Perinatal Mortality Review	0		
Patient Safety Incident Investigation Report (PSIIR)	0		
Structured Judgement Review (SJR)	0		
Thematic review	0		

After Action Review (AAR) is a shorter investigation process than the comprehensive SI report and aims to capture maximum learning in a timely way. A standard template is used.

Clinical Case Review The Trust is in the process of designing a Clinical Case Review Form so that clinicians can capture salient contributing factors in an incident to elicit timely learning and clear outcomes.

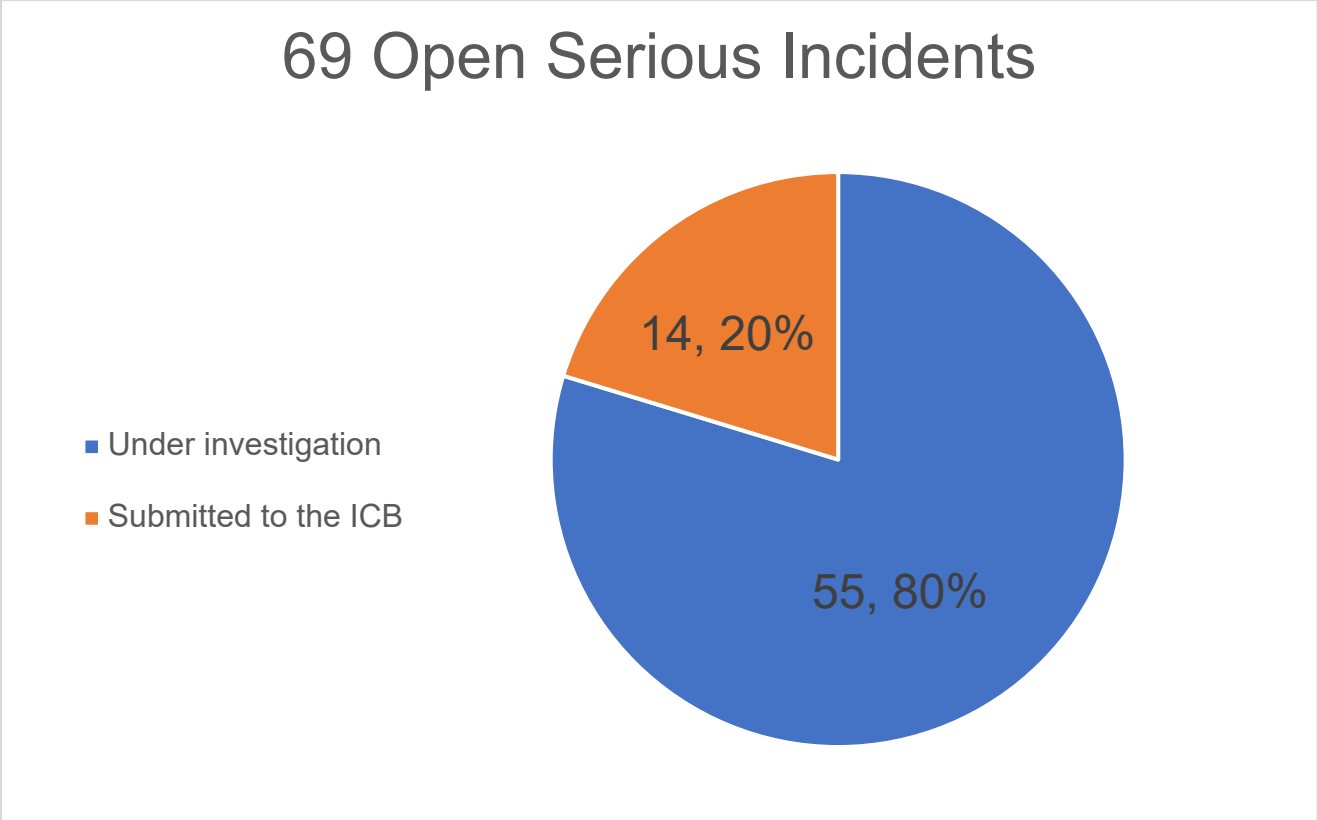
Cancer 104-day Harm Review: Any patient exceeding 104 days on a cancer pathway is subject to a clinically led investigation of potential harm which is known as a clinical harm review (CHR). This applies to all specialities managing patients on cancer pathways.

Mortality and Morbidity (M&M) review and Perinatal Mortality Review: Clinically led, multidisciplinary review of care to identify learning. External review is required for Perinatal Mortality Review.

Structured Judgement Review blends traditional, clinical-judgement methods with a standard format. The approach requires trained reviewers to make safety and quality judgements over phases of care and to make explicit written comments about care for each phase and to score for each phase to identify if appropriate care was given throughout.

Thematic review uses a specific methodology to identify patterns and themes within data, both quantitative and qualitative. Learning is drawn from the themes.

Total number of open Serious Incidents per Care Group as at 31 August 2023.



Of the 69 open Serious Incidents, 14 have been submitted to the ICB (6 in August 2023 and 8 prior to August 2023).

Of the 55 under investigation: 42 are not yet due, 11 have Non-closure requests (NCRs) pending and 2 cases have breached.

Care Group	Total number of open SI's
Children's Services	1
Clinical Support Services (Care Group)	4
Corporate	2
General and Specialist Medicine (Care Group)	15
Surgery - Head and Neck, Breast and Dermatology (Care Group)	2
Surgery and Anaesthetics (Care Group)	17
Urgent and Emergency Care (Care Group)	11
Women's Services	17
TOTAL	69

Never Events

There were no Never Events reported in August 2023 on StEIS or Datix

Duty of Candour

Between 1 August and 31 August 2023 using the Duty of Candour documented on Datix, a total of 33 moderate, severe or death harm incidents (or declared as a Serious Incident) required Duty of Candour. Of these, 18 have been documented as fully meeting all three elements of the criteria for Duty of Candour and demonstrating 100% compliance for all relevant cases.

The remainder needed further investigation or harm review against the criteria to either downgrade or uphold and undertake the Duty of Candour as appropriate.

Care Group	No of incidents where DoC is documented as applying	Face to Face or phone call completed within 10 days	Face to Face or phone call not completed within 10 days	Letter of apology sent	Where Investigations have been submitted to ICB, findings shared via DoC process.
Children's Services	1	1	0	1	0
GSM	7	7	0	7	0
SHNBD	2	2	0	2	1
SA	4	4	0	4	1
UEC	2	2	0	2	0
Women's Services	2	2	0	2	0
Total	18	18	0	18	2

On 18 August 2023 an addition was made to the Duty of Candour section of Datix to clarify a telephone call communication should be considered as an appropriate verbal Duty of Candour. This has ensured all verbal Duty of Candour is captured in the metrics.

Learning from Incidents

Of the 6 cases closed by the ICB this month there are 2 Safeguarding thematic reviews. The learning from these reports will be shared amongst the clinical teams but are not suitable for this section of the report.

Below are 2 examples of completed SI investigations which have been closed by the ICB. The cases below have been anonymised as far as possible to make appropriate for sharing in a public forum.

WEB247641
The Incident
This incident was the delay in diagnosis and treatment of Age-Related Macular Degeneration for a patient who had been referred for assessment in 2016.

The patient was referred to EKHUFT outpatient services by community opticians due to concerns for their vision. The patient was added to the Ophthalmology waiting list however this was not appropriately followed up and the patient has suffered irreversible eyesight loss.

The Findings:
The investigation found that there was a missed opportunity to provide an earlier diagnosis of Age Related Wet Macular Degeneration (AMD) which led to a delay with instigating earlier treatment to prevent permanent eyesight loss.

The patient's demographics were not updated when the referral was received. It is assumed that the team responded to the referral without cross checking the demographics. However, it has not been possible to determine when or how this occurred due to the change in patient administration systems in 2018 resulting in no available audit data.

The patient was subsequently diagnosed with Wet Macular Degeneration in the left eye and was told to monitor the right eye as there was as subtle Dry Macular Degeneration. The patient was advised to report to the community optician should they feel any disturbance in the central vision or distortion of straight lines.

As per the investigation process, a clinical opinion was sought from the Ophthalmology consultant who advised the discrepancy in vision was due to the delay in the patient not being seen within a timely manner. The patient's vision deteriorated due to the progression of the disease.

Improvements required:
- The Patient Service Centre are undertaking a process map of Pre-Registration to ensure a streamlined and robust process.
- AMD referrals are sent to the Ophthalmology team who have a weekly team meeting to book the patient in within 2 weeks of the referral being received.
- Pre-Registration appointments guide given to all staff to adhere to which includes cross checking the patient's demographics.
- Incident debrief amongst Pre-Registration team.

What do staff need to do?
The following action has now been completed and is in place; AMD referrals to be sent directly to Ophthalmology who have a weekly team meeting to book patients within 2 weeks this is now completed.
The remaining actions below are outstanding with due dates for the end of September and end of December; Pre-Registration guide given to all staff to adhere to which includes cross checking demographics, Patient Service Centre are undertaking a process map of Pre-Registration to ensure a streamlined and robust process and Incident debrief amongst registration team.

WEB245598

The Incident

An elderly person fell from an electric scooter and fractured their hip (left neck of femur).
They had surgery and were transferred to the ward. They experienced confusion and one-to-one care was put in place.

Following a change of ward, their confusion continued and a Deprivation of Liberty Safeguards (DoLS) was put in place. One-to-one care remained.

The one-to one carer left the patient and they sustained an unwitnessed fall on the ward causing further damage to the right femur.

The patient deteriorated and palliative care was put in place. Sadly the patient died 2 days later.

Good practice to share:

A Mental Capacity Assessment (MCA) was completed, along with daily activity chart.
Patient had DoLS in situ and 1:1 care requirement had been identified and shift filled.

Improvements required:

- Issue personal call bell to any 1:1 nurse.
- 1:1 staff to inform ward team when shift has ended and need for someone to take over.

Recommendations

- Raise awareness of expectations of enhanced observation nursing (1:1).
- Education on correct procedure for lying/standing blood pressure measurements.
- Order Enhanced Observation Tabard for nursing staff.

What do staff need to do?

- Purchase Enhanced Observation Tabards for staff to wear.
- Share learning Trust Wide.
- Share findings and actions at daily huddles and team meetings.

RECOMMENDATION The Trust Board are asked to review and discuss this report which details the management of Serious Incidents.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Safer Nursing Staffing**

Meeting date: **5 October 2023**

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

Paper Author: **Deputy Chief Nursing Officer**
Associate Director of Nursing Professional Workforce and CPD

Appendices:

APPENDIX 1: EKHUFT Safer Staffing

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	It is a regulatory requirement that the Trust's Safe Staffing position should be reported to the Board monthly. This meets the National Quality Board guidance and Developing Workforce Safeguards guidance from NHS England and Improvement.
Summary of key issues:	• Update on key Registered Nursing and Midwifery workforce metrics (vacancy, turnover, fill rates) as per NHS England (NHSE) guidance. • Assurance/Mitigation.
Key recommendations:	The Board of Directors is invited to: 1. **NOTE** the content of the report and; 2. Receive **ASSURANCE** that the hospital is safely staffed or has mitigations in place; 3. **NOTE** the progress being made in relation to the recruitment pipeline and the actions that are being taken to mitigate potential foreseen issues.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships
Link to the Board Assurance Framework (BAF):	**BAF 35** - Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.
Link to the Corporate Risk Register (CRR):	**CRR 116** - Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate nursing staffing levels and skill mix to meet patient's needs. **CRR 68** – Risk to the delivery of the operational constitutional standards and undertakings. **CRR 76** Care is potentially compromised as a consequence of staffing not meeting planned numbers per shift.

East Kent Hospitals University NHS Foundation Trust

	CRR 84 – Lack of timely recognition and response to the deteriorating patient.
Resource:	Y - Safer Staffing Business Case approved December 2021
Legal and regulatory:	Y – Care Quality Commission (CQC), National Quality Board and NHSE
Subsidiary:	N

Assurance route:

Previously considered by: Quality and Safety Committee

East Kent Hospitals University NHS Foundation Trust

Safer Staffing

Are we safe? – August 2023

Sponsor – **Chief Nursing and Midwifery Officer (CNMO)**

Author - Associate Director of Nursing, Workforce and Education

We care

Quality and Safety;
Reducing harm and delivering safe services

East Kent Hospitals University NHS Foundation Trust

Safer staffing

Safer staffing
The Trust continues to monitor nursing and midwifery numbers and skill mix in response to clinical need on a daily basis. In August 2023 the Trust is showing an overall average compliance rate of 99% for registered nurses and 112% for HCSWs, this includes the unfunded bed base.

Many of our clinical areas are working over their establishment, this is being reviewed by the Chief Nurses Office at monthly PMOs with all the care groups. Early indicators are that these additional staff are covering the unfunded bed base, enhanced care (specialling) and incorrect rostering practices. To gain more accuracy and control on the additional shifts above establishment that are being requested the level of authorisation have been uplifted to:

- All shifts for NHSP Bank authorised by band 8a or above in hours (band 7 out of hours). This process went live on the HealthRoster system on 23 August 2023.
- All agency to be authorised by Head of Nursing (or Deputy in their absence). This process (know as the 'golden key') went live on the NHSP system on Friday 15 September.
- Standard Operating Procedures have been produced to support these new processes and include guidance on how to review staffing to support decision making.

RN Fill Rate Day	HCSW Fill Rate Day
91%	110%

RN Fill Rate Night	HCSW Fill Rate Night
97%	133%

Nursing and Midwifery (Registered) vacancies

- Not reportable this month

Nursing and Midwifery (Unregistered) vacancies

- Not reportable this month

Safe
People feel safe, reassured and involved

We care

Monthly Ward Overview (fill rate) August 2023

		Nurse to Patient Ratio	Skill Mix Ratio (RN/HCSW)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)
KENT AND CANTERBURY HOSPITAL	BRABOURNE HAEMATOLOGY W/	1 - 4	73/27	85%	78%	100%	-
KENT AND CANTERBURY HOSPITAL	CLARKE WARD - K&C	1 - 6	66/34	97%	100%	69%	99%
KENT AND CANTERBURY HOSPITAL	HARBLEDOWN WARD - K&C	1 - 4	69/31	86%	100%	97%	115%
KENT AND CANTERBURY HOSPITAL	INVICTA T&O WARD K&C	1 - 6	65/35	62%	61%	64%	61%
KENT AND CANTERBURY HOSPITAL	KENT WARD - K&C	1 - 6	65/35	97%	102%	115%	98%
KENT AND CANTERBURY HOSPITAL	KINGSTON WARD - K&C	1 - 6	62/38	84%	91%	100%	119%
KENT AND CANTERBURY HOSPITAL	MOUNT & MCMASTER WARD - K	1 - 6	62/38	88%	93%	90%	116%
KENT AND CANTERBURY HOSPITAL	NEUROREHAB NURSING	1 - 6	65/35	71%	99%	80%	137%
KENT AND CANTERBURY HOSPITAL	RENAL MARLOWE WARD - K&C	1 - 6	66/34	78%	101%	96%	121%
KENT AND CANTERBURY HOSPITAL	ST LAWRENCE WARD - K&C	1 - 6	65/35	88%	80%	100%	98%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	ACUTE MEDICAL UNIT A - QEQM	1 - 4	66/33	92%	92%	97%	91%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	ACUTE MEDICAL UNIT B - QEQM	1 - 4	66/34	91%	98%	91%	126%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	BIRCHINGTON WARD - QEQM	1 - 6	65/35	75%	105%	91%	103%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	BISHOPSTONE WARD - QEQM	1 - 6	65/35	97%	135%	98%	179%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	CHEERFUL SPARROWS WARD F	1 - 6	63/37	94%	94%	102%	134%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	CHEERFUL SPARROWS WARD M	Unfunded		54%	26%	49%	129%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	CORONARY CARE UNIT - QEQM	1 - 3	74/26	82%	93%	93%	119%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	DEAL WARD - QEQM	1 - 6	62/38	102%	165%	103%	161%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	FORDWICH WARD - QEQM	1 - 4	66/34	94%	109%	107%	116%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	QUEX MEDICAL WARD - QEQM	1 - 6	62/38	90%	134%	90%	166%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	RAINBOW WARD - QEQM	1 - 4	83/17	79%	-	79%	

Monthly Ward Overview (fill rate) August 2023

		Nurse to Patient Ratio	Skill Mix Ratio (RN/HCSW)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	SANDWICH BAY FRAILTY WARD	Unfunded		107%	115%	101%	268%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	SEABATHING WARD - QEQM	1 - 6	62/38	98%	105%	97%	130%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	ST AUGUSTINE'S WARD - QEQM	1 - 6	62/38	82%	148%	84%	202%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	ST MARGARETS WARD - QEQM	1 - 6	61/39	86%	118%	84%	95%
WILLIAM HARVEY HOSPITAL (ASHFORD)	ACUTE MEDICAL UNIT (AMU) - W	1 - 4	66/34	116%	130%	139%	154%
WILLIAM HARVEY HOSPITAL (ASHFORD)	BARTHOLOMEW UNIT - WHH	1 - 6	70/30	92%	115%	100%	100%
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE J1 WARD - WHH	1 - 6	65/35	94%	136%	99%	190%
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE J2 WARD - WHH	1 - 4	62/38	113%	93%	107%	94%
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE K WARD - WHH	1 - 6	66/34	80%	81%	91%	104%
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE L WARD - WHH	1 - 6	66/34	128%	177%	129%	162%
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE M1 WARD - WHH	1 - 6	60/40	112%	102%	118%	121%
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE M2 WARD - WHH	1 - 6	60/40	91%	112%	99%	118%
WILLIAM HARVEY HOSPITAL (ASHFORD)	CORONARY CARE UNIT - WHH	1 - 3	83/17	96%	77%	100%	100%
WILLIAM HARVEY HOSPITAL (ASHFORD)	KENNINGTON FRAILTY WARD - V	1 - 6	65/35	94%	143%	100%	165%
WILLIAM HARVEY HOSPITAL (ASHFORD)	KINGS A2 WARD - WHH	1 - 6	68/32	92%	127%	102%	127%
WILLIAM HARVEY HOSPITAL (ASHFORD)	KINGS B WARD - WHH	1 - 6	63/37	84%	129%	105%	148%
WILLIAM HARVEY HOSPITAL (ASHFORD)	KINGS C WARD - WHH	1 - 6	64/36	102%	80%	101%	90%
WILLIAM HARVEY HOSPITAL (ASHFORD)	KINGS C2 MEDICAL WARD - WHH	1 - 6	65/35	93%	113%	97%	138%
WILLIAM HARVEY HOSPITAL (ASHFORD)	KINGS D WARD - WHH	1 - 6	62/38	92%	152%	98%	191%
WILLIAM HARVEY HOSPITAL (ASHFORD)	OXFORD WARD - WHH	1 - 4	65/35	94%	179%	99%	200%
WILLIAM HARVEY HOSPITAL (ASHFORD)	PADUA WARD - WHH	1 - 4	80/20	81%	-	91%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	RICHARD STEVENS WARD - WHH	1 - 6	66/34	98%	183%	104%	176%
WILLIAM HARVEY HOSPITAL (ASHFORD)	ROTARY SUITE - WHH	1 - 5	65/35	107%	95%	100%	123%
WILLIAM HARVEY HOSPITAL (ASHFORD)	SEACOLE WARD - WHH	Unfunded		90%	85%	99%	99%

Quality and Safety;
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Assurance/Mitigation

Ward fill rate
The inpatient ward staffing is reviewed daily by the DoN utilising Safe Care (part of the healthroster system). This allows the DoN to have full oversight of the hospitals bed base and redeploy staff across wards according to patients acuity and demand.

There is a significant unfunded bed base on each site:

WHH – 48
QEQM – 56

These are on additional wards that have been created and do not include additional beds that are on wards as these are just one or two that can be absorbed into the nursing ratio of that ward.

The wards that are under their planned fill rate are moving staff to support the unfunded bed base this is demonstrated by the lower fill rate of some wards seen on the table, to mitigate the risk on the ward the ward manager is coming into the numbers, and the allocation of patients being reallocated so that the nursing ratio is 1- 7 rather than 1-6, safe staffing ratios on our substantive wards allow us to have this flex for a limited period while the unfunded bed base is reviewed.

Safe
People feel safe, reassured and involved

We care

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

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

Meeting date: **5 October 2023**

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

Paper Author: **Deputy Director of Information**

Appendices:

APPENDIX 1: August 2023 IPR

Executive summary:

Action required:	Discussion
Purpose of the Report:	The report provides the monthly update on the operational performance, Quality & Safety, Workforce and Financial organisational metrics. The metrics are directly linked to the We Care 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 with a wider view of metrics is presented for the September Board meeting. The reported metrics have been expanded significantly within the report to provide clear visibility on all metrics associated with the Integrated Improvement Plan programmes of work, statutory reporting and other agreed key metrics. The attached IPR is now ordered into the following strategic themes: • **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. At the start of each strategic theme section is a performance summary followed by a more detailed page for each of the reported metrics.

Key performance points (August Reported Month):

Patients

- All type Emergency Department (ED) performance is now behind plan at 71.9%.
- Type 1 ED performance is under plan at 46.1%.
- Cancer 28 Faster Diagnosis Standard (FDS) has deteriorated in month to 59.1%.
- Diagnostics performance has further deteriorated with key issues remaining in CT and endoscopy.

Quality & Safety

- 12 Serious Incidents (SIs) declared in the month.
- 0 never events reported in August.
- The number of overdue incidents increased in month by 274.
- Hospital Standardised Mortality Ratios (HSMR) remains below 100 and appears to have plateaued at an index figure of around 93.

People

- Sickness absence remains below the desired threshold at 4.9% but has been increasing for 3 months.
- Vacancy rate remains below the desired threshold, with improvements appearing to plateau.
- Staff turnover has reduced further to 9.2% and has now sat below the national standard (10%) for eight consecutive months.
- Staff engagement score improved from the prior quarter but remains below the target threshold.
- Completed medical job plans remains below the target at 52.3%.
- Appraisal rates further improved to 73%.

Sustainability

- The financial position is adverse to plan by £ 14.4 million Year to Date (YTD).
- Cost Improvement Programme (CIP) delivery is significantly below the plan for month 5.
- The current value of the pipeline is £13.8m, a (£0.5m) (3%) decrease in value vs. the prior month.
- Premium pay remains high with drivers that include escalation beds, and additional 1:1 care needs.

Maternity

- 1 SI declared in the month of August for women's health in Gynaecology.
- Complaint response times are below the target threshold.
- Perinatal mortality remains low and in line with the prior month.
- FFT recommend rate is 90.2% for the month.
- Staff engagement score has improved on the prior quarter to 6.15.

Key recommendations:	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the metrics reported in the Integrated Performance Report.

Implications:

Links to 'We Care' Strategic Objectives:	• **Quality and Safety** • **Patients** • **People** • **Partnerships** • **Sustainability**
Link to the Board Assurance Framework (BAF):	**BAF 32**: There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 34**: Failure to deliver the operational constitutional standards due to the fluctuating nature of the Covid-19 pandemic necessitating a localised directive to prioritise P1 and P2 patients. **BAF 31:** Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements and Covid-19, leading to harm, including death, breaches of externally set objectives, possible regulatory action, prosecution, litigation and reputational damage.
Link to the Corporate Risk Register (CRR):	**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

East Kent Hospitals University NHS Foundation Trust

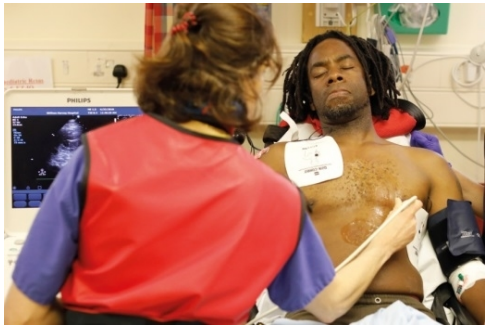
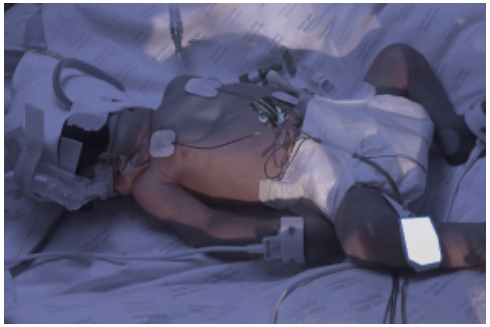
Integrated Performance Report

August 2023







Patients

Operational Performance

Integrated Improvement Plan

NHS
East Kent Hospitals University
NHS Foundation Trust

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
Operational Perfomance	ED Compliance	73.0%	Aug-23	71.9%			65	70	74	Special cause of improving nature or lower pressure due to higher values
	Type 1 Compliance 4hrs	55.0%	Aug-23	45.7%			38	45	52	Common cause (no significant change)
	Ambulance Handovers within 30m	95.0%	Aug-23	89.7%			75	83	91	Special cause of improving nature or lower pressure due to higher values
	12Hr Trolley Waits (MTD unvalidated)	0	Aug-23	908			402	725	1,049	Special cause of concerning nature or higher pressure due to higher values
	Super Stranded >21D	107	Aug-23	241			199	234	268	Special cause of improving nature or lower pressure due to lower values
	Not Fit to Reside (pats/day)	300.0	Aug-23	193.0			156	186	217	Special cause of concerning nature or higher pressure due to higher values
	Cancer 28d Performance	75.0%	Aug-23	59.1%			56	66	75	Common cause (no significant change)
	RTT Total Incomplete Pathways	Sigma	Aug-23	86.8K			67,4...	71,162	74,853	Special cause of concerning nature or higher pressure due to higher values
	Cancer Over 62d on PTL	67	Aug-23	431			161	264	367	Special cause of concerning nature or higher pressure due to higher values
	Cancer Over 104d on PTL	0	Aug-23	84			19	40	62	Special cause of concerning nature or higher pressure due to higher values
	DM01 Compliance	75.0%	Aug-23	53.6%			57	64	72	Special cause of concerning nature or higher pressure due to lower values
	RTT 52w Breaches	Traj.	Aug-23	4,767			3,366	3,808	4,250	Special cause of concerning nature or higher pressure due to higher values
	RTT 65w Breaches	0	Aug-23	1,292			1,136	1,459	1,781	Special cause of improving nature or lower pressure due to lower values

August Performance Summary

Emergency Department: The type 1 and all types (type 1 & 3) deteriorated in August with Type 1 at 46.1% v 51.3% in July and All types at 71.6% v 74.0% . The WHH reported the larger drop in performance (type 1 44.9% v 52.2% in July) with a comparable deterioration in both the admitted and non-admitted type 1 performance. Drivers that affected performance: increase in type 1 non-admitted presentations, ambulance conveyances increased and highest number reported since Nov 22: % discharges for both simple and complex deteriorated with simple discharges reporting the lowest weekly % in the last 12 months. The Emergency Care Delivery Group (ECDG) workstreams continue to focus on delivery of the new clinical models to reduce the number of patients dwelling in the Emergency Department (ED). Ambulance handover compliance against the 30 min standard continues to show an upward improvement trend when compared to the previous 12 months. The reporting metric – 12 hour total time in ED did deteriorate in August 10.1% v 8.95 in July but remains an improving trend when compared to the previous 12 months.

Cancer: 28D FDS; Reduced performance in month, key learning and actions in place, new 2ww transformation work underway to support sustainable compliance going forward. Cancer 62 and 104 day breaches remain extremely high, highest contributing factors are with the Lower GI and Urology Cancer Pathway. Breach reports, Datix, harm reviews and learning documented and actions built into improvements needed.

Diagnostics: Diagnostics: Diagnostic performance has deteriorated further in August to the lowest reportable performance to date. Improvement continues to be observed in NOUS but the scale of breaches in excess of 6 weeks in August have peaked to the highest level reported with significant increase in MRI.

Referral to Treatment Waiting Times: 52 week breaches continue to grow and exceed trajectory. The impact of referral growth, waiting longer for first out patient appointments and diagnostic tests means our ability to reduce 52 week breaches are challenging, compounded by Industrial Action since April 2023.

Type 1 Emergency Department 4h Compliance

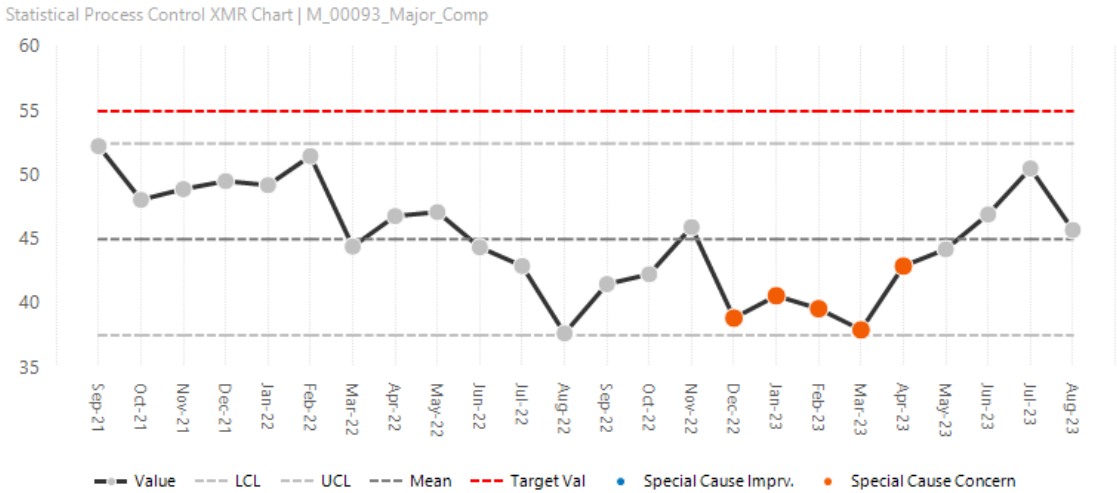
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This four-hour standard measures the total time patients spend in the emergency department from arrival time to admission, transfer [to another provider] or discharge. For patients arriving by ambulance, the clock starts when the patient is handed over from the ambulance staff to hospital staff or 15 minutes after the ambulance arrives at A&E (whichever is earlier). This metric only contains Type 1 (ED) attendances.

Type 1 Compliance 4hrs

Month	Value
Sep-22	41.5%
Oct-22	42.3%
Nov-22	46.0%
Dec-22	38.9%
Jan-23	40.6%
Feb-23	39.6%
Mar-23	38.0%
Apr-23	42.9%
May-23	44.2%
Jun-23	47.0%
Jul-23	50.5%
Aug-23	45.7%



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
ED Single point of access for all patients requiring urgent and emergency care	• Direct Access Pathways (DAPs) implemented since March '23 and include pathways to SDEC/SEAU/Majors Assessment/CAU • Training to be progressed for the Medical staff at QEQM	• SC/DS/HT/RL • WK/SC/JW/DB	• On going monitoring in place via daily ED review meetings • September	• Work to progress the DAPs ahead of the opening of the CAU end Sep. • Review of the DAP to MAU in readiness for the opening of the new MAU • Training packs in place | Clinical lead will provide the training package over 2 weeks
Internal processes not fully aligned to operational delivery	• Implementation of internal escalation processes	• SC/RL/DB/DS/ WK/JW/CS	• Sep 2023	• Internal plans development | in progress at WHH, work commencing at QEQM
Whole Hospital Response Establishing CDUs at WHH/QEQM	• Trust wide development of IPS. GIRFT recommendation • CDU Models agreed for QEQM • CDU Model being explored at WHH to go live Oct 23. Requires phase 3b of the build to be completed	• SC.DCMO/Clinical leads/Ops Leads • Clinical leads MDs DoN	• Dec 2023 • Sep 2023 (QEQM) • Oct 2023	• Work with support form the GIRFT team to support IPS implementation • Internal training planned for September • Daily meetings to support the work required to create the space required for the CDU

Emergency Department 4h Compliance (all types)

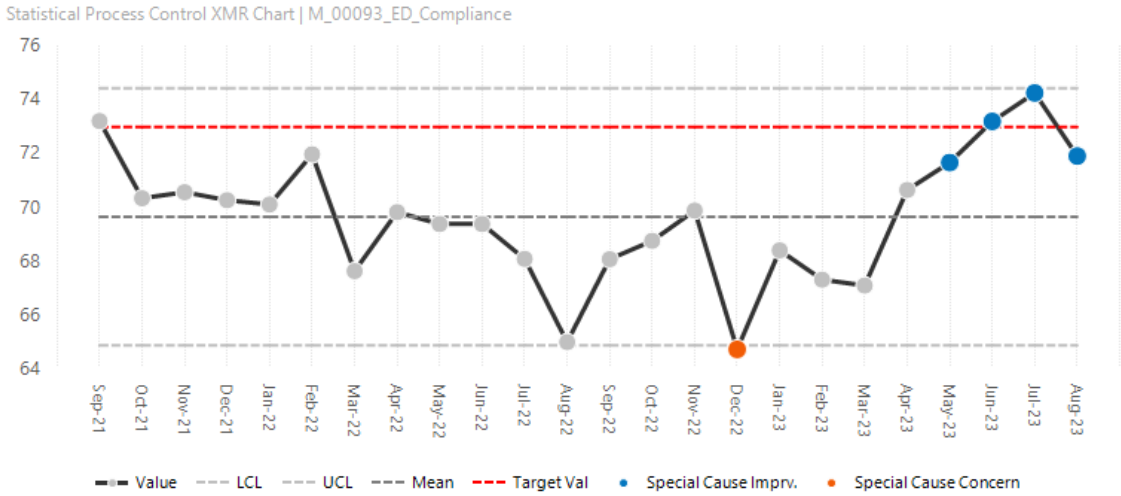
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This four-hour standard measures the total time patients spend in the emergency department from arrival time to admission, transfer [to another provider] or discharge. For patients arriving by ambulance, the clock starts when the patient is handed over from the ambulance staff to hospital staff or 15 minutes after the ambulance arrives at A&E (whichever is earlier). This metric combines Type 1 (ED) and Type 3 (UTC) attendances.

ED Compliance

Month	Value
Sep-22	68.1%
Oct-22	68.8%
Nov-22	69.9%
Dec-22	64.7%
Jan-23	68.4%
Feb-23	67.3%
Mar-23	67.1%
Apr-23	70.7%
May-23	71.7%
Jun-23	73.2%
Jul-23	74.3%
Aug-23	71.9%



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to higher values(| | | | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Lack of timely UTC pathways and direct access from the front door. Requirement for direct access pathways GP/Secamb.	• Review of the UTC pathways supported by the ICB Clinical Lead • Further work progressing to increase activity and cohort into the UTC	• Clinical ED leads /UTC leads/ Head of Ops	• Aug 2023 • Oct 23	• Pathways reviewed and commenced work through the HCP and the SECAMB development for DAP to UTC • Work in train to develop DAP for GPs – linked to the work in West Kent . Forum for shared learning with EKUFT led by the ICB
Same Day Emergency Care (SDEC) capacity and utilisation. Includes development work with Children's for DAP to CAU to reduce numbers waiting in Paediatric ED.	• Review SDEC criteria using the Ambulatory Care Condition Directory. Limitations at QEQM due to the number of Acute Medics • Expansion of hours to be established across both sites	• Clinical Leads /MDs /Head of Ops/BI Lead	• Sep 2023 2 month plan	• July reported the highest number of patients seen in the SDECs. • CAU pathway development to be progressed at QEQM and pilot started September with a review at the Oct ECDG
Capacity available in Medical and Surgical Assessment units at QEQM/WHH	• Pilot units in place; restricted due to ED build. • Move the services to dedicated space October • Introduce DAP pathways for GP/Secamb and ED	• Clinical Leads/MDs /Head of Ops/BI Lead	• July 2023 3 month plan	• Work commenced Jan '23 | WHH pilot in place since Mar '23 • QEQM commenced Jul '23

Ambulance Handovers within 30m

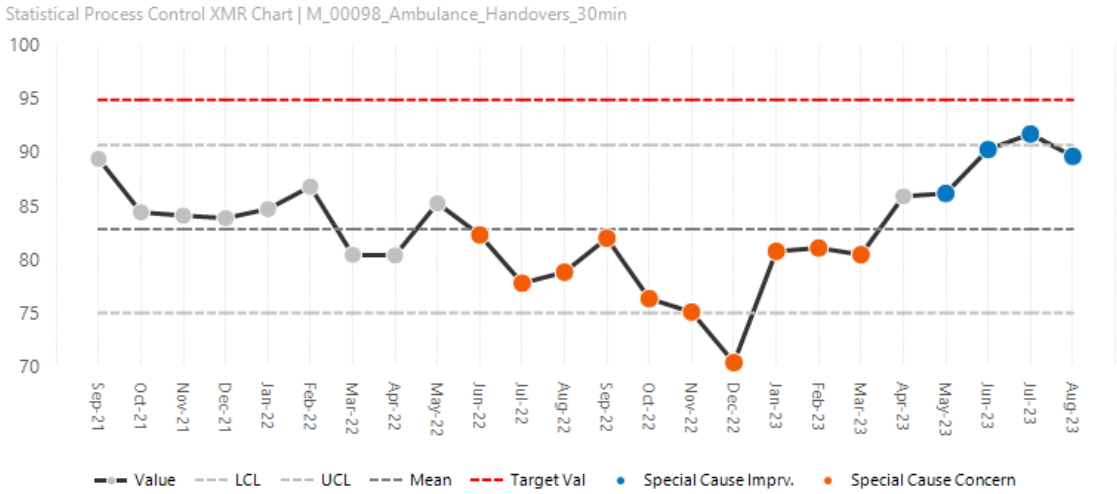
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The proportion of Ambulance handovers completed within 30 minutes of arrival. Incomplete timestamps are excluded from the performance.

Ambulance Handovers within 30m

Month	Value
Sep-22	82.1%
Oct-22	76.4%
Nov-22	75.1%
Dec-22	70.4%
Jan-23	80.8%
Feb-23	81.1%
Mar-23	80.5%
Apr-23	86.0%
May-23	86.2%
Jun-23	90.4%
Jul-23	91.8%
Aug-23	89.7%



Understand the most recent data point

Variation Type
Special cause of improving nature or lower pressure due to higher values(| | | | | | Two Out Of Three Beyond Two Sigma Group)
Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
High numbers of ambulance conveyances to the Emergency Departments at QEQM/WHH (national outlier)	• Working with the HCP and SECAMB partners . Implementation the Alt-ED model • Support from GIRFT – one of the key recommendations following the review in July	• HCP/Hospital Site teams /Secamb	• Sep 2023; 3 month plan	• Establishing the HCP action plan to support the Alt-ED roll-out and the GIRFT action plan to support UCR pathways
Review of process for accepting and transferring of patients at the front door	• Introduction of front door streaming and RAT to support early handover of patients. Early ED triggers in place to reduce risk for off-loading . • Streaming in place to support direct access to SDEC/MAU/SAEU/CAU/UTCs against patient criteria	• Clinical lead ED and Head of Ops	• In place	• ED reviewing their internal plans to ensure early triggers resolve potential issues with off loads /Over capacity EDs
Time to Dr Initial Assessment	• Introduction of the Dr Initial Assessment(WHH) to support timely reviews and assessment of pts arriving on ambulances • To develop model at QEQM	• Clinical lead ED and Head of Ops	• In place and on-going • September	• To implement the model at QEQM • Tracing to commence September to include all DAP s and early assessment and patient plans

>12h Total Time In Emergency Department

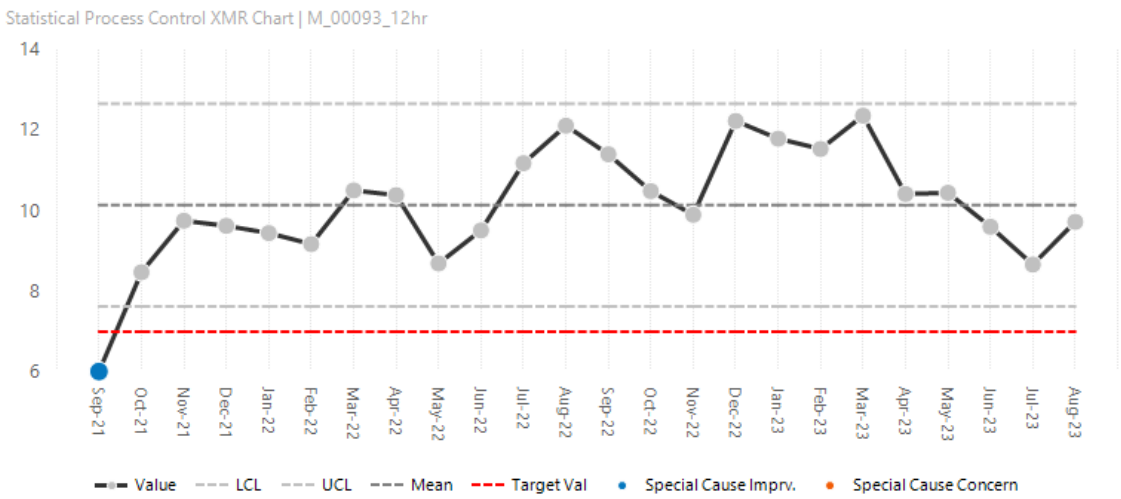
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This measure counts the proportion of patients whose total time in the emergency department exceeded 12 hours.

12 Hr Total Time in Department

Month	Value
Sep-22	11.4%
Oct-22	10.5%
Nov-22	9.9%
Dec-22	12.2%
Jan-23	11.8%
Feb-23	11.5%
Mar-23	12.4%
Apr-23	10.4%
May-23	10.5%
Jun-23	9.6%
Jul-23	8.7%
Aug-23	9.7%



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Number of patients waiting for a bed (admitted cohort)	Implementation of; • Daily pathway zero meeting • Specialty in-reach to the front door • Frailty units established • Clinical forums to right size bed base and ensure appropriate configuration	• Clinical leads /MDs /Head of Ops		• Creation of integrated hubs at the front door with access to domiciliary care to reduce admissions | On track • SAFER Bundle roll-out | Commenced WHH • Focussed work to improve patient flow at QEQM | External support tbc
Use of corridor to manage high numbers of pts in ED	• Implement SAFER Bundles • Protection of the DAP pathways and assessment units • Increase UTC/SDEC activity • Review of internal triggers aligned to the new OPEL Framework (live from Oct 23) and work with HCP to align system wide response requirements	• Clinical leads /MDs /Head of Ops • HCP/MDs	• On going • Sep 2023	• Internal triggers and access and use of escalation areas completed WHH pending approval. QEQM – in development • HCP Event September to agree system plans to support OPEL framework ahead of live date
High number of Mental Health (MH) patients in ED. Long waits due to lack of inpatient MH facilities	• Daily external escalation processes to be approved by the HCP to support oversight and planning • External ICB support to EKMHT to manage capacity access OOA	• DoNs/MDs /MDs/COO /CNO/HCP leads	• On-going • Oct/Nov 2023	• ED internal processes in place to support patients in ED • 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

Super Stranded Patients (>21d LoS)

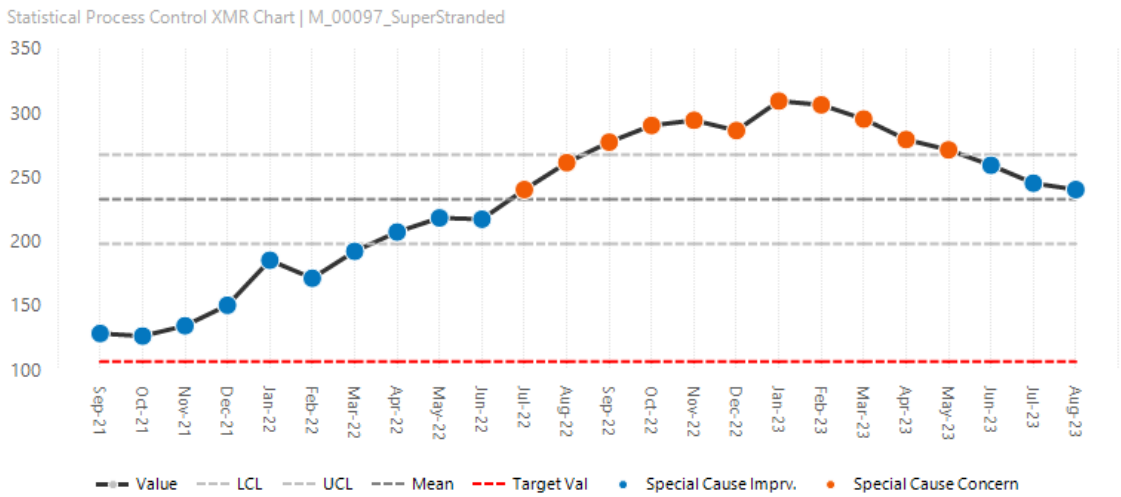
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The NHS defines a super stranded patient as someone who has spent 21 days or more in hospital.
This metric counts the number of Super Stranded patients at the time snapshot was taken, in this case the last day of the month.

Super Stranded >21D

Month	Value
Sep-22	278
Oct-22	291
Nov-22	295
Dec-22	287
Jan-23	310
Feb-23	307
Mar-23	296
Apr-23	280
May-23	272
Jun-23	260
Jul-23	246
Aug-23	241



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to lower values(Above Mean Run Group | | | | | Descending Run Group |)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Long Stay Patients	• Roll out of SAFER bundle. Under the 'R' – 'Regular Review' principle patients with a LoS of more than 14 days will be reviewed at a weekly Super Stranded MDT	• Site MDs	• End October	• SAFER Board Round Bundle launched at WHH w/c 21st August. The programme will run from August to October 2023. Timetabled roll out to all WHH wards. • QEQM PRISM Inpatient Flow Improvement Project due to commence w/c 25th September.
Access to community capacity	• East Kent Health and Care Partnership Urgent and Emergency Care Plan for 23/24 is structured with 5 priority areas of work: Increasing urgent and emergency care capacity, Making it easier to access the right care, Improving discharge, Expanding pro-active care outside of hospital, Increase workforce size and flexibility.	• HCP/COO	• 23/24 Year End	• Alerts are now available for RTS to contact discharge co-ordinators, and similarly when a patient becomes medically optimised alerts can be sent from the ward to RTS. • Work continues to consolidate the RTS and Ward Discharge planning PTLs. • A single referral form is in development for enhanced discharge pathway planning.

Patients No Longer Fit to Reside in Hospital

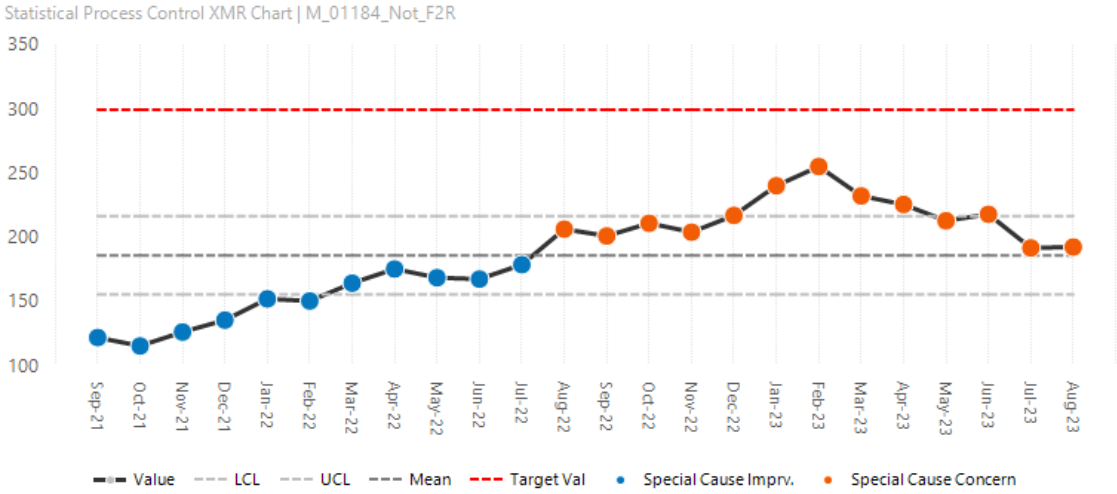
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The status of a patient is captured and recorded by clinical teams on a daily basis. Where a patient is deemed 'no longer fit to reside' (nlftr) this means that their care could be safely given in a setting outside of the acute hospital.
This metric measures the number of patients classified as nlftr each day in the month and expresses this as an average over the month.

Not Fit to Reside (pats/day)

Month	Value
Sep-22	201.6
Oct-22	211.5
Nov-22	204.5
Dec-22	217.6
Jan-23	240.7
Feb-23	255.7
Mar-23	232.8
Apr-23	226.1
May-23	213.4
Jun-23	218.5
Jul-23	192.3
Aug-23	193.0



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to higher values(Above Mean Run Group | | | | | |)

Variation indicates consistently passing the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Access to community capacity	• East Kent Health and Care Partnership Urgent and Emergency Care Plan for 23/24 is structured with 5 priority areas of work: Increasing urgent and emergency care capacity, Making it easier to access the right care, Improving discharge, Expanding pro-active care outside of hospital, Increase workforce size and flexibility.	• HCP/COO	• 23/24 Year End	• Development of generic Health and Social Care (Home First Support Worker) – The first 8 of 25 Home First Support Workers have been appointed. Rolling recruitment programme continues across health and social care. Recruitment of band 6 Team Manager and Admin. Supporting P1 discharges. • Stroke/rehab bed capacity (15 beds); The first 8 beds opened on 17th July. There are currently 9 beds open and a plan in place to incrementally increase to 15 beds by the Beginning of November.
Long Stay Patients	• Roll out of SAFER bundle. Under the 'R' – 'Regular Review' principle patients with a LoS of more than 14 days will be reviewed at a weekly Super Stranded MDT	• Site MDs	• End Oct	• SAFER Board Round Bundle launched at WHH w/c 21st August. The programme will run from August to October 2023. Timetabled roll out to all WHH wards. • QEQM PRISM Inpatient Flow Improvement Project due to commence w/c 25th September
Ward/RTS comms.	• PTL improvements provide the ward and RTS with a traffic light system highlighting the patient status on the RTS caseload. Alert system rolled out to provide two-way communication between ward and RTS for patient reviews.	• GS and Gastro DHoN	• End Oct	• Alerts are now available for RTS to contact discharge co-ordinators, and when a patient becomes medically optimised alerts can be sent from the ward to RTS. • Work continues to consolidate the RTS and Ward Discharge planning PTLs. • A single referral form is in development for enhanced discharge pathway planning.

Cancer 28d Faster Diagnosis

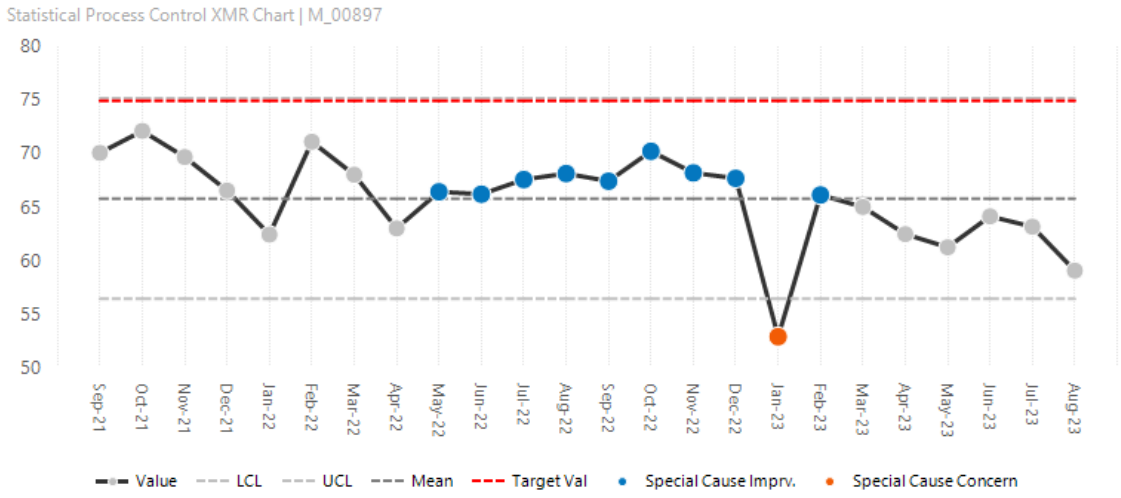
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

There is a national requirement to diagnose or rule out cancer for patients referred on a cancer pathway within 28 days of receipt of referral.
This metric measures the % pf patients discharged or given a diagnosis in each month within 28 days of their referral.

Cancer 28d Performance

Month	Value
Sep-22	67.5%
Oct-22	70.3%
Nov-22	68.3%
Dec-22	67.7%
Jan-23	52.9%
Feb-23	66.2%
Mar-23	65.1%
Apr-23	62.5%
May-23	61.3%
Jun-23	64.2%
Jul-23	63.2%
Aug-23	59.1%



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Diagnostic reporting for CT's & MRI's (current reporting time is 2 weeks for CT's and 6 weeks for MRI's) Ref to exam - CT- 2-3 days if bloods done, if not 14 days. MRI 11 days.	Reduce referral to reporting to 10 days for CT and MRI	• Radiology • Cancer Trackers • Phlebotomy	• End Oct 2023	• Improved escalation process being piloted for bloods, vetting, booking and reporting • Awaiting confirmation of 2 locum staff starting to support CTbx, NOUS BX and reporting
Qfit process not consistently applied and current waiting time for endoscopy booking is 4 weeks.	Qfit process to be consistently applied and sustained. To reduce waiting time to Scope to 10 days for 2ww and screening patients	• Endoscopy • Qfit Facilitator • AMD Surgery	• Dec 2023	• Endoscopy - Insourcing agreed to the end of September- working every weekend on all sites. No lists for October currently, being reviewed. • STT implemented for Lower GI. SOP for Qfit finalised and implemented 1st September but need to agree with the clinicians how we review who is using it at EKHUFT and how we ensure that those staff that aren't, are encouraged to. • The endoscopy request form is being updated to include qFIT result. • Lead GP is contacting practices who are showing zero utilisation of Qfit to encourage them to utilise Qfit.
Waits for typing of cancer patient clinic letters , typing for Urology, Upper and Lower GI. Averaging 8-12 weeks.	Typing of letters for those tumour sites to be completed within 7 days.	• Care Group Lead Medical Secs	• End Oct 2023	• Benign letters agreed to support improvement, while waiting time improved for comprehensive letter • Updates on progress circulated to teams 3 times a week to support improvement

Cancer Patients >62d on PTL

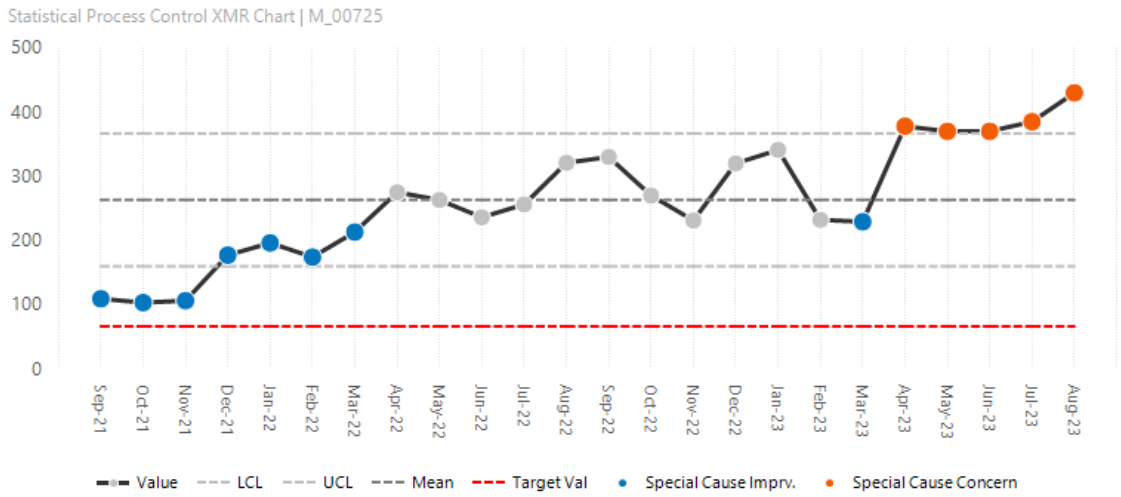
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The number of patients on a Cancer Pathway who have been waiting 62d or more from point of referral and have not yet received treatment. This metric is a snapshot count of patients as at month end.

Cancer Over 62d on PTL

Month	Value
Sep-22	331
Oct-22	271
Nov-22	232
Dec-22	321
Jan-23	342
Feb-23	233
Mar-23	230
Apr-23	379
May-23	371
Jun-23	371
Jul-23	386
Aug-23	431



Understand the most recent data point

Variation Type	
H	Special cause of concerning nature or higher pressure due to higher values(| | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)
F	Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Diagnostic waiting time for U/S Guided Biopsies. Average wait time 4-5 weeks	Reduce wait time to diagnostic to 7-10 days.	• Radiology • Cancer	• Oct 2023	• Radiology Improvement plan in place • Options for dedicated lists on the K&C site being explored • Options within the Alliance being explored to support the teams involved • Awaiting confirmation of 2 locum staff starting to support CTbx, NOUS BX and reporting
Inadequate capacity within out-patients for F2F appointments post MDM to discuss treatment options post MDM	• Increase Outpatient capacity for decision to treat (DTT) OPA's. OPA to be available within 5 days following the MDM. • Provide Increased straight to test (STT) capacity to release medical time for F2F OPA's etc.	• FDS Lead Clinician • Out-patient Lead	• Oct 2023	• 2ww Transformation Working Group established • STT for lower expanding capacity in September • STT prostate funding agreed posts due to be advertised • STT Lung and Upper in place, under review for additional learning/improvement following patients feedback

Cancer Patients >104d on PTL

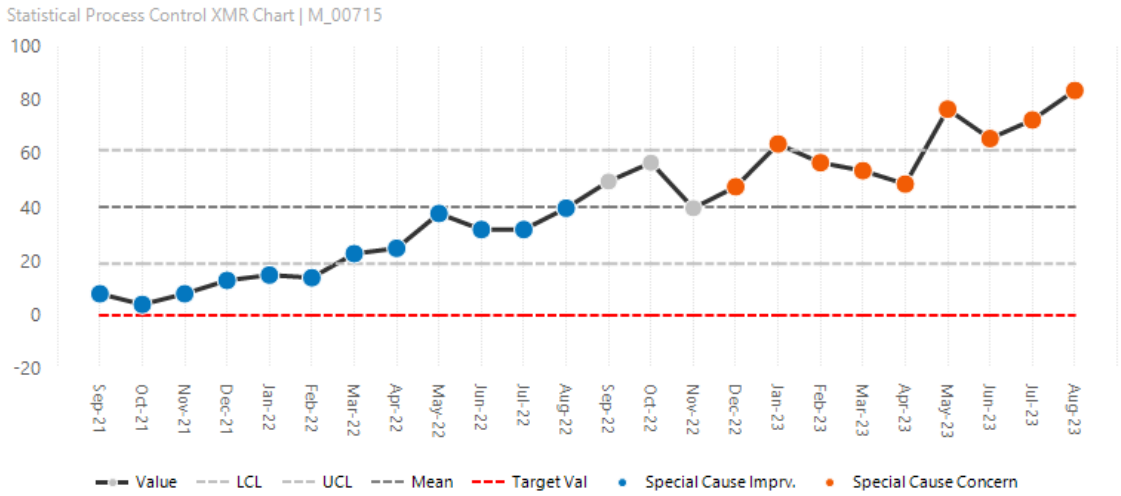
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The number of patients on a Cancer Pathway who have been waiting 104d or more from point of referral and have not yet received treatment. This metric is a snapshot count of patients as at month end.

Cancer Over 104d on PTL

Month	Value
Sep-22	50
Oct-22	57
Nov-22	40
Dec-22	48
Jan-23	64
Feb-23	57
Mar-23	54
Apr-23	49
May-23	77
Jun-23	66
Jul-23	73
Aug-23	84



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to higher values(Above Mean Run Group | | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Urology Surgical capacity	Increase surgical capacity by exploring mutual aid options with MFT for RALP and Alliance for Cystectomy	• MD • AMD and MD K&C • MDT Lead for Urology	• Sep 2023	• Pathway agreed with MFT, awaiting financial detail • K&M Cancer Alliance meeting being arranged. So far patients not engaging in having surgery elsewhere.
Tertiary referral – delays with receiving communication back from tertiary centres.	Improved collaboration between EKHUFT and tertiary centres.	• Senior Service Managers EKHUFT • Tertiary Centres • EKHUFT Compliance Managers	• Sep 2023	• Established weekly PTL meetings for UGI with our London colleagues. • Meetings with Kings took place on 1st and 14th August to review IPT transfers, and correct completion of documents. • Joint Kent & Medway Escalation PTL to be set up with GSTT as issues across all Trusts.
Patient engagement throughout pathways, multiple cancellations/DNA's	Ensure GP's are informing the patients they are being referred on a cancer pathway and not all investigations will be at the hospital nearest to them.	• Care Group Leads/ CNS's • GP's/Support Workers/Patient Engagement Officer Kent & Medway Cancer Alliance	• Oct 2023	• 2ww Transformation Working Group. • Working with our GP Cancer Lead to ensure patients are being told they are on a cancer pathway at referral • STT implementation • Early escalation to Cancer CNS's to support patients • Development of 2ww information of Trust web page to support patients and their relatives/carers on a cancer pathway, being designed

Diagnostic Waiting Times: DM01

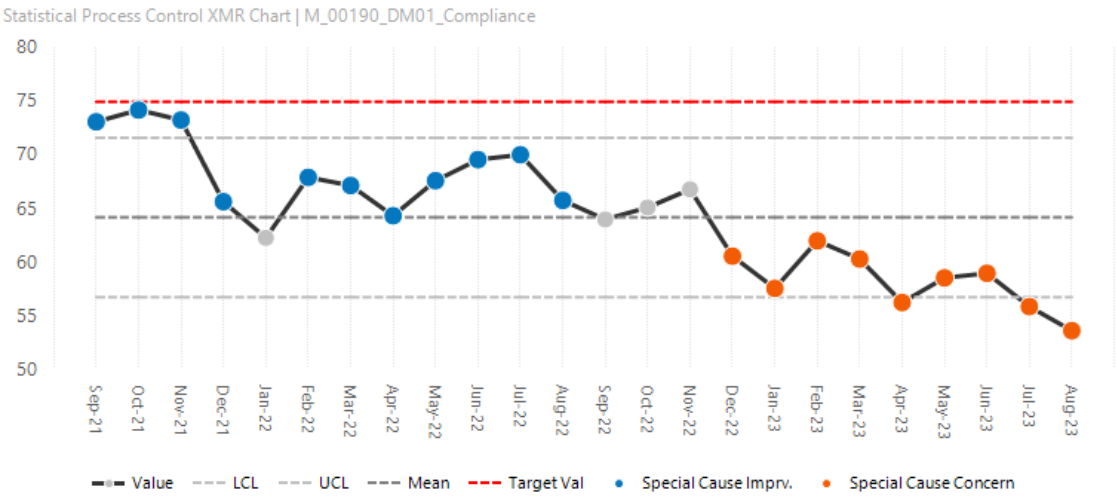
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Diagnostic tests/procedures are used to identify and monitor a person's disease or condition and which allows a medical diagnosis to be made. The national waiting time standard states that no more than 1% of patients should wait more than 6 week for their diagnostic test. The Trust currently has a stretch target to hit 75% by March 2024.

DM01 Compliance

Month	Value
Sep-22	64.0%
Oct-22	65.1%
Nov-22	66.8%
Dec-22	60.6%
Jan-23	57.6%
Feb-23	62.0%
Mar-23	60.3%
Apr-23	56.3%
May-23	58.6%
Jun-23	59.0%
Jul-23	55.9%
Aug-23	53.6%



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to lower values(| Below Mean Run Group | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE(S)	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
CT issues; • CT Cardiac • CT Vetting • Ranzac protocol	• Cardiac | awaiting review of external funding • Vetting | training plan for Junior Dr's • Ranzac | agree protocol	• DCOO • Rad: Clinical Lead • Rad: Clinical Lead	• tbc • Start Sep 24 • Start mid Sep 24	• Awaiting financial approval • Training completed – vetting numbers improving • protocol awaiting sign off – T&F group started
MRI scanning capacity	Additional MRI scanners X2 to meeting 19/20 plan of 120%. Trust agreed 100%	• Trust	• No agreement or timescale. To be reviewed at Business Planning	• 2 MRI's would achieve DM01 compliance in 6 months + reduced backlog position
Endoscopy Capacity | Demand outstrips capacity	Procurement underway to insource 1,000 scopes per month for 12 months, STW in place whilst procurement concludes to deliver an additional 50 lists per month in the interim	• TS	• Implementation Sep-Oct 2023 dependent on governance/sign off	• Contract award going to FPC 25/09 for sign off and then Trust Board

Referral to Treatment Waiting Times: 65w Waits

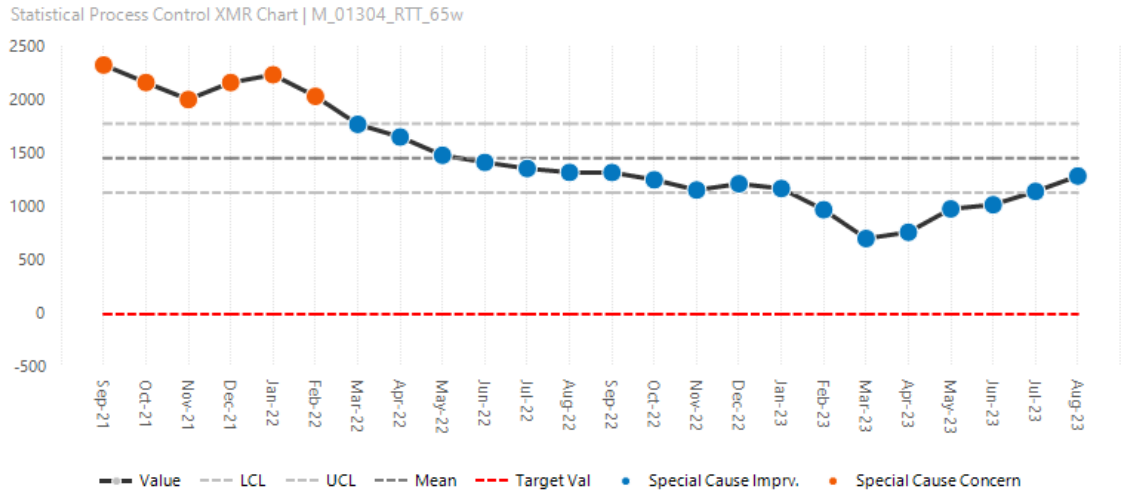
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of RTT reportable patients waiting in excess of 65 weeks to start treatment.
The Trust has a stretch target to eliminate 65w waits by the end of March 2024.

RTT 65w Breaches

Month	Value
Sep-22	1,325
Oct-22	1,257
Nov-22	1,161
Dec-22	1,219
Jan-23	1,175
Feb-23	976
Mar-23	707
Apr-23	766
May-23	984
Jun-23	1,023
Jul-23	1,148
Aug-23	1,292



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to lower values(| Below Mean Run Group | | | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Non-admitted pathway delays impacting ability to reduce breaches	• Weekly recovery meetings re-set with MD's focussed on recovery actions	• COO/ DCOO	• Sep 2023	• Review waiting list deep dive findings • Set weekly actions with MD's aligned to validation/outpatient transformation
Sickness absence has significantly impacted ability to recover longest waiting patients in ENT	• Local and regional (Inc. London) capacity options exhausted • Meeting with ICB to agree alternate options due to inability to recover at regional level	• COO	• Oct 2023	• Trajectory to be revisited to account for impact of: 1. Ongoing Industrial Action 2. Increasing volume of urgent/priority patients capacity 3. Theatre equipment/workforce limitations
Diagnostic delays – impacting ability to scan/scope routine (longer waiting RTT patients) creating significant increase in 78 week breaches	• Endoscopy Insourcing tender process underway • Deep dive in Radiology with new DCOO • Executive support required to progress radiology booking/vetting process	• COO/ CMO	• Sep 2023	• Endoscopy scoring completed/pending financial approval • Review improvement plan and consider impact of actions to yield improvement due to deteriorating position • Immediate recovery plan required for vetting and booking to utilise available capacity

Referral to Treatment Waiting Times: 52w Waits

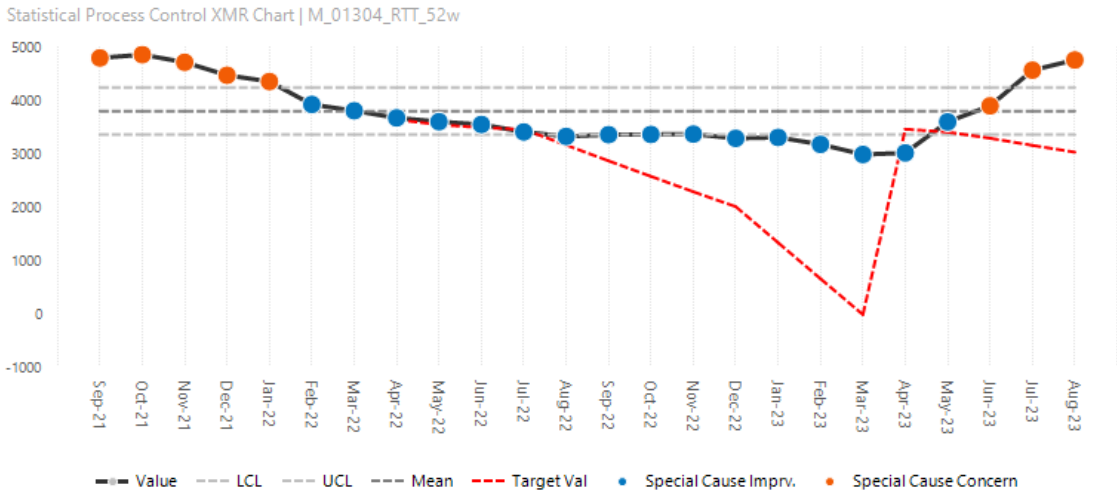
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of RTT reportable patients waiting in excess of 52 weeks to start treatment.

RTT 52w Breaches

Month	Value
Sep-22	3,368
Oct-22	3,372
Nov-22	3,379
Dec-22	3,299
Jan-23	3,317
Feb-23	3,187
Mar-23	2,997
Apr-23	3,027
May-23	3,608
Jun-23	3,907
Jul-23	4,575
Aug-23	4,767



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to higher values(| | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Elective activity below plan / Industrial Action – accumulated impact of cancelled patients and lost capacity (due to not booking patients)	• PRISM to commence programme of work to improve theatre productivity	• Managing Directors • PRISM/MD's	• Oct 2023	• MD observing and revising current 642 Theatre meetings to ensure they align with theatre improvement/maximise utilisation/cases per session • PRISM commencing end of Sept to set programme of improvement work
Non-admitted validation - in ability to maintain 12 weekly validation targets for every patient	• Implement two way text messaging for all non-admitted patients to support requirement to validate and ensure compliance against the validation standard	• Elective Recovery Director	• 31 October 2023	• Approve logic for all admitted/non-admitted pathways and roll out with BI/IT team • Scope capacity/ability to progress patient portal roll out to aid longer term validation targets
Elective capacity to meet demand	• Review stretch targets set for business planning 23/24 with COO/Exec Team • Consider 24/25 business planning approach/actions due to scale of growth in waiting list size	• COO/BI and Elective Director	• Oct 2023	• Paediatric capacity increase planned from Oct 23 with longer term plan required • Specialities quantifying actions and timeframes to increase theatre cases

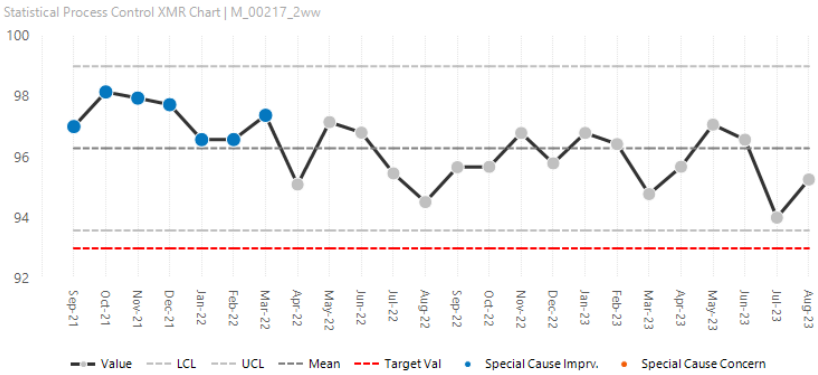
Cancer Performance

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

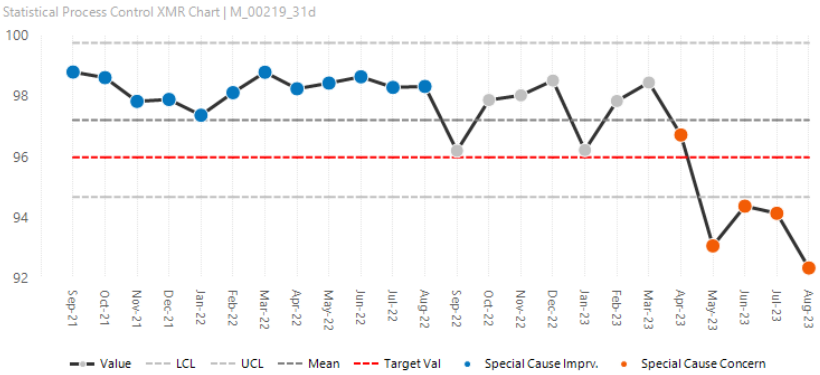
Cancer 2ww Performance

Month	Value
Sep-22	95.7%
Oct-22	95.7%
Nov-22	96.8%
Dec-22	95.8%
Jan-23	96.8%
Feb-23	96.4%
Mar-23	94.8%
Apr-23	95.7%
May-23	97.1%
Jun-23	96.6%
Jul-23	94.0%
Aug-23	95.3%



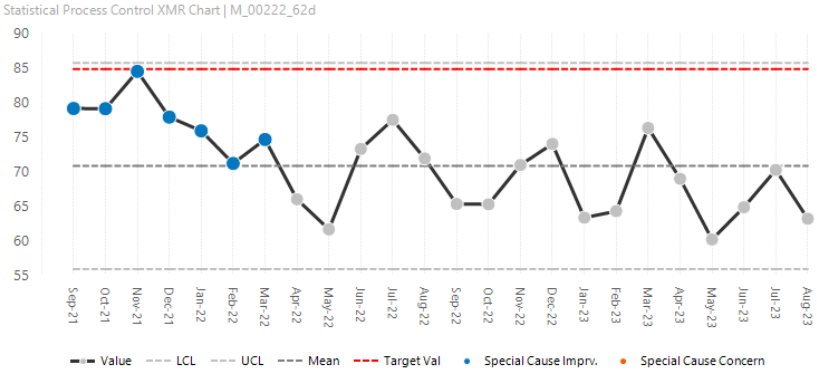
Cancer 31d Performance

Month	Value
Sep-22	96.2%
Oct-22	97.9%
Nov-22	98.1%
Dec-22	98.5%
Jan-23	96.2%
Feb-23	97.9%
Mar-23	98.5%
Apr-23	96.7%
May-23	93.1%
Jun-23	94.4%
Jul-23	94.2%
Aug-23	92.3%



Cancer 62d Performance

Month	Value
Sep-22	65.4%
Oct-22	65.4%
Nov-22	71.1%
Dec-22	74.1%
Jan-23	63.4%
Feb-23	64.4%
Mar-23	76.4%
Apr-23	69.1%
May-23	60.3%
Jun-23	64.9%
Jul-23	70.4%
Aug-23	63.3%



PERFORMANCE UPDATE

2ww performance has improved slightly in month and remains compliant with the national standard. Waits within endoscopy remain long and there are continued delays with biopsy and diagnostic booking and reporting.

31 Day Performance reduced due to reduced capacity for skin procedures. In the summer there is always an increase in referrals which impacts on capacity.

62d performance remains within normal variation.
Improvement actions are;

- Straight to Test (STT) pathways for Lung, Lower GI, Upper GI and Haematuria
- Enhanced escalation process in place for Consultant reviews, tertiary referrals, surgical dates and diagnostics to reduce the number of days on the pathway
- Engagement with Care Groups to support booking of patients
- Improving access to blood tests for cancer patients so that diagnostics can be booked earlier

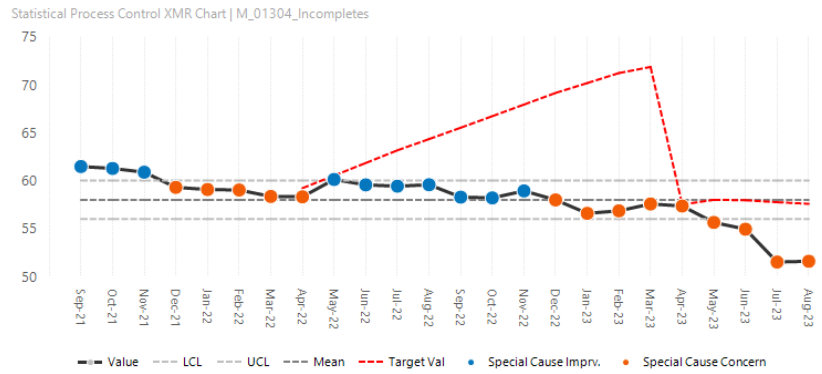
RTT Performance

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

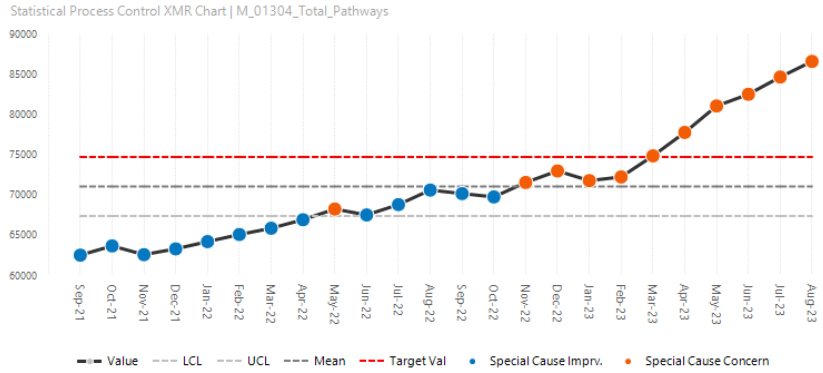
RTT Incomplete Performance

Month	Value
Sep-22	58.4%
Oct-22	58.3%
Nov-22	59.0%
Dec-22	58.1%
Jan-23	56.7%
Feb-23	56.9%
Mar-23	57.7%
Apr-23	57.5%
May-23	55.7%
Jun-23	55.0%
Jul-23	51.6%
Aug-23	51.7%



RTT Total Incomplete Pathways

Month	Value
Sep-22	70.3K
Oct-22	69.9K
Nov-22	71.7K
Dec-22	73.1K
Jan-23	71.9K
Feb-23	72.4K
Mar-23	75.0K
Apr-23	77.9K
May-23	81.2K
Jun-23	82.7K
Jul-23	84.8K
Aug-23	86.8K



PERFORMANCE UPDATE

Performance continues to deteriorate monthly due to our inability to increase capacity significantly beyond plan for patients waiting beyond 18 weeks for first definitive treatment.

The volume of total incomplete pathways is growing rapidly each week – a proportion of the referrals can be attributed to referral growth from primary care but a growing volume of out of area patients are being referred via non-primary care pathways to our clinicians.

Weekly more patient RTT pathways are being started (clock start) compared to those being ended (clock stop).

Elongated pathway waits in first, follow up and diagnostics are contributing to our ability to treat and end pathways before 78 weeks. The volume of 78 week breaches are increasing weekly and are forecast to continue growing due to demand for cancer and lack of capacity to treat routine patients.

Validation has been a key focus for speciality teams since last year, approximately 50% of the total RTT PTL is validated. The plan to roll out a digital solution, to support teams validating, is progressing. Furthermore the option to utilise the patient portal to support this programme of work is being reviewed and considered.

DM01 performance is impacting waiting times – an improvement plan to support recovery in the most challenged diagnostic modalities is underway but performance has significantly deteriorated in August to its lowest position. The deterioration in diagnostics performance is contributing to the decline in RTT performance.

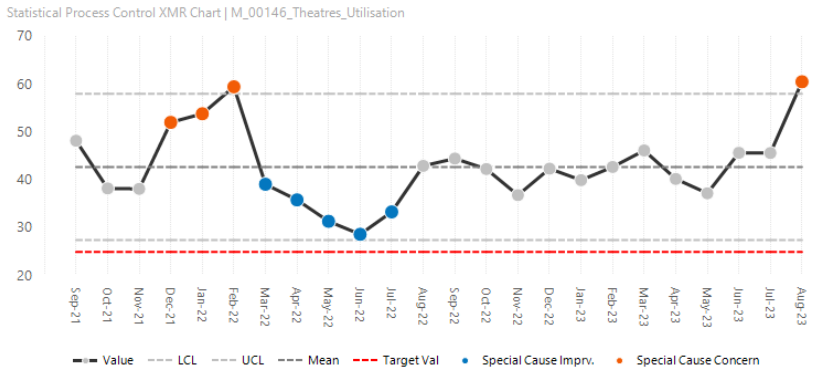
Efficiency Metrics

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

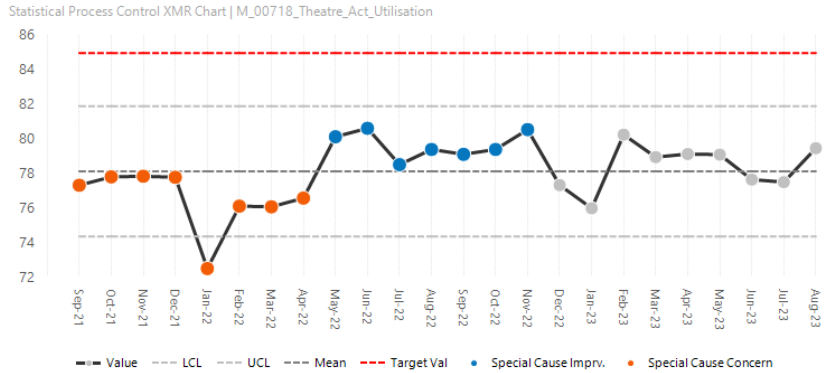
Theatre Session Opp.

Month	Value
Sep-22	45
Oct-22	42
Nov-22	37
Dec-22	42
Jan-23	40
Feb-23	43
Mar-23	46
Apr-23	40
May-23	37
Jun-23	46
Jul-23	46
Aug-23	61



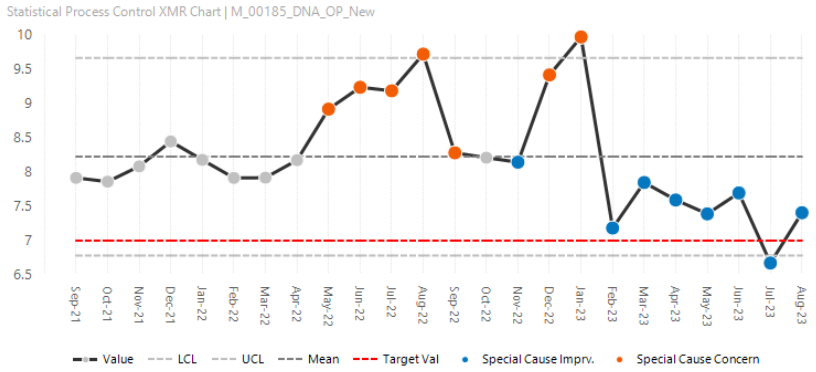
Theatre Actual Utilisation

Month	Value
Sep-22	79.1%
Oct-22	79.4%
Nov-22	80.6%
Dec-22	77.4%
Jan-23	76.0%
Feb-23	80.3%
Mar-23	79.0%
Apr-23	79.2%
May-23	79.1%
Jun-23	77.7%
Jul-23	77.5%
Aug-23	79.5%



DNA Rate OP New

Month	Value
Sep-22	8.3%
Oct-22	8.2%
Nov-22	8.1%
Dec-22	9.4%
Jan-23	10.0%
Feb-23	7.2%
Mar-23	7.9%
Apr-23	7.6%
May-23	7.4%
Jun-23	7.7%
Jul-23	6.7%
Aug-23	7.4%



PERFORMANCE UPDATE

Theatre session opportunity spiked in August due a large number of lists being cancelled. Doctor strike action was a contributing factor to the increase and is likely to continue into September with more strike action planned.

Theatre actual utilisation remains within normal variation around 78-79% utilised. Teams are being asked to book up to a minimum of 90% utilised in order to meet the aim of 85% actual utilisation moving forward. The Elective Orthopaedic Centre is aiming for an actual utilisation of 90%.

The theatre efficiency programme will be reviewed in line with new operational changes and specialty plans to improve theatre performance will be evaluated to ensure they are quantified and deliverable in line with theatre capacity and workforce.

DNA rates are showing signs of an improving nature with rates in July of 6.8%, below the Trust aim of 7%. Increasing numbers of patients now have the ability to choose their appointment date as specialties are moving back to the electronic referral service which appears to be having a positive impact and decreasing capacity lost due to DNA.

Quality & Safety

Quality & Safety

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
Quality	Serious Incidents	Sigma	Aug-23	12			1	18	35	Common cause (no significant change)
	Overdue Incidents	0	Aug-23	2,669			3,963	5,025	6,086	Special cause of improving nature or lower pressure due to lower values
	Incidents - Moderate / Severe	Sigma	Aug-23	32			9	34	58	Common cause (no significant change)
	HSMR	96.0	May-23	93.3			87	91	95	Common cause (no significant change)
	Pressure Ulcers	Sigma	Aug-23	113			75	108	142	Common cause (no significant change)

August Performance Summary

Incident Reporting: There were 2,339 patient incidents reported in August, of which 12 were declared as serious incidents at the Serious Incident Declaration Panel, which is chaired by the Chief Nursing and Midwifery Officer, the Chief Medical Officer or the Director of Quality Governance. This compares with 2,194 in July, 2,353 in June and 2,448 in May. A detailed report on these will be presented to CEMG on 4 October and Trust Board on 5 October, however a summary of each is presented on the next two slides.

Mortality: Following an upward trend in HSMR between October 2022 and March 2023, HSMR has now stabilised and is expected to improve further based on preliminary data available for June 2023. Analysis by the Mortality Surveillance Steering Group will continue to investigate potential causes for the upward trend seen prior to March 2023 and deliver any findings to the committee.

Harm Events: The number of harm events shows a plateauing trend this financial year with a subsequent increase in cases taken to the Serious Incident Declaration Panel, although not all cases presented resulted in an SI being declared. There has been improved clinician presence at this panel and following in-depth discussion the number of cases deemed to reach SI thresholds has not increased.

Serious Incidents

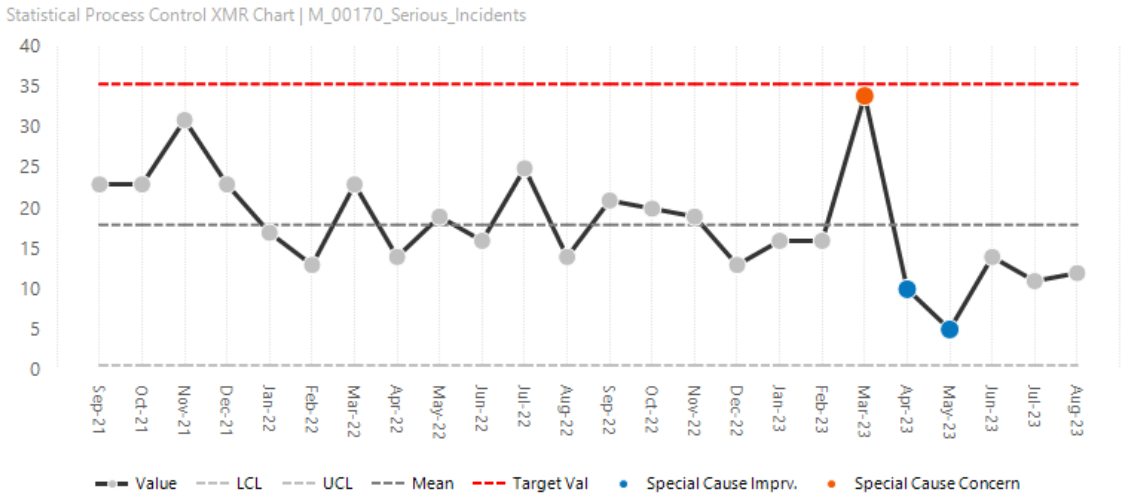
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures any incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System). Any incidents that are subsequently downgraded are removed retrospectively therefore this number is subject to change. Serious Incidents are reported by the date the investigation started and not the date the incident occurred or was reported.

Serious Incidents

Month	Value
Sep-22	21
Oct-22	20
Nov-22	19
Dec-22	13
Jan-23	16
Feb-23	16
Mar-23	34
Apr-23	10
May-23	5
Jun-23	14
Jul-23	11
Aug-23	12



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates inconsistently passing and falling short of the target

As described on the previous slide, there were 12 SIs reported in August and which are currently being investigated. In summary these were:

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
• Five HCAI/ infection prevention and control incidents	• A rapid review of five deaths linked to orthopaedic Surgical Site Infections (SSIs) at QEQM, led by the CN&MO, was undertaken. An in-depth and detailed action plan has been created and actions are being monitored at twice weekly meetings, led by the CN&MO.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• A more detailed report on these will be presented to CEMG on 4 October and Trust Board on 5 October 2023.
Continued on next page				→

Serious Incidents

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures any incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System). Any incidents that are subsequently downgraded are removed retrospectively therefore this number is subject to change. Serious Incidents are reported by the date the investigation started and not the date the incident occurred or was reported.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
• Two surgical/ invasive procedure incidents	• A patient was burned during a procedure due to the use of chlorhexidine (alcohol based) on the surgical site and the use of electrosurgery while the field was still wet. A review of the process used was undertaken (re use of chlorhexidine), to ensure standard practice is adhered to. • A complication occurred during the procedure whereby the catheter became sutured in. The catheter balloon was inappropriately inflated in the patient's urethra. A formal step has been introduced whereby the consultant asks if the catheter is inserted and mobile before the inflator is introduced.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• A more detailed report on these will be presented to CEMG on 4 October and Trust Board on 5 October 2023.
• Two sub-optimal care of deteriorating patients incidents	• Failure to promptly escalate a patient with a high NEWS2 score. Shared with the senior nursing team and operational teams at meeting on 15/08/2023. Matrons discussing daily the importance of early escalation and discussing patients in "real time" to ensure the correct escalation and treatment plans are in place. • Failure to promptly escalate a patient with sepsis. Training is underway with junior members of the nursing team to give them the tools to confidently escalate and raise concerns. The ward is developing a 'rhythm of the day' to ensure the nurse in charge is aware of all concerns and deteriorations of patients as part of their checks	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• A more detailed report on these will be presented to CEMG on 4 October and Trust Board on 5 October 2023.
• One diagnostic delay incident	• When the histology was available following the first LLETZ procedure, the woman was not given the correct follow up. Colposcopy management team to review records to see if there are any other women affected.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• A more detailed report on these will be presented to CEMG on 4 October and Trust Board on 5 October 2023.
• One unwitnessed patient fall with head injury	• described on slide 24			
• One pressure ulcer incident	• described on slide 24			

Overdue Incidents

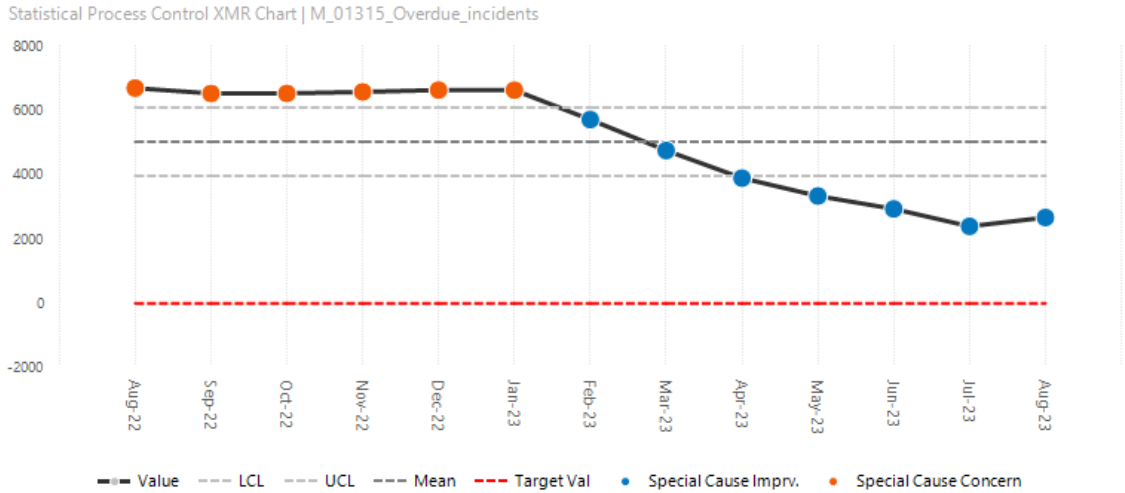
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of incidents which are overdue their agreed timescale for closure (all types) both overall and at each key stage of the investigation process: Awaiting review (AWAREV), In Review (INREV) and Awaiting Final Approval (AWAFA)

Overdue Incidents

Month	Value
Sep-22	6,531
Oct-22	6,532
Nov-22	6,579
Dec-22	6,637
Jan-23	6,635
Feb-23	5,716
Mar-23	4,755
Apr-23	3,897
May-23	3,340
Jun-23	2,938
Jul-23	2,395
Aug-23	2,669



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to lower values(| | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
There was a target set to have closed all overdue incidents by the end of August. Despite good progress, the deadline was not met. The majority of these incidents are in two care groups (Women's Health and General Specialist Medicine) both of which have depleted governance teams currently and are prioritising Serious Incidents over lower harm incidents.	• The focus remains on closing these incidents and a regular update is given by the Governance Matrons during weekly meetings with the Deputy Director of Quality Governance.	• Director of Quality Governance	• 31 November 2023	• Significant improvement has been seen across all care groups as seen in making this huge reduction. Additional support has been given to Women's Health and GSM care groups, who report the largest numbers and therefore require the greatest resource.

Incidents Causing Harm

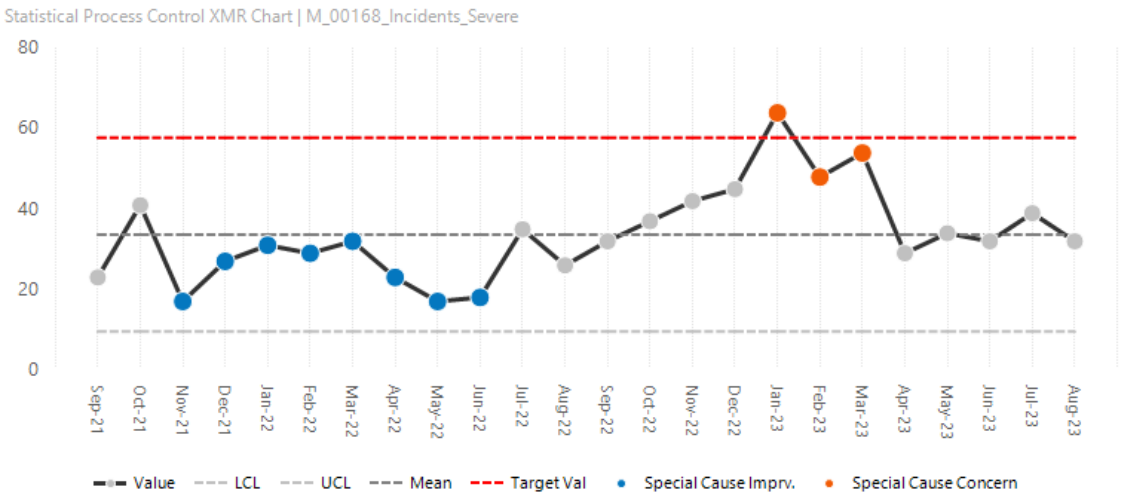
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of clinical incidents where the harm status was moderate or above.

Incidents - Moderate / Severe

Month	Value
Sep-22	32
Oct-22	37
Nov-22	42
Dec-22	45
Jan-23	64
Feb-23	48
Mar-23	54
Apr-23	29
May-23	34
Jun-23	32
Jul-23	39
Aug-23	32



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
One unwitnessed patient fall with head injury. One unwitnessed patient fall with fractured pubic rami	The Falls Specialist Nurse Service is reviewing the plan to ensure staff receive appropriate training and education to prevent and manage patient falls. Current provision includes: • Targeted learning from incidents • Ready to Care programme • Fundamentals of Care in GSM & Surgery • International Nurses / OSCE Training • Preceptorship • Ward based FallStop Champions In progress is review of online RCP endorsed training provision.	• Lead Nurse for Falls	• Education and training plan is currently being reviewed. • Review to be completed by October 2023.	Trust-Wide Falls Improvement Plan has on-going elements which are in the process of being implemented: • 78% complete • 6% on schedule to complete • 11% in progress and overdue • 5% not started
One moderate harm category 3 pressure ulcer on buttock acquired on ward.	The Pressure Ulcer Trust Wide Improvement plan includes the following focus points: • Leadership and culture • Early identification and intervention • Learning and Prevention • Education and training • Equipment • Clinical Pathways • System wide working to develop system wide community of practice.	• Lead Nurse for Tissue Viability	• Trustwide Improvement plan on-going	Trust-wide Tissue Viability Improvement action plan has ongoing elements which are in the process of being implemented: • 66% complete • 15% on schedule to complete • 8% in progress and overdue • 11% not started.

Hospital Standardised Mortality Ratio (HSMR)

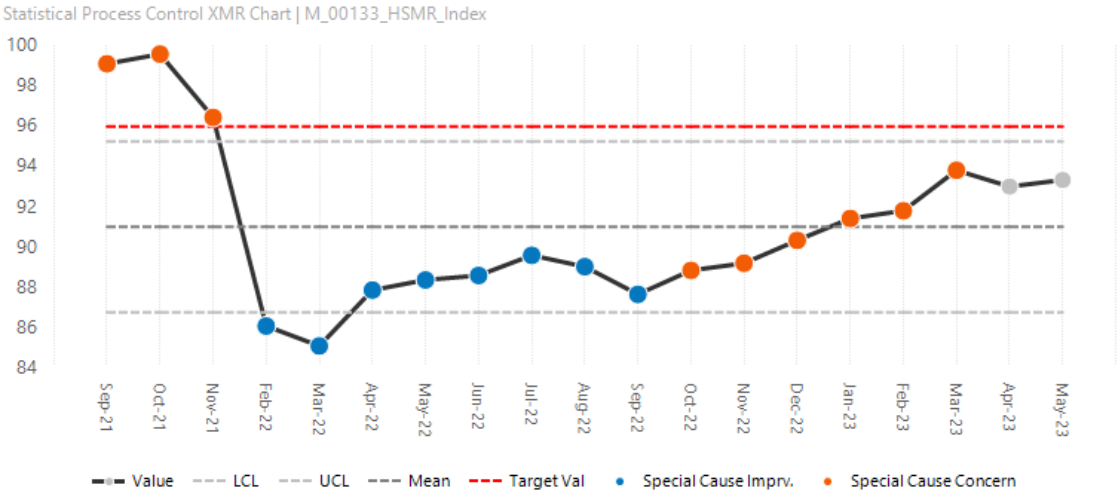
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

HSMR is a statistical number that enables the comparison of mortality rates between hospitals. This prediction takes account of factors such as the age and sex of the patient, their primary diagnosis, specialist palliative care and social deprivation of the area they live in. It is based on the 56 diagnostic groups which contribute to 80% of in-hospital deaths in England. HSMR is based on the likelihood of a patient dying of the condition with which they were admitted to hospital. If a Trust has an HSMR of 100 it means the number of patients who died is exactly as expected.

HSMR

Month	Value
Jun-22	88.6
Jul-22	89.6
Aug-22	89.0
Sep-22	87.6
Oct-22	88.8
Nov-22	89.2
Dec-22	90.3
Jan-23	91.4
Feb-23	91.8
Mar-23	93.8
Apr-23	93.0
May-23	93.3



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates consistently passing the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
To agree, develop and implement a Trust-wide Fractured Neck of Femur Pathway that will address and improve the eight Key Performance Indicators on the National Hip fracture database	• Analyse the recent increase to relative risk reported on Telstra Health UK via MSSG • Confirm remaining comments from WHH regarding fast track process • Launch ring fencing/fast track pilot on Seabathing and Kings C1	• KCVH CG	• Ongoing	• Ongoing work to understand and mitigate risks of recent rise in mortality and identification of surgical site infection.
Emergency Weekend Mortality is higher at the WHH site (specifically on Saturday) than national expected performance	• Review and analyse data in MSSG • Link and compare data through Telstra and integrate with the fractured neck of femur improvement plan • Review impact of higher than average patient complexity (Charlson Comorbidity) score.	• CMO	• Ongoing	• Identified at previous MSSG meeting for further investigation analysis.
"Rest of Miscellaneous Operations", "Viral Infection", and "Acute Myocardial Infarction" all have a higher than expected mortality rate	• Review and analyse data in MSSG • Identify any areas of concern and develop countermeasures for this to address relative risk above 100.	• CMO	• Sep 2023	• Analysis ongoing

Pressure Ulcers

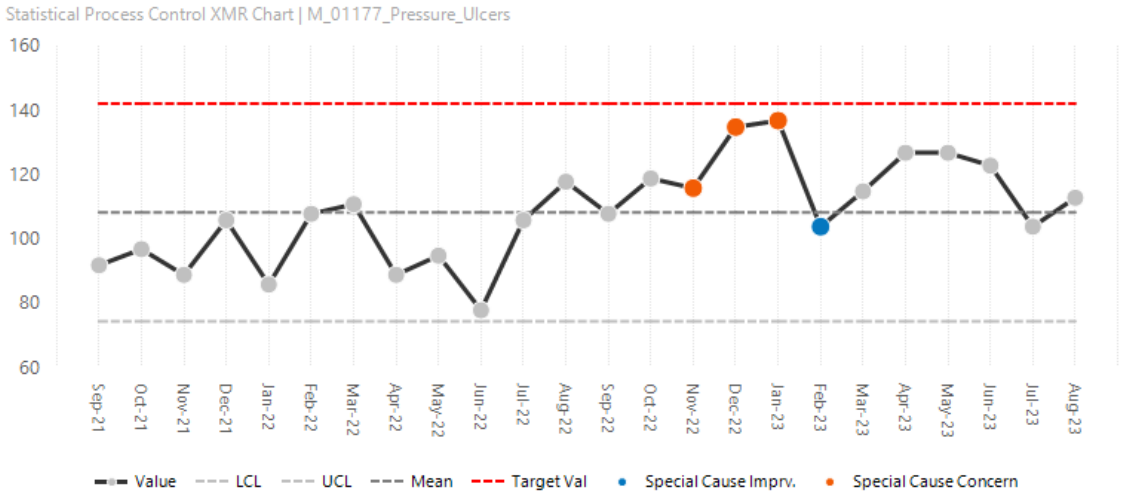
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Pressure ulcers (also known as pressure sores or bedsores) are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. They can happen to anyone, but usually affect people confined to bed or who sit in a chair or wheelchair for long periods of time.
This measure counts the number of hospital acquired pressure ulcers graded 1 to 4.
Datasource: DATIX

Pressure Ulcers

Month	Value
Sep-22	108
Oct-22	119
Nov-22	116
Dec-22	135
Jan-23	137
Feb-23	104
Mar-23	115
Apr-23	127
May-23	127
Jun-23	123
Jul-23	104
Aug-23	113



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Inaccurate Waterlow Risk assessment score resulting in delays or inappropriate pressure ulcer (PU) prevention interventions	• To rollout PURPOSE T risk assessment to replace Waterlow trust wide.	• Lead Tissue Viability Nurse (TVN) Specialist.	• Trust wide Rollout Jan 2024	• Training being undertaken in QE and WHH EDs. • WHH ED: Purpose T in use. • QEQM ED: to commence use of purpose T in October. • Maternity: to commence use in November. • Sunrise team adapting Purpose T for upload end 2023.
Patients with heel ulcers (9 all DTI or unstageable)	• Training being provided on wards to improve correct usage of HeelPro Boots.	• TVN	• Nov 2023	• Training provided to QEQM. • Training to commence at WHH and K&C.
• Lack of skin inspection (13) • Support surface/medical devices (8)	• SKINS bundle updated with prompts. • New wound assessment documentation	• TVN	• Oct 2023	• All documentation updated Sept 2023.
Prolonged length of stay in ED on a trolley increasing Patient harm from Hospital Acquired PU Trust wide.	• Increased TVN presence in ED ensuring appropriate risk assessment and equipment is in place. Targeted education. • Trial of a stretcher trolley for ED with high-risk mattress improving comfort & enhancing PU prevention.	• Lead TVN Specialist.	• Mar 2024	• Tissue Viability team presence in ED when on site. • ED trolley remains in tender process. • Recliner chairs now in place. • Patients transferred onto beds and active mattresses whenever space allows.

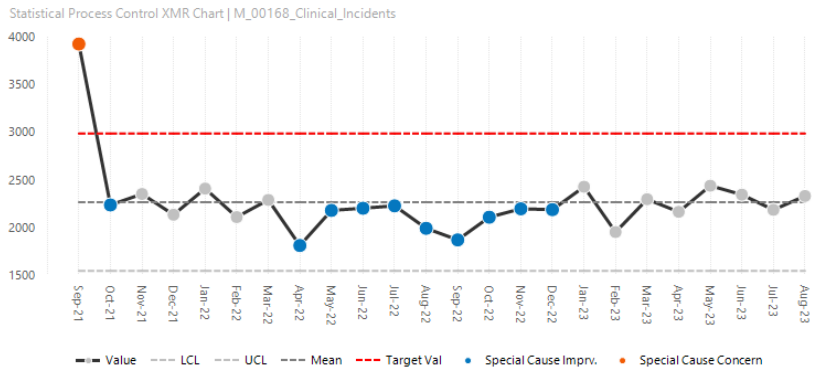
Incident Reporting

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

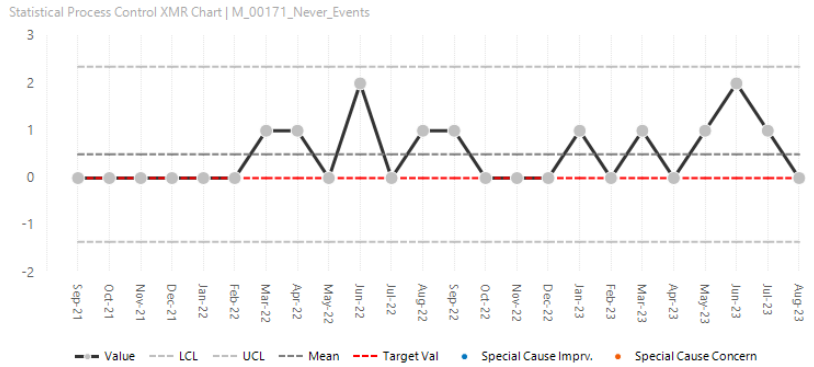
Clinical Incidents

Month	Value
Sep-22	1,879
Oct-22	2,117
Nov-22	2,205
Dec-22	2,196
Jan-23	2,436
Feb-23	1,961
Mar-23	2,305
Apr-23	2,173
May-23	2,447
Jun-23	2,353
Jul-23	2,194
Aug-23	2,339



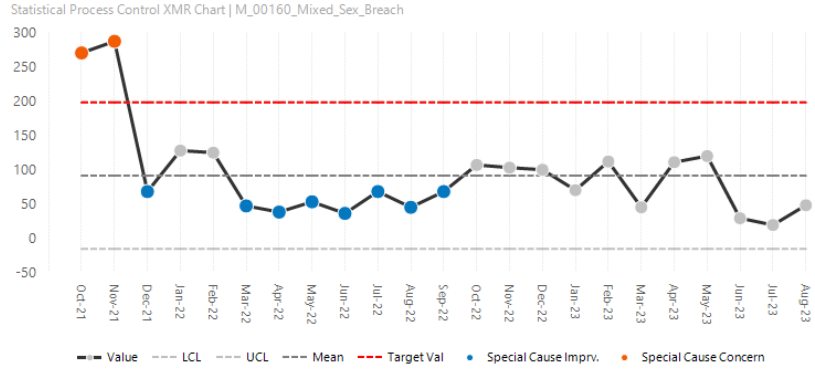
Never Events

Month	Value
Sep-22	1
Oct-22	0
Nov-22	0
Dec-22	0
Jan-23	1
Feb-23	0
Mar-23	1
Apr-23	0
May-23	1
Jun-23	2
Jul-23	1
Aug-23	0



Mixed Sex Breaches

Month	Value
Sep-22	69
Oct-22	108
Nov-22	104
Dec-22	101
Jan-23	71
Feb-23	113
Mar-23	46
Apr-23	112
May-23	121
Jun-23	30
Jul-23	20
Aug-23	49



PERFORMANCE UPDATE

Clinical Incident reporting continues to show common cause variation and no significant change. It remains below the upper threshold set for clinical incidents. Ensuring that no-harm events are scrutinised gives assurance that all of these events are captured.

There were no Never Events in August 23.

Mixed sex breaches: The graph shows us incidences of unjustifiable Mixed Sex Accommodation breaches due to non clinical reasons. The key objective is to achieve zero Mixed sex accommodation breaches. In March 23 it was agreed with the ICB that SEAU would change to Surgical SDEC and therefore out of scope for national reporting, resulting in consistency across Kent and Medway. In July 23 a further agreement was reached with the ICB that MAU breaches are those sharing mixed sex accommodation for greater than 4 hours, with a decision to admit, but that the breach declared will be for the individual patient and not the unit as a whole.
No complaints have been received about mixed sex accommodation from patients during the last 3 months.

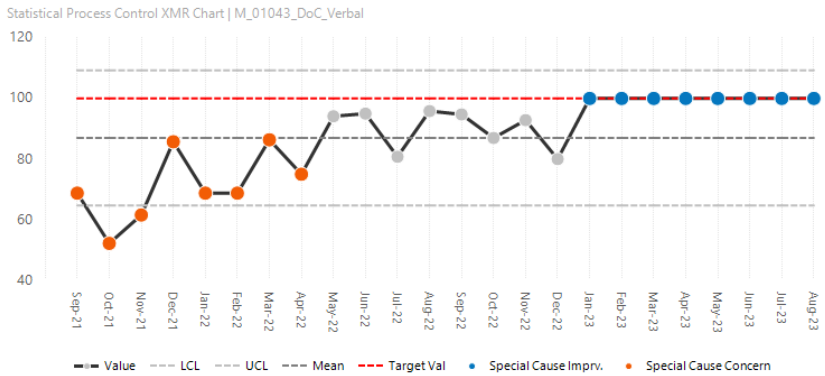
Duty of Candour

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

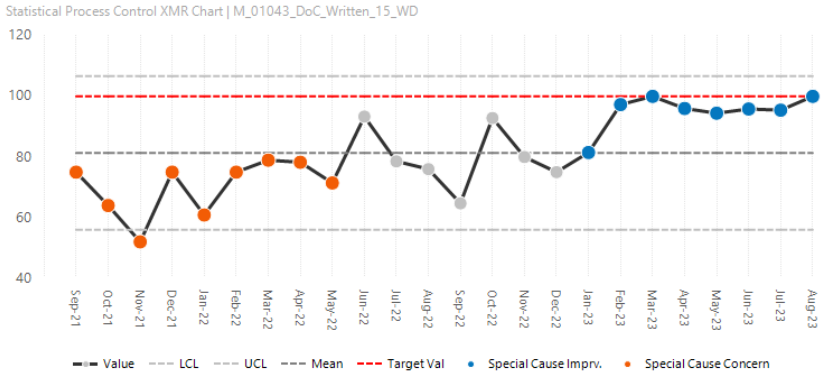
Duty of Candour - Verbal

Month	Value
Sep-22	94.7%
Oct-22	87.0%
Nov-22	92.9%
Dec-22	80.0%
Jan-23	100%
Feb-23	100%
Mar-23	100%
Apr-23	100%
May-23	100%
Jun-23	100%
Jul-23	100%
Aug-23	100%



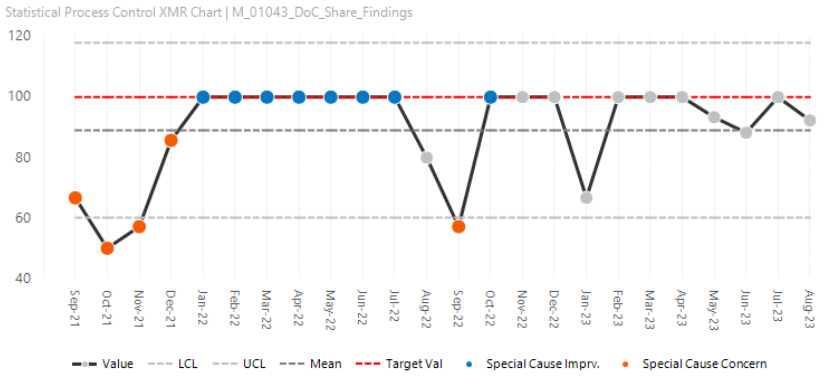
Duty of Candour - Written 15wd

Month	Value
Sep-22	64.7%
Oct-22	92.9%
Nov-22	80.0%
Dec-22	75.0%
Jan-23	81.5%
Feb-23	97.3%
Mar-23	100%
Apr-23	96.0%
May-23	94.4%
Jun-23	95.8%
Jul-23	95.5%
Aug-23	100%



Duty of Candour - Findings

Month	Value
Sep-22	57.1%
Oct-22	100%
Nov-22	100%
Dec-22	100%
Jan-23	66.7%
Feb-23	100%
Mar-23	100%
Apr-23	100%
May-23	93.3%
Jun-23	88.2%
Jul-23	100%
Aug-23	92.3%



PERFORMANCE UPDATE

Duty of Candour (DoC) metrics have been upheld since January 2023. The data for July had a discrepancy which has been resolved. Both Verbal DoC and the follow-up letter are 100% compliant.

The final DoC letter which accompanies the completion of the investigation report achieved 92.3% compliance. This is due to some cases being discussed verbally and then a meeting made to share the evidence without the letter being sent at that point.

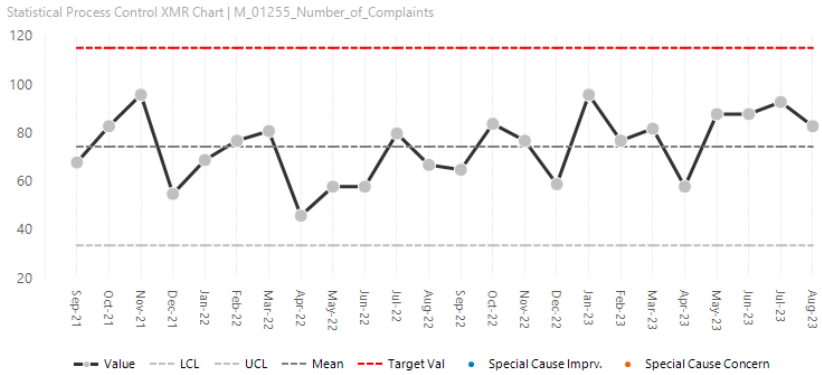
Complaints

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

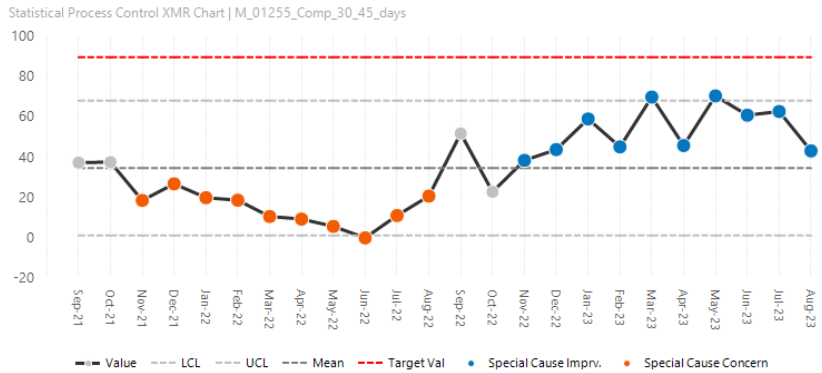
Complaints Number

Month	Value
Sep-22	65
Oct-22	84
Nov-22	77
Dec-22	59
Jan-23	96
Feb-23	77
Mar-23	82
Apr-23	58
May-23	88
Jun-23	88
Jul-23	93
Aug-23	83



Complaint Response

Month	Value
Sep-22	52.0%
Oct-22	22.9%
Nov-22	38.6%
Dec-22	44.0%
Jan-23	59.3%
Feb-23	45.3%
Mar-23	70.1%
Apr-23	46.0%
May-23	70.7%
Jun-23	61.1%
Jul-23	63.0%
Aug-23	43.3%



PERFORMANCE UPDATE

August 2023 saw 997 contacts to the department resulting in 82 new formal complaints and 451 new PALS contacts being taken forward. 8% of contacts in August 2023 were taken forward as new formal complaints.
As a seasonal comparison of August 2023 to August 2022: there were 74 new complaints, a 10.8% increase in formal complaints and 610 PALS, a 35.3% decrease in the number of PALS.

The highest number of contacts are in relation to gastroenterology and cardiology. The DQG is currently arranging to meet with the operational teams to determine what needs to be done to reduce the number of contacts.
96% of the new complaints were acknowledged within three working days, this is above the target of 90%.

August 2023 saw a decrease in performance of responses within timescales to 43.3%, from 64% in July 2023. As a seasonal comparison there has been an improvement on performance when compared to August 2022, responses within timescales was 20%.

The sustained increased number of new complaints continues to affect complaint response performance, partly this is due to the complexity of PALS and complaints being received.

A thematic review of the seven complaints where a delay has been the most significant factor has been completed for August however no specific themes have emerged.

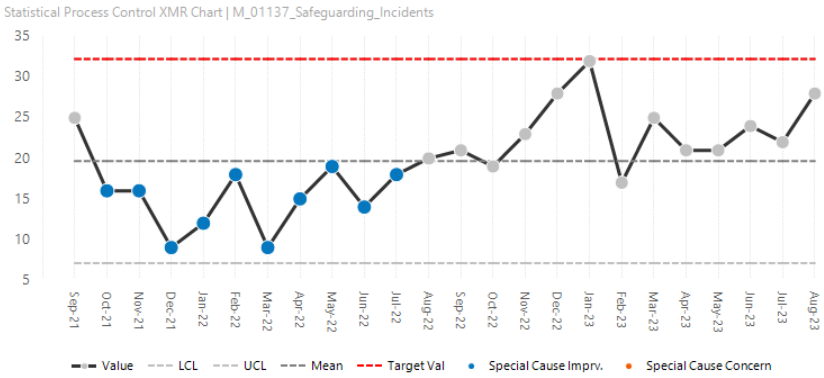
Safeguarding

Statutory Metrics

NHS
East Kent Hospitals University
NHS Foundation Trust

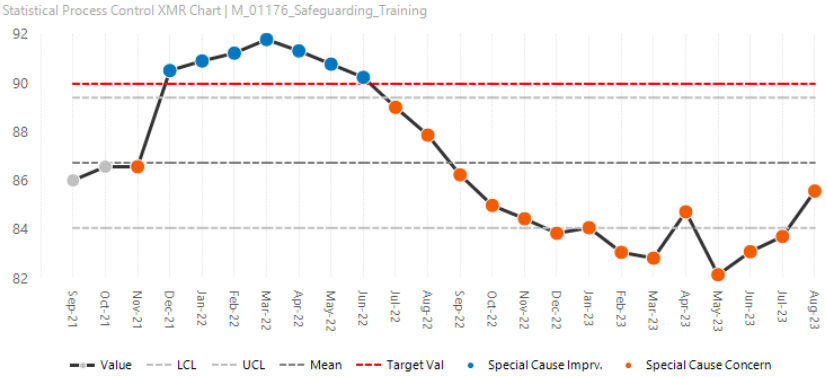
Safeguarding Incidents

Month	Value
Sep-22	21
Oct-22	19
Nov-22	23
Dec-22	28
Jan-23	32
Feb-23	17
Mar-23	25
Apr-23	21
May-23	21
Jun-23	24
Jul-23	22
Aug-23	28



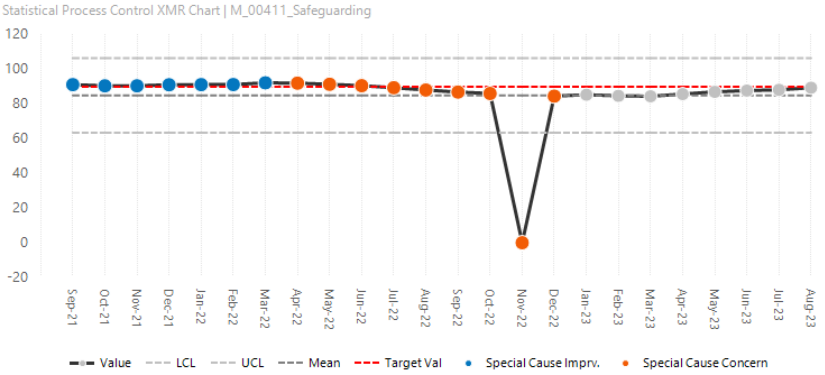
Safeguarding Adults Training

Month	Value
Sep-22	86.3%
Oct-22	85.0%
Nov-22	84.5%
Dec-22	83.9%
Jan-23	84.1%
Feb-23	83.1%
Mar-23	82.9%
Apr-23	84.8%
May-23	82.2%
Jun-23	83.1%
Jul-23	83.7%
Aug-23	85.6%



Safeguarding Children Training

Month	Value
Sep-22	87.0%
Oct-22	86.2%
Nov-22	0.0%
Dec-22	84.6%
Jan-23	85.5%
Feb-23	84.8%
Mar-23	84.6%
Apr-23	85.8%
May-23	87.1%
Jun-23	87.8%
Jul-23	88.3%
Aug-23	89.5%



PERFORMANCE UPDATE

The reporting of all safeguarding metrics is outlined in the Business report and safeguarding dashboard with KPIs. This report goes to the Safeguarding Operational Group with exception to the Safeguarding Assurance Committee. Safeguarding metrics were also reported in the last Schedule 4 to the ICB.

There has been an increase in safeguarding concerns being raised, which appears to be more from people with complex mental health and relatives of patients with complex needs. The risk register has been reviewed and updated to reflect this increase. It has been identified that the number of open section 42 and overdue was incorrect and a more in depth audit of this is being undertaken urgently to establish the nature and extent of the number of backlog and outstanding section 42s, as part of mitigation for the risk on the risk register.

With regards to training - there remains a shortfall in training compliance at level 2 (children and adults) and 3 (children and adults) across the Care Groups at the agreed local level of **85% in line with national level** (end of June compliance).

The trajectories in place from all Care Groups is not reflected below as this has been a challenge obtaining this since the Care Groups changed. However, the compliance by December 2023 remains and the Care group will need to provide an update on this if this is likely to change.

1. Critical Care, Anaesthetics and Specialist Surgery: L2C – **85%,** L3C – **90%,** L2A – **88%** and L3A – **66%.**
2. Diagnostics, Cancer and Buckland : L2C – **81%,** L3C – **86%,** L2A - 86**% L3A- 48%**
3. Kent & Canterbury and Royal Victoria - L2C – **87%,** L3C – **71%,** L2A – **79%** and L3A – **62%.**
4. QEQM - L2C – **81%,** L3C – **86%,** L2A – **80%** and L3A – **73%.**
5. WHH :- L2C – **not provided,** L3C – **87%,** L2A – **77%** and L3A – **66%.**
6. Women and CYP: - L2C – **82 %,** L3C – **86%,** L2A – **85%** and L3A – **72%.**
7. Corporate - L2C – **83%** L3C – **93%,** L2A – **88%** and L3A – **66%.**

The safeguarding team continue to provide more sessions and support, however, the DNA remains high. This is being addressed by the Deputy Chief Nurse and the Care Groups Governance.
This is also being addressed through the NHSE and ICB Safeguarding Oversight Meetings, ICB PQM through schedule 4 requirements and the CQC must do requirements relating to safeguarding training.

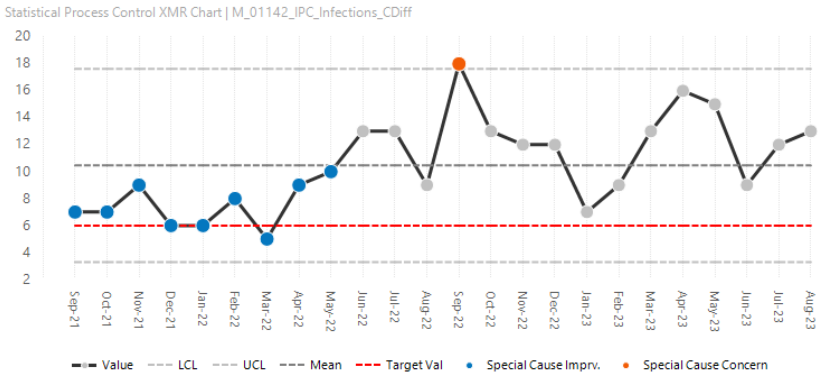
Infection Prevention Control

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

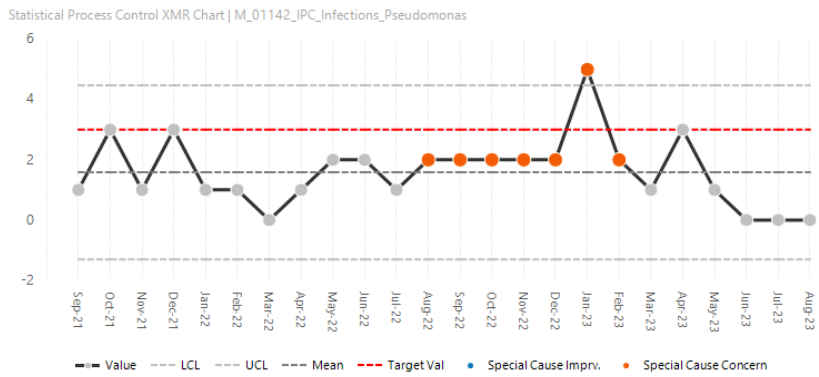
IPC: CDiff Infections

Month	Value
Sep-22	18
Oct-22	13
Nov-22	12
Dec-22	12
Jan-23	7
Feb-23	9
Mar-23	13
Apr-23	16
May-23	15
Jun-23	9
Jul-23	12
Aug-23	13



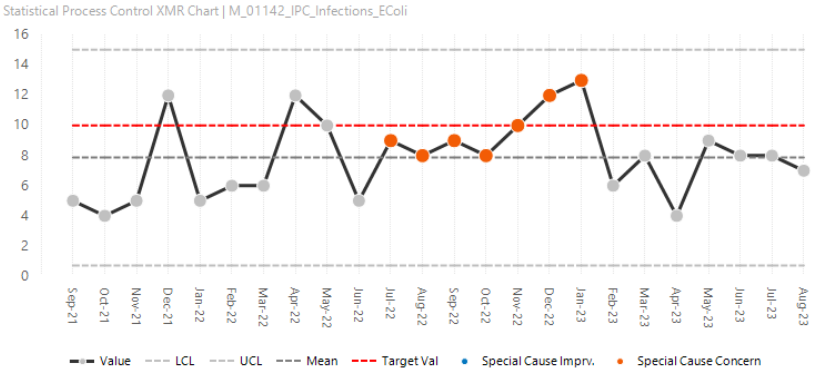
IPC: Pseudomonas Infections

Month	Value
Sep-22	2
Oct-22	2
Nov-22	2
Dec-22	2
Jan-23	5
Feb-23	2
Mar-23	1
Apr-23	3
May-23	1
Jun-23	0
Jul-23	0
Aug-23	0



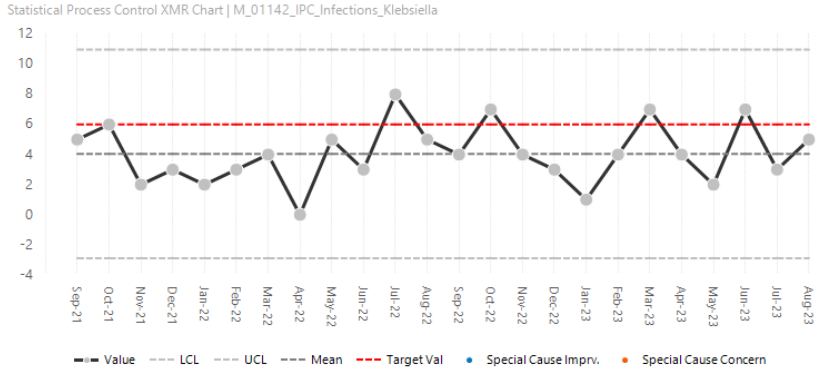
IPC: EColi Infections

Month	Value
Sep-22	9
Oct-22	8
Nov-22	10
Dec-22	12
Jan-23	13
Feb-23	6
Mar-23	8
Apr-23	4
May-23	9
Jun-23	8
Jul-23	8
Aug-23	7



IPC: Klebsiella Infections

Month	Value
Sep-22	4
Oct-22	7
Nov-22	4
Dec-22	3
Jan-23	1
Feb-23	4
Mar-23	7
Apr-23	4
May-23	2
Jun-23	7
Jul-23	3
Aug-23	5



PERFORMANCE UPDATE

Performance against trajectories for the gram negative bacteraemias remains just above on target, with ongoing monitoring and local actions underway where incidences occur.

The C-dif trajectory remains one of concern, and the Trust will not meet the planned threshold this year. All cases are reviewed for learning, and the main focus remains antimicrobial stewardship, and owing to an outbreak of c-dif associated with environmental spread; accounting for 6 cases, cleaning of the environment and equipment. C-dif rates remain a regional concern, and the Trust are active participants in the regional c-dif reduction group, lead by the ICB.

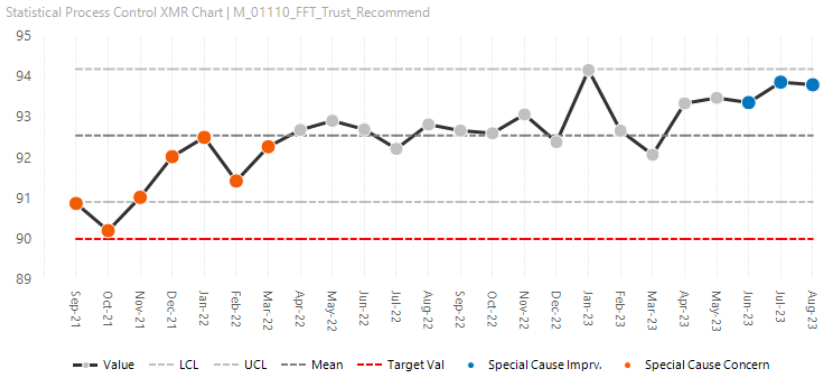
Friends & Family Test

Statutory Metrics

NHS
East Kent Hospitals University
NHS Foundation Trust

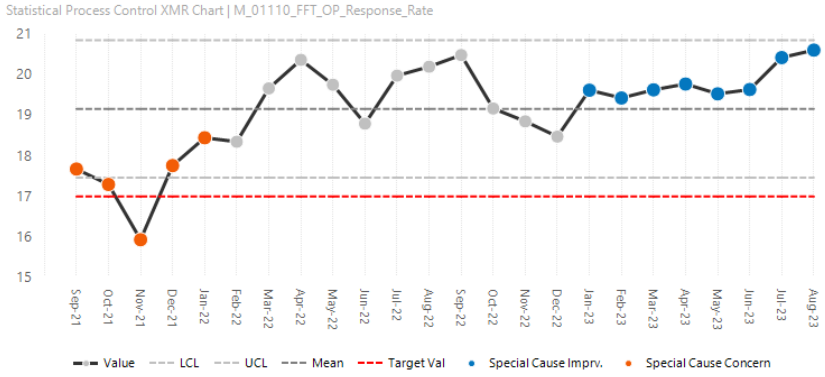
FFT Trust Recommend

Month	Value
Sep-22	92.7%
Oct-22	92.6%
Nov-22	93.1%
Dec-22	92.4%
Jan-23	94.2%
Feb-23	92.7%
Mar-23	92.1%
Apr-23	93.4%
May-23	93.5%
Jun-23	93.4%
Jul-23	93.9%
Aug-23	93.8%



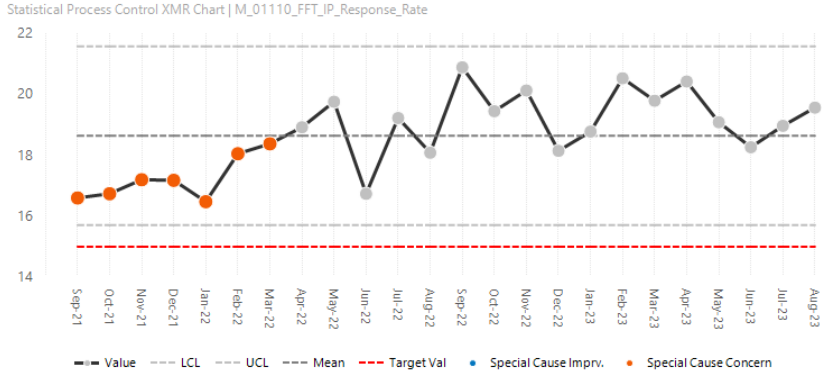
FFT OP Response Rate

Month	Value
Sep-22	20.5%
Oct-22	19.2%
Nov-22	18.9%
Dec-22	18.5%
Jan-23	19.6%
Feb-23	19.4%
Mar-23	19.6%
Apr-23	19.8%
May-23	19.5%
Jun-23	19.6%
Jul-23	20.4%
Aug-23	20.6%



FFT IP Response Rate

Month	Value
Sep-22	20.9%
Oct-22	19.5%
Nov-22	20.1%
Dec-22	18.2%
Jan-23	18.8%
Feb-23	20.5%
Mar-23	19.8%
Apr-23	20.4%
May-23	19.1%
Jun-23	18.3%
Jul-23	19.0%
Aug-23	19.6%



PERFORMANCE UPDATE

The percentage of patients who would recommend an NHS trust is now referred to nationally as the satisfaction level. The trust's overall satisfaction level has remained over our target level of 90% for the past two years at between 92.1% and 94.2% from August 2022 to August 2023.

Our Friends and Family Test (FFT) response rate for outpatients has been between 18.5% and 20.5% from August 2022 to August 2023.
There is no longer a national target for response rates.

Our FFT response rate for in-patients is between 18.1% and 20.9% from August 2022 to August 2023. **Triangulation of theming from FFT, the national in-patient survey and our Trust in-patient survey shows that patients are dissatisfied with the discharge process and information given when leaving hospital.**

For **Urgent and Emergency Care** our FFT satisfaction level in July was **87%** compared to the national score of **81%. It has been 85% plus for the last three months. This is a positive trend.**

How we compare with national data:
The most recent national data available is for July 2023. For in-patient care, the **national** satisfaction level is **95%** and for outpatient care it is **94%.** Therefore, our satisfaction level for in-patients of an average of **90%** for June to August 2023 is **significantly lower** and **slightly higher** for outpatients at around **95%.**

How we compare with other acute (hospital) trusts in Kent and Medway:
In-patient: In July we scored **92**%, Dartford and Gravesham scored **94**%, Maidstone and Tunbridge Wells scored **97**% and Medway **93**%. Comparing response numbers we received 748 responses, Dartford and Gravesham received 919 responses, Maidstone and Tunbridge Wells received 1,810 responses and Medway received 1,609 responses. **It should be noted that these trusts use a mix of methods including online and paper forms as well as texts, which may account for a higher number of responses. However, as we also use an on-going inpatient survey, we achieve a higher volume of insight overall.**

Out-patients: In July 2023 we scored **95**%, Dartford and Gravesham scored **94**%, Maidstone and Tunbridge Wells scored **96**% and Medway **92**%. Comparing response numbers we received 12,320 responses, Dartford and Gravesham received 1,635 responses, Maidstone and Tunbridge Wells received 3,724 responses and Medway received 1,799 responses. **A new Theming Tracker enables our services to theme free text comments.**

People

People, Leadership & Culture

Integrated Improvement Plan

NHS
East Kent Hospitals University
NHS Foundation Trust

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
People	Sickness	5.0%	Aug-23	4.9%			4	5	7	Special cause of improving nature or lower pressure due to lower values
	Vacancy Rate	10.0%	Aug-23	7.9%			8	10	12	Special cause of improving nature or lower pressure due to lower values
	Staff Turnover Rate	10.0%	Aug-23	9.2%			10	10	11	Special cause of improving nature or lower pressure due to lower values
	Premature Turnover Rate	25.0%	Aug-23	13.7%			15	16	16	Special cause of improving nature or lower pressure due to lower values
	Staff Engagement Score	6.80	Aug-23	6.27			6	6	6	Special cause of concerning nature or higher pressure due to lower values
	Statutory Training	91.0%	Aug-23	92.1%			83	90	97	Special cause of improving nature or lower pressure due to higher values
	Medical Job Planning Rate	90.0%	Aug-23	52.3%			26	39	51	Special cause of improving nature or lower pressure due to higher values
Leadership & Culture	Staff Advocacy Score	6.70	Aug-23	5.83			6	6	6	Special cause of concerning nature or higher pressure due to lower values

August Performance Summary

People Metrics: Sickness absence remains below the desired threshold at 4.9% but has been increasing for 3 months. Vacancy rate remains below the desired threshold, with improvements appearing to plateau. Staff turnover has reduced further to 9.2% and has now sat below the national standard (10%) for eight consecutive months. Premature turnover remains stable, continuing to improve incrementally – and currently stands at 13.7%, below the proposed new threshold. Statutory training has improved to 92.1%, the highest it has been in over a year, although compliance across the medical staff group (74%) remains an issue.

Engagement Metrics: The National Staff Survey launched on Monday 18th September, with 10 weeks of fieldwork underway and a closing date of Friday 24th November. Response rates will be published weekly to identify areas in need of support, but engagement results will not be updated again until 2024 due to the national embargo. The latest results (in Q2) showed that staff engagement (6.27) is up 7 points and is in the second quartile nationally, against a revised national standard of 6.50. Motivation is up 8 points to 6.69 and involvement is up 6 points to 6.29. Both motivation and involvement are now within 0.1 of the national average. A comprehensive range of activity is planned throughout the NSS fieldwork to ensure response rates are as high as possible and give credible results. Included within this are socialising the actions that have taken place since last years' survey to combat survey fatigue, along with establishing the confidentiality and anonymity that is instrumental to a successful rollout.

Leadership Metrics: Staff Advocacy (5.83) was up 7 points to 5.83 in Q2 but remains in the lowest quartile nationally. As advocacy metrics fall within the national embargo, the next update on this will be in 2024. It continues to represent the domain of engagement which is furthest (0.6 away) from the national standard (6.4) and is the primary contributor to reduced staff engagement levels across the organisation. Recent evidence has demonstrated advocacy levels are considerably higher (up to 62 points) in We Care areas than their non-We Care counterparts, and work is ongoing to roll this out further across more areas of the organisation through waves 7 and 8, with 337 further colleagues trained since Sept 22.

Staff Sickness

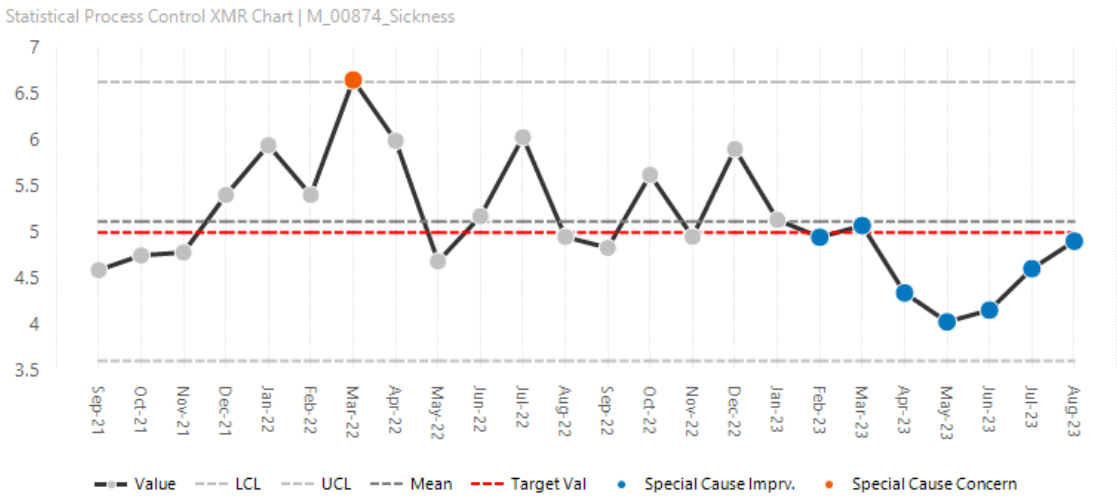
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The percentage of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs).
Data Source: Healthroster, eRostering for the current month (unvalidated) with previous months using the validated position from ESR.

Sickness

Month	Value
Sep-22	4.8%
Oct-22	5.6%
Nov-22	5.0%
Dec-22	5.9%
Jan-23	5.1%
Feb-23	4.9%
Mar-23	5.1%
Apr-23	4.3%
May-23	4.0%
Jun-23	4.2%
Jul-23	4.6%
Aug-23	4.9%



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to lower values(| Below Mean Run Group | | | |)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining **sickness absence** below 5%, and improved against our fellow Trusts in the ICB	• Working with NHSEI on the Absence Tool Kit to review current sickness management processes and develop actions for improvement.	• Heads of P&C, P&CBPs	• End Sept 23	• Toolkit completed, and Absence Actions plan developed actions, including a focus on areas of high sickness absence and high premium pay costs.
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.	• Head of Staff Experience, Heads of P&C, P&CBPs, OH	• Ongoing	• Anxiety/Stress related sickness absence approximately half of what it was 2 years ago, and maintaining around 15% of all absences. Care Group Teams monitor stress related absence monthly, down to ward level.
Improved pro-active absence management	• New P&C Care Group Teams to focus on absences through a Care Group deep dive, and P&C support.	• P&C Care Group Teams	• End Sept 23	• Deep Dive absence review taking place during September to identify areas with low absence management and high sickness.

Staff Vacancy Rate

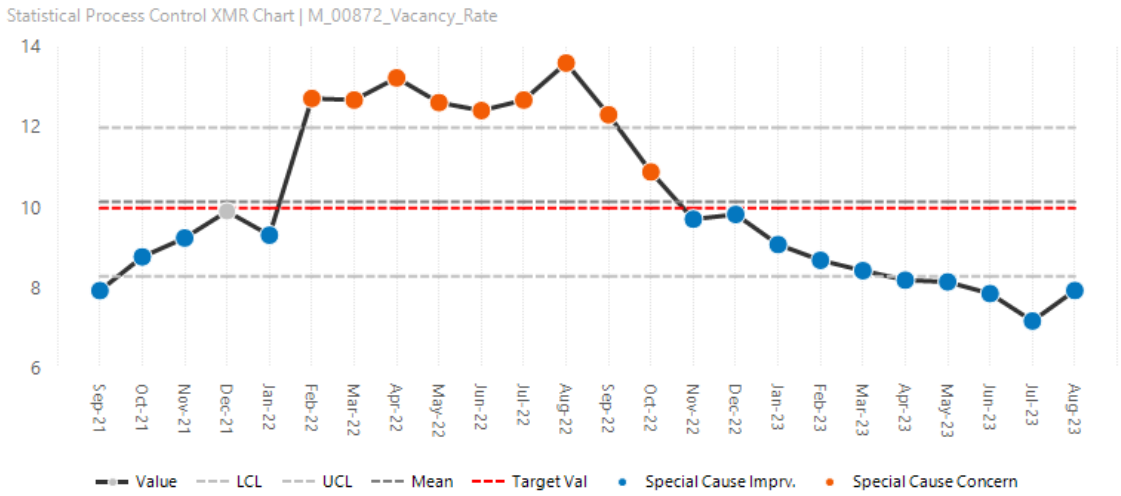
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The proportion of vacant positions against the number of Whole Time Equivalent (WTE) funded establishment.
Datasource: ESR

Vacancy Rate

Month	Value
Sep-22	12.3%
Oct-22	10.9%
Nov-22	9.7%
Dec-22	9.8%
Jan-23	9.1%
Feb-23	8.7%
Mar-23	8.4%
Apr-23	8.2%
May-23	8.2%
Jun-23	7.9%
Jul-23	7.2%
Aug-23	7.9%



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to lower values(| Below Mean Run Group | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates inconsistently passing and falling short of the target

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.	• Heads of P&C • P&CBPs	• Ongoing	• New P&C Teams to focus on vacancies as part of Exec Efficiency Meetings and PRMs, supported by Care Group leads meetings.
Reduction in Premium Pay by focusing on hard to recruit roles.	• Workforce Strategies developed for care Groups, focusing on those areas with hard to recruit posts, and a plan to address this.	• Strategic Workforce Lead • Heads of P&C • P&CBPs	• End Sept 23	• Top 7 Hard to Recruit Consultant roles vacancy rate decreased from 21.5% to 20.8% in July 23. Further hard to recruit roles out to advert with social media campaigns.
Minimising risk of turnover by improving retention and reducing time to hire.	• Focus on time to hire, with Dashboard set up to monitor.	• Head of Resourcing	• Ongoing	• Time to hire 9.1 weeks. • Band 5 Nursing vacancy rate down to 9.3% • HCSW vacancy rate down o 7.82%

Staff Turnover Rate

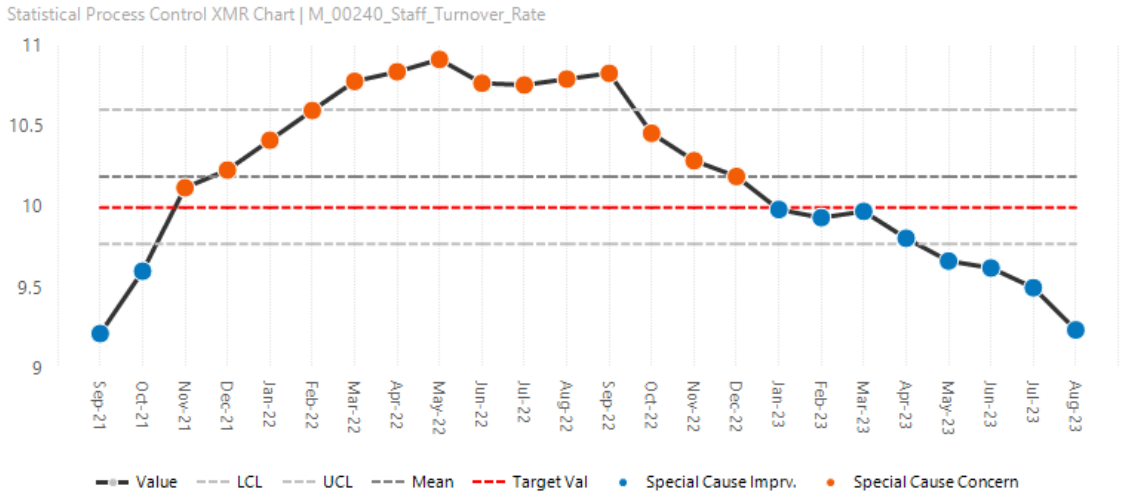
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The number of staff leaving & joining the Trust against Whole Time Equivalent (WTE).
Metric excludes; Doctors in training, fixed term and bank staff and the following leaving reasons, Death in Service, Employee Transfer, Dismissal, Flexi Retirement, Pregnancy & Redundancy.

Staff Turnover Rate

Month	Value
Sep-22	10.8%
Oct-22	10.5%
Nov-22	10.3%
Dec-22	10.2%
Jan-23	10.0%
Feb-23	9.9%
Mar-23	10.0%
Apr-23	9.8%
May-23	9.7%
Jun-23	9.6%
Jul-23	9.5%
Aug-23	9.2%



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to lower values(| Below Mean Run Group | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
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 has been below the desired threshold for 8 consecutive months & stands at **9.2%**
Maintaining **Nurse Turnover** against a gold standard of 10%	• Implementation of actions against the Nursing Workforce Retention Action plan	• Associate Director of Nursing	• Ongoing	• Nurse Turnover has been below the desired threshold for 18 consecutive months & stands at **8.4%**
Reducing **Healthcare Support Worker** Turnover below 13.5%	• Introduction of the HCSW Voice Programme and continued delivery of the Ready to Care programme	• Matron for Recruitment & Career Dev.	• Ongoing	• HCSW Turnover has been below the desired threshold for 8 consecutive months & stands at **11.1%**

Premature Staff Turnover Rate

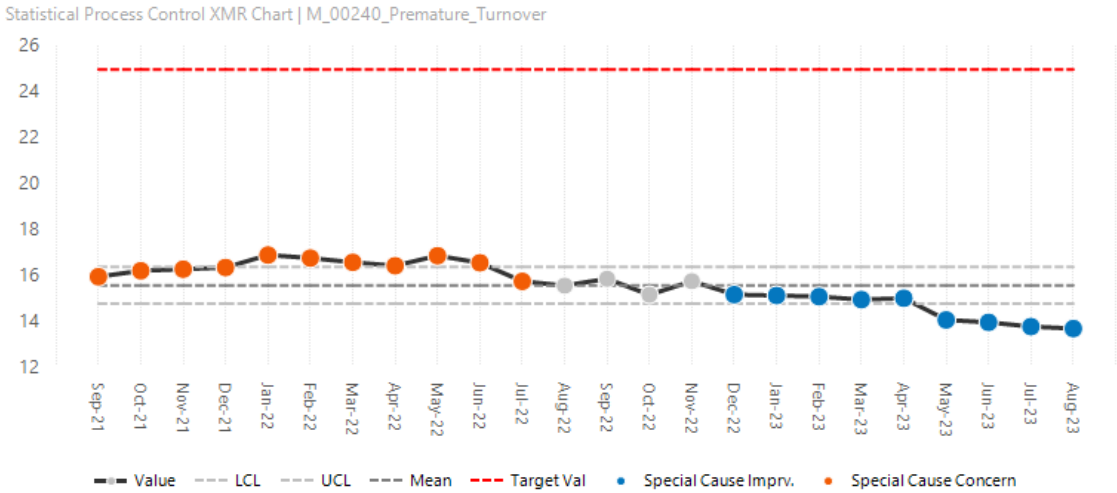
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The number of staff leaving the Trust within their first year of employment as a proportion of the total number of staff in the organisation with less than 12 months' service.
Metric excludes; Doctors in training, fixed term and bank staff and the following leaving reasons, Death in Service, Employee Transfer, Dismissal, Flexi Retirement, Pregnancy & Redundancy.

Premature Turnover Rate

Month	Value
Sep-22	15.9%
Oct-22	15.2%
Nov-22	15.8%
Dec-22	15.2%
Jan-23	15.1%
Feb-23	15.1%
Mar-23	15.0%
Apr-23	15.0%
May-23	14.1%
Jun-23	14.0%
Jul-23	13.8%
Aug-23	13.7%



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to lower values(| Below Mean Run Group | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently passing the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
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 (**13.7%**) has been below the suggested new threshold (15%) for 4 consecutive months and on a positive downward trend
Reduction in **Premature Turnover** below desired threshold of 15%	• Efforts to improve the new starter experience through onboarding and induction	• Head of Staff Experience	• Ongoing	• Premature turnover improved by 3% across 18-months. Evidence that initial experience is strong but needs bolstering across first 6 months
Improvement in the **New Starter Experience** (as denoted by the Kent & Medway NSES)	• Efforts to improve the new starter experience through onboarding and induction	• Head of Staff Experience	• End Jan 24	• Overall net engagement score for new starters (73%) 17% ahead of the K&M average (56%) as at 19/09/23

Staff Engagement Score

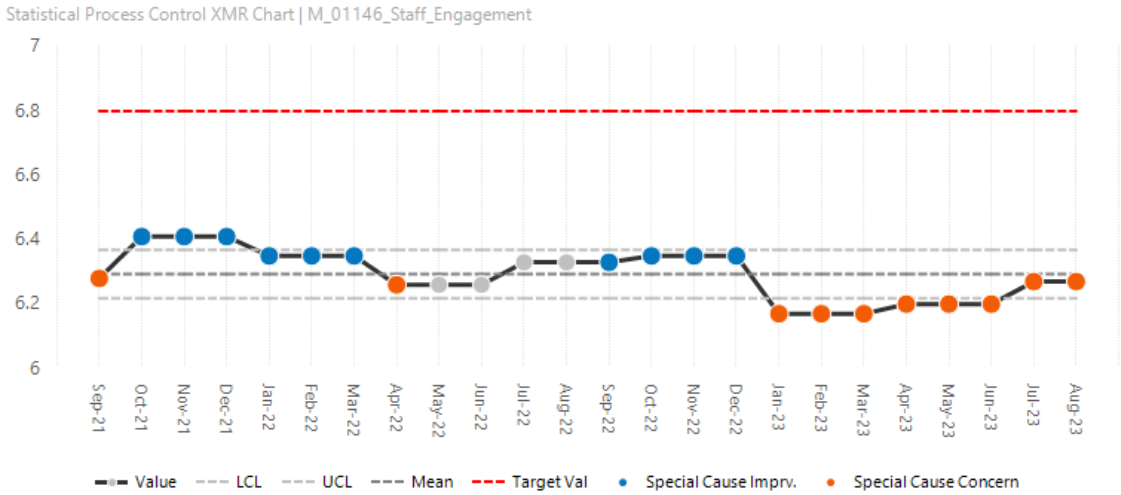
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

National annual staff survey results provided by Picker March each year.
Staff engagement questions added to Staff Friends and Family quarterly surveys commencing March 2021.
9 questions in staff survey and replicated in quarterly staff FFT (3 x motivation, 3 x involvement and 3 x advocacy) which provide overall engagement score.

Staff Engagement Score

Month	Value
Sep-22	6.33
Oct-22	6.35
Nov-22	6.35
Dec-22	6.35
Jan-23	6.17
Feb-23	6.17
Mar-23	6.17
Apr-23	6.20
May-23	6.20
Jun-23	6.20
Jul-23	6.27
Aug-23	6.27



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to lower values(| Below Mean Run Group | | | |)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Engagement levels (6.3) are below the national average (6.5)	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated	• Head of Staff Experience	• Next results available Jan/ Feb 24 (post-NSS)	• Staff Engagement levels have improved by 7 points quarter on quarter, with equitable improvements across each of the three domains of engagement
Actions/ interventions initiated to improve staff engagement	• Examples include; the introduction of a brand-new benefits platform to tackle satisfaction with pay, and a brand-new EAP to take more positive action on HWB	• Head of Staff Experience	• Ongoing	• Overall SE: 6.27 (up 7 points vs. Q1) • Motivation: 6.69 (up 8 points vs. Q1) • Involvement: 6.29 (up 6 points vs. Q1) • Advocacy: 5.83 (up 7 points vs. Q1)
National Staff Survey 2023	• Driving response rates across the 2023 NSS is key to improving engagement and the credibility of associated results	• Head of Staff Experience	• Sept 23 – Nov 23	• NSS launched successfully, with 803 respondents in the first day. Work taking place across an MDT to drive best-ever response rate

Statutory Training

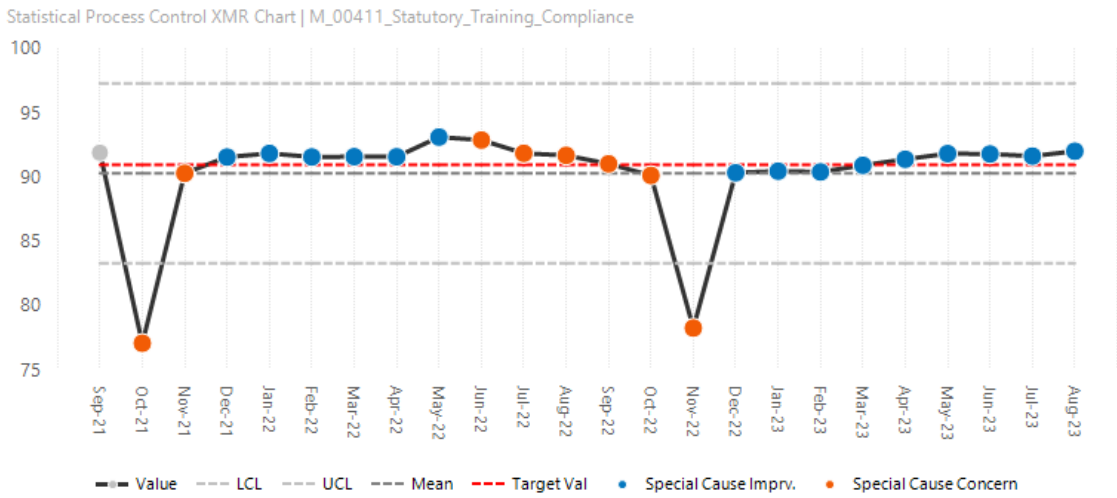
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The proportion of staff who have successfully completed Mandatory training in;
Child Protection, Equality and Diversity, Fire Safety Awareness, Health and Safety Awareness, Infection Control, Information Governance and Manual Handling Awareness.
Data source: ESR

Statutory Training

Month	Value
Sep-22	91.1%
Oct-22	90.2%
Nov-22	78.3%
Dec-22	90.4%
Jan-23	90.5%
Feb-23	90.5%
Mar-23	91.0%
Apr-23	91.4%
May-23	91.9%
Jun-23	91.9%
Jul-23	91.7%
Aug-23	92.1%



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to higher values(Above Mean Run Group | | | | | |)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Medical staff levels of 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.	• Head of L&D • Heads of P&C • P&CBPs • CMO	• End Oct 23	• Paper written to identify areas of lowest compliance. Issue not helped by new policy removing ability to stop study leave if non-compliant.
Capacity within face to face statutory learning, particularly Resus.	• Resus team currently at 50% capacity due to vacancies and sickness absence. Being addressed through the Corporate Team	• Deputy Chief Nurse • Resus Team	• End Nov 23	• Care Groups ensuring that the most essential, non-compliant staff are booked on Resus training first.
Low compliance with Trainee Drs, as they do not complete this on arrival, and no agreement to who chases this especially after rotation.	• P&C Leads to work with Med Ed on supporting improvements with this, particularly focusing on induction and rotation.	• DME • Head of L&D • P&C Senior Team	• End Nov 23	• Head of P&C to work with Care Groups to seek support from Med Ed management team.

Medical Job Planning Rate

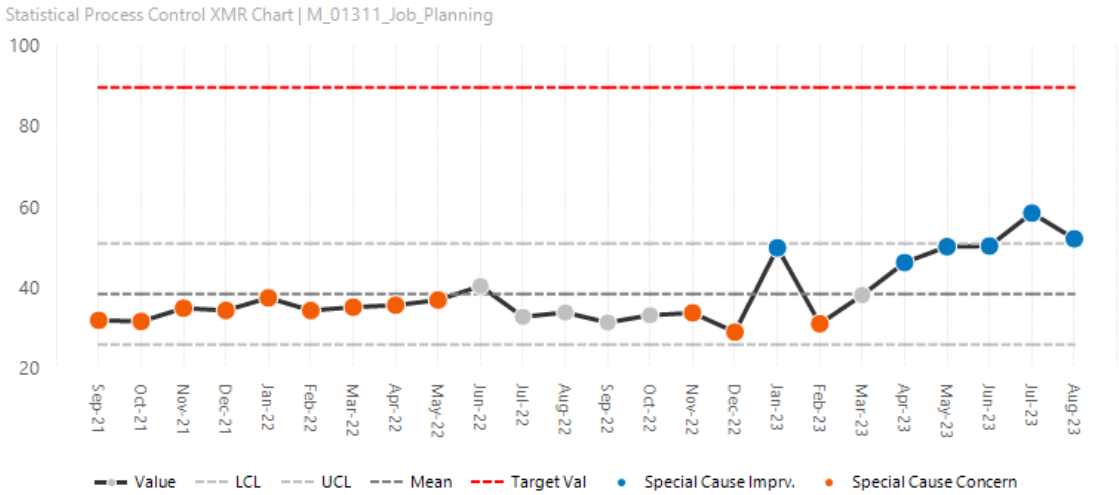
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Number of staff who have a fully signed off job plan in the current job planning cycle (1 April - 31 March), as a proportion of the total number of staff. A signed off job plan requires approval from the local Specialty Lead, the Care Group Clinical Director, and the Hospital Medical Director. Exclusions: This job planning data refers to non-training consultant and SAS grade doctors only and is not required by other doctor grades.

Medical Job Planning Rate

Month	Value
Sep-22	31.5%
Oct-22	33.3%
Nov-22	33.9%
Dec-22	29.1%
Jan-23	50.1%
Feb-23	31.2%
Mar-23	38.3%
Apr-23	46.4%
May-23	50.4%
Jun-23	50.5%
Jul-23	58.7%
Aug-23	52.3%



Understand the most recent data point

Variation Type

H — Special cause of improving nature or lower pressure due to higher values(| | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

F — Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
While job planning compliance has improved across most of the specialities, Emergency Medicine and Acute Medicine continue to have the lowest compliance.	• Job planning project manager to meet with speciality leads/general managers to provide bespoke training and support, and to establish drop-in clinics to capture issues and support the sign-off of job plans. Develop welcome packs for new starters to include advice and guidance on job planning. Job planning project manager to work with clinical leads to design template job plans for vacant posts.	• CMO	• End Dec 23	• Meeting dates set up with specialities • ESR/e-JobPlan reconciliation completed
The hierarchies for specialities and sign-off on e-JobPlan do not align to the new structure.	• CMO operational support team to prepare Allocate for the switch over. Activate new structure on e-JobPlan. Transfer existing users into the correct Care Groups/specialities	• CMO	• End Aug 23	• Updates discussed with Allocate. • Adjustments to be made once speciality leads (1st Sign-off) have been identified for the new structure.
The previous process for managing LCEA's did not effectively encourage uptake of job planning	• New LCEA policy to be approved for use. • LCEA applications to only be accepted if suitable engagement with the job planning process is evident, establishing a baseline with which to judge excellence.	• CMO	• Sept 23	• Draft policy with the LNC for consultation

Staff Advocacy Score

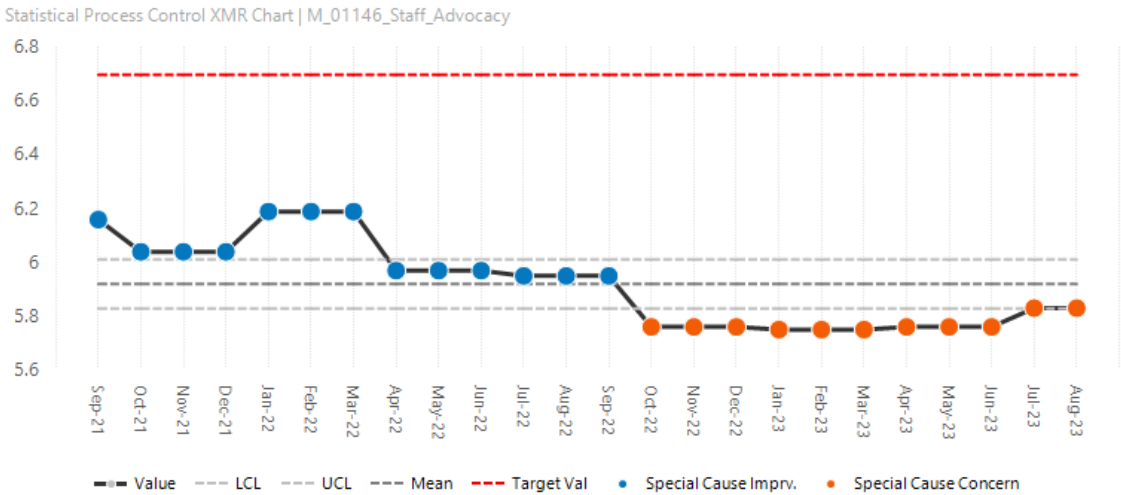
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

National annual staff survey results provided by Picker March each year.
Staff advocacy questions added to Staff Friends and Family quarterly surveys commencing March 2021.
3 advocacy questions in staff survey and replicated in quarterly staff FFT, these are a subset of the staff engagement score.

Staff Advocacy Score

Month	Value
Sep-22	5.95
Oct-22	5.76
Nov-22	5.76
Dec-22	5.76
Jan-23	5.75
Feb-23	5.75
Mar-23	5.75
Apr-23	5.76
May-23	5.76
Jun-23	5.76
Jul-23	5.83
Aug-23	5.83



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to lower values(| Below Mean Run Group | | | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Advocacy levels (5.8) are significantly below the national standard (6.4)	• Continued action is required to repair the reputation of the organisation & the extent to which staff would recommend as a place to work and be treated	• Executive Team	• End Nov 24 (post NSS)	• Staff Advocacy improved by 7 points quarter-on-quarter, from 5.76 (Q1) to 5.83 (Q2), but remain in quartile 1 when benchmarked nationally
Staff Advocacy levels remain in Quartile 1 when benchmarked nationally	• Increased rollout of We Care as a programme to drive staff engagement levels	• Head of Transformation	• Ongoing	• Staff Advocacy levels are 62 points higher in We Care areas than non-We Care counterparts – increased roll-out to 337 more staff and 1114 overall
The extent to which staff would recommend the Trust as a place to work or be treated	• A behavioural framework has been drafted which, alongside We Care, Appraisals, TED & CLP should serve to shift culture	• Head of Organisational Development	• End Aug 23	• First proof created and socialised at CEMG. Visual to describe how it fits alongside We Care strategic objectives & other programmes socialised

Appraisal Rates

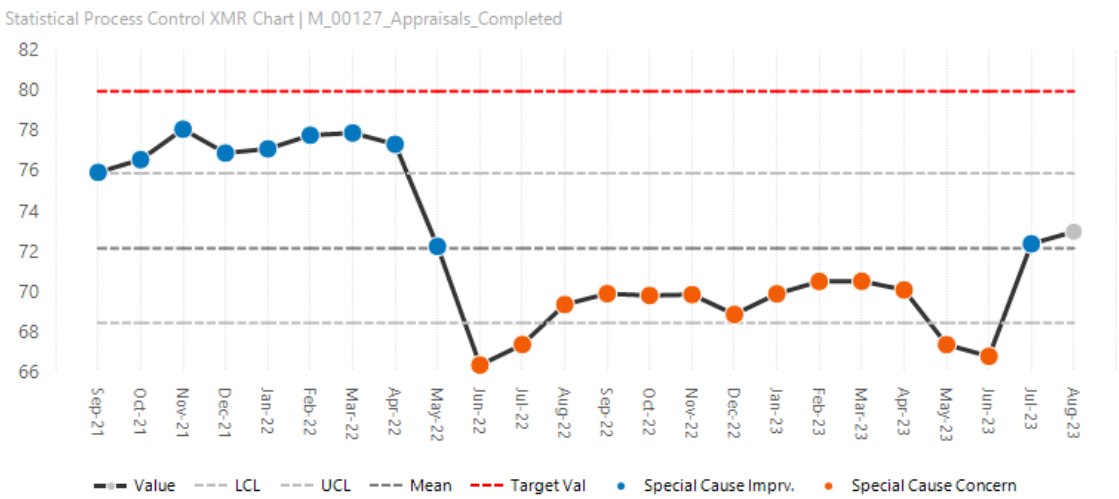
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Number of staff who have completed an appraisal and objective setting meeting in the preceding 12 months, as a proportion of the total number of staff.
Exclusions: Doctors, Secondary Assignments, Career Break, Maternity & Adoption, External Secondment and Unpaid Suspensions. Staff who have worked at the Trust for less than 12 months.
Datasource: ESR

Appraisals Compliance

Month	Value
Sep-22	69.9%
Oct-22	69.8%
Nov-22	69.9%
Dec-22	68.9%
Jan-23	69.9%
Feb-23	70.5%
Mar-23	70.5%
Apr-23	70.1%
May-23	67.4%
Jun-23	66.8%
Jul-23	72.4%
Aug-23	73.0%



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Managers not uploading completion dates to ESR	• Recent "amnesty" of information resulted in 350 additional dates added to ESR that hadn't yet been uploaded.	• Heads of P&C • PCBPs	• End Sept 23	• 350 names added to ESR that had previously not been updated • Identifying areas where support needed for updated ESR training
Admin & Clerical appraisal rates remain below threshold, with 642 outstanding appraisals.	• Focus within the new Care Groups on improving A&C appraisal rates, and ensuring they are uploaded to ESR.	• Care Group MDs • Heads of P&C • PCBPs	• End Oct 23	• New P&C Care Group teams to work locally with targeting areas of low A&C appraisal compliance – WHH Care Group being targeted during Sep/Oct 23
Quality of appraisal remains low, according to staff survey	• Identify lowest 10 areas of compliance in each Care Group, triangulated with sickness absence and turnover rates, to support positive intervention.	• P&CPs • Heads of P&C	• Mid Sept 23	• P&CBPs have created list of Top 10 areas to focus interventions on, to be presented to Senior Leads in People & Culture and across Care Groups

Sustainability

Financial Sustainability

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
Finance	I&E YTD Actual Group (£M)	Traj.	Aug-23	-50.290			-25	-14	-3	Special cause of concerning nature or higher pressure due to lower values
	Efficiencies Green Schemes (£M)	40	Aug-23	2			2	10	18	Special cause of concerning nature or higher pressure due to lower values
	Efficiencies YTD Variance (£M)	0.0	Aug-23	-6.3			-9	-4	1	Common cause (no significant change)
	Premium Pay	Traj.	Aug-23	10.7K			6,893	8,531	10,169	Special cause of concerning nature or higher pressure due to higher values

August Performance Summary

Financial Position: The financial position YTD is £14.4m away from a plan of £35.9m totalling a deficit YTD of £50.3m. The key drivers behind the deficit variance are Strike action £1.1m by the Junior doctors and Consultants (excluding the impact of April industrial action, which has now been funded through the new ERF guidance), non payment of A4C pay award of £0.6 & Medical and Dental pay award £1.2m, non-delivery of efficiency savings £11.5m YTD (net of £0.3m delivery of income CIP) of which £7.2m has been allocated to Pay and £3m to non pay. The agency spend YTD is £21.5m which is £9.9m away from the agency cap.

Efficiencies: The Care Groups recognised recurrent savings of £0.2m in August, and £0.7m on a YTD basis, which is below Plan. As well as the £40m CIP requirement, the run rate is required to improve significantly in order to deliver the 23/24 Plan.
Additional non-recurrent efficiencies of £5.1m have been achieved YTD when taking into consideration the reported financial position adjusted for the known overspends (such as pay award funding shortfall, impact of strike action, increased levels of utilisation for nursing & medical staffing above plan and 1-2-1 specialling). Work is underway to understand if these non-recurrent efficiencies are able to be turned into recurrent efficiencies.
The current value of the pipeline is £13.8m, a (£0.5m) (3%) decrease in value vs. the prior month, but some of this relates to improvement required to reduce the run-rate overspend from FY23, and £0.4m relating to a loss-making procedure which remains under review.
The majority of ideas currently identified through the care group process are less than £50k (60%) or less than £250k (20%), but working across the cross-cutting themes of Workforce, Elective and Non-Elective productivity, Theatres, we are predominantly scoping larger group-wide to significantly increase the value of CIP schemes next month. This work includes linking in with the Nursing Agency cost deep-dives, and a review of Admin and Clerical vacancies.

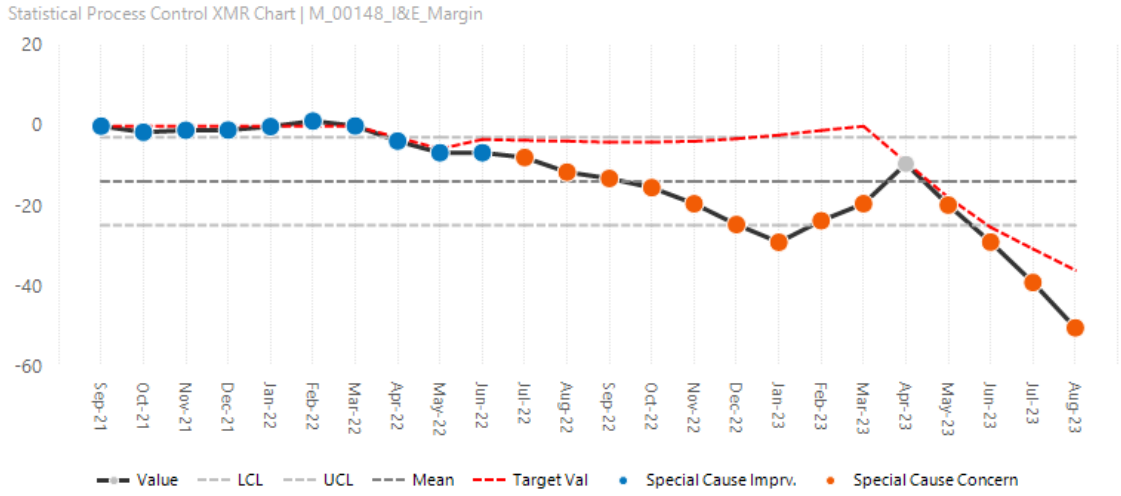
I&E YTD Actual Group (£m)

Integrated Improvement Plan

NHS
East Kent Hospitals University
NHS Foundation Trust

I&E YTD Actual Group (£M)

Month	Value
Sep-22	-13.015
Oct-22	-15.313
Nov-22	-19.323
Dec-22	-24.520
Jan-23	-28.935
Feb-23	-23.555
Mar-23	-19.317
Apr-23	-9.379
May-23	-19.651
Jun-23	-28.895
Jul-23	-38.976
Aug-23	-50.290



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to lower values(| | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently passing the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensure national grip and control level 4's are embededd into the Trust for pay & non pay areas	• All level 4 grip and controls are being rolled out to the wider Trust for both pay and non pay.	• CFO	• On-Going	• Vacancy panel for clinical posts is embedding led by CPO. Nursing workforce review embedding led by CNMO. Investment panel being implemented led by CFO
Run rate continues to be above plan due to utilisation in excess of establishment	• Workforce plans included in the level 4 grip & controls are being embedded to review medical and nursing workforce arrangements	• CNMO & CMO	• On-Going	• Nursing PMO's continue. Golden key has been implemented • CMO has commenced reviewing high cost agency for Medical & Dental
Non delivery of CIP to date and non achievement of a robust in year CIP plan.	• Increased levels of plans needed to close the CIP plan. Non recurrent CIP's to be externally reported	• Care group MD's • PMO • Exec Team	• End October -23	• Workforce & Finance Recovery meetings have now commenced. Further work is needed on the corporate areas to ensure CIP delivery

Financial Efficiencies: Green Rated Schemes

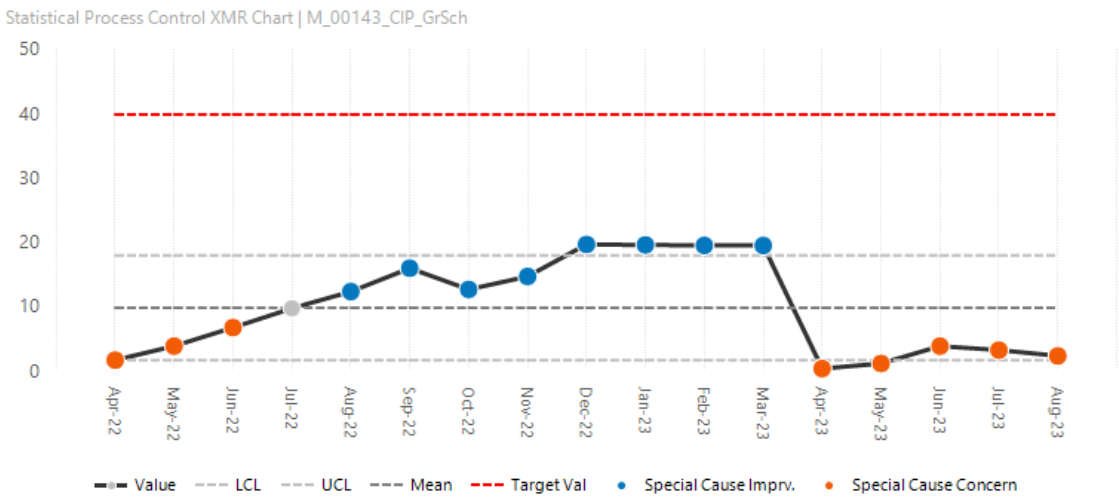
Integrated Improvement Plan

NHS East Kent Hospitals University NHS Foundation Trust

Efficiencies Green Schemes is the sum of delivered schemes YTD plus the sum of forecast of green rated schemes as a percentage of the annual efficiencies target. If the percentage rated Green is < 90% then overall rating is RED.

Efficiencies Green Schemes (£M)

Month	Value
Sep-22	16
Oct-22	13
Nov-22	15
Dec-22	20
Jan-23	20
Feb-23	20
Mar-23	20
Apr-23	0
May-23	1
Jun-23	4
Jul-23	3
Aug-23	2



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to lower values(| | | | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining organisational focus during restructure	• Move to 3 part Executive led PRMs from September (Wk1 Activity & Productivity, Wk3 Finance & workforce, Wk4 Performance management); • Continue CEO and CFO messaging to organisation on finance and efficiency; • PMO re-aligned to new care group structure, and to attend Wk1 and Wk3 meetings • CIP targets for new care groups being re-calculated based on re-structured budgets	EMT CEO/CFO/ADFI ADFI Finance/PMO	01/09/23 Ongoing 30/09/23 30/09/23	• Current being set up, existing fortnightly efficiency meetings now include EMT. • CFO released enhanced controls 08/08. • Care Groups contacted, invites extended to PMO • PMO liaising with Finance re: values
Pace of scheme development	• CFO/CSPO led admin and clerical vacancy review; • CNO led deep dives on nursing agency spend rolled out with care groups; • Weekly meetings between CFO/CPSO and FID/ADFI on progress and rapid improvement opportunities;	CFO/CSPO CNO CFO/CSPO	Sept/Oct 23 Underway Underway	• Care group responses to be discussed during next Finance/Workforce PRMs. • £1m benefit from reducing pool nurses (but this may be run rate reduction, not CIP)
Identification of opportunities sufficient to reach the required £40m	• EMT agreed 5 cross cutting themes for focus with Exec leads; • New Turnaround Director appointed, meeting with PMO	EMT/ADFI TD/PMO	Ongoing 25/09/23	• Theme values being developed. • TD/ADFI met 21/09, PMO meeting scheduled for 25/09

Financial Efficiencies YTD Variance

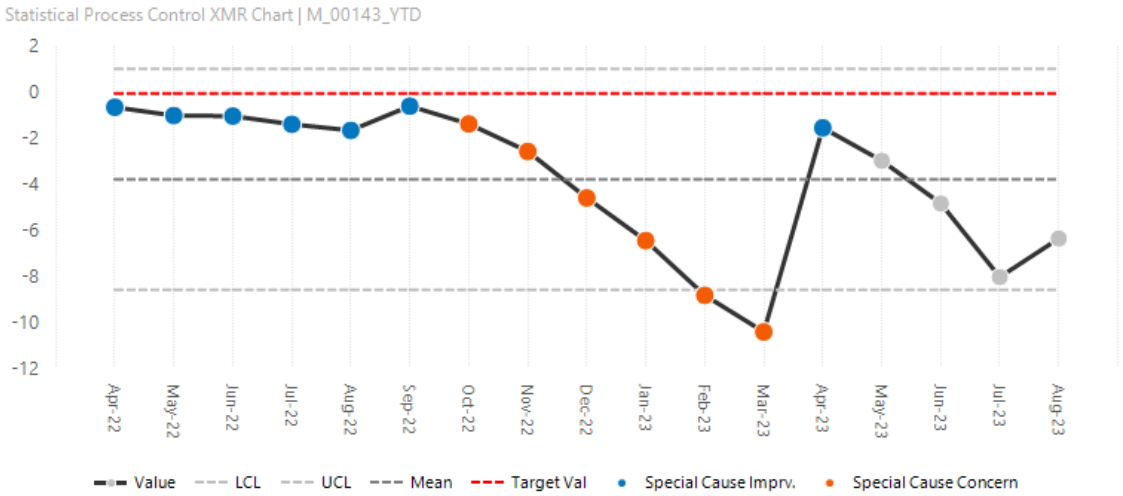
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Efficiencies YTD Variance (£M) is the difference between the YTD delivered efficiencies and YTD efficiencies target. If that number is zero or positive, the Trust is delivering the expected efficiencies.

Efficiencies YTD Variance (£M)

Month	Value
Sep-22	-0.6
Oct-22	-1.3
Nov-22	-2.5
Dec-22	-4.6
Jan-23	-6.4
Feb-23	-8.8
Mar-23	-10.4
Apr-23	-1.5
May-23	-2.9
Jun-23	-4.8
Jul-23	-8.0
Aug-23	-6.3



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring finance and CIP transparency while reflecting underlying organisational improvement	• Additional non-recurrent efficiencies of £5.1m have been achieved YTD when taking into consideration the reported financial position adjusted for the known overspends (such as pay award funding shortfall, impact of strike action, increased levels of utilisation for nursing & medical staffing above plan and 1-2-1 specialling). Work is underway to understand if these non-recurrent efficiencies are able to be turned into recurrent efficiencies.	CFO/PMO PMO	Sept On-going	• Methodology and calculation agreed at FPC, used for Mth5 reporting • PMO to analyse variances with a view establishing whether there are any recurrent savings inherent in the underspends
Agency usage and cost at a similar level to this time last year	• Context: Nursing agency costs remain high • Action: Greater controls through authorisation and "golden key" process • Action: Super-numery period reduced to two weeks for IENs • Context: High cost medical agency (HCMA) use remains high, ongoing issue. • Action: FID/PMO working with care groups to review HCMA value add.	• CNMO • CNMO • CNMO/FID • FID/PMO	• Ongoing • 22/09 • TBC • Sept/Oct 23	• Golden Key went live 18/09 • Initial discussions held, meeting TBA. • Initial discussions held, meeting TBA. • To feed work into Finance & w/f PRMs.

Premium Pay

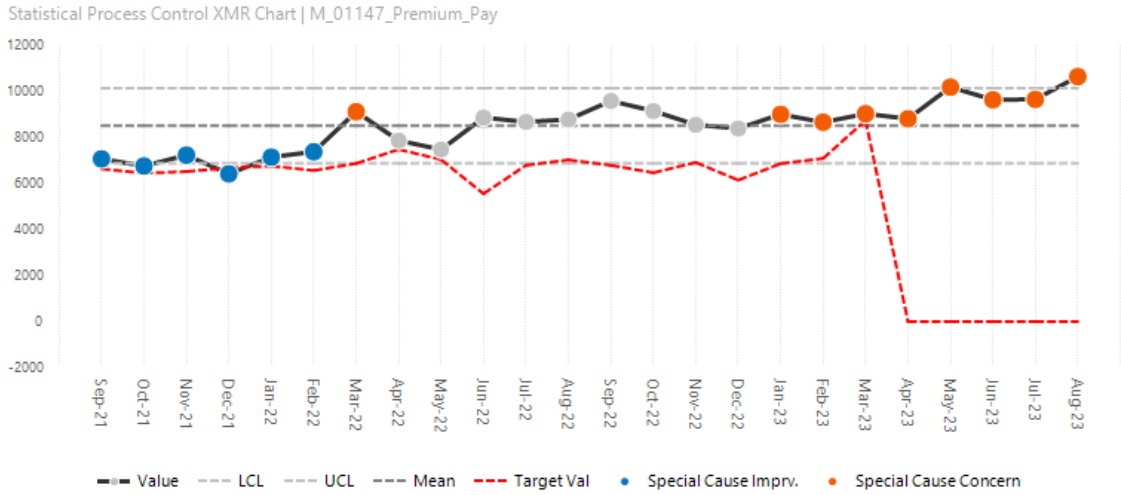
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Summary metric of Trust premium pay items Agency (NHSP and direct engagement), Bank, WLI payments, Locally Agreed Group, Medical Short Sessions, Other Medical Locum costs and Overtime (excl additional basic) in £.

Premium Pay

Month	Value
Sep-22	9,618
Oct-22	9,178
Nov-22	8,577
Dec-22	8,413
Jan-23	9,034
Feb-23	8,689
Mar-23	9,058
Apr-23	8,839
May-23	10.2K
Jun-23	9,666
Jul-23	9,687
Aug-23	10.7K



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to higher values(Above Mean Run Group | | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Timely information that can be used to target areas of high premium pay usage.	• Premium Pay Dashboard now live, and updated regularly.	• Information Lead • Strategic Workforce Lead • Heads of P&C	• End Sept 23	• CMO, Heads of P&C and P&CBPs to use this Dashboard and information to support Care Grp Exec Efficiency meetings.
Reduction in Premium Pay by focusing on hard to recruit roles.	• Workforce Strategies developed for care Groups, focusing on those areas with hard to recruit posts, and a plan to address this.	• Strategic Workforce Lead, Heads of P&C, P&CBPs	• End Sept 23	• First draft Workforce Strategies in place, to be reviewed regularly with Care Groups and Resourcing
Appointment of managed service provider to reduce agency spend as above the Trust agency spend cap.	• Seek Board approval for procurement. • Onboard provider.	• CPO/ Procurement • Deputy CPO	• End Nov 23	• Approval and procurement process underway and on target.

East Kent Hospitals University NHS Foundation Trust

Maternity

Maternity

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
Maternity	Serious Incidents Maternity	Sigma	Aug-23	1			-3	3	9	Common cause (no significant change)
	Maternity Incidents Moderate / Sev...	Sigma	Aug-23	2			-3	3	9	Common cause (no significant change)
	Maternity Complaints	Sigma	Aug-23	1			-2	6	14	Common cause (no significant change)
	Maternity Complaint Response	90.0%	Aug-23	60.0%			-35	34	103	Common cause (no significant change)
	Extended Perinatal Mortality	5.87	Aug-23	3.58			4	5	6	Special cause of improving nature or lower pressure due to lower values
	FFT Maternity Response Rate	15.0%	Aug-23	11.2%			7	11	16	Common cause (no significant change)
	FFT Maternity Recommended	90.0%	Aug-23	90.2%			85	91	98	Common cause (no significant change)
	FFT Maternity (IP) Recommended	90.0%	Aug-23	91.1%			85	93	101	Common cause (no significant change)
	Maternity Engagement Score	6.90	Aug-23	6.15			6	6	6	Special cause of improving nature or lower pressure due to higher values

August Performance Summary

Incidents: There was 1 serious incident reported in August for Women's Health for Gynaecology. There were no serious incidents reported for maternity in August.

Complaints: 1 Stage 1 complaints received in August 2023 for Maternity. There are currently 20 open complaints of which 2 have breached (25/09/2023).

Patient Involvement: FFT Response rate 11.0% - 252 comments made in total. 90.2% extremely likely or likely to recommend

Staff Engagement: Score 5.89 – decrease in month

Maternity Serious Incidents

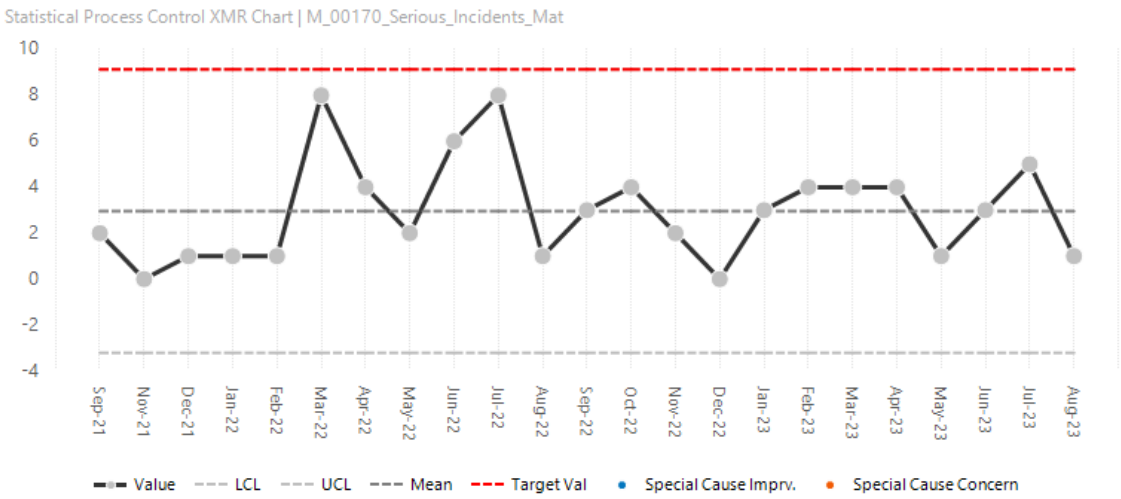
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures any maternity incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System). Any maternity incidents that are subsequently downgraded are removed retrospectively therefore this number is subject to change. Serious Incidents are reported by the date the investigation started and not the date the incident occurred or was reported.

Serious Incidents Maternity

Month	Value
Sep-22	3
Oct-22	4
Nov-22	2
Dec-22	0
Jan-23	3
Feb-23	4
Mar-23	4
Apr-23	4
May-23	1
Jun-23	3
Jul-23	5
Aug-23	1



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
There were 0 serious incidents reported in August for Maternity. There was one Gynaecology serious incident.	Gynaecology Incident: delay in treatment of squamous cell carcinoma	• Interim Head of Governance	• 13/11/23	RCA commenced.
At month end there are 15 open SI's in women's Health – 11 for maternity and 4 for gynaecology.	For all SI investigations to be completed within agreed timeframes.	• Interim Head of Governance	• Monthly - ongoing	• All open SI's under investigation are within agreed timeframes. • There is 1 NCR breach (also old RCA breach) and 2 RCA breach in August.
Closure of actions from SI's on the datix actions module.	• Focussed work to close open actions on datix module with action owners • Weekly progress reporting of backlog and current position	• Interim Head of Governance	• 30/11/23	• The number of overdue actions from the backlog has reduced from 345 to 222 at 25/09. However, the overall current overdue actions has increased due to action plans being added to the module. Progress on closing these actions have been impacted in July and August with the high annual leave period, vacancies and the Patient Safety Team supporting clinical staffing.

Maternity Incidents Causing Harm

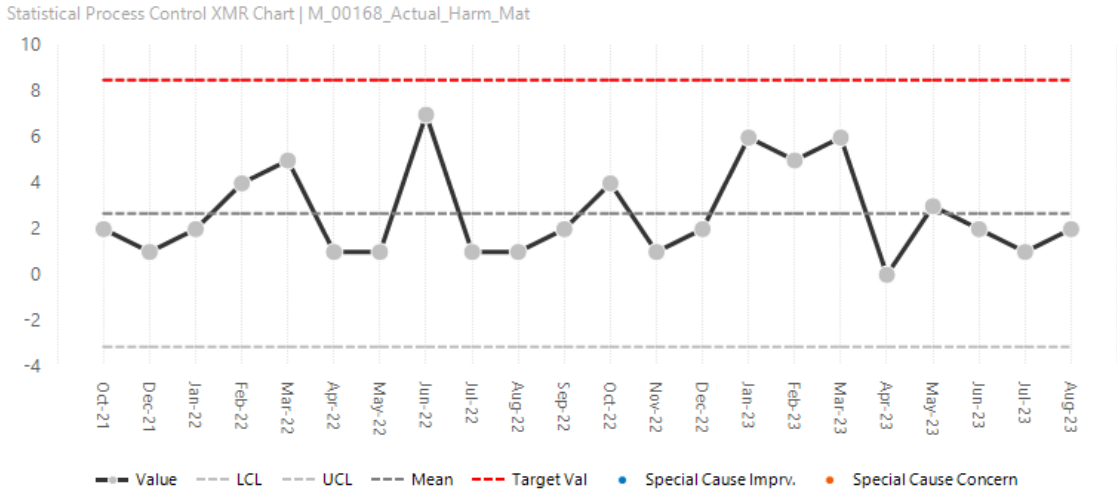
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of maternity incidents where the harm status was moderate or above.

Maternity Incidents Moderate / Severe

Month	Value
Sep-22	2
Oct-22	4
Nov-22	1
Dec-22	2
Jan-23	6
Feb-23	5
Mar-23	6
Apr-23	0
May-23	3
Jun-23	2
Jul-23	1
Aug-23	2



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Rapid review of moderate incidents and other incidents on maternity trigger list.	• Rapid review process reviewed • MDT attendance • Learning identified	• Interim Head of Governance	• Monthly - ongoing	• Themes and learning identified from rapid reviews disseminated via Message of the Week, Safety Threads, Lunch and Learn.
Closure of datix open more than 6 weeks	• Focussed work to close open actions on datix module with action owners • Weekly progress reporting of backlog and current position	• Interim Head of Governance	• 30/11/2023	• The number of open datix from the backlog for Women's Health has reduced from 762 to 114 at 25.09.2023. For maternity, the June backlog has reduced from 686 to 101. However, the overall current overdue datix has plateaued. Progress on closing these incidents has been impacted in July and August with the high annual leave period, vacancies and the Patient Safety Team supporting clinical staffing.

Maternity Complaints

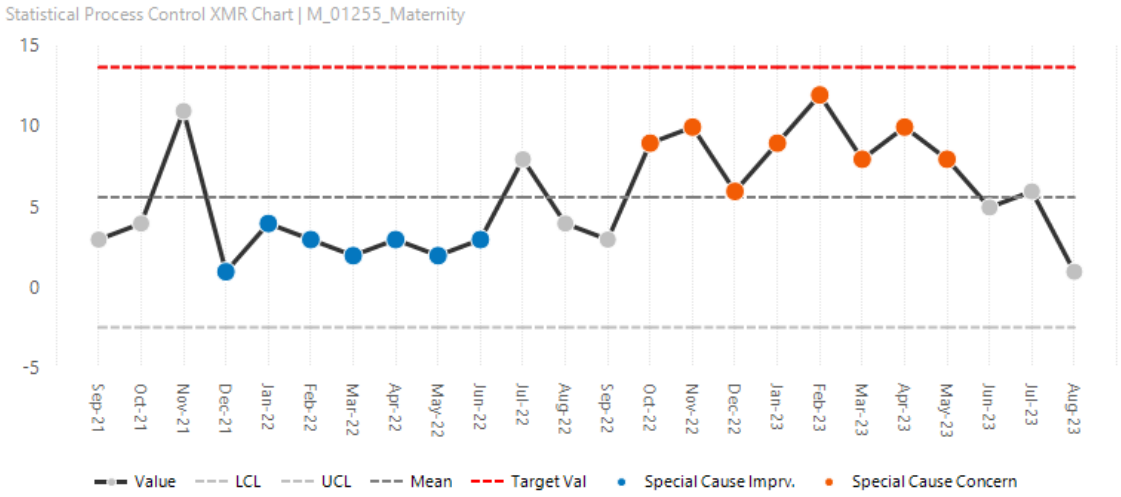
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of complaints made to Obstetrics, Midwifery or New-born Hearing Screening Services.

Maternity Complaints

Month	Value
Sep-22	3
Oct-22	9
Nov-22	10
Dec-22	6
Jan-23	9
Feb-23	12
Mar-23	8
Apr-23	10
May-23	8
Jun-23	5
Jul-23	6
Aug-23	1



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
1 Stage 1 complaints received in August 2023 for Maternity	Client unhappy with treatment: Obstetric USS – sonographers attitude Staff introducing themselves in theatre Sent to HOMs and Clinical Lead, as well as other Care Groups for comments	Patient Experience and Complaints Coordinator	Monthly reporting	Some current complaints are awaiting leads to be assigned. Clinical Director has scheduled time to complete.
Recurrent themes in feedback: • Delay in Discharge from Post natal ward • Timely administration of pain relief • Informed Consent	• Pain assessment • Training (for all staff) – specifically on standardised support/advocacy approaches and consent • Discharge • Support for birthing partners • How the Trust shares its actions and improvement plans with the wider community	Deputy Director of Midwifery		Between Mar-Aug '23, the Patient Voice and Involvement Team (PV&I) has spoken with more than 60 parents, families, carers and stakeholder organisations. The work is in addition to the hundreds of Your Voice Is Heard calls completed each month by Patient Experience Midwives and the ongoing feedback provided to the Trust by the Maternity and Neonatal Voices Partnership. The PV&I Team spoke with mothers who had been involved in the Reading the Signals report as well as many who had chosen not to engage at that stage. We also spoke with carers, birthing partners, family members and stakeholder organisations. While we are satisfied that the demographic we engaged with matches that accessing our services in East Kent, it should be noted that underserved communities (including people experiencing deprivation, disability and language and accessibility barriers) often bring the most complex feedback and are the least likely to engage and there is undoubtedly more work to do to hear their voices

Maternity Complaints Response Rate

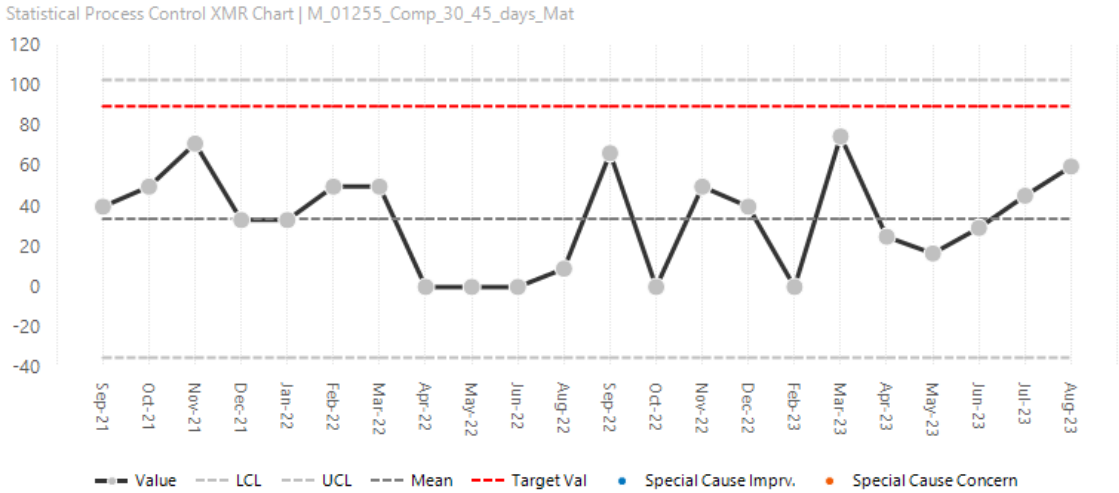
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the proportion of complaints which were responded to within the agreed timescale of the complaint being received. This includes both 30 and 45 working day timescale targets.
Complaint Types included are Formal, External and MP Formal that have not been rejected.
Complaint Stages included are extensions 1,2,3 and extensions agreed by Chief Nurse, Local Resolution, On Hold and Withdrawn.

Maternity Complaint Response

Month	Value
Aug-22	9.1%
Sep-22	66.7%
Oct-22	0.0%
Nov-22	50.0%
Dec-22	40.0%
Feb-23	0.0%
Mar-23	75.0%
Apr-23	25.0%
May-23	16.7%
Jun-23	29.4%
Jul-23	45.5%
Aug-23	60.0%



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Competing priorities of clinical staff cause delays in case reviews and providing the Complaint Coordinator with comments for content	• Complaint Coordinator has set up weekly 'huddle' meetings with HOMs and newly appointed Clinical Lead to try and spotlight urgent cases .	• Patient Experience and Complaints Coordinator	• Weekly and • Bi-Weekly meetings	• There are currently 20 open complaints of which 2 have breached.

Extended Perinatal Mortality

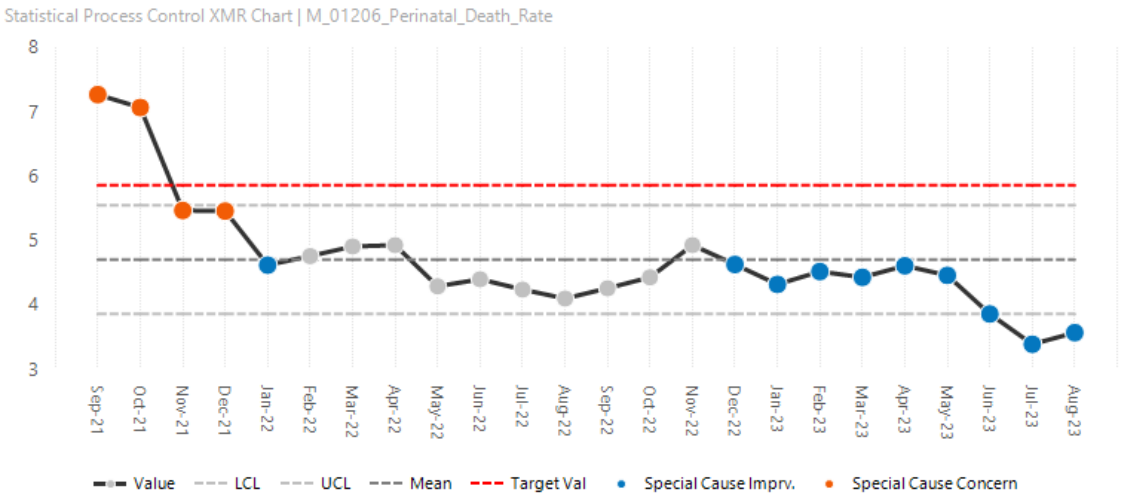
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Extended perinatal mortality refers to all stillbirths and neonatal deaths, MBRRACE methodology is used, which excludes births <24+0 weeks gestation and terminations (even if over 24+0w). The rate is per 1000 total births.
Datasource: Euroking & PAS
Threshold based on the average of the Trust's comparator group (Trust with level 3 NICU) from the 2021 MBRRACE report.

Extended Perinatal Mortality

Month	Value
Sep-22	4.27
Oct-22	4.44
Nov-22	4.94
Dec-22	4.64
Jan-23	4.33
Feb-23	4.53
Mar-23	4.44
Apr-23	4.62
May-23	4.47
Jun-23	3.87
Jul-23	3.40
Aug-23	3.58



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to lower values(| Below Mean Run Group | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently passing the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
In August there were 2 stillbirths reportable to MBRRACE – twins born at 25+3 weeks gestation.	The rolling 12 month rate for stillbirths remains below the lower confidence limit at 2.56 stillbirths per 1,000 births. In the 12 month rolling period, there have been 15 stillbirths reportable to MBRRACE.	Emma Parkin	Monthly	• Presentation prepared for PMRT review in Sept.
In August there was 1 neonatal death reportable to MBRRACE – Late neonatal death. Referred to coroner.	The rolling 12 month rate for neonatal deaths remains lower than both the threshold and average at 1.03 neonatal deaths per 1,000 livebirths, and has been so for 16 consecutive periods.	Emma Parkin / Liz Perkins	Monthly	• Reported by GSTT for PMRT – review commenced • Death of baby following an unexpected collapse reported as SI and RCA in progress.
Perinatal Mortality Review Tool	All neonatal deaths and stillbirths are reviewed through the Perinatal Mortality Review Tool by a multidisciplinary panel and external attendees.	Emma Parkin	Monthly	• PMRT Lead Midwife in post from mid June. 100% of perinatal mortality reviews include an external reviewer

Maternity Friends & Family Test: Response Rate

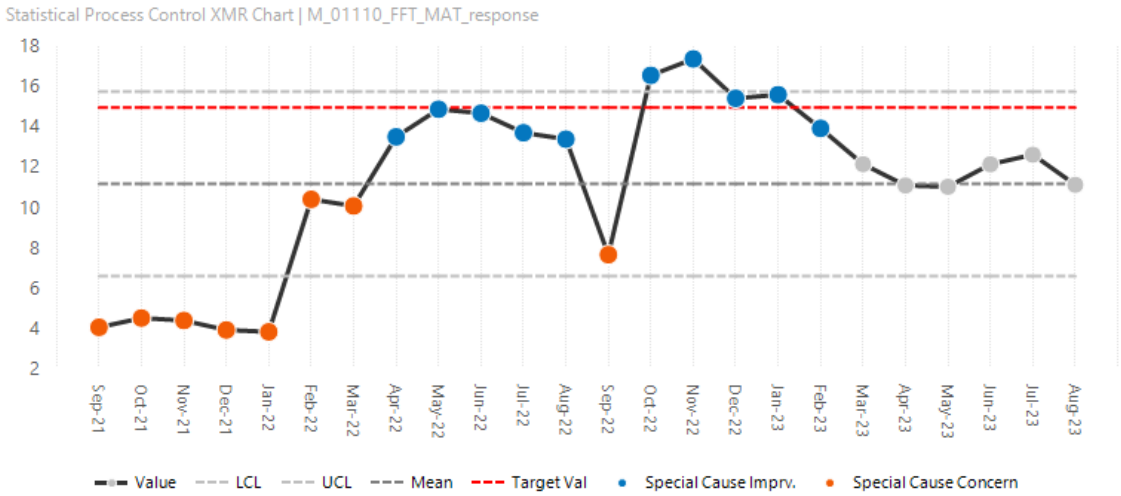
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of responses to the maternity friends and family questionnaires and displays as a % of the total questionnaires sent.

FFT Maternity Response Rate

Month	Value
Sep-22	7.7%
Oct-22	16.6%
Nov-22	17.4%
Dec-22	15.5%
Jan-23	15.6%
Feb-23	14.0%
Mar-23	12.2%
Apr-23	11.1%
May-23	11.1%
Jun-23	12.2%
Jul-23	12.7%
Aug-23	11.2%



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Response rate 11.2% 252 comments made in total.	• 90.2% extremely likely or likely to recommend	• Patient Experience Midwives	• Monthly	• There is a new PTL for FFT- the aim that FFT feedback is themed in a standardised way and is comparable.
Response rates are typically low for FFT therefore only reflect a minority of women, birthing people and their families, and their experiences	• Embedded communications plan and Patient Voices Model to improve service user and workforce engagement, feedback and experience	• Patient Experience Midwives	• March 2024	• This is a milestone within the Maternity and Neonatal Improvement Plan presented to Trust Board for approval in September 2023

Maternity Friends & Family Test: Recommended

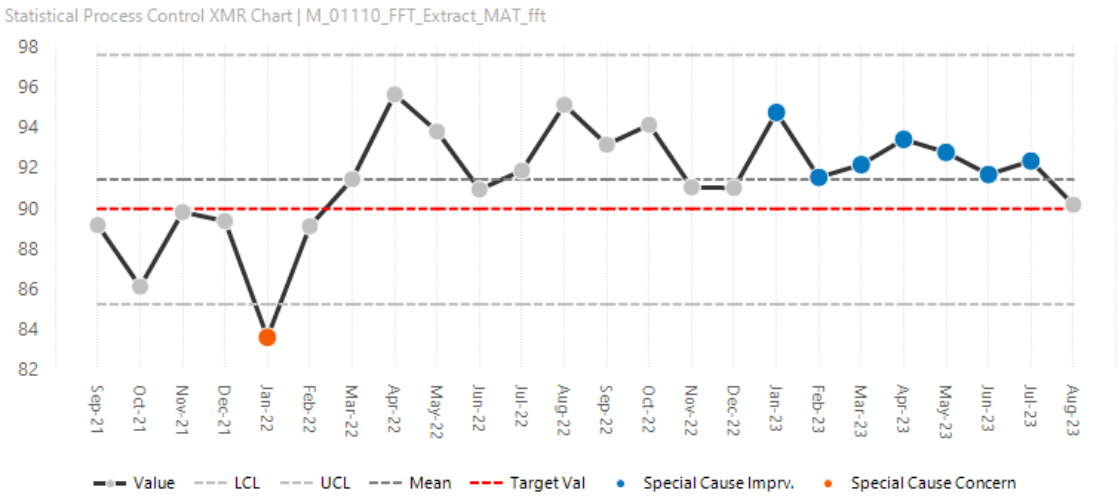
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric is a summary of all Maternity Friends & Family responses which indicated that the woman would recommend the Trust's Maternity Services.

FFT Maternity Recommended

Month	Value
Sep-22	93.2%
Oct-22	94.2%
Nov-22	91.1%
Dec-22	91.0%
Jan-23	94.8%
Feb-23	91.6%
Mar-23	92.2%
Apr-23	93.5%
May-23	92.8%
Jun-23	91.7%
Jul-23	92.4%
Aug-23	90.2%



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
The responses show 90.2% extremely likely or likely to recommend which is a decrease from July 92.4%	New PTL for FFT being used to theme in a standardised and comparable way.	• PEM	• Monthly	

Maternity Friends & Family Test: Inpatient Recommended

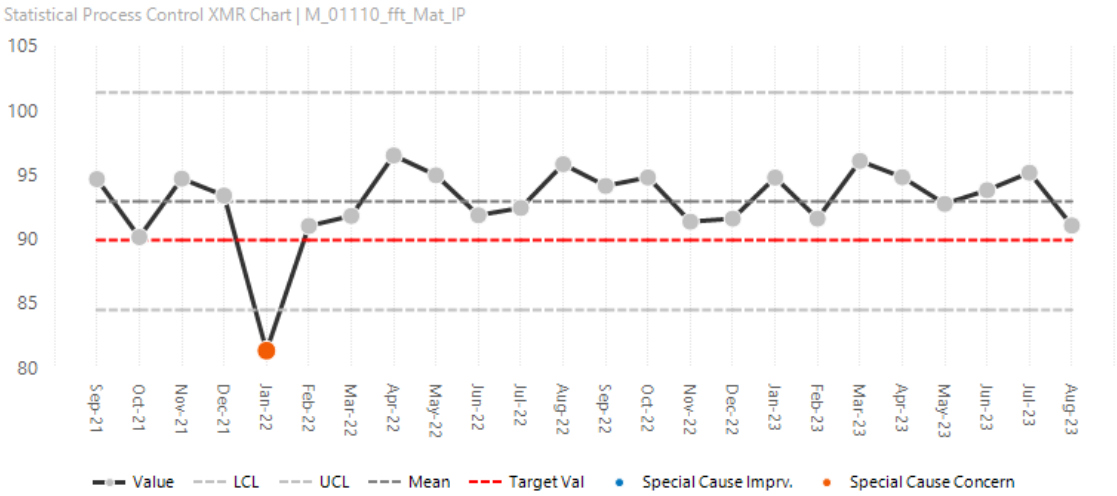
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric is a summary of Inpatient Maternity Friends & Family responses which indicated that the woman would recommend the Trust's Maternity Services.

FFT Maternity (IP) Recommended

Month	Value
Sep-22	94.2%
Oct-22	94.9%
Nov-22	91.4%
Dec-22	91.7%
Jan-23	94.9%
Feb-23	91.7%
Mar-23	96.2%
Apr-23	94.9%
May-23	92.8%
Jun-23	93.9%
Jul-23	95.2%
Aug-23	91.1%



Understand the most recent data point

Variation Type
Common cause (no significant change)(No Special Cause Flags)
Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Response rates are typically low for FFT therefore only reflect a minority of women, birthing people and their families, and their experiences	• Embedding in discharge process with the introduction of the new post natal discharge process . • Increase awareness via Maternity Voice Partnership • Include in Walking the Patch and standard work for the Discharge coordinators • Explore use of link to QR code	• Liane Ashley	• December 23	• This is a milestone within the Maternity and Neonatal Improvement Plan presented to Trust Board for approval in September 2023

Maternity Staff Engagement Score

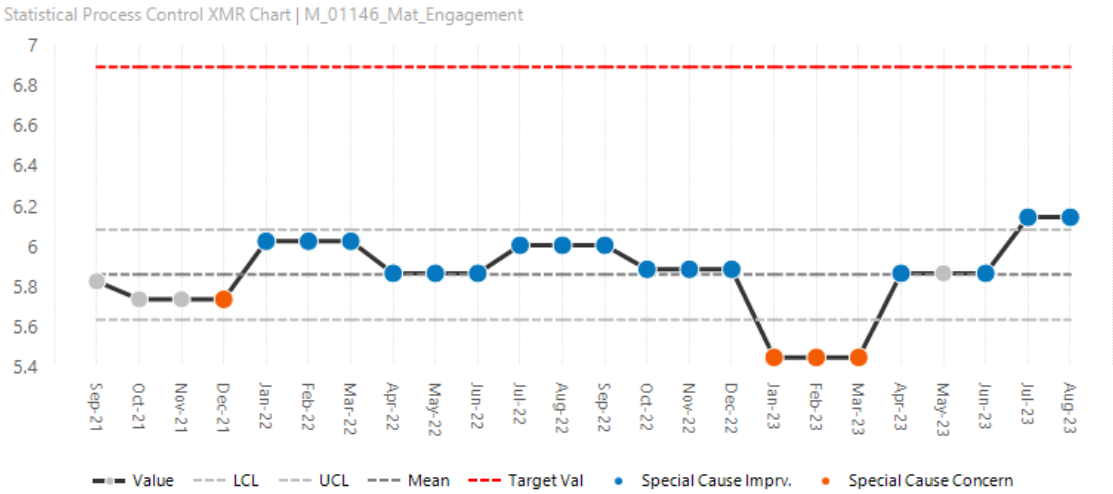
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

National annual staff survey results provided by Picker March each year.
Staff engagement questions added to Staff Friends and Family quarterly surveys commencing March 2021.
9 questions in staff survey and replicated in quarterly staff FFT (3 x motivation, 3 x involvement and 3 x advocacy) which provide the overall engagement score.

Maternity Engagement Score

Month	Value
Sep-22	6.01
Oct-22	5.89
Nov-22	5.89
Dec-22	5.89
Jan-23	5.45
Feb-23	5.45
Mar-23	5.45
Apr-23	5.87
May-23	5.87
Jun-23	5.87
Jul-23	6.15
Aug-23	6.15



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to higher values(| | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Opportunities for Staff Engagement	• Introduction of " We Hear You " providing platform for feedback • Embedding Safety Champions Forum • Band specific Meetings /away days • Increase Appraisal rates and SMART objectives • Promoting Freedom to Speak Up Guardians and arrange dedicated walkarounds • Embedding retention conversations • Compassionate attendance at work conversations following absences	• Adaline Smith DDOM	• December 23	

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

Report title: **Month 5 Finance Report**

Meeting date: **5 October 2023**

Board sponsor: **Interim Chief Finance Officer**

Paper Author: **Interim Deputy Chief Finance Officer**

Appendices:

Appendix 1: M5 Finance Report

Executive summary:

Action required:	Information
Purpose of the Report:	The report is to update the Board on the current financial performance and actions being taken to address issues of concern.
Summary of key issues:	The Group reported an in-month position of £11.3m against a plan of £5.3m, resulting in a deficit variance of £6m. The Year to Date (YTD) position is £50.3m against a plan of £35.9m, giving a YTD variance to plan of £14.4m. The agreed financial plan for 2023/24 is a £72m deficit. Delivery of the 2023/24 financial plan is based upon some extremely challenging assumptions as it requires that the Trust: 1) Delivers £40m of efficiency savings on a cash releasing efficiency basis. 2) Delivers a stretch activity target. 3) Reduces not medically fit to reside patients. 4) Eliminates 65-week breaches. 5) No additional unknown cost pressures are presented without mitigation in year. 6) Non-elective pressures are within planning tolerances. 7) Full control measures are reintroduced.

Group Position

	This Month			Year to Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
EKHUFT Income	74,068	76,149	2,081	356,772	361,844	5,072
EKHUFT Employee Expenses	(49,677)	(54,846)	(5,169)	(244,327)	(256,884)	(12,557)
EKHUFT Non-Employee Expenses	(29,912)	(31,980)	(2,068)	(149,303)	(155,813)	(6,510)
EKHUFT Financial Position	**(5,521)**	**(10,678)**	**(5,156)**	**(36,858)**	**(50,853)**	**(13,995)**
Spencer Performance After Tax	(5)	32	37	158	43	(115)
2gether Performance After Tax	90	149	59	460	512	51
Rephasing/Consolidation Adjustments	56	(887)	(943)	45	(491)	(536)
Consolidated I&E Position (pre Technical	**(5,380)**	**(11,384)**	**(6,004)**	**(36,195)**	**(50,789)**	**(14,594)**
Technical Adjustments	64	70	6	285	499	214
Consolidated I&E Position (incl adjs)	**(5,316)**	**(11,314)**	**(5,998)**	**(35,910)**	**(50,290)**	**(14,380)**

We care

The key drivers to the Group's YTD deficit are:

Key Drivers	£000
Non-delivery of recurrent efficiency savings	(£11,491)
Nursing drivers: Escalation Beds / 1:1 Specialing / Supernumery Nurses	(£5,366)
Unfunded Pay Award (Medical and Dental £1,183k, Agenda for Change (AfC) £535k and AfC Bonus £100k)	(£1,818)
Strike Action impact unfunded (Junior Doctors 13 days less April 4 days as now funded through the new Elective Recovery Fund (ERF) guidance)	(£990)
Strike Action Consultants (2 days in August)	(£100)
Non-recurrent savings (Programme Management Office (PMO) Non-recurrent savings plus additional £5.1m (Underspends))	£5,285
Group YTD Deficit	**(£14,380)**

Trust Pay is overspent by £12.6m YTD due to non-delivery of Cost Improvement Programme (CIP), increased levels of staffing utilisation, mainly in nursing (c128 Whole Time Equivalent (WTE)) & Medical & Dental (c196 WTE) and high cost of agency premium to cover escalation areas still open above plan £0.6m, increased levels of 121 nursing care £2.6m and delayed Internationally Educated Nurse (IEN) supernumerary cover above plan £2.3m.

Trust Non-Pay is overspent by £6.5m primarily driven by non-delivery of efficiencies (£4.6m), rechargeable drugs costs (offset by corresponding increase in income) and IT systems contracts relating to Laboratory Information Management System (LIMS) (again, offset by an increase in income).

Trust Income is above plan YTD by £5.1m mainly due to additional allocation from the Integrated Care Board (ICB) for Health and Care Partnership (HCP) East Kent projects £0.5m, Pathology LIMS £0.5m, Cancer Alliance income (Targeted lung checks) £0.7m, high cost drugs and devices overperformance £2.6m (matched by a corresponding increase in expenditure) and non-recurrent CIP of £0.3m.

In line with the previous ERF guidance, at Month 4, no income underperformance was reported. To compensate Trusts for the Doctors strike in April, new ERF guidance has reduced our ERF target by 2% for the year and converted it into fixed funding (£2.7m) allocated to April. This funding is to cover the expenditure consequence of the April strike (£440k) as well as the estimated activity loss in April. Trusts are now required to report the actual income performance against their plan.

As at Month 5, the Trust is behind its activity plan by £2.7m, predominantly due to cancelled elective activity as a result of the Doctor's strikes. Although

	there is no improvement to the position reported in Month 4, the risk of April's non-delivery of the target is now eliminated. However, if there is no further change to the ERF guidance or target, and the current activity run-rate remains and the strikes continue, we could have an income underperformance risk of £8.8m at year-end. The Group cash balance (including subsidiaries) at the end of August was £26.8m. The Trust drew £10.8m of working capital (Public Dividend Capital (PDC)) in the month, making a YTD total of £32.7m. Total capital expenditure at the end of August was broadly on plan with a £7.9m spend against a plan of £7.8m. The Trust has achieved very little efficiency savings so far this year, with £1.1m achievement against the £12.6m YTD plan, of which £0.7m is recurrent. Additional non-recurrent efficiencies of £5.1m have been achieved YTD when taking into consideration the reported financial position adjusted for the known overspends (such as pay award funding shortfall, impact of strike action, increased levels of utilisation for nursing & medical staffing above plan and 121 specialing). Work is underway to understand if these non-recurrent efficiencies are able to be turned into recurrent efficiencies.
Key recommendations:	The Board is asked to review and **NOTE** the financial performance and actions being taken to address issues of concern.

Implications:

Links to 'We Care' Strategic Objectives:	**Our sustainability**
Link to the Board Assurance Framework (BAF):	**BAF 38**: Failure to deliver the financial breakeven position of the Trust as requested by NHS England (NHSE).
Link to the Corporate Risk Register (CRR):	**CRR 137:** There is a risk that the Trust will not be able to meet its 2023/24 efficiencies target equating to £40m.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: Finance and Performance Committee – 25 September 2023.

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2023/24

August 2023

Interim Chief Finance Officer
Michelle Stevens

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Month 05 (August) 2023/24

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Executive Summary
Month 05 (August) 2023/24

Executive Summary

The Group reported an in-month position of £11.3m against a plan of £5.3m, resulting in a deficit variance of £6m. The Groups YTD position is £50.3m against a plan of £35.9m, giving a YTD variance to plan of £14.4m.

From the 1st of April electives and outpatients (apart from follow ups) have been reinstated to payment by results, however current guidance states that Trusts need to report on full delivery of the activity plan due to timings of data collection.

The Trust worked with Kent & Medway NHS system partners to resubmit a financial plan for 2023/24 at the beginning of May. The plan is a deficit position of £72m post a small inflationary allocation. The rest of the ICB need to deliver a breakeven position to achieve the ICB target of £48m deficit. The Trust has now had approval for the £72m deficit position and confirmation that 2023/24 is the first year of the three year trajectory to achieve financial balance.

Delivery of this deficit plan for 2023/24 is a stretch for the Trust as it is based on a higher level of activity than 2022/23 and requires £40m of efficiency savings on a CRES basis and full adherence to cost control measures.

Group Position

	This Month			Year to Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
EKHUFT Income	74,068	76,149	2,081	356,772	361,844	5,072
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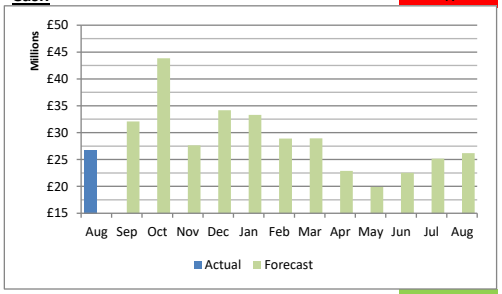
As at Month 5, the Trust is behind its activity plan by £2.7m, predominantly due to cancelled elective activity as a result of the Doctor's strikes. Although there is no improvement to the position reported in Month 4, the risk of April's non-delivery of the target is now eliminated. However, if there is no further change to the ERF guidance or target, and the current activity run-rate remains and the strikes continue, we could have an income underperformance risk of £8.8m at year-end.

Income and Expenditure R

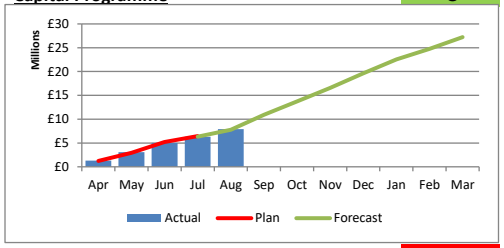
The key drivers behind the deficit are Strike action £1.1m by the Junior doctors and Consultants (excluding the impact of April industrial action, which has now been funded through the new ERF guidance), non-delivery of efficiency savings £11.5m YTD (net of £0.3m delivery of income CIP) of which £7.2m has been allocated to Pay and £3m to non pay. Pay overspent by £12.6m YTD due to non delivery of CIP and increased levels of staffing utilisation mainly in nursing (c128 WTE) & Medical & Dental (c196 WTE) and high cost of agency premium. Total non-Pay overspend of £6.5m, driven by non-delivery of efficiency savings (£4.6m), rechargeable drugs costs (offset by corresponding increase in income) and IT systems contracts relating to LIMS (also offset by an increase in income).

Cash R



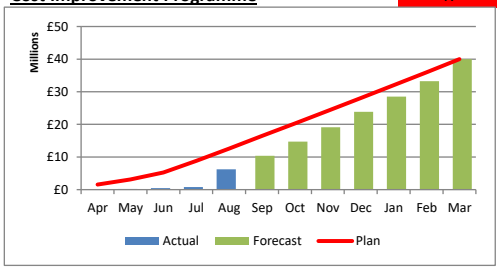
The Group cash balance (including subsidiaries) at the end of August was £26.8m.
The Trust drew £10.8m of working capital (PDC) in the month, making a YTD total of £32.7m.

Capital Programme G



Total capital expenditure at the end of August was broadly on plan with a £7.9m spend against a plan of £7.8m plan.

Cost Improvement Programme R



The Trust has achieved £1.1m efficiency savings so far this year against a £12.6m plan. Additional non-recurrent efficiencies of £5.1m have been achieved YTD by recognising the reported financial position adjusted for known overspends.

Income and Expenditure Summary
Month 05 (August) 2023/24

Unconsolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	9,407	7,996	(1,411)	42,340	39,263	(3,077)
Non-Electives	22,780	19,470	(3,310)	110,720	93,281	(17,439)
Accident and Emergency	4,227	4,070	(156)	21,074	19,627	(1,447)
Outpatients	10,143	9,590	(553)	47,275	48,489	1,214
High Cost Drugs	4,070	4,863	793	20,349	22,442	2,093
Private Patients	14	15	1	71	136	65
Other NHS Clinical Income	18,908	25,167	6,259	92,360	115,643	23,283
Other Clinical Income	133	146	13	666	628	(38)
Total Income from Patient Care Activities	**69,681**	**71,317**	**1,635**	**334,855**	**339,509**	**4,654**
Other Operating Income	4,386	4,832	445	21,916	22,335	418
Total Income	**74,068**	**76,149**	**2,081**	**356,772**	**361,844**	**5,072**
Expenditure						
Substantive Staff	(43,136)	(47,081)	(3,945)	(211,280)	(218,702)	(7,422)
Bank	(3,638)	(4,061)	(423)	(17,658)	(18,966)	(1,309)
Agency	(2,903)	(3,703)	(800)	(15,390)	(19,216)	(3,826)
Total Employee Expenses	**(49,677)**	**(54,846)**	**(5,169)**	**(244,327)**	**(256,884)**	**(12,557)**
Other Operating Expenses	(29,051)	(31,213)	(2,163)	(144,984)	(151,855)	(6,871)
Total Operating Expenditure	**(78,728)**	**(86,059)**	**(7,331)**	**(389,311)**	**(408,739)**	**(19,428)**
Non Operating Expenses	(861)	(767)	94	(4,319)	(3,958)	361
Income and Expenditure Surplus/(Deficit)	**(5,521)**	**(10,678)**	**(5,156)**	**(36,858)**	**(50,853)**	**(13,995)**

Consolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Income from Patient Care Activities	69,250	72,875	3,625	340,748	346,669	5,921
Other Operating Income	4,512	4,725	213	22,542	21,191	(1,351)
Total Income	**73,762**	**77,600**	**3,838**	**363,290**	**367,860**	**4,570**
Expenditure						
Employee Expenses	(51,425)	(59,169)	(7,744)	(263,326)	(277,703)	(14,377)
Other Operating Expenses	(26,786)	(29,014)	(2,228)	(131,505)	(136,918)	(5,413)
Total Expenditure	**(78,211)**	**(88,183)**	**(9,972)**	**(394,831)**	**(414,621)**	**(19,790)**
Non-Operating Expenses	(931)	(801)	130	(4,654)	(4,028)	626
Income and Expenditure Surplus/(Deficit) (pre Technical adjs)	**(5,380)**	**(11,384)**	**(6,004)**	**(36,195)**	**(50,789)**	**(14,594)**
Technical Adjustments	64	70	6	285	499	214
Consolidated I&E Position (incl adjs)	**(5,316)**	**(11,314)**	**(5,998)**	**(35,910)**	**(50,290)**	**(14,380)**

Income from Patient Care Activities

The £4.7m overperformance YTD on clinical income is primarily for funded service developments not included in the plan in the following areas:

- Additional Cancer Alliance (Targeted Lung Checks) new income stream confirmed (£0.7m)
- One-off funding for Pathology LIMS from the ICB to cover expenditure on digital path system (£0.5m)
- EK Healthcare Partnership funding for Virtual Wards and schemes targeted at discharges (£0.5m)
- Vascular reconfiguration and Continuous Glucose Monitoring funding not included in plan (£0.6m)
- High cost drugs/devices overperformance (£2.6m) - matched by a corresponding increase in expenditure
- Prior year income benefit (£0.4m)
- Offset by underperformance against other smaller contracts (£0.3m).

The majority of commissioner income is paid on a block basis with the exception of Elective Recovery Activity and high cost drugs and devices.

The full year Elective Recovery target has been reduced by 2% as a result of national guidance to compensate Trusts for the impact of the doctor's strike in April, and converted into fixed funding (£2.7m) allocated to April. This funding is to cover the expenditure consequence of the April strike (£440k) as well as the estimated activity loss in April. Trusts are now required to report the actual income performance against their plan. As at Month 5, the Trust is behind its activity plan by £2.7m, predominantly due to cancelled elective activity as a result of the Doctor's strikes.

Other Operating Income and Expenditure

Other operating income is favourable to plan in August and YTD by £0.4m. The in-month variance mainly relates to Recovery Support income of £0.2m, PACS / RIS recharges to other organisations of £0.1m and above plan income for GP trainees of £0.1m.

Total operating expenditure is adverse to plan in August by £7.3m and by £19.4m YTD, including CIPs which are reported as £3.6m adverse in month and £11.8m adverse YTD.

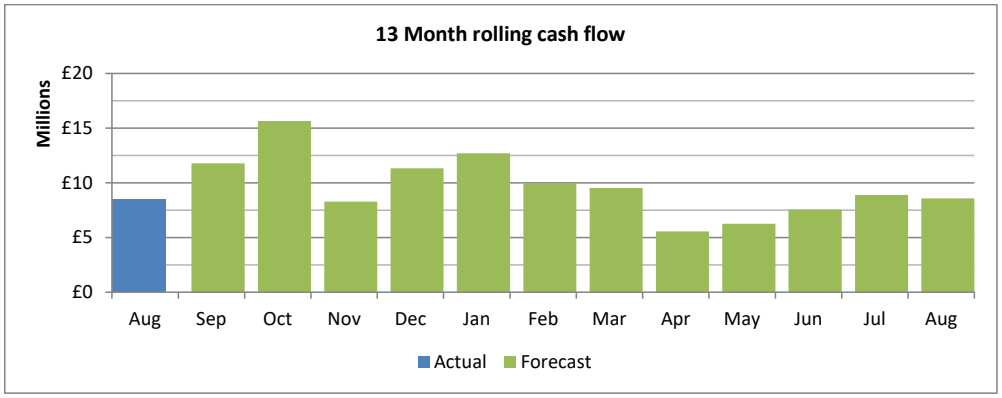
Employee expenses performance is adverse to plan in August by £5.2m and by £12.6m YTD. Pay CIP schemes are adverse to plan in August by £2.0m and by £7.2m YTD. Additional costs of £3.2m have been accrued to account for the medical pay award in excess of the 2% included in the original plan. Plans were adjusted to reflect pay award funding from the ICB of £2.0m, leaving an estimated deficit of £1.2m YTD. The adverse position also reflects the impact of cover during strike action by Junior Doctors and Consultants, which is estimated at £0.4m in August and £1.1m YTD, together with an identified shortfall on the AfC pay award of £0.1m for 2022/23 YTD and a funding gap for 2023/24 of £0.1m in month and £0.5m YTD. WTE over-utilisation increased by 22 from 300 to 322 reflecting the indicative direct costs for escalation beds of £1.4m in August and £6.8m YTD (Variance to plan of £0.1m in month and £0.6m YTD), and 1:1 specialing of £0.7m in August and £3.9m YTD (Variance to plan of £0.5m in month and £2.6m YTD).

Total expenditure on pay in August was £54.8m, an increase of £4.3m when compared to July, mainly relating to the medical pay award uplift, locum claims which grew by £0.5m, and increased provisions for IEN salary underpayments of £0.6m.

Other operating expenditure is adverse to plan by £2.2m in August and by £6.9m YTD. CIP schemes relating to all other operating expenditure headings are adverse to plan by £1.6m in August and by £4.6m YTD. The main drivers for the overspend in month are higher than planned spend on drugs and supplies and services - clinical totalling £1.4m and contracts with the subsidiary which are adverse to plan by £0.3m.

Other operating expenditure reduced month on month by £0.9m, predominantly relating to LIMS project Clinisys charges of £0.5m incurred in July.

Cash Flow
Month 05 (August) 2023/24



Unconsolidated Cash balance was £16.4m at the end of August 23, £8.0m above plan.

Cash receipts in month totalled £86.5m (£5.5m above plan):
K&M ICB paid £55.6m in August. (£1.5m below plan)
NHS England paid £12.4m in August (£1.2m above plan)
Other NHS receipts totalled £1.8m (£0.6m above plan)
Non NHS Receipts totalled £5.9m (£1.2m above plan largely due to receipts from 2gether, Spencer Hospitals and Charitable Funds)
Revenue Support is £4.0m above plan in month.

Cash payments in month totalled £86.0m (£0.6m below plan)
Creditor payment runs including Capital payments were £29.5m (£0.2m above plan)
Payments to 2gether were £1.8m below plan. Payroll was £1.0m above plan.

YTD cash receipts total £426.9m (£27.4m above plan - largely driven by receipts from NHS England over plan (£20.7m, of which £17.2m was unconsolidated pay award in June), VAT reclaims under plan (£7.4m - to be recovered in October), revenue support above plan by £13.7m).

YTD cash payments total £429.0m (£19.4m above the plan - driven by payments to 2gether below plan (£9.9m), Payroll over plan (£22.6m, predominantly due to the unconsolidated pay award) and creditor payments over plan (£6.7m, due to increase in bank and agency spend)).

2023/24 Plan

The revised plan submitted to NHSE in May 2023 shows a technically adjusted deficit position at the end of 2023/24 of £72.8m. Revenue support for the full deficit amount is forecast in the year.

Forecast

Monthly payments on account (£71m YTD) continue to be made to 2gether Support Solutions in lieu of invoices being paid whilst charges are being reviewed. However, invoices were authorised for payment in Month 5 and the VAT reclaim will be received in September/October. The VAT reclaim received will enable a significant payment to creditors to clear backlog invoices in October.

£8.1m Revenue Support has been received in September.

The Trust has submitted a request for £18.2m Q3 revenue support. £6.4m in October, £6.0m in November and £5.7m in December, in line with the original planned £72m deficit.

Creditor Management

The Trust moved to 59 day creditor terms in Month 05 (moving out further in early September).

In prior months, payments to one key supplier were being held and invoices cleared only if the funds were available. To avoid late payment charges being levied, it has been agreed to clear their balance by the end of October at a rate of £2m per week. As at 31st August 23, £4.1m was overdue for payment to them, and a further £3.3m of current invoices.

At the end of August 2023, the Trust was recording 71 creditor days (Calculated as invoiced creditors at 31st August/ Forecast non-pay expenditure x 365).

Cost Improvement Summary

Month 05 (August) 2023/24

Delivery Summary	This Month			Year to Date			Forecast	
Programme Themes £000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Outturn**	**Variance**
Agency	917	-	(917)	3,176	-	(3,176)	5,517	(3,777)
Bank	-	-	-	-	-	-	9	9
Workforce	269	66	(203)	1,170	142	(1,028)	3,154	70
Outpatients	27	-	(27)	107	-	(107)	274	(70)
Procurement	145	63	(82)	553	296	(257)	1,892	264
Medicines Value	85	46	(39)	289	227	(62)	938	(62)
Theatres	235	-	(235)	753	-	(753)	2,686	(314)
Care Group Schemes *	1,363	102	(1,261)	3,984	419	(3,565)	14,027	(441)
Sub-total	**3,041**	**276**	**(2,764)**	**10,033**	**1,084**	**(8,949)**	**28,498**	**(4,321)**
Central	708	5,148	4,440	2,523	5,148	2,625	11,502	4,321
Grand Total	**3,749**	**5,424**	**1,676**	**12,556**	**6,232**	**(6,324)**	**40,000**	**-**

* Smaller divisional schemes not allocated to a work stream

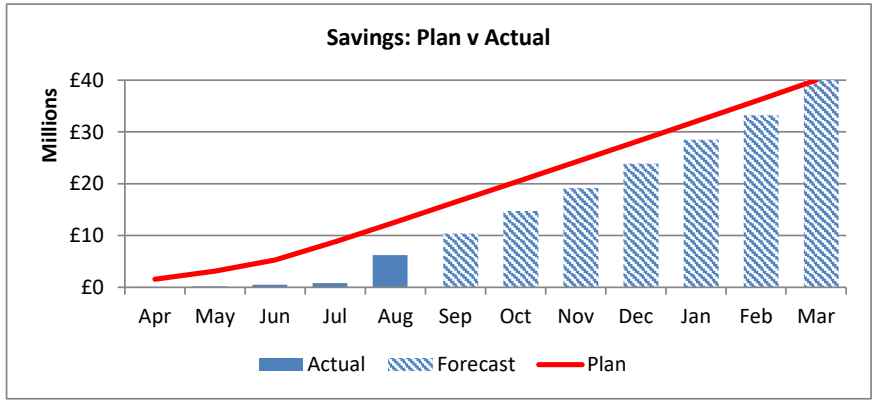
Delivered £000		
Month	**Target**	**Actual**
April	1,563	58
May	1,581	149
June	2,149	290
July	3,514	311
August	3,749	5,424
September	3,890	
October	3,873	
November	3,874	
December	3,874	
January	3,929	
February	3,989	
March	4,015	
	40,000	**6,232**

The submitted Efficiencies plan for 2023/24 is £40m. The Trust recognised recurrent savings of £0.2m in August, and £0.7m on a YTD basis, which is significantly below Plan. YTD underperformance is primarily due to timing of schemes in Theatres, Procurement and Care Groups currently being developed.

Additional non-recurrent efficiencies of £5.1m have been achieved YTD when taking into consideration the reported financial position adjusted for the known overspends (such as pay award funding shortfall, impact of strike action, increased levels of utilisation for nursing & medical staffing above plan and 1-2-1 specialling). Work is underway to understand if these non-recurrent efficiencies are able to be turned into recurrent efficiencies.

The current value of the pipeline is £13.8m, a (£0.5m, 3%) decrease in value vs. the prior month, but this relates predominantly to efficiencies being confirmed as reduction to run-rate overspends from FY23, rather than CIPs.

The majority of ideas currently identified through the care group process are less than £50k (60%) or less than £250k (20%), but working across the cross-cutting themes of Workforce, Elective and Non-Elective productivity, Theatres, we are predominantly scoping larger group-wide to significantly increase the value of CIP schemes next month. This work includes linking in with the Nursing Agency cost deep-dives, and a review of Admin and Clerical vacancies.



Capital Expenditure
Month 05 (August) 2023/24

Capital Programme	Annual	Annual	Year to Date		
£000	Plan	Forecast	Plan	Actual	Variance
Emergency Department Expansions	4,271	4,433	2,943	4,433	(1,490)
Community Diagnostics Centre	2,845	2,845	0	38	(38)
Mechanical Thrombectomy	2,608	2,446	50	26	24
Diagnostics Clinical Equipment	2,550	2,550	0	0	0
Information Development Group	2,000	2,000	1,125	696	429
Medical Devices Group	1,666	1,666	690	276	414
Electronic Medical Records	1,545	1,545	635	602	33
Stroke HASU	1,463	1,463	67	691	(624)
Diagnostics Imaging Capacity	1,433	1,383	183	(0)	183
Patient Environment Investment Committee	3,771	3,771	690	49	641
Charity Donations	900	900	326	146	180
Other Build	736	736	686	77	609
Subsidiaries	519	589	104	70	34
Other IT	375	375	0	375	(375)
Other Medical Equipment	259	259	259	90	169
Trust IFRS16 Acquisitions	0	254	0	254	(254)
Lease Cars	0	8	0	8	(8)
All Other	0	0	0	90	(90)
	26,941	**27,224**	**7,758**	**7,922**	**(164)**

Funded By:	Plan	Forecast	Change
Operational Cash	21,515	21,632	117
System Set Underutilisation	(2,850)	(2,981)	(131)
Donations	900	900	0
Disposals	250	250	0
System Capital PDC	1,463	1,463	0
PDC	5,663	5,613	(50)
Carried Forward PDC	0	131	131
New Lease Loans	0	333	333
New Lease Repayments	0	(117)	(117)
	26,941	**27,224**	**283**
Under/(Over) Commitment	**0**	**0**	

The Trust submitted the final 5-year Capital Plan to NHSE on 4th May 2023, the programme totalling £26.94m in 2023/24.

The latest forecast for the year, as at M5, is £27.2m, representing a £0.28m net increase from the original plan; this is due to New Lease Loans taken in-year totalling £0.33m, offset by a £0.05m reduction in the Diagnostic Imaging Capacity PDC funding assumed (and associated spend plans), to align it to the final funding figure provided in the MOU.

Capital Spend Position - as at M5

The Group's gross capital year-to-date spend to the end of Month 5 was £7.9m, against a YTD plan of £7.8m. This represents a £0.1m net overspend, as a result of:

- Underspends totalling £2.7m (including £1.2m on PEIC and Other Build projects, £0.8m on MDG, Diagnostics Imaging and Other Medical Equipment, £0.5m on IDG and Electronic Medical Records (EMR) schemes and £0.2m on Charity Donations, Subsidiaries and Mechanical Thrombectomy);
- Overspends totalling £2.9m (including £1.5m on the ED Expansion programme, £0.6m on Stroke HASU, £0.4m on Other IT schemes, £0.3m on IFRS16 items and £0.1m overall on other small overspend items);

The Trust is currently holding circa £3.7m worth of unfunded cost pressures, including:

• £1.55m on the WHH Fire Alarm PA Upgrade, which was approved by the Trust Board on 1st June 2023;

• £1.06m on the ED Expansion Programme, as presented to the Executive Team at the Capital Prioritisation event that took place on 31st May 2023;

• £0.9m related to the enabling works required for the installation of the QEQM MRI, for which the Trust accepted central PDC Funding to procure the MRI, albeit funding for the enabling works was not secured;

• £0.19m estimated for completing the Maternity Entonox remedial works at WHH (over and above the existing budget), as a result of higher than expected costs; these costs are contingent upon confirmation from the 2SS Estates Team whether or not additional remedial works are required to address the WHH medical gases issue

These are yet to be reflected in the year-end forecast position, pending identification of suitable mitigating actions. There are ongoing conversations with Kent and Medway ICB regarding the funding of these cost pressures and an update will be provided in the upcoming reports.

Statement of Financial Position

Month 05 (August) 2023/24

£000	Opening	To Date	Movement	
Non-Current Assets	**402,107**	**399,484**	**(2,623)**	▼
Current Assets				
Inventories	6,749	7,437	688	▲
Trade Receivables	11,677	11,012	(664)	▼
Accrued Income and Other Receivables	29,981	28,764	(1,217)	▼
Assets Held For Sale			-	
Cash and Cash Equivalents	18,618	16,463	(2,155)	▼
Total Current Assets	**67,025**	**63,676**	**(3,348)**	▼
Current Liabilities				
Payables	(41,537)	(61,952)	(20,415)	▲
Accruals and Deferred Income	(46,653)	(41,972)	4,681	▼
Provisions	(2,887)	(2,809)	78	▼
Borrowing	(4,838)	(3,104)	1,734	▼
Net Current Assets	**(28,892)**	**(46,161)**	**(17,269)**	▼
Non Current Liabilities				
Provisions	(3,405)	(3,365)	41	▼
Long Term Debt	(77,371)	(75,656)	1,715	▼
Total Assets Employed	**292,439**	**274,302**	**(18,137)**	▼
Financed by Taxpayers Equity				
Public Dividend Capital	454,994	487,710	32,716	▲
Retained Earnings	(217,590)	(268,443)	(50,853)	▼
Revaluation Reserve	55,035	55,035	-	
Total Taxpayers' Equity	**292,439**	**274,302**	**(18,137)**	▼

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

Trust closing cash balance was £16.5m (£16m in July) £8m above plan. See cash report for further details. Cash has been supported in year by £32.7m of PDC working capital.

The Trust's application for Q2 borrowing for month 5 in the form of working capital PDC was approved and drawn in August to the level of £10.8m.

The current I&E adverse variance to plan (c£14m) is having an impact on cash - and the Trust's ability to pay creditors to terms - this impact is clearly seen in the Better Payment Practice Code figures. The Trust has commenced discussions with NHS England around potential additional borrowing prior to any formal changes to forecast.

Trade and other receivables have reduced from the 2023/24 opening position by £0.7m (£5.6m reduction in July). Key drivers are detailed on the Cash report

Payables have increased by £20.4m (£19.3m increase in July). See Working Capital sheet for more detail on debtors and creditors.

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

PDC increased in month by Working Capital (£10.8m).

East Kent Hospitals University NHS Foundation Trust

BOARD OF DIRECTORS (BoD)

Report title: **Integrated Improvement Plan (IIP) Report Including Metrics**

Meeting date: **5 October 2023**

Board sponsor: **Chief Executive**

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

Appendices:

APPENDIX 1: **Progress Update on Delivery of the IIP since last month and agreed metric reporting**
APPENDIX 2: **Updated IIP**
APPENDIX 3: **IIP Risk Register**

Executive summary:

Action required:	**Information**
Purpose of the Report:	To update the Board on progress of delivery of the IIP, performance against the agreed metrics and to provide oversight of key risks to delivery.
Summary of key issues:	The IIP update report includes an update on progress against the programme milestones and the updated version of the programme itself. One programme of six (Leadership and Governance) is green following the progress that has been made. Three of six programmes are rated as Amber with good progress noted in quality and safety and maternity. The biggest areas of risk to delivery, against the agreed milestones and exit criteria, are in the finance programme and elements of the operational performance programme, particularly the diagnostics pathway. Both the finance and operational performance programmes are currently RAG rated red.
Key recommendations:	The Board of Directors is invited to **DISCUSS** the report and progress of delivery of the Integrated Improvement Plan to date.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients • People • Partnerships • Sustainability

East Kent Hospitals University NHS Foundation Trust

Link to the Board Assurance Framework (BAF):	**BAF 32** – There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered. **BAF 34** – There is a risk that our constitutional standards are not met. **BAF 38** – Failure to deliver the financial plan of the Trust as requested by NHS England (NHSE).
Link to the Corporate Risk Register (CRR):	N/A
Resource:	Yes - Discussions with National team regarding the use of available resources.
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: Oversight and Assurance is provided through the Strategic Improvement Committee

East Kent Hospitals University Foundation Trust
Report on Integrated Improvement Plan

Journey to Exit NOF4

September 2023 Summary for Trust Board 5 October 2023

Purpose of Report

NHS
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This report has been established to update the Board on progress of delivery of the Integrated Improvement Plan. It is also intended to give the Board oversight of key risks to delivery; and to update on key evidence that has been added to the evidence repository to support exit from the Recovery Support Programme (RSP).

Delivery of the Integrated Improvement Plan is overseen by the EKHUFT Strategic Improvement Committee (SiC) which is chaired by the Chief Executive.

The Board will receive an update on the IIP on a monthly basis focusing on successes, challenges and actions to mitigate any key risks to delivery. We will also provide a quarterly deep dive to demonstrate impact and progress against the overall programme objectives.

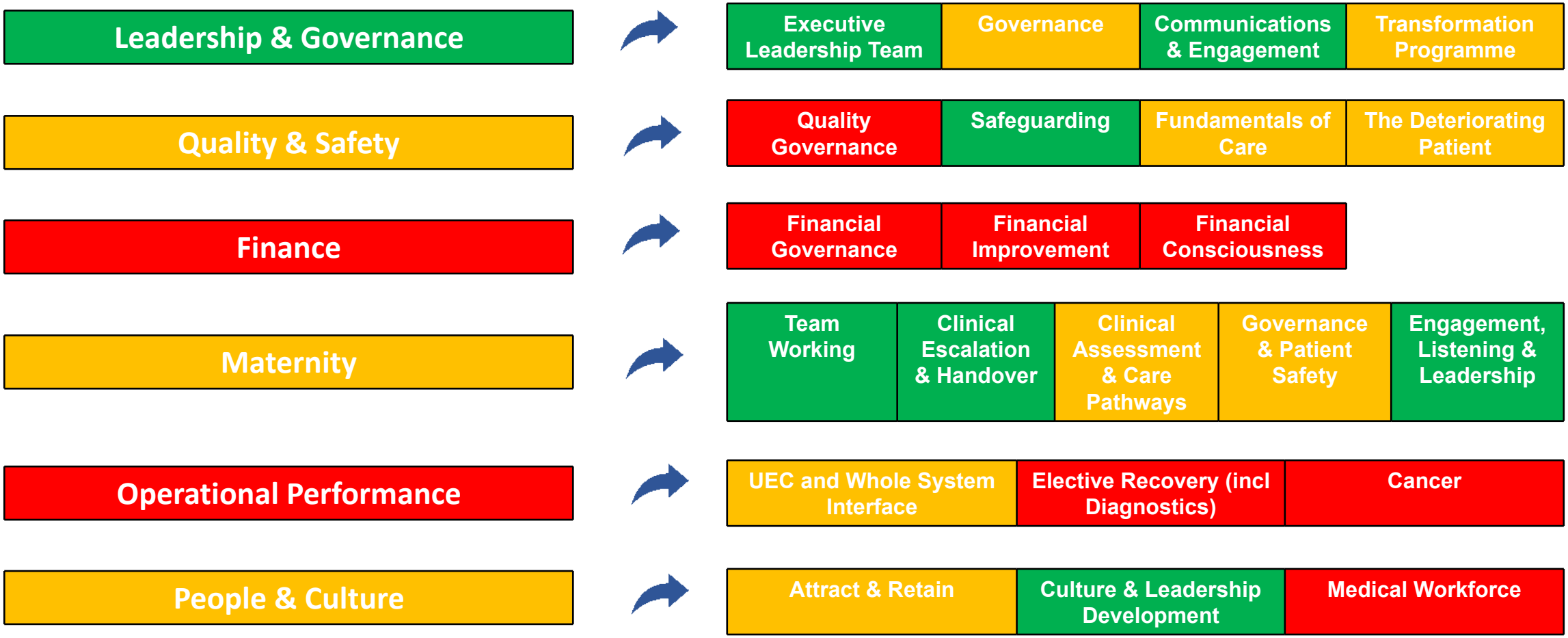
High-level Summary on Programme Delivery

	Priority area of focus in IIP	Summary update
Leadership & Governance	Leadership Development	Good progress has been made with recruitment of the CMO, with offer in progress and the Deputy CMO awaiting a start date. The organisational restructure has concluded and 10 remaining vacancies are to be interviewed for throughout October. The Leadership Behavioural Framework has now been signed off and moves to the implementation phase.
	Governance Framework	The governance model review and the workstream is on track to report to October board. The next step will be to implement and embed the clear framework for governance oversight within and throughout the Care Groups, ensuring that all staff are clear on their responsibilities for the management and learning from risks, incidents and complaints.
Maternity	Maternity Transformation	The Trust Board approved the Maternity Neonatal Improvement Plan on 7th September. This will enable new milestones to be planned out with clinical leads which will include recognition of the deteriorating woman and clinical care pathways. Progress has been made within sonography, with the number of scans within the backlog reducing significantly over the last period.
Operational Performance	UEC Patient Pathways	Work continues on the delivery of improvements across all components on the urgent and emergency care pathway. Key progress includes completion of training for direct access pathways, the Clinical Decision Unit (CDU) has been established at QEQM and the MAU pilot has been completed at the WHH. A programme of improvement work focused on inpatient flow commences at the QEQM at the beginning of October. The Trust is being supported with external funding in the engagement of additional resource for this programme from Prism.
Quality & Safety	The Deteriorating Patient	Progress continues to be made within education with the pilot now complete. A decision was made to change the e-learning NEWS2 modules priority from essential to mandatory. The Programme continues to demonstrate a positive improvement.
	Ward Accreditation	Significant progress has been made this period with the Ward Accreditation programme with the programme completion date reducing by two months to Jan-24, this progress has also reduced the residual risk score (reflected on the risk register slide).
People & Culture	Culture & Leadership	Progress continues with Culture & Leadership Development. This month the Equality Diversity & Inclusion Strategy has been approved and communication plan is being developed. Planning continues to launch a Trust wide behaviour survey, with a view to include external partners.
Finance	Workforce Plan	There has been enhanced communication across the organisation confirming the YTD financial position, encouraging people to think about how they can make change. An additional resource has been sourced to assist with the financial recovery plan.

Integrated Improvement Programme – RAG Reported Progress

East Kent Hospitals University NHS Foundation Trust

Progress Summary by Programme:



Progress Summary by Individual Project:

The Quality Governance, Financial Governance, Financial Improvement, Financial Consciousness, Elective Recovery (including diagnostics), Cancer and Medical Workforce projects are reported as **off track, far from meeting exit criteria** in this period, with a further 8 projects are rated as **having issues, with work to do to meet exit criteria**. The remaining 7 projects are all **on track, expect to meet exit criteria**.

Alignment of the Overarching Delivery Improvement Milestones with the IIP

East Kent Hospitals University NHS Foundation Trust

The Strategic Improvement Committee with support from the NHSE Intensive Support Team, have undertaken a thorough review of the required 2023/24 overarching delivery improvement milestones as directed by the NHSE Regional Director and aligned these milestones with the previously agreed IIP. The majority of requirements were already underway however, this exercise has ensured any additional milestones are now incorporated into programmes (if required) or original milestones enhanced to meet the required output. Below are the overarching delivery milestones of which the Trust Board are to be aware of and assured are reflected in the IIP to provide measurable improvements and monitoring moving forward for internal, regional and national reporting. The full revised IIP as at September 2023 can be found in Appendix A.

Leadership & Governance

- Executive Development Plan in place and relevant recruitment plans enacted
- All executive posts appointed to
- Comms and engagement plan approved and operational
- Culture & Leadership Programme having demonstrable impact
- New operational structure in place
- Improved staff survey results
- Evidence of strengthened clinical leadership and ownership
- Governance Review completed
- Evidence that Board is sighted on key risks with aligned BAF and Board level Risk Register

Operational Performance

- 4 hours – reach 76%
- Type 1 – maintain >60%
- 12 hours - maintain <5%
- Diagnostics - attain regional mean of 22%
- Cancer backlog - achieve plan of 224
- Electives - sustainable plan for Otology in place
- Elective - zero at 78 weeks

Finance

- Medium term financial plan developed
- Recurrent efficiency schemes delivered
- Delivery of the 23/24 planned deficit
- Temp staff expenditure - £38.486m reduction delivery
- Efficiencies Delivery - delivery of £40m

Quality of Care

- Training on SI and NE delivered in induction for all new staff
- Reduced time between identification and reporting of an SI.
- Learning from SIs and Board assurance of practice improvements.
- Deteriorating patient education programme and dashboard in place
- Reduced number of SIs over the 60-day deadline for completion of investigation.
- Audit programme presented to the Board demonstrating improvements in patient safety as a result of serious incident management.
- Quality governance structure and framework in place – to include robust safeguarding governance.
- Improved clinical leadership and engagement.
- Safeguarding policies in place, ratified alongside a communication plan
- Safeguarding training needs analysis and trajectory completed
- Annual safeguarding report completed and published/plan for publication.
- Sustainable safeguarding workforce team in place
- Foundations for effective safeguarding in place.

Maternity

- Induction of new maternity leadership.
- Obstetric oversight of triage services in place.
- No overdue (breached) SIs / HSIB investigations.
- Quarterly audits supporting appropriate clinical escalation showing improvement
- Maternity Transformation plan completed and approved by Board.
- Obstetric consultant job planning completed.
- Scoping and reopening of WHH Midwifery Led Unit.
- Demonstrable improvement that staff feel listened to.
- All key obstetric safety roles assigned and operational.
- Confidence in the learning environment for students evidenced at Board.
- Leadership structure - midwifery & obstetric embedded and operational.
- Incorporation of ultrasound into maternity services.
- Independent case review process to be established with clear outputs and Board oversight.

Programme: Leadership & Governance

Key progress in programme during last period
• CMO interviews concluded, offer accepted and currently awaiting approval from the Treasury • Deputy CMO appointed, awaiting start date. • Quality Governance framework approved at CEMG 6th September 23 and will now be fully implemented • Risk appetite statement agreed and published. • Quality Governance framework approved at CEMG 6th September 23 and will now be fully implemented. • Implementation of CLP leadership survey communications campaign and publication of assets to describe what the CLP journey will look like. • Good progress with Comms & Engagement workstreams please see slide 12 for further details. • A number of milestones have been evidenced and closed.

Milestones off track	Target Date	What are we doing about it?
1.403: Continue the Cultural and Leadership Programme focus in maternity and review effectiveness	May-23	Care group QUAD is enrolled onto NHS perinatal C&L programme which includes 8 separate development days. Phase 2 of the NHSI perinatal CLP the SCORE culture survey will be repeated and goes live on 17th Oct 23. This will enable benchmarking against 2018 results. Confirmation of leadership and culture session from Frontier Leadership (Army Leadership model in the NHS) - booked for WH Quality Board on 17 Oct 2023.
1.405: Develop and adopt the Behavioural Code in Maternity	Jun-23	Maternity has received the link to the Trust level leadership behaviours survey through Trust News, published 7th Sep 23 in order to progress milestone.

Key Project Risks	Residual Score
Unable to appoint CFO substantively due to unsuitable candidates.	9
Loss of focus on operational delivery due to the ongoing effect of the restructure.	6
No substantive COO following the resignation from the current postholder.	9

Programme: Quality & Safety

Key progress in programme during last period

- Additional milestones for Q2, 3 and 4, as discussed with NHSE at the recent RSP meeting, and how these will be measured through the IIP have been discussed and drafted for SIC approval.
- Board development session was held 1st Aug 23 with risk appetite statements agreed and risk tolerance levels considered.
- Learning review of safeguarding learning is shared at SAC in August 23.
- Patient Voice Involvement Officer for KCH now in post
- Key members of staff from ward accreditation and falls team are on phased return from sick leave, reducing the residual score on risk identified in IIP risk register.
- AIS codes on PAS/Sunrise now match national SNOMED codes.
- Deteriorating patient pilot education programme complete.
- Inaugural Deterioration Patient Safety meetings continue with good representation.
- Deteriorating Patient lead now a member at SI panel.
- Paper to be shared at PSC on 6th September 23 on Thematic Review of Sub-optimal Care of Deteriorating Patients Across the Kent and Medway System from Jan 22 - April 23 . There was 52 incidents in total in Kent & Medway with under 50% attributed to EKHUFT, equating to on average 1/2 per month, all of which was known and actioned/shared learning. It is important to recognise though that the data was not triangulated with the number of beds or patients bed days. This then raises the question regarding the comparability of the data in that it may lead to patient safety concerns when in fact it reflects the difference in size of providers. This provides assurances this project is sighted and actioning the relevant incidents reported.
- e-learning NEWS2 module – decision on changing priority from essential to mandatory now formally agreed.

Key Project Risks	Residual Score
Delay to PSIRF Implementation	12
Capacity in Ward Accreditation Team	8
Capacity in BI team to support deteriorating patient dashboard	12
Head of Nursing for FoC & Quality on an interim arrangement until end September 23	12

Milestones off track	Target Date	What are we doing about it?
4.101b: Revised organisational structure, with clearly defined roles and responsibilities within quality governance structure and framework.	Aug-23	Linked to milestone 4.101a. The document will require aligning with revised organisational structure once implemented.
4.103d: Upon approval of B/C there will then be a period of transition from one system to the other	Oct-23	Once business case is approved this transitional piece of work will take place but likely to go past the milestone target date.
4.105: Commence transitioning across to the new PSIRF	Aug-23	Learning framework to support the transition will be sent to CEMG and Patient Safety Committee in September 23 for comment and approval in October 23. Thereafter will commence transition.
4.206: Review sub-contracted safeguarding arrangements as part of quality schedule and oversight arrangements and monitor the effectiveness and sustainability.	Aug-23	Audit undertaken to identify the subcontracted services and how they are currently commissioned. Effectiveness of the quality, commissioning and monitoring arrangements to be discussed at the Task and Finish group once it commences in September 23.
4.303: Review current FOC workstreams	Jun-23	FoC governance framework is planned to be published in September23, dependent on the organisations governance framework being published.
4.305: Publish FOC framework and KPIs	Jul-23	Unable to publish FoC Governance framework until milestone 4.303 & 4.304 is complete.
4.306: Develop trajectory for further reduction in FoC incidents resulting in moderate harm and above	Jul-23	Nursing leads producing trajectory proposals to be presented initially to FOC Lead Nurse and FOC committee by September 23. Links with milestones 4.304 and 4.305.
4.401: Agree with ICB the required funding for Patient safety specialist role	Mar-23	A decision is to be made for Patient safety specialist role as it is currently covered by secondment which is due to cease in September 23.
4.401: 4.408: c) Implement deteriorating patient education programme across the organisation	Sep-23	New milestone linking with national requirements to implement by Q2. Requires escalation at SiC as unable to meet national target date of Q2. Further work is underway to understand what activities can be achieved.

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Programme: Finance

Key progress in programme during last period

- Terms of Reference for newly formed Capital Investment Group & Business Case Scrutiny Group (formally SIG) now developed and to be ratified by end of September 23.
- Resource sourced internally to support further development and progress of Financial Recovery Plan.
- Additional financial review sessions with the new Care Group Medical Directors have taken place.
- Strengthened communications on finance and efficiency including updating intranet page including YTD financial position.

Key Project Risks	Residual Score
There are currently no project leads within the IIP finance workstream	6
Additional support needed with the updating of the Financial Recovery Programme	8
Risk to the delivery of the Trusts 2023/24 Efficiency Plan	12
Identify and prioritize development of "harder to achieve" improvements	12

Milestones off track	Target Date	What are we doing about it?
6.102: Effective Care Group oversight approach in place	Jun-23	Recovery oversight meetings are now in the diary up until March 2024. Restructure is complete with oversight meetings starting in September 23 being Exec led. Financial control messages are very evident throughout the Trust. Reduction in run rate will demonstrate effectiveness.
6.103: Embed monthly finance reviews with Care Groups	Jun-23	Effectiveness of these meetings to be initially reviewed in October 2023 following the review of the previous efficiency meetings which have been superseded with exec led oversight meetings.
6.104: SFIs definition & refresh	Jul-23	SFIs ratified at Audit Committee in April 2023. A further review will be undertaken to ensure the revised governance processes being imbedded into the Trust are reflected. This will also look at further financial controls and ensure that they are easy to interpret. Aiming to complete refresh by November 23.
6.105: Meeting structure and review of TOR s	Jul-23	Work to be progressed with involvement of executive colleagues.
6.106: Review, relaunch and embed Strategic Investment Group (SIG)	Aug-23	SIG has been repurposed into Capital Investment Group & Business Case Scrutiny Group. ToRs to be developed and will be ratified by end September 2023.
6.108: Rebasing to revised hospital structure	Sep-23	Work has commenced to ensure effective reporting post restructure. First reporting period will be October 23.
6.203: Model years one and two of FRP	Jun-23	Draft FRP document submitted to July 2023 Trust board. Further work to finalise required via engagement with key stakeholders. Awaiting national guidance.
6.204: Update FRP document	Jun-23	This links to milestone 6.203.
6.204a: Medium term financial plan developed	Sep-23	New metric added & to be developed.
6.205: Fully develop FY24 efficiencies	Jul-23	Trust Board approved additional resource to drive efficiency programmes, currently valued at £11.4M (mostly recurrent). A number of schemes need values to be worked through.
6.206: Identify and prioritize development of "harder to achieve" improvements	Jul-23	Executive led sessions have been held with the new care group Medical Directors to develop further improvements.
6.207: Develop multi-year productivity and efficiencies approach covering pathway improvement and GIRFT	Jul-23	Focus required on 23/24 key themes initially, prior to 24/25 being considered.

Programme: Maternity

Key progress in programme during last period

- Documented attendance of / agreed process for Obstetrics at safety huddles and shift handovers; this is captured and held by Labour Ward so records requested.
- Progress simulation training now that dedicated training spaces have been assigned.
- Submission of SCORE survey template to NHSE in readiness for launch of the survey on 16th October 23.
- Sunrise updated to include MEWS assessment of pregnant women presenting in ED. Labour ward coordinator is point of contact in Maternity for ED.
- Review of outcomes from weighted decision matrix process with senior leadership team and apply to clinical pathways within the MNIP.
- Outcome from escalation of capacity concerns to deliver the escalation tool projects via the current clinical audit programme, within existing resources in the WH Governance team.
- Appointment of 'Audit Lead' midwife.
- Stop the clock foetal monitoring metrics reviewed with foetal monitoring midwives to agree future data set.
- Further FMU Process Mapping day with NHSI MIAs was postponed, now booked in for 18th October 23.
- MNIP charters are to be presented at September 23 Trust Board for approval.
- Map out the steps to undertake a SCORE culture survey.
- Meeting with South East London maternal medicine network to understand the needs and share learning for the maternal medicine pathway at EKHUFT.
- Progress made against backlogs for open incidents, SI investigations, complaints.
- Progress made against Governance Project Plan - 70% on track/complete against actions. 37% assured. Group meeting monthly.
- Launch of Safety Thread.
- Progress against backlog of Patient Information Leaflets (PILs).
- Reestablishment of 'real time reporting' working group to get maternity antenatal clinics onto PAS.
- MNIP programme lead meeting with ICB/LMNS programme lead for maternity services 6 weekly to discuss maternity improvement as a region

Milestones off track	Target Date	What are we doing about it?
2.202: Embedded quarterly audits supporting appropriate clinical escalation showing improvement; SBAR, MEOWS, sepsis and VTE	Jun-23	Project plans for improvements to SBAR and VTE processes were developed and have progressed slowly; once implemented the new quarterly audits (aligned to the annual clinical audit plan) will demonstrate outcomes of these improvement interventions. Clinical audit plan due to be agreed at clinical audit day (14.09). Audit lead midwife now appointed and currently going through induction process. Service improvements identified for VTE and SBAR dates to be reviewed.
2.301: Centralisation of telephone triage	Jul-23	Update provided to Director of Maternity 11th Sep 23 to take implementation forward with Matrons
2.306: Implementation of revised bereavement pathway	Aug-23	Pending approval of the Bereavement Guideline on 28 July 2023 guideline not yet approved (July 23). Some elements are in place but some are yet to implemented which are being progressed.
2.401: No overdue (breached) SIs / HSIB investigations	May-23	Continued progress against backlogs for open incidents, SI investigations, Complaints. AS at 15/9 SI/HSIB Breaches - 0 Open actions - 250 Open Incidents - 130 Open complaints – 18 / overdue Complaint responses - 4 No. of Expired Guidelines - 30 of 110 No. of Expired Patient Information Leaflets (PILs) - 40 of 61 - appointment of patient information midwife to improve the quality of, and access to patient information The current backlogs that we have are predicted to fall behind against the trajectory due to a management vacancy in the Governance team (Pt. Safety Matron).

Key Project Risks	Residual Score
Revised model for telephone triage system not yet finalised	2
Revised Quality & Safety Framework not yet produced	3
Unfilled vacancies in maternity teams	12
Inadequate estates for maternity services	12

Programme: Operational Performance

Key progress in programme during last period

- GIRFT completed review - 60 attended the session from across the system. GIRFT submitted their recommendations and outline of on-going support. Next steps is to work with the key stakeholders from EKHUFT and HCP to deliver the programme. GIRFT onsite visits across 13th, 14th, 15th September with an ICB System feedback session held on 15th to determine how GIRFT recommendations can be supported.
- Training for direct access pathways completed at both acute sites.
- QEQM - ED Observation (CDU) established with further review of patient criteria to optimise utilisation. Metrics in place .
- WHH MAU pilot completed with the next phase model completed to manage HCOOP patients against the MAU criteria. To be ratified at the September 23 Emergency Care Delivery Group for commencement October 23 once the ED build completed.
- Al-ted work planned to be completed by end of September 23 with planned implementation thereafter in October 23.
- Access Policy approved via Policy Assurance Group.
- PRISM to commence to support theatre improvement.
- Bid submitted to increase diagnostic capacity in EK (£80m underspend against CDC programme).
- Kent & Medway Elective Leads review of Board Assurance Letter - scoping options/sharing best practice to support reduction in OP FUP/Increase PIFU/validation of all pathways/increase first OP capacity for 65 week risk cohort.
- Endoscopy contract selection completed. Awaiting CFO sign off for final progression. Funding requested from the ICB to fund part/all of the Endoscopy insourcing contract.

Key Project Risks	Residual Score
Diagnostic delays in cancer pathways due to increased activity	16
Inability to comply with 2023/24 activity plan	12
NLFTR position to support emergency flow and 12 hour breach reduction	9
78 week elimination due to inability to secure additional endoscopy and otology capacity	15
Inability to fully validate patients at 12 week wait as per Board assurance letter	6

Milestones off track / due in next 2 months	Target Date	What are we doing about it?
3.111: Established pathways to the MDU at KCH (nurse led)	Jun-23	Pathways established. Service yet to be activated. Discussion planned for September ECDG. Confirmation received from ICB to fund majority of project, recruitment in early stages.
3.113: WHH End of Life Model implemented	Jun-23	Work in progress. The model of care has been agreed. The medical cover impacted by staffing constraints. End of Life clinical forum now established an led but palliative care nurse consultant. Expect update late October 23.
3.114: Patient Flow SAFER principles in place across Trust with metrics focussed on discharges by 10.00, golden patients, reduction in 12-hour ED waits	Aug-23	On track to implement SAFER principles at WHH. Being supported by interim Director of Discharge Improvement. Comms plan being developed & launched in August 23. For QEQM this will start at the tenure of the new HD supported by Prism.
3.205: Validation plan agreed and implemented for all diagnostic modalities utilising digital transformation available within the Trust	Jul-23	Technical logic drafted for two-way text messaging. Quantify cost of full roll out completed every 12 weeks to deliver validation requirements moving forwards. Awaiting costing information.
3.206: Actions agreed and implementation started to deliver diagnostics stretch target (tbc)	Sep-23	DM01 trajectory for end August targeted position of 63.1%. Actual performance 55.9% (July). Trust DCOO provided updated diagnostics plan in August 23 to ICB. Further internal scrutiny of plan is required and will go through the Planned Care Improvement Group in September 23. Expect updated plan in October 23 with clear and redefined actions and nominated leads. To improve Endoscopy/NOUS requires insourcing and investment - schemes submitted to the ICB for funding request.
3.209: Produce and ensure there is a sustainable plan for Otology long waiting patients	Sep-23	No external capacity can be sourced to support EKHUFT recovery. Remap of capacity aligned to trajectory to eliminate breaches by the end of January 2024. Remodel capacity with returning long term sickness absent consultant. Capacity mapping expected to be completed w/c 25th September and to be reviewed at Planned Care Board held Tuesday 19th September 23.
3.302: Internal improvements in place to meet 62-day compliance	Aug-23	509 breaches at the time of writing (15/08/23) this is an unvalidated figure.

Programme:	People & Culture

Key progress in programme during last period
• All evidence submitted for blue milestones. • Deployment has begun on the diagnostics that make up the discovery phase of Culture Leadership Programme. Include planning of Trust wide behaviour survey and deploy to external partners (to be agreed). Plan for survey to go live in early September 23. • Development of proposal for succession planning for when new Care Group senior teams are in place. • EDI Strategy approved. • Communication plan for EDI Strategy developed. • Submission of rostering paper to interim CMO. • As at 20th September 1007 staff members have completed the staff survey.

Key Project Risks	Residual Score
Capacity to scale up delivery of the Leadership Development Programme	9
Culture and Leadership Programme currently not aligned with wider IIP programmes	6
Lack of senior medical leadership, resource in information team, changes in personnel in care groups	8

Milestones off track	Target Date	What are we doing about it?
5.102: Workforce specialty developed plans linked to clinical adjacencies	Jun-23	Plans complete, awaiting sign off. Action plans will then become BAU.
5.103: Workforce strategy inclusive of recruitment strategy developed and communicated	Jun-23	Strategy finalised and is now going through approval process, once approved by P&C committee this will be communicated across the organisation.
5.106: Nursing pipeline plan developed 3-5 years	Jul-23	Plan developed - updates received and revised version to be submitted to Head of P&C Programmes to review initially.
5.108: Appraisal quality reviews	Jul-23	Limited responses received to date, Further discussions to be progressed to agree next actions required to improve milestone progression.
5.209: Culture & Leadership Development rolled out Trust wide	Jul-23	Diagnostic phase 2 required and commenced July 2023 and due to complete by December 23 (discovery phase).
5.303: Dashboard for medical attraction and trends built	Jun-23	Working towards target date of end of Sept 23 to have a skeleton dashboard in place.
5.306: Specialist Registration (CESR) programme development	Jun-23	Work has begun to develop a governance structure and a view to consolidate the protocol trustwide.
5.308: Development of a medical workforce dashboard	Sep-23	Further guidance required from new CMO on requirements for dashboard.
5.3.10: Review of clinical digital induction	Sep-23	Scope yet to be developed, meeting arranged with interim CMO.

Integrated Improvement Plan Communications and Engagement Update: September

Key progress during last period:

- The 'Meet your change team' campaign has continued, sharing Culture Leadership Programme (CLP) change team members' stories in weekly Trust newsletter and Staff Facebook page, including video messages.
- Two-week CLP leadership survey completion campaign, supported by change team members encouraging peers to complete the survey through their day-to-day network and video messages on the Staff Facebook page.
- Gathering stories from frontline staff on the improvements they have been making to support our objectives. These will be shared with all staff during EKHUFT Improvement Week commencing 18 September 23.
- Ten-week annual NHS Staff Survey campaign assets completed (campaign begins w/c 18 September 23). The mix of communications activity includes videos from staff representing different staff groups, exec messages, posters personalised to different staff groups, desktop wallpaper advertising and a Staff Facebook campaign, as well as 'you said we did' updates in the weekly Trust newsletter.
- Internal and external comms celebrating staff and patient stories.
- Monthly round-up of stories about wards/teams using 'We care' in Trust News.
- Monthly stakeholder bulletin featuring Improvement Week stories.
- Communications with maternity service users on the new process for contacting their community midwives.

Plan for next month:

- Annual members' meeting 25 September 23.
- Annual NHS Staff Survey completion campaign.
- This month's focus in key internal comms channels, including the monthly team brief and staff forum, will be the implementation of PSIRF and a just and learning culture.
- See ME first Equality, Diversity and Inclusion campaign to launch during Black History Month (moved from Inclusion Week in September).
- Accessible information campaign launch, aimed at enabling staff to better support the communication needs of patients, carers and parents who have a disability, sensory loss or impairment.
- Publication of progress made in the first year following 'Reading the Signals'.
- Meetings with key stakeholders to discuss improvements to the service with the Exec and clinical team.
- Briefings stakeholders to build support for capital investment.
- Continue to link patient and staff stories to improvement plan and use campaign approach to engage all staff in individual projects.

Limitations to delivery of Comms & Engagement plan:

- Number and pace of initiatives for staff to be aware of/engaged in. Mitigation for this; 'joining the dots' in the narrative to describe how each supports our improvement journey; a monthly focus on one key theme.

Evidence of impact of actions undertaken:

- As at 14 September, 692 staff had completed the CLP leadership survey
- The Staff Facebook page following has continued to grow steadily, we are currently at 758 followers.

High Level IIP Programme Risk Summary

Definitions

Movement in month – Key:

★	New Risk	⬇	A decrease in risk score
⬌	The score remains the same	⬆	A rise in risk score

East Kent Hospitals University NHS Foundation Trust

Key risks to delivery in this period:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Mitigating Actions	Date of Last Review	Residual Risk Score	Risk Trend
3.3.01	14.06.23	Operational Performance	Jane Dickson	Diagnostic delays in cancer pathways due to increase in activity.	20	a) Radiology improvement meeting weekly b) Radiology reports waiting longer than 15 days post diagnostic are prioritised and cleared. c) All diagnostics are aimed to be booked within 5-10 days of receiving referral. d) Specific focus required on Endoscopy and Urology pathways and capacity e) Heavy sedation capacity for Endoscopy to be agreed. Pending confirmation of Endoscopy insourcing funding and ICB bid to secure underspend via CDC budget. f) Mutual Aid plan for urology to be agreed.	20.09.23	16	⬌
6.1.03	07.08.23	Financially Sustainable	Michelle Stevens	Risk to the delivery of the Trusts 2023/24 Efficiency Plan.	16	a) Enhanced Controls measures have been issued to all care groups to ensure adherence to the national controls required for a level 4 organisation.	05.09.23	12	⬇
6.1.04	07.08.23	Financially Sustainable	Michelle Stevens	Risk of identifying and prioritising the development of “harder to achieve” improvements from Care Groups.	16	a) Conversations are on going with care groups to fully understand areas which could be explored to reduce spend but with a clear understanding of the clinical impact on the decisions.	05.09.23	12	⬇
3.4.01	23.08.23	Operational Performance	Jane Dickson	Delays to eliminate 78 week waits due to inability to secure additional endoscopy and otology capacity immediately before January 2024.	15	a) a) No immediate mitigation to reduce 78 week breaches before January 2024. Work continues to explore.		15	⬌

High Level IIP Programme Risk Summary

East Kent Hospitals University NHS Foundation Trust

Definitions

Movement in month – Key:

★	New Risk	↓	A decrease in risk score
↔	The score remains the same	↑	A rise in risk score

Opened risks in this period:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Update	Date of Last Review	Residual Risk Score	Risk Trend
1.103	20.09.23	Leadership & Governance	Tracey Fletcher	No substantive COO following the resignation from the current postholder.	16	a) Interim COO in place for unplanned care who has experience, knowledge and understanding of the organisation.	25.09.23	9	★
2.102	20.09.23	Maternity	Michelle Cudjoe	Unfilled vacancies, combined with high levels of maternity leave and short term sickness will have an effect on patient outcomes and quality and safety. Inadequate midwifery staffing levels may result in women receiving sub-optimal care during labour.	20	a) Daily site-wide SitRep to assess safe staffing and ensure escalation policy is appropriately followed. b) Line bookings of NHSP and agency, framework and off framework with applied incentive. c) Specialist midwives redeployed to fill gaps. d) Suspension of continuity of care. e) Utilisation of managers on call and community midwives. f) Risk also logged on corporate risk register.	22.09.23	12	★
2.402	20.09.23	Maternity	Michelle Cudjoe	Inadequate Estates in Maternity. There are numerous issues with estates. A few examples are delivery rooms being too small to accommodate essential equipment, ventilation is poor, triage is cramped. Overall capacity does not support delivery. Poor estate means that maternity are unable to provide appropriate care, privacy and dignity and staff are not able to work effectively.	20	a) Induction rates standardised across sites - Daily SitReps for induction demand and capacity. b) Introduction of quality rounds on both units that includes estate elements against CQC compliance. c) Neonatal service attend postnatal ward daily to facilitate discharges. d) Portable suction unit available in each labour room. e) Pure air scavenging unit and ventilation in labour rooms on both sites. f) Risk assessments for the resuscitaires are undertaken to ensure maximum safety within constraints of the room size.	22.09.23	12	★

High Level IIP Programme Risk Summary

East Kent Hospitals University NHS Foundation Trust

Closed risks in this period:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Update	Date of Last Review	Residual Risk Score	Risk Trend
5.2.01	14.06.23	People & Culture	Andrea Ashman	In order to support Culture and Leadership Programme trust wide, additional funding for 1 Programme Director and 1 seconded Programme Manager was requested from NHSE (RSP funding). Currently funding has not been approved and received however, NHSE confirmed to 'go at risk' to ensure the project is not delayed. If funding is not received this will be an overspend for the organisation.	9	Funding now agreed from RSP.	20.08.23	4	↓
5.2.02	14.06.23	People & Culture	Andrea Ashman	Due to insufficient funding within Culture and Leadership Programme unable to undertake practical arrangements for launch of Culture and Leadership Programme trust wide including events / booking venues.	9	Funding now agreed from RSP.		4	↓

Summary

- At the beginning of the reporting period 22 risks were recorded on the IIP risk register (reported in August 23).
- In total 25 key areas of risk discussed in this reporting period (September 23) relating to delivery against the IIP with 3 new risks added and 2 risks agreed to be closed. These relate to funding to support the People & Culture programme which has since been approved and provided by the Recovery Support Programme funding (as above).
- 11 risks during this period have reduced residual scores due to improvements in mitigating actions supporting progression of reducing risk.
- 23 risks now remain open on the IIP risk register post review, summary per programme is as follows; 4 Finance, 3 Leadership & Governance (1 increase), 5 Maternity (increase of 2), 5 Operational Performance, 3 People & Culture (decrease of 2), 4 Quality & Safety risks. Work is progressing well to strengthen risk monitoring within the IIP with particular focus on ‘confirm & challenge’ at the Strategic Improvement Committee.
- Please see Appendix B for a full detailed IIP Risk Register.

East Kent Hospitals University Foundation Trust
Integrated Improvement Plan

Journey to Exit NOF4
September 2023

Updated Integrated Improvement Plan

Taking a phased approach to delivery…

NHS
East Kent Hospitals University NHS Foundation Trust

1 Stabilising

Steadying the ship…

Control and stability is in place. Improvement Plan is defined and mobilised.

- Executive Team in place
- Improvement Plan defined & resourced
- Delivery is managed

2 Performing

…Getting into the pack

Integrated Improvement Plan delivering to allow exit from NOF4 and set the foundations to embed safe, well led care.

- IP projects delivering to plan
- Minimum of average across Kent and Medway for all areas of IP

3 Transforming

…Leading the field

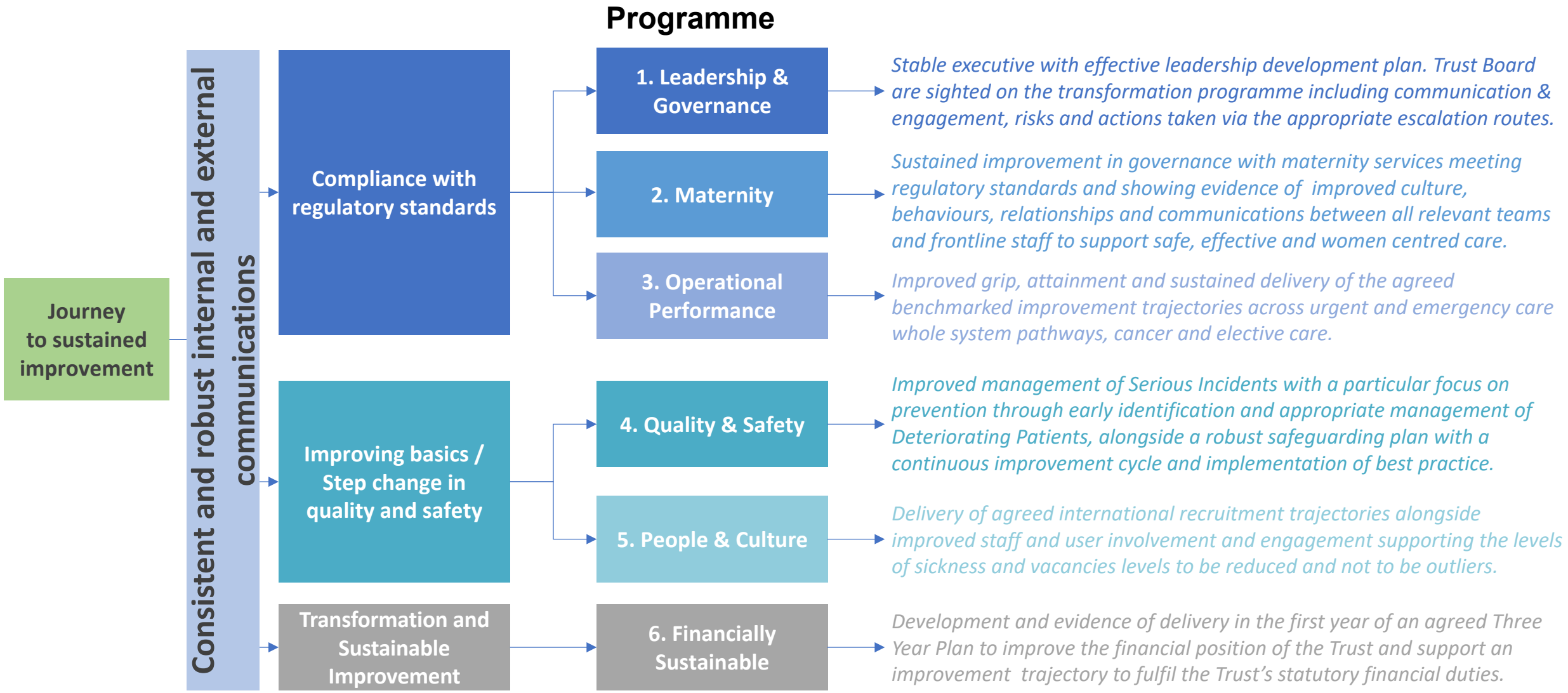
Designing and delivering the long-term vision for EKHUFT.

- Outstanding provider of care
- Place of choice to train and thrive
- Upper quartile performance nationally

Consistent and robust internal and external communications

What the Integrated Improvement Plan is aiming to deliver?

East Kent Hospitals University NHS Foundation Trust



Integrated Improvement Plan Portfolio

NHS East Kent Hospitals University NHS Foundation Trust

Portfolio: EKHUFT Integrated Improvement Plan (IIP) — SRO: CEO

	SRO: CEO	SRO: CN&MO	SRO: COO	SRO:CN	SRO: CPO	SRO: CFO
Programme:	1. Leadership & Governance Programme	2. Maternity Programme	3. Operational Performance Programme	4. Quality & Safety Programme	5. People & Culture Programme	6. Financially Sustainable Programme
Project:	1.1 Executive Leadership Team	2.1 Team Working	3.1 UEC Whole Pathway Flow	4.1 Quality Governance	5.1 Workforce	6.1 Financial Governance
	1.2 Governance	2.2 Clinical Escalation & Handover	3.2 Elective Recovery	4.2 Safeguarding	5.2 Culture & Leadership	6.2 Financial Improvement
	1.3 Communications & Engagement	2.3 Clinical Assessment & Care Pathways	3.3 Cancer	4.3 Fundamentals of Care	5.3 Medical workforce	6.3 Financial Consciousness
	1.4 Transformation Programme	2.4 Governance & Patient Safety		4.4 The Deteriorating Patient		
		2.5 Engagement Listening & Leadership				

Compliance with regulatory standards

Improving basics / Step change in quality and safety

Transformation and Sustainable Improvement

Consistent and robust internal and external communications

Exit Criteria as at May 2023

1	Leadership & Governance	• Executive leadership team posts filled. • Executive leadership development plan in place. • Trust Board sighted on key risks and actions taken via appropriate escalation routes, which is demonstrated by an aligned BAF and board risk register. • Evidence of effective communication, which is aligned across the Board and executive, with clear engagement channels between the frontline and the Board and outwards to ICB/NHSE/system partners, inclusive of routes of escalation for risks and concerns. • In response to the 2022 Independent Investigation into Maternity Services, evidence of Board oversight and leadership of a structured transformation programme approach with a clear Quality Improvement methodology to address culture, psychological safety and teamworking within the maternity service, which delivers an improvement in the performance of the metrics for maternity services. • The Trust is making a full contribution to the HCP for East Kent, the provider collaboratives and the ICS.
2	Operational Performance	• Evidence of an improved grip and realistic refreshed improvement trajectory in UEC whole pathway performance and out of hospital flow, benchmarked both nationally and regionally, by March 2024, aiming to move the performance to the 76% floor for all types of the national plan. • Embedding of essential operational management including rota management, job planning, waiting list oversight and theatres scheduling. • Sustained improvement in cancer 62-day performance by March 2024. • Elective recovery plan implemented with evidence of delivery against trajectory and continued reduction in 52ww and P2 patients by March 2024 with elimination of 78 week waits.
3	Quality and Safety	• Evidence of an improved process based on best practice and in accordance with framework standards for the management of serious incidents with evidence of delivery, leadership and learning from incidents, reflecting a single approach which aligns to the Trust governance process. • Evidence of sustained improvement in safeguarding compliance with the NHS Safeguarding Accountability and Assurance Framework 2022 overseen by the Trust Board, including oversight of any sub-contracted activity, with continuous cycle of review, assessment and implementation of best practice and learning.
4	Maternity	• Evidence of improved and sustained maternity governance process in place. • Evidence of improvements in service with clear process for providing evidence of compliance and completed regulatory actions by March 2024. • Evidence of improved culture, behaviours, relationships and communications between all relevant teams and frontline staff.
5	People & Culture	• Evidence of staff and user involvement in improvements and changes made through methods of capturing feedback e.g. use of template proformas asking staff how they have been involved in specific improvements. • Staff survey demonstrating an improvement in staff engagement and Trust leadership in line with national/peer/ICS. • Staff sickness and vacancy trajectories tracked and reduced to agreed trajectories in line with regional and national position with no evidence of being a significant outlier when compared with the rest of the ICS. • Improvement in the retention and turnover rates for all staff groups and sustained improvement in vacancy rate trajectory in the hard to recruit specialties. • International nursing and Clinical Support Worker recruitment trajectories agreed and evidence of delivery against these by March 2024.
6	Finance	• Agreed financial recovery plan in place supported by a clear evidence base, approved of by the board and agreed with the ICB that is compliant with financial improvement trajectories agreed by NHSE and system. • Delivery of the 23/24 planned deficit or better. • Evidence of improved delivery against agreed financial plans, trajectories, and envelopes. • The Trust fulfils its statutory duties with regard to financial management. • Robust oversight, financial controls and processes are in place and overseen through appropriate financial governance procedures. • That the Trust benchmarks well against the Model Hospital financial efficiencies, or where this is not the case has a trajectory which brings alignment as soon as possible. • The Trust and system have a shared understanding of risks to the financial plan and have agreed mitigations in place. • Control of the costs of overseas recruitment against plan.

Alignment of the Overarching Delivery Improvement Milestones with the IIP

NHS East Kent Hospitals University NHS Foundation Trust

The Strategic Improvement Committee with support from the NHSE Intensive Support Team, have undertaken a thorough review of the required 2023/24 overarching delivery improvement milestones as directed by the NHSE Regional Director and aligned these milestones with the previously agreed IIP. The majority of requirements were already underway however, this exercise has ensured any additional milestones are now incorporated into programmes (if required) or original milestones enhanced to meet the required output. Below are the overarching delivery milestones of which the Trust will also be monitored against.

Leadership & Governance

- Executive Development Plan in place and relevant recruitment plans enacted
- All executive posts appointed to
- Comms and engagement plan approved and operational
- Culture & Leadership Programme having demonstrable impact
- New operational structure in place
- Improved staff survey results
- Evidence of strengthened clinical leadership and ownership
- Governance Review completed
- Evidence that Board is sighted on key risks with aligned BAF and Board level Risk Register

Operational Performance

- 4 hours – reach 76%
- Type 1 – maintain >60%
- 12 hours - maintain <5%
- Diagnostics - attain regional mean of 22%
- Cancer backlog - achieve plan of 224
- Electives - sustainable plan for Otology in place
- Elective - zero at 78 weeks

Finance

- Medium term financial plan developed
- Recurrent efficiency schemes delivered
- Delivery of the 23/24 planned deficit
- Temp staff expenditure - £38.486m reduction delivery
- Efficiencies Delivery - delivery of £40m

Quality of Care

- Training on SI and NE delivered in induction for all new staff
- Reduced time between identification and reporting of an SI.
- Learning from SIs and Board assurance of practice improvements.
- Deteriorating patient education programme and dashboard in place
- Reduced number of SIs over the 60-day deadline for completion of investigation.
- Audit programme presented to the Board demonstrating improvements in patient safety as a result of serious incident management.
- Quality governance structure and framework in place – to include robust safeguarding governance.
- Improved clinical leadership and engagement.
- Safeguarding policies in place, ratified alongside a communication plan
- Safeguarding training needs analysis and trajectory completed
- Annual safeguarding report completed and published/plan for publication.
- Sustainable safeguarding workforce team in place
- Foundations for effective safeguarding in place.

Maternity

- Induction of new maternity leadership.
- Obstetric oversight of triage services in place.
- No overdue (breached) SIs / HSIB investigations.
- Quarterly audits supporting appropriate clinical escalation showing improvement
- Maternity Transformation plan completed and approved by Board.
- Obstetric consultant job planning completed.
- Scoping and reopening of WHH Midwifery Led Unit.
- Demonstrable improvement that staff feel listened to.
- All key obstetric safety roles assigned and operational.
- Confidence in the learning environment for students evidenced at Board.
- Leadership structure - midwifery & obstetric embedded and operational.
- Incorporation of ultrasound into maternity services.
- Independent case review process to be established with clear outputs and Board oversight.

1. Programme Overview: Leadership and Governance

SRO: CEO

Programme Objectives (A)

- Stable and substantive executive leadership team in place including an effective executive leadership development plan.
- Effective and transparent corporate governance model supported by an improved. accountability framework to strengthen risk management, governance and assurance.
- Structured, systematic and meaningful communication and engagement both internally and externally underpinning the transformation programme.
- Effective Board oversight and leadership of transformation programme approach with clear Quality Improvement methodology to address culture, safety and teamworking .
- The Trust makes a full contribution to the East Kent HCP, provider collaboratives & ICS.

Projects (B)

1.1 Executive Leadership Team	Recruitment programme in place to recruit a substantive executive leadership team. Develop and implement a comprehensive executive leadership development plan to support both individual and team development.
1.2 Governance	Review and refresh the governance model to be aligned with the organisation restructure and in particular to embed ward to board assurance to support appropriate and timely escalation and embed a culture of on-going learning.
1.3 Communications & Engagement	To develop and implement a clear and consistent approach to internal and external communications and engagement with all our stakeholders to support the delivery of our vision, values aims and strategic objectives.
1.4 Transformation Programme	Develop a structured transformation approach, initially focused on maternity services, with built in Quality Improvement methodology to build a sustainable long-term approach to continuous improvement.

Success Measures (C)

- Substantive executive leadership posts filled by March 2024 (>90%).
- Successful external Well Led Assessment.
- Identification of risks and effective controls and learning as evidenced in BAF, Risk Management, SI process and triangulation at all levels.
- Positive executive leadership is reflected in ongoing staff and partner's feedback.
- Positive feedback on both internal and external communications and engagement.

Project Leads (D)

- CPO – Recruitment, induction and leadership development plan
- CNO – Governance Model
- DC&E – Communications and engagement
- DSD&P – Transformation Programme

NOF 4 Exit Criteria contribution (E)

1

- Executive leadership team posts filled.
- Executive and Board leadership development plan in place.
- Trust Board sighted on key risks and actions taken via appropriate escalation.
- Evidence of effective communication and engagement channels between the frontline and the Board and external partners including escalation of risks.
- Evidence of Board oversight and leadership of a structured transformation programme approach with a clear Quality Improvement methodology within maternity to address culture, psychological safety and teamworking.
- Full contribution made to the HCP for East Kent, provider collaboratives & ICS.

1. Leadership and Governance Programme – Product Milestones

East Kent Hospitals University NHS Foundation Trust

1.1 Executive Leadership		
Milestone 1	1.101: Substantive COO in post	Apr-23
Milestone 2	1.102: Executive Director induction plans in place and on-going	Apr-23
Milestone 3	1.103: Review and refresh Executive Leadership Development Plan	Jun-23
Milestone 4	1.104: Current vacant Executive Director posts successfully recruited to	Jun-23
Milestone 5	1.105: Critical mass of substantive Executive Directors in post (>50%)	Dec-23
Milestone 6	1.106: Executive Team Leadership Development Programme commenced with critical mass in post	Dec-23
Milestone 7	1.107: External Well Led Governance Review commissioned with plan to report to Board	Mar-24
Milestone 8	1.108 Substantive executive leadership posts filled by March 2024 (>90%).	Mar-24
Milestone 9	1.1.09 Evidence of strengthened clinical leadership and ownership - appointment of CMO and associated structure to support.	Mar-24

1.2 Governance		
Milestone 1	1.201: Review and refresh Governance Model to ensure it is aligned with the organisation restructure	Jul-23
Milestone 2	1.202: Undertake external diagnostic on Board effectiveness	Oct-23
Milestone 3	1.203: Embed Integrated Improvement Plan Governance and Reporting	Dec-23
Milestone 4	1.204: QI Oversight/Governance	Jan-24
Milestone 5	1.205: Risk Management Training	Jan-24
Milestone 6	1.206: EKHUFT New Governance Model Live	Mar-24
Milestone 7	1.207: External Well Led Review Completed	Apr-24

1.3 Communications and Engagement		
Milestone 1	1.301: Outline Communications and Engagement Plan published	May-23
Milestone 2	1.302: Monthly programme of activity including key messages, feedback, quick wins and success stories	May-23
Milestone 3	1.303 Detailed Communications and Engagement Plan developed, based on feedback received, and rolled out across Trust	Jul-23

1.4 Transformation Programme		
Milestone 1	1.401: Revise Trust organisational structure and launch consultation	Apr-23
Milestone 2	1.402: Refocus We Care Programme	Apr-23
Milestone 3	1.403: Continue the Cultural and Leadership Programme focus in maternity and review effectiveness	May-23
Milestone 4	1.404: Develop the Leadership Behavioural Framework	Jun-23
Milestone 5	1.405: Develop and adopt the Behavioural Code in Maternity	Jun-23
Milestone 6	1.406: Pilot “Civility Saves Lives” in Maternity	Jun-23
Milestone 6	1.406a: Review the effectiveness of the “Civility Saves Lives” pilot in Maternity	Dec-23
Milestone 7	1.407: Introduce a simple tool to assist staff to challenge poor behaviours	Jun-23
Milestone 8	1408: Start the leadership programme for team leader, first line, middle manager	Jul-23
Milestone 9	1.409: Undertake recruitment to new organisational structure	Aug-23
Milestone 9	1.409a: Interviews to be completed and positions appointed to	Oct-23
Milestone 9	1.409b: All appointees in post	Jan-24
Milestone 10	1.410: Undertake an external diagnostic of board effectiveness	Oct-23

2. Programme Overview: Maternity

SRO: CNO&MO

Programme Objectives (A)

- Deliver high quality, safe, effective and personalised maternity and neonatal services in partnership with service users.
- Identify opportunities to learn to continually ensure that women receive the best care for themselves and their babies, that meets their wishes and needs.
- Embed an inclusive culture where staff feel valued, listened to and supported to deliver patient centred.
- Deliver a safe maternity service that is underpinned by a first-class clinical governance process, to drive and improve the delivery of high-quality person-centred care.

Projects (B)

2.1 Team Working	Review to Assess: consultant arrangements; roles and responsibilities of senior staff; triage oversight and shift handovers including safety huddles. Review and strengthen existing plans to support safe challenge around behaviours and to build teams that value, support and trust each other.
2.2 Clinical Escalation and Handover	Development of systems and processes to allow staff to recognise deteriorating patients including sepsis management assessment and CTG tools. This will include a review and audit of emergency pathways to ensure these are appropriate and informed by woman's experience.
2.3 Clinical Assessment and Care Pathways	Development of care pathways: High Dependency Units, Triage, centralised telephone triage, ANNBS/Sonography, Discharge, and VTE. Focus on SBAR Handover process and escalation processes. Undertake staff surveys to identify barriers and levels of staff confidence to escalate concerns.
2.4 Governance & Patient Safety	Agree quality and safety framework aligned to Trust and national ambitions Ensure there are no backlogs in Patient Safety activities. Learning to be identified and communicated through regular incident learning events and monthly sharing of learning from incidents.
2.5 Engagement Listening & Leadership	Coproduced communication plan to ensure staff feel listened to, and staff receive relevant and timely information. Maternity User Engagement framework aligning to Trust Patient Involvement Strategy. Service will work with partners to develop high quality supported training experiences.

Success Measures (C)

- Positive experiences of care reported through Your Voice is Heard.
- Compliance with MDT attendance at handovers/rounds.
- Appropriate senior obstetric oversight for triage.
- Clinical MDT development of action plans.
- Regulatory action plans closed within agreed timeframes.
- Quarterly staff survey reporting that staff feel safe to escalate and report harm.
- Reduction in formal complaints.
- Reduction in the number of repeat incidents with the same causal factors e.g. consultant oversight or failure to escalate.

Project Leads (D)

- Team Working – CD, and Director of Midwifery
- Clinical Escalation &Handover – CD, Director of Midwifery
- Clinical Assessment & Care Pathways – Deputy Director of Midwifery
- Governance & Patient Safety– Head of Governance
- Engagement, Listening & Leadership – CD, and Director of Midwifery

NOF 4 Exit Criteria Contribution (E)

4

- Evidence of improved and sustained maternity governance process in place.
- Evidence of improvements in service with clear process for providing evidence of compliance and completed regulatory actions by March 2024.
- Evidence of improved culture, behaviours, relationships and communications between all relevant teams and frontline staff.

2. Maternity Programme – Product Milestones

East Kent Hospitals University NHS Foundation Trust

2.1 Team Working		
Milestone 1	2.101: Obstetric consultant job planning completed	Sep-23
Milestone 1	2.101a: Ensure obstetric oversight of triage services is undertaken by an obstetric registrar in line with best practice	Jul-23
Milestone 2	2.102: Implementation of the 'one-stop shop' concept to achieve the ANNBS KPIs, national standards, and person-centred care	Sep-23
Milestone 3	2.103 - All members of the MDT within maternity to attend regular joint training which will be monitored (work together, train together)	Mar-24

2.2 Clinical Escalation and Handover		
Milestone 1	2.201: Demonstrable improvement with fetal heart monitoring guideline compliance	Sep-23
Milestone 2	2.202: Embedded quarterly audits supporting appropriate clinical escalation showing improvement; SBAR, MEOWS, sepsis and VTE	Jun-23

2.3 Clinical Assessment and Care Pathways		
Milestone 1	2.301: Centralisation of telephone triage	Jul-23
Milestone 2	2.302: Full implementation of Saving Babies Lives Care Bundle (SBLCB) v3	Mar-24
Milestone 3	2.303: Agree model and implementation plan for improved discharge pathway	May-23
Milestone 4	2.304: Implementation of discharge pathway	Jul-23
Milestone 5	2.305: Agree model and implementation plan for HDU	Mar-24
Milestone 6	2.306: Implementation of revised bereavement pathway	Aug-23
Milestone 7	2.037: Scoping and reopening of WHH Midwifery Led Unit	Sep-23
Milestone 8	2.308: Incorporation of ultrasound into maternity services	Mar-24

2.4 Governance		
Milestone 1	2.401: No overdue (breached) SIs / HSIB investigations	Jun-23
Milestone 2	2.402: Agree maternity Quality and Safety framework	Sep-23
Milestone 3	2.503: Maternity CQC must do's actioned and checked	Jun-23
Milestone 4	2.504: Maternity Transformation plan completed and approved by Board	Sep-23
Milestone 5	2.505: All key obstetric safety roles assigned and operational	Sep-23
Milestone 6	2.506: Independent case review process to be established with clear outputs and Board oversight	Mar-24

2.5 Engagement, Listening & Leadership		
Milestone 1	2.501: Coproduced plan for engagement with the workforce on development of the MNIP, and future service developments	Oct-23
Milestone 2	2.502: Coproduced (staff and a service users) revised Maternity strategy agreed and communicated	Oct-23
Milestone 3	2.503: Coproduced maternity user engagement framework agreed and approved through MPNI	Sep-23
Milestone 4	2.504: Demonstrable improvement that staff feel listened to (quarterly survey)	Dec-23
Milestone 5	2.505: Induction of new maternity leadership	Jun-23
Milestone 6	2.506: Leadership structure - midwifery & obstetric embedded and operational	Mar-24
Milestone 7	2.507: Confidence in the learning environment for students evidenced at Board.	Mar-24

3. Programme Overview: Operational Performance

SRO: COO

Programme Objectives (A)

- Trust urgent and emergency care (UEC) performance, and Trust's contribution to the whole system UEC pathway performance, improved and delivery sustained in line with the refreshed improvement trajectories.
- Elective Recovery Plan implemented and recovery sustained against the agreed improvement trajectory to deliver the national elective recovery standards.
- Cancer Performance Plan delivered against the agreed trajectories.

Projects (B)

3.1 UEC & Whole System Interface Flow	Emergency Care Delivery Group driving internal improvements and ensuring appropriate linkage with whole system interfaces. Scope includes: pre-hospital; Emergency Department; Acute Medicine including SDEC; wards and specialties; ED capital builds; job planning aligned to UEC capacity and demand and engaging with out of hospital/system key interfaces.
3.2 Elective Recovery (including Diagnostics)	Elective Care Delivery Group driving internal improvements including diagnostics, with a focus on the continued reduction of 52ww and P2 patients. Scope to include clinical harm reviews undertaken for all long waiters and job planning aligned to elective capacity and demand.
3.3 Cancer	Cancer Care Group to drive internal improvements to address the backlog and meet the national cancer standards with a focus on the continued reduction of 62 day+ and 104-day patients on the cancer PTL. Scope to include clinical harm reviews undertaken for all long waiters.

Success Measures (C)

Trust UEC performance, and the Trust's contribution to the whole system UEC pathway performance, against refreshed local trajectories in line with regional and national standards including:

- Ambulance handover delays
- Emergency Department Type 1 (50%) and All Types 4-hour performance (76%)
- Emergency Department Type 1 12-hour performance and impact of crowding qualitative measures
- 21-day Long length of stay

Elective Recovery performance against agreed local trajectories and national standards including:

- Eliminate patients waiting longer than 65 weeks
- Reduce 52 week waits in line with agreed improvement trajectory
- Deliver OP transformation targets (PIFU 5%/ Virtual appointments 25%/ Reduce follow up activity 25%)
- Deliver diagnostic stretch target in line with the agreed trajectory

Cancer Recovery performance against agreed local trajectories and national standards including:

- Compliant with Faster Diagnosis Standard (FDS) and 62-day performance
- Eliminate patients waiting longer than 104 days on the PTL
- Increased delivery of diagnostic tests within the Buckland Clinical Diagnostic Centre by 25%
- Implement Straight to Test Services to meet the 28 day Faster Diagnostic Standard

Project Leads (D)

- UEC Lead - UEC & Whole System Interface Flow
- Elective Care Lead - Elective Recovery including Diagnostics
- Cancer Lead - Cancer Recovery

NOF4 Exit Criteria Contribution (E)

2

- Evidence of an improved grip and realistic refreshed improvement trajectory in UEC whole pathway performance and out of hospital flow, benchmarked both nationally and regionally, by March 2024 aiming to move to 76% floor for all types.
- Elective recovery plan implemented with evidence of delivery against trajectory and continued reduction in 52ww and P2 patients by March 2024 with elimination of 78 week waits.
- Sustained improvement in cancer 62-day performance by March 2024.

3. Operational Performance Programme – Product Milestones

East Kent Hospitals University NHS Foundation Trust

3.1 Urgent and Emergency Care (UEC) and Whole System Interface Flow		
Milestone 1	3.101: WHH Emergency Department Build Phase 3 started	Mar-23
Milestone 2	3.102: WHH implementation of the front door clinical model established	Mar-23
Milestone 3	3.103: QEQM End of Life Model implemented	Mar-23
Milestone 4	3.104: Co-horting wards pathway 1 across WHH/QEQM implemented supported with daily pathway zero reviews, development of board rounds and PTL	Apr-23
Milestone 5	3.105: Updated Patient Choice Process rolled out Trust wide (Discharge)	Apr-23
Milestone 6	3.106: Direct Access Pathways launched in Acute Medicine, General Surgery & Orthopaedics with training programme for nurse streaming roll out	Apr-23
Milestone 7	3.107: QEQM Emergency Department Build Phase 2 started	Apr-23
Milestone 8	3.108: UTC new inclusion and exclusion criteria implemented	Apr-23
Milestone 9	3.109: MAU Pilot at WHH with access to Short stay Ward, SDEC virtual clinics for acute medicine	Apr-23
Milestone 10	3.110: Direct Access Pathways launched in Respiratory, Gastroenterology and Cardiology with hot clinics established in SDEC	May-23
Milestone 11	3.111: Established pathways to the MDU at KCH (nurse led)	Jun-23
Milestone 12	3.112: QEQM Emergency Department Build Phase 3 started	Jun-23
Milestone 13	3.113: WHH End of Life Model implemented	Jun-23
Milestone 14	3.114: Patient Flow SAFER principles in place across Trust with metrics focussed on discharges by 10.00, golden patients, reduction in 12-hour ED waits	Aug-23
Milestone 15	3.115: WHH Emergency Department Build Phase 3 completed	Sep-23
Milestone 16	3.116: Critical UEC medical and nurse staffing rotas and job planning in line with the DAP and Dedicated assessment units- business plans	Oct-23
Milestone 17	3.117: Bed reconfiguration plan to support establishment of medical and surgical assessment models approved	Oct-23
Milestone 18	3.118: QEQM Emergency Department Build Phase 3 completed	Dec-23
Milestone 19	3.119: A&E four-hour 76% performance delivered	Mar-24

3.2 Elective Recovery (including diagnostics)		
Milestone 1	3.201: P2 monitoring report amended to highlight compliance/non-compliance with weekly oversight across each speciality	Apr-23
Milestone 2	3.202: Business planning assumptions agreed by executive management team and detailed speciality stretch targets articulated	May-23
Milestone 3	3.203: Trust Access Policy revised to incorporate clinical review policy and the new Kent and Medway Access Policy	May-23
Milestone 4	3.204: Outpatient transformation plan re-launched with key milestones and stretch targets for transformation including activity increases (1st OP) and decreases (follow-up)	Jun-23
Milestone 5	3.205: Validation plan agreed and implemented for all diagnostic modalities utilising digital transformation available within the Trust	Jul-23
Milestone 6	3.206: Actions agreed and implementation started to deliver diagnostics stretch target (tbc)	Sep-23
Milestone 7	3.207: Volume of 65-week breaches reduced before December 2023 (in line with winter planning and risk of elective cancellations)	Nov-23
Milestone 8	3.208: Eliminate all 65-week patients as per trajectory and ensure 52 week planned forecast delivered	Mar-24
Milestone 9	3.209: Produce and ensure there is a sustainable plan for Otology long waiting patients.	Sep-23

3.3 Cancer		
Milestone 1	3.301: Clinical harm reviews fully embedded with shared learning and improvement cycle	Mar-23
Milestone 2	3.302: Internal improvements in place to meet 62-day compliance	Aug-23
Milestone 3	3.303: Internal improvements in place to meet 28-day compliance	Sep-23
Milestone 4	3.304: Buckland Clinical Diagnostic Centre increased delivery of diagnostic tests to cancer patients by 25%	Dec-23
Milestone 5	3.305: Mobile Cancer Unit increased from 3 to 5 days per week raising awareness whilst providing services to facilitate earlier diagnosis	Dec-23
Milestone 6	3.306: Internal improvements in place to deliver the 75% early diagnosis ambition	Mar-24
Milestone 7	3.307: No cancer patients waiting over 104 days on the PTL	Mar-24

4. Programme Overview: Quality & Safety

SRO: CNO

Programme Objectives (A)

- Learning framework embedded to support improved early identification and appropriate management of Serious Incidents (SIs).
- Robust safeguarding sustainability plan in place with continuous improvement programme with the key aim to address gaps in systems and process at care group level through a revised training programme and a new safeguarding competency framework for staff.
- Refreshed Fundamentals of Care framework focused on key service priorities, aligned to Quality Strategy.
- Improved focus, identification and proactive management of deteriorating patients.

Projects (B)

3.1 Quality Governance	• Review SI process ensuring alignment to Patient Safety Incident Review Framework to improve early & appropriate escalation with clear accountability. • Implement the revised SI Declaration Process and enhance clinical engagement. • Learning to be identified and communicated within and outside the Trust through regular learning events and monthly sharing of learning from incidents.
3.2 Safeguarding	• Delivery of safeguarding sustainability plan with improvement audit cycle • Implement training and safeguarding competency framework enabling staff to demonstrate increased understanding and practical application. • Implement Safeguarding recommendations from Internal Audit. • Review sub-contracted safeguarding arrangements as part of quality schedule and oversight arrangements.
3.3 Fundamentals of Care	• Develop the Fundamentals of Care Framework to guide priorities and provide assurance that they are integrated into care at all levels of the organisation, enabling the patient voice to be at the centre of services. • Implement evidence-based revision of ward accreditation programme • Implement Patient Voice and Involvement Strategy.
3.4 The Deteriorating Patient	• Design and deliver a continuous improvement programme using a safety improvement coaching approach to improve the timely recognition, escalation and response to identify the deterioration patient. • NEWS 2 e-learning module, deteriorating patient education programme, deteriorating patient dashboard, CQUIN –NEWS2.

Success Measures (C)

- Reduction in cases of moderate harm and above for the top 5 recurring incidents, with a month-on-month improvement trajectory for each, and look to switch the KPI aligned to PSIRF later in the year.
- Reduction in the number of repeat incidents with the same causal factors.
- Reduction in Hospital Falls with Harm.
- Reduction in Hospital acquired pressure damage.
- Improvement in KPIs that are within the Fundamentals of Care Framework.
- Increase in NEWS compliance (escalation process).
- Reduction in inpatient admissions to ITU related to the deteriorating patient.
- Increase in compliance of safeguarding concerns (KASCFs) being submitted by the care groups within 24hrs of the request from the safeguarding team (KPI on safeguarding dashboard).
- Reduction in delays in the completion of section 42 investigations – increasing & compliance of investigations completed within 30 days (KPI on safeguarding dashboard).

Project Leads (D)

- Incident Reporting and Learning Framework Lead
- Deteriorating Patient Lead
- Fundamentals of Care Framework/Ward Accreditation Lead
- Patient Voice and Involvement Lead
- PSafeguarding Lead

NOF4 Exit Criteria Contribution (E)

3

- Evidence of an improved process based on best practice and in accordance with framework standards for the management of serious incidents with evidence of delivery, leadership and learning from incidents, reflecting a single approach which aligns to the Trust governance process.
- Evidence of sustained improvement in safeguarding compliance with the NHS Safeguarding Accountability and Assurance Framework 2022 overseen by the Trust Board, including oversight of any sub-contracted activity with continuous cycle of review, assessment and implementation of best practice and learning.

4. Quality & Safety Programme – Product Milestones (1)

East Kent Hospitals University NHS Foundation Trust

4.1 Quality Governance		
Milestone 1	4.101a: Define and describe a quality governance structure and framework for senior leaders to work within to support the delivery of safe, effective and compassionate care	Jul-23
Milestone 1	4.101b: Revised organisational structure, with clearly defined roles and responsibilities within quality governance structure and framework for senior leaders to work within to support the delivery of safe, effective and compassionate care	Aug-23
Milestone 2	4.102: Implement and deliver SI and NE training in induction for new staff	Jun-23
Milestone 3	4.103: Develop new cross Trust Patient Safety Incident Response systems and processes (replacing current SI process), including beginning to share the learning from SIs. Process improvements:- a. Improved decision making at point of declaring an SI achieved April 2023 including reduced time between identification and reporting of SI. b. Improved SI investigation approval process implemented from 25 May 2023 c. Business case (B/C) for new Patient Safety Incident Response System pending approval d. Upon approval of B/C there will then be a period of transition from one system to the other	Oct-23
Milestone 4	4.104: EKHUFT Learning from Serious Incidents Framework Designed	Oct-23
Milestone 5	4.105: Commence transitioning across to the new PSIRF	Aug-23
Milestone 6	4.106: Board BAF & Risk Management Session	Oct-23
Milestone 7	4.107: Review corporate risk register to ensure aligned with Board Assurance Framework and with clear cyclic process implemented for review.	Sep-23
Milestone 8	4.108: EKHUFT SI Learning Framework Implemented	Nov-23
Milestone 9	4.109: Ensure Board are sighted on SI summary & learning to be assured of practice improvements.	Sep-23
Milestone 10	4.110: Patient Safety Incident Response Plan Implementation	Feb-24
Milestone 11	4.111: Production of an audit programme presented to the Board demonstrating improvements in patient safety as a result of serious incident management with a clear cycle of continued reporting (at least bi-annual).	Jan-23

4.2 Quality Safeguarding		
Milestone 1	4.201: Demonstrate sustainable safeguarding team workforce that is consistent with the requirements as outlined in the NHSE SAAF and statutory guidance.	Dec-23
Milestone 2	4.202: Demonstrate up to date safeguarding polices that are consistent with statutory guidance and NHSE SAAF requirements relating to both children and adults with a Communication Plan to be rolled out.	Jun-23
Milestone 3	4.203: Using the Training Needs Analysis, demonstrate a clear training and competency trajectory for all levels to ensure that the Trust achieves its statutory duties relating to this at all Care Group levels.	Nov-23
Milestone 3	4.203a: Ensure that Care Groups reach the target of 90% compliance	Mar-24
Milestone 3	4.203b: Roll out the competency assessments to ensure that staff are able to implement theory into practice.	Mar-24
Milestone 4	4.204: Demonstrate effective process for safe working practices that is consistent with statutory guidance and responds and manages allegations against staff timely.	Aug-23
Milestone 5	4.205: Demonstrate an effective safeguarding process for responding and investigating safeguarding working practices that is consistent with statutory guidance.	Aug-23
Milestone 6	4.206: Review sub-contracted safeguarding arrangements as part of quality schedule and oversight arrangements and monitor the effectiveness and sustainability of these.	Aug-23
Milestone 7	4.207: Demonstrate clear leadership and management at all levels and a sustainable safeguarding governance that is in line with statutory requirements and NHSE SAAF requirements.	Mar-23
Milestone 8	4.208: Demonstrate an effective system for responding and managing restrictive and restraint practices that is in line with statutory duties and best practice guidance.	Aug-23
Milestone 9	4.209: Demonstrate an effective system in place where there is learning from safeguarding investigations and incidents where staff are supported through supervision, coaching and mentoring as required.	Oct-23

4. Quality & Safety Programme – Product Milestones (2)

East Kent Hospitals University NHS Foundation Trust

4.3 Fundamentals of Care (FOC)		
Milestone 1	4.301: Develop and Launch Dementia Strategy.	May-23
Milestone 2	4.302: Gap analysis of compliance with Accessible Information Standards.	May-23
Milestone 3	4.303: Review current FOC workstreams	Jun-23
Milestone 4	4.304: Review FoC delivery plans - to include things like Dementia Strategy and Patient Voice	Jul-23
Milestone 4	4.304a) Embed all aspects of the FoC delivery plans and review effectiveness	Dec-23
Milestone 5	4.305: Publish FOC framework and KPIs	Jul-23
Milestone 6	4.306: Develop trajectory for further reduction in FoC incidents resulting in moderate harm and above.	Jul-23
Milestone 7	4.307: Thematic review of Root Causes of Harm incidents of FoC workstreams to drive further improvement plans and approaches, such as peer to peer learning.	Oct-23
Milestone 8	4.308: Complete first accreditation for all inpatient wards.	Nov-23
Milestone 9	4.309: Implementation of first 6 months of Year 2 of Patient Voice and Involvement Strategy.	Feb-24
Milestone 10	4.3.10: Compliance with Accessible Information Standards.	Feb-24
Milestone 11	4.311: FoC Metrics Deep-dive Review and Refresh (plan for 24/25)	Mar-24

4.4 The Deteriorating Patient		
Milestone 1	4.401: Agree with ICB the required funding for Patient safety specialist role and Improvement Project	Mar-23
Milestone 2	4.402: Confirm The Deteriorating Patient Safety Improvement Project building on current Trust improvement capacity	Jun-23
Milestone 3	4.403: CQUIN -CCG3: Recording of the NEWS2 score, escalation time and response for unplanned critical care admissions is compliant	May-23
Milestone 4	4.404 ED sepsis dashboard:	Apr-23
Milestone 5	4.405: Deteriorating Patient Dashboard developed and shared with care groups	Oct-23
Milestone 6	4.406: Launch NEWS2 e-learning module	Apr-23
Milestone 7	4.407: a) Commence pilot for deteriorating patient education programme	Jun-23
Milestone 7	4.407: b) Agree with stakeholders the bespoke deteriorating patient education programme	Oct-23
Milestone 7	4.407: c) Implement deteriorating patient education programme across the organisation	Q2
Milestone 8	4.408: Incorporation of Vital Pac (electronic physiological observations platform) into Sun Rise	Mar-24
Milestone 9	4.409:Monthly thematic review of Root Causes of Harm incidents of deteriorating patient workstreams to drive further improvement plans and approaches	Apr-23

5. Programme Overview: - People and Culture

SRO: CPO

Programme Objectives (A)

- Design & Embed NHS's Culture & Leadership Programme within EKHUFT to make EKHUFT a Great Place to Work & Learn.
- Deliver tactical task and finish work to drive improvements to key metrics, e.g. appraisal, rostering compliance and visibility of job-planned hours.
- Develop an attraction and retention strategy to deliver a sustainable workforce.
- Improving attendance toolkit to be used to assess and generate outcomes for an improved sickness rate.
- Collation and monitoring of recruitment and training trajectories for IENs and HCSWs inclusive of training date for OSCE and ready to care to ensure that colleagues are ward ready and trained.

Projects (B)

5.1 Attract and Retain	• Strategy developed alongside workforce plans by speciality in correlation to the clinical adjacencies programme. Attendance and collaboration as a Kent and Medway partnership. Dashboards built to support People and Culture KPIs.
5.2 Culture and Leadership	• Strategic, group wide transformation project to engage the workforce in designing embedding a new culture within EKHUFT, through initiatives such as Culture Leadership programme, behaviour framework, Pulse Survey Reviews, Embedding Culture Dashboard, EDI Strategy & Plan and embedding a Culture Change Team within trust.
5.3 Medical workforce	• Tactical task and finish work to develop dashboards demonstrating improvement in key medical workforce metrics, e.g. appraisal, training compliance, rostering compliance, visibility of job-planned hours etc. Medical attraction and recruitment programme plan and working group in place.

Success Measures (C)

- Improved 'National Staff survey (YOY trend) / Pulse data (1/4ly trend): increased response rate, engagement and staff recommending EKHUFT as a place to work
- Improved National Staff survey (Manager questions YOY trend)
- Improved Culture dashboard monthly data trends
- Improved WRES / WDES / F2SU data
- Improved 'Appraisal Conversation' completion rates
- Leadership development (Development plan + 360 feedback – Board to HLT)
- Improved 'Well Led' domain CQC rating (date tbc)
- Improved People Metrics / KPI's (recruitment, vacancy rate, retention, job planning, /pipelines, disciplinary's and sickness rates)
- Listening Sessions/Anecdotes / staff live feedback
- Pastoral Care award
- Development of and improved performance against medical workforce dashboard
- Job planning and PA review completed by May 2023
- Specialist registration (CESR) programme to be expended and rolled out.

Project Leads (D)

- Programme Director, Culture & Leadership Programme
- Head of People and culture Programmes
- Interim Chief Medical Officer

NOF 4 Exit Criteria Contribution (E)

5

- Evidence of staff and user involvement in and feedback on specific improvements.
- Improved staff engagement and Trust leadership in line with national/peer/ICS.
- Staff sickness and vacancies tracked and reduced so Trust not an outlier across ICS.
- Improved retention and turnover rates for all staff groups and sustained improvement in vacancy rate trajectory in hard to recruit specialties.
- International nursing and Clinical Support Worker recruitment trajectories agreed and evidence of delivery against these by March 2024.

5. People & Culture Programme – Product Milestones

East Kent Hospitals University NHS Foundation Trust

5.1 Attract and Retain		
Milestone 1	5.101: Recruitment trajectories produced and progress monitored for IENs and HCSWs	May-23
Milestone 2	5.102: Workforce specialty developed plans linked to clinical adjacencies	Jun-23
Milestone 3	5.103: Workforce strategy inclusive of recruitment strategy developed and communicated	Jun-23
Milestone 4	5.107: Utilise NHSE absence tool to carry out diagnostic	Jul-23
Milestone 5	5.104: Absence audit completed with analysis of outcomes	Jun-23
Milestone 6	5.105: Pastoral Care award	Jun-23
Milestone 7	5.106: Nursing pipeline plan developed 3-5 years	Jul-23
Milestone 8	5.108: Appraisal quality reviews	Jul-23

5.2 Culture & Leadership Development		
Milestone 1	5.201: Launch of New Starter Experience survey	Jan-23
Milestone 2	5.202: Development of enhanced NSS dashboard	Feb-23
Milestone 3	5.203: Launch of new Benefits platform & EAP	Feb-23
Milestone 4	5.204: Publication of enhanced NSS dashboard	Mar-23
Milestone 5	5.205: Promote & communicate	Mar-23
Milestone 6	5.206: Thematic analysis of NSS free-text comments	Apr-23
Milestone 7	5.207: Review of We Care progress through NSS data	Apr-23
Milestone 8	5.208: Behavioural framework created	Jun-23
Milestone 9	5.209: Culture & Leadership Development rolled out Trust wide	Jul-23
Milestone 9	5.209: Culture & Leadership Programme having demonstrable impact (leadership behaviour surveys)	Dec-23
Milestone 10	5.210: Define EDI Strategy & Plan	Jul-23
Milestone 11	5.211: Effective succession planning and cycle established	Jul-23 - Dec-23

5.3 Medical Workforce		
Milestone 1	5.301: Medical attraction programme plan developed for fragile clinical services	Jun-23
Milestone 2	5.302: Digital and social media targeted recruitment	Jun-23
Milestone 3	5.303: Dashboard for medical attraction and trends built	Jun-23
Milestone 4	5.304: Rostering trial	Sep-23
Milestone 5	5.305: Medical Job Planning assessment of levels of attainment and trajectory developed to reach level 4	Sep-23
Milestone 6	5.306: Specialist Registration (CESR) programme development	Sep-23
Milestone 7	5.307: Pastoral Care for all international recruits	Sep-23
Milestone 8	5.308: Development of a medical workforce dashboard	Sep-23
Milestone 9	5.3.09: Development of GMC survey dashboard	Sep-23
Milestone 10	5.3.10: Review of clinical digital induction	Sep-23

6. Programme Overview: Financially Sustainable

SRO: CFO

Programme Objectives (A)

- Achieve financial sustainability within the ICS financial envelope through the design and delivery of a Three-Year Financial Plan
- Enable and embed sound financial `governance and practice from ward to board.
- Create a multi-year productivity and efficiency programme across care group and pathways.
- Improve financial consciousness across the organisation through the development and roll out of a financial and efficiency communications strategy.
- Drive financial sustainability alongside planned trajectory to reduce carbon footprint.

Projects (B)

6.1 Financial Governance	• Project to embed strong financial governance, productivity and efficiency delivery governance across the organisation. • Reinstate and embed financial training.
6.2 Financial Improvement	• Develop a Three-Year Plan to move EKHUFT to a sustainable financial position. Establish a Financial Improvement and PMO infrastructure to increase the amount of recurring CIP delivered. Articulate the ask and potential EKHUFT opportunity from the East Kent £.
6.3 Financial Consciousness	• Project to engage staff on the financial challenge the Trust faces and the productivity and efficiency opportunity available to the Trust through making the most of our money for patients.

Success Measures (C)

- Review of the whole financial governance aligned to organisational restructure including appropriate agreed oversight, assurance and performance management to support budget holders to deliver.
- Financial Improvement Oversight Group (FIOG) well attended and discussing and progressing full range of productivity and efficiency improvements.
- Regular review of key financial oversight mechanisms to ensure efficacy.
- Three-year FRP developed reflecting engagement with key stakeholders and agreed as credible.
- Two consecutive quarters of Year 1 3YP run-rate delivered.
- Improvement over the year in underlying financial run rate.
- Programme of regular communications and engagement underway with Trust staff relating to finance, productivity, and efficiency.

Project Leads (D)

- Interim Chief Financial Officer
- Interim Deputy Chief Financial Officer
- Assistant Director of Financial Planning
- Assistant Director Financial Accounting
- Director of Contracting & Income
- Assistant Director Financial Improvement

NOF4 Exit Criteria Contribution (E)

- Agreed Financial Recovery Plan in place supported by clear evidence base, approved by the board and compliant with agreed trajectories.
- Evidence of improved delivery against plans, trajectories and envelopes.
- The Trust fulfils its statutory duties with regard to financial management.
- Robust oversight, financial controls and processes are in place and overseen through appropriate financial governance procedures.
- Benchmarks well against model hospital efficiencies or has agreed trajectory.
- The trust and system have a shared understanding of risks to the financial plan and have agreed mitigations in place.
- Control the costs of overseas recruitment against plan.

6. Finance Programme – Product Milestones

East Kent Hospitals University NHS Foundation Trust

6.1 Financial Governance		
Milestone 1	6.101: Implement Financial Improvement Oversight Group (FIOG)	Mar-23
Milestone 1	6.101a: Review effectiveness of FIOG	Oct-23
Milestone 2	6.102: Effective Care Group oversight approach in place	Jun-23
Milestone 3	6.103: Embed monthly finance reviews with Care Groups	Jun-23
Milestone 4	6.104: SFIs definition & refresh	Jul-23
Milestone 5	6.105: Meeting structure and review of TOR	Jul-23
Milestone 6	6.106: Review, relaunch and embed Strategic Investment Group (SIG)	Aug-23
Milestone 7	6.107: Budget Holder training restarted and embedded	Sep-23
Milestone 8	6.108: Rebasing to revised hospital structure	Sep-23
Milestone 9	6.109: Joint Trust and ICB action plan re. Financial Recovery Plan (FRP) Development	Ongoing

6.2 Financial Improvement		
Milestone 1	6.201: Develop and agree FRP core base year (FY24)	Mar-23
Milestone 2	6.202: Update deficit drivers analysis	May-23
Milestone 3	6.203: Model years one and two of FRP	Jun-23
Milestone 4	6.204: Update FRP document	Jun-23
Milestone 4	6.204a: Medium term financial plan developed	Sep-23
Milestone 4	6.204b: Delivery of 23/24 planned deficit or better	Mar-24
Milestone 5	6.205: Fully develop FY24 efficiencies	Jul-23
Milestone 5	6.205a: Deliver recurrent efficiency schemes	Dec-23
Milestone 6	6.206: Identify and prioritize development of “harder to achieve” improvements	Jul-23
Milestone 7	6.207: Develop multi-year productivity and efficiencies approach covering pathway improvement and GIRFT	Jul-23
Milestone 8	6.208: Review and sign off including FRP base year Q1, Q2 and Q3 reviews	Jan-24
Milestone 9	6.209: Review and sign-off FRP including: Trust and ICB sign off and FRP progress quarterly reviews	Jan-24
Milestone 10	6.210: Input to Kent and Medway System Finance Work	Ongoing
Milestone 11	6.2.11: Achieve Agency Cap	Mar-24

6.1 Financial Governance		
Milestone 1	6.301: Implement Clinical Leaders Efficiency Group (CLEG) to engage clinicians in productivity and efficiency, followed by a review of the approach	Mar-23
Milestone 1	6.301a: Review the effectiveness of CLEG	Mar-23
Milestone 2	6.302: Update financial and efficiency communications strategy	Mar-23
Milestone 3	6.303: Regular communications on finance and efficiency	Ongoing
Milestone 4	6.304: Regular updates to and oversight by FPC & FIOG	Ongoing

Integrated Improvement Plan (IIP) Governance & Reporting

Assurance updates to System Oversight Group, Trust Board & RSP Review Meetings

SRO: CEO

EKHUFT Strategic Improvement Committee (SIC)

NHSE Intensive Support Director: Moira Durbridge

A

Format:
1. Chaired by Chief Executive or nominated deputy
2. Attended by SROs or nominated deputy in absence
3. 1 Hour fortnightly within existing EKHUFT EMT Time
4. Risks and issue management to support 'confirm or challenge' process
5. Standard monthly highlight report per programme
6. Monthly sign-off of IIP Reporting Pack for Trust Board

Portfolio:

B

Format:
1. Chaired by Chief Executive
2. Attended by NHSE Improvement Director, IIP Programme Director, Deputy IDs
3. Delivery Highlights & look forward
4. Risks & Issues by Exception
5. Benefits Identification
6. Time & Materials to date

Programme:

C

Format:
1. Chaired by SRO
2. Attended by Project Leads & other stakeholders as required
3. Monthly Highlight report per Programme
4. Product & Action Tracker for Weekly Huddles

SRO: CEO	SRO: CN&MO	SRO: COO	SRO: CN&MO/CMO	SRO: CPO	SRO: CFO
1. Well Led Programme	2. Maternity Programme	3. Operational Performance Programme	4. Quality & Safety Programme	5. People & Culture Programme	6. Financially Sustainable Programme
Weekly Delivery Huddle	Weekly Delivery Huddle	Weekly Delivery Huddle	Weekly Delivery Huddle	Weekly Delivery Huddle	Weekly Delivery Huddle
1.1 Executive Leadership	2.1 Team Working	3.1 Whole UEC Pathway Flow	3.1 Quality Governance	5.1 Attract and retain	5.1 Financial Governance
1.2 Governance	2.2 Clinical Escalation & Handover	3.2 Elective Recovery	3.2 Safeguarding	5.2 Culture & Leadership	5.2 Financial Improvement
1.3 Comms & Engagement	2.3 Clinical Assessment & Care Pathways	3.3 Cancer Improvement	3.3 Fundamentals of Care	5.3 Medical Workforce	5.3 Financial Consciousness
1.4 Transformation Programme	2.4 Continual Learning		3.4 The Deteriorating Patient		
	2.5 Engagement, Listening & Leadership				

Project:

D

Format:
1. Project Leads to choose most appropriate format to drive delivery, e.g. Daily Huddles, Delivery Group, Project Board, Task & Finish Group etc
2. Mandatory for all Projects to update monthly Highlight Report in standard format with PMO suport
3. Project milestones to explicitly link in with gateway criteria to access additional resources

IIP Open Risk Register (as at 25th September 2023)

Risk Ref	Date Raised	Risk Register	Workstream	Risk Author	Risk Owner	Risk Description	Likelihood	Impact	Inherent Risk Score	Mitigating Actions	Progress Notes	Likelihood	Impact	Residual Risk Score	Date of Last Review	Date Risk Closed
Risk reference number	Date identified	IIP / BAF or Corporate risk	IIP Workstream	Risk raised by	Risk responsibility of	What is the risk to delivery? This is a risk that "something happens" due to the "cause" leading to "consequence/impact".	(1-5) & category	(1-5) & category	Severity of risk before controls implemented	What are the mitigating actions (ensure clear dates are provided)	Progress notes including date of update	(1-5) & category	(1-5) & category	Severity of risk after controls implemented	Date risk was last reviewed at SiC	Date risk was closed at SiC
1.101	14.06.2023	IIP	Leadership & Governance	Ben Stevens	Tracey Fletcher	Unable to appoint CFO substantively due to lack of suitable candidates and potential risk to executive team and financial workstreams / improvements required.	4 - likely	4 - likely	16	a) Interviews for the substantive Chief Finance Officer role were held in April 2023. Agreed with regional colleagues to continue the current interim arrangement for up to 12 months to ensure cover during the period required to undertake a second substantive process to make a permanent appointment. b) Working with NHSE and SE Regional team to support recruitment for substantive position.	**14.09.2023** - Turnaround Director funded by RSP starts in October 2023 to support financial delivery	3 - possible	3 - moderate	9	25.09.23	
1.102	14.06.2023	IIP	Leadership & Governance	Ben Stevens	Tracey Fletcher	The current restructure has the potential to detract from the BAU operations of the Trust and impact on progress against the IIP.	3 - possible	3 - moderate	9	a) Ensure restructure is concluded by 16th August 2023 and appointment to leadership posts to progress IIP programmes at pace.	**26.06.23** - Restructure on track to conclude by 16th August at the latest. **22.08.23** - new organisational structure has gone live on 14th August 23. **25.09.23** - Some vacant positions are await recruitment. Residual score to remain the same at this time.	3 - possible	2 - low	6	25.09.23	
1.103	25.09.2023	IIP	Leadership & Governance	Andrea Ashman	Tracey Fletcher	No substantive COO following the resignation from the current postholder.	4 - likely	4 - likely	16	a) Interim COO in place for unplanned care who has experience, knowledge and understanding of the organisation	**25.09.2023** - Trust have engaged with an agency to start the recruitment process for the COO	3 - possible	3 - moderate	9	25.09.23	
2.101	29.06.2023	IIP	Maternity	Leane Jeffrey	Michelle Cudjoe	Work commissioned to external adviser whose contract expired April/May 2023. Work incomplete, draft document still not received mid June 2023. This framework sets out Governance structures throughout the service, without which there are insufficient systems of control.	4 - likely	2 - low	8	a) The service is currently working towards V2.0 of the Maternity Quality & Safety Framework (Risk Management Strategy) until the refreshed version is available to ensure there continues to be structures for maintaining oversight, and managing of overdue governance related activities. b) Work progresses internally with an MDT to produce the final QSF. This will be ratified at the Women's Health Guidelines Group in Aug and assurance/ratification at MNAG in September. c) New QSF will be published by end August 2023.	Next MNIP governance group meeting 17th August (postponed from 10th) **15.09.23** Governance Review is complete at Trust level. Work to be undertaken with the Care Group to embed the process. **22.09.23** - residual score reduced.	2 - unlikely	1 - negligible	2	22.09.23	
2.301	29.06.2023	IIP	Maternity	Leane Jeffrey	Michelle Cudjoe	The original model for this service has been revised by the incoming substantive DoM meaning that systems which underpin this service need to be reconsidered and revised. Until agreed and implemented, the current triage system remains in place.	3 - moderate	3 - moderate	9	a) Existing telephone triage system remains operational with supporting guideline in place. b) A planning meeting was held 06/07 to redefine the scope of work to be completed to enable centralisation. c) Weekly meetings to be reformed to facilitate revised model with much of the work completed through delivery of the original plan and other elements are underway i.e. triage PTL boards. d) This will appear as an agenda item on the next Women's Health Care Group Governance meeting on 28th July for agreement of way forward with a revised date for completion.	**15.09.23** DoM/DDoM to discuss way forward with Matrons and HoMs **22.09.23** - residual score reduced.	3 - moderate	1 - negligible	3	22.09.23	
2.102	22.09.2023	IIP	Maternity	Leane Jeffrey	Michelle Cudjoe	Unfilled vacancies, combined with high levels of maternity leave and short term sickness will have an effect on patient outcomes and quality and safety. Inadequate midwifery staffing levels may result in women receiving sub-optimal care during labour.	5 - almost certain	4 - likely	20	a) Daily site-wide SitRep to assess safe staffing and ensure escalation policy is appropriately followed b) Line bookings of NHSP and agency, framework and off framework with applied incentive c) Specialist midwives redeployed to fill gaps d) Suspension of continuity of carer e) Utilisation of managers on call and community midwives	This is also on the Corporate Risk Register -CRR122.	3 - possible	4 - significant	12	22.09.23	
2.402	22.09.2023	IIP	Maternity	Leane Jeffrey	Michelle Cudjoe	Inadequate Estates in Maternity There are numerous issues with estates. A few examples are delivery rooms being too small to accommodate essential equipment, ventilation is poor, triage is cramped. Overall capacity does not support delivery. Poor estate means that maternity are unable to provide appropriate care, privacy and dignity and staff are not able to work effectively.	4 - likely	4 - significant	20	a) Induction rates standardised across sites - Daily SitReps for induction demand and capacity b) Introduction of quality rounds on both units that includes estate elements against CQC compliance c) Neonatal service attend postnatal ward daily to facilitate discharges d) Portable suction unit available in each labour room e) Pure air scavenging unit and ventilation in labour rooms on both sites f) Risk assessments for the resuscitaires are undertaken to ensure maximum safety within constraints of the room size	This is also on the Corporate Risk Register -CRR144.	4 - likely	3 - moderate	12	22.09.23	
3.1.01	14.06.2023	IIP	Operational Performance	Sandra Cotter	Jane Dickson	The current process for accounting for the NLFTR has been reviewed in partnership with HCP in which there are a number of recommendations to be considered and taken forward. This will impact reducing the NLFTR position to support emergency flow and 12 hour breach reduction.	3 - possible	4 - significant	12	a) The recommendations will be monitored via the ECDG/HCP delivery groups. b) SAFER roll-out planned July 23 across all sites. c) Additional resource being secured to support enhanced discharging. Awaiting approval for 1 candidate. d) Future of the integrated hubs to determine pathways for patients will continue to be evolved over the next 6 months.	**26.06.23 -** update on SAFER/PTL roll out via the ECDG .	3 - possible	3 - moderate	9	20.09.23	

3.2.01	14.06.2023	IIP	Operational Performance	Lisa Neal	Jane Dickson	Inability to comply with 2023/24 activity plan at Trust level in order to stabilise waiting list and reduce long waiters due to increased theatre activity (cases per session), staffing issues, competency impacting on ability to deliver head & neck activity, consultant sickness in ENT, volume of paediatric patients due to limited access to paeds provision at K&CH and no elective provision at QEQM and WHH.	3 - possible	4 - significant	12	a) ENT system meeting 22 June 2023 chaired by Planned Care Lead (CEO Medway) to consider hub/spoke model and short term recovery actions to reduced breaches before January 2024. b) Increase frequency of PTL meetings in surgery agreeing daily tasks and actions to support breach reduction at pace. c) Analysis of cases per session completed for each speciality to review reason for reduced activity per session (based on slight increase in theatre time compared to pre covid) and quantify theatre actions to increase activity levels. d) Refreshed activity plan in Q2/3/4 for each speciality where activity needs to be increased to sustain waiting list position and eliminate breaches over 65 weeks by March 2024. Rate limiting steps identified (Theatre workforce and equipment, paediatric provision and ENT otology c capacity) require quantifiable and measurable actions to support elective activity and reduction in waiting list and waiting times. e) Specialities to articulate robust recovery actions through weekly activity/performance meetings and agree transformational actions to improve planned care across the trust through the monthly Planned Care Improvement Meeting.	**26.06.23 -** Out patient activity is above plan in Q1 (year to date position). Elective and diagnostic activity is approximately 94% of plan. Referrals are not above plan and are in line with predicted levels based on the previous years(2019- 2022) referral pattern and growth.	4 - likely	3 - moderate	12	20.09.23	
3.3.01	14.06.2023	IIP	Operational Performance	Sarah Collins	Jane Dickson	Diagnostic delays in cancer pathways due to increase in activity.	5 - almost certain	4 - significant	20	a) Radiology improvement meeting weekly b) Radiology reports waiting longer than 15 days post diagnostic are prioritised and cleared. c) All diagnostics are aimed to be booked within 5-10 days of receiving referral. d) Specific focus required on Endoscopy and Urology pathways and capacity e) Heavy sedation capacity for Endoscopy to be agreed. Pending confirmation of Endoscopy insourcing funding and ICB bid to secure underspend via CDC budget. f) Mutual Aid plan for urology to be agreed.	**26.06.23 -** Updates and progress to be recorded at weekly performance meetings	4 - likely	4 - significant	16	20.09.23	
4.1.01	14.06.2023	IIP	Quality & Safety	Katy White	Jane Dickson/ Rebecca Martin	Not upgrading our system to the most up to date version (as with all Trusts using Datix) will delay the PSIRF transition. The Trust has been supported in this work with an agency Datix Project Lead. This post was initially funded by NHSE for 6 months until March 23. As there is not the specialist capability within the Trust to continue managing the Datix upgrade without this support. This specialist remains in post supporting the Trust, however in doing so is incurring a financial overspend.	5 - almost certain	4 - significant	20	a) This has been escalated to a Director at Datix for their intervention. It is unlikely that we will meet the deadline for September 23 (as with all Trusts using Datix). b) Full cost of overspend being costed for the agency Datix Project Lead. c) A business case is being developed to secure an alternative system, which will be aligned to other Kent and Medway Trusts. d) A roadmap for delivery is to be presented to relevant governance committees in September 23. e) updated datix fields	**20.09.23** - roadmap produced inline to deliver plan to implement. Residual score reduced at SiC.	4 - likely	3 - moderate	12	05.09.23	
4.3.01	20.6.23	IIP	Quality & Safety	Wendy-Ling Relph	Jane Dickson/ Rebecca Martin	Ward Accreditation Team are currently small in number with a team member having long term sickness. They may not be able to complete a first accreditation for all inpatient wards by end of November 2023 as the original trajectory anticipated.	5 - almost certain	4 - significant	20	a) Alternative solutions are being explored, including the potential of utilising additional internal staff and reviewing the current accreditation timetable. b) One staff member now returned from long term sick and progressing with plans.	**15.09.23** - Sickness within the team has now resolved. Working practices and priorities have been reviewed. The first accreditation for all wards is now planned to be completed before the end of December, meaning that completion of this action will be delayed, but by only 3 weeks. The risk of lack of completion of the whole section of Quality & Safety is therefore greatly reduced. Residual score now reduced.	4 - likely	4 - significant	8	05.09.23	
4.4.02	14.06.2023	IIP	Quality & Safety	Ian Setchfield	Jane Dickson/ Rebecca Martin	The build of the deteriorating dashboard is dependent on the current integration of VitalPAC functionality within Sunrise which is a very complex process. The predicted timeline for rolling out this functionality is later this year or early next year with dates yet to be confirmed. This links with milestone 4.408 with a target date to achieve by March 24 and also CQC action on Sepsis screening. In the meantime, questions relating to deteriorating patient compliance have been included in Tendable and will be ready for reporting from July 23.	4 - likely	3 - moderate	12	a) Continue to discuss at Sunrise Vitals Integration Steering Group. b) Deteriorating patient is now available on the Tendable Ward platform (from August 23) as an interim measure posing additional challenging questions. Care Groups will be able to produce their own reports on deteriorating patients. Although this will not be as robust as Sunrise it will provide assurances against Trust Policy i.e. escalation. c) Risk owner member of Sunrise Vitals Integration Steering group – any changes to predicted timeline will be included in PSC deteriorating patient report, along with Tendable deteriorating patient reports.	**19.06.23 -** Meeting with Dudley NHS Trust (16.05.23) who have developed a deteriorating dashboard using Sunrise was productive. Once VitalPAC integrated within Sunrise the build of the dashboard should be able to be developed at pace thereafter. **05.09.23** - discussions at SiC at length, Deteriorating Patient programme to discuss with ICB to ensure this action is appropriate and will be suffice as this is a quarterly RSP requirement.	4 - likely	3 - moderate	12	05.09.23	

5.2.03	14.06.2023	IIP	People & Culture	Andrea Ashman	Andrea Ashman	Culture and Leadership Programme currently not fully aligned with wider IIP programmes (including 'we care' programmes). This means there could be two separate culture pieces of work taking place causing conflicts for the organisation.	3 - possible	3 - moderate	9	a) Discussions continue regularly with IIP SRO & Programme SRO re: new strategy to align CLP with existing programmes and to reduce duplication.	**20.06.23** - Venue and budget code now booked to hold launch days in July 2023. **05.09.23** - residual score reduced.	3 - possible	2 - low	6	05.09.23	
5.2.04	14.06.2023	IIP	People & Culture	Andrea Ashman	Andrea Ashman	Capacity is limited (only 3.6wte available) in order to scale up delivery of the Leadership Development Programmes at each of the levels required (Leading Others, First Line Leader, Mid-level Leader) as planned. Each of these 5-day programmes are scheduled to run 3x per annum and to do so will require more facilitators. The team are also holding a vacancy due to the required financial efficiencies.	4 - likely	4 - significant	16	a) Consultation now complete with appointments made however some vacancies still remain which are to be advertised in September 23. b) Post recruitment the OD team will prioritise delivering the Leadership Development Programme fully as capacity will be available.	**05.09.23** - residual score reduced.	3 - possible	3 - moderate	9	05.09.23	
6.1.01	14.06.2023	IIP	Financially Sustainable	Michelle Stevens	Michelle Stevens	Due to vacancies within the Finance team there are currently no project leads within the IIP finance workstream. This is a risk to ensuring there is pace and delivery of the programme and could cause delays to ensuring financial savings and improvements are achieved in the organisation.	3 - possible	3 - moderate	9	a) Deputy CFO commenced in post 17th July of which a full handover has been undertaken with clear objectives. b) The CFO is currently both SRO and project lead for the finance programme within the IIP. c) RSP team offered urgent financial recovery support which has been approved and will be available from October 23 in order to bring pace to financial programme.	**05.09.23** - discussion at SiC, RSP support available from October 23. Residual score reduced.	2 - unlikely	3 - moderate	6	05.09.23	
6.1.02	14.06.2023	IIP	Financially Sustainable	Michelle Stevens	Michelle Stevens	In order to support updating Financial Recovery Programme additional support is being explored. Current post holder leaving end of July 23, organisation off plan and further grip required.	3 - possible	3 - moderate	9	a) Deputy CFO commenced in post 17th July of which a full handover was undertaken with clear objectives. b) A draft version of the FRP was presented to the Trust Board in July 23, it was agreed further work with key stakeholders is required to finalise draft aimed at presenting again in October to achieve target date of Jan 24. c) RSP team offered urgent financial recovery support which has been approved and will be available from October 23. d) Comms to support with staff engagement to support financial consciousness.	**05.09.23** - discussion at SiC, RSP support available from October 23. Residual score reduced.	2 - unlikely	4 - significant	8	05.09.23	
5.02.05	09.08.23	IIP	People & Culture	Louise Goldup	Andrea Ashman	Lack of leadership and engagement from Medical Office to drive forward pace of People and Culture milestones for medical workforce and ensure this is consistently applied.	4 - likely	4 - significant	16	a) New interim CMO fully engaged in P&C workstreams and regular meetings in place to review milestones. b) Appointment of medical workforce lead in August 23, regular meetings in place to increase engagement and review milestones. c) Detailed plans currently being produced by medical office to support milestones with clear timescales and leads being identified. d) Medical workforce dashboard being progressed. e) Medical Office have implemented regular meetings with Care Group Medical Directors to drive pace. □	**05.09.23** - residual score added.	2 - unlikely	4 - significant	8	05.09.23	
6.1.03	07.08.23	IIP	Financially Sustainable	Michelle Stevens	Michelle Stevens	Risk to the delivery of the Trusts 2023/24 Efficiency Plan.	4 - Likely	4 - Significant	16	a)Enhanced Controls measures have been issued to all care groups to ensure adherence to the national controls required for a level 4 organisation	**05.09.23** - discussion at SiC, residual score reduced.	4 - Likely	3 - moderate	12	05.09.23	
6.1.04	07.08.23	IIP	Financially Sustainable	Michelle Stevens	Michelle Stevens	Risk of identifying and prioritising the development of "harder to achieve" improvements from Care Groups.	4 - Likely	4 - Significant	16	a)Conversations are on going with care groups to fully understand areas which could be explored to reduce spend but with a clear understanding of the clinical impact on the decisions	**05.09.23** - discussion at SiC, residual score reduced.	4 - Likely	3 - moderate	12	05.09.23	

4.3.02	09.08.23	IIP	Quality & Safety	Wendy-Ling Relph	Jane Dickson	Head of Nursing for FoC & Quality (who is also clinical Lead for Nutrition) is currently recruited on an interim arrangement until end December 23 as a secondment. Post holder is chair of key quality strategic meetings, project lead for IIP FoC, line manager of specialist nurses, coach & mentor to nursing teams. Risk of instability to lead on FoC workstreams if future of post is not agreed promptly. □	4 - Likely	4 - significant	16	a) Corporate team restructure is currently being reviewed. □ b) There is a plan to substantively recruit and submit to vacancy panel prior to December 23 to ensure work continues.		4 - likely	3 -moderate	12	05.09.23	
3.4.01	23.08.23	IIP	Operational Performance		Jane Dickson	Delays to eliminate 78 week waits due to inability to secure additional endoscopy and otology capacity immediately before January 2024.	5 - almost certain	3 - moderate	15	a) No immediate mitigation to reduce 78 week breaches before January 2024. Work continues to explore.	**14.09.23** - No system capacity available to support EKHUFT otology recovery.	5 - almost certain	3 - moderate	15	20.09.23	
3.5.01	23.08.23	IIP	Operational Performance		Jane Dickson	Inability to fully validate all patients from 12 weeks wait as per Board Assurance letter received 4 August due to lack of capacity.	4 - likely	2 - low	8	a) System wide challenge acknowledged at Planned Care Board 22nd August 23. b) Proceed with two way text message roll out. Increased spend to be approved before roll out can commence c) Review of EKHUFT Access Governance/Validation workforce compared to MFT/MTW/DGH d) Progress patient portal opportunities with IT to consider role in validation.	**14.09.23** - Elective Leads across K&M unable to deliver/achieve national requirement. System review of Access Governance support in place confirms EKHUFT, based on size of Trust/PTL, have a significantly reduced team compared to neighbouring Trusts.	3 - possible	2 - low	6	20.09.23	

RISK MATRIX						
Impact	5. Extreme	5. L	10. M	15. H	20. E	25. E
	4. Significant	4. L	8. M	12. M	16. H	20. E
	3. Moderate	3.V L	6. L	9. M	12. M	15. H
	2. Low	2. VL	4. L	6. L	8. M	10. M
	1. Negligible	1. VL	2. VL	3. VL	4. L	5. L
		1. Rare	2. Unlikely	3. Possible	4. Likely	5. Almost certain
		Likelihood				

E	Extreme Risk
H	High Risk
M	Moderate Risk
L	Low Risk
VL	Very Low Risk

IIP Closed Risks

Risk Ref	Date Raised	Risk Register	Workstream	Risk Author	Risk Owner	Risk Description	Likeihood	Impact	Inherent Risk Score	Mitigating Actions	Progress Notes	Likeihood	Impact	Residual Risk Score	Date of Last Review	Date Risk Closed
2.303	29.06.2023	IIP	Maternity	Michelle Cudjoe	Jane Dickson	Postnatal guideline supporting implementation of improved discharge pathways was not reviewed as planned by the WH guideline group on 16 June 2023. This poses a threat to the milestone target date of July 23 and until approved the service will continue to operate the current discharge model.			12	a) Postnatal Ward Manager (QEQM) to work with Guideline Midwife to circulate the postnatal guideline for review and approval. b)The postnatal guideline will be circulated via email, by exception for chairs action to agree the new model for implementation by end of July 23.	**18.07.23** - Discussed with programme manager, obtain approval at SiC on 26.07.23 that this risk is a duplicate and is now merged with risk 2.302 to enable closure. 26.07.23 - risk agreed to be closed at SiC as a duplication.				26.07.23	26.07.23
2.401	29.06.2023	IIP	Maternity	Michelle Cudjoe	Jane Dickson	Whist pending development and approval of the new maternity Quality & Safety framework, the service is working to the draft V2 of the QSF. Structures for maintaining oversight, and managing of overdue governance related activities require further work particularly to ensure there are no overdue/breached governance related activities inlcuding SIs/HSIB investigations.			16	a) To ensure there is some strengthened governance in the interim the maternity service is working to V2 of the QSF until the final version is published in August 2023. b) There are trackers being used to monitor progress of all governance related activities, including backlogs. c) In additon there is now a dedicated patient safety team progressing with overdue governance to ensure focus.	**18.07.23** - Discussed with programme manager, obtain approved at SiC on 26.07.23 that this risk is a duplicate and is now merged with 2.302 to enable closure. 26.07.23 - Risk agreed to be closed at SiC as now a duplication.				26.07.23	26.07.23
4.4.01	14.06.2023	IIP	Quality & Saf	Ian Setchfield	Jane Dickson/ Rebecca Martin	Unable to support deteriorating patient training across the organisations as proposed due to funding provided by HEE not available.	3 - possible	3 - moderate	9	a) Plan is to utilise money for additional resuscitation training provided by an external supplier, which improves the deteriorating patient pathway. b) Full resuscitation training needs and costings to be finalised & submitted to HEE. c) Funding since recieved in June 23 to enable rollout of training across the organisation (funding supports both training and posts). Allocation of remaining funding to support additional deteriorating patient workstreams need to be agreed with CNMO.	**19.06.23 -** Funding agreed for £300k one off via HEE (which supports both training and posts). Money has been transferred to the Trust from the ICB - risk can therefore now be closed. **18.07.23** - Project Lead to requested for closure to be submitted to the SiC on 26.07.23. **26.07.23** - Risk agreed to be closed at SiC now funding is recieved risk is removed.			6	26.07.23	26.07.23
2.302	29.06.2023	IIP	Maternity	Michelle Cudjoe	Jane Dickson	Postnatal guideline was not reviewed as planned by the WH guideline group on 16 June 2023. This poses a threat to the milestone date of July and until the service will continue to operate the current discharge model.	3 - possible	5 - extreme	15	a) Corresponding postnatal guideline has been updated which sets out the improved model for the discharge pathway. However, the guideline was not reviewed as planned by the Women's Health Guideline Group on 16 June 2023 due to insufficient time on the agenda to consider and approve. b) The postnatal guideline was planned to be circulated via email, by exception for chairs action however it has since been agreed for wider discussion at the Women's Health Audit Group on 18/07 for ratification.	**16.08.23** - guidance published on 4th August. Request to SiC to close risk.	3 - possible	3 - moderate	9	16.08.23	24.08.23
5.2.01	14.06.2023	IIP	People & Culture	Andrea Ashman	Andrea Ashman	In order to support Culture and Leadership Programme trust wide, additional funding for 1 Programme Director and 1 seconded Programme Manager was requested from NHSE (RSP funding). Currently funding has not been approved and received however, NHSE confirmed to 'go at risk' to ensure the project is not delayed. If funding is not received this will be an overspend for the organisation.	3 - possible	3 - moderate	9	a) NHSE confirmed to go 'at risk' with budget codes so not to hold project up and regular updates received from RSP team. b) Posts are recruited to and programme has commenced, moving forward to diagnostics.	**20.06.23 -** still awaiting if funding has been allocated and amount. **07.09.23** - funding now agreed from RSP, residual risk score reduced. Request to SiC on 20th Sep to close. **20.09.23** - risk agreed to be closed.	2 - unlikely	2 - low	4	05.09.23	20.09.23

5.2.02	14.06.2023	IIP	People & Culture	Andrea Ashman	Andrea Ashman	Due to insufficient funding within Culture and Leadership Programme unable to undertake practical arrangements for launch of Culture and Leadership Programme trust wide including events / booking venues.	3 - possible	3 - moderate	9	a) NHSE confirmed to go 'at risk' with budget codes so not to hold project up for posts to progress with programme. Internally also 'gone at risk' to account for additional revenue required to support events. b) Launch days and conference centre now booked to enable diagnostics to be commenced. b) Working with SRO to realign budgets to support future funding.	**07.09.23** - funding now agreed from RSP, residual risk score reduced. Request to SiC on 20th Sep to close. **20.09.23** - risk agreed to be closed.	2 - unlikely	2 - low	4	05.09.23	20.09.23