REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM JANUARY 2025

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
BAIRD, STEWART	Acting Chairman	Stone Venture Partners Ltd (started 23 September 2010) **(1)** Stone VP (No 1) Ltd (started 15 August 2017) **(1)** Stone VP (No 2) Ltd (started 1 December 2015) **(1)** Hidden Travel Holdings Ltd (started 16 May 2014) **(1)** Hidden Travel Group Ltd (started 15 October 2015) **(1)** Trustee of Kent Search and Rescue (Lowland) (started 2013) **(4)** Director of SJB Securities Limited (started 30 October 2013) **(1)** Non-Executive Director of Continuity of Care Services Ltd (started 1 October 2022) **(1)** Director of Cleo Systems 24 Limited (started 1 January 2025) **(1)** HotelShop UK Limited (started 1 January 2025) **(1)** Rapid Relocate Limited (started 1 January 2025) **(1)**	1 June 2021 (First term)
BLISSETT, NORMAN	Chief People Officer	To be advised	20 January 2025
CATTO, ANDREW	Non-Executive Director	Group Chief Executive Officer, Integrated Care 24 (IC24) **(1)** (including Director of Cleo Systems 24 Ltd, Brightdoc 24 Limited, Idental Care 24 Ltd.) Board Member of east Kent Health and Care Partnership (HCP) **(1)** Director of Transforming Primary Care **(1)**	1 November 2022 (First term)
DESAI, KHALEEL	Director of Corporate Governance	Non-Executive Director/Trustee of The Mines Advisory Group (MAG) Charity **(4)**	29 April 2024
FLETCHER, TRACEY	Chief Executive	None	Appointed 4 April 2022
HAYES, SARAH	Chief Nursing and Midwifery Officer	Charity Trustee, The 1930 Fund for Nurses (Charity) **(4)**	18 September 2023

REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM JANUARY 2025

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

REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM JANUARY 2025

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
SYKES, CLAUDIA	Non-Executive Director	Director, Cloudier Skies Ltd **(1)** (started 21 December 2022) Chair, East Kent Health and Care Partnership (HCP) (**1**) (1 January 2024) Chair, Kent and Medway VCSE Alliance **(5)** (September 2022)	1 March 2023 (First term)
van der LEM, ANGELA	Chief Finance Officer	None	6 November 2024
WALKER, CATHERINE	Non-Executive Director	Chair of Advisory Appointments Committee, Kings College NHS Foundation Trust **(1)** Tribunal Member, Ministry of Justice **(1)** Panel Member/Chair, High Speed 2 **(1)** Panel Member/Chair, East West Rail **(1)**	25 October 2024 (First term)
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

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 FOURTY FIRST MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 5 DECEMBER 2024 1.00 PM HELD IN THE SEMINAR ROOMS, BUCKLAND HOSPITAL, DOVER AND WEBINAR TELECONFERENCE

PRESENT:

Mr S Baird	Acting Chairman (Chair)	SB
Dr A Catto	NED/Quality and Safety Committee (Q&SC) Chair/Nominations and Remuneration Committee (NRC) Chair	AC
Mr S Corben	NED/2gether Support Solutions (2gether) NED In-Common	
Ms T Fletcher	Chief Executive (CE)	TF
Ms S Hayes	Chief Nursing and Midwifery Officer (CNMO) (by Webinar – left meeting at 1.40 pm)	SH
Mr R Hodgkiss	Chief Operating Officer (COO)	RH
Dr D Holden	Chief Medical Officer (CMO)	DH
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	OO
Mr B Stevens	Chief Strategy and Partnerships Officer (CSPO)	BS
Ms C Sykes	NED/Charitable Funds Committee (CFC) Chair/People & Culture Committee (P&CC) Chair/*Reading the Signals Oversight Group* Chair	CS
Ms A van der Lem	Chief Finance Officer (CFO)	AvdL
Mrs C Walker	NED	CW

ATTENDEES:

Mr M Blakeman	Improvement Director NHS England (NHSE)	MB
Mr K Desai	Director of Corporate Governance (DCG)	KD
Ms C Doran	Quality Lead for East Kent locality, NHS Kent & Medway Integrated Care Board (ICB) (by Webinar)	CD
Dr N Newton	Major Trauma Director (minute number 24/091)	NN
Mrs N Yost	Executive Director of Communications and Engagement (EDC&E)	NY

IN ATTENDANCE:

Mr N Daw	Governor and Membership Lead	ND
Miss S Robson	Board Support Secretary (Minutes)	SR

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

Mr D Esson	Member of the Public
Ms C Heggie	Member of the Public
Ms N Reckling	Member of Staff
Ms H Yeo	Member of the Public

MINUTE NO.		ACTION
24/077	**CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE** The Acting Chairman opened the meeting, welcomed everyone present, and noted apologies received from Ms D Viner (DV), Interim Chief People Officer (CPO); and Professor C Holland (CH), Associate NED (non-voting Board member).	
24/078	**CONFIRMATION OF QUORACY** The Acting Chairman **NOTED** and confirmed the meeting was quorate.	

24/079 **DECLARATION OF INTERESTS**

There were no new interests declared.

24/080 **MINUTES OF THE PREVIOUS MEETING HELD ON 3 OCTOBER 2024**

DECISION: The Board of Directors **APPROVED** the minutes of the previous meeting held on 3 October 2024 as an accurate record.

24/081 **MATTERS ARISING FROM THE MINUTES ON 3 OCTOBER 2024**

B/06/23 – Redesigning Patient Pathways in the Emergency Departments (EDs)
The COO stated a review looking at new signage across all areas had been undertaken at Queen Elizabeth the Queen Mother Hospital (QEQM), and a similar review was also needed to be undertaken at William Harvey Hospital (WHH). The Board of Directors **APPROVED** this action for closure.

B/10/24 – Action to address incidents of assaults on staff
The CSPO reported security had been increased in the EDs, along with a review and update of the security staff service specification that would be taken forward by 2gether Support Solutions (2gether) to keep Trust staff safe. Any incidents of assaults on staff would be monitored by P&CC and reported to the Board in the P&CC Chair Assurance Report. The Board of Directors **APPROVED** this action for closure.

B/22/24 – NED site visit feedback template
The DCG reported an online feedback template was being looked at with the hope this would be in place by January 2025.

B/23/24 – Presentation of future quarterly progress update reports to P&CC on actions to address and support reducing incidents of violence and aggression against staff
The CNMO confirmed she would be discussing with the P&CC NED Chair to agree a timeline to present a report to P&CC. The Board of Directors **APPROVED** this action for closure.

B/25/24 – Summary of comparison data on how Trust compared with similar Trusts of its neonatal nursing workforce percentage to be included in future MNAG Chair Assurance Reports
The CNMO commented this action was being worked on and would be reported to MNAG prior to being reported to the Board, action would remain open.

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

24/082 **CHAIRMAN'S REPORT**

The Acting Chairman highlighted the following key elements:

- Recognition of the huge efforts and hard work by all staff supporting performance improvements to reduce waiting lists and continued support in managing the upcoming winter pressures;
- Trust presenting a progress update the following week (week commencing 9 December) to the National Recovery Support Programme team;
- Merry Christmas and Happy New Year wishes to everyone.

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

24/083 **CHIEF EXECUTIVE'S (CE's) REPORT**

The CE highlighted the significant increased Trust's response rate to the 2024 National NHS Annual Staff Survey from the previous year, as yet no indication on what the staff feedback incorporated, with the commitment to continue to work with colleagues to address issues raised.

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

24/084 **WOMEN'S CARE GROUP MATERNITY AND NEONATAL ASSURANCE GROUP (MNAG) CHAIR'S REPORT**

The CNMO reported the Care Quality Commission (CQC) were visiting Maternity Services that day, supported by the Director of Midwifery (DoM), and that an additional Board meeting would be scheduled within the next two weeks for the DoM to provide a briefing and discuss this MNAG report and the Clinical Negligence Scheme for Trusts (CNST) compliance elements.

ACTION: Identify and schedule an additional extra-ordinary BoD meeting to be held in the next two weeks for Board members to discuss the MNAG report and the Clinical Negligence Scheme for Trusts (CNST) compliance elements. — DCG/ Board Support Secretary

The NEDs raised the review and actions in respect of the neonatal deaths. The CNMO stated an update on the review and actions would be provided by the DoM at the extra-ordinary BoD meeting, noting all cases had been reviewed internally, and the independent external review report once completed would be presented through the Trust's governance structure. The Acting Chairman confirmed this issue had been discussed at MNAG. The CMO noted the external review being undertaken to identify any themes, there appeared not to be a capacity issue, and the deaths related to extremely premature babies.

The Acting Chairman commented on the minor estates works funding he understood had been identified and enquired when these works would be implemented. He also asked about a timeline for the bereavement suite works at WHH. The CSPO confirmed minor estates work were in progress and being overseen by the Women's Health leadership team, in respect of the WHH bereavement suite due to logistics of the capital works needed (changes to rooms) these were to be undertaken March/April 2025 for completion within this timeframe.

The Board of Directors **NOTED** the MNAG Chair Assurance Report from the 8 October and 12 November 2024 MNAG meetings.

24/085 **CARE QUALITY COMMISSION (CQC) UPDATE REPORT**

The CNMO highlighted the following key elements:

- Regular CQC update reports presented to the Q&SC;
- Continued closure of the 2023 inspection action plans, with an additional 6% closed since the last Board report, 9% of overall actions (18 actions out of 206) remained open with further closures expected over the forthcoming reporting period;

- Trust's ward and clinical accreditation process had been strengthened and was now in alignment with CQC assessment.

The CMO reported to address the target not being met in respect of the statutory and mandatory training for doctors, action had been taken by writing to all consultants to complete any non-compliant training as a priority.

The NEDs asked about what improvement plans were in place to improve the self-assessment percentage rates and whether there were any gaps to not achieving this. The CNMO commented some areas had been particularly tough on how they had scored themselves (particularly Women's Health), with the CNMO, CMO and COO challenging them on their scores and receiving assurance of their actions. Noting this process was being further reviewed in respect of the self-assessment tool in advance of the next round of meetings, which also included additional elements required to be added. Two Care Groups would be reviewed against this tool to test this, as well as introducing a peer assessment review process who would be in attendance at the meetings along with Executive Directors.

The Board of Directors **NOTED** the CQC update report and the assurance provided in relation to progress with inspection action plans, query management, and the CQC self-assessment and check and challenge meeting programme.

24/086 **RISK REGISTER REPORT**

The CNMO highlighted the following key elements:

- A highly experienced Risk Manager had been recruited who would support and also provide challenge of the Trust's risk management;
- Significant improvement reducing overdue actions, eight currently with continued work strengthening and embedding to further reduce these;
- Close monitoring of risks by the Clinical Executive Management Groups (CEMG) and Board Committees;
- Risk 3386 – potential risk of inaccurate records due to Euroking back copying, working with Care Group to mitigate this risk, that would be further mitigated with a new system in January 2025.

The Acting Chairman asked for assurance that all risks were being identified and how to ensure no risks were being missed. He reiterated the importance of NEDs following up with staff about risks during site visits and actions to mitigate these. The CNMO commented on the improved risk management process in place within Care Groups and their ownership of their individual risks, continued triangulation of risks across all areas throughout the organisation with discussions at CEMG.

The NEDs raised concern the October 2024 Risk Review Group had been cancelled, which was disappointing and the need for this to be challenged. It was noted the implementation of a new system, InPhase, and the risks around legacy of information. The CNMO reported this issue had also been raised at the CEMG, noting the Director of Quality Governance was reviewing the legacy risks and any risks around moving to the new system that would be escalated where appropriate through the risk management process.

The NEDs raised Datix incidents and how the Board were made aware of these. The CNMO stated narrative around these and associated risks would be covered within the IPR.

The Board of Directors **NOTED** the Significant Risk Report for assurance purposes and for visibility of key risks facing the organisation.

24/087 **BOARD ASSURANCE FRAMEWORK (BAF)**

The DCG highlighted the following key points:

- BAF presented progress against principle risks and Trust achieving its strategic objectives, all aligned with risks on the Significant Risk Register (SRR);
- 13 risks on BAF assigned to specific Board Committees that owned these risks (with meeting agendas set against these), monitoring of actions and progress, and assurance of the monitoring and review process overseen by IAGC;
- BAF Risk 001 Covid-19 pandemic: wording had been updated reflecting current position;
- Reviewing inclusion of a digital/cyber risk escalated from SRR to the BAF;
- Changes to risk rating reflecting improvements in operational performance.

The NEDs enquired whether the Trust had considered a segmentation approach going forward in respect of Covid and the historic impact on its waiting lists. The DCG commented this was covered within the Our Patients, Our Quality and Safety, and Our Sustainability strategic objectives, noting these had been recently reviewed and updated, and agreed future reflection and review specifically around this point.

The IAGC NED Chair acknowledged the improved and strengthened BAF developed that aligned with the SRR, with assurance provided at IAGC of both these processes to manage and review risks as well as escalation.

The Board of Directors **NOTED** the status of the Principle Risks in the BAF.

The CNMO left the meeting at this point.

24/088 **INTEGRATED CARE BOARD (ICB) STRATEGY (KENT AND MEDWAY (K&M) NHS STRATEGY 2024/25 – 2029/30)**

The CSPO highlighted the following key points:

- All NHS provider organisations (including primary care, looking at care at home, and prevention) had contributed to the strategy, identifying strategic themes (patient access; outcomes and experience; people; sustainable services; and financial sustainability);
- Strategy focussed on sustainability and core priorities against a continuous improvement methodology in respect of working together around the opportunities to collectively address the challenges within the local healthcare system;
- Trust's strategy currently being developed would include triangulation and alignment with this strategy (as with all other NHS provider organisations);
- Strategy had been presented through the ICB governance structure and being presented to all NHS provider organisations for approval.

The NEDs enquired whether a local system risk register was being looked at being produced. The CE acknowledged this would be beneficial to have in place for the local system and agreed to raise this issue with the ICB's CE.

ACTION: Raise with ICB's CE whether producing a local system-wide risk register was being looked at as part of the development of the ICB K&M Strategy. CE

The NEDs raised a key weakness in the strategy about the support needed from the Community to support with required care for patients enabling patients to be discharged home from hospital. The CSPO confirmed this issue had been raised as an area of concern at the meetings held to discuss the strategy. He emphasised the Trust's Financial Sustainability Plan (FSP) and targets within this, and the FSP would be a component of this strategy. The Acting Chairman stated the Board had approved the Trust's FSP at its Closed meeting held that morning.

DECISION: The Board of Directors:

- **NOTED** the co-production approach to the development and delivery of NHS Strategy;
- **APPROVED** the NHS Strategy endorsing the direction of travel as described in the A3s.

24/089 **INTEGRATED PERFORMANCE REPORT (IPR)**

The following key performance points were noted for the month of October 2024:

Patients

- ED 4 hour wait performance above 50% since May 2024 (against 50% threshold), 12 hours continued to be challenging with a sustained reduction and remained an outlier. Type 1 compliance continued to exceed tier 1 milestones each month. ED activity continued to be significant with 9% increase from number of patients seen at the same time the previous year;
- Sustained six month improvement on Cancer performance;
- Elective long waiting patients had significantly reduced now at 11 patients (from its highest of 786);
- Consistent reduction in 78 and 65 week breaches month on month;
- Reduction in endoscopy backlog now at 663 patients moving to a sustainable position;
- Improvement in diagnostics DM01 compliance for patients waiting less than six weeks, at 77% against the trajectory target of 75%.

Quality

- No Never Events reported;
- Compliance across all Duty of Candour metrics improving with both verbal and written compliance at 100%.

People

- Sickness absence rates above alerting threshold of 5%, currently at 5.09%, due to significant increase in absence related to coughs, cold and influenza;
- Appraisal compliance continued to improve, now at 79.4%, 1% less than the desired threshold;
- Staff turnover improved to 8.8%.

The Acting Chairman enquired about the driving themes for patients having to wait over 12 hours in ED. The COO commented the challenges with admitting these patients to available beds and continued work to improve patient flow, discharge and bed capacity. He emphasised the biggest challenge was the admission pathway for mental health patients and the Trust continued to work closely with K&M NHS and Social Care Partnership Trust (KMPT) to support these patients

around additional service provision diverting away from ED. He noted the success at Medway Hospital around a safe haven service working effectively to reduce these admissions to ED and the Trust was exploring what could be done and learning from this service.

The NEDs enquired about whether the Trust was in a suitably sustainable performance position during this winter period. The COO highlighted the winter period remained a challenge due to increased activity, the improvements in performance and initiatives to support during this period and the Trust was on target to deliver reduction in elective waits.

The NEDs asked about the endoscopy backlog, the sustainability of this for those patients on the waiting list and any harm for patients as a result of the delays, and progress of the work to address and discharge patients no longer fitting the criteria to reside. The COO commented on the improvement work that had seen a reduction in patient length of stay (LoS) as well as improving patient flow, recognising much more work was needed to further improve this. The endoscopy services was currently in a sustainable position and would continue to work six/six-half days a week.

The NEDs acknowledged the success of the Trust's collaborative work with KMPT in managing mental health patients outside the ED environment by the mental health liaison triage.

The CE thanked the COO for his hard work and commitment in supporting the performance improvements.

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

24/089.1 **MONTH 7 FINANCE REPORT**

The CFO reported on the following key points:

- In line to achieve the annual planned deficit for 2024/25;
- Thanks to all staff for their support and hard work towards achieving the financial plan emphasising the importance of their continued help in meeting the year-end target;
- Continued to work towards financial sustainability against the grip and control processes in place for current Financial Year (FY), as well as focus for future years;
- Income to date below plan (mainly due to reduced number of patients no longer fitting criteria to reside in hospital), offset by reduction in expenditure;
- Expected to deliver the £49m Cost Improvement Programme (CIP) target set for 2024/25, currently £0.3m ahead of plan Year to Date (YTD), as well as focussing on continued cost and productivity improvements.

The NEDs raised capacity within the Trust to maintain focus on sustaining the current financial grip and control, noting the Trust's Internal Auditors would be undertaking an audit review of these processes. The CFO highlighted the good work implementing cost improvements that included reducing agency spend, the need to continue the focus on monitoring the processes in place and these were being adhered to.

The Board of Directors reviewed and **NOTED** the financial performance of Month 7.

24/090 **REPORT ON JOURNEY TO EXIT NHS OVERSIGHT FRAMEWORK (NOF4) AND INTEGRATED IMPROVEMENT PLAN (IIP)**

The CSPO highlighted the overall rated amber for Leadership, Governance and Culture, also Urgent Emergency Care (UEC) and Planned Care, with Finance rated green.

NHSE's Improvement Director noted good progress across the programmes against the metrics in the plan with the exception of the long waits in ED that was a key focus of the Trust. The CSPO reported an exit review meeting would be held the following week with the National team, and continuing to make progress on the work during the last quarter to move from amber to green.

The NEDs raised the evidence in respect of sustainably removing corridor care and going forward how would this be achieved, particularly during the winter period. The COO reported the Trust was effective in respect of ambulance handovers (other trusts had delays) and this resulted in impacting increased waiting times for patients in ED and corridor care, and was a risk to achieving the metric and meeting the exit criteria. The CSPO reiterated the Trust's ambition to reduce and eliminate corridor care, whilst recognising the continued challenges and that there had been a reduction in the use and number of patients treated corridor care, focussing on the quality and safety of care for all patients within all ED areas.

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

24/091 **MAJOR TRAUMA (TRAUMA UNIT PEER REVIEW)**

The Trauma Director reported on the following key points:

- Complex major trauma affected all ages, genders and backgrounds (including patients who were vulnerable and abused children, to functional employable adults to return to the workforce, and the elderly (elderly trauma 50:50 split across two sites (WHH and QEQM) significant number of falls);
- Supported by great staff and teams in the two EDs with over 1,000 ISS 9 points per annum, over 156 trauma patients admitted in the month of August, 12 months at WHH 508 and at QEQM 455;
- Trust peer reviewed against Trauma Quality Indicator (TQUIN) measures of 22, with compliance at 20 green, and 2 amber. Trust's trauma care flagship in most areas and had been part of the Channel 4 Emergency programme;
- Patients provided with rehabilitation prescription automatically attached to Electronic Despatch Note (EDN), and the importance of robust data for trauma patients;
- Trust provided Trauma Care After Resuscitation (TCAR) course with ward nurses trained to care for trauma patients transferred to the wards, as well as in-house Trauma Team Members (TTM) and Paediatrics TTM course;
- Robust governance processes in place;
- No separate funding allocated for major trauma services, continued to lobby for additional funding.

The Acting Chairman enquired about the impact of the new ED environment. The Trauma Director highlighted these significantly improved facilities in providing the appropriate space to accommodate the full trauma team to treat patients along with all the required equipment and easy accessibility of the necessary supplies.

The NEDs enquired whether there had been an increase in trauma activity. The Trauma Director commented previously there had been around 800 to 1,000

patients and that these had increased to around 1,500 (highlighting a significant amount of these related to elderly falls). It was recognised the increasing population in East Kent and the rise in major trauma activity. There were also seasonal peaks around trauma injuries.

The Board of Directors received and **NOTED** presentation on Major Trauma.

24/092 **WINTER PLANNING AND CAPACITY**

The COO provided a verbal report highlighting the following key points:

- Demand and capacity modelling undertaken identifying gap in beds during the winter period at peak (February 2025) of 372 (135 of which mitigated by Trust's internal LoS improvements that were on track around improving patient flow and patient discharge). Following the impact of mitigations, interventions and schemes this bed gap had been reduced to 15;
- Funding allocation provision to the system of £7.7m to support improvements to patient pathways and address demand. Schemes included Single Point of Access where Multi-Disciplinary Teams (MDTs) looked at ambulance calls and whether appropriate to be conveyed to hospital (evidenced this had been successful) with a reduction of 400 ambulances in November 2024 from November 2023. Investment for Virtual Wards to manage 24 patients in their own homes and not requiring in-patient bed provision;
- All staff working extremely hard managing demand and looking at alternatives to address demand, with thanks to all staff particularly those working in the urgent care pathway looking after patients within very pressured environment;
- Nationally seeing an increased demand in urgent care activity.

The Acting Chairman enquired about corridor care and action to address this, and whether the 372 bed gap this year was an increase or decrease from the previous year. The COO reported the aim to not have any corridor care and that this would mean the Trust's bed occupancy of 100% against the national assumption of 92%. He agreed to check and confirm whether the 372 bed gap this year was an increase or decrease from the previous year. He stated the number of patients and time spent being treated in corridor care had improved and reduced that year from the previous year.

ACTION: Check and confirm whether the 372 bed gap in 2024 was an increase or decrease from that in 2023. COO

The NEDs enquired about Virtual Wards and the feasibility of increasing the number of patients if needed during the winter period. The COO highlighted the need to recruit staff to support this over the winter and the behavioural change for staff in managing these patients virtually. As well as ensuring patients received the care needed in the appropriate setting and had the necessary support they required. The CMO commented there was a focus on specific areas of patients that could effectively be managed and supported virtually to increase patient numbers.

The NEDs commented on the improved efficiency around patient flow and discharges during the winter period impacted by additional funding provision, and whether this could be continued throughout the year. The COO commented this was the Trust's plan, and the CMO added that the Single Point of Access would also be extended beyond winter.

The NEDs asked whether there were any risks to the 15 bed gap being increased. The COO stated further increase in demand presented a constant risk as well as not achieving any of the winter schemes above and beyond the modelling, with mitigations covered within the full capacity protocol detailing the actions to address demand and capacity.

The Board of Directors **NOTED** the verbal report on Winter Planning and Capacity.

24/093 **WORKFORCE RACE EQUALITY STANDARDS (WRES) AND WORKFORCE DISABILITY EQUALITY STANDARDS (WDES)**

The DCG on behalf of the Interim CPO highlighted the following key elements:

- Specific measures (indicators) to compare the workplace and career experiences of staff from Black, Asian and Minority Ethnic (BAME) backgrounds from white backgrounds;
- WRES and WDES action plans had been developed and there needed to be ongoing focussed work on key areas to ensure improved staff experiences, and aligning this with the work around culture and leadership programme, staff behaviour, and staff survey. Noting the Staff forum in place to obtain staff feedback to further support this work;
- Benchmarked data was currently under embargo, that would be presented to P&CC as well as monitoring progress against the action plans, and updates to be reported to the Board in the P&CC Chair Assurance Report.

The Acting Chairman enquired whether trends would be identified. The CE confirmed updates would include trends as well as comparison with local and national trusts.

The Board of Directors **NOTED** the WRES and WDES Action Plans for assurance.

24/094 **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS:**

24/094.1 **NOMINATIONS AND REMUNERATION COMMITTEE (NRC) – CHAIR ASSURANCE REPORT**

The NRC Chair highlighted the following key issues:

- Approval of the appointment of the substantive CPO;
- Progress update on the recruitment of a COO;
- Update on progress of the mid-year appraisal reviews for the CE, Executive Directors, and the year-end appraisal reviews for the NEDs.

The Board of Directors **NOTED** the 3 December 2024 verbal NRC Chair Assurance Report.

24/094.2 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

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

- Positive progress with closing open incidents and embedding business as usual within the Care Groups;
- Significant improvement of implementation of NICE guidelines that was currently exceeding the 26% trajectory;

- Association for Perioperative Practice (AFPP) external review, with good practice identified and opportunities for further improvement to ensure high standards of theatre practice. A further report would be presented early in 2025 for Q&SC to monitor progress of actions against the recommendations;
- NHSE's national review of the standards of all paediatric audiology services, there was a minimal risk of deafness not being identified. The main issues were around the external and local peer reviews and the quality of these, and that the tests were being carried out within an adult environment. The Q&SC would continue to closely monitor this service;
- Endoscopy backlog update with 17 cases of potential harm identified across all waiting lists with no further cases in December, and five cases being reviewed. Noted the effective harm review embedded process in place;
- Mixed sex accommodation breaches continued to be closely monitored, showing high rates of ITU stepdown breaches, with focussed work on patient flow and LoS to address and reduce these breaches.

The Board of Directors **NOTED** the 24 September 2024 Q&SC Chair Assurance Report.

24/094.3 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The FPC Chair reported on the following key issues:

- Trust would be exiting Tier 1 for cancer, diagnostics and elective, thanks to all staff for their hard work in achieving this;
- Good progress made in respect of grip and control and financial sustainability, noting out of the 109 actions that 96 had been completed, nine remained in progress and four remained outstanding. This would continue to be closely monitored to ensure ongoing progress;
- Verbal report from November FPC meeting, noting good progress against the performance metrics. Area of concern remained patients no longer fitting the criteria to reside that had deteriorated and continued to be a pressure issue, Trust continued to work with partners to address this in conjunction with the winter plan work;
- Over-performance against the CIP currently delivery of £26m against the planned £25.7m, with good progress looking at schemes for 2025/26;
- Month 7 financial position of the Group delivering a deficit of £7.5m against the month of £7.6m, and the YTD deficit of £53.9 against the £54m plan;
- Financial Sustainability Plan (FSP), and the Nurse staffing establishment review approved and recommended to the Board for approval.

The Board of Directors **NOTED** the 31 October 2024 FPC Chair Assurance Report and the verbal report from the 26 November 2024 FPC meeting.

24/094.4 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

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

- P&CC meetings now being held bi-monthly, with agenda items aligning for focussed discussions around the key risks within the BAF;
- Approval and recommendation for Board approval of the additional investment into the nursing establishment around future needs and

requirements, replacing agency staffing with substantive staffing in a number of areas;
- NSS and the good response rate of 54.7% and best ever achieved, thanks to staff for completing the survey and sharing their experience of working at the Trust. Awaiting the outcome of the survey with commitment to look at and focus on the actions from staff concerns and feedback that would also include EDI improvements;
- Review of exit interview results and the need for early interventions to address reasons raised to reduce staff leaving the Trust, supported by the culture and leadership programme work;
- Really good progress made with compliance on appraisal completion, now at 79.4% against the 80% target, with thanks to all staff in driving forward this improvement. Recognising the importance of the quality of these appraisals and discussions with staff around training and development opportunities;
- Good open and honest discussion about the WRES and WDES acknowledging not as much progress had been made as had as expected, and an action plan on how this could be improved, closing the gaps and ensuring embedding in all areas throughout the Trust to be presented at the next meeting.

The Acting Chairman confirmed the nursing establishment review had been approved by the Board at its Closed meeting held that morning.

The Board of Directors **NOTED** the 27 November 2024 P&CC Chair Assurance Report.

24/094.5 **CHARITABLE FUNDS COMMITTEE (CFC) CHAIR ASSURANCE REPORT**

The CFC Chair reported the next meeting would be held in January 2025, highlighting the extensive work and activity of the Charity team over the festive period visiting the various Trust sites, supported by the Executive Directors and League of Friends.

The Board of Directors **NOTED** the verbal CFC Chair Assurance Report.

24/094.6 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR ASSURANCE REPORT**

- **2GETHER SUPPORT SOLUTIONS (2GETHER) ANNUAL REPORT AND FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2024**
- **SPENCER PRIVATE HOSPITALS (SPH) 2023/24 ANNUAL REPORT AND AUDITED FINANCIAL STATEMENTS**
- **EAST KENT HOSPITALS CHARITY (EKHC) ANNUAL REPORT AND ACCOUNTS 2023/24 AND MANAGEMENT REPRESENTATION LETTER**

The IAGC Chair highlighted the following key points:

- 2023/24 Annual Reports and Accounts presented for 2gether, SPH and EKHC along with EKHC's Management Representation Letter approved and recommended for approval by the BoD;
- Good positive discussions in respect of progress of the governance programme, and improved governance arrangements and structure (corporate and clinical), this was an ongoing improvement journey to ensure these continued to be embedded;

- Assurance from Internal Auditors of monitoring outstanding management actions, escalation process in place to address these and robust monitoring required by the Executive Team on progress of the actions;
- Assurance of progress against the annual CIP and improving financial performance grip and control, processes were embedded and would continue to be closely monitored by FPC;
- Trust below subsector average of 70% in respect of declarations of interest, work being undertaken to improve the declarations required by staff, and a progress update would be presented to the next meeting;
- Assurance from External Auditors around embedding lessons learned from previous annual audits in preparation for the 2024/25 audit to ensure presentation of the draft annual accounts for approval to meet the submission deadline.

The Acting Chairman commented on the Board Committee meetings and the positive improvements of how these were operating in respect of their format, papers presented, discussions and challenge.

DECISION: The Board of Directors:

- **NOTED** the 1 November 2024 IAGC Chair assurance report;
- **APPROVED** 2gether's Annual Report and Financial Statements for the year ended 31 March 2024;
- **APPROVED** SPH's 2023/24 Audited Financial Statements;
- **APPROVED** EKHC's Annual Report and Accounts and the Management Representation Letter for 2023/24.

24/095 **ANY OTHER BUSINESS**

There were no other items of business raised.

24/096 **QUESTIONS FROM THE PUBLIC**

The Acting Chairman reported questions had been received in advance of the meeting and summarised these as noted below:

- Questions received from Mrs Bonney, Governor:
  - Question 1 - Would like to understand why if you book a blood test online the earliest you can get a test is a week in advance, and if you telephone the booking service you can get a test the next day? The letter sent to patients encouraged the use of the online booking system that identified a gap.
- The COO responded stating the online booking system introduced in 2020, noting there was limited provision of Phlebotomists and with online this was a week out with slots available for urgent and on the day appointments. There were plans for the Trust to increase its capacity at the Community Diagnostic Centre (CDC) by an additional 250 slots per week that would increase those available online.
  - Question 2 - Why requests for a blood test were by a letter, and why was letter not emailed or details sent to the blood test booking service or internal co-ordination between consultants and diagnostics?
- The COO responded commenting the Trust was looking at developing a Digital Strategy on how it could move to electronic platforms as other trusts had. Noting the future National push to utilise the NHS App and using the correspondence within this. The Acting Chairman noted a presentation on

the development of the Trust Digital Strategy would be at the January 2025 BoD Development Strategy Session, that would include how to enable patients receiving details of their appointments promptly electronically along with timelines.

- Question from Mrs Smith, member of Trust staff about band 2 Health Care Assistant (HCA) Workers doing a band 3 role of a clinical nature and when will the Trust see and give these staff the respect and remuneration with which they deserve. As a loyal NHS worker, not asking for the world, just the reward that most HCA'S deserve.

- The CE responded stating this was an issue in the Trust and for other trusts around a shift in National guidance, the Trust was working through how it ensured it was making these changes, work was in progress as well as discussions with all parties, with the aim to concluding these by the end of the financial year. It was noted a discussion about this had been held at the Closed BoD meeting held that morning.

24/097 **RESEARCH AND INNOVATION (R&I) REPORT**

The Acting Chairman reported the meeting was ahead of time and apologised that the R&I item would be deferred to the next meeting enabling the Director of R&I to attend to present to the Board.

The Chair closed the meeting at 3.50 pm.

Date of next meeting: Thursday 6 February 2025

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Matters Arising from the Minutes on 5 December 2024**

Meeting date: **6 February 2025**

Board sponsor: **Acting Chairman**

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 Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	None
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: None

MATTERS ARISING FROM THE MINUTES ON 5 DECEMBER 2024

1. Purpose of the report

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

2. Background

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

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

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/33/23	Present an update to the Board on progress monitoring the gap analysis, action plan, work needed and any additional support to enable implementation of the ten Sexual Safety in Healthcare - Organisational Charter commitments.	~~Jun-24~~/ ~~Jul-24~~/ ~~Oct-24~~/ ~~Dec-24~~/ Feb-25	Chief People Officer (CPO)	Open	**06.06.24 -** Initial principles implemented with training sessions provided, information available for staff on the Trust's staff intranet, liaising with other Trusts in respect of training best practice. Development of a specific policy around sexual safety and speaking up, and accessing support. Lead Freedom to Speak Up Guardian working on a paper to be presented to the July 2024 Board meeting. **July 2024 -** Update on Sexual Safety will be included in the regular six monthly Freedom to Speak Up (FTSU) report due to be presented to the October 2024 Board meeting, deferred to December 2024. **September 2024 -** The FTSU Team is experiencing a high number of absences. As a result, interim measures have been put in place to maintain the service by the Executive Team acting through the CPO as a priority. There is also a project to consider partnership working to ensure resilience and reliability of the service. This is being considered with the involvement of all key stakeholders. In the interim, the CPO will continue to report to the P&CC and to the Chair recognising this is a priority for the Board. This is also now a Significant Risk for the Trust. **January 2025 –** A decision has been made to outsource the FTSU service to an independent external provider

					to enable a 24/7 365 days a year confidential service and ensure long term sustainability of the service and reduce the associated risk.
B/09/24	Next PV&I Annual Report for 2024-25 to include statistics and data on how feedback from patients was being provided shown as a pie chart.	May-25	Chief Nursing & Midwifery Officer (CNMO)	Open	Item for future Board meeting.
B/15/24	**25.07.24 -** Present progress update CQC reports to the BoD at each of the bi-monthly meetings (increasing frequency from quarterly) to ensure oversight of progress to close the Must and Should do requirements. **03.10.24 -** Liaise with the Q&SC NED Chair about presenting a CQC and Well Led update report with progress updates on Must Do and Should Do requirements (trajectory for closure by December) to a future BoD meeting following presentation at Q&SC.	~~Oct 24~~/ Feb-25	CNMO	To Close	**03.10.24 -** The Quality and Safety Committee received a full update report on 24 September. In summary there are 12 Must Do (out of 28) and 7 Should Do (out of 25) requirements that remain open (some requirements feature on multiple action plans). The number of open actions related to each Must and Should Do is shown in the table below. There is a total of 32 out of 206 actions open across all action plans. Of these 32 open actions, 28 are expected to close by 30 October and 4 are expected to close by 31 December 2024. **05.12.24 -** CQC Update Report presented to 05.12.24 Board meeting. A**ction for agreement for closure at 06.02.25 Board meeting.**
B/19/24	Liaise working together to explore the feasibility of the Trust's website being able to translate/speak providing information/text into users preferred language choice. Also look at the feedback around difficulties of digital accessibility, and the feasibility of producing a video for health professionals raising awareness of how to	~~Dec 24~~/ Feb-25	Executive Director of Communications and Engagement (EDC&E)/ Associate Director of Patient Experience (ADoPE)	Open	**22.01.25 -** IT advise that most internet browsers allow translation of website content, therefore a plug-in is not needed. Communications agreed to work with IT on a simple guide, including how to switch this on if viewing the website on Android or Apple phones. The Patient Voice and Involvement team has delivered "seeing the person" sessions to all the staff in the William Harvey Hospital Emergency Department during November and December, as well as delivering sessions as part of the Ready to Care programme.

	speak/treat service users with empathy ensuring everyone had a positive patient experience when accessing healthcare services.				
B/20/24	Liaise with the ADoPE and Beyond the Page's Co-Chief Executive Officer to look at and explore the possibility of extending/ promoting opportunities available with Apprenticeship roles to migrant women in the community.	~~Dec-24~~/ Feb-25	CPO	Open	Verbal update to be provided at 06.02.25 Board of Directors meeting.
B/21/24	Liaise with NHSE's Improvement Director to schedule a future Board discussion session about the IIP vulnerabilities, risks and mitigations in place at a future Board Development Strategy Session.	Jan-25	Director of Corporate Governance (DCG)	To Close	**January 2025 -** Being explored for discussion at the January 2025 Board Development Strategy Session. **06.02.25 -** Discussion held at 9 January 2025 Board Development Strategy Session. **Action for agreement for closure at 06.02.25 Board meeting.**
B/22/24	Include in NED site visit feedback template section in respect of the risk management process and this supporting validation that this was effective, taking into consideration feedback from interacting with staff during these visits and their feedback on any areas of concern.	~~Dec-24~~/ Feb-25	DCG	Open	**December 2024 -** Online feedback template being looked at, to hopefully be in place by January 2025.
B/25/24	Include in future MNAG Chair Assurance Reports a summary of comparison data on how the Trust compared with similar Trusts in respect of its neonatal nursing	~~Dec-24~~/ Feb-25	CNMO/ Director of Midwifery (DoM)/ Deputy DoM	Open	Was being worked on, to be reported to MNAG prior to being reported to the Board.

	workforce percentage.				
B/27/24	Identify and schedule an additional extra-ordinary BoD meeting to be held in the next two weeks for Board members to discuss the MNAG report and the Clinical Negligence Scheme for Trusts (CNST) compliance elements.	Dec-24	DCG	To Close	Additional meeting held on 13.12.24. **Action for agreement for closure at 06.02.25 Board meeting.**
B/28/24	Raise with Integrated Care Board's (ICB's) Chief Executive (CE) whether producing a local system-wide risk register was being looked at as part of the development of the ICB Kent & Medway (K&M) Strategy.	Feb-25	CE	Open	Verbal update to be provided at 06.02.25 Board of Directors meeting.
B/29/24	Check and confirm whether the 372 bed gap in 2024 was an increase or decrease from that in 2023.	Feb-25	Chief Operating Officer (COO)	Open	Verbal update to be provided at 06.02.25 Board of Directors meeting.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Patient Story**

Meeting date: **6 February 2025**

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

Paper Author: **Lead for Patient Voice and Involvement**

Appendices:

Appendix 1: Slide deck – training programme

Executive summary:

Action required:	Information
Purpose of the Report:	To hear the stories of patients who are homeless and understand some of the key issues they have shared with the Patient Voice and Involvement Team during a co-production exercise that has resulted in patient-developed training. This training will be delivered to staff by the Patient Voice and Involvement Team and will include video footage of the Emmaus Companions who shared their stories. These patient stories highlight both negative and positive experiences and how care, compassion and understanding makes a positive patient experience more likely.
Summary of key issues:	Working with Emmaus, a local charity working to end homelessness, we identified an opportunity to develop training to raise awareness with operational staff across our trust around the following issues: • Using a holistic approach when treating a patient with no fixed address; • Trust, respect and dignity when treating a socially marginalised patient; • The risks and impact of prescribing certain medications; • Safe and appropriate discharges for homeless patients; • The individual, service and system-level barriers to accessing services for people with complex health and social care needs. Emmaus will be present at the Board meeting.
Key recommendations:	The Board of Directors are asked to commit to ensuring our services: • Demonstrate compassion to those we look after; • Model compassionate leadership; • Work to improve the experience of vulnerable people, including those with pre-existing conditions, mental health, homeless people and substance abuse, when they are receiving care within the Trust.

Implications:

Links to Strategic Objectives:	• Quality and safety • Patients
Link to the Trust Risk Register:	**CRR 1579:** Detriment to patients with a disability as we are non-compliant with the statutory Accessible Information Standard (AIS) and Reasonable Adjustments Digital Flag.
Resource:	No
Legal and regulatory:	Care Quality Commission (CQC) regulations. NHS England guidance on involving people and communities. Equality Act 2010 public sector equality duties.
Subsidiary:	No

Assurance route:

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

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"Why does nobody understand and listen to me?" – Anonymous

A training programme co-designed and
co-produced with the homelessness charity Emmaus Dover

"You don't know my story"
-Anonymous

We care

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East Kent Hospitals University NHS Foundation Trust

The creation of this programme…

The Patient Voice and Involvement Team works with communities that may not have a voice that is heard when giving feedback on their treatment in hospital. After meeting with the 27 Companions living at Emmaus Dover, it was clear that their experiences were not the high standard that we are aiming for in our hospitals. The feedback led to this programme being co-designed and co-produced with the companions and staff members. This is them telling their story and getting their voices heard.

Emmaus is a non-religious community made up of staff, volunteers, and 'Companions'. Companion is the name they use for their residents who live and work together within their Community homes.

"Staff treat us like alcoholics and drug addicts"
-Anonymous

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Learning Objectives

This programme will benefit frontline staff across our trust by raising awareness on the importance of;

- Using a **holistic approach** when treating a patient with no fixed address
- **Trust, respect and dignity** when treating a socially marginalised patients
- The **risks and impact** of prescribing certain medications
- **Safe and appropriate discharges** for unhoused patients
- The individual, service and system-level **barriers** to accessing services for people with multiple needs

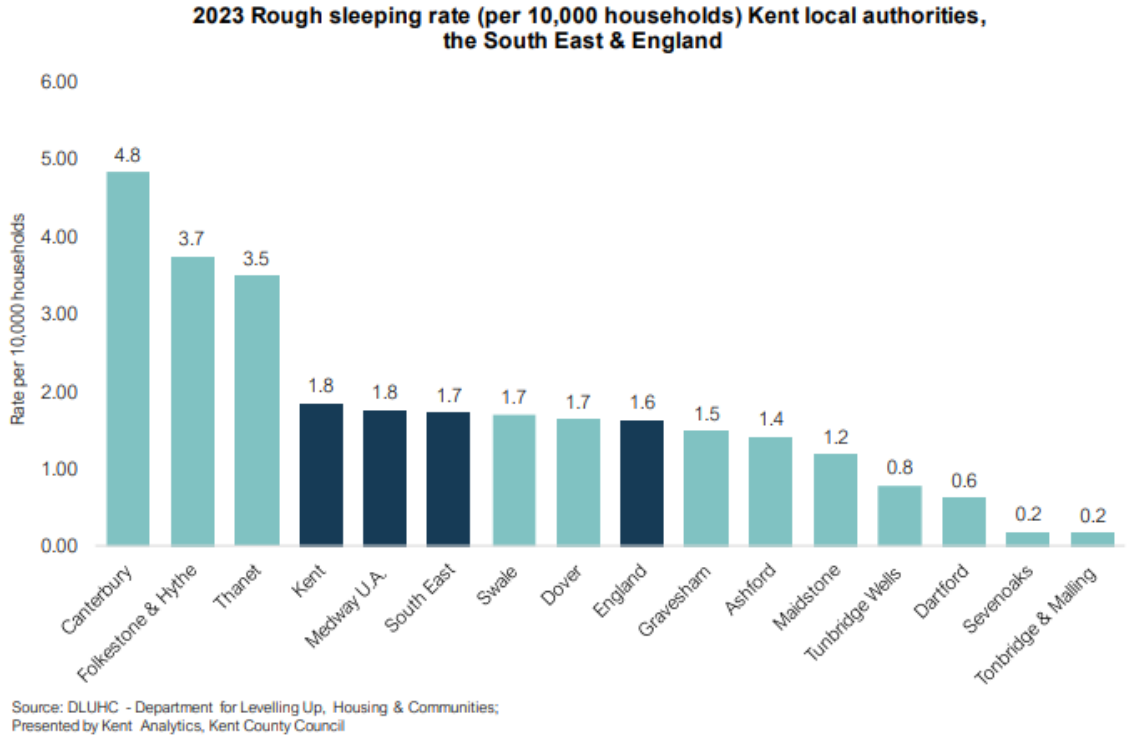
"Open your eyes, wake up"
-Anonymous

We care

Homelessness in East Kent

East Kent Hospitals University NHS Foundation Trust

Chart 1: Rate of rough sleepers per 10,000 households: 2023



Source: DLUHC - Department for Levelling Up, Housing & Communities;
Presented by Kent Analytics, Kent County Council

The Annual Rough Sleeping Snapshot shows that an estimated 3,898 people were sleeping rough in England on a single night in autumn 2023.

When comparing Kent to the South East and England figures Kent has a slightly higher rate of rough sleepers per 10,000 households than seen nationally and regionally.

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The Three Key Themes

1. Labelling, bias and misunderstandings
2. Prescriptions
3. Safe discharges

"Being homeless is not a disease"
- Anonymous

We care

What causes homelessness?

- Homelessness is a complex issue that can be caused by various factors. Understanding the different causes of homelessness is crucial in order to effectively address and support individuals who experience unstable housing.
- By understanding the various causes of homelessness, we can work towards developing integrated approaches that address the underlying issues and increase access to support.

'If a homeless person presents at a hospital, it will probably mean that they have something urgent to be looked, at as they will be aware of the prejudices they will be faced with.'
– Emmaus Leader

Theme 1 – Labelling, Bias and Misunderstanding

East Kent Hospitals University NHS Foundation Trust

What causes homelessness?

Loss of employment	Lack of social housing	Inequality and discrimination
Cost of living crisis	Lack of mental health and addiction treatment services	Family conflict
Domestic violence	Substance misuse	Traumatic life events

"Don't treat me like a criminal"
-Anonymous

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Theme 1 – Labelling, bias and misunderstanding

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VIDEO

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Barriers to healthcare

- Being homeless increases the difficulties people face in accessing health and education services due to their locations or not having official documents for registering for the services. Some people feel embarrassed being regarded as homeless.

- If a person is homeless, they may move around geographically which can also mean there is a lack of continuity in the healthcare and education they receive. Healthcare and education services are not usually joined up, which may mean a breakdown in services being offered to a homeless person.

"Don't judge the fact I'm not registered with a GP" – Anonymous

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What is multiple disadvantage?

- Multiple disadvantage refers to the experience of facing a combination of different challenges and barriers that make it even more difficult for individuals to access and benefit from services and support. It is important to understand that multiple disadvantage is not about a single issue or disadvantage but rather the cumulative impact of several factors that intersect and compound each other, resulting in a more complex and entrenched situation for those that experience multiple disadvantage.

- These factors can include but are not limited to, homelessness, substance use, mental health issues, poverty, unemployment, domestic violence, language or cultural barriers, and lack of access to adequate education. Each factor on its own can result in barriers and significantly impact an individual's ability to access and engage with services, but when they coexist, they create a web of compounding challenges that can seem overwhelming to overcome.

Just because someone presents at a GP practice or a hospital unshaven, in dirty clothes and under the influence of a substance/alcohol doesn't mean that they are not in any less pain than someone smartly dressed'
– Emmaus leader

We care

Prescriptions

- We heard that on more than one occasion healthcare professionals prescribed medication that fed into a person's addiction. The most common of this example is Co-Codamol which is an opioid and could very quickly lead to someone returning to Class A drugs.

- Medication cannot be seen as a quick fix. An unhoused patient needs to be treated with a holistic approach, so that underlying (physical and mental) health conditions are not missed.

'It seems to be seen as a very quick fix to keep doing repeat prescriptions without any medication reviews leading to someone becoming addicted to the medication.' – Emmaus leader

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Prescriptions

- Medication is often prescribed without any questions being asked and with no information gathered about the current medication a person is taking; the patient can then experience serious complications.

- An example of this: The side effects of Ibuprofen. Ibuprofen can reduce the effect of anti-depressants, which is only explained on the side effects leaflet that comes with them. Someone in pain could increase the possibility of doing harm to themselves or others without an understanding of what is happening. For some, an addiction could lead to them becoming homeless or committing crimes: all because no-one asked the right questions or listened to them at time when they needed help the most.

"Treat me holistically, not like a number" - Anonymous

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Ensuring safe discharges

- Patient safety is important, and we need to treat all of our patients according to their needs. Think about the time of day and their destination. Being discharged with no where to go in the early hours of the morning can be **scary and dangerous.** *Have the homeless pathway team been contacted? Has the discharge destination charity (if applicable) been made aware of the discharge? Has the patient got sufficient funds to get home or to the place where they are sleeping?*

- Ensure the patient knows what to expect post-discharge, so they don't feel abandoned when leaving the hospital. Also think about whether the patient will have difficulties accessing aftercare (i.e. if they aren't registered with a GP).

- When prescribing medication, be aware that some patients will not have a HC2 certificate or have access to a pharmacy.

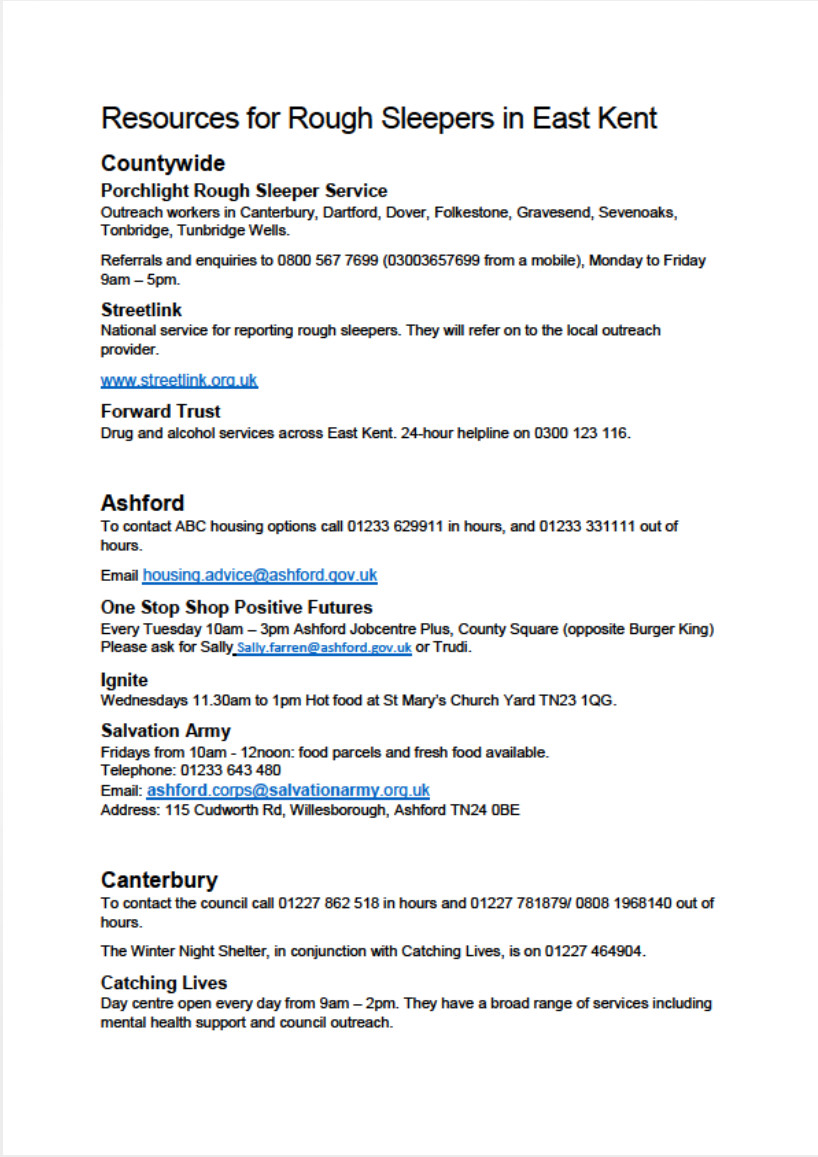
"I'm human. Treat me like one" - Anonymous

We care

Signposting to other services

East Kent Hospitals University NHS Foundation Trust

- To be updated



Resources for Rough Sleepers in East Kent

Countywide

Porchlight Rough Sleeper Service
Outreach workers in Canterbury, Dartford, Dover, Folkestone, Gravesend, Sevenoaks, Tonbridge, Tunbridge Wells.

Referrals and enquiries to 0800 567 7699 (03003657699 from a mobile), Monday to Friday 9am – 5pm.

Streetlink
National service for reporting rough sleepers. They will refer on to the local outreach provider.

www.streetlink.org.uk

Forward Trust
Drug and alcohol services across East Kent. 24-hour helpline on 0300 123 116.

Ashford

To contact ABC housing options call 01233 629911 in hours, and 01233 331111 out of hours.

Email housing.advice@ashford.gov.uk

One Stop Shop Positive Futures
Every Tuesday 10am – 3pm Ashford Jobcentre Plus, County Square (opposite Burger King)
Please ask for Sally Sally.farren@ashford.gov.uk or Trudi.

Ignite
Wednesdays 11.30am to 1pm Hot food at St Mary's Church Yard TN23 1QG.

Salvation Army
Fridays from 10am - 12noon: food parcels and fresh food available.
Telephone: 01233 643 480
Email: ashford.corps@salvationarmy.org.uk
Address: 115 Cudworth Rd, Willesborough, Ashford TN24 0BE

Canterbury

To contact the council call 01227 862 518 in hours and 01227 781879/ 0808 1968140 out of hours.

The Winter Night Shelter, in conjunction with Catching Lives, is on 01227 464904.

Catching Lives
Day centre open every day from 9am – 2pm. They have a broad range of services including mental health support and council outreach.

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Video from companion discussing signposting/what patients want on discharge

East Kent Hospitals University NHS Foundation Trust

Finish with an impactful video (different clips/quotes from different companions edited together to finish on)

"Please treat me with respect."

"If I ask for help, please help me."

"Ask me questions that are relevant."

"Don't just push me aside."

"We are all human and deserve to be treated in fair and equal manner."

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Resources to support you…

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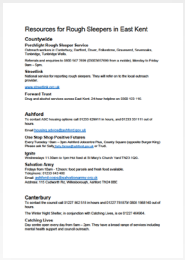
CLICK THE IMAGES FOR MORE INFORMATION


Resources for Rough Sleepers in East Kent

Countywide

Ashford

Canterbury

Making a homeless referral

Signposting (As on slide 14)

Identifying patients experiencing homelessness

Admission and Discharge support

Resources (on staff zone)

Our statutory responsibilities

Homeless Pathway team

Safeguarding

We care

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East Kent Hospitals University
NHS Foundation Trust

Research and Innovation (R&I) Board report February 2025

Ms Jessica Evans

Director R&I and EKHUFT Clinical Trials Unit

Consultant Colorectal Surgeon

We care

Background

- Change of R&I strategy

Focus - commercial / interventional & homegrown

- Review of roles and responsibilities

Improve efficiency

Workforce planning

- Merger of oncology and haemoncology teams – Cancer research team

- Finance review

Recruitment

- Pledge for 2023-24 was 1067 and we exceeded the target with 1987 recruits. 2024-25 pledge is 1014 and we are on track to exceed it again this year.

- 2023-24 we opened 55 new studies, 84% of which were commercial/interventional.

Type	2023-24	2024-25
Non-commercial Observational	9 (16%)	5 (20%)
Commercial/Interventional	46 (84%)	20 (80%)
TOTAL	55	25

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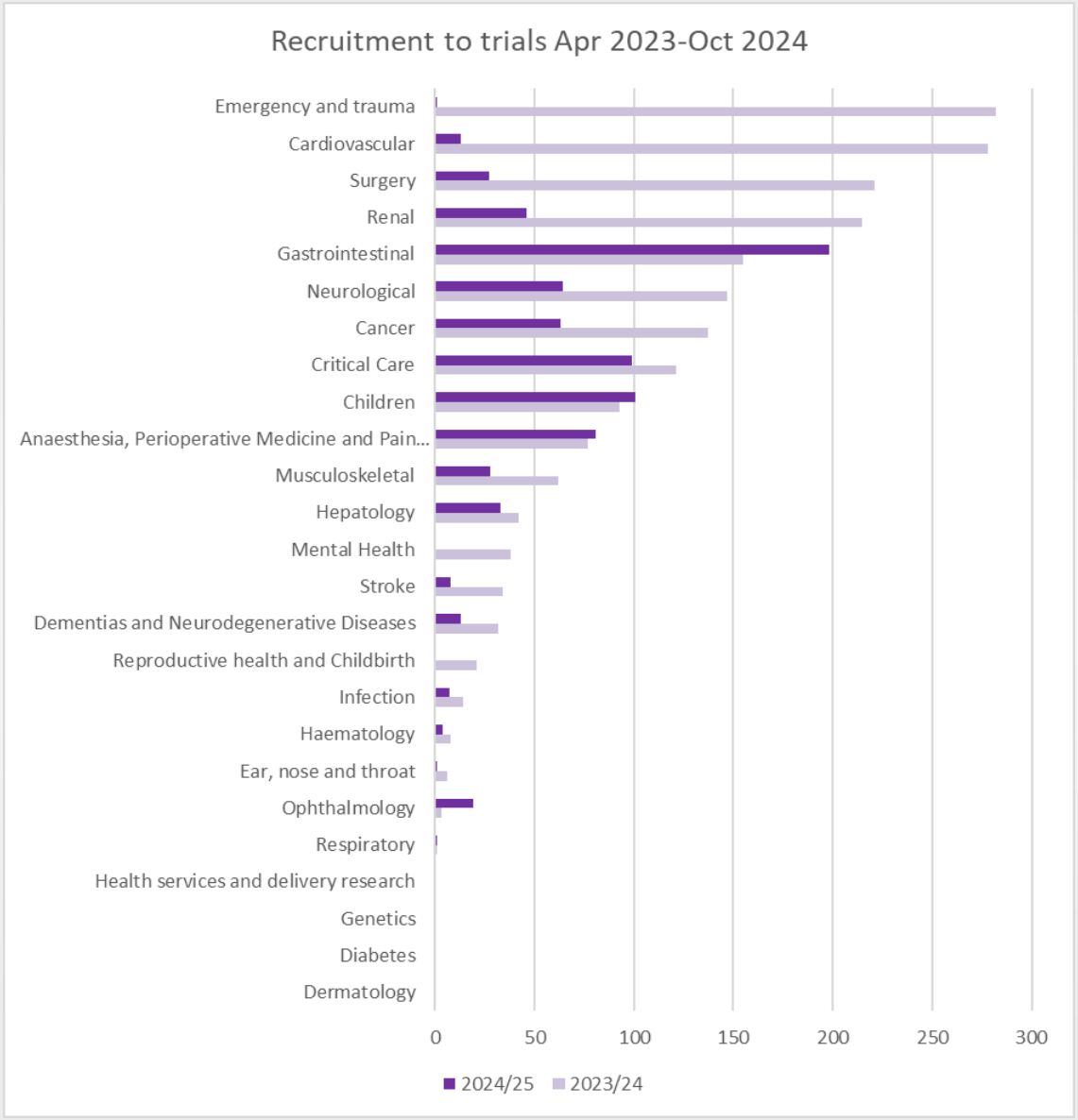


We care

Commercial studies

- Cost savings 2023/24 - £143, 670, plus estimated drug cost savings in excess of £1.3M in 18 months

Income:

- 2022/23 - £566,095
- 2023/24 - £840,490

- 2024/25 Invoiced £825,000 FY so far, projected over £1M by end financial year

- **35 Grey Area Projects** (GAPs) registered and approved so far in 2024 (tracking ahead of last year's total of 42 for the whole year) – home grown research and innovation.
- **133 papers with EKHUFT authors.**

  Of which 64 had EKHUFT as first author.
- Successful appointment Anaesthetic & Haem **research fellow** - increased recruitment.
- Professor and 2 x joint clinical-academic Allied Health Professional (AHP) roles with Canterbury Christ Church University (CCCU)

- **Unsuccessful Robot bid from National Institute for Health & Care Research (NIHR) & commercial research centre**

- **Academic clinical fellows** – awarded NIHR

  Renal in place. Surgical start October 2025

Cancer team merger

- 2022-23, before the merger, the Haem Onc and Oncology teams set up **5 studies** (4 of which were commercial and/or interventional) and recruited 155 participants (7 to commercial studies and 98 to non-comm interventional).
- **2023-24** the teams set up **9 studies** (8 were commercial and/or interventional) and recruited 113 participants (including 8 to commercial studies and 96 to non-comm interventional studies).
- So far in 2024-25, the team has opened 5 new studies – all commercial, and recruited 67 participants, 11 to commercial studies and 54 to non-comm Interventional studies)

- That equates to an **increase in commercial and/or Interventional activity** post merger.

- Setup – increase in commercial/interventional studies from 80% in 2022-23 to 89% in 2023-24, then a larger increase with 100% of studies setup being commercial/interventional so far in 2024-25.

Clinical Trials Unit (CTU)

- Facility opened June 2022
- **8 open studies** running through CTU – mix of home grown (CI) and commercial.

- **5 successful grants (Total value £1.165m)**
- £70k NIHR ARC – Paediatric Speech & Language Therapy (SALT)
- £250k NIHR ICA – Paediatric Physiotherapist
- £125k.NIHR ICA – Paediatric Occupational Therapy (OT)
- £240k Innovate UK – External partner - extended reality for digital mental health.
- £500k ISOFITTER – Hypertension

- **4 grant applications submitted and under review (total value approx. £1.3M)**; 4 of which are with external partners (including Secondary Care, Primary Care, SMEs)
- **ICU mouthcare** – funded by Stryker.

Studies opened in 2023/2024

- ANTIFECHEMO – still open (Adjuvant antimicrobial effects on human blood samples)
- Gum-GB – still open (Understanding changes in the gut microbiome in patients with gallstone disease and its impact on patient outcomes)
- VESPA – still open (Virtual Evaluations of joint health using wearable Sensors in Persons with haemophilia)

Closed studies in 2023/2024

- Home-based Electroencephalogram (EEG) neurofeedback to reduce chronic neuropathic pain, a cohort clinical trial – **over recruited**
- PROFILE – **over recruited (**Progression of haemophilic joint health)

- **11** studies currently in various stages of development

Other events

- September 2023 Board event

- March 2024 - **Let's Talk Research: Collaboration can make it happen!**

Organised and joint hosts. Excellent feedback.

- **Feb 2025 - PI meeting**

Six stages of crisis

NHS
East Kent Hospitals University
NHS Foundation Trust

All externally funded

We care

- Patients treated in research active institutes have better health outcomes.

- Clinical research is the single most important way in which we improve our healthcare – by identifying the best means to prevent, diagnose and treat conditions. *(gov.uk policy paper)*

Summary

- ‘New beginnings’ established
- Strategy progressing ahead of target
- Finances / income increasing

- *Challenges / the future*

Ongoing increase interventional / commercial studies – space/ staff

Embedding research at the heart of everything we do

Care group adoption as part of every day practice

Large NIHR grants for Trust

Reaching point of having to turn away commercial Clinical Trial of an Investigational Medicinal Product (CTIMPs) (including cancer studies with novel treatment) – will cap commercial income and treatment options for patients.

Cancer RDT

East Kent Hospitals University NHS Foundation Trust

- **TRAC** - this has been a benefit to the patient and organisation. De-escalating treatment therefore **massive cost** and time saving to the trust.
- **Her-2 Radical** - Again treatment de-escalated. **Top UK recruiter**
- **Optimissm** - Received notification in April ‘24 that the **study published in European journal of Haematology was one of the top 10 most-cited papers. MYELOMA study**, Dr Lindsay Cited.
- **RADAR** - **One of UK highest recruiters**. Personalised treatment and giving access to additional treatment for high risk patients.
- **FLAIR**- June ’23 received copy of article in **The Lancet** with Dr Young cited.
- **MajesTEC-7** - **1st UK patient** recruited. Access to novel treatment.
- **Excaliber - highest UK recruiter**
- **Beigene 304/305** - Zanubrutinib proved to be of benefit with limited side effects in CLL. Long Term extension study opened to allow continued access
- **Polarix** - This study meant Polatuzimab became first line DLBCL

We care

QEQM RDT

- **NAIAD** -**cost saving £126,000** in GI genius equipment and service included and recruit 200 patients. Investigating if use **AI** increases polyp detection rates.

- **Silver** – **top recruiting international study**. Commercial study of wound dressings. Chief investigator at QE.

- **Harmonie** - a phase III randomised study of nirsevimab (versus no intervention) in preventing hospitalisations with RSV infection in babies. 19 babies recruited at QEQM. Link - Press Release: Nirsevimab delivers 83% reduction in RSV infant hospitalizations in a real-world clinical trial setting. They are hoping that this will become part of the vaccine program for infants.

- **SDEC study** –Randomised study duration of treatment in UTI. Determining length of antibiotic treatment in pyelonephritis. Will **change practice.**

- **Chelsea II-** end of life care study. New area of research in Trust.

- **Infinite lock** – commercial study in orthopaedics. Novel zip tie for shoulder dislocation.
- **SCBU** – **International study** surfactant down Endotrachael tube vs igel tube

- **Airways** – over recruitment. Randomising cardiac arrest comparison intubation
- **Radical** – randomised denervation spine. Pain control.

KCH RDT

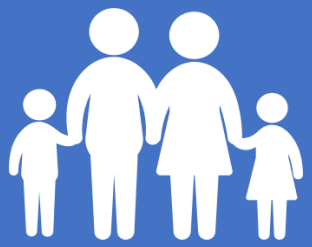
- **Turing** – 2nd highest recruiter nationally - A randomised, two-arm (1:1 ratio), double blind, placebo controlled phase III trial to assess the efficacy, safety, cost and cost-effectiveness of rituximab in treating de novo or relapsing NS in patients with MCD/FSGS (TURING)
- **Frexalt** – first recruit in Europe - comparing frexalimab (SAR441344) to placebo in adult participants with nonrelapsing secondary progressive multiple sclerosis – we were the lead for this one and Harikrishnan is CI.
- **Perseus** – highest recruiter nationally Comparing Oral SAR442168 to Placebo in Participants With Primary Progressive Multiple Sclerosis
- **Find-CKD** – 2nd highest recruiter nationally - Efficacy and safety of finerenone in subjects with non-diabetic CKD – recruited 6 patients
- **Origin-3** - first recruit nationally - Study to Evaluate the Efficacy and Safety of Atacicept in Subjects with IgA Nephropathy (IgAN) – recruited 2 against a target of 1
- **Sapphire** – first recruit nationally - Study of Obexelimab in Patients with Warm Autoimmune Hemolytic Anemia

Feedback

"the whole EKHUF team have been fantastic in set-up. From the 13 sites 'selected' for this project, EKHUFT have been the easiest and most professional to work with"

"the team were very helpful and set-up time was good"

"Great team to work with, communication and feedback was from all departments."



"a pleasure to work with, always responsive and proactive."

Research & Innovation
Good for you, good for the NHS

NHS
East Kent Hospitals University
NHS Foundation Trust

Participant in Research Experience Survey (PRES) 2023/24

EKHUFT 247 Surveys returned

48%

"Fantastic care by all the staff "

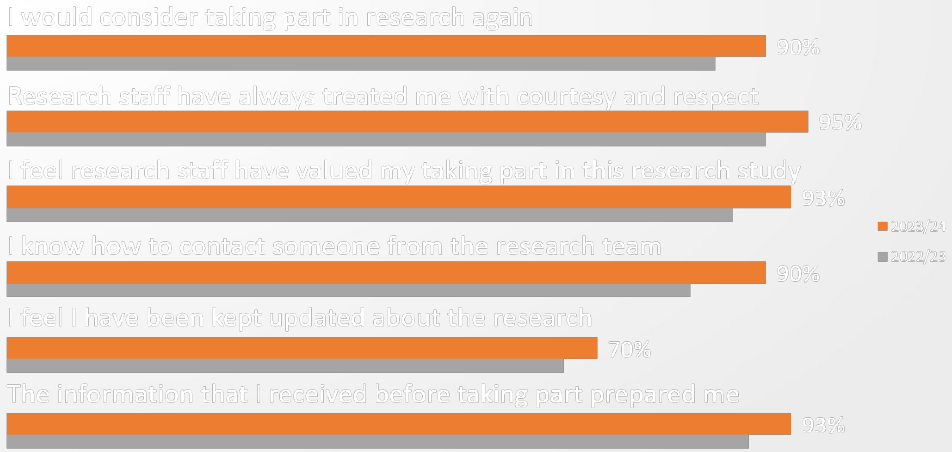
"I have felt I have learnt more about my medical condition and also had regular updates."

"To feel part of something positive; improve future health care"

"I have enjoyed being part of the study. Everything was explained and I was looked after really well."

"Good guidance and support from research team. Being kept up to date with progress. All staff polite and professional, at all times. Thank you."

"It was good to have somebody else to talk to at what was a difficult time of my life."



We care

East Kent Hospitals University NHS Foundation Trust

Chairman's Report, January 2024

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

If my last report was a look back over 2024, this report looks forward to the upcoming year.

Invariably our starting point in January is always the enormous strain and pressures we experience as an acute trust with two Emergency Departments (EDs). There is no doubt that patients and staff have experienced a really challenging start to the year. The cold weather; increased levels of flu; and ever-increasing numbers of patients attending our EDs at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) has led to significant strain on our acute service. The compounding effect of Norovirus at QEQM was another unwanted but all too common challenge for us and others across the NHS. I am pleased to say that at time of writing all but one ward remained closed at QEQM.

It has and continues to take an enormous team effort to cope with the numbers of patients we are seeing in our EDs. I often feel totally overawed by the calm, professional and caring way our staff – and others such as our Paramedics and our 2gether Support Solutions (2gether) colleagues – approach what is rightly described as the national winter crisis. In our case we have particularly struggled with our 12 hour waits; contrasted against our 4 hour (Tier 1) target where we are exceeding national targets.

My sincerest thanks to all those involved with our EDs and their super-human efforts over the last few months.

Trust Strategy

Looking forward, I want to draw attention to the work underway on the Trust strategy. This is a crucial moment for the Trust. In step with the NHS 10-year strategy, we have also embarked on our own 10-year horizon view and strategic direction. In formulating our strategy, I am particularly pleased at the breadth and scope of the engagement we have undertaken. It has been vitally important to hear from as many people as possible who care about the Trust's future direction. Hundreds of people who come into contact with our Trust whether as patients, staff, partners or commissioners have informed the direction we propose to take. It is an energising process for the Board to think about where we want the Trust to be but one which carries considerable responsibility too. We will continue to share details on our direction of travel as we formulate them in upcoming Boards.

Staff Survey

Another crucial touchpoint for the work the Trust is doing is our Staff Survey results. The Board were encouraged we met our first target of significantly increasing engagement and the numbers of our colleagues who have completed the survey is the highest we have had in many years and tracked very high across the NHS. I want to thank everyone who took the

time to share their experiences of working for EKHUFT and those in the team who worked tirelessly to encourage completion.

We will begin to see results from the Staff Survey in the next month or so and Tracey and her team will report into our People & Culture Committee and to the Board. These results will continue to inform the Trust's culture and leadership workstream and the Board are very aware of the effort and time it will take to really improve the collective experience of our 10,000 strong workforce.

Council of Governors

I was grateful to Olu who in my absence chaired our regular Council of Governors meeting this month. The Governors provide invaluable input and do a vital job in holding our non-executive directors to account. They provided important insights from the perspectives of our members and the wider communities we serve. The Governors heard from each of our non-executive director chairs of Board sub-committees and their assessment of the performance of the Trust.

In addition to updates on the Trust's performance and activities, the Governors also heard details of our plans for data, digital and technology. Explanatory details of the Trust's new employee voice forum was also shared.

I want to repeat my thanks to our Governors on behalf of the Board for their continued commitment to representing the views of our communities and the time they give to the Trust.

Board changes

The Trust's executive director positions are now all filled with substantive, permanent appointments. Norman Blissett joined us this month as the Trust's new Chief People Officer and we will also welcome Dan Gibbs from Hampshire and Isle of Wight Integrated Care Board (ICB) in February as our new Chief Operating Officer. We are delighted to have both of them in the Trust as they bring considerable proven experience over many years in the NHS.
We are also advertising for two non-executive roles on the Trust's Board. Link to the advert will be available on the Trust's website and we welcome a broad and diverse range of applicants who feel they can help lead the Trust. Please do look.

I will close where I started and recognise the ongoing challenges patients are facing in our EDs. The seasonal pressures continue and we all recognise that our 12-hour wait is not where we want it to be and a considerable amount of effort is being made to address this. Equally I want to recognise the effort and dedication of our front-line ED staff who are making a huge difference to people's lives in very difficult circumstances.

Acting Chairman
Stewart Baird

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **6 February 2025**

Board sponsor: **Chief Executive**

Paper Author: **Chief Executive**

Appendices:

N/A

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	The Chief Executive's Report provides an update on key activities and events in the Trust. The report highlights the national context, the Trust's developments, achievements and provides strategic updates.
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 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

1.1 The Chief Executive's Report provides an update on key activities and events in the Trust. The report highlights the national context, the Trust's developments, achievements and provides strategic updates.

2. INTRODUCTION

2.1 Executive appointments

As reported previously, Rob Hodgkiss, the Trust's Chief Operating Officer, will be leaving his role at the end of January, having served just over one year in post. A recruitment exercise for Rob's successor has been undertaken and Dan Gibbs, will join the Trust on Friday 7 February 2025 from NHS Hampshire and Isle of Wight Integrated Care Board.

Debbie Viner, who took over from Andrea Ashman as Interim Chief People Officer in August 2024, will also leave the Trust at the end of the month. Norman Blissett, who worked for the Trust between January 2022 and November 2023 as Deputy Chief People Officer has been appointed to the substantive Chief People Officer role having spent the intervening period at Kings College Hospital NHS Foundation Trust.

I would like to take this opportunity to thank Rob and Debbie for everything they have done at the Trust and for their commitment to East Kent.

3. CLINICAL EXECUTIVE MANAGEMENT GROUP (CEMG)

At meetings of the CEMG in January 2025, the group approved a business case to right size theatre staffing levels across the Trust to reflect 46 weeks of elective activity and 52 weeks of emergency activity at the Queen Elizabeth the Queen Mother Hospital (QEQM) and William Harvey Hospital (WHH) and 50 weeks of elective activity and 52 weeks of emergency activity at Kent & Canterbury Hospital (K&C).

The group also approved the Social Media and Digital Engagement Platform policy and agreed for a business case to be developed for Paediatric Critical Care and Oncology Shared Care, with the Trust recommended to become a designated centre for Paediatric Critical Care (PCC) providing Level 2 care, and a Paediatric Oncology Shared Care Unit (POSCU) delivering enhanced level care locally to children from April 2025.

4. INTERNAL UPDATE

4.1 Performance update

The past year has seen improvements in a range of performance measures which are positive for patient care and experience. The number of patients waiting 78

weeks or more for treatment significantly reduced from a high of 752 in January 2024 to just 7 at the end of December 2024 (currently 1). Consistent reductions have also been achieved in the number of patients waiting 65 weeks or over since January 2024, with a reduction of over 2,300 patients in this position, from a high of 2,698 in January to 219 at the end of December 2024, with a further reduction to 165 by the end of the month.

The number of patients waiting six weeks or more for a diagnostic test has reduced significantly, increasing performance to 81% being seen within 6 weeks, which is the Trust's best performance in four years.

The backlog of Endoscopy waiters for routine and surveillance procedures has reduced by just over 9,000 since December 2023 to 373 at the time of writing. There is still, however, significant further progress required in performance on a range of fronts, in line with national standards which the Trust's patients should expect to be meet, most notably the Cancer Faster Diagnostic Standard and 12hr waits in our Accident & Emergency (A&E) department. Improvements have been made across both these indicators, however there is more to do to address this position for patients.

National elective reform guidance published in January 2025 captures the national position, such that 6.3m patients are waiting for circa 7.5m appointments, procedures or operations, with two in five waiting more than 18 weeks. Intensive work will be required by all NHS Trusts over the coming four years to meet the new Government's expectations that are set out in this guidance. The Trust's starting point means that we need to double down our efforts to continue to achieve the progress that we have began to see over the past 12 months and ensure this is sustained.

4.2 Finance update

The Trust's pre-non-recurrent deficit support revenue allocation to month 9 (December 2024) is £69.2m against a planned deficit of £67.1m; a £2.1m adverse variance year to date. Until Month 8, the Year to Date position had hit the monthly planned deficit figures. In Month 9, there was an overspend by £2m against the planned deficit figure. However, the profile of the plan in the final four months of the year and Trust's reducing run rate suggests that the Trust will recover this overspend and still meet the plan for the full year. The Trust remains focused to ensure that the planned deficit for the full year is met, and managing risks to the position which include operational pressures, surge demand and the impact on elective (i.e. planned) work.

Detailed finance information is available in the finance report.

4.3 People initiatives

The 2024 NHS Staff Survey closed on Friday 29 November 2024 with a much-improved response rate of 63% when compared to previous years. To put this into

context, this represents a 22% increase from last year (41%) and is 15% ahead of the national average (48%).

Over 6,000 staff shared their feedback, which is 2,000 more than last year. The response rate was representative across various groups, with every Care Group and Staff Group achieving a majority, and some groups improving by as much as 28%.

The results were received early in the New Year, and we have already begun analysing the data to identify key themes. Towards the end of the year, we adopted a more progressive approach, enabling us to socialise the results earlier and act on them quicker.

While we are under the national embargo until March, workshops will be held across the Trust, involving staff in the actions taken in response to the survey. This will support our ongoing efforts around strategy, culture and leadership.

5. EXTERNAL UPDATE

5.1 Winter vaccination pop ups

Whilst the number of patients with flu fluctuates, it continues to place additional demand on our services and can also be a very serious illness. In response to this we have set up flu and Covid pop-up vaccination clinics at the K&C, the QEQM and WHH entrances, which will be open to all eligible visitors and patients, with no appointment necessary. Vaccination is free, quick and easy and remains the best way to protect ourselves, each other, our patients and our families and friends as these viruses circulate and peak in waves through the winter months.

6. OTHER AREAS TO NOTE

6.1 Care Quality Commission inspection of Maternity Services

The Care Quality Commission (CQC) carried out a two-day inspection of the Trust's maternity services at the WHH and QEQM on Wednesday 4 and Thursday 5 December 2024.

I would like to thank everybody who took part and supported the inspection team's visit, detailing the improvements that have been made since their last visit.

The CQC will continue to verify the evidence it has gathered and we will continue to provide any further evidence that should be requested in advance of any feedback and their report being published.

6.2 Developing our Trust Strategy

The Strategy and Partnerships team have been coordinating a comprehensive engagement programme with staff, patients and our wider health and care partners to codesign the Trust strategy. Since August 2024, they have met with

44 clinical specialties to explore the speciality's short, medium and long terms clinical goals and actions for their services. The richness and diversity of the output from these sessions has been invaluable.

In addition to specific service goals we have also distilled themes around workforce, digital enablement and research and development opportunities. This work will feed into a prioritisation process whereby the Trust leadership team will consider all of the outputs and from that determine the shape and content of the Trust's clinical strategy for the next 10 years.

In tandem, we have been working with our external partner, Kaleidoscope, to develop our overarching organisational strategy that sets out our purpose, vision and strategic aims. Between October and December 2024 a total of 28 engagement events were held both online and face-to-face and we have heard directly from over 700 members of staff, through face to face meetings on all of our sites and through an online survey. We have also spoken with patient groups and held 12 guided interviews with a wide range of our system partners. We have extensively explored both our current reality and our future vision for the organisation that we want to be by 2035.

Through this process of engagement and co-design, we have been able to clearly identify what matters to our patients, staff and partners. This will provide the bedrock for our organisational strategy, which I look forward to sharing with you in the coming months.

6.3 Official unveiling of the new MRI unit at Buckland Hospital

The new state-of-the-art MRI unit at the Community Diagnostic Centre (CDC) at Buckland Hospital was officially opened on Monday 9 December 2024.

This unit represents the final phase of the NHSE CDC capital project funding for the Dover site, which will be open seven days a week, increasing diagnostic capacity and reducing patient waits.

Work to expand diagnostic services at Buckland Hospital began in 2021, with a new CT scanner, followed by a mobile MRI scanner, and new consultation, changing and waiting rooms, whilst existing ultrasound and X-ray services have also been expanded.

This new facility increases capacity, reduces pressure on the acute hospital sites, whilst improving health outcomes for local patients by providing faster diagnoses and is another important step to ensuring we are providing the right care, in the right place, at the right time.

6.4 Cardiac Resynchronization Therapy at the WHH

The cardiology team at the WHH were the first in the UK to install a new generation of Cardiac Resynchronization Therapy with Defibrillator (CRT-D)

device, a combination device used as a pacemaker and an implantable cardioverter defibrillator.

The device, by manufacturer Microport, was implanted last month by consultant cardiologist Dr Intisar Mirza.

The new generation CRT-D has a longer battery life, improving patient experience. It also has additional algorithms in place to evaluate lead performance, meaning teams are able to detect lead problems earlier. The device also has additional Bluetooth functionality that enables better connection with remote monitoring, easing the workload of clinical staff while improving patient care.

7. CONCLUSION

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

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **6 February 2025**

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

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

Appendices:

APPENDIX 1: December 2024 IPR

Executive summary:

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

Integrated Improvement Plan

- DM01 Performance, reduction of the Endoscopy Backlog, reduction in elective long waiting patients and the number of patients with a total time in the Emergency Department (ED) of over 12hrs are all showing statistical improvement.
- Cancer 62d combined performance has exceeded the national standard for six consecutive months, sustaining the improvements seen throughout the year.
- The financial efficiency programme, Type 1 four-hour Emergency Department Compliance and the number of patients on a Cancer Pathway for over 62d are all demonstrating improving performance but are currently not demonstrating a stable enough position to consistently pass the thresholds set. Progress this year is positive.
- Staff Engagement Score is displaying variation of a concerning nature with values consistently below the exit criteria thresholds. The level of engagement with the 2024 NHS Staff Survey was the best in the Trusts' history, with over 6,000 staff sharing their feedback and a response rate of 63%.

Patients

- Consistent reductions in 78 & 65 week breaches continue into month 9 with remaining challenges to demand seen in ENT, adult and paediatric.
- Type 1 Compliance continues to exceed the tier 1 milestones in each month.
- Improvements in 62d Cancer standard sustained with performance above the national standard for six consecutive months.
- Attendances were again above contract at Trust level in December 2024 for Type 1 and Urgent Treatment Centre (UTC), although admissions remain below plan due to challenges in flow through in particular to the Same Day Emergency Care (SDEC) and front door services.

Quality & Safety

- There were no new Never Events reported in December.
- The Trust at the end of December had:
    - 13 nationally reportable Patient Safety Incident Investigations (PSIIs) ongoing;
    - 6 Local PSIIs.
- Compliance with Safeguarding Training for both Adults and Children has improved and is now over the 90% target threshold set.
- In December, 100% compliance was achieved for verbal and written components, and sharing findings of the investigation in writing. This the second consecutive month that 100% compliance has been achieved across all three components.

People

- Sickness absence rates remain above the alerting threshold (to 5.6%) for the second month running, after being below

	the threshold since January 2024. This appears related to a large increase in the numbers of staff absent with coughs, colds and influenza. • Appraisal compliance has remained at the Trust-level threshold (80%), currently standing at 80.0%, and is the highest level since COVID. • Staff turnover has improved (to 8.7%) and continues the positive trend that has been observed across the last two years. It is now the lowest it has been in over two years and remains on a positive trajectory. **Finance** • The Group has reported a Year to Date (YTD) deficit of £69.2m against a deficit plan of £67.1m to Month 9. Until Month 8 the year to date position had hit the monthly planned deficit figures. • Trust pay expenditure is in line with month 8 spend in month. • One emerging risk to the submitted 2024/25 financial plan relates to pay award funding (£1.6m YTD and £2.1m for the year). This has been offset by non-recurrent benefits YTD, however if additional funding is not agreed, it could be a risk to our year-end position if not offset by other positive movements. • The Trust non pay run rate increased in month, mainly in drugs and supplies and services. • The Trust has delivered £35.2m of efficiencies in the first nine months, £0.3m above the YTD plan. **Maternity** • The extended perinatal rate remains consistently below the threshold of 5.42 per 1,000 births, with the December 12 month rolling rate at 3.91 per 1,000 births - the same rate as reported in November. • At month end (December 2024) there were six open Maternity and Newborn Safety Investigations (MNSI) cases with mainly draft reports received. The service currently has two internal PSIIs. • Four moderate patient safety incidents were reported in December.
Summary 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:	• Patients • People • Future • Sustainability • Quality and Safety
Link to the Trust Risk Register:	**CRR 77:** Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 78:** There is a risk that patients do not receive timely access to emergency care within the Emergency Department (ED).
Resource:	N
Legal and regulatory:	N
Subsidiary:	Y - Working through with the subsidiaries their involvement and impact on We Care.

Assurance route:

Previously considered by: Quality and Safety Committee – 28 January, People and Culture Committee – 29 January, and Finance and Performance Committee – 30 January

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: MONTH 9 (M9) FINANCE REPORT

Meeting date: 6 FEBRUARY 2025

Board sponsor: CHIEF FINANCE OFFICER (CFO)

Paper Author: INTERIM DEPUTY CFO

Appendices:

Appendix 1: M9 FINANCE REPORT

Executive summary:

Action required:	Information
Purpose of the Report:	The report is to update the Board on the financial performance to December 2024 (Month nine).
Summary of key issues:	**The Finance Report:** Until Month 8 of the financial year, the year to date (YTD) position had hit the monthly planned deficit figures. In Month 9, there is an overspend by £2.1m against the planned deficit. However, the profile of the plan in the final three months of the year and the Trust's reducing run rate suggest that the Group will recover this overspend and still meet the plan for the full year, albeit with a need to proactively monitor and manage in year risks, which include operational pressures, surge demand and the impact on elective (i.e. planned) work. Excluding the Non-recurrent Deficit Support Revenue Allocation, the Group is reporting a YTD variance to plan to Month 9 of £2,057k, as detailed below.

£000	YTD Plan	YTD Actual	YTD Variance
Patient care income	£698,625	£684,543	(£14,082)
Other income	£48,555	£49,887	£1,332
Employee Expenses	(£522,892)	(£520,730)	£2,162
Other operating expenses	(£284,877)	(£277,892)	£6,985
Non-operating expenses	(£7,013)	(£5,522)	£1,491
Technical Adjustments	£463	£518	£55
TECHNICALLY ADJUSTED SURPLUS/(DEFICIT) EXCLUDING DEFICIT SUPPORT	**(£67,139)**	**(£69,196)**	**(£2,057)**

Patient care income has underperformed YTD by £14.1m predominantly due to three reasons. Firstly, within Spencer Private Hospitals (SPH) due to consultant availability impacting on activity levels (i.e. reducing activity), although improvements have been seen in months 7 and 8, pre the Christmas period. Secondly, due to the successful reduction in patients residing in our hospital past the RTS < 7 days date. The Trust has seen a

	(£2.7m) reduction in planned income from the risk share agreement it holds with the Integrated Care Board (ICB), with this offset by the reduction in pay costs as a result of not opening those beds. Lastly, this is due to underperformance in Elective Recovery Fund (ERF); under-performance of some income generating Cost Improvement Programme (CIP) schemes (Note – CIPs overall are on plan, with offsetting improvements) and a change in the ERF calculation (communicated by NHS England (NHSE) to Trusts in September), such that a higher number of working days is now required to generate the same income. Other income is overachieving by £1.3m YTD, predominantly driven by education and training income exceeding plan. Within employee expenses, there is an estimated shortfall of £2.1m for the year and £1.6m YTD relating to the impact of the pay award uplifts for Medical and Agenda for change staff. This is currently offset by non-recurrent benefits in the YTD pay position. A £49m in-year CIP target has been set for 2024/25. The Trust has recognised recurrent savings of £26.5m YTD to December and non-recurrent savings of £8.7m totalling a delivery of £35.1m against a plan of £34.9m. Trust is currently on plan to deliver just under the full year target of £49m i.e. £48.6m forecast. The Group cash balance (including subsidiaries) at the end of December was £66.8m. Total capital expenditure at the end of December was £9.7m spend against a plan of £18.2m. A list of high priority schemes was presented to and approved by the Finance and Performance Committee (FPC) in October in response to the slippage reported in October 2024. The endorsed mitigation schemes are now progressing at pace and the underspend against the YTD plan is expected to recover by the end of Q4.
Key recommendations:	The Board of Directors is asked to review and **NOTE** the financial performance of Month 9.

Implications:

Links to Strategic Theme:	Having Healthy Finances by providing better, more effective patient care that makes resources go further.
Link to the Trust Risk Register:	**BAF FPC 006:** There is a risk that the Trust, as part of the Kent and Medway Integrated Care System (ICS), is unable to deliver the scale of financial improvement required to achieve breakeven or better within the funding allocation that has been set over a 3-year period. This would lead to regulatory action and/or limits on our ability to invest in strategic priorities/provide high quality services for patients. **SRR 3664**: Failure to deliver the Trust financial plan for 2024/25.

East Kent Hospitals University NHS Foundation Trust

Resource:	**N** - Key financial decisions and actions may be taken on the basis of this report.
Legal and regulatory:	**N**
Subsidiary:	**N**

Assurance route:

Previously considered by: Finance and Performance Committee - 30 January 2025.

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2024/25

December 2024

Chief Finance Officer
Angela van der Lem

We care

Group Summary
Month 09 (December) 2024/25

	Trust			2gether Support Solutions			Spencer Private Hospitals			Consolidation Adjustments			Group		
	Year to Date			Year to Date			Year to Date			Year to Date			Year to Date		
(£'m)	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
NHS Income From Commissioners - exc. D&D	639.590	624.438	(15.152)	0.000	0.000	0.000	15.829	13.535	(2.294)	(2.160)	(2.150)	0.010	653.259	635.823	(17.436)
NHS Income From Commissioners - Drugs	36.204	40.144	3.941	0.000	0.000	0.000	2.849	1.984	(0.865)	0.000	0.025	0.024	39.053	42.153	3.100
NHS Income From Commissioners - Devices	6.313	6.567	0.254	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(0.000)	6.313	6.567	0.254
Other Income	49.786	51.402	1.616	119.607	113.126	(6.481)	0.011	0.038	0.027	(120.849)	(114.679)	6.170	48.555	49.887	1.332
Total Income	**731.892**	**722.551**	**(9.341)**	**119.607**	**113.126**	**(6.481)**	**18.689**	**15.557**	**(3.132)**	**(123.008)**	**(116.804)**	**6.204**	**747.180**	**734.430**	**(12.750)**
Substantive Staff (inc. Apprenticeship Levy)	(427.158)	(422.429)	4.729	(30.849)	(31.174)	(0.325)	(6.438)	(5.759)	0.679	1.881	0.535	(1.346)	(462.564)	(458.827)	3.737
Bank Staff	(32.898)	(35.026)	(2.128)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(32.898)	(35.026)	(2.128)
Agency/Contract	(24.961)	(24.716)	0.245	(1.922)	(1.515)	0.407	(0.547)	(0.646)	(0.099)	0.000	0.000	0.000	(27.430)	(26.877)	0.553
Total Employee Expenses	**(485.017)**	**(482.171)**	**2.846**	**(32.771)**	**(32.689)**	**0.082**	**(6.985)**	**(6.405)**	**0.580**	**1.881**	**0.535**	**(1.346)**	**(522.892)**	**(520.730)**	**2.162**
Drugs	(35.022)	(34.620)	0.402	0.000	(0.002)	(0.002)	(2.991)	(1.984)	1.007	2.106	1.879	(0.227)	(35.907)	(34.727)	1.180
Rechargeable Drugs	(36.180)	(40.897)	(4.717)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(36.180)	(40.897)	(4.717)
Rechargeable Devices	(6.313)	(6.567)	(0.254)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(6.313)	(6.567)	(0.254)
Supplies and Services - Clinical	(36.220)	(34.494)	1.726	(31.553)	(43.546)	(11.993)	(1.320)	(1.680)	(0.360)	1.187	0.967	(0.220)	(67.906)	(78.753)	(10.847)
Supplies and Services - General	(110.983)	(112.752)	(1.769)	(22.329)	(14.366)	7.963	(0.225)	(0.183)	0.042	110.680	107.918	(2.762)	(22.857)	(19.383)	3.474
Clinical negligence	(26.294)	(26.294)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(26.294)	(26.294)	0.000
Depreciation and Amortisation	(17.147)	(16.993)	0.154	0.000	(0.748)	(0.748)	(0.162)	(0.252)	(0.090)	0.000	0.000	0.000	(17.309)	(17.993)	(0.684)
Other non pay	(41.309)	(33.467)	7.842	(31.445)	(20.581)	10.864	(6.513)	(4.735)	1.778	7.156	5.505	(1.651)	(72.111)	(53.278)	18.833
Total Other Operating Expenses	**(309.468)**	**(306.084)**	**3.384**	**(85.327)**	**(79.243)**	**6.084**	**(11.211)**	**(8.834)**	**2.377**	**121.129**	**116.269**	**(4.860)**	**(284.877)**	**(277.892)**	**6.985**
Non Operating Expenses	(7.056)	(5.948)	1.108	0.186	0.501	0.315	(0.143)	(0.075)	0.068	0.000	0.000	0.000	(7.013)	(5.522)	1.491
Profit/Loss	**(69.649)**	**(71.652)**	**(2.003)**	**1.695**	**1.695**	**0.000**	**0.350**	**0.243**	**(0.107)**	**0.002**	**0.000**	**(0.002)**	**(67.602)**	**(69.714)**	**(2.112)**
Less Technical Adjustments	0.463	0.518	0.055	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.463	0.518	0.055
Technically Adjusted Profit/Loss	**(69.186)**	**(71.134)**	**(1.948)** 1	**1.695**	**1.695**	**0.000** 2	**0.350**	**0.243**	**(0.107)** 3	**0.002**	**0.000**	**(0.002)** 4	**(67.139)**	**(69.196)**	**(2.057)** 5
Non Recurrent Deficit Support Revenue Allocation	61.377	61.377	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	61.377	61.377	0.000
Deficit Support Adjusted Profit/Loss	**(7.809)**	**(9.757)**	**(1.948)**	**1.695**	**1.695**	**0.000**	**0.350**	**0.243**	**(0.107)**	**0.002**	**0.000**	**(0.002)**	**(5.762)**	**(7.819)**	**(2.057)**

1. Trust:
The Trust, in line with national change, has received Non-recurrent Deficit Support Revenue Allocation to month 9 of £61.4m (£78.4m for the year). This non-recurrent allocation reduces our planned deficit from £85.8m to £7.4m. Due to this allocation being non-recurrent in nature, we are presenting the finance report with this deficit support income 'below the line' enabling the focus to remain on the recurrent position. Excluding the Non-recurrent Deficit Support Revenue Allocation, the Trust year-to-date deficit is £71.1m against a plan deficit of £69.2m; a £2m adverse variance YTD. The key drivers include:

- Income from patient care activities is £11.0m below plan, despite a £4.2m overperformance in drugs and devices. ERF income is £9.0m below plan YTD, including CIPs, with £2.7m underperformance in ICB discharge funding due to a successful project reducing inpatients not fit to reside and a £1.8m YTD (£2.4m FYE) national adjustment in ERF Baseline funding.
- Other operating income is favourable to plan by £1.6m YTD. Income for education and training, research and innovation and car parking are favourable to plan YTD by a total of £1.7m, offset by below plan cash donations, charitable income and staff accommodation rental income totalling £0.4m.
- Employee expenses is favourable to plan by £2.8m YTD. Substantive staff are favourable to plan by £4.7m YTD, with underspends in most staffing groups except medical staff and senior managers. Expenditure on temporary staff is adverse to plan by £1.9m YTD.
- Other operating expenses is favourable to plan by £3.4m YTD. In month and YTD overspends on rechargeable drugs and devices are offset by additional income. YTD, overspends on drugs, supplies and services non clinical and consultancy totalling £7.1m are offset by underspends on supplies and services clinical, purchase of healthcare, premises and establishment and other costs totalling £10.2m.

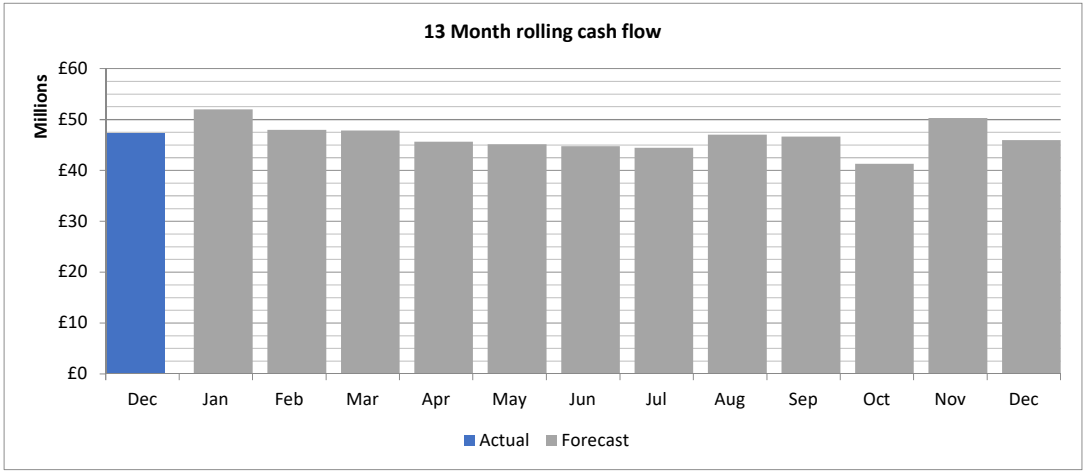
2. 2gether Support Solutions
2gether Support Solutions reported a YTD surplus of £1.7m, which is in line with the plan. Trust capital expenditure, both for the month and YTD, remains below plan, with 2gether and Trust staff collaborating to meet the capital plan by year-end. Income underperformance has been offset by underspends in non-pay costs, as well as bank interest received.

3. Spencer Private Hospitals
Spencer Private Hospitals reported a YTD surplus of £0.2m in operating profit and profit after tax, £0.1m below plan. December, being traditionally a low-activity month, saw reduced surgical procedures during the Christmas period and the limited availability of consultant surgeons. Despite this, costs were kept below budget to help offset the impact.

4. Consolidation Adjustments
Consolidation adjustments remove all inter-company transactions for income and expenditure, indicating that we are on track with the year-to-date plan.

5. Group
Until Month 8 of the financial year, the year to date position had hit the monthly planned deficit figures. In Month 9, there is an overspend by £2.1m against the planned deficit. However, the profile of the plan in the final three months of the year and the Trust's reducing run rate suggest that the Group will recover this overspend and still meet the plan for the full year, albeit with a need to proactively manage in year risks.

Cash Flow
Month 09 (December) 2024/25



Unconsolidated Cash balance was £40.0m at the end of December 2024, £27.9m above plan.

Cash receipts in month totalled £85.1m (£1.5m above plan):

- K&M ICB paid £63.8m in December (£6.7m above plan - this includes unplanned receipts received in month for non-recurrent deficit support £6.5m and £0.2m invoices cleared)
- NHS England paid £13.5m in December (£0.8m above plan)
- VAT received was £4.2m in December (£0.7m above plan)
- Other receipts totalled £3.6m (£0.6m above plan - of which, Capital PDC drawdowns were £0.5m over plan)
- No PDC revenue support was received in month (£7.2m below plan) - see Revenue support commentary.

Cash payments in month totalled £92.3m (£11.0m above plan)

- Creditor payment runs including Capital payments were £26.0m (£7.7m above plan).
- £15.2m payments to 2gether were £1.2m above plan.
- Total payroll was £51.1m, £2.1m above plan (PAYE, NI and Pensions payments relate to the November payroll which included backdated pay award, above original plan)

2024/25 Cash Plan

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

Revenue Support

In Q1 2024/25 the Trust received £21.5m of PDC revenue support. In Q2 2024/25 the Trust received a further £21.5m.

In September the Trust was notified of a £78.45m FYE non-recurrent deficit support revenue allocation and received a cash payment of £45.8m from K&M ICB in Month 7, which will be followed by £6.5m per month in months 8 - 12.

In light of this allocation, no further PDC Revenue support requests are expected to be made this financial year.

Creditor Management

The Trust paid to 30 day creditor terms for suppliers in Month 9.

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

Statement of Financial Position

Month 09 (December) 2024/25

	Trust			2gether Support Solutions			Spencer Private Hospitals			Consolidation Adjustments			Group		
(£'m)	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**
Non Current Assets	**379.770**	**370.833**	**(8.937)**	**67.469**	**66.275**	**(1.194)**	**4.408**	**4.309**	**(0.099)**	**(145.701)**	**(143.492)**	**2.209**	**305.946**	**297.925**	**(8.021)**
Inventories	7.878	8.010	0.132	5.245	5.245	0.000	0.047	0.103	0.056	0.000	0.000	0.000	13.170	13.358	0.188
Trade Receivables	37.592	43.742	6.150	25.520	10.229	(15.291)	5.397	4.785	(0.612)	(31.706)	(16.501)	15.205	36.803	42.255	5.452
Accrued Income and Other Receivables	(3.504)	(3.567)	(0.063)	(0.127)	(0.255)	(0.128)	(0.134)	(0.081)	0.053	0.000	0.000	0.000	(3.765)	(3.903)	(0.138)
Assets Held For Sale	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Cash and Cash Equivalents	17.955	39.969	22.014	12.413	23.902	11.489	2.049	2.881	0.832	0.000	0.000	0.000	32.417	66.752	34.335
Current Assets	**59.921**	**88.154**	**28.233**	**43.051**	**39.121**	**(3.930)**	**7.359**	**7.688**	**0.329**	**(31.706)**	**(16.501)**	**15.205**	**78.625**	**118.462**	**39.837**
Payables and Accruals	94.290	81.853	(12.437)	23.247	16.924	(6.323)	5.103	5.173	0.070	(27.854)	(12.853)	15.001	94.786	91.097	(3.689)
Deferred Income and Other Liabilities	8.100	8.815	0.715	0.000	0.000	0.000	0.000	0.000	0.000	(0.006)	(0.014)	(0.008)	8.094	8.801	0.707
Provisions	10.035	11.221	1.186	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	10.035	11.221	1.186
Borrowing	4.270	4.228	(0.042)	2.524	2.690	0.166	0.105	0.093	(0.012)	(4.334)	(4.448)	(0.114)	2.565	2.563	(0.002)
Current Liabilities	**116.695**	**106.117**	**(10.578)**	**25.771**	**19.614**	**(6.157)**	**5.208**	**5.266**	**0.058**	**(32.194)**	**(17.315)**	**14.879**	**115.480**	**113.682**	**(1.798)**
Provisions	3.423	3.467	0.044	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	3.423	3.467	0.044
Borrowing	71.611	68.248	(3.363)	50.475	48.640	(1.835)	1.964	1.894	(0.070)	(115.804)	(112.365)	3.439	8.246	6.417	(1.829)
Non Current Liabilities	**75.034**	**71.715**	**(3.319)**	**50.475**	**48.640**	**(1.835)**	**1.964**	**1.894**	**(0.070)**	**(115.804)**	**(112.365)**	**3.439**	**11.669**	**9.884**	**(1.785)**
Net Assets	**247.962**	**281.155**	**33.193**	**34.274**	**37.142**	**2.868**	**4.595**	**4.837**	**0.243**	**(29.409)**	**(30.314)**	**(0.904)**	**257.422**	**292.820**	**35.397**
Public Dividend Capital	559.544	603.015	43.471	30.267	30.267	0.000	0.048	0.048	0.000	(30.315)	(30.315)	0.000	559.544	603.015	43.471
Retained Earnings	(373.566)	(383.842)	(10.276)	5.085	6.874	1.789	1.736	1.979	0.243	0.363	0.535	0.172	(366.382)	(374.454)	(8.072)
Revaluation Reserve	61.983	61.981	(0.002)	0.000	0.000	0.000	2.812	2.812	0.000	(0.535)	(0.535)	0.000	64.260	64.258	(0.002)
Taxpayers Equity	**247.961**	**281.154**	**33.193 1**	**35.352**	**37.141**	**1.789 2**	**4.596**	**4.839**	**0.243 3**	**(30.487)**	**(30.315)**	**0.172 4**	**257.422**	**292.819**	**35.397**

1. Trust:

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

Current Assets - Current assets have increased from the 2023/24 opening position by £28m mainly due to £22m increase in cash balance and debtors increased by £6m. Please see Cash and Working capital pages for additional details.

Current Liabilities - Current liabilities have decreased by £10.6m due to reduction in payables (£12.4m - See Working Capital sheet for more detail) offset by increases in other liabilities and provisions by £0.7m and £1.2m respectively.

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

Public Dividend Capital - Increased to date by £43m reflecting PDC revenue support received up to September 2024.

2. 2gether Support Solutions:

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

Current Assets - Current assets have decreased from opening position by £4m mainly due to reduction in receivables. which led to increased cash balance.

Current Liabilities - Current liabilities have decreased by £6.2m from the opening position, primarily due to a reduction in payables.

3. Spencer Private Hospitals:

Current Assets - Current assets have increased primarily due to a decrease in trade receivables, which led to a corresponding rise in the cash balance.

Current Liabilities - Current liabilities have Increased primarily due to an increase in invoices payable.

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

Capital Expenditure
Month 09 (December) 2024/25

Capital Programme	Annual	Annual	Year to Date		
£000	Plan	Forecast	Plan	Actual	Variance
Critical Priorities (PEIC)	4,000	4,478	3,077	1,671	1,406
MDG - Medical Devices Replacement	2,249	3,001	1,545	557	988
Diagnostics Clinical Equipment Replacement Programme (ERP)	3,618	758	2,637	552	2,085
IDG - IT Systems Replacement	700	700	695	659	36
Electronic Medical Records (EMR)	800	800	651	357	294
Subsidiaries - 2Gether Support Solutions (2SS)	618	618	457	182	275
Subsidiaries - Spencer Private Hospitals (SPH)	150	179	105	157	(52)
Mechanical Thrombectomy	2,028	1,685	1,507	1,519	(12)
Renal – Expansion of dialysis services (Phase 2)	964	0	955	0	955
Stroke HASU	1,118	1,118	487	211	276
Pathology S8 - GP and Community Order Comms (LIMS)	140	140	140	140	0
Maternity Estates Review	1,594	535	525	41	484
Diagnostics Imaging (QEQM MRI)	2,100	200	1,050	0	1,050
Community Diagnostics Centre (CDC) - Buckland (EKHUFT)	1,033	804	1,033	794	239
Fire Compartmentation Strategy	4,000	4,100	2,321	2,233	88
Digital Histhopathology - 2024/25 (Year 2)	407	407	377	316	61
QEQM MRI Power Upgrade	45	0	45	0	45
Donated Assets	900	662	630	560	70
Vacuum Assisted Biopsy and Excision System (VAB/VAE)	0	70	0	0	0
TransNasal Endoscopy Service (TNE)	0	450	0	0	0
Block and Beam replacement - WHH	0	372	0	36	(36)
Subsidiaries Right of Use Assets (RoUA) - IFRS16 Leases	0	103	0	103	(103)
ANPR Parking Equipment Replacement	0	588	0	0	0
Procurement of 2x Mobile CT Scanners & Generators	0	2,600	0	0	0
Trust IFRS16 Acquisitions	242	139	0	78	(78)
All Other	0	(90)	0	(420)	420
	26,706	**24,416**	**18,237**	**9,749**	**8,488**

Funded By:	Plan	Forecast	Change (+) increase (-) reduction
Operational Capital	21,887	21,887	0
Donations	900	662	(238)
PDC	1,347	1,867	520
	24,134	**24,416**	**282**

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

The Group's gross capital year-to-date expenditure to the end of Month 9 2024/25 was £9.75m. This represents a £8.5m underspend against the YTD Plan of £18.2m.

The underspend against the YTD plan is driven by slippage across most major schemes, previously reported following the re-forecasting exercise conducted post M5 reporting. The proposed slippage mitigation schemes have been endorsed by the Finance and Performance Committee (FPC) in October 2024 and subsequent revisions were discussed and endorsed at the Capital Investment Group (CIG) meeting in November 2024.

The endorsed mitigation schemes are now progressing at pace and the revised forecast on individual capital schemes has been reflected as part of the M9 reporting.

The underspend against the YTD plan is expected to recover by the end of Q4 and whilst the reported slippage has now been mitigated in-year, there will be additional cost pressures on the 2025/26 Capital Programme as a result. The impact of the 2024/25 capital slippage on the 2025/26 Capital Programme has been quantified and incorporated within the ongoing 2025/26 Operational Planning process.

Cost Improvement Summary
Month 09 (December) 2024/25

Delivery Summary

Programme Themes £000	This Month Plan	This Month Actual	This Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance
0.01 Estate Utilisation & Rationalisation	39	89	50	267	347	80
0.02 Procurement	799	514	(285)	5,570	4,090	(1,480)
0.03 Digital Utilisation & Rationalisation	30	3	(27)	80	25	(55)
0.04 Income – Capture, Coding and Pricing	633	633	-	4,100	4,100	-
0.05 Financial Control & Governance	6	22	16	70	201	132
0.06 Low Value Interventions	1	-	(1)	3	-	(3)
0.07 Drugs & Devices	56	146	90	777	1,352	575
0.08 Length of Stay	1,193	1,192	(1)	4,867	3,982	(885)
0.09 Medically Optimised for Discharge Pathway	-	-	-	-	-	-
0.10 Theatre Utilisation	398	299	(98)	3,949	2,813	(1,135)
0.11 Admission Avoidance	-	-	-	-	-	-
0.12 Outpatients	284	377	93	2,556	2,608	52
0.13 Diagnostics	261	101	(160)	1,728	2,194	466
0.14 Medical Staffing	345	258	(87)	3,453	1,970	(1,482)
0.15 Nursing and Midwifery	84	145	61	1,168	895	(273)
0.16 Allied Health Professionals	90	36	(54)	705	592	(113)
0.17 Other Workforce	248	181	(67)	1,738	1,638	(101)
Care group Led Schemes **	50	554	504	3,790	8,347	4,558
Grand Total	**4,517**	**4,550**	**33**	**34,819**	**35,156**	**336**

Delivered £000

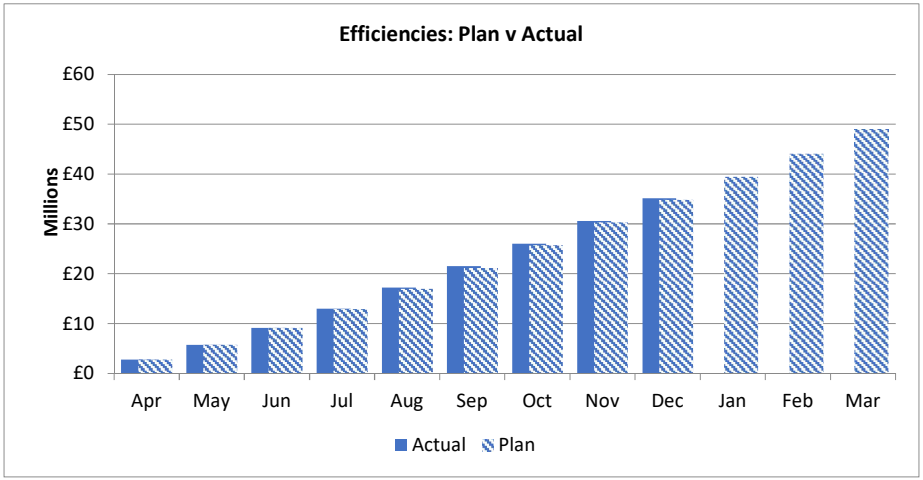
Month	Target	Actual
April	2,786	2,906
May	2,957	3,082
June	3,440	3,196
July	3,715	3,837
August	4,057	4,221
September	4,247	4,298
October	4,501	4,505
November	4,597	4,575
December	4,517	4,535
January	4,630	
February	4,636	
March	4,915	
	49,000	**35,156**
		71.7%

Efficiencies

The agreed Efficiencies plan for 2024/25 is £49.0m. CIP delivery is above plan to Month 9 by £0.34m. Recurrent savings of £4.0m have been delivered in December, and £26.5m on a YTD basis.

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

The PMO is collaborating effectively with the Financial Recovery Director and Director of Continuous Improvement. The focus is now on developing the detailed pipeline scheme PIDs for FY2526 based on areas included in the Financial Sustainability Plan. Efforts are on advancing projects through the gateway stages - Red, Amber and Pipeline, towards Green status. This will put the trust in a strong position and ensure robust plans are in place for FY2526, whilst maintaining delivery of the current year.



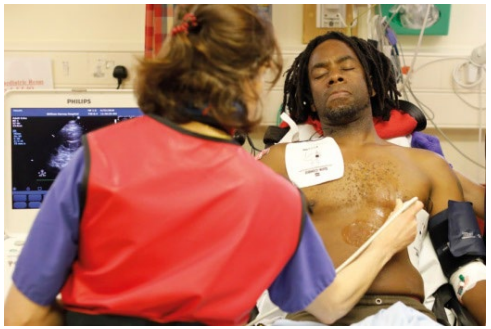
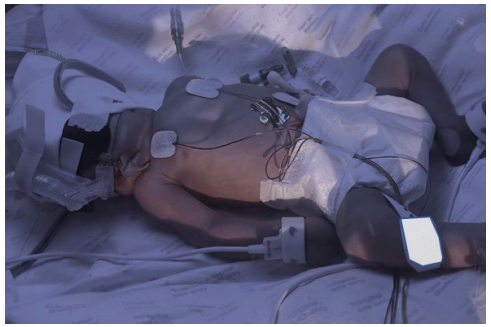
Integrated Performance Report

DECEMBER 2024







Integrated Performance Report

Statistical Process Control

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

What is statistical process control (SPC)?

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

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

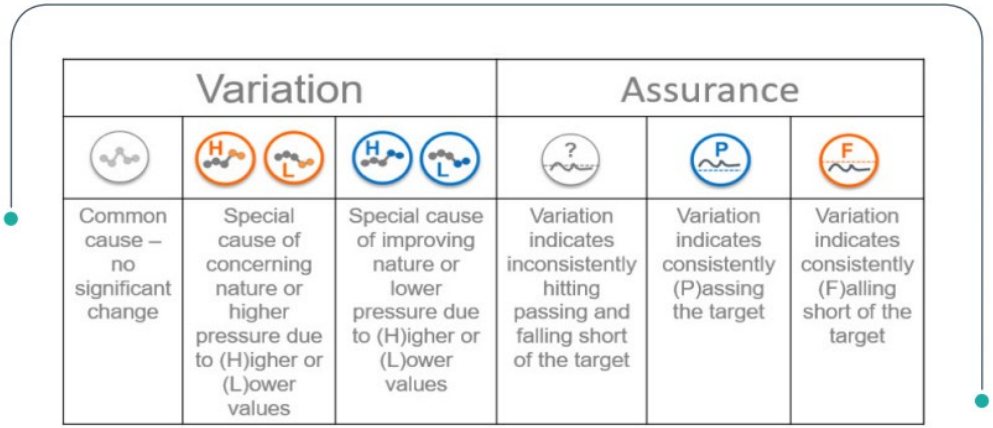
The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

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

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

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



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

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

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

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

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

Integrated Improvement Plan (IIP)

Summary Highlights

Executive Summary:

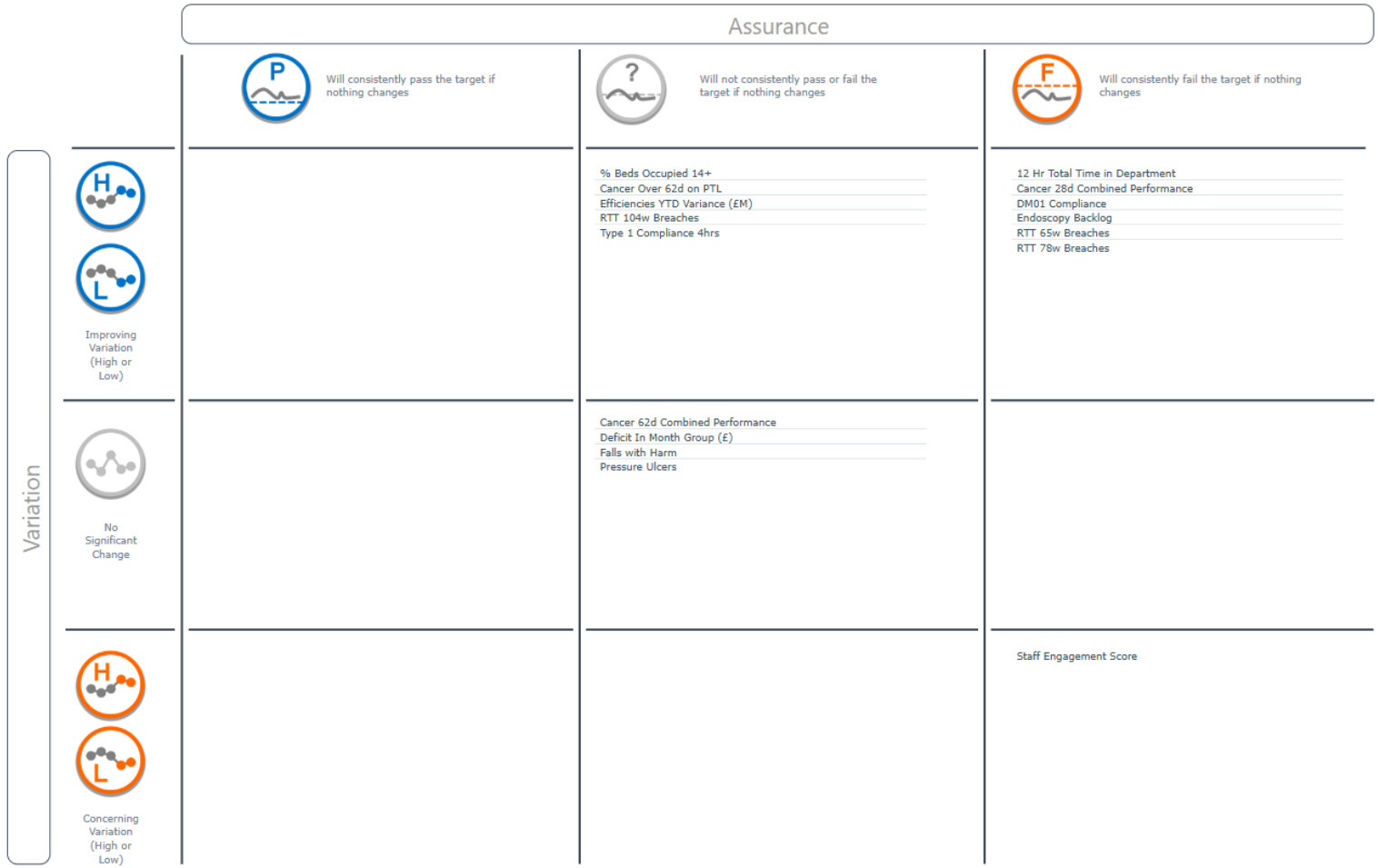
DM01 Performance, reduction of the Endoscopy Backlog, reduction in elective long waiting patients and the number of patients with a total time in the ED department of over 12h are all showing statistical improvement.

The financial efficiency programme, Type 1 four hour Emergency Department Compliance and the number of patients on a Cancer Pathway for over 62d are all demonstrating improving performance but are currently not demonstrating a stable enough position to consistently pass the thresholds set. Progress this year is positive.

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

Though it is not yet flagging a statistical improvement it is worth noting that Cancer 62d combined performance has exceeded the national standard for six consecutive months, sustaining the improvements seen throughout the year.

Staff Engagement Score is displaying variation of a concerning nature with values consistently below the exit criteria thresholds. The level of engagement with the 2024 NHS Staff Survey was the best in the Trusts' history, with over 6,000 staff sharing their feedback and a response rate of 63%. Survey results have now been received and shared with the Executive team under the national embargo.



Integrated Improvement Plan (IIP)

Exit Criteria Metrics: Dashboard

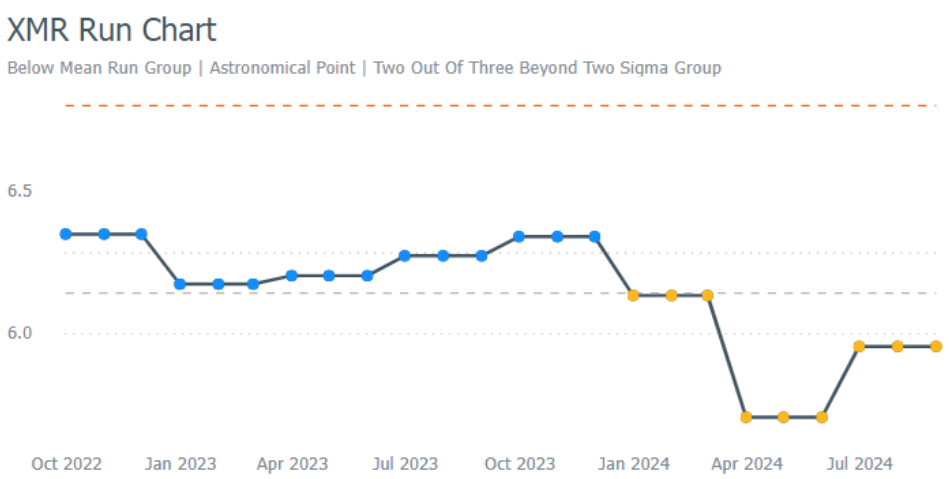
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24
People	IIP		Staff Engagement Score			6.80	6.13	6.13	6.13	5.70	5.70	5.70	5.95	5.95	5.95			
Patients	IIP		Type 1 Compliance 4hrs			50.0%	42.9%	45.1%	50.3%	47.4%	53.2%	52.0%	54.7%	56.2%	56.5%	54.1%	53.7%	54.7%
	IIP		12 Hr Total Time in Department			8.0%	11.1%	10.3%	9.4%	10.0%	9.5%	9.6%	9.4%	9.2%	9.2%	9.7%	9.5%	10.2%
	IIP		% Beds Occupied 14+			30.0%	34.3%	32.5%	30.6%	32.5%	30.8%	29.6%	30.0%	30.8%	34.3%	32.0%	28.2%	29.1%
	IIP		Cancer 28d Combined Performance			77.0%	57.8%	66.9%	68.3%	64.9%	70.2%	70.4%	72.6%	71.0%	69.8%	71.3%	71.8%	74.5%
	IIP		Cancer 62d Combined Performance			70.0%	56.1%	55.6%	69.1%	66.2%	64.1%	63.0%	71.6%	73.2%	72.8%	70.4%	74.1%	74.7%
	IIP		Cancer Over 62d on PTL			200	419	244	188	236	237	233	203	244	215	193	203	216
	IIP		RTT 65w Breaches			575	2,698	2,695	2,301	2,203	1,802	1,656	1,360	1,269	572	346	247	216
	IIP		RTT 78w Breaches			0	752	653	485	465	272	82	35	32	34	11	10	7
	IIP		RTT 104w Breaches			0	6	13	24	15	1	1	0	1	0	0	0	0
	IIP		Endoscopy Backlog			1,763	9,116	8,005	7,238	18.5K	15.5K	12.3K	9,054	5,991	3,912	1,989	1,173	1,119
	IIP		DM01 Compliance			75.0%	54.2%	61.6%	61.2%	62.5%	63.5%	60.9%	61.3%	64.0%	68.5%	77.2%	83.3%	81.0%
Quality	IIP		Falls with Harm			12	2	10	4	6	3	4	2	7	5	7	9	8
	IIP		Pressure Ulcers			112	113	91	76	84	84	82	79	72	77	92	85	84
Sustainability	IIP		Deficit In Month Group (£)			4.9M	11.0M	10.2M	12.2M	8.8M	7.3M	7.1M	8.3M	6.3M	7.3M	7.5M	9.8M	7.0M
	IIP		Efficiencies YTD Variance (£M)			0.0	-20.5	-23.7	-26.9	0.0	0.0	0.0	0.1	0.3	0.3	0.3	0.3	0.3

Integrated Improvement Plan (IIP)

Staff Engagement Score

Staff Engagement Score

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



Understanding the Latest Performance

Concern flag alerting for more than 4 periods

For the month beginning 01/09/2024 the latest Staff Engagement Score performance is 5.95 against a static target of 6.80 (higher is better).

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

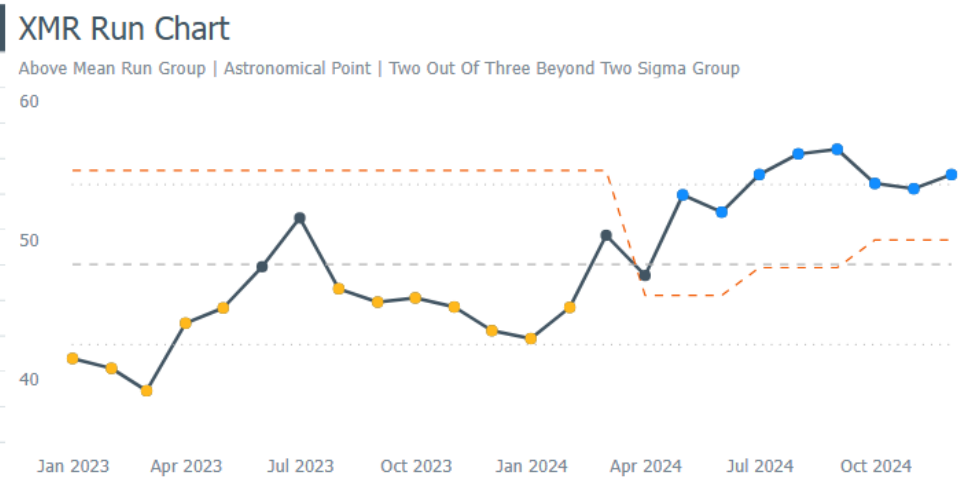
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Engagement levels (5.95) are below the national average (6.78).	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated	Head of Staff Experience	End Mar 26	• The level of engagement with the 2024 NHS Staff Survey was the best in the Trusts' history, with over 6,000 staff sharing their feedback and a response rate of 63%. Survey results have now been received and shared with the Executive team under the national embargo. Results themselves cannot be reported for Q3 until the embargo is lifted but a robust plan is in place, approved at CEMG, and shared with P&CC. Work is underway to identify focus areas for 2025 using the Operational Excellence model, ensuring activity is evidence-led and attends to areas where the Trust is furthest from national standards.
Actions/ interventions initiated to improve staff engagement	• Activity taking place across NSS plan, CLP immediate actions delivery plan and local Care Group People Plans	Head of Staff Experience	End Dec 25	• A comprehensive and progressive plan has been approved which represents a sustainable, evidence-led and long-term approach to staff survey outcomes. It moves the Trust away from an embargo-led process which is protracted and inhibits progress, and toward a change-led process, based on the principles of sharing earlier and acting quicker. Business units have been established to support Care Groups in identifying key challenges and taking appropriate action. The units have been initiated, pre-briefs have taken place and Care Group sessions planned across the next four weeks.
2024 NHS Staff Survey	• Driving response rates across the 2024 NSS is key to improving engagement and the credibility of associated results	Head of Staff Experience	End Nov 24	• This action is complete. The response rate to the 2024 survey was the highest in the Trusts' history (63%), with feedback from more colleagues than ever has been recorded before (6224). Most importantly, it is representative, with all Care Groups, Staff Groups and Corporate areas achieving a majority response (>50%). The final rate exceeds the 50% target set by 1,261 responses. This promising level of engagement represents a particular opportunity and it is now critical that a comprehensive array of action follows.

Integrated Improvement Plan (IIP)

Type 1 Emergency Department; Four Hour Compliance

Type 1 Compliance 4hrs

Timescale	Value	SPC
Jan-24	42.9%	
Feb-24	45.1%	
Mar-24	50.3%	
Apr-24	47.4%	
May-24	53.2%	
Jun-24	52.0%	
Jul-24	54.7%	
Aug-24	56.2%	
Sep-24	56.5%	
Oct-24	54.1%	
Nov-24	53.7%	
Dec-24	54.7%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/12/2024 the latest Type 1 Compliance 4hrs performance is 54.7% against a Trajectory target of 50.0% (higher is better).

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

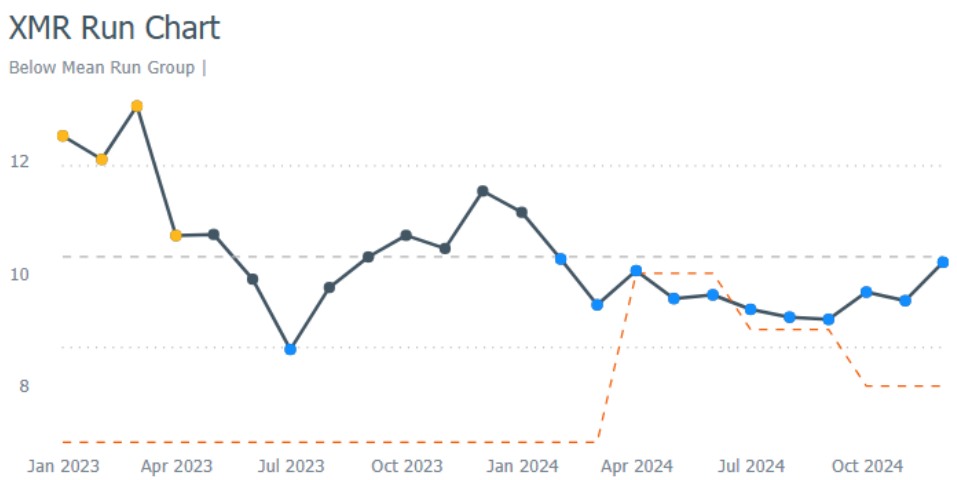
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Attendance Avoidance	• Extension of the SPOA model developed during 2024/5 to incorporate functions of an 'emergency portal' – advice and guidance, same day emergency care access – primary and secondary care; acute GP referral management; ambulance 'stack reviews'; frailty response, care home support and update of DOS. • Development of direct access pathways and extending use of the virtual wards, same day emergency care services	• COO • Dep COO UEC • CN/CL ED	• Q4 • Q4	• Performance 547% which is ahead of trajectory for Q3 • SPOA – implementation of single SPOA December 2024 –increase community capacity being recruited to further support the SPOA attendance avoidance – Q4 • Frailty model: winter funding secured to support QEQM and WHH frailty SDEC test of change • Acute Virtual ward – winter funding secured for test of change for acute virtual ward at QEQM and WHH – expansion to 12 per site from Feb '25
Safe and Effective ED	• Workstream associated with RLoS programme –focus on ensuring ED systems and processes are standardised across sites, workforce aligned to demand (medical and non-medical), internal standards are embedded with clear escalation, grip and control • Review of CDU model on both sites; introduce CDU at WHH Q4	• CL ED • Dep COO UEC • MDs	• Q4 • Q4	• ED Internal professional standards drafted; mechanism for monitoring being developed in conjunction with escalation framework Safe & Effective ED workstream established: focus on validation, roles and escalation through patient pathways for phase 1 • Heatmap for demand profiles requested to ensure workforce alignment: due Q4
Admission avoidance	Front door alternatives to ED: • Review & development of AMU model & SDEC at WHH with DA pathways • Review of effectiveness of AMU model and SDEC at QEQM	• SiteTri • Dep COO UEC	• Q4	• AMU workstream established for WHH: direct access, workforce, pathways & data for demand and capacity completed: SDEC test of change in place. Inc. utilisation to support ED noted • AMU model at QEQM under review; standardised operational policies drafted • Reset for front door in December; increased use of SDEC and frailty models noted

Integrated Improvement Plan (IIP)

12 Hour Total Time in Emergency Department

12 Hr Total Time in Department

Timescale	Value	SPC
Jan-24	11.1%	
Feb-24	10.3%	
Mar-24	9.4%	
Apr-24	10.0%	
May-24	9.5%	
Jun-24	9.6%	
Jul-24	9.4%	
Aug-24	9.2%	
Sep-24	9.2%	
Oct-24	9.7%	
Nov-24	9.5%	
Dec-24	10.2%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/12/2024 the latest 12 Hr Total Time in Department performance is 10.2% against a Trajectory target of 8.0% (lower is better).

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

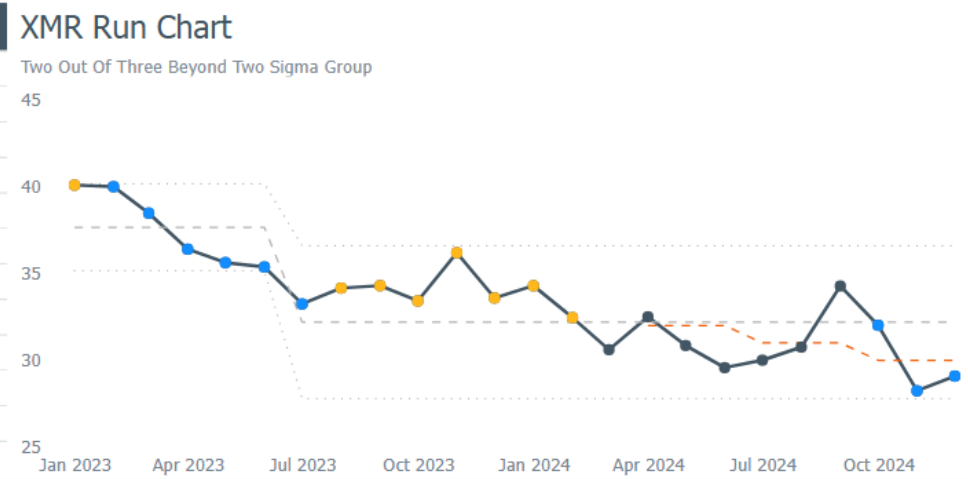
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Demand outstrips capacity	• Improve timeliness for decision to admit • Direct pathways to assessments units following decision to admit • Increase senior decision maker time on assessment units • Improve flow into downstream wards – internal flow workstream from RLoS and proactive site management • Reducing Length of Stay Programme – reduce delays in patient pathways and robust and proactive management of flow	• Tri MD Tri DoN	Quarter 4	• Medical workforce review underway supported by Deputy MD • RLoS programme roll out; Internal flow and SAFER bundle core improvement prog. • Workstream established to review direct admission pathways • Cross site ED T&F group in place; development of 12h recovery plan including establishment of effective CDUs on both sites • RLoS; further reduction to support more patients managed through the core beds • GP streaming pilot enacted in Dec to redirect to UTC – under evaluation
Weekend profiles	• Improve discharge profile at weekends to match demand • Implement criteria led discharge • Review support functions at weekends to support discharges • Improve w/e planning & proactive transfer processes across sites	• CG Tri	Quarter 4	• Diagnostics for key reasons for delays at weekend finalised – meeting with pharmacy established regarding times of operation and centralised model • Workstream to be established for criteria led discharge • Escalation and discharge policies under review; to be finalised quarter 4 & to include expectations to support 7d services-awaiting sign off CEMG
High number of Mental Health (MH) patients in ED with long waits	• Daily external escalation processes to be approved by the HCP to support oversight and planning • ICB support to EKMHT to manage OOA access • SAFEHAVEN roll out underway across both sites • Review Medway and lessons learned from safe Haven introduction and impact on patient wait times at the front door	• CG Tri WHH/ QEQM	Quarter 3	• ED internal processes in place to support patients Plans in place with HCP/MH to put in 24/7 LPS to the sites/ Safehavens to be co-located at QEQM with plans to be established fully by Q4. Plan for Safe Haven at WHH in development • Focus for 24/25 on escalation and capacity to manage long stayers- SOP for escalation developed by MD for WHH and QEQM

Integrated Improvement Plan (IIP)

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

% Beds Occupied 14+

Timescale	Value	SPC
Jan-24	34.3%	
Feb-24	32.5%	
Mar-24	30.6%	
Apr-24	32.5%	
May-24	30.8%	
Jun-24	29.6%	
Jul-24	30.0%	
Aug-24	30.8%	
Sep-24	34.3%	
Oct-24	32.0%	
Nov-24	28.2%	
Dec-24	29.1%	



Understanding the Latest Performance

Improvement flag alerting for 3 periods

For the month beginning 01/12/2024 the latest % Beds Occupied 14+ performance is 29.1% against a Trajectory target of 30.0% (lower is better).

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

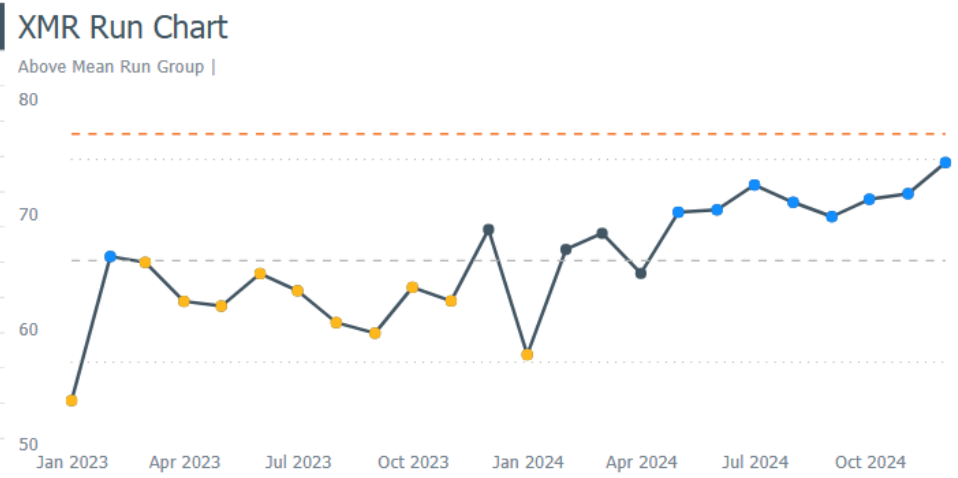
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patients meeting the criteria to reside >14 days	• Revisit criteria to reside and develop training plan to improve data completeness and quality • Consider out of hospital alternatives to patients residing – virtual ward expansion, ESD, hospital at home, increased community capacity etc • Review discharge dependency requirements for therapy and diagnostics – alternative pathways to deliver this as part of RLoS programme	• Dep COO UEC/CG DoN • COO/Dep COO UEC • Deputy COO/MD DCB	• Q4 • Q4 • Q4	• Overview of training requirements developed as part of RLoS programme with regards to data quality and completeness for C2R • Virtual ward task and finish group established – revision of ToR to expand scope and opportunities – pilots for acute medicine virtual ward August QEQM and Sept for WHH • Therapy review underway –test of change for ESD as part of winter scheme – Jan 25 • Review of function of site discharge coordinators – listening events held on both acute sites in October – follow up event January 25 with review also of IDT establishment wit the system partners
Patients not meeting the criteria to reside >14 days	• Demand and capacity for D2A pathways – working with HCP partners to review demand and capacity to mitigate delays for patients waiting to access D2A capacity • Review of internal codes – therapy reviews required for discharge – develop D2A approach	• COO/Deputy COO-UEC • System Partners	• Q4 • Q4	• Test of change in place for therapies at Board rounds and D2A approach in development across system wide therapy review • System schemes in development to expand capacity to support patients to be cared for OOH – on-going discussions with ICB to expand D2A pathways as part of winter resilience – reduction in wait times for P1 noted • Revised model for management of complex patients – soft launch Sept-Nov
Grip and control: all LOS	• Implement weekly stranded reviews on all sites; SAFER • Develop standards for managing complex patients across their pathway – internal and external • Develop escalation systems and processes	• Deputy COO-UEC • MDs	• Q4	• LOS for patients >14 days under review at specialty level – focus on frailty • Discharge and escalation policy signed off CEMG Dec – chair sign off Jan 25 • SAFER bundle – revisit and standardise process for consistent implementation– impact assessment q4 • Stranded review and escalation process drafted for consideration.

Integrated Improvement Plan (IIP)

Cancer 28 Day Faster Diagnosis Compliance

Cancer 28d Combined Performance

Timescale	Value	SPC
Jan-24	57.8%	
Feb-24	66.9%	
Mar-24	68.3%	
Apr-24	64.9%	
May-24	70.2%	
Jun-24	70.4%	
Jul-24	72.6%	
Aug-24	71.0%	
Sep-24	69.8%	
Oct-24	71.3%	
Nov-24	71.8%	
Dec-24	74.5%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/12/2024 the latest Cancer 28d Combined Performance performance is 74.5% against a static target of 77.0% (higher is better).

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

The biggest contributing factors are: 07 - Lower GI (48.1% , 308*), 09 - Gynaecological (69.4% , 136*), 06 - Upper GI (66.9% , 97*). *Breaches

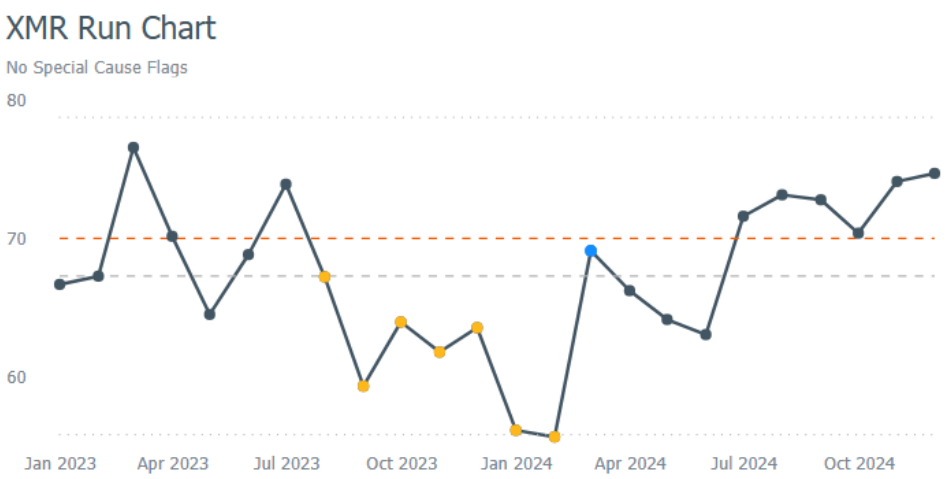
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Access to timely diagnostics	• Reduce wait times for CT and US Guided Biopsy, US. • Endoscopy booking times • Breast US booking times	• Radiology • Endoscopy	• Ongoing	• Efforts are ongoing to boost CT and US biopsy capacity by onboarding new substantive staff members. Training is in progress. We await the outcome of the procurement exercise for insourcing capacity, supported by tiered funds. • In December, Breast US capacity was affected by staff sickness. With insourcing now active in January, booking times for Breast Urgent Cancer appointments have been reduced to under one week. A working group has been established to review specialty and radiology job plans to ensure that demand can be met with the substantive capacity throughout 25/26
Letter backlog	• Timely consultant dictation of cancer letters to patients • Timely admin support to process dictated letters	• Cancer compliance • Admin • Consultant	• Ongoing	• The escalation process has been revised to highlight all breaches monthly, ensuring teams are aware of any outstanding letters from previous months. • The letter backlog grew in December due to reduced clinician availability over the festive period - teams are actively working to reverse this trend.
Lower GI	• Key contributing specialty to the non compliant position • Low ranking specialty for 28D against national benchmarking data	• Specialty	• Q4	• The adoption of the LGI Cancer Pathway has now been ratified by the Cancer Alliance. • First outpatient appointments (OPA) are now being scheduled within one week or referral, a significant improvement from the previous two-plus weeks, though sustained effort is needed to maintain this position. • Onsite booking for Endoscopy is being supported as booking on the day of your OPA can save days in the pathway. • Virtual Colonoscopy (VC) requests are being reviewed to ensure compliance with the updated pathway criteria and adherence to the new VC request protocols • The Cancer Alliance is leading medium-term improvement programme: establishing minimum data sets for primary care referrals and expanding the criteria for Straight to Test services.

Integrated Improvement Plan (IIP)

Cancer 62 Day Performance

Cancer 62d Combined Performance

Timescale	Value	SPC
Jan-24	56.1%	
Feb-24	55.6%	
Mar-24	69.1%	
Apr-24	66.2%	
May-24	64.1%	
Jun-24	63.0%	
Jul-24	71.6%	
Aug-24	73.2%	
Sep-24	72.8%	
Oct-24	70.4%	
Nov-24	74.1%	
Dec-24	74.7%	



Understanding the Latest Performance

No Special Cause Variation

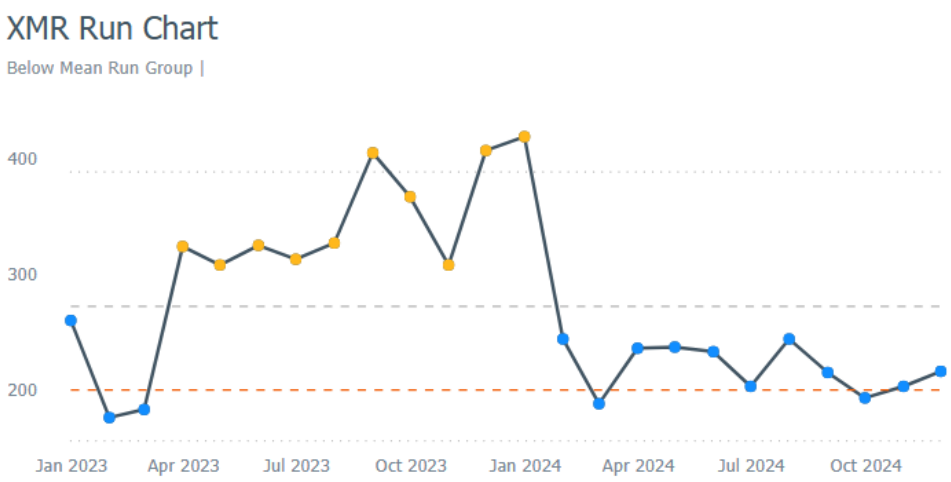
For the month beginning 01/12/2024 the latest Cancer 62d Combined Performance performance is 74.7% against a static target of 70.0% (higher is better).

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

The biggest contributing factors are: 11 - Urological (73.1% , 20*), 01 - Breast (68.8% , 15*), 03 - Lung (50.9% , 13*). *Breaches

Cancer Over 62d on PTL

Timescale	Value	SPC
Jan-24	419	
Feb-24	244	
Mar-24	188	
Apr-24	236	
May-24	237	
Jun-24	233	
Jul-24	203	
Aug-24	244	
Sep-24	215	
Oct-24	193	
Nov-24	203	
Dec-24	216	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/12/2024 the latest Cancer Over 62d on PTL performance is 216 against a static target of 200 (lower is better).

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

The biggest contributing factors are: 07 - Lower GI (79*), 11 - Urological (38*), 08 - Skin (20*). *Number

Integrated Improvement Plan (IIP)

Cancer 62 Day Performance; Action Plan

Cancer 62d Performance & >62d PTL Patient Actions

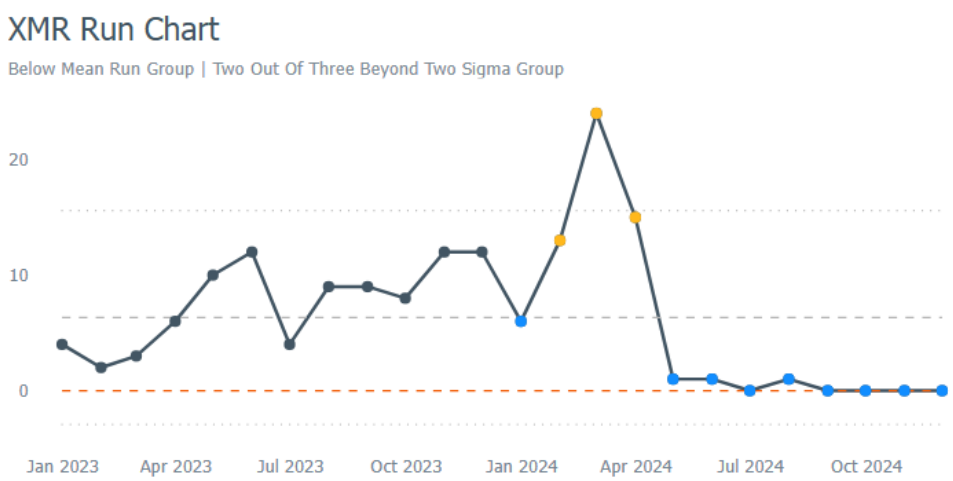
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Grip and control of backlog position	• Clear actions outlined in PTL to progress patients. • Close monitoring of treatment booking times • Escalation through operational access meetings for areas of concern	• Cancer Operational lead/ compliance	• Ongoing	• Targeted escalation for patients against agreed thresholds for Histopathology, Radiology and Endoscopy. All diagnostics types now being escalated after a 7 day period. The majority of reporting is completed within 7 days. • 104 review now completed at operational access meetings with 63-104 watchlist being communicated. 104+ diagnostic reporting being escalated for 24 hour turnaround.
Capacity for diagnostics	• Staff vacancies contributing to reduced radiological diagnostics	• Radiology	• Ongoing	• Tiering funding provided to support insourcing for US, Guided CT and US biopsy, endoscopy • Successful recruitment across the clinical team within radiology will boost substantive capacity for CT and US biopsy capacity
Urology surgical capacity	• Limited consultant robotic capacity	• Urology	• Q4	• Mat leave return in September for consultant to support RALP – the consultant is now independent and capacity for cancer surgery for RALP will continue to increased • Substantive consultant post advertised with suitable candidates shortlisted
Surgical booking out times	• Elongated time between MDM and surgical treatment	• All surgical specialties	• Ongoing	• Close monitoring of booking out times for all surgical treatments across all specialties supported by 31D breach reviews • Cancer services reviewing the time from MDM to Decision to Treat discussions due to the impact on the 62d compliance standard
Pathway awareness	• Patients being referred to Urgent Suspected Cancer Pathways without an awareness of the likely clinical appointments or likely diagnostic tests	• All specialties	• Year end 24/25	• The Cancer Alliance 28-day pathway patient information leaflet is set for release in October 2024. • Ensuring initial clinical discussions clearly outline the urgent suspected cancer pathway process.
MTW H&N	• Patients being transferred from MTW for cancer surgery impacting on clinical capacity	• Compliance/ H&N	• Q3	• Pathway transfer now being monitored and an increasing number of patients are being transferred with the appropriate diagnostics completed. • Head & Neck surgical capacity remains challenged. Out to ad for substantive consultants.
Breast Pathway	• Radiological support to reduced the timings at the start of the pathway by establishing one stop clinics. Patients being booked at 2 weeks. Aim to reduce to one week.	• Radiology	• Q4	• Insourcing capacity has improved the position with patients now being seen within a week of referral. • Detailed planning in progress to established dedicated one-stop clinics for 25/26 to maintain the anticipated improvement.

Integrated Improvement Plan (IIP)

Referral to Treatment Waiting Times; 104 & 78 week waits

RTT 104w Breaches

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



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

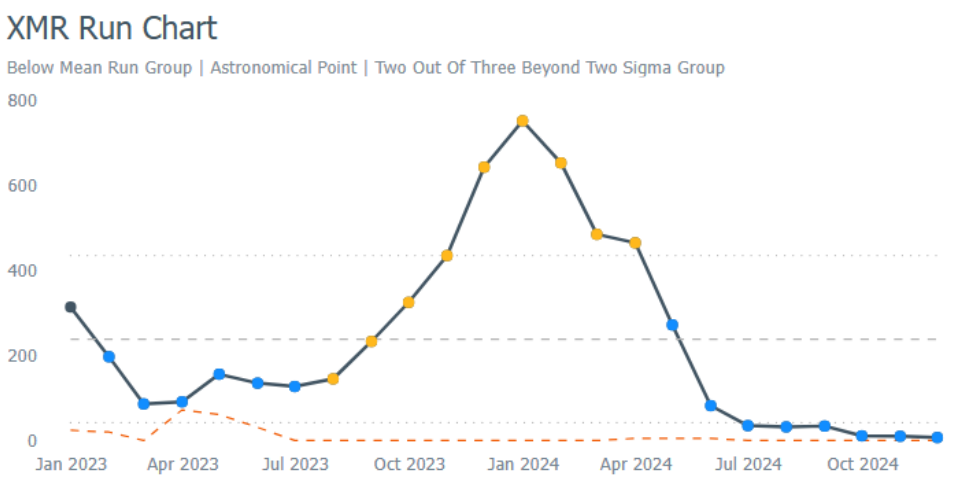
For the month beginning 01/12/2024 the latest RTT 104w Breaches performance is 0 against a static target of 0 (lower is better).

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

The biggest contributing factors are: 143 - ORTHODONTICS (0*), 145 - ORAL AND MAXILLOFACIAL SURGERY (0*), 170 - CARDIOTHORACIC SURGERY (0*). *Breaches

RTT 78w Breaches

Timescale	Value	SPC
Jan-24	752	
Feb-24	653	
Mar-24	485	
Apr-24	465	
May-24	272	
Jun-24	82	
Jul-24	35	
Aug-24	32	
Sep-24	34	
Oct-24	11	
Nov-24	10	
Dec-24	7	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/12/2024 the latest RTT 78w Breaches performance is 7 against a Trajectory target of 0 (lower is better).

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

The biggest contributing factors are: 120 - EAR NOSE AND THROAT (5*), 104 - COLORECTAL SURGERY (1*), 215 - PAEDIATRIC EAR NOSE AND THROAT (1*). *Breaches

Integrated Improvement Plan (IIP)

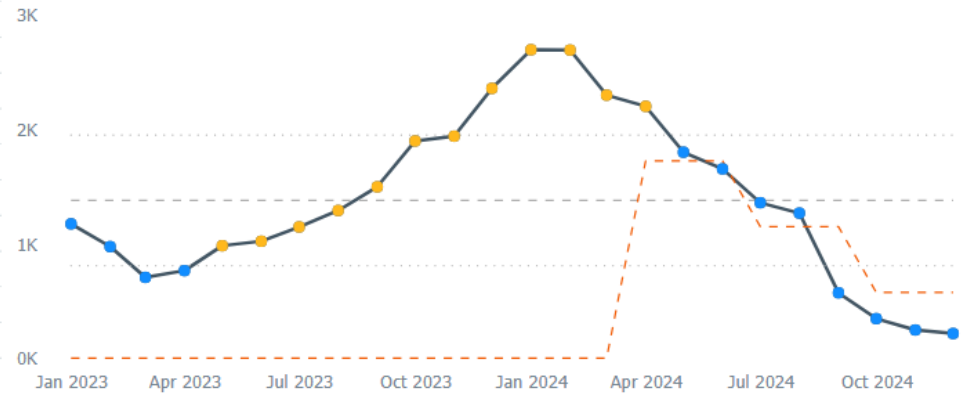
Referral to Treatment Waiting Times; 65 week waits

RTT 65w Breaches

Timescale	Value	SPC
Jan-24	2,698	
Feb-24	2,695	
Mar-24	2,301	
Apr-24	2,203	
May-24	1,802	
Jun-24	1,656	
Jul-24	1,360	
Aug-24	1,269	
Sep-24	572	
Oct-24	346	
Nov-24	247	
Dec-24	216	

XMR Run Chart

Astronomical Point | Descending Run Group | Two Out Of Three Beyond Two Sigma Group



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/12/2024 the latest RTT 65w Breaches performance is 216 against a Trajectory target of 575 (lower is better).

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

The biggest contributing factors are: 215 - PAEDIATRIC EAR NOSE AND THROAT (90*), 120 - EAR NOSE AND THROAT (68*), 301 - GASTROENTEROLOGY (11*). *Breaches

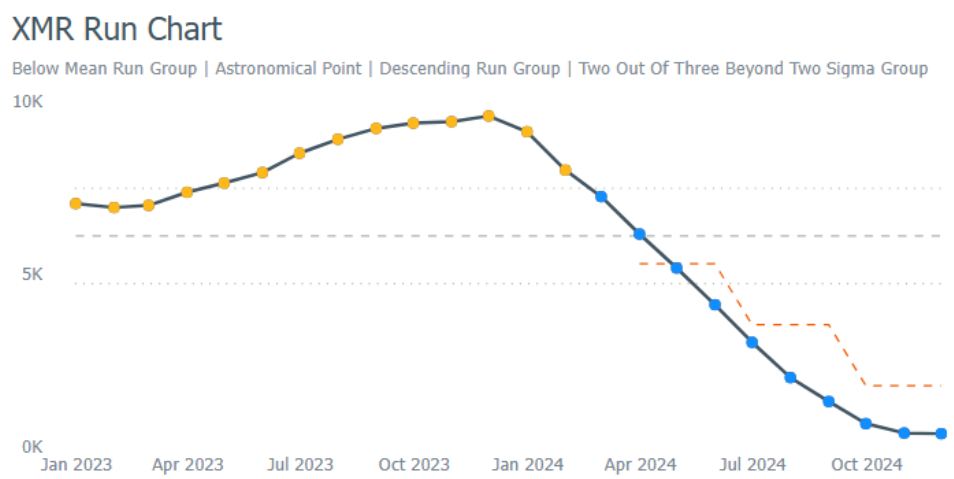
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Drive to eradicate 65 weeks by end of March 2025	• Weekly clearance against trajectory monitored at Access with clear delivery plans for non-compliance. • Continued drive through daily oversight and management of risk cohort through care group PTL's and into Trust Access meeting. • Theatre programme to improve utilisation to 85% and drive clearance of backlog. • All internal capacity being directed to key risk cohorts from dropped sessions • Independent Sector capacity aligned to support risk cohorts	• COO • COO • MD – CCAS • MD - CCAS • MD – CCAS	• Ongoing • Ongoing • March 25 • Ongoing • Aug-Oct	• Performance shared weekly with all specialities, paeds ENT insourcing has commenced beginning of January 2025. • In place • Commenced • Commenced • Commenced

Integrated Improvement Plan (IIP)

Endoscopy Backlog; Overdue Surveillance and Routine Waits

Endoscopy Backlog

Timescale	Value	SPC
Jan-24	9,116	
Feb-24	8,005	
Mar-24	7,238	
Apr-24	6,153	
May-24	5,170	
Jun-24	4,108	
Jul-24	3,018	
Aug-24	1,997	
Sep-24	1,304	
Oct-24	663	
Nov-24	391	
Dec-24	373	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/12/2024 the latest Endoscopy Backlog performance is 373 against a Trajectory target of 1,763 (lower is better).

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

The biggest contributing factors are: Colon (139*), Dual (118*), OGD (83*). *Overdue Waiters

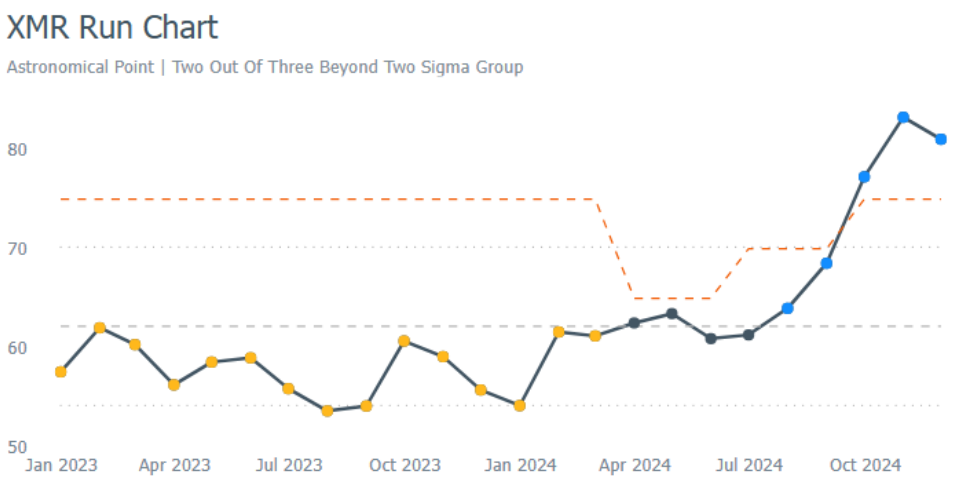
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Theatre utilisation and bookings	• Reception staff workforce review completed and additional staff required part of 25/26 business plans • Business planning for 25/26 to ensue ongoing sustainability.	• Endoscopy recovery lead	• Ongoing	• Activity now sustained at c.520 procedures a month (deliberately reduced from previous 550/month) • Forward booking now sustained at 1200 -1500 patients. • We now consistently have under 500 patients to book on the PTL all within the JAG standards (i.e. 373 at end of December 24)
Demand management	• Implementing a Triage system to demand management the service.	• Endoscopy recovery lead • Clinical lead	• ongoing	• Process designed, sunrise chances made, SOP written. • New Triage process started – currently rejecting around 40 patients a week ongoing. • Engagement with Colorectal surgeons starting, but need to improve. • Review of the STT requests / process to begin in January.
Waiting list accuracy	• A program of staged validation against new clinical standards.	• Endoscopy recovery lead • Clinical lead	• Ongoing	• Action complete

Integrated Improvement Plan (IIP)

Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

DM01 Compliance

Timescale	Value	SPC
Jan-24	54.2%	
Feb-24	61.6%	
Mar-24	61.2%	
Apr-24	62.5%	
May-24	63.5%	
Jun-24	60.9%	
Jul-24	61.3%	
Aug-24	64.0%	
Sep-24	68.5%	
Oct-24	77.2%	
Nov-24	83.3%	
Dec-24	81.0%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/12/2024 the latest DM01 Compliance performance is 81.0% against a Trajectory target of 75.0% (higher is better).

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

The biggest contributing factors are: MRI (90.2% , 531*), Non Obstetric Ultrasound (80.8% , 512*), Sleep Studies (45.2% , 430*). *Breaches

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
MRI back log	• MSK demand management • Capacity and Template review. • Booking team and process review.	• DM01 recovery lead / HOO for Imaging	• Ongoing	• Initial referral standards circulated with ICB GP`s waiting feedback. • Bookings efficiency in core capacity has increased activity by 10%. • Extension of a mobile unit with CDC funding increasing capacity unit the end of March. • DM01 performance has dropped to 81.2% this id mainly due to festive holiday reduction in capacity which should recover quickly
NOUS back log	• Review underutilised capacity • Booking team and process review.	• DM01 Rec Lead / HOO for Imaging	• Sept 24	• New booking visualisation tool working well supporting the team to use all capacity. • DM01 up to 84.6%, review ongoing expectation that this will increase following festive reduction in capacity. • Although the service continues to improve, a major review of the booking and capacity underway to ensure service sustainability.
Echocardiography Back log	• Capacity gap	• Cardiology GM	• Ongoing	• Performance improved to 53% due to better chronological booking, total PTL remaining at 1,119. • Insourcing delayed due to staffing issues with the provider. • Funds allocated to support a validation program. • Activity gap mitigation to be addressed as part of business planning.

Integrated Improvement Plan (IIP)

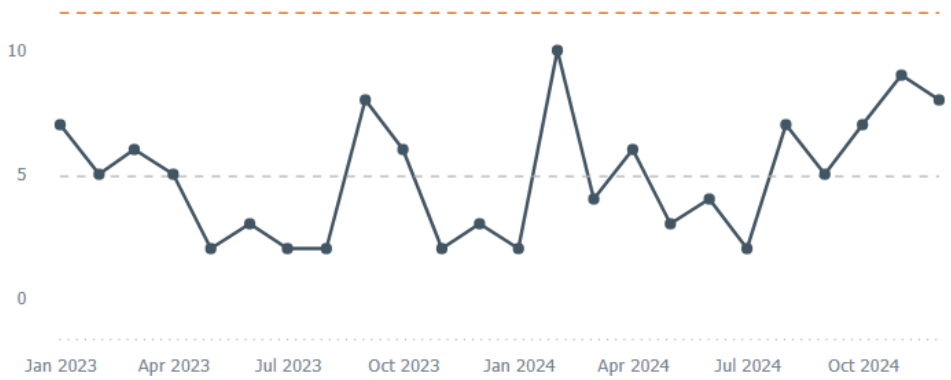
Patient Falls with Moderate or Above Harm Recorded

Falls with Harm

Timescale	Value	SPC
Jan-24	2	
Feb-24	10	
Mar-24	4	
Apr-24	6	
May-24	3	
Jun-24	4	
Jul-24	2	
Aug-24	7	
Sep-24	5	
Oct-24	7	
Nov-24	9	
Dec-24	8	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/12/2024 the latest Falls with Harm performance is 8 against a (6 Sigma Threshold) target of 12 (lower is better).

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Harm from falls increasing since July 2024.	• Trends from Hot Spot areas identified Trust Wide, Care Group to report progress and local actions in to Falls Steering Group.	ADoN/ Falls Lead/ Care Group DoNs.	March '25	• Hot spots wards working with falls team and through 'We Care' to learn from trends in all falls and actions being put in place to address. • Hot Spot areas to share improvements at bi monthly Falls Steering Group

Integrated Improvement Plan (IIP)

Falls with Harm; Actions Table

Falls with Harm (con't)

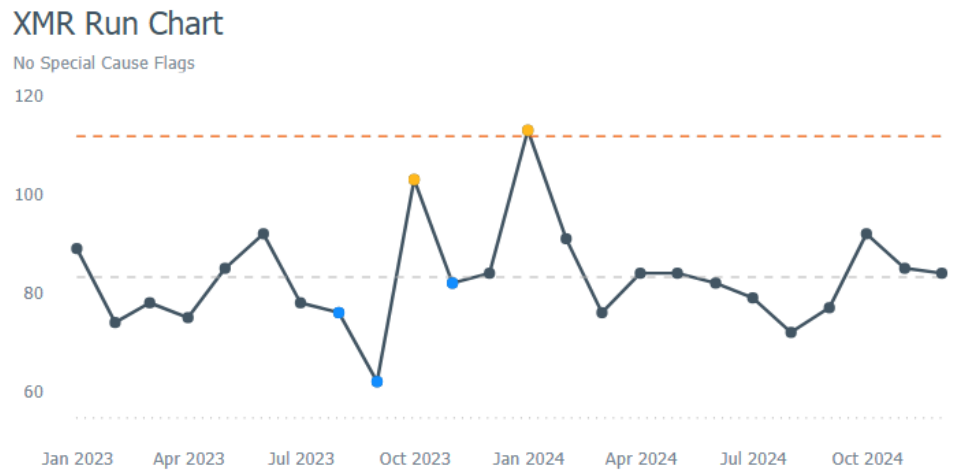
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
A consistent theme in audits and incidence data is that MFRACP risk assessments are incomplete or inaccurate leading to delayed Falls prevention and treatment strategies and increase in patient falls. Findings from completed risk assessments not always acted upon correctly.	• To provide training and education on risk assessment completion.	ADON FoCC/CNIO	• February 2025	• Associate Director of Fundamentals of Care and Chief Nursing Information Officer reviewing all risk assessments on Sunrise. IT software being trialled 'to prevent system drop outs'.
		ADoN FoC/ADoN WDET.	• June 2025	• To design a two day clinical induction programme for new starters to include all aspects of Fundamentals of Care
		Falls Lead	• June 2025	• Moodle training developed for End of Bed (EOB) risk assessment to be added to ESR to support training for Multifactorial Risk Assessment Care Plan completion.
	• MHRA Trolley and Bed rail risk assessment education for completion as per alert to be provided.	ADoN FoC	• January 2025	• Trustwide review of embedding of bed rail risk assessment and training being undertaken. Review to be presented to FOCC February 2025.
	• Falls dashboard to be created to include MFRACP completion including time reports and clinician status completing.	Falls Lead	• March 2025	• IT agreed and in queue for Sunrise amendments.

Integrated Improvement Plan (IIP)

Pressure Ulcers; Hospital Associated

Pressure Ulcers

Timescale	Value	SPC
Jan-24	113	
Feb-24	91	
Mar-24	76	
Apr-24	84	
May-24	84	
Jun-24	82	
Jul-24	79	
Aug-24	72	
Sep-24	77	
Oct-24	92	
Nov-24	85	
Dec-24	84	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/12/2024 the latest Pressure Ulcers performance is 84 against a (6 Sigma Threshold) target of 112 (lower is better).

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
A consistent theme in audits and incidence data is that risk assessments are incomplete or inaccurate leading to delayed pressure ulcer prevention strategies and increase in pressure ulcer development or deterioration.	• To review pressure ulcer training with a view to produce a mandatory module. Moodle training being developed regarding end of bed risk assessments.	TV Lead AND for FOC/ADN for WDET	**April 2025**	• Lead TVN presented at Statutory Mandatory and Essential Training Steering Group represented on 13th November 2024. Discussed with meeting chair need to adjust TNA. meeting chair for update. • To design a two-day clinical induction programme for new starters to include all aspects of Fundamentals of Care
	• Liaising with Sunrise regarding simplifying the risk assessment process.	ADON for FOC/ CNIO	**February 2025**	• Associate Director of Fundamentals of Care and Chief Nursing Information Officer reviewing all risk assessments on Sunrise. IT software being trialled 'to prevent system drop outs'. • To design a two day clinical induction programme for new starters to include all aspects of Fundamentals of Care.
	• Working with the Quality improvement and ward accreditation teams to audit identified areas of concern. These areas to present improvements to TVSG.	**QI Lead**	**April 2025**	• Continual project as part of CQUIN. Results presented to individual areas and local action plans to be presented to Tissue Viability Steering group in January 2025. Providing training to areas identified in the ward accreditation as not meeting target for PURPOSE T completion. Ongoing action.
	• Trust Wide Improvement Plan (TWIP) to be reviewed to align with Patient Safety Incident Review Framework.	TV lead/Care groups	**April 2025**	• TWIP to be reviewed. Working with Improvement & Transformation Team to formulate an effective action plan for 2025/26. Stakeholders review meeting to be held on 26/2/25.

Integrated Improvement Plan (IIP)

Pressure Ulcers; Action Table

Pressure Ulcers (con't)

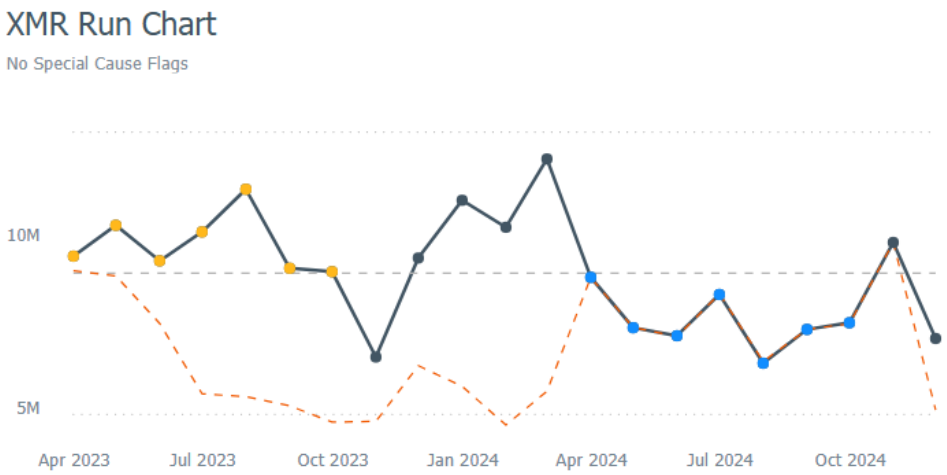
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Increased pressure damage noted due to long gaps in repositioning. With an increase in shear.	• To develop guidance on the repositioning of patients with unstable spinal issues.	TV Lead	March 2025	• Short guidance provided in updated Pressure Ulcer Prevention policy. Further national guidance is being developed.
	• To review current foam mattresses and tender for replacements.	Manual Handling and TV Leads	April 2025	• One mattress has been shortlisted as part of tender process. Demo day held at QEQM on 8/1/25 for IPC and Falls team to review. Modifications to be made to evacuation sheets prior to purchase
	• To review data to drill down into themes and barriers for repositioning gaps. Attendance from specialist teams and clinical teams' representation.	TV Lead	March 2025	• Trustwide, multidisciplinary stakeholder event set for 26th February 2025. • TV reviewing data in preparation for the event.
An increasing number of hospital acquired moisture associated skin damage (MASD) is contributing to the high numbers of hospital acquired pressure ulcers.	• Identify suitable incontinence products with colleagues from the Procurement Team, To include a trust wide education programme on the correct use and application of incontinence products.	TV Lead	January 2025	• Discussed at Procurement assurance group in November to produce a reduced formulary to streamline products. Company representative to attend ward managers meetings to raise awareness. To be discussed at February Stakeholder event.
	• To ensure that learning from incidents is captured on the Trust wide improvement plan to ensure that the correct actions are in place.	TV Lead	March 2025	• Trustwide, multidisciplinary stakeholder event set for 26th February 2025.
Delay in obtaining appropriate support surface for the most vulnerable patients starting within the Emergency Departments.	• To improve the trollies in ED to include a high specification mattress.	MH Lead	April 2025	• Mitigations in place for potential issues with Radiology concerns. Trial recommenced on 8th January. Procurement to discuss how the trial has progressed with radiology on 10th January 2025.
	• Training on accurate risk assessment will improve the compliance with pressure ulcer prevention strategies. Modules being developed for pressure ulcer risk assessment and correct interventions on ESR.	WDET/ FoC	March 2025	• Risk assessment module for ESR completed. ADoN FoC and ADoN WFD to review and develop governance processes. Timeframe to be confirmed.
	• ED representation to be involved in the TWIP stakeholder event to discuss themes and barriers to obtaining equipment.	ADON ED	March 2025	• Trustwide, multidisciplinary stakeholder event set for 26th February 2025. • TV reviewing data in preparation for the event.

Integrated Improvement Plan (IIP)

Income & Expenditure Monthly Deficit (Group)

Deficit In Month Group (£)

Timescale	Value	SPC
Jan-24	11.0M	
Feb-24	10.2M	
Mar-24	12.2M	
Apr-24	8.8M	
May-24	7.3M	
Jun-24	7.1M	
Jul-24	8.3M	
Aug-24	6.3M	
Sep-24	7.3M	
Oct-24	7.5M	
Nov-24	9.8M	
Dec-24	7.0M	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/12/2024 the latest Deficit In Month Group (£) performance is 7.0M against a Trajectory target of 4.9M (lower is better).

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

The biggest contributing factors are: CORPORATE (10.6M*), OTHER (5.4M*), CRITICAL CARE, ANAESTHETICS AND SPECIALIST SURGERY CARE GROUP (3.1M*). *£'s

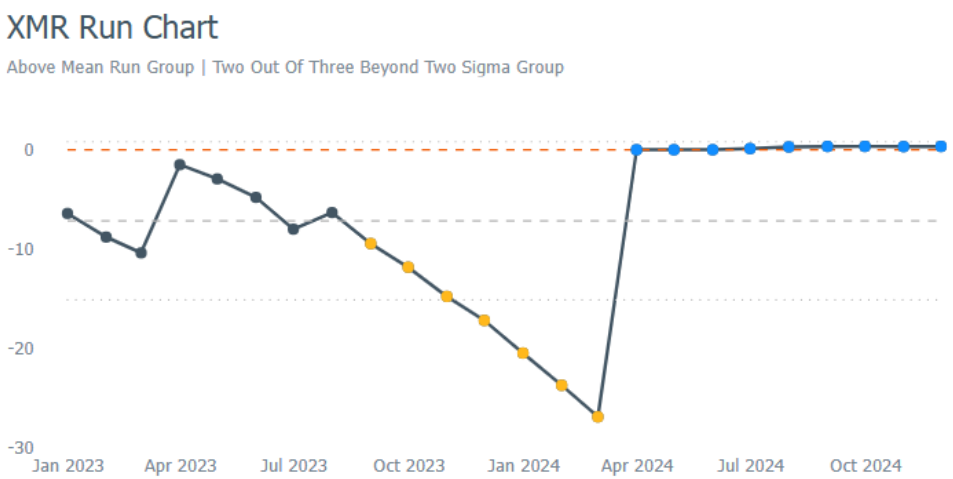
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining achievement of financial plan through Quarters two to four	• Increase level of CIP plan being developed to mitigate any potential slippage against efficiency schemes • Embedded bi-weekly FIPB with full Care Group representation and Theme lead presentations on a rotation basis	• Theme leads • PMO	• Q3 & Q4	• Until Month 8 the year to date position had hit the monthly planned deficit figures. In Month 9, there is an overspend by £2.1m against the planned deficit. However, the profile of the plan in the final three months of the year and the Trust's reducing run rate suggest that the Group will recover this overspend and still meet the plan for the full year, albeit with a need to proactively manage in year risks. • In year we are on plan to deliver the CIP target with tight continued focus on the recurrency of individual themes to support year on year benefits. • Looking to 25-26 and our Financial Sustainability Plan (FSP) for the coming financial years, the Trust launched its CIP development plan for 25/26 in November. The Trust is required to deliver a level of CIP which will support meeting the 25-26 (year 1) deficit plan, with at least the same level of ambition as being delivered in year.
Currently 3 additional cost pressures are being mitigated on a non-recurrent basis	• Reporting into the ICB on the shortfall of the pay award funding. YTD £1.6m & £2.1m estimated FYE. • HCP monies have reduced from prior year by £1.8m YTD and £2.4m FYE. • The number of working days ERF baseline change has impacted the Trust by £1.8m YTD and £2.4m FYE	• CFO	• Q4	• On-going monitoring of the financial impact of the pay awards. • Delivery of the NLF2R has reduced both pay and non pay in year.

Integrated Improvement Plan (IIP)

Financial Efficiencies; YTD Variance

Efficiencies YTD Variance (£M)

Timescale	Value	SPC
Jan-24	-20.5	
Feb-24	-23.7	
Mar-24	-26.9	
Apr-24	0.0	
May-24	0.0	
Jun-24	0.0	
Jul-24	0.1	
Aug-24	0.3	
Sep-24	0.3	
Oct-24	0.3	
Nov-24	0.3	
Dec-24	0.3	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/12/2024 the latest Efficiencies YTD Variance (£M) performance is 0.3 against a static target of 0.0 (higher is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensure identification of CIP opportunities sufficient to reach the required £49m Recurrent CIP target for 2024/25	• PWC support to PMO function • Financial Recovery Director in post	Financial Recovery Director	• On-going	• The trust is £0.3m above plan with CIP delivery at Month 9 of £35.2m, of which £8.6m is non-recurrent. • Current year pipeline view is now broadly focused on delivering forecast year end position. • The key focus is now on development of FY2526 and considering opportunities that can be brought forward to FY2425.
Ensuring robust CIP reporting of achievement	• Streamlined reporting process • Robust CIP Methodology	Financial Recovery Director DOF	• On-going	• CIP Methodology defined for each scheme. • CIP reporting process streamlined. • CIP forecasting in process of validation with Theme leads and Finance business partners.
Insufficient PMO Resource to support the development and execution of the CIP Programme	• PWC support to PMO function in place • Formulate a new PMO structure and resourcing profile	Financial Recovery Director	• December 2024 and Q4	• New PMO Structure proposed and approved by Execs. Trust to proceed with securing the necessary resources to bolster the PMO and support the CIP programme effectively. • 2 Band 7, 1 Band 8a and 1 Band 8b appointed substantively. Further candidates to finalise joining dates in Q4.

Patients

Assurance

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

Patients

Executive Summary:

Unplanned Care
Attendances were again above contract at Trust level in December 2024 for Type 1 and UTC, although admissions remain below plan due to challenges in flow through in particular to the SDEC and front door services.

Whilst the number and time that patients are spending in the corridor is significantly less than the same period last year, this remains a concern with regards to National performance against the 12 hour standard and the associated patient experience and remains a core focus for improving flow through the hospitals, as well as avoiding admissions and attendances and therefore impacts on our ability to exit national tiering.

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

Planned Care
Robust plans in place to manage 78 weeks to single figures, noting challenges with capacity within paediatric ENT with insourcing due to start in January 2025.

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

Endoscopy waiting list remains around 4,500 and is sustainable at the current run rate, operating a 6.5 day week.

Theatre utilisation was 76.7% in December 2024. Theatre Utilisation transformation programme of work ongoing with senior level governance of 8-6-4-2 process and check and challenge of list level planned utilisation at specialty scheduling meetings.

DM01 improvement program continues to deliver with a small deterioration in performance due to reduced activity over the Christmas and New Year period.

Patients

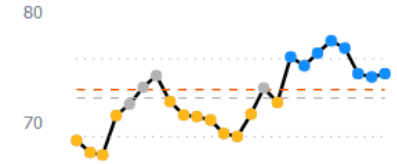
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24
Patients	NAT		ED Compliance			73.0%	68.8%	70.8%	73.1%	71.8%	76.0%	75.2%	76.3%	77.4%	76.8%	74.4%	74.1%	74.4%
	IIP		Type 1 Compliance 4hrs			50.0%	42.9%	45.1%	50.3%	47.4%	53.2%	52.0%	54.7%	56.2%	56.5%	54.1%	53.7%	54.7%
	IIP		12 Hr Total Time in Department			8.0%	11.1%	10.3%	9.4%	10.0%	9.5%	9.6%	9.4%	9.2%	9.2%	9.7%	9.5%	10.2%
	NAT		12Hr Trolley Waits			0	1,368	1,111	1,131	1,207	1,227	1,189	1,085	1,033	1,017	1,171	1,121	1,326
	NAT		Ambulance Handovers within 30m			95.0%	89.4%	88.0%	87.9%	88.3%	92.6%	88.1%	87.7%	89.8%	88.6%	86.6%	90.0%	88.4%
	IIP		% Beds Occupied 14+			30.0%	34.3%	32.5%	30.6%	32.5%	30.8%	29.6%	30.0%	30.8%	34.3%	32.0%	28.2%	29.1%
	KEY		Super Stranded >21D			107	244	229	209	224	214	205	203	212	237	212	178	184
	NAT		Not Fit to Reside (pats/day)			100.0	184.5	166.2	168.9	171.9	170.5	171.8	180.4	189.3	197.4	195.0	157.7	155.3
	IIP		Cancer 28d Combined Performance			77.0%	57.8%	66.9%	68.3%	64.9%	70.2%	70.4%	72.6%	71.0%	69.8%	71.3%	71.8%	74.5%
	NAT		Cancer 31d Combined Performance			96.0%	92.5%	95.3%	91.5%	93.5%	96.2%	95.0%	96.3%	95.7%	95.8%	93.4%	94.7%	97.2%
	IIP		Cancer 62d Combined Performance			70.0%	56.1%	55.6%	69.1%	66.2%	64.1%	63.0%	71.6%	73.2%	72.8%	70.4%	74.1%	74.7%
	IIP		Cancer Over 62d on PTL			200	419	244	188	236	237	233	203	244	215	193	203	216
	KEY		Cancer Over 104d on PTL			0	84	62	43	38	36	42	39	54	50	36	40	33
	KEY		Cancer Rapid Access Perf			93.0%	93.0%	97.1%	95.9%	94.5%	94.6%	96.1%	94.7%	91.2%	94.0%	83.3%	87.1%	93.2%
	NAT		RTT Incomplete Performance			50.2%	49.0%	50.1%	50.8%	51.9%	52.0%	51.0%	50.3%	50.8%	50.9%	50.5%	51.2%	52.0%
	NAT		RTT Total Incomplete Pathways			88.7K	90.0K	87.2K	85.4K	86.9K	87.5K	85.8K	85.6K	88.1K	86.7K	86.0K	85.6K	83.0K
	NAT		RTT 52w Breaches			5,662	6,912	6,691	6,613	6,356	5,700	5,186	4,773	4,657	3,735	3,353	3,119	2,959
	IIP		RTT 65w Breaches			575	2,698	2,695	2,301	2,203	1,802	1,656	1,360	1,269	572	346	247	216
	IIP		RTT 78w Breaches			0	752	653	485	465	272	82	35	32	34	11	10	7
	IIP		RTT 104w Breaches			0	6	13	24	15	1	1	0	1	0	0	0	0

Patients

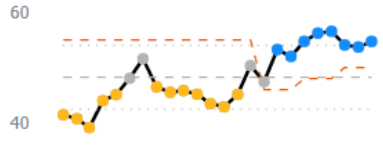
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24
	IIP		Endoscopy Backlog			1,763	9,116	8,005	7,238	18.5K	15.5K	12.3K	9,054	5,991	3,912	1,989	1,173	1,119
	IIP		DM01 Compliance			75.0%	54.2%	61.6%	61.2%	62.5%	63.5%	60.9%	61.3%	64.0%	68.5%	77.2%	83.3%	81.0%
	KEY		Theatre Session Opp.			25	45	42	33	40	40	33	40	51	39	44	35	45
	NAT		DNA Rate OP New			7.0%	7.8%	7.0%	6.7%	6.8%	7.0%	6.9%	7.3%	7.8%	7.8%	7.6%	7.7%	8.1%
	NAT		Theatre Uncapped Utilisation			85.0%	76.7%	78.1%	79.2%	80.7%	78.5%	79.9%	78.0%	79.2%	77.1%	77.7%	78.0%	76.7%

Patients

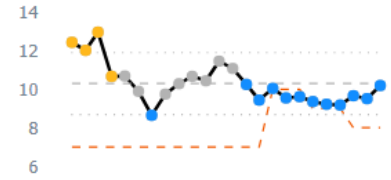
ED Compliance



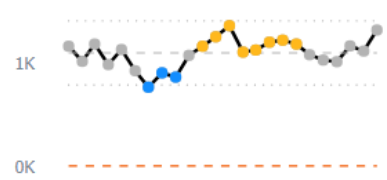
Type 1 Compliance 4hrs



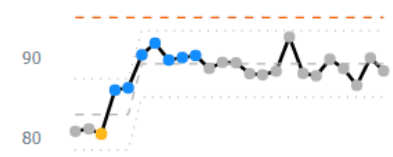
12 Hr Total Time in Department



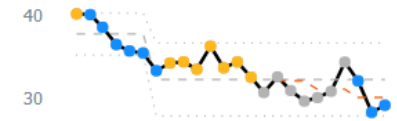
12Hr Trolley Waits



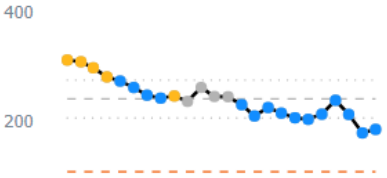
Ambulance Handovers within 30m



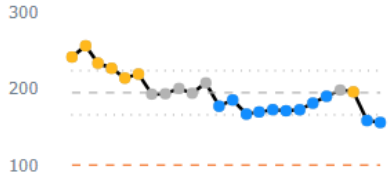
% Beds Occupied 14+



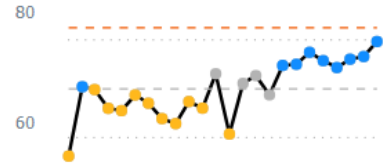
Super Stranded >21D



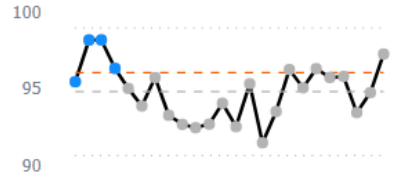
Not Fit to Reside (pats/day)



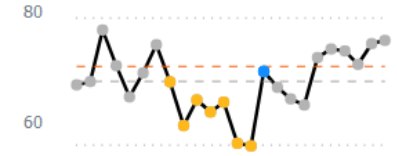
Cancer 28d Combined Performance



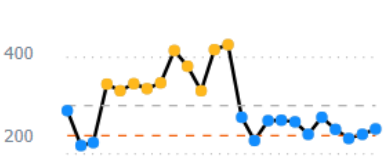
Cancer 31d Combined Performance



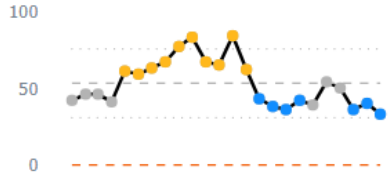
Cancer 62d Combined Performance



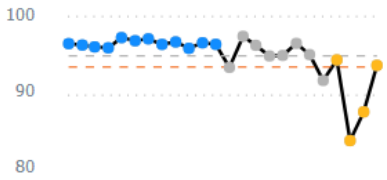
Cancer Over 62d on PTL



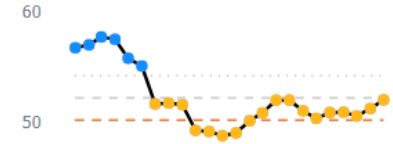
Cancer Over 104d on PTL



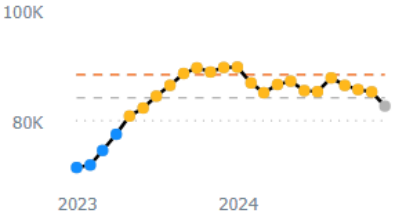
Cancer Rapid Access Perf



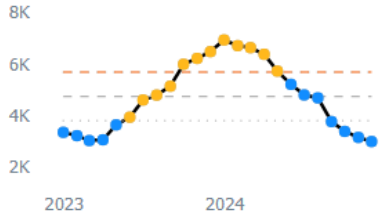
RTT Incomplete Performance



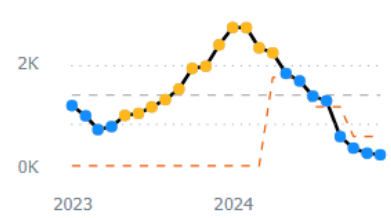
RTT Total Incomplete Pathways



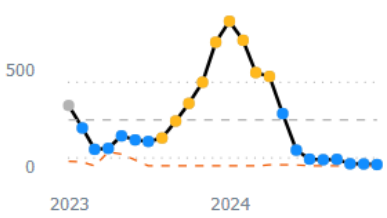
RTT 52w Breaches



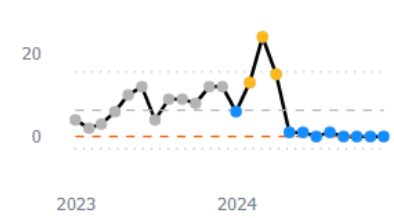
RTT 65w Breaches



RTT 78w Breaches

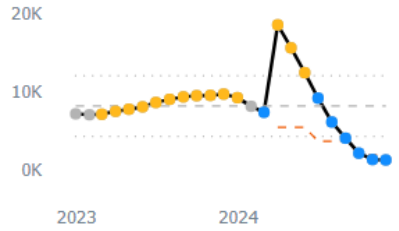


RTT 104w Breaches

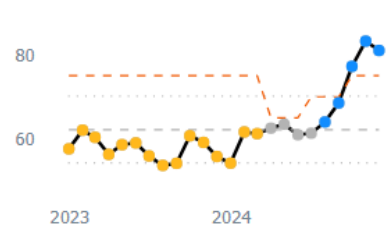


Patients

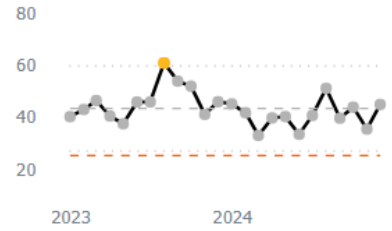
Endoscopy Backlog



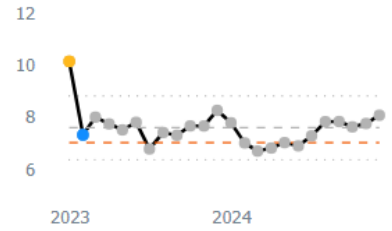
DM01 Compliance



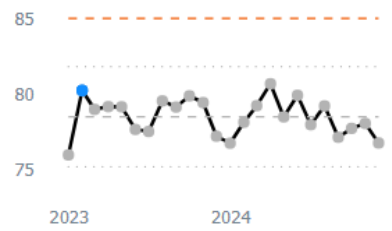
Theatre Session Opp.



DNA Rate OP New



Theatre Uncapped Utilisation



Quality and safety

Assurance

Variation

	P — Will consistently pass the target if nothing changes	? — Will not consistently pass or fail the target if nothing changes	F — Will consistently fail the target if nothing changes
H / L — Improving Variation (High or Low)		Duty of Candour - Verbal Safeguarding Adults Training Safeguarding Children Training	AARs Overdue Complaint Response NICE Compliance Overdue Incidents VTE Assessment Compliance
No Significant Change	FFT Satisfaction Level - Outpatient	After Action Reviews (AARs) Complaints Number Duty of Candour - Findings Duty of Candour - Written 15wd Falls with Harm FFT Satisfaction Level - Inpatient IPC: CDiff Infections IPC: EColi Infections IPC: Klebsiella Infections IPC: MRSA Infections IPC: MSSA Infections IPC: Pseudomonas Infections Mixed Sex Breaches	FFT Satisfaction Level - ED
H / L — Concerning Variation (High or Low)		PSII - Internal	HSMR

Quality and safety

Executive Summary:

Safeguarding Incidents:
Our overall training compliance as a Trust is 93.3% for Adult Safeguarding and 91.7% for Children Safeguarding. There remain identified groups of staff below 85% compliance described in CR3733, they are monitored through the operational safeguarding group. The safeguarding team have offered additional capacity in the training schedules. The Care Groups (CG) have produced trajectories which are discussed at CG PRMs. The maternity services are seeing a significant increase in safeguarding referrals and the level of safeguarding supervision, while improving is 27% currently. A business case, funded by CNST achievement is being progressed to place two additional safeguarding practitioners in the maternity services, initially for a one year period.

Complaint Response:
December 2024 has seen a continued increase in performance of responses for stage 1, a performance trajectory was set in September 2024. The Key Performance Indicator (KPI) of 85% compliance was achieved in December 2024. Work is ongoing to continue to meet the KPI including: weekly reporting, training for care group staff, a focus on the quality of responses by working closely with the care groups, targeted work on the 90+ working day old complaints.

Patient Safety Incident Investigations
Incidents are reviewed and investigated in accordance with the Trust's Patient Safety Incident Response Framework (PSIRF) Policy and Plan. There are national requirements for which a patient safety incident investigation (PSII) is required; and local requirements where the complexity and the potential learning is deemed to warrant a detailed systems analysis. PSIIs explore decisions and actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can.

The Trust at the end of December had:
13 nationally reportable PSIIs ongoing: 5 NEs, 1 antenatal screening, 1 medication incident identified through LfD, and 6 Maternity and Neonatal Safety Investigations (MNSI)).
6 Local PSIIs (including one Maternity case identified via PMRT review)

Never Events:
There were no new Never Events reported in December. Current Never Event investigations are ongoing.

Duty of Candour:
In December, 100% compliance was achieved for verbal and written components, and sharing findings of the investigation in writing. This the second consecutive month that 100% compliance has been achieved across all three components. Twice weekly governance meetings are in place to identify and resolve barriers to completion and an escalation plan is in place to ensure cases approaching completion date are escalated to Triumvirate and DQG prior to becoming overdue

Quality and safety

Executive Summary:

Overdue Incidents:
Although work to reduce overdue incidents continues, despite great efforts, the number of overdue incidents did not decrease in December. In December 756 incidents became overdue, with an average of 32 incidents becoming overdue daily (an increase from 23 per day in November), this offsets any closures of existing overdue incidents and accounts for why the total number does not appear to be reducing. Quality Governance staff continue to provide daily support to Care Group staff however clinical staff report challenges in ringfencing time to complete incident reviews. The Corporate Team continue to close those incidents that are near completion or completed, for those that require further work by nursing or medical staff they provide direct support if required, as well as twice weekly updates and reminders. We need to understand further the underlying factors that are preventing timely closure. Once completed, a detailed plan with a trajectory will be created by the end of January 2025. The Triumvirates will be provided with the plan and twice weekly updates on progress against their trajectory will continue.
Review of incidents overdue by 6 months or more has identified the small proportion open for justifiable reasons e.g. safeguarding awaiting KCC, remaining SI, PSIIs.

InPhase:
There has been a number is functionality issues that have arisen during the first phase of implementation with the Risk, Policies and CQC Apps. All these issues are significant and therefore has stalled progress until confirmation that InPhase will adapt their system to meet our needs. Confirmation of this has been gained last week however we require a meeting with their technical team and our App leads to provide final assurance that the adaptations will be of the required standard. The significant risks within the project have now been reduced as it was agreed to allowed the Datix contract to lapse for a further year, providing time for appropriate testing prior to go live. The project plan for Stage 2. (NICE, CAS, Complaints & PALS and Audit Lifecycle) and Stage 3. Incidents, Safeguarding, Claims and Action Planning, has now been agreed

Infection Prevention and Control:
C-dif and E-coli cases remain below the current thresholds, Klebsiella is breaching, albeit on a downward trajectory, however, the Trust has already breached the year end threshold for pseudomonas, which continues to increase, therefore significant focus is now on environmental factors that maybe influencing these cases. MRSA and MSSA rates remain lower than the previous year. There has been a significant norovirus outbreak in QEQM hospital, impacting 9 wards, regular outbreaks meetings in place and support to sites continues.

Mixed Sex Breaches
65 breaches occurred in month. There were 45 patients unable to be stepped down from critical care within the four hour standard. There were two occasions where patients were admitted to AAU overnight and shared same sex accommodation, resulting in 19 patients being affected. There was one occasion on RSW at WHH that a patient was boarded in the corridor resulting in 1 breach to the Mixed Sex Standard.
There is one toilet available for patients in AAU for both male and female patients to use, resulting in 19 patients being affected. A plan is in place for this to be resolved during January 2025.

Quality and safety

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24
Quality	NAT		Patient Safety Incidents			2,243		762	1,951	1,938	1,979	1,846	2,040	1,865	1,889	2,108	2,081	1,972
	NAT		Patient Safety Incidents - Mod/Sev			62		12	39	37	27	47	38	38	33	50	44	49
	NAT		Never Events			0	1	0	1	0	0	1	0	2	2	1	0	0
	NAT		PSII - National			0	1	0	1	0	0	1	4	3	2	2	0	1
	NAT		PSII - Internal			0	0	0	0	0	0	0	1	1	1	0	2	0
	NAT		After Action Reviews (AARs)			0	9	12	11	9	7	3	11	5	5	6	10	3
	NAT		AARs Overdue			0	37	40	44	49	51	52	45	27	23	24	26	25
	KEY		Overdue Incidents			0	2,986	1,663	1,358	822	1,406	1,557	1,164	724	688	659	734	757
	IIP		Falls with Harm			12	2	10	4	6	3	4	2	7	5	7	9	8
	NAT		Safeguarding Incidents			54	42	34	53	33	50	32	29	28	31	33	38	34
	NAT		Safeguarding Children Training			90.0%	91.9%	93.6%	93.5%	94.3%	93.6%	93.3%	92.3%	91.8%	91.2%	91.3%	91.5%	91.7%
	NAT		Safeguarding Adults Training			90.0%	89.8%	91.7%	92.1%	93.2%	93.5%	93.6%	93.0%	93.4%	92.7%	93.0%	93.1%	93.3%
	NAT		Duty of Candour - Findings			100%	92.9%	100%	100%	100%	81.3%	84.2%	91.7%	74.3%	94.6%	87.5%	100%	100%
	NAT		Duty of Candour - Written 15wd			100%	88.5%	95.5%	89.5%	70.0%	64.0%	64.3%	48.4%	82.8%	88.9%	96.4%	100%	100%
	NAT		Duty of Candour - Verbal			100%	90.9%	91.3%	94.7%	76.2%	78.3%	78.9%	86.4%	87.9%	100%	95.8%	100%	100%
	NAT		IPC: EColi Infections			13	13	14	17	10	11	16	14	13	16	9	9	13
	NAT		IPC: CDiff Infections			12	11	8	14	4	4	6	9	8	12	11	11	9
	NAT		IPC: Klebsiella Infections			7	5	4	5	10	7	7	9	7	11	5	6	9
	NAT		IPC: Pseudomonas Infections			2	3	4	3	2	2	4	5	2	4	2	7	4
	NAT		IPC: MRSA Infections			0	1	0	1	0	0	0	0	1	0	0	1	0
	NAT		IPC: MSSA Infections			6	8	7	2	6	7	5	8	6	8	5	2	7

Quality and safety

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24
	KEY		HSMR			96.0	103.7	103.5	102.9	102.9	102.2	102.1	102.8					
	IIP		Pressure Ulcers			112	113	91	76	84	84	82	79	72	77	92	85	84
	NAT		Mixed Sex Breaches			152	132	134	132	120	24	36	76	56	57	68	52	65
	KEY		Complaint Response			85%	10.0%	15.5%	18.8%	0.0%	4.3%	7.8%	17.3%	18.6%	30.9%	55.4%	70.6%	85.4%
	KEY		Complaints Number			116	100	81	77	101	102	79	95	92	99	89	89	95
	NAT		FFT Satisfaction Level - ED			90.0%	80.3%	79.4%	80.5%	81.6%	83.7%	83.8%	83.6%	88.1%	86.9%	82.9%	81.2%	81.4%
	NAT		FFT Satisfaction Level - Outpatient			90.0%	95.5%	95.4%	95.2%	95.9%	95.7%	95.7%	95.4%	95.6%	95.7%	95.3%	95.8%	95.8%
	NAT		FFT Satisfaction Level - Inpatient			90.0%	90.0%	92.0%	89.8%	89.4%	91.1%	90.5%	92.3%	91.0%	90.0%	88.9%	91.5%	91.4%
	NAT		VTE Assessment Compliance			95.0%	91.6%	92.4%	92.5%	92.3%	93.2%	93.4%	92.7%	93.3%	93.7%	94.1%	93.6%	92.5%
			NICE Compliance			65.0%				4.3%	8.6%	16.5%	25.2%	34.4%	50.0%	62.9%	63.4%	74.6%

Quality and safety

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patient Safety Incident Response (PSIR) Framework: National and Local Patient Safety Incident Investigations (PSIIs)	• Terms of Reference (ToR) for Learning Response Approval Panel (LRAP) have aligned to the NHS Oversight requirements. The draft ToR have been circulated for comments and will be finalised by the end of January 2025. • PSIR Plan review to commence January 2025 to align refreshed plan with Quality Account timeframes (April 25 to March 26). • Re-introduce patient safety training programme by 31 March 2025: PSIRF, Swarm, AAR, Incident Investigation, Engagement/Duty of Candour, Human Factors	• Head of Patient Safety and Improvement	31/03/2025	• Weekly report to Executives includes detail of PSIIs. • Training Needs Analysis in place. Review of training content underway to further align with the National Patient Safety Syllabus. • Aiming to re-introduce AAR and Swarm in January 2025. PSIRF, Engagement/Duty of Candour in February 2025. Incident Investigation and Human Factors in March 2025.
One new nationally reportable PSII in December 2025	Maternity PSII: A baby cooling incident • Presented at IRP • Reported on StEIS 20/12/2024 • DoC completed • Referred for MNSI investigation	• Head of Patient Safety and Improvement	20/06/2025	
Overdue incidents	• Governance Managers focus on supporting closure of incidents in areas with highest number of overdue incidents (e.g. EDs and Acute Medicine) • Governance staff daily ward visits currently limited due to IPC outbreaks but still making contact to provide support • Corporate led weekly review of overdue incidents with quality governance teams and twice weekly governance calls. • Weekly reports of overdue incidents are sent to Triumvirates to provide accurate data on progress. • Weekly report of incidents due in the next two weeks to be followed up with handlers provided by Governance Managers.	• Head of Patient Safety and Improvement • Care Group Directors	31/03/2025	• Continued escalation to Heads of and Directors of Nursing and Medical Directors to enable senior oversight and support. • In relation to medical delays, escalation to the Chief Medical Officer will occur after 4 days of no response. • New trajectories for care groups for closure of overdue incidents to less than 200 by end of March 2025 is being produced and will be circulated to care groups and governance teams.

Quality and safety

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Complaint Performance is below the standard we would expect	• Specific resource continues to be focussed on response reviewing within the complaints team, to drive quality and timeliness of responses. • Weekly reporting is provided to identify breaching complaints and, also age of complaints. • An enhanced escalation process with the triumvirates, supporting promotion of quality and responsive resolutions. • Complainants are updated and advised of any delays within the complaints process. • Fortnightly meetings with care group specialties to discuss progress with trajectories and aged complaints. • Training for care group staff being undertaken, offering 'bite size' sessions concentrating on areas where improvement is required. • Targeted work on the 90+ working day old complaints.	• Head of CPBS	• Ongoing in line with agreed trajectory for clearing the complaint breaches	• Trajectory set, to meet KPI target of 85% within timescales by end of December 2024. Trajectory and LPI met. • The number of stage 1 complaints over 60 working days has significantly reduced from 239 at the end of August, to 57 as at 31.12.2024.
IPC Measures: Due to changes in thresholds, Klebsiella and Pseudomonas Blood stream infections are now over the threshold, and without intervention will breach	• CLEAN campaign continues with focus on antimicrobial stewardship • Environmental and equipment reviews continue	• IPR Team	January 2025	• Trust wide review of FR cleaning ratings and additional protocols commenced • Trust wide review of roles and responsibilities for cleaning in process • Training from Tristel team completed Trustwide
Continued mixed sex breaches	• Clear escalation plan put in place for AAU. • Full capacity protocol	• ADoN for AAU WHH • Chief Operating Officer	• Dec 2024 • October 2024	• Meeting held with key stakeholders and plan agreed • Presented to CEMG for discussion 2nd October, awaiting final sign off.

Quality and safety

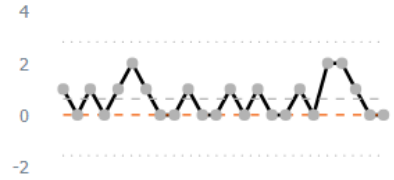
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT Inpatient: satisfaction levels remain around the Trust target of 90% satisfaction. There are significant disparities between satisfaction levels at the three sites, with K&CH scoring much higher than WHH and QEQM. Patient flow through EDs impacts on clinical care and patient outcomes (mobility / skin integrity) and patient experience once on a ward (e.g. being moved several times, lack of handover of key information)	• Improve communication with and involvement of carers / families of patients. • Supporting patients living with dementia by having fewer moves around wards • Supporting the wellbeing of parents / carers whose child / children are receiving inpatient care (Sophie's Legacy) (providing food and drinks when parents/carers stay on the ward with their child). • Supporting patients to get up and dressed; not stay in bed.	• Matron and ward managers • With support from the Dementia team, and Lead for Moving and Handling • Patient Voice and Involvement team	• By early October 2024	**COMPLETED:** • Carers policy published 14.6.24 and on Staff Zone and public website. • Carers leaflet printed + online version on patient information library (link from Carers page) • Updated carers page on Staff Zone • Expanded use of Carers Passports • John's Campaign is on-going • Audit of chairs on wards and plans to improve bedside seating. • Carers Survey continues to indicate a lack of involvement of carers / family in their loved one's care, with only 52.9% of carers saying they were asked about the needs of the person they look after to help plan their care, and only 51.3% saying they were asked if they wanted to be involved in the care of the patient and 36% of people saying they were **not** involved as much as they wanted to be in decisions about their loved one's care and treatment.
FFT Inpatient: satisfaction levels remain around the Trust target of 90% satisfaction. There are significant disparities between satisfaction levels at the three sites, with K&CH scoring much higher than WHH and QEQM. Patient flow through EDs impacts on clinical care and patient outcomes (mobility / skin integrity) and patient experience once on a ward (e.g. being moved several times, lack of handover of key information)	• Improve communication with and involvement of carers / families of patients. • Supporting patients living with dementia by having fewer moves around wards • Supporting the wellbeing of parents / carers whose child / children are receiving inpatient care (Sophie's Legacy) (providing food and drinks when parents/carers stay on the ward with their child). • Supporting patients to get up and dressed; not stay in bed.	• Matron and ward managers • With support from the Dementia team, and Lead for Moving and Handling • Patient Voice and Involvement team	• By early October 2024	**COMPLETED:** • Carers policy published 14.6.24 and on Staff Zone and public website. • Carers leaflet printed + online version on patient information library (link from Carers page) • Updated carers page on Staff Zone • Expanded use of Carers Passports • John's Campaign is on-going • Audit of chairs on wards and plans to improve bedside seating. • BSL video interpreting posters with QR code to provide direct access to 'Interpreters Live' **DELAYED:** • Communication passport for people with hearing or visual impairments being developed in partnership with KCC Sensory Services team

Quality and safety

Patient Safety Incidents

Patient Safety Incidents - Mod/Sev

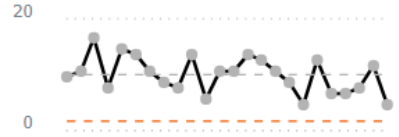
Never Events



PSII - National

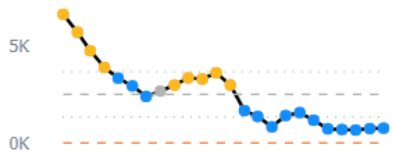
PSII - Internal

After Action Reviews (AARs)

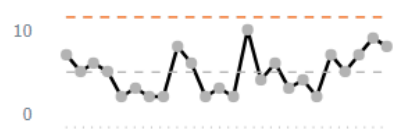


AARs Overdue

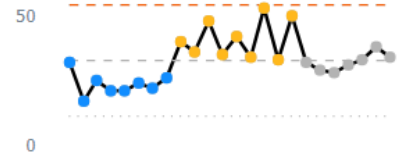
Overdue Incidents



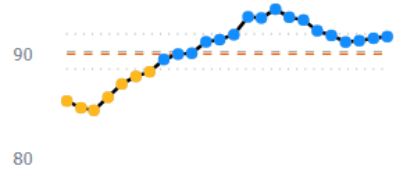
Falls with Harm



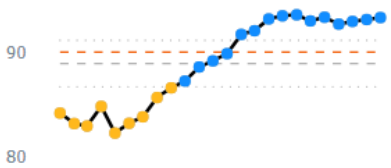
Safeguarding Incidents



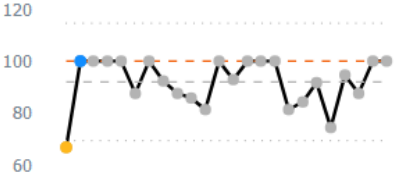
Safeguarding Children Training



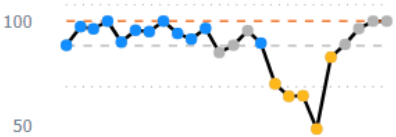
Safeguarding Adults Training



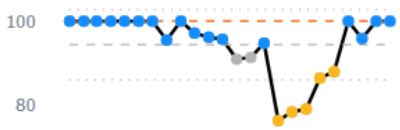
Duty of Candour - Findings



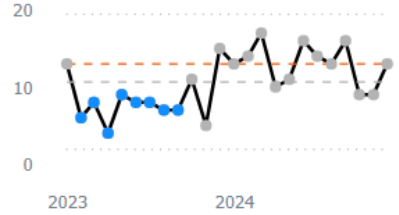
Duty of Candour - Written 15wd



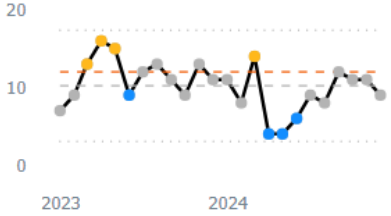
Duty of Candour - Verbal



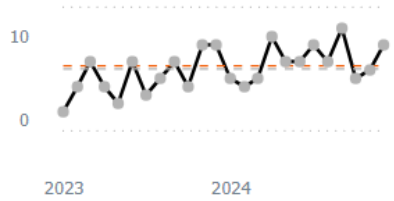
IPC: EColi Infections



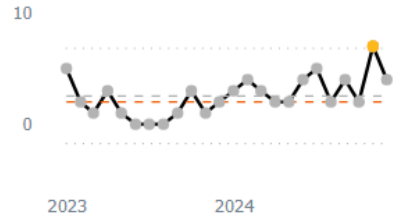
IPC: CDiff Infections



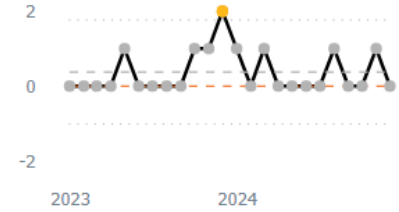
IPC: Klebsiella Infections



IPC: Pseudomonas Infections

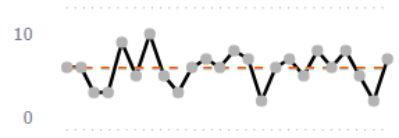


IPC: MRSA Infections

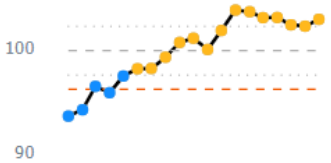


Quality and safety

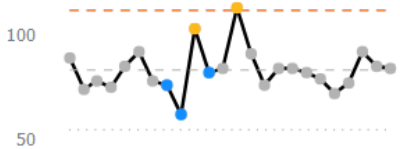
IPC: MSSA Infections



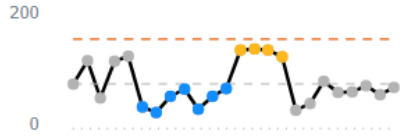
HSMR



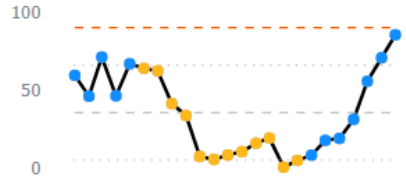
Pressure Ulcers



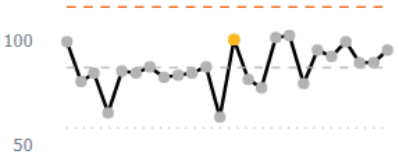
Mixed Sex Breaches



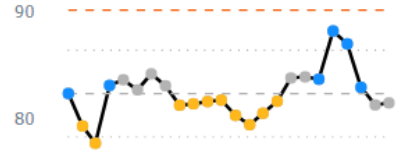
Complaint Response



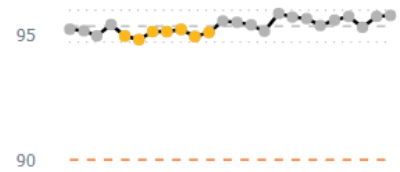
Complaints Number



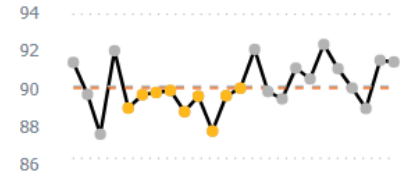
FFT Satisfaction Level - ED



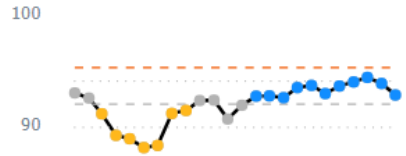
FFT Satisfaction Level - Outpatient



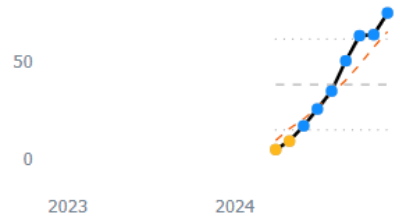
FFT Satisfaction Level - Inpatient



VTE Assessment Compliance



NICE Compliance



Quality and safety

Staff Type	Vacancy Rate Dec-24 (Target 10%)	Sickness Rate Dec-24 (Target 5%)	Safe Care Red Flags Dec-24
Registered Nursing & Midwifery	6.70%	5.59%	414
Registered Nursing Associate	N/A	N/A	
Health Care Support Worker	18.68%	N/A	

Staff Type	Care Hours Per Patient Day (CHPPD) Dec-24	Avg Fill Rate Day Dec-24	Avg Fill Rate Night Dec-24
Registered Nursing & Midwifery	6.7	88%	92%
Registered Nursing Associate	0.1	100%	100%
Health Care Support Worker	3.1	78%	100%

Safe Staffing:
CHPPD is calculated by dividing the number of actual nursing (both registered and HCSW) hours by the number of patients on the ward at 23:59; this advises of the 'nursing' or care hours that are available to each patient per day. Currently our CHPPD is higher than our peer organisations. Further work is required to review the budgets to ensure only staff working within the inpatient area are allocated to the budget identified.

Following approval of the January 2024, updated rosters will go live on the 27th January 2025 with vacancies being recruited too. Rostered shifts, including start and finish times, have been scoped for discussion to ensure future alignment.

The average fill rates for December 2024 are at an acceptable level, however one red shift was declared in the Emergency Department at QEQM. A round table has been undertaken to ensure the shift was escalated in real time and to support learning. The red shift escalation process has been shared with Tactical and Strategic commanders with training made available for site-based teams as required, along with golden key access for NHSP shifts to be released as agency shifts.

People

Assurance

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

People

Executive Summary:

Sickness absence rates remain above the alerting threshold (to 5.6%) for the second month running, after being below the threshold since January 2024. This appears related to a large increase in the numbers of staff absent with coughs, colds and influenza, more than doubling since September – from 513 to 1108 related episodes. Put in context, this has risen from accounting for 0.47% in September, 0.76% in October, 0.81% in November and 1.08% in Decmber. By way of comparison, there have been 242 sickness episodes relating to stress, anxiety and depression, a month on month decrease. An increase remains blunted by the provision of face-to-face counselling and the development of a greater network of wellbeing advocacy and peer support.

Vacancy rate remains relatively stable at 8.8%, having remained at/ around this position for the last quarter. This is down from a height of 9.6% four months ago. The highest vacancy rate is in the QEQM Care Group (9.5%) which is primarily driven by vacancies across UEAM (13.1%). The lowest is across the William Harvey Hospital Care Group (5.7%).

Staff turnover has improved (to 8.7%) and continues the positive trend that has been observed across the last 2 years. It is now the lowest it has been in over 2 years and remains on a positive trajectory. Nursing turnover continues to improve and is now at 7.0% - the lowest it has been in >18 months. In fact, there has been a continuous and positive reduction in nurse turnover since February 2023. Whilst positive, this still equates to 231 nurses and midwife leavers across the last 12 months. Health Care Support Worker turnover has reduced from a height of 24% in May ’23 and currently stands at 9.6%. Premature turnover has improved to 13.5%. This is the best rate since January ’24. Taken together, DCB and CCASS account for almost half (46%) of all premature turnover – although it is noted these are the two largest Care Groups.

Appraisal compliance has remained at the Trust-level threshold (80%), currently standing at 80.0%, and is the highest level since COVID. Rates are highest in Strategic Development and Capital Planning (85.6%). In fact, rates are also above 80% in DCB (81.3%), WCYP (81.0%), KCRVH (82.5%) and CCASS (80.7%). Rates are lowest in Corporate (72.4%) and WHH (76.8%).

Statutory training compliance increased to 92.4%, and improved subtly (by 0.4%) month-on-month. This continues to exceed the Trust-level threshold (91%). All Care Groups are above 90% and although compliance for medical staff remains below the expected threshold, this has responded positively in-month and improved again to 82.2%. Compliancy is highest against the Equality and Diversity modules (95.8%) and lowest against Information Governance (88.6%).

People

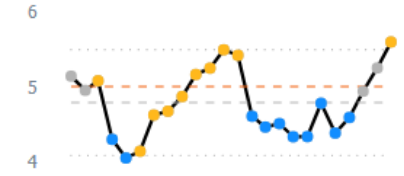
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24
People	NAT		Sickness			5.0%	5.4%	4.6%	4.5%	4.5%	4.3%	4.3%	4.8%	4.4%	4.6%	4.9%	5.2%	5.6%
	NAT		Vacancy Rate			10.0%	7.9%	8.4%	8.7%	8.2%	8.7%	9.2%	8.7%	9.6%	8.7%	8.6%	8.7%	8.8%
	NAT		Staff Turnover Rate			10.0%	9.2%	9.2%	9.2%	9.3%	9.2%	9.2%	8.9%	8.9%	8.9%	8.8%	8.7%	8.4%
	NAT		Premature Turnover Rate			25.0%	14.1%	14.5%	14.9%	14.6%	15.0%	14.9%	15.2%	14.9%	14.8%	14.8%	14.4%	13.5%
	KEY		Appraisals Compliance			80.0%	73.9%	73.6%	73.8%	76.6%	74.7%	74.1%	75.0%	74.8%	77.9%	79.4%	80.3%	80.0%
	IIP		Staff Engagement Score			6.80	6.13	6.13	6.13	5.70	5.70	5.70	5.95	5.95	5.95			
	KEY		Staff Advocacy Score			6.70	5.70	5.70	5.70	4.99	4.99	4.99	5.34	5.34	5.34			
	NAT		Statutory Training			91.0%	91.4%	91.9%	92.0%	92.2%	92.4%	92.5%	92.2%	92.4%	92.2%	92.2%	92.4%	92.4%
	KEY		Infection Control Training			90.0%	92.9%	93.1%	92.9%	92.9%	93.2%	93.7%	93.4%	93.7%	93.5%	93.4%	93.3%	93.2%
	KEY		Hand Hygiene Training			85.0%	72.7%	74.2%	74.9%	75.8%	76.3%	76.8%	79.7%	79.2%	79.0%	79.1%	93.1%	92.9%
	KEY		Medical Job Planning Rate			90.0%	61.1%	70.5%	45.3%	45.3%	44.1%	37.0%	36.5%	33.3%	32.5%	30.3%	32.0%	27.9%

People

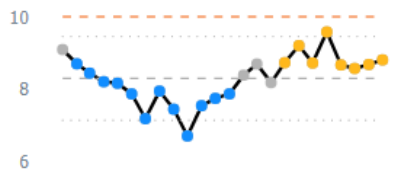
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring vacancy rate remains below the Trust threshold of 10%.	• Monthly monitoring of vacancies across Care Groups, ensuring that active recruitment is taking place. • Focus on hard to recruit areas and supporting new ways of working to reduce reliance on temporary staffing.	Heads of P&C P&CBPs	• Ongoing	• Vacancies at Band 2 remain paused whilst the Trust undertakes the nationally expected work reviewing Band 2/3 roles. • Working with Finance, Temporary Staffing and the CMO office to target areas of long-term and high-cost medical agency, and alternative ways of working. • Vacancies in maternity improved to 11.4% following the recruitment of student midwives in September, but have risen again (to 13%).
Keeping Anxiety & Stress related absence to a minimum, and below 15% of all absences.	• Support from Health & Wellbeing Team and Occ Health to focus on areas of high stress related sickness. Improved Return To Work interviews to support intervention.	Heads of P&C, P&CBPs, OH	• Ongoing	• 403 staff have accessed the service, with 971 counselling sessions delivered and clinically reliable change in 82.1% of staff. • New bid for funding from the East Kent Charity due at CFC in January 2025 , to combine EAP funds and continue to deliver on-site clinical psychology from February 2025 (when it is currently due to expire).
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 remains around **8.4%** and has achieved the gold standard (10%) for over a year. It is currently at the lowest rate the Trust has seen in 2 years.
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 (**13.5%**) remains within the desired parameters (≤15%) and has improved to levels not seen since January 2024.
Staff Engagement levels (5.95) are below the national average (6.78)	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated. • Focus on improving engagement and response rate for 2024 staff survey, with the launch linked to the Culture & Leadership programme implementation.	Head of Staff Experience	• Mar 25	• The response rate to the National NHS Staff Survey is a marker of engagement in itself and acts as a precursor to the scores which are released in January '25. The Trust closed with one of the highest response rates in the country (63%), has achieved a majority response and the highest number of respondents in the Trusts' history. Plans are underway to act on this early in 2025.
Medical staff levels of statutory training compliance are consistently low at an average of 75%. Has been below 80% for 4 years.	• Identifying those staff who are not compliant, and working with GMs and Clinical Leads to address compliance. • Care Groups contacting individuals directly to support improvement of compliance, particularly with trainee doctors.	CMO	• Dec 24	• Compliance is at 82.2%, which is the highest it has been in 4 years. All Care Groups are targeting improvement within medical staff compliance – with medical staff compliance lowest in the Corporate Care Group (76.5%).

People

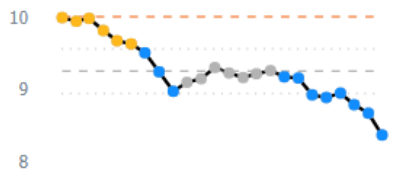
Sickness



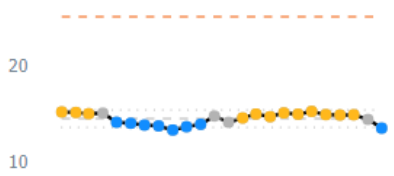
Vacancy Rate



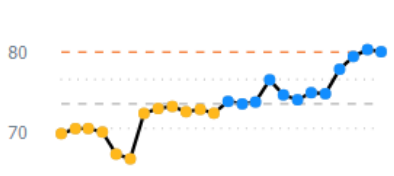
Staff Turnover Rate



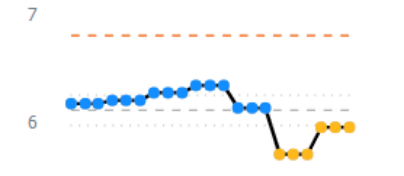
Premature Turnover Rate



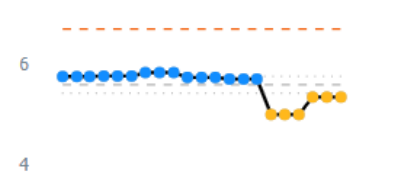
Appraisals Compliance



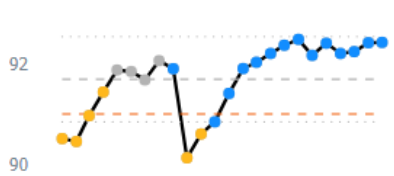
Staff Engagement Score



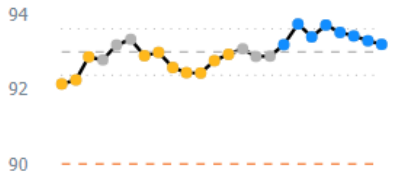
Staff Advocacy Score



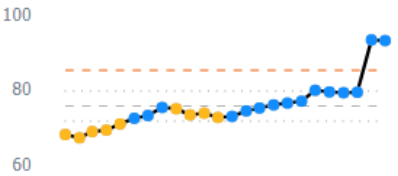
Statutory Training



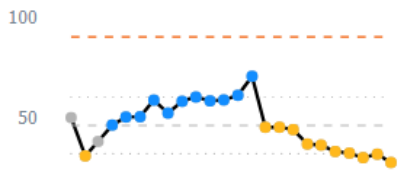
Infection Control Training



Hand Hygiene Training



Medical Job Planning Rate



2023 2024 2023 2024 2023 2024 2023 2024 2023 2024

Sustainability

Assurance

Variation

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

Sustainability

Executive Summary:

The Group has reported a YTD deficit of £69.2m against a deficit plan of £67.1m to Month 9. Until Month 8 the year to date position had hit the monthly planned deficit figures. In Month 9, there is an overspend by £2.1m against the planned deficit. However, the profile of the plan in the final three months of the year and the Trust's reducing run rate suggest that the Group will recover this overspend and still meet the plan for the full year, albeit with a need to proactively manage in year risks.

Trust pay expenditure is in line with month 8 spend in month. Bank spend reduced by £0.5m and agency and Direct Engagement spend increased by £0.1m. The run rate on substantive staff increased in month by £0.5m, with Christmas bank holiday costs of £0.4m being recognised in December. YTD the Trust is favourable to plan in pay by £2.8m.

The Trust non pay run rate increased in month, mainly in drugs and supplies and services – clinical and general. This includes the operated healthcare facility (OHF) where spend increased in month mainly due to EME true-up, patient feeding, security costs and consumable purchases.

One emerging risk to the submitted 2024/25 financial plan relates to pay award funding (£1.6m YTD and £2.1m for the year). This has been offset by non-recurrent benefits YTD, however if additional funding is not agreed, it could be a risk to our year-end position if not offset by other positive movements. The change in Elective recovery Fund (ERF) baseline due to the increased number of working days has also impacted the Trust's ERF by £1.8m YTD and a FYE of £2.4m. As previously reported the Trust has seen a reduction of HCP monies for prior year projects by £1.8m YTD and FYE of £2.4m. The Trust has been mitigating these risks with non-recurrent benefits.

The Trust has delivered £35.2m of efficiencies in the first nine months, £0.3m above the YTD plan.

Sustainability

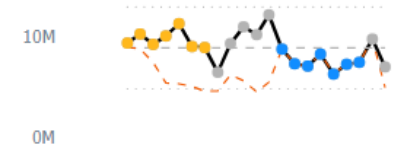
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24
Sustainability	IIP		Deficit In Month Group (£)			4.9M	11.0M	10.2M	12.2M	8.8M	7.3M	7.1M	8.3M	6.3M	7.3M	7.5M	9.8M	7.0M
	KEY		Variance to Plan (£)			0K	-5,381K	-5,721K	-6,718K	-5K	5K	-28K	20K	53K	1K	-31K	1K	-2,070K
	KEY		Premium Pay			11M	8.7M	8.7M	10M	8.1M	8.4M	7.9M	8.8M	8.9M	8.0M	8.6M	8.6M	8.0M
	KEY		WTE worked (Premium Pay)			1,243	959	1,041	1,131	963	1,019	968	1,031	1,049	1,017	996	967	975
	KEY		Total Pay Spend In Month			62M	52M	51M	60M	51M	51M	51M	51M	52M	51M	66M	54M	54M
	KEY		WTE worked (All Pay Spend)			10,374	10,210	10,274	10,286	10,115	10,103	9,984	10,049	10,048	10,105	10,138	10,096	10,144
	KEY		Efficiencies Green Schemes (£M)			40	13	13	13	3	5	4	11	15	16	20	25	28
	IIP		Efficiencies YTD Variance (£M)			0.0	-20.5	-23.7	-26.9	0.0	0.0	0.0	0.1	0.3	0.3	0.3	0.3	0.3

Sustainability

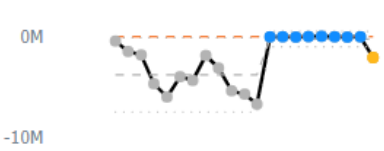
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
ID Medical finding it challenging to swap out high pay premium medical workers and/or negotiate alternative terms, such as becoming Direct Engagement (DE). Many of the high cost agency have been working with the Trust long term and embedded in the organisation.	• ID Medical Managed Service meeting with each Care Group, reviewing each Medical worker for alternative options. • Working with CMO/DCMO to meet with Managing Directors and Medical Directors to highlight the issue and gain support to reduce premium pay workers. • Need to increase DE workers, making the savings on VAT payments.	CPO	Ongoing	• The ID Medical Managed Service have met and are continuing to work with all Care Groups to source alternative, more cost efficient candidates to replace those high-cost long term locums. • 13 of 130 locums currently working at the Trust are engaged via standard placement. • A restriction is now in place in relation to new standard placement bookings. Our DE throughput, currently at 90%. This is expected to increase to 92% by the end of January. • Two long term locums are currently in the process of migrating to the bank/joining the Trust substantively.
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for AfC rates.	• Sign up to the Kent and Medway Collaborative AFC Rate Card • Areas above cap to work with IDM & South East Temp Staffing Collaborative team to reduce inline with stepping down timescales.	CPO	• July 25	• Signed up to the rate card and commenced on 1st June 24, with the second step down to be applied from the 1st October 24. • Only areas above cap are Maternity and Paediatrics. Rates have now been agreed for Maternity until the end of 2024, agency usage is then expected to be removed from February 2025. • Meetings held with the SE collaborative to review all agency suppliers, discuss any issues and outliers as we work towards aligning our rates across Kent. Further meetings to be arranged with suppliers. SETS are to setup regular meetings with suppliers to understand what is driving rates and workforce pressures across the region. • Working with the ICB, a number of new controls/processes have been implemented to support with controlling overall demand and reduce our reliance on agencies. This will also support the Trust in achieving our objectives in relation to the workforce CIP schemes.
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for Medical rates.	• Sign up to the Kent and Medway Collaborative Medical Rate Card • Areas above cap to work with IDM & South East Temp Staffing Collaborative team to reduce inline with stepping down timescales. • Regular meetings now held across the collaborative to current issues as we worked towards rate parity across the region.	CPO	• Ongoing	• South East Temp Staffing Collaborative team met with CMO & DCMO as part of the consultation. • The rate card was approved by the board on the 11th September, IDM have sent a communication out to all of approved suppliers to address any outliers. • CMO, DCMOP are currently reviewing the rate cards to establish where the Trust sits against the step downs. • The ID Medical managed have provided a report detailing all locums engaged at the Trust and their hourly rates in comparison to the applied ceiling caps. IDM to provide a plan to bring those above the cap in line with the rate framework, starting with those closest to the current cap. Expected in January.

Sustainability

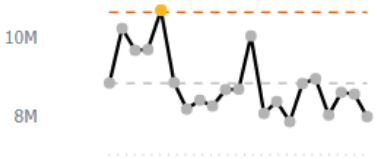
Deficit In Month Group (£)



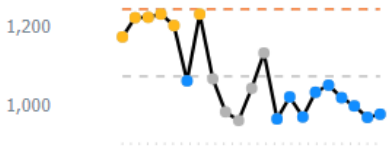
Variance to Plan (£)



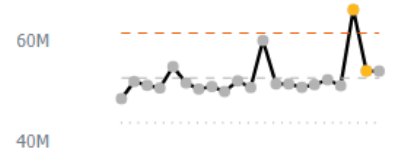
Premium Pay



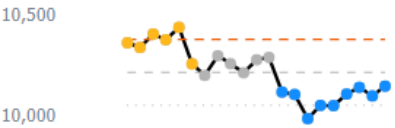
WTE worked (Premium Pay)



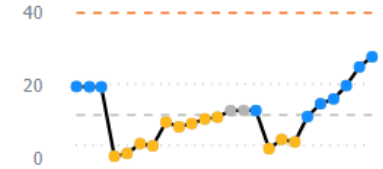
Total Pay Spend In Month



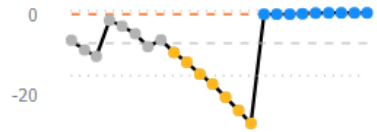
WTE worked (All Pay Spend)



Efficiencies Green Schemes (£M)



Efficiencies YTD Variance (£M)



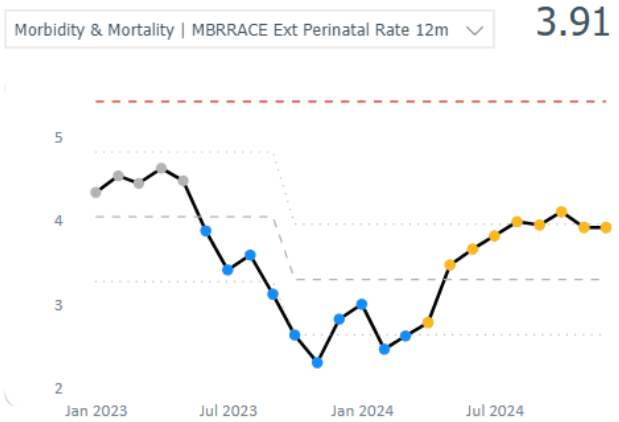
Maternity

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

Maternity

Executive Summary:

The extended perinatal rate remains consistently below the threshold of 5.42 per 1,000 births, with the December 12 month rolling rate at 3.91 per 1,000 births - the same rate as reported in November.



This rate includes both stillbirths and neonatal deaths. In December, the neonatal death rate decreased from 2.38 to 1.87 due to no neonatal deaths reportable over the past three months. However, the stillbirth rate increased from 1.53 to 2.04, with three stillbirths occurring in December. Despite this increase, the stillbirth rate remains significantly below the threshold of 3.61, while the neonatal death rate is now slightly above the threshold of 1.82.

The Friends and Family Test (FFT) maternity response rate, calculated using the national methodology based on delivery episodes, has remained below average for consecutive months. Local and LMNS initiatives continue to be explored to improve the uptake in addition to exploring the timeliness of the text systems and utilisation of QR codes at each touchpoint.

Consistent and significant improvement in complaints response rate maintaining 100%v in December.

No new referral made to MNSI in December.

At month end (December 2024) there were 6 open MNSI cases with mainly draft reports received.
The service currently has 2 internal PSII's. Please view table of progress related to maternity service PSII's.

4 moderate patient safety incident were reported in Decvember under the following categories:

- External Neonatal screening related incident
- Postnatal Maternal Death – Out of Hospital Cardiac Arrest
- Massive Obstetric Haemorrhage 2.5l
- Massive Obstetric Haemorrhage 2.0l

There is no themed link between incidents. In two incidents Maternity care provision was external to EKHUFT.
New guidance in Incident grading will mean all MOH will be graded as moderate harm.

The maternity service has noted an upward trajectory in overdue Datix reports during December.

Maternity: Metric Dashboard

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24
Maternity	KEY		Maternity Patient Safety Incidents M...			6		0	5	1	1	3	2	2	1	0	3	4
	KEY		Maternity Complaints			20	11	7	1	7	7	6	7	9	14	2	7	2
	KEY		Maternity Complaint Response			90.0%	50.0%	22.2%	72.7%	0.0%	20.0%	0.0%	50.0%	66.7%	40.0%	87.5%	100%	100%
	KEY		Extended Perinatal Mortality			5.87	2.99	2.45	2.61	2.77	3.46	3.65	3.81	3.98	3.94	4.10	3.91	3.91
	NAT		FFT Maternity Response Rate			15.0%	14.1%	12.8%	11.5%	9.2%	9.1%	12.1%	11.1%	10.7%	9.9%	12.0%	10.6%	10.1%
	NAT		FFT Maternity Recommended			90.0%	92.0%	91.3%	88.1%	91.9%	93.7%	95.2%	92.4%	88.3%	92.4%	95.6%	92.8%	90.4%
	NAT		FFT Maternity (IP) Recommended			90.0%	94.1%	92.9%	90.9%	92.7%	94.8%	95.3%	93.0%	89.3%	96.6%	97.1%	91.9%	95.2%
	KEY		WH Engagement Score			6.90	6.35	6.35	6.35	6.07	6.07	6.07	6.12	6.12	6.12			

Note: A new Trust metric for PSII will be incorporated into the scorecard from January 2025 data. Please see subsequent slide for details on Maternity PSII's

External and Internal PSII's

MNSI – National Investigation

PSII – Local Investigations

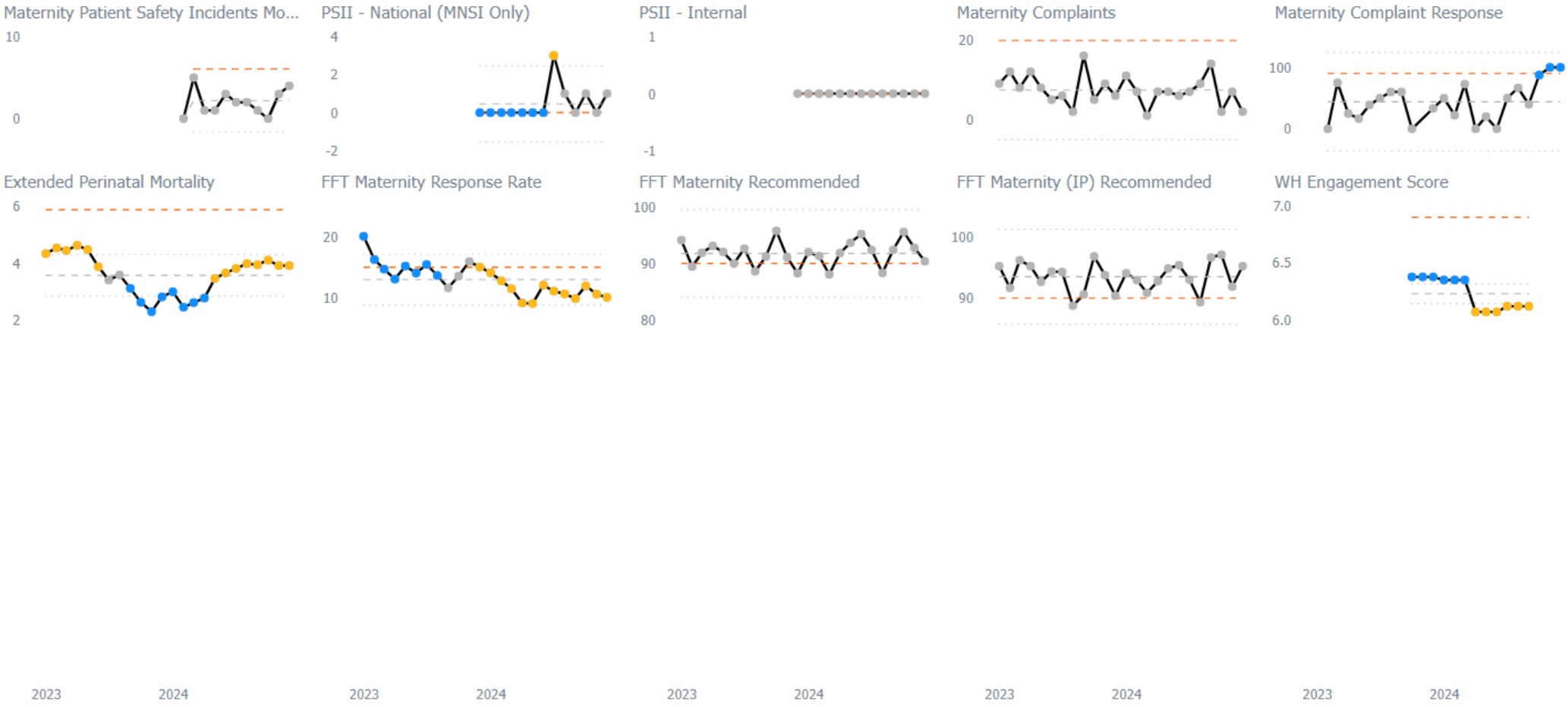
MI -037522	Final Report received (November 2024)	No safety recommendations. 2 Safety Prompts – • Are any barriers present when there is a need for staff to escalate to the neonatal team? • How are staff supported to undertake timely escalation in the face of competing demands? Culture survey undertaken – RCOG Team of the Shift initiative launched led by Consultant Midwife Telephones procured for installing inside the MLU birthing rooms to support escalation processes.
MI-037577	Final report received (December 2024)	1 Safety Recommendation - The Trust to ensure a process is implemented to ensure staff confirm the required ventilator settings prior to a baby being placed on a ventilator and perform regular checks of the ventilator settings whilst the baby remains ventilated. The Trust to develop and implement an induction training programme for all new staff in the neonatal unit on use of ventilators. 2 Safety Prompts – • NLS algorithm during neonatal resuscitation, staff education to ensure compliance with timing for chest compressions. • therapeutic cooling should only be started once a baby is in a stable condition following resuscitation and should be kept warm. The report has been shared with the neonatal team and education teams with actions in place to address the above safety recommendation and prompts.
MI-037583	Draft report received	No Safety recommendations within draft report
MI-037872	Awaiting draft report	Investigation remains in progress
MI-038554	Awaiting draft report	Investigation remains in progress
WEB282476	Investigation in progress	Immediate actions taken in response to incident Report due to the learning response approval panel (LRAP) February 2025
WEB278381	Investigation complete	Investigation report presented at the learning response approval panel (LRAP) minor amendments completed and resubmitted Report to be shared with NHSE (antenatal screening) Nationally Reported.

MNSI safety recommendations and safety prompts are monitored via the care group governance processes alongside actions aligned to local PSII's

Maternity: Actions

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT scores	• Review existing process in relation to the promotion of the FFT	• Patient Experience Team		• QR codes being introduced on Congratulations on your Birth Cot Cards • Promotion of the FFT as well as the YVIH initiative • Exploration of text reminders • Work with the LMNS to promote engagement
Overdue Incidents	• Email and communication with individual action owners with ongoing monitoring and expected completion date • Agreed with corporate team an understanding that some maternity incidents will remain open for longer than 6 weeks, given the complex nature of some investigations.	• Denise Newman Head of Governance		• Slight increase in number of overdue incidents in the month of December • Number of maternity overdue incidents in December is 118 • Agreed number of incidents to be closed by teams on a daily basis • All overdue incident handlers for Women's Health emailed weekly • Continued monitoring of incident management has identified an increase in maternity overdue incidents, initiating increased surveillance and support. • Additional resource allocated to Governance Team to prioritise closure of incidents
External Review Neonatal Deaths	• Aggregate review of all NNDs from 1st April 2023 to 31st March 2024 by an external Neonatologist, senior midwife and Neonatal Nurse	• Adaline Smith Dep Director of Midwifery		• Honorary contracts in place for external review team • All families will be contacted by the PMRT midwife to inform them followed by a letter • Confirmation received from external team that the reports will be available by the 31st January. To date no immediate concerns have been shared.
Complaints	• Increase in the number of stage two complaints returning noted.	• Denise Newman, Head of Governance		• Complaints response target = **100% in December.** • Arranging to meet with Corproate Team to agree triaging of returning complaints and the offer of local resolution meetings.

Maternity: Metric Run Charts



East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **6 February 2025**

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

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

Appendices:

Appendix 1: **IIP Progress Report – January 2025**

Executive summary:

Action required:	Discussion
Purpose of the Report:	This report has been provided to update the Board of Directors at EKHUFT on delivery progress of the IIP during December 2024 and offers assurance based on evidence gathered to support the transition criteria set within the NHS England Recovery Support Programme (RSP) National Oversight Framework Segment 4 (NOF4).
Summary of key issues:	The report includes an update by programme and project for Month 9, measured by the quarterly metrics set. It also details the closing position of Q3 for both performance metrics and evidence position supporting transition. The Leadership, Governance & Culture programme remains amber this month, with three metrics outstanding from Q2 (Recruitment of Chair, Managing Director (MD) development plans and evidence of an active and effective Freedom to Speak Up (FTSU) service and evidence of learning from concerns raised) which all have clear plans to deliver in Q4. Seven of the ten metrics set for Q3 were met and delivery plans are in place for 100% of Board to have undertaken a 360 degree review, Delivery of Care Quality Commission (CQC) Must Do's and FTSU report to Board on learning and changes, all to complete during Q4. Urgent Emergency Care (UEC) remains amber this month, achieving both Length of Stay (LoS) and Type 1 in December. 12hrs remains a focus, along with the reduction of harm levels, which remains outstanding from Q2. This is making good progress with processes embedding and evidence of learning. Planned Care also remains amber this month with zero 78ww's outstanding from the Q1 metrics, but with a plan to clear the remaining seven by the end of January through insourcing. Four of the Q3 metrics have delivered and the three Cancer metrics were narrowly missed at the end of December.

We care

East Kent Hospitals University NHS Foundation Trust

	The Finance Programme moves to amber this month following a £2M variance, despite the continued reduction in run rate. The Cost Improvement Programme (CIP) delivered and remains £336k ahead of Year to Date (YTD) plan. Programme Management Office (PMO) continue to work to align IIP associated risks with the Trust significant risk register. PMO continues to collate evidence in preparation for the Q3 reviews in January and February.
Key recommendations:	The Board of Directors is invited to **DISCUSS** the report.

Implications:

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

Assurance route:

Previously considered by: Clinical Executive Management Group (CEMG)

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

Journey to Exit National Oversight Framework 4 (NOF4) – IIP Progress Report

January 2025

Purpose of Report

East Kent Hospitals University NHS Foundation Trust

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

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

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

East Kent Hospitals University NHS Foundation Trust

Q3 Performance Metrics Progress for M9

Quarterly Performance Metrics - Leadership, Culture & Governance – M9

East Kent Hospitals University NHS Foundation Trust

	Transition Criteria	Q1 Metric	Q2 Metric	Q3 Metric	RAG position at M9
1	A Stable Executive team with clear and robust organisation wide governance in place supported by an agreed board development programme	• 24/25 Board development programme in place • All substantive Managing Director (MD) posts appointed to	• Recruitment to substantive Chief Finance Officer (CFO) post • Recruitment to Substantive Chair post • At least one Board development session • Managing Director Development Plan developed and agreed	• At least one Board development session • 100% of Board to have undertaken a 360 degree review • Evidence of Board receiving oversight of regulatory actions with clear improvement plans and following up on actions • Delivery of Care Quality Commission (CQC) Must Do's (within capital restrictions)	• Chief People Officer (CPO) in post and substantive Chief Operating Officer (COO) recruited. Recruitment process continues for the Chair. • Board Development session took place in November • Proposal under review for delivery of the 360 degree reviews. • Regulatory Oversight Group in place, meeting bi-monthly and reporting into Quality & Safety Committee, then to Trust board. • Revised plan in place for completion of CQC Must Do's • An aspirant directors programme is currently being sought for the MDs.
2	Demonstrable improvement in the culture of the whole organisation in particular the safeguarding and the safety culture, and effective engagement with the workforce.	• Evidence of consultant engagement events • Relaunch of 'we care' including roll out of training events • Phase 2 Culture and Leadership Programme (CLP) – design stage commenced	• Consistent application of 'we care' Quality Improvement (QI) methodology 'sustain' • Active and effective Freedom to Speak Up (FTSU) service and evidence of learning from concerns raised	• Evidence of improved and effective engagement of staff, patients and wider stakeholders • Increased uptake of staff survey in 24/25 • Evidence of safety improvements and maintenance of quality standards • FTSU Report to Board on learning and changes	• Improved and effective engagement demonstrated through 700+ staff interaction on the strategy development, 57 patient group interactions and a number of stakeholder events held. • Consistent application of 'We Care' methodology agreed through the sustainability plan. • Staff Survey response rate at 58%, highest recorded in the organisations history. • F2F counselling re-introduced in February 2024, 234 clients (staff) have been seen, with 971 counselling sessions delivered across a 9-month period. Across 9-month pre and post implementation, sickness absence has reduced from 5.49% (above alerting thresholds) to 4.33% (below alerting thresholds). • FTSU Report to Board on learning and changes delayed due to the decision to outsource the service. Guardian due to commence contract in January 25
3	Development of organisation strategy for clinical	Commence development of organisation strategy for clinical pathways.	• Stage 1 – Completion of Situational analysis and background information • Development of site estates master plans	• Finalised summary of the situational analysis to allow progress to the next stage of development. • Engagement with external support partner	• Finalised summary of the situational analysis to allow progress to the next stage of development - All specialty meetings complete with strategy prioritisation events now taking place in order to shape the next step of the clinical strategy. • Engagement with external support partner – Engagement events have taken place, led by Kaleidoscope, across all sites and through staff forum. Strategy Prioritisation days held, facilitated jointly by Kaleidoscope and the Trust.

Key	RAG position
Green	On track
Amber	Off track but plans in place to recover position in next quarter
Red	Off track

Quarterly Performance Metrics – Urgent Care – M9

East Kent Hospitals University NHS Foundation Trust

	Transition Criteria	Q1 Metric	Q2 Metric	Q3 Metrics	RAG position
4	Consistent improvement in performance to deliver Urgent Emergency Care (UEC) type 1 to >50% and 12 hour waits to below 8%	**Type 1 – 46%** **12h - <10%**	**Type 1 - 48%** **12h - <9%**	**Type 1 – 50%** **12h - 8%**	• The Type 1 trajectory at Month 9 was achieved with a performance of 53.69% against a Q3 target of 50% . At the end of Q3 Type 1 was at 54.71%. It has been consistently above 50% since May, with the highest performance since August 2021. • In Month 9, 10.2% of patients were waiting in the department >12 hours against a quarter target of 8%. Discussions continue with system partners for wider support. • Engagement from Healthcare Partnership (HCP) through MADE events, with learning to be embedded throughout Q4. Targeted interventions to improve this position include the opening of the Clinical Decision Unit (CDU) at William Harvey Hospital (WHH) in November as well as the launch of the new acute medicine model. Funding from the winter system schemes is also supporting extending the frailty front door pilots at the front door, the expansion of the acute virtual wards on both acute sites and extending CT scanning into the evening and weekends.
5	Demonstrable quality, safety and operational improvements across the whole UEC pathway reducing the proportion of patients occupying beds with 14+length of stay.	**14+ LoS – 32%** **Evidence of updated/review safety & harm prioritisation policies**	**14+ LoS – 31%** **Reduction in deteriorating patient/serious incidents across the UEC pathway**	**14+ LoS – 30%** **Reduction in deteriorating patient/ serious incidents across the UEC pathway** **Exit Tier 1**	• The Length of Stay (LoS) for NEL >14 days performance in Month 9 was recorded at 29.1% against a target of less than 30%. The delivery of this trajectory is at risk due to the changes in contract provider of the P1 pathways and the increase in patients not meeting the criteria to reside. There has now been the formation of a national oversight group (DSOG) who are meeting to review P1, P2 and P3 patients with a view to see what support can be given. • Following the implementation of the Standard Operating Procedure (SOP) in Q2, a process review will be undertaken in Q3 to refine the process further. Further work on communication across ED's is being undertaken, the Director of Quality Governance presented at ECDG to discuss process and share learning. With assistance from clinical lead, the proforma has been tweaked and local teams are now engaged. The Q3 reviews continue with report due at the end of Dec 24 detailing quarterly harms. Workplans for Mortality & Morbidity (M&Ms) to be formalised to ensure the route for capturing learning. Q3 will aim to sustain the current level of harms that occur in our Emergency Departments (EDs). Data is being reported for deteriorating patients with a critical care admission with learning shared at M&Ms.

Key	RAG position
Green	On track
Amber	Off track but plans in place to recover position in next quarter
Red	Off track

Quarterly Performance Metrics – Planned Care – M9

East Kent Hospitals University NHS Foundation Trust

	Transition Criteria	Q1 Metric	Q2 Metric	Q3 Metric	RAG position
6	To deliver Zero 104 and 78 week waits with consistent reduction in overall Patient Tracking List (PTL) and 65 week waits in order to deliver zero by March 2025	104ww – less than five 78 ww – zero 78 weeks by June 2024 65ww reduction of 25% (from March 24 outturn)	78 ww - zero maintained 65ww – reduction of 50% (from March 24 outturn)	78 ww – zero patients maintained 65ww – reduction of 75% (from March 24 outturn)	• There is a clear plan to reduce 78ww to 0 by the end of Jan through insourcing that commenced 23 November. Currently 7 patients remaining. • 65ww delivering above trajectory, with a March baseline of 2301, Q3 reduction of 75% (575 remaining). Current position is 250, on track to reduce to 0 in M12.
7	To deliver Cancer Faster Diagnosis Standard (FDS) c77% and 62d combined performance c70% with consistent reduction in 62d backlog	**62 Day backlog – within Fair Shares allocation (<200)** **62 day performance – 70%** **Faster Diagnostic Standard – 75% or above** **Exit Tier 1 for cancer**	**62 Day backlog – within Fair Shares allocation (<200)** **62 day performance – 70%** **Faster Diagnostic Standard – 75% or above**	**62 Day backlog – within Fair Shares allocation (<200)** **62 day performance – 75% or greater** **Faster Diagnostic Standard – 80% or above**	• 62d backlog: October - 193, November - 203, December - 216 • 62d compliance: October - 70.4%, November – 74.1%, December – 74.7% • 28d compliance: October - 71.15%, November - 70.92%, December -71% • Moving out of Tier 1 for Cancer, with official notification received on 8th November.
8	Consistent trajectory towards DMO1 compliance c5% and endoscopy delivery plan agreed and delivered	**Diagnostics – to achieve 35%** **Endoscopy Backlog/ Surveillance List – reduction of 25% on March 24 baseline**	**Diagnostics – to achieve 30%** **Endoscopy Backlog / Surveillance List – reduction of 50% on March 24 baseline**	**Diagnostics - to achieve regional mean of 22% (mean based on 23/24)** **Endoscopy Backlog / Surveillance List – reduction of 75% on March 24 baseline**	• DM01 position M9 – 84.4% - on target to achieve the Q3 metric • Endoscopy backlog reduced from March outturn of 7238 to 391 at M9.

Key	RAG position
Green	On track
Amber	Off track but plans in place to recover position in next quarter
Red	Off track

Quarterly Performance Metrics – Finance – M9

East Kent Hospitals University NHS Foundation Trust

	Transition Criteria	Q1 Metric	Q2 Metric	Q3 Metrics	RAG position
9	Delivery of 2024/25 plan inclusive of the Cost Improvement Programme (CIP), income and expenditure plans [Phasing subject to finalisation of the plan]	**A year to date deficit of £23.1m or better by the end of Q1.**	**A year to date deficit of £45.0m or better by end of Q2 (£21.9m in the quarter).**	**A year to date deficit of £67.1m or better by end of Q3 (£22.1m in the quarter).**	• Year to Date (YTD) deficit plan was not delivered in M9, reporting a £2M variance. Run rate continues to reduce and overspend expected to be recovered in M10 • YTD total CIP of £35,155k (ahead of plan by £336k YTD). • Emerging risks relate to the shortfall in funding to cover the 23/24 and 24/25 pay reforms/pay awards (£2.1m. Currently offset by non-recurrent benefit YTD), an Elective Recovery Fund (ERF) Central Baseline Adjustment for working days (£2.8m) and a potential risk of a further ERF baseline change for 24/25 due to 23/24 forecast outturn return (£2.8m).
10	Robust financial oversight, governance, and a strong financial control environment in place	**Re-audit of controls by Finance Recovery Director to demonstrate progress on implementation. Report shared with FIOB and partners as necessary by the end of Q1**	**Formal re-audit of controls commissioned with report available by end of Q2 with aim to move to near 100% compliance.**	No metric set	
11	Agreement of a Medium-Term Financial Recovery Plan (FRP) with system / region and national partners and demonstrable	**Initial scoping and engagement plan complete by end of Q1**	**Near final document for discussion shared with partners by the end of Q2**	Final agreed document with partner support agreed and taken through Board by the end of Q3	• Financial Sustainability Plan draft completed and shared with NHS England (NHSE) and other system partners. • Trust Board approval - December. Integrated Care Board (ICB) approval pending - Date TBC. • Interdependence with ICB recovery plan is both a key risk and opportunity. The trust is actively engaged in the system process, supporting the leadership of a system wide workshop with Miles Scott (Chief Executive Officer (CEO) at Maidstone and Tunbridge Wells NHS Trust (MTW)) who is CEO SRO at a system level for the plan production.

Key	RAG position
Green	On track
Amber	Off track but plans in place to recover position in next quarter
Red	Off track

East Kent Hospitals University NHS Foundation Trust

Evidence Supporting Transition to NOF3

Impact to NOF4 Transition Criteria – Leadership, Governance & Culture – Q2

Transition Criteria RAG agreed in preparation for internal Q3 review

East Kent Hospitals University NHS Foundation Trust

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

Suggested Evidence

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

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

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

Impact to NOF4 Transition Criteria – Urgent & Emergency Care – Q2

Transition Criteria RAG agreed in preparation for internal Q3 review

East Kent Hospitals University NHS Foundation Trust

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

Suggested Evidence

- Type 1 to exceed 50% sustainably
- 12 hours from arrival to be below 8%
- Sustainable removal of corridor care
- Compliance with NHSE Tiering requirements and governance
- Evidence of reduction of Length of Stay through improvements in simple and timely discharge
- Patients requiring emergency care or experiencing a deterioration in their condition receive timely, appropriate escalation and treatment
- Evidence of effective safety prioritisation and harm avoidance processes across UEC pathways that incorporates sustained learning from incidents

Impact to NOF4 Transition Criteria – Planned Care – Q2

Transition Criteria RAG agreed in preparation for internal Q3 review

East Kent Hospitals University NHS Foundation Trust

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

Suggested Evidence

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

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

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

Impact to NOF4 Transition Criteria – Finance - Q1

Transition Criteria RAG agreed in preparation for internal Q3 review

East Kent Hospitals University NHS Foundation Trust

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

Suggested Evidence

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

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

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

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Significant Risk Register Report**

Meeting date: **6 February 2025**

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

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

Appendices:

None

Executive summary:

Action required:	Assurance
Purpose of the Report:	This paper presents the current Significant Risk Report to ensure Board oversight of those risks rated as high and above (15>). All have an assigned Executive Director and are required to be updated monthly and reported through the Clinical Executive Management Group (CEMG) and the appropriate Board Sub Committees to Board. This paper demonstrates movement in month, details those risks that have been de-escalated from the Significant Risk Register due to the mitigations in place and new risks.
Summary of key issues:	The majority of the risks contained in the Significant Risk Report have had a documented review within the last four weeks. As of the 27 January 2025 when the Significant Risk Register was extracted there were nine risks with associated overdue actions. There has been some deterioration in actions being completed within the specified timeframe/and or an update provided to document reason for the delay and where appropriate an extension. This issue was escalated at the Risk Review Group on 21 January 2025 (there were 19 over due at this time) and it was requested that updates were provided by 24 January 2025 to enable an accurate position to go to Clinical Executive Management Group (CEMG), Board Sub Committees and the Board. Ten risks were updated following this. Monthly meetings continue with the executive leads for each significant risk (and their deputy/wider team as requested) to ensure regular oversight and scrutiny. The last Risk Review Group meeting was held on 21 January 2025.

	The Diagnostics, Cancer and Buckland Hospital Care Group (DCB CG) provided a deep dive into their risks. There has been progress although not all Significant Risks were in date by the meeting. The DCB Care Group has the most significant risks out of all of the Care Groups. Comments and challenge were provided in relation to this and also aged risks (risks over two years). Feedback from DCB CG included the need for a more user-friendly system and action tab linked to monthly review sign off (to prevent actions not being completed, reviewed or amended). The DCB Care Group suggested there are several members of the team who do not have the right 4Risk access. The Head of Risk Management and Assurance is to liaise with the team to ensure an up to date list is provided and approved by a member of the Care Group leadership team. Corporate Nursing provided a deep dive into their risks. Action to be taken to review risks where residual and target risk is the same to assess whether the risk still needs to be open. There were three areas of escalation from the meeting as below: • Urgent review of overdue risks by Care Group and Corporate Leads. All Significant Risks should be updated monthly and audit trail provided where there is slippage. This is an improving position but needs to be embedded in business as usual processes. • Training Needs Assessment (TNA) and training rollout plan – a brief was provided by the Head of Risk Management and Assurance who is currently pulling together a TNA and tiered rollout plan. This will come to the February Risk Review Group with training to commence within Q4. • There were a number of actions that came out of the deep dive presentations. These were captured on the meeting action log and are to be taken forwarded by the Care Group leads. Project planning for the implementation of InPhase continues. Several areas have been urgently escalated with the senior InPhase team due to a lack of functionality within the system, against the required specification. A technical meeting is due with the supplier on 30 January 2025 where they are proposing solutions to the main issues that have been raised.
Key recommendations:	The Board of Directors is asked to receive the Significant Risk Report for **ASSURANCE** purposes and for visibility of key risks facing the organisation.

Implications:

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

East Kent Hospitals University NHS Foundation Trust

	• Partnerships • Sustainability
Link to the Trust Risk Register:	This paper provides an update on the significant risks (to be known as the 'significant risk report') to the Trust which replaces the Corporate Risk Register (CRR).
Resource:	Yes. Additional resource will be required to mitigate some of the significant risks identified.
Legal and regulatory:	Yes. The Trust is required to comply with the requirements of a number of legal and regulatory bodies including but not limited to: • NHS England (NHSE) • Care Quality Commission (CQC) • Health and Safety Executive
Subsidiary:	2gether Support Solutions Spencer Private Hospitals

Assurance route:

Previously considered by: Clinical Executive Management Group (CEMG) on 5 February 2025.

Reports are provided to the following Board Sub Committees:

- Finance and Performance Committee (monthly) – 30 January 2025
- Quality and Safety Committee (bi-monthly) – 28 January 2025
- People and Culture Committee (bi-monthly) – 29 January 2025
- Integrated Audit and Governance Committee (quarterly) – 31 January 2025

It should be noted that as the Risk Register is a live document the supporting information was extracted on 27 January 2025.

East Kent Hospitals University NHS Foundation Trust

SIGNIFICANT RISK REPORT

1. Purpose of the report

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

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

1.3 The last Risk Review Group took place on 21 January 2025. A deep dive presentation was provided by the Diagnostics, Cancer and Buckland (DCB) Care Group and Corporate Nursing. There were three escalations which are timely review of overdue actions associated with Significant Risks by Corporate and Care Group leads, the development of a training needs analysis and plan (see Section 5) and the actions that came out of the deep dive presentations to be taken forward by the Care Group leads.

2. Background

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

2.2 One of the outputs of the Trust Risk Review was the creation of a Significant Risk Report. The latest is summarised in Section 3 of this report.

2.3 The Risk Review Group was established in early February 2024. The Group, which meets monthly and is chaired by the CNMO, by the October 2024 meeting will have received deep dive presentations from all Clinical Care Groups and by December 2024 for all Corporate Care Groups. A work planner for the next 12 months was presented for sign off at the next Risk Review Group meeting on 26 November 2024.

3. Current Significant Risk Register

3.1 There are currently 32 risks in total on the Significant Risk Report (up from 29 in the December Board report).

3.2 There are no changes to the residual risk scores of the risks which were also reported in the December report.

3.3 There are overdue actions associated with nine of the risks (marked in bold for clarity). These have been escalated for immediate attention with the Risk Owners and Delegates via the Risk Review Group and directly.

3.4 The Significant Risk Register is summarised below:

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
1891	Corporate Operations **Accountable Executive: Chief Operating Officer (COO)**	Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway	Extreme (20)	No change	Low (6)	Demand and capacity modelling to be confirmed by all systems partners for all P1 to P3 patients as part of the system wide better use of beds programme to inform 2526 redesign. Person Responsible: Interim Managing Director Due: 31/03/25 Conduct a comprehensive review of current Emergency Department (ED) processes and identify areas for improvement – focussing initially on the opportunity to reduce the number of patients spending 12+ hour in ED. Introduction of Clinical Decision Unit (CDU) at William Harvey Hospital (WHH) required by end of Jan 25. Conduct a comprehensive review of current ED processes and identify areas for improvement – focussing initially on the opportunity to reduce the number of

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
						patients spending 12+ hour in ED Person Responsible: Interim Managing Director Due: 31 Jan 2025
3386	Care Group - Women's Health **Accountable Executive: CMNO**	Potential risk of inaccurate records due to Euroking back copying	Extreme (20)	No change	Low (4)	Work continues to implement MSR 2.1.1 into the Euroking Test environment to then be tested. If the testing is successful, then Trust to decide whether to move this into the live Euroking environment or stick with the current bespoke MSR. We were informed by Magentus that there are clinical risks noted against the bespoke MSR (which MSR 2.1.1 mitigates) so Magentus are going to send documentation regarding this so the Trust can make an informed decision. End date of Magnetus support as part of NPSA project unclear. Update to be provided monthly. Person Responsible: Clinical Information Systems (CIS) Manager Due: 03 Feb 25

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
2406	Care Group - Diagnostics, Cancer and Buckland **Accountable Executive: Chief Strategy & Partnerships Officer (CPSO)**	Delay to patient diagnosis from potential loss of Nuclear Medicine service at William Harvey Hospital (WHH)	High (16)	No change	Low (4)	Camera to be installed / work to be completed. Update and extension to date – awaiting removal of hand basin following Infection Prevention Control (IPC) approval to meet Guidelines. Person Responsible: Chief Technologist Nuclear Medicine & Osteoporosis Due: 28 February 25
2934	Care Group - Women's Health **Accountable Executive: CPSO**	Inadequate theatre capacity at Queen Elizabeth the Queen Mother Hospital (QEQM) for maternity services	High (16)	No change	Low (4)	Review and improve the efficiency of C-Section lists Person Responsible: Service Manager Women's Health Due: 28 Jan 2025. Progress plans with strategic development with potential NHS England (NHSE) funding to support the needed maternity estate expansion (including obs theatre) at QEQM Person Responsible: Operations Director Due: 30 Apr 2025 **Review and implement solutions with clinical teams for late theatre starts and overruns**

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
						Person Responsible: Service Manager Women's Health **Due: 23 Dec 2024**
3354	Queen Elizabeth Queen Mother Care Group **Accountable Executive: CPSO**	Clinical environment not fit for purpose in many areas	High (16)	No change	Low (4)	**Estates issues for all ward areas to be addressed with the Estates team to ensure an ongoing programme of maintenance and repair.** **Person Responsible: Director of Nursing** **Due: 30 Nov 2024**
3553	William Harvey Hospital (WHH) Care Group **Accountable Executive: CPSO**	Failure of Cardiac Catheter Suite equipment (Lab 1, 2 & 3) WHH	High (16)	No change	Low (6)	Business Continuity Plan (BCP) to be updated following Sept 23 failure of both Percutaneous Coronary Intervention (PCI) labs at WHH and agreed with region. Discussion to be had with radiology re role of Interventional Radiology (IR) suite in BCP given that they have the same equipment. New BCP template circulated and discussed with emergency planning. Still awaiting feedback from radiology. Diagnostic BCPs to be incorporated.

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
						Person Responsible: General Manager (GM) Due: 31 Jan 2025 Business case for installation to be submitted. Currently in draft format. Handover has now taken place between Trust and PricewaterhouseCoopers (PWC). Staffing requirements being worked up for new lab 3. Person Responsible: General Manager (GM) Due: 21 Feb 2025
2158	Care Group - Diagnostics, Cancer and Buckland **Accountable Executive: Chief Medical Officer (CMO)**	Risk of Patient harm and treatment due to unreported Accident & Emergency (A&E) chest xrays	High (16)	No change	Low (4)	**External review by Regional Adviser commissioned. Report received. Recovery plan to be developed and approved.** **Person Responsible: CMO** **Due: 20 December 2024**
678	Care Group - Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Insufficient Pharmacy support for the safe (and secure) use of medicines on wards	High (15)	No change	Low (4)	Review current working models to release clinical pharmacy time e.g. late nights, dispensary commitments.

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
						Person Responsible: Deputy Lead CS Pharmacist Due: 31 Mar 2025 **Submit Paeds case to BSG (submitted to DCB for approval) in Dec 2024 (as new format required)** **Person Responsible: Deputy Lead CS Pharmacist** **Due: 31 Dec 2024** Consider Full 7-day service from Pharmacy following action from CQC Must do. Person Responsible: Director of Pharmacy Due: 1 Apr 2025 Start to recruit to GSB BC (assuming case is approved) submitted Oct 24 Person Responsible: Deputy Lead CS Pharmacist Due: 31 Jan 2025 **Work is happening within the care group to define the best leadership structure for the pharmacy service. This must deliver several operational**

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
						and strategic Must Dos including a description of how many staff can work differently (medicines reconciliation on wards) if we are more efficient in our drug dispensing and discharge processes **Person Responsible: Managing Director** **Due: 31 Oct 2024**
2796	Kent & Canterbury and Royal Victoria Care Group **Accountable Executive: CPSO**	There is a risk of delay in dialysis treatment due to high number of Renal Dialysis machines that are over 15 years old	High (15)	No change	Low (6)	**In the process of finalising the rolling replacement programme for dialysis machines across all of the dialysis units to ensure that there is a clearly shown sub-set within the MDG capital allocation that will be reviewed monthly at the Trust's Capital Investment Group** **Person Responsible: General Manager** **Due: 30 Sept 2024**
1831	Queen Elizabeth Queen Mother Care Group	Privacy and dignity will be adversely affected when patients are treated in non-care spaces	High (15)	No change	Low (6)	Reverse rating streaming in place to identify patients who need resus and those who are well enough to be cared for in noncare space.

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
	Accountable Executive: CMNO					Ongoing monitoring via incident reporting Person Responsible: Deputy Head of Nursing Due: 31 Jan 2025 Fundamentals of care training to be completed by staff re privacy and dignity Person Responsible: Deputy Head of Nursing Due: 31 Jan 2025 Assess progress of clinical harm reviews and associated learning Person Responsible: Associate Medical Director Due: 28 Feb 2025 Fortnightly QEQM UEC delivery group set up with a wide range of improvement programmes to support improvements in flow across the site. This delivery group provides the governance oversight on local care group improvement schemes and reports through to Trust Emergency Care

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
						Delivery Group for overall oversight Person Responsible: Managing Director Due: 31 Jan 2025
3556	William Harvey Hospital Care Group **Accountable Executive: CNMO**	Delays in delivery and personal care are resulting in an increased risk of pressure ulcers and falls occurring	High (15)	No change	Low (6)	Continued Implementation of the Emergency Floor Improvement plan which includes direct pathways such as right sizing Same Day Emergency Care (SDEC), Surgical Emergency Admissions Unit (SEAU) and Urgent Treatment Centre (UTC) Person Responsible: Head of Operations Due: 31 Jan 2025
3367	Corporate Medical **Accountable Executive: CMO**	Lack of timely review of diagnostic test results	High (15)	No change	Low (6)	**Developing a page on Sunrise for consultants to review all results that are allocated to them** **Person Responsible: Chief Clinical Information Officer** **Due: 01 Oct 2024**
679	Care Group – Diagnostics, Cancer and Buckland	Failure to supply, from Pharmacy, scheduled chemotherapy	Extreme (20)	No change	High (15)	**Options regarding future plan for APU presented at Capital Investment Group (CIG). Presentation will be by SD but**

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
	Accountable Executive: CMO	treatments to patients				**support for options provided by APU staff.** **Actions will be generated following outcome of SIG. Modular option presented to Executive. Initial presentations taking place for either short term (to cover remedial works) or longer term provision.** **Person Responsible: Interim Accountable Pharmacist** **Due: 31 Dec 2024** **Commence £250K of remedial work required** **Person Responsible: CMO** **Due: 31 Dec 2024** Replacement of the unit with offsite licensed facility as part of the Integrated Care System (ICS) strategy and linked to the national aseptic review. Person Responsible: Director of Pharmacy Due: 30 Sep 2029

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
3557	Care Group – William Harvey **Accountable Executive: COO**	Increased length of stay for mental health patients awaiting inpatient community beds	High (16)	No change	Moderate (9)	**Work with external partners/ commissioners to ensure provision of service meets the needs of mental health patients in a timely way. Ongoing meetings with Kent & Medway NHS and Social Care Partnership Trust (KMPT). KMPT provide LP team to ED streaming at QEQM.** **Steering group looking into recovery beds and safe havens across East Kent.** **Person Responsible: Associate Director of Nursing** **Due: 29 Nov 2024** **Ensure safeguarding vulnerable adults and paediatric training compliance in place for all relevant staff.** **Person Responsible: Associate Director of Nursing** **Due: 30 Nov 2024** **Recruit mental health nurses. New mental health lead appointed and will start in 3/12.**

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
						Strategy and recruitment plan will sit within their portfolio for registered mental health nurses **Person Responsible: Specialist Nurse Practitioner** **Due: 2 Dec 2024**
1895	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Current CT and MRI reporting backlog presents a clinical risk due to potential delays in diagnosis and treatment	High (16)	No change	Moderate (9)	**External review by Regional Adviser commissioned. Report received. Recovery plan to be developed and approved.** **Person Responsible: VMO** **Due: 20 December 2024** **4 additional posts to be recruited to as part of vacancy factor** **Person Responsible: Consultant Radiologist** **Due: 30 Sept 2024** **Waiting for 4 Radiologist to come into post following successful recruitment CDC business case.**

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
						Person Responsible: Consultant Radiologist **Due: 31 Oct 2024**
1628	Care Group – William Harvey **Accountable Executive: CNMO**	Staffing mix and experience impact on the ability of the Care Group to provide services to paediatric patients in line with the Royal College of Paediatrics and Child Health (RCPH) standards	High (16)	No change	Low (4)	Medical staff to attend advanced training (Paediatric Immediate Life Support (PILS) and then Advanced Paediatric Life Support (APLS)). Paediatric ED Consultants in place for WHH and QEQM. Person Responsible: Consultant Due: 31 March 2025 Advertise and recruit into Matron post. Use internal and external networks to promote role. Interim in place in meantime. Person Responsible: Associate Director of Nursing Due: 31 March 2025
2234	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Failure to meet national histopathology Turnaround Time (TAT's) to support cancer pathway	High (16)	No change	Moderate (8)	1.0 Whole Time Equivalent (WTE) histopathologist vacancies recruited to do rolling advert has ceased. To be reviewed at end of February with potential closure. Person Responsible: Head Biomedical

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
						Scientist Cellular Pathology Due: 28 February 2025 Trust involved in discussions regarding a Kent & Medway Joint Venture. Trust to ensure areas of pressure are highlighted and worked up. Continues to progress. Person Responsible: CMO Due: 28 February 2025 Review a workforce/ workload points-based manager system to manage workload in line with RC Path Guidance Person Responsible: Stuart Turner Due: 31 Mar 2025 Kent and Medway Pathology Network (KMPN) Digital Histopathology & AI project to improve performance and resilience. NB: this is an adjunct to maintaining service delivery and performance and NOT all histology cases

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
						can be reported using AI. Person Responsible: Head Biomedical Scientist Cellular Pathology Due: 30 Apr 2025
2899	Care Group – Women's Health **Accountable Executive: CMO**	Consultant obstetric vacancies at QEQM may result in an inability to deliver the service	High (16)	No change	Moderate (9)	Associate Medical Directors for Care Group to get advice and support from Jonathan Purday regarding learning from successful recruitment on QEQM site Person Responsible: Operations Director Due: 31 Jan 2025 Re-advertise for the 3 vacancies at QEQM. Post held off until after April so that the cohort who get their Certificate of Completion of Training (CCT) in October could apply Person Responsible: Associate Medical Director Due: 28 Mar 2025
3384	Corporate – Strategic Development & Capital Planning	The ability to deliver safe and effective services & implement improvements	High (16)	No change	Moderate (12)	Deliver the 24/25 Capital programme as per the signed off plan.

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
	Accountable Executive: CSPO	across Trust estate is compromised due to financial constraints for capital funding and assets replacement				Person Responsible: Director of Strategy & Business Development Due: 30 Apr 2025 Progress to full business case for the replacement of maternity facilities at QEQM. Person Responsible: Director of Strategy & Business Development Due: 01 Sept 2025
2599	Corporate – Medical **Accountable Executive: CMO**	There is a risk of inadequate medical staffing levels and skills mix to meet patients' needs	High (15)	No change	Low (6)	**Programmes to support career progression and attraction of consultant posts for long term locums becoming substantive (i.e. Certificate of Eligibility of Specialist Registration (CESR))** **Person Responsible: Head of Medical Workforce** **Due: 2 Sept 2024** **Review the consultant medical recruitment process – focusing on specialities (Health Care of Elderly People (HCOOP) first tranche)**

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
						Person Responsible: Workforce Information & Rostering Project Lead **Due: 30 Nov 2024**
3700	Corporate – Finance & Performance Management **Accountable Executive: Chief Finance Officer (CFO)**	Failure to agree a Medium-term Financial Recovery Plan with System / Region and National Partners **Accountable Executive: CFO**	Extreme (20)	No change	Moderate (12)	Agreement of the Medium Term Financial Plan (MTFP) with Board, ICB & NHSE Person Responsible: CFO Due: 31 July 2025
3701	Corporate – Nursing **Accountable Executive: CNMO**	Staff may experience physical and psychological harm as they are frequently subjected to verbal and physical abuse from patients exhibiting challenging behaviours	High (16)	No change	Low (6)	Liaising with KMPT to agree a tiered training approach to meet needs of all staff groups Person Responsible: Deputy Chief Nurse Due: 31 Jan 2025 Security service provision contract will form basis of specification for 2gether to tender the service. Service to be re-tendered, contract awarded and live by April 2025 Person Responsible: Associate Director of Safety

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
						Due: 1 April 2025
3702	Care Group – Critical Care, Anaesthetics and Specialist Surgery **Accountable Executive: COO**	Delayed discharge of patients from Critical Care when medically fit to be transferred to the ward	High (16)	No change	Moderate (8)	Corporate 'We Care' project to be implemented with the transformation team Person Responsible: Director of Nursing Due: 31 Mar 2025 Work with site triumvirate on priority for critical care wardables to be discharged from Critical Care Person Responsible: Director of Nursing Due: 31 Mar 2025
3699	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Loss of blood and blood products impacting patient safety and significant financial loss, due to staff not being alerted to a temperature control failure following failure of the trust wide blood transfusion laboratory remote temperature alert system	High (15)	No change	Very Low (1)	No actions

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
1814	Corporate – Strategic Development & Capital Planning **Accountable Executive: CSPO**	Loss of access to key operational / clinical systems from threats (cyber air con, break of external circuits, fire, floods etc) for a protracted period	High (15)	No change	Moderate (10)	No actions
1350	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Failure to provide ward stock medicines in a timely fashion due to obsolescence of Pharmacy TWS Distribution robot	High (15)	No change	Moderate (12)	Need to have additional spare bands for the robot as down to the last two – find engineering companies who may make them. Quotes to be requested. Person Responsible: Chief Pharmacy Technician Due: 31 Mar 2025 Replace Robot – Present case for replacement to DCB finance and performance meeting to get the case approved in advance of business planning and should capital become available in the interim Person Responsible: Chief Pharmacy Technician Due: 1 July 2025

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
3719	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	There is a risk of patient harm from availability, delays and errors in Systemic Anti-Cancer Therapy (SACT) prescribing for adults due to system failures with the ARIA medonc system being out of date at Kent and Medway Cancer Collaborative (KMCC)	High (15)	No change	Low (5)	ARIA system failure to be included in local business continuity plans Person Responsible: Clinical Matron Due: 31 Jan 2025 New E-Prescribing system to be procured and implemented across the Cancer Alliance Person Responsible: Interim Head of Operations Due: 31 March 2025
3761	Corporate – People and Culture **Accountable Executive: Chief People Officer (CPO)**	Inability to provide Freedom to Speak Up (FTSU) statutory service, support staff to speak up about safety concerns they may have and for those concerns to be acted on.	High (15)	NEW	Low (4)	Mobilise and embed outsourced independent service Person Responsible: Interim CPO Due: 21 Feb 2025
3660	Care Group – Children & Young People **Accountable Executive: CNMO**	Failure to NHSE requirement to complete Improving Quality in Physiological Services	High (15)	NEW	Very Low (2)	Benchmarking completed by UKAS Person Responsible: Head of Community Child Health/Children and Young People

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
		(IQIPS) accreditation by April 2025.				(CYP) Therapy Service Due: 10 Feb 2025 Completion of Action Plan based on gap analysis Person Responsible: Head of Community Child Health/CYP Therapy Service Due: 28 Feb 2025 Completion of Gap Analysis Person Responsible: Head of Community Child Health/CYP Therapy Service Due: 10 Mar 2025 To provide updates to Trust Board as required Person Responsible: Head of Community Child Health/CYP Therapy Service Due: 28 Mar 2025
3727	Care Group – Critical Care, Anaesthetics and Specialist Surgery **Accountable Executive: CMO**	Staff attendance with resus training	Extreme (20)	NEW	High (16)	Letter to be sent to all staff from Chief Nurse/Medical director if Did Not Attend (DNA) Person Responsible: Lead Resuscitation Officer Due: 31 Mar 2025

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
2123	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CSPO**	Health and Safety Risk to staff and the potential unavailability of records at the point of need due to lack of storage space for Health Records	Extreme (20)	NEW	Low (4)	Executive team Risk Owner has changed to CSPO. Risk to be reviewed and actions updated. Person Responsible: CSPO Due: 31 Jan 2025
3358	Care Group – Children and Young People **Accountable Executive: COO**	Failure to provide first audiology appointment within 6 weeks of referral (DM01) leading to delay in identification and treatment for children	Extreme (20)	NEW	Low (4)	To look at locum or outsourcing to help improve DM01 position Person Responsible: Head of Community Child Health/CYP Therapy Service Due: 28 Feb 2025 To understand how surveillance compliance fits with DM01 and ensure system is set up to capture any delays in surveillance Person Responsible: Operations Manager Due: 24 April 2025
3752	Corporate – Nursing **Accountable Executive: CNMO**	There is a risk that the Trust is non-compliance with HBN 04-01 2009 as additional beds have historically been put in	Extreme (20)	NEW	Low (4)	Recommendation to Executive to pilot removing two additional beds on three wards – decision pending Person Responsible: CNMO Due: 31 Jan 2025

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to November 24 report	Target Risk Score	Actions summary
		permanently into four bedded bays to create six bedded bays				Undertake Trust-wide, a bed space measurement review (to be supported by Directors of Nursing on each site). Plan to be agreed as to the process for doing this Person Responsible: Interim Director of Quality Governance Due: 31 Jan 2025

3.5 The below table shows the risk register entries by clinical or corporate care group and residual risk score. All Significant Risks have been allocated an Accountable Executive.

	Residual Risk Score				
Care Group	**15**	**16**	**20**	**25**	**Total**
CCASS CG		1	1		2
DCB CG	3	4	2		9
K&C CG	1				1
QEQM CG	1	1			2
WHH CG	1	3			4
WCYP CG	1	2	2		5
Corporate Medical	2				2
Corporate Nursing		1	1		2
Corporate Operations			1		1
Corporate Strategic Development	1	1			2
Corporate Finance			1		1
Corporate People and Culture	1				1
TOTAL	**11**	**13**	**8**	**0**	**32**

East Kent Hospitals University NHS Foundation Trust

CHANGE SINCE LAST REPORT	+1	-2	+4	0	+3

4. Changes since the last report

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

- Inability to provide Freedom to Speak Up (FTSU) statutory service, support staff to speak up about safety concerns they may have and for those concerns to be acted on (risk ref: 3761) Corporate – People and Culture. Approved at December 2024 Risk Review Group.
- Failure to NHSE requirement to complete IQIPS accreditation by April 2025. (Risk ref: 3660) Care Group – Children & Young People. Approved at December Risk Review Group.
- Health and Safety Risk to staff and the potential unavailability of records at the point of need due to lack of storage space for Health Records, (risk ref: 2123) Care Group – Diagnostics, Cancer and Buckland. Approved at December 2024 Risk Review Group.
- There is a risk that the Trust is non-compliance with HBN 04-01 2009 as additional beds have historically been put in permanently into four bedded bays to create six bedded bays. (Risk ref: 3752) Corporate – Nursing. Approved at November Risk Review Group.
- Staff attendance with resus training, (risk ref: 3727) Care Group – Critical Care, Anaesthetics and Specialist Surgery. Approved at November 24 Risk Review Group.

4.2 Escalations from the Significant Risk Report

- Failure to provide first audiology appointment within six weeks of referral (DM01) leading to delay in identification and treatment for children, (risk ref: 3358) Care Group – Children and Young People. Previously residual risk score moderate (8). Escalated to extreme (20) and approved at November 2024 Risk Review Group.

4.3 De-escalations from the Significant Risk Report

- There is a demand and capacity gap in respiratory sleep and diagnostic services which risks patients breaching Referral to Treatment (RTT), DMO1 and Cancer targets. (Risk ref: 3642).

Care Group – Queen Elizabeth, The Queen Mother. This has been deescalated from a 16 (high) to a 12 (moderate) on 02/12/24.

- Lack of Fire Door Compliance. (Risk ref: 3720). Care Group – Queen Elizabeth, The Queen Mother. This has been de-escalated from a 16 (high) to a 4 (low) on 13/12/24. As the residual risk score is now at target the care group will confirm if this can be closed.

5. Corporate Risk Management Update

5.1 An update was provided at the Risk Review Group on 21 January 2025 by the Head of Risk Management and Assurance who is currently pulling together a Training Needs Analysis (TNA) and tiered training implementation plan. This will come to the February Risk Review Group with training to commence within Q4.

5.2 There are two outstanding open Management Actions following the 2024 Risk Management Audit (two Management Actions were closed in December 2024). There has been continued work to improve risk management oversight and assurance through the clinical and corporate care groups but it has been agreed that the next audit scheduled for March 2025 will revisit arrangements to ascertain how embedded governance arrangements are – and evidenced by movement in residual risk ratings.

5.3 Project planning for the implementation of InPhase continues. Several areas have been urgently escalated with the senior InPhase team due to a lack of functionality within the system against the required specification. A technical meeting is due with the supplier on 30 January 2025 where they are proposing solutions to the main issues that have been raised.

6. Conclusion

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

End.

East Kent Hospitals University NHS Foundation Trust

BOARD OF DIRECTORS (BoD) ASSURANCE REPORT

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

Meeting dates: **4 December 2024 and 14 January 2025**

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

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

Quorate: **Yes**

Appendices:

None

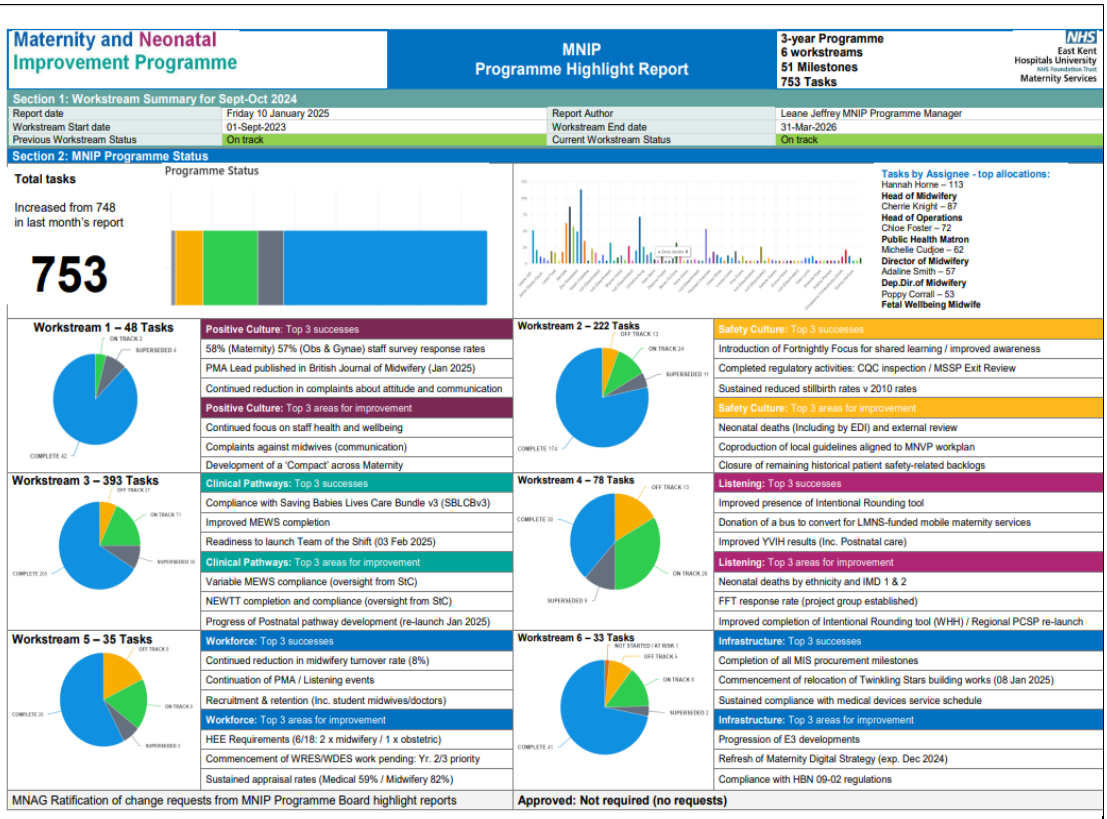
Declarations of interest made:

None

Assurances received at the Committee meeting:

Papers for discussion /approval	Summary of papers presented at MNAG 4 December 2024 and 14 January 2025.
Maternity and Neonatal Improvement Programme (MNIP) Update	Workstream reviews at MNAG, programme Board meetings continue with Executive Senior Responsible Officers (SROs) holding workstream leads to account. At each MNAG meeting a highlight oversight report is presented for each workstream focusing on progress made in month and any milestones that were off track against the trajectory. The reports and exceptions were approved by MNAG.

East Kent Hospitals University NHS Foundation Trust



Maternity and Neonatal Improvement Programme

MNIP Programme Highlight Report

3-year Programme
6 workstreams
51 Milestones
753 Tasks

East Kent Hospitals University NHS Foundation Trust Maternity Services

Section 1: Workstream Summary for Sept-Oct 2024

Report date	Friday 10 January 2025	Report Author	Leane Jeffrey MNIP Programme Manager
Workstream Start date	01-Sept-2023	Workstream End date	31-Mar-2026
Previous Workstream Status	On track	Current Workstream Status	On track

Section 2: MNIP Programme Status

Total tasks

Increased from 748 in last month's report

753

Programme Status

Tasks by Assignee - top allocations:
Hannah Horne – 113
Head of Midwifery
Cherrie Knight – 87
Head of Operations
Chloe Foster – 72
Public Health Matron
Michelle Cudjoe – 62
Director of Midwifery
Adaline Smith – 57
Dep.Dir.of Midwifery
Poppy Corrall – 53
Fetal Wellbeing Midwife

Workstream 1 – 48 Tasks	Positive Culture: Top 3 successes	Workstream 2 – 222 Tasks	Safety Culture: Top 3 successes
	58% (Maternity) 57% (Obs & Gynae) staff survey response rates		Introduction of Fortnightly Focus for shared learning / improved awareness
	PMA Lead published in British Journal of Midwifery (Jan 2025)		Completed regulatory activities: CQC inspection / MSSP Exit Review
	Continued reduction in complaints about attitude and communication		Sustained reduced stillbirth rates v 2010 rates
	Positive Culture: Top 3 areas for improvement		Safety Culture: Top 3 areas for improvement
	Continued focus on staff health and wellbeing		Neonatal deaths (Including by EDI) and external review
	Complaints against midwives (communication)		Coproduction of local guidelines aligned to MNVP workplan
	Development of a 'Compact' across Maternity		Closure of remaining historical patient safety-related backlogs
Workstream 3 – 393 Tasks	Clinical Pathways: Top 3 successes	Workstream 4 – 78 Tasks	Listening: Top 3 successes
	Compliance with Saving Babies Lives Care Bundle v3 (SBLCBv3)		Improved presence of Intentional Rounding tool
	Improved MEWS completion		Donation of a bus to convert for LMNS-funded mobile maternity services
	Readiness to launch Team of the Shift (03 Feb 2025)		Improved YVIH results (Inc. Postnatal care)
	Clinical Pathways: Top 3 areas for improvement		Listening: Top 3 areas for improvement
	Variable MEWS compliance (oversight from StC)		Neonatal deaths by ethnicity and IMD 1 & 2
	NEWTT completion and compliance (oversight from StC)		FFT response rate (project group established)
	Progress of Postnatal pathway development (re-launch Jan 2025)		Improved completion of Intentional Rounding tool (WHH) / Regional PCSP re-launch
Workstream 5 – 35 Tasks	Workforce: Top 3 successes	Workstream 6 – 33 Tasks	Infrastructure: Top 3 successes
	Continued reduction in midwifery turnover rate (8%)		Completion of all MIS procurement milestones
	Continuation of PMA / Listening events		Commencement of relocation of Twinkling Stars building works (08 Jan 2025)
	Recruitment & retention (Inc. student midwives/doctors)		Sustained compliance with medical devices service schedule
	Workforce: Top 3 areas for improvement		Infrastructure: Top 3 areas for improvement
	HEE Requirements (6/18: 2 x midwifery / 1 x obstetric)		Progression of E3 developments
	Commencement of WRES/WDES work pending: Yr. 2/3 priority		Refresh of Maternity Digital Strategy (exp. Dec 2024)
	Sustained appraisal rates (Medical 59% / Midwifery 82%)		Compliance with HBN 09-02 regulations
MNAG Ratification of change requests from MNIP Programme Board highlight reports		Approved: Not required (no requests)	

Workstream1: Developing a positive culture.

Top 3 successes

NHS Annual Staff Survey Response rates
Celebratory events and Awards /nominations
Identification of critical posts for succession planning

Top 3 areas of concern

Quarterly survey results re: Health and wellbeing
Complaints re communication form midwives
Maternity Freedom to Speak Up Guardian (FSUG)

Workstream 2: Developing and sustaining a culture of safety learning and support.

Top 3 successes

Progression of Maternity Patient Safety Incident Response Framework (PSIRF) Plan
Improved Q3 Stop the Clock results
Sustained reduced stillbirth rates v 2010 rates

Top 3 areas of concern

A backlog of historical patient safety related activities
Neonatal deaths (Including by Equality, Diversity and Inclusion (EDI)) and Hypoxic-ischaemic encephalopathy (HIE) rates
'Off track' workstream tasks

	Workstream 3: Clinical Pathways that underpin safe care. **Top 3 successes** Electronic Medicines Compendium (EMC) Pathway launched 08 October 2024 Plans for launch of Diabetes care in pregnancy group Nationally comparable clinical outcomes. **Top 3 areas of concern** Delayed Royal College of Obstetricians & Gynaecologists (RCOG) Team of the Shift (escalation framework). Postpartum haemorrhage (PPH)>=1500ml per 1000 higher than national and regional average. Maternity Early Warning Score (MEWS) completion and compliance. **Workstream 4: Listening to and working with women and families with compassion.** **Top 3 successes** Launch of Perinatal Mental Health Service project group Progression of tackling health inequalities via EDI group Improved Your Voice is Heard (YVIH) results for October (Including Postnatal care) **Top 3 areas of concern** Neonatal deaths by ethnicity and Index of Multiple Deprivation (IMD) 1 & 2 Friends and Family Test (FFT) response rate Embeddedness of intentional rounding tool **Workstream 5: Growing retaining and supporting our workforce.** **Top 3 successes** Identification of critical posts for succession planning Joint working with Staff Experience team (staff survey) Recognition and reward events **Top 3 areas of concern** Health Education England (HEE) Requirements Workforce Race Equality Standard (WRES)/Workforce Disability Equality Standard (WDES) work pending Analysis of feedback from Stay/Exit Interviews **Workstream 6: Infrastructure and Digital.** **Top 3 successes** Completion of all Maternity Incentive Scheme (MIS) procurement milestones New birthing pool under construction in Room 2 (William Harvey Hospital (WHH) Midwife Led Unit (MLU)) Clinical reviews of Phase 1 architect plans **Top 3 areas of concern** Non-compliance with environmental checks re: minor works

	Progression of E3 developments pending National Patient Safety Agency (NPSA) deadline Care Quality Commission (CQC): Relocation of Twinkling Stars /2nd Obstetric theatre
Clinical Negligence Scheme for Trusts (CNST) SA8 **Training Needs Analysis (TNA) and Training Plan for Year 3 of the Maternity Training Programme**	**Presented to MNAG 4 December 2024** **Purpose of the Report:** To evidence that training plans meet the requirements for the professional groups as set out in the maternity incentive scheme year 5, Core Competency Framework version 2, Saving Babies Lives Version 3 and training based upon current needs of the local maternity and neonatal system. To evidence to the Local Maternity and Neonatal System (LMNS) that local training plans are in place, the syllabus of which is derived from current evidence, national guidelines/recommendations, any relevant local audit findings, risk issues and case review feedback. To evidence that the local training faculty is multi-professional and representative of the current maternity and neonatal teams, to ensure protected time, for the midwifery educators, obstetricians and anaesthetists to be able to support local training. Validation and sign off on EKHUFT 3-year maternity training plan three times a year and more specifically the year 3 training programme. Approved at MNAG. **Summary of Key Issues** Ensure that the training plans are collaborative, multi-professional, inclusive and are based on local learning needs following staff feedback, Serious Incidents (SIs), service user feedback and audit. Provide assurance that the EKHUFT 3-year maternity training plan and TNA meet the requirements of for the professional groups as set out in the Core Competency Framework version 2, Maternity Incentive Scheme year 5, Saving Babies Lives version 3 framework for training that meets the requirements of the LMNS. The LMNS are assured that the TNA meets the requirements of local, regional and national standards. The LMNS are assured that the 3-year plan meets the requirements of the local, regional and national standards. The LMNS are assured that there is Multi-Disciplinary Team (MDT) training and working.
CNST SA9 Perinatal Quality Surveillance Tool (PQST) Oct 24	**Presented to MNAG 04 December 2024** **Purpose of the Report:** The purpose of this report is: To provide assurance that the service is using the tool and reporting to the required standard set out in the NHS implementing a Revised Perinatal Quality Surveillance Model Report December 2020. **Summary of key issues:**

- Total Babies born in October 510.
- Supernumerary status compliance reported at 100% at WHH, 100% at Queen Elizabeth the Queen Mother Hospital (QEQM).
- Compliance of 1:1 in Labour was reported as 100% on both sites.
- Level 3 Safeguarding compliance as of the end of October has remained above the 90% threshold (93.4%).
- Child protection level 3 compliance as of the end of October remains compliant at 94.9%.
- MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK, stillbirths – two intra-uterine deaths reportable in October (35 and 42 weeks).

One Neonatal death reported – baby born in poor condition at 38+1 weeks gestation (uterine rupture). Baby therapeutically cooled case referred and accepted by Maternity and Newborn Safety Investigations (MNSI). Baby sadly died at ten days of age. This has been previously captured in September dashboard, baby born in September but sadly died in October.

Top 3 risks remain:

1	Inadequate theatre capacity at QEQM for maternity services
2	Consultant obstetric vacancies at QEQM may result in an inability to deliver the service
3	Out of hours closure of Women's Health Suite (Gynaecology)

In October the service had:

- Two open cases being investigated by MNSI
- Two internal Patient Safety Incident Investigations (PSIIs)

The Trust/ Care group score card is currently not displaying the number of internal/external PSIIs, this has been escalated to the corporate team.

- CQC visit took place over two days 4th and 5th of December on both sites.
- Walk the Patch completed on both sites.
- Maternity and Neonatal Voices Partnership (MNVP) attended the Equity and Equality meeting where the Trust had a presentation for **Sister Circle** to discuss the offer of the Maternity Mates support programme for women who need additional support navigating maternity services, housing, financial support and language interpretation.

Patient Experience

- Friends and Family (FFT) received 366 responses, which is an overall 8.9% response rate.

	• Response rate Key Performance Indicator (KPI) - 70%. The service achieved a response rate of 81.6%. The team spoke to 420 families. This is an increase from September which was 81% response rate. **This is the best response rate since YVIH was commenced.**
CNST SA 1 **PERINATAL MORTALITY REVIEW TOOL (PMRT) REPORT – Q3 2024/25**	**Presented to MNAG January 14 2025** **Purpose of the Report:** The purpose of this report is to assure the MNAG and Trust Board that all stillbirths and neonatal deaths are reviewed using the national electronic PMRT. This is in accordance with the standards set out in NHS Resolutions (NHSR) Maternity Incentive Scheme (MIS) which aim to continue to support the delivery of safer maternity care. **Summary of Key Issues:** The report confirms that during the Quarter 3 reporting period the service has used the tool to the required standard as set out in NHSR, CNST MIS Year 6. During Quarter 3, there have been a total of nine cases reported. Of these nine cases, two were not supported; a neonatal death (NND) at 17 weeks at home, and one Medical Termination of Pregnancy (MTOP) at 22 weeks and therefore not supported for a full PMRT review. Of the seven supported cases, two were neonatal deaths and five were still births/Intrauterine deaths (IUD'S). Both supported and unsupported. A PMRT generated Case List, pulled from the PMRT, shows the cases to date and their reporting stage. This has been shared with the Board Safety Champion. Within the last quarter the Trust reported all cases to MBRRACE within seven days of the death, with surveillance being completed within one calendar month. Within the last quarter the Trust had a 100% compliance rate of commencing the review within the allocated time scales. There is a 100% compliance with external reviewers at PMRT meetings, as a result of the bereavement and governance midwives from neighboring trusts supporting one another. The LMNS meet quarterly to discuss running themes and issues. The last meeting was on 7 October 2024. The next meeting is scheduled for 13 January 2025. The board generated report shows the cases that have published reviews within this quarter at the Multidisciplinary PMRT meeting. All cases are on schedule to be completed in the time frame and adhering to the time frames set by the national framework for PMRT reviews.

CNST SA6 **Saving Babies Lives Q3 Update**	**Presented at MNAG 14 January 2025** **Purpose of the Report:** To provide the Board with assurance of compliance or actions in place to reach compliance. **Summary of key issues:** Self-assessment for Q6 was submitted on 30/11/24 and is awaiting LMNS validation. An action plan has been created for each outstanding element and intervention to ensure compliance. Element 1: Self-assessment showed 80% implementation. There are two outstanding interventions relating to the expansion of an in-house smoking cessation service. Element 2: Self-assessment showed 100% compliance. Element 3: Self-assessment showed 100% compliance. Element 4: Self-assessment showed 100% compliance. Element 5: Self-assessment showed 96% compliance. There is one outstanding intervention relating to provision of IV antibiotics given in pre term labour. Element 6; Self-assessment showed 83% compliance. There is one outstanding intervention relating to the completion of a HbA1c measurement between 24+0-30+0 gestation. Total compliance has been self-assessed as 94%. In CNST year 6 the focus of submissions is: progression, trajectories, and meeting LMNS targets. Evidence of sustained improvement. Local themes and trends. Continuous learning Weekly meetings with the LMNS are ongoing for support to meet each intervention.
CNST SA9 Perinatal Quality Surveillance Tool (PQST) Nov 24	**Presented to MNAG 14 January 2025** **Summary of key issues:** • Total Babies born in November 459. • Supernumerary status compliance reported at 100% at WHH, 100% at QEQM. • Compliance of 1:1 in Labour was reported as 100% on both sites. • Level 3 Safeguarding compliance as of the end of November has remained above the 90% threshold (91.9%). • Child protection level 3 compliance as of the end of November remains compliant at 94.5%. • No MBRRACE stillbirths or Neonatal deaths reportable. • One case referred to MNSI in November. • Three Moderate harms reported. In November the service had:

- Two open cases being investigated by MNSI with three final reports returned to the Trust following completed investigation. Finding presented and shared via safety symptoms.
- Two internal PSIIs.

The Trust/ Care group score card is currently not displaying the number of internal/external PSIIs, this has been escalated to the corporate team.

MNVP Funding escalation

At this time, the LMNS is unable to provide adequate MNVP Lead time to enable MNVP attendance as a quorate member at the required Trust assurance and Governance meetings as set out in year 6 CNST guidance.

It had been agreed at LMNS board in July 2024 that a 0.5 band 7 MNVP system level governance lead would be recruited to fulfil this obligation. However, due to the recent financial restrictions placed on the Integrated Care Board (ICB) the role is awaiting executive sign off by the ICB Chief Executive. The risks associated with not providing the necessary resource to the MNVP has been clearly communicated throughout the LMNS and ICB and we continue to champion the need for this role.

Patient Experience

- Friends and Family (FFT) received 330 responses, which is an overall **8.7% response rate**.
- 66 compliment emails sent from FFT feedback.
- Your Voice is Heard - Response rate KPI - 70%. The service achieved a response rate of 77.4% and the team spoke to 357 families. This is a slight decrease from September and October of 81%.

Training and Education

- PS/PA update session compliance currently remains below the LMNS compliance expectation of 70%, locally compliance is set at 90%. November data demonstrates 61% compliance with an increase to 68% in December. The trajectory for January is 78.3%, the matrons and roster clerks have been contacted to allocate out of date staff to the available training dates.
- Training compliance for fetal monitoring is >90% for all staff groups in November and remains above 90% in December and this is also reflected in the trajectory for January 2025
- PRactical Obstetric Multi-Professional Training (PROMPT) compliance is above 90% for all staff groups and this is also reflected in the December data. The trajectory for January 2025 also remains above 90% for all staff groups.
- Newborn Life Support (NLS) for all staff groups with the exception of Obstetric consultants is ≥90%, but as of December compliance has increased to 94.3% with two Consultants remaining non-compliant.

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- Neonatal / Paediatric consultant compliance falls to 71.4% in December, the booked dates were not attended as planned in December but an alternative date has been organised for 7 January 2025. The trajectory for January 2025 is currently 92.8% as long as all booked staff attend.
- NLS compliance for Advanced Neonatal Nurse Practitioner (ANNP) is 100% this data is reflected on the Dashboard as of December 2024.

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<tr><td>CNST SA9 Safety Champions Feedback</td><td>

Together with the Chief Executive Officer (CEO) both the Non-Executive Director (NED) for Maternity and the Executive Director (ED) for Maternity undertake regular walkabouts and listening events across the service.

Feedback from the October and November listening events: The following issues were raised and have been/are being addressed:

Safety Champions Feedback	Issues escalated	Actions
CNMO attended Safety Summit Tracey Fletcher (CEO) and Sarah Hayes (CNMO) hosted a tea trolley dash Listening Event on Thursday 21st November from 12:00 to 13:00 hrs	Presentation from Inpatient Matron on QI project focusing on thermoregulation of the neonate	Review timings of Safety Summit to increase /promote attendance Share feedback from recent MNSI referrals Ask staff to identify subjects for presentation they would like to hear more of

Safety Champions Feedback	Issues escalated	Actions
Safety Champion walks about continue CEO and Chief Nurse, Midwifery Officer completed a Tea trolley round	One member of staff has been her for 44 years, Team asked how we celebrate long service Uncomfortable working conditions in kitchen	Advertise Trust celebration awards Air conditioning sourced

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<tr><td>CNST SA10 Q3 Serious Incidents (SI)/Duty of Candour (DoC)/Early Notification Scheme (ENS)</td><td>

The purpose of this paper is to assure the MNAG that all qualifying cases are referred to the (MNSI/CQC) and to NHSR's ENS. This is in accordance with the standards set out in NHSR Maternity Incentive Scheme which aim to continue to support the delivery of safer maternity care (Safety Action 10). It also briefs the Board on Maternity SIs.

- During Q3 one case was referred to MNSI for external PSII, there were no cases reported requiring internal PSII during this time frame.

The service received two final reports from MNSI and two draft reports sent for factual accuracy.

Key learning points from the final reports received highlighted have been acted upon and shared with the team:

- The report confirms that during the Quarter 3 reporting period the service has reported 100% of qualifying cases to MNSI and to NHSR's ENS as set out in NHSR, CNST Maternity Incentive Scheme Year 6, from 1 October – 31 December 2024.

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East Kent Hospitals University NHS Foundation Trust

Matters to escalate to Quality & Safety Committee (Q&SC) and Board	1. Limited access to Freedom to Speak Up Guardian (FTSUG) owing to staffing. 2. CNST LMNS peer review at the end of January prior to Board Declaration on 6 February 2025. 3. Neonatal death review external report expected 31 January 2025. 4. Impact of Estates on clinical care in relation to Triage CQC Visit 4 and 5 December 2024.

Other items of business:

None

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

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

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

Item	Purpose	Date
MNAG asks the BoD to discuss and **NOTE** this MNAG Chair Assurance Report.	Assurance	6 February 2025
MNAG asks the BoD to approve the neonatal workforce report and contents of the action plan in compliance with CNST Safety Action 4 required standard.	Approval	6 February 2025
MNAG asks the BoD to receive assurance that a Quarterly Perinatal Mortality Review Tool paper has been received for Q3 2024/25 demonstrating our compliance in line with CNST standard requirements. MNAG ask the BoD to receive assurance and note that a full maternity dashboard and safety review has been completed and continues to be monitored by the senior maternity team, demonstrating our compliance in line with CNST Safety Action 6 standard requirements.	Assurance	6 February 2025

East Kent Hospitals University NHS Foundation Trust

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

Committee:	**Quality and Safety Committee (Q&SC)**
Meeting dates:	**26 November 2024**
Chair:	**Dr Andrew Catto, Non-Executive Director (NED)**
Paper Author:	**Executive Assistant**
Quorate:	**Yes**

Appendices:

None

Declarations of interest made:

Catherine Walker advised the Committee that she remained on the Board of KMPT until the end of November.

Andrew Catto advised that in relation to item 126/24: Improving Experience of Patients Staying in the Emergency Department (ED) for Over 24hrs - Jointly William Harvey and Queen Elizabeth Care Groups that he was a member of the Primary Care Urgent Treatment Centre (UTC) Alliance.

East Kent Hospitals University NHS Foundation Trust

Assurances received at the Committee meeting - focus on learning and improvement:

Agenda item	Summary
QUALITY GOVERNANCE REPORT (PATIENT EXPERIENCE, INQUESTS, CLAIMS, INCIDENTS AND CENTRAL ALERTING SYSTEM (CAS)).	The Committee received the report and **NOTED** the following key updates: • There were two Never Events in September (A wrong implant/prosthesis and a retained foreign object post-procedure). A two-year look back review of never events in the Trust has been completed to identify themes, (Local Safety Standards for Invasive Procedures (LocSSIPs) had been identified as key and is being addressed). The two-year look back would be presented to the January 2025 Q&SC. • Verbal Duty of Candour (DoC) achieved 100% compliance in September 2024, with significant improvements to the written and findings elements also demonstrated. A clear escalation plan was now in place to ensure timely completion, and this would be kept under review. • The total number of overdue incidents was 688 at the end of September, however, with the number of incidents becoming overdue increases by 23 daily (above trajectory). This would be reviewed again in January 2025. • There were 1922 overdue actions, associated with 483 incidents, dating back to 2018. A new trajectory has been produced to further reduce the backlog by the end of 2024. • There were 100 new complaints received in September 2024. Complaint response times were showing an improving position which was positive, however a significant amount of work was still required to meet the trajectory. • There remained a focus on Local Resolution Meeting (LRM) process as positive outcomes were being achieved. • Due to team pressures, the Patient Advice and Liaison Service (PALS) team were responding to emails 18 working days old, this was outside of the policy. Capacity to answer 'live' phone calls was also reduced. Concern was expressed about this given the impact on patient experience. • The progress on National Institute for Health and Care Excellence (NICE) Guidelines implementation has exceeded the trajectory, with 50% having been implemented.
ANTIMICROBIAL STEWARDSHIP (AMS) UPDATE	The Committee received the report and **NOTED** the following key updates: • The Trust had an AMS strategy and plan. Monthly Key Performance Indicator (KPI) audits examined ward-level compliance with antimicrobial guidelines. • The focus remained working collaboratively with the Infection Prevention Control (IPC) Team to reduce rates of *Clostridioides difficile* infections (CDI). • Electronic Prescribing & Medicines Administration (ePMA) was a key control tool. The AMS team was working with the Chief Informatics Officer to strengthen antibiotic stewardship.

East Kent Hospitals University NHS Foundation Trust

IMPROVING EXPERIENCE OF PATIENTS STAYING IN THE ED FOR OVER 24HRS - JOINTLY WILLIAM HARVEY AND QUEEN ELIZABETH CARE GROUPS	The Committee received the report and **NOTED** the following key updates: • The NHS England (NHSE) Southeast Regional Team wished to obtain insights into the provision of safe, effective care to patients in all emergency departments in the Southeast region, particularly those who were being treated in escalation areas. • Both William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) were able to demonstrate to NHSE that safety and patient experience improvements had been made to each area. However, it was recognised that we were still on an improvement journey (given the safety risk associated with long waits and corridor care). • The WHH ED nursing team received the Nursing Team of the year award.
ENDOSCOPY UPDATE	The Committee received the report and **NOTED** the following key updates: • The number of patients actively requiring surveillance had reduced to under 5,000 and alternatives to endoscopy were being explored. A business case was under consideration (this will support a more sustainable position going forwards). • It was noted that there had been patient harm resulting from the process delays. The harms would be escalated to the Board and Council of Governors (CoG).
MONTHLY SIGNIFICANT RISK REGISTER REPORT	The Committee received the report and **NOTED** the following key updates: • There were 31 risks in the significant risk register,15 of which were aligned to the quality risks. • There were three risks that had been closed and three risks which had deescalated since the previous report. • There were overdue actions associated with five of the risks. These had been escalated for immediate attention with the risk owners and the accountable executives informed. • The new Head of Risk had recently joined the Trust, and it was confirmed that risk was a shared Trust wide responsibility.

CARE QUALITY COMMISSION (CQC) UPDATE REPORT	The Committee received the report and **NOTED** that: • All Care Groups had attended an internal CQC self-assessment check and challenge meeting, and the process was being further developed for the next round of meetings. Culture, staffing, environment, equipment and documentation were the most common identified areas for improvement. • Implementation of the InPhase CQC application over the coming months would improve visibility, reporting and efficiency of CQC self-assessment and action plan management. An update on the InPhase implementation would be received at the January 2025 Q&SC. • The closure of actions for the 2023 inspection action plans continued with an additional 6% of actions closed since the last Q&SC report. 9% of overall actions (18 actions out of 206) remain open with further closures expected over the forthcoming reporting period. Some were still incomplete post their extended due dates and were with the relevant executive director for decision on next steps. • The monthly submissions of the Section 31 return for Maternity were submitted on 1 October and 1 November 2024. • CQC queries have continued at a slightly raised level and responses submitted on time. • The CQC had recently reverted to their previous engagement and inspection model and an engagement meeting was held on 4 November 2024 using their new agenda format. Meetings will now be bi-monthly for 1.5 hours with the next meeting on 16 January 2025. • The team was working with care group triumvirates to ensure a consistent approach to the CQC well-led domain.
PATIENT DOCUMENTATION AUDIT UPDATE	The Committee received the report and **NOTED** the following key updates: • It was confirmed that 100 consecutive forms were audited in each of the review areas and mandated information would be compulsory to complete on the electronic system. • The patient documentation audit report identified several opportunities for improvements.
HUMAN ISSUE AUTHORITY (HTA) INSPECTION GOVERNANCE UPDATE	The Committee received the report and **NOTED** the following key updates: • It was noted that it was a very reflective and thorough report which did not highlight any major areas of concern.
INFECTION PREVENTION AND CONTROL (IPC) REPORT	The Committee received the report and **NOTED** the following key updates: • The new national infection control reportable thresholds had been published. • *Clostridioides difficile* continued to remain well below threshold for the year, as did *E-coli* bloodstream infections. However, Klebsiella and

	Pseudomonas was over the threshold, and there was significant focus on reducing these. • There had been one MRSA bacteraemia reported, which identified learning in relation collection of blood cultures. • The Integrated Care Board (ICB) and NHSE IPC teams undertook surveillance visit to both WHH and QEQM in July 2024, their reports identified improvements in relation to Surgical Site Infection Surveillance (SSIS), compliance to IPC measures and improvements in maternity IPC compliance. • There had been 13 COVID incidents, one C-diff outbreak (novel ribotype), two suspected measles incidents (Not measles), two pertussis cases and a norovirus outbreak in since the last report. • The Deputy Director of Infection Prevention Control and Director of Facilities were collaboratively reviewing and implementing a domestic services improvement plan. • Infection Prevention Control training compliance was improving, and how we recorded training compliance had been updated, making the compliance data more accurate. • The risk associated with holes in wraps had reduced as the Trust had purchased dedicated metal boxes to store the theatre equipment. • The IPC Team were employing Patient Safety Incident Response Framework (PSIRF), which allowed staff to focus on actions instead of investigations. All IPC cases were reviewed on a quarterly basis with ICB and pharmacy colleagues. • The Trust infection rates were comparing favourably with those of our peers.
COST IMPROVEMENT SCHEME QUALITY IMPACT ASSESSMENTS (QIA)	The Committee received the report and **NOTED** the following key updates. • The Q&SC role was to provide oversight to the current QIA process and ensure there was opportunity to challenge. • Going forward the Trust would need to complete QIAs for projects outside of our Quality Improvement programme.
EMERGENCY PLANNING & RESILIENCE ANNUAL REPORT	The Committee received and **NOTED** the regulatory compliance chair's reports: • The report provided annual assurance to the Committee on the workstreams, risks and activities within Emergency Planning Resilience and Response (EPRR). • The Trust rated as compliant in the annual self-assessment assurance process against the NHSE Core Standards for EPRR. • It was confirmed that the Trust self-assessed the service against the NHSE core standard and the submitted the results and evidence to the ICB to review and validate our compliance, the ICB then submitted our scores to NHSE. Once the Trust score had been confirmed by the ICB the confirmation would be submitted to this Committee for noting. It was the agreed that the report would need to go the Trust Board for final review.

MATERNITY & NEONATAL ASSURANCE GROUP (MNAG)	The Committee received the report and **NOTED** the following key updates: • Challenges with access to Freedom to Speak Up Guardian (FTSUG) was being addressed by the Interim Chief People Officer (CPO). It was noted this was on the risk register and mitigations were in place for maternity staff who wished to raise concerns. The aim was to have a plan in place by January 2025. • The maternity screening review visit took place in November 2024 and positive feedback was received. • Clinical Negligence Scheme for Trusts (CNST) was at review stage with the Local Maternity System (LMS). • Impact of our estate continued to be an issue.
DEMONSTRATING IMPROVEMENT FORM LEARNING FROM DEATHS PROCESS INCLUDING THE LEAD MEDICAL EXAMINER REPORT	The Committee received the report and **NOTED** the following key updates: • Changes to legislation around death certification came into law on 9 September 2024, making the involvement of the medical examiner service statutory in non-coronial deaths (this had impacted on the workload for the Medical Examiner Team). • There had also been changes to how the Hospital Standard Mortality Ratio (HSMR) (in hospital deaths) were calculated. The Trust was within the expected range for HSMR, however, for our Summary Hospital-level Mortality Indicator (SHMI) which included the deaths of patients who had died within 28 days of leaving hospital, the Trust was outside the expected range. The reasons for this is being explored by the Chief Medical Officer (CMO) and team.
DETERIORATING PATIENT UPDATE	The Committee received the report and **NOTED** the following key updates: • A focus on senior review. • An increase in cardiac arrests. • Understanding our crude mortality figures.
SAFE STAFFING REVIEW – DEEP DIVE.	The Committee received the report and **NOTED** the following key updates • The review was benchmarked against the national standard and had been reviewed by Finance and Performance Committee (F&PC) and by the People and Culture Committee (P&CC) soon. • It was presented to Q&SC to provide assurance that the relevant safeguards were in place, and it was requested the Committee accept the report for submission to the Board of Directors.
INTEGRATED PERFORMANCE REVIEW (IPR)	The Committee received and **NOTED** the IPR.
PATIENT EXPERIENCE	The Committee received and **NOTED** the Patient Experience report.

East Kent Hospitals University NHS Foundation Trust

COMMITTEE ASSURANCE REPORT	
MORTALITY SURVEILLANCE & STEERING GROUP (MSSG) CHAIR'S REPORT	The Committee received and **NOTED** the Mortality Surveillance & Steering Group report.
CLINICAL AUDIT AND EFFECTIVENESS CROUP (CAEG) CHAIR'S REPORT	The Committee received and **NOTED** the Clinical Audit and Effectiveness Group report.
PATIENT SAFETY COMMITTEE (PSC) CHAIR'S REPORT	The Committee received and **NOTED** the Patient Safety Committee (PSC) report.
SAFEGUARDING COMMITTEE ASSURANCE REPORT	The Committee received and **NOTED** the Safeguarding Committee report.

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	6 February 2025

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: **26 November 2024**

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

Paper Author: **Executive Assistant**

Quorate: **Yes**

Appendices: **None**

Declarations of interest made:

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

Assurances received at the Committee meeting:

Agenda item	Summary
Significant Risk Register	The Chief Nursing & Midwifery Officer (CNMO) presented the report, noting more details have been provided in the report and that this is in a much better position with improvements having been made. SH explained the report provides an oversight of the risks overseen in this committee which are mainly held by Executives; the Chief Operating Officer, Chief Strategy Officer and Chief Finance Officer. The Committee received assurance that the updating of risks was being actively managed and overseen. The Committee received assurance the Significant Risk Register is being kept up to date and that any corrective/mitigating actions are being monitored.
Review of FPC Board Assurance Framework (BAF) Risks	The Committee reviewed its BAF Risks as it does at each Committee, recognising the agenda had been framed with reference to the BAF. The Director of Corporate Governance (DoCG) highlighted to the committee the risks which are being overseen by other committees are 2406 and 679 and advised there had not been much change since last month's reporting.
We Care Integrated Performance Report (IPR) (M11): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT),	The Committee noted the IPR operational metrics and in particular noted the following key points: – Type 1 remains above the 50% trajectory for the month of October. It declined in September but had now gone up in the month of November and is being tracked at just under 55%. – 12hrs reduced in November and currently being tracked at 9.2%.

Cancer and Diagnostics	– Cancer performance remains in a good position, and Faster Diagnosis Standard (FDS) compliance and 62-day backlog are in a good place. – Endoscopy backlog continues to reduce to a level which is more sustainable. – There are still some challenges in the 78 and the 65-week breaches for long waiting patients in ENT and work is continuing to eradicate this position by the nationally imposed deadline of 22 December, but it would be challenging to get to zero on the 65 weeks by this date. – Diagnostics at the end of October was 77% and is now at 82.2% which is the highest the trust has been for 5 years and on track to deliver the diagnostic position, which has been a great achievement from the teams involved. NHS England's Improvement Director asked to note that the 12hr 9.2% is still higher than the 8% trajectory exit criteria, that it is off target and that it will be raised at the national meeting on the 12 December as a cause for concern.
Patients no Longer Fitting the Criteria to Reside	The Committee noted the discussion in the We Care agenda item and the Chief Operating Officer (COO) advised the numbers had decreased since the last meeting, with the latest count at **124** as of the previous day. However, there are concerns about under reporting at the William Harvey Hospital (WHH) site, as its numbers are significantly lower compared to Kent & Canterbury Hospital (K&C) and Queen Elizabeth the Queen Mother Hospital (QEQM). Efforts are underway to educate staff at WHH to ensure accurate recording of No Criteria to Reside (NCTRs). A Multi Agency Discharge Event (MADE) at the WHH site on Wednesday will focus on addressing the rise in homeless patients, who are contributing to the NCTR numbers. This increase reflects broader economic conditions and is straining NHS resources. TS highlighted the financial strain on social care, highlighting the difficulties faced by local councils across the country.
Winter Plan	The Committee noted the update regarding the Winter Plan. The COO stated that the finalised winter plan will be presented to the next Board, and the full capacity protocol should be approved at the next Clinical Executive Management Group (CEMG) meeting. The elective plan for winter is being finalised, particularly for the first two weeks in January. The monies from the Health and Care Partnership (HCP) have been agreed for the additional nursing requirements for virtual ward.
Cost Improvement Programme (CIP) Oversight and Assurance	The Committee Received an Update of the CIP report and noted the following key points:

	• In month EKHUFT was on plan. • Year to Date (YTD) remains slightly over plan just over £26m with a plan of £25.7m. • Scheme by scheme forecast for the full year is coming out at £48.95m against £49m plan. This is based from inside the programme, business lead and theme leads. The Financial Recovery Director was monitoring the recurrent elements in delivery YTD, aiming for 75%. Procurement CIP is forecasting £5.3m, which is slightly below target of £7.9m. The current plan is to improve forecast to £5.96m. The COO asked how much control do we have over this. The Financial Recovery Director confirmed we have full control and engagement. The 2025/26 CIP plan was launched last week and we are in a good place in terms of planning for next year (another £49m expected). The key milestone is the 14 March £49m of recurrent schemes. A key first milestone is to aim to reach £25m of schemes fully planned by the 19 December. The milestone then moves to £36m at the end of January and then to £48m.
Update on External Engagement of the 5-Year Capital Plan	The Committee Received an Update on the External Engagement of the 5-Year Capital Plan with the following key points: • **Mechanical Thrombectomy.** The build has now completed and has delivered a genuine underspend. • **Hyper Acute Stroke Unit (HASU).** The completion of the Full Business Case is on track and work has commenced with the new P23 partner. • **Diagnostic Imaging: QEQM MRI**. There has been significant delay in this programme which has been deferred to 2025/26. • **Community Diagnostic Centre Buckland (CDC).** The build has now completed and has delivered a genuine underspend. • **Maternity QEQM.** Early Release funds have been awarded to the Trust to complete the NHSE Short Form Business Case to RIBA 4. The work is on track and will be taken forward with the new P23 partner. • **Fire Remedial works/Compartmentation.** This is an extremely complex programme that will require significant operational input – it cannot be undertaken by 2gether in isolation. A full plan is being produced by 2gther to enable the operational teams to provide insight and advice on the timing of the various clinical area closures. Chief Strategy and Partnerships Officer (CSPO) suggested there was increased capital availability between now and the end of the financial year, with £1.5m available. However, any slippage could impact next year's budget.

Month 7 Finance Report	The Committee received an update and noted the following in the report. The Chief Finance Officer (CFO) reported a balanced position for month 7, highlighting risks that require careful management and highlighting the importance of focusing on the CIP initiatives in the second half of the year. The CFO also informed the committee of Kent and Medway's wider financial position and management actions.
Financial Sustainability Plan Update (FSP)	The Committee received an update regarding the FSP. The CFO emphasised the FSP's purpose of guiding EKHUFT to achieve a sustainable financial position within three years and supporting exiting of NOF4 as one of the criteria to be met (i.e. having a medium-term financial plan). The FSP has been the subject of substantial work under the leadership of Tim Glenn, the Interim CFO until October 2024. The CFO asked for support from this committee to take this plan to the Trust Board in December, as Version 1 of what will be an iterative document. The report was **APPROVED** by the committee to be presented at the next Board meeting.
Business Planning 2025/26	The Committee received an update from Chief Strategy and Partnerships Officer (CSPO) on Business Planning 2025/26. The CSPO provided an update on the business plan for 2025/26, highlighting the completion of the first draft of capacity assumptions for care groups. working business planning to date included consideration of demand levels, hitting the 52-week target, and achieving a 6% activity increase in line with the work on the FSP. The next deadline for care group work on planning is approaching, and Performance Review Meetings (PRMs) are being used to review progress. Further review is needed on workforce planning The timelines are as follows: • December - Care groups to complete first draft. • January – present update to execs and FPC. • February – approval FPC and Board.
Workforce Quarterly Report to Include Substantive, Bank and Agency Usage, Spend, Recruitment Challenges, Action Plan.	The Committee received an update from the Interim Chief People Officer and highlighted the following key points: • Vacancy rate for Healthcare Support Workers (HCSWs) has increased to 14.86% and band 5 nurses have decreased to 4.9%. • Agency usage/spend for medics has increased in recent months, with a number of long term, high cost locums remaining in post. The ID Medical Managed service are continuing to face some barriers in

	relation to replacing some of these locums with more cost-efficient alternatives. • Agency usage for medics continues to offer the Trust the greatest saving potential in relation to temporary staffing. The Trust are currently working on a number of workforce schemes to reduce our reliance on agency locums and in turn increase our bank optimisation The CNMO suggested minor changes to band 5 registered nurses, which will be aligned with other trusts through a safer staffing review.
Business cases: over £1.75m Requiring Investment £2.5m for Self-Funding. Capital Business Cases Over £1m	The Committee noted there were no business cases to discuss.
2gether Support Solutions (2gether) Review Update	The Committee received an update from CSPO of the 2gether review plan which was deferred from last month and highlighted the following key points: 1. Assessment of the benefits realisation of the original business case. 2. Review and consider the current VAT benefit. 3. The view on operational efficiency and effectiveness of the structure. 4. Summary view on the services provided. A number of summary observations have been made in the report by PricewaterhouseCoopers (PwC): • The financial savings delivered through the VAT benefits are clear. • Perceptions on the quality of the service performance are mixed and there is material room for improvement across the service delivery. • There is a need to re-establish relationships at a senior level. • The governance framework requires review and resetting. • A reflection on and rationalisation of the Key Performance Indicators is required. • A renewed contract management structure would be beneficial. • A value for money assessment needs to be undertaken. The committee were asked to approve the next steps which the committee **APPROVED.**
Capital Investment Group (CIG) Assurance Report	The report was taken as read with nothing further to add.

East Kent Hospitals University NHS Foundation Trust

Business Case Scrutiny Group (BCSG) Assurance Report	The Safer staffing paper was approved by the committee last week. The paper was **APPROVED** by the committee.
Financial Improvement Programme Board (FIPB) Assurance Report	There was nothing further to add.
Patients Travelling Expenses Policy	The Committee agreed they were happy with the policy.
Feedback to Board of Directors	The Committee noted no feedback to Board Members.
Referrals to Other Board Committees	The report was **APPROVED** by the committee to be presented at the next Board meeting.

Item	Purpose	Date
FPC asks the BoD to discuss and **NOTE** this FPC Chair Assurance Report.	Assurance	6 February 2025

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: **7 January 2025**

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

Paper Author: **Executive Assistant**

Quorate: **Yes**

Appendices: **None**

Declarations of interest made:

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

Assurances received at the Committee meeting:

Agenda item	Summary
Significant Risk Register	The Chief Nursing & Midwifery Officer (CNMO) presented the report, noting the details included within the report. Work within the team is continuing on overdue actions with the care groups over the next week, with the majority overseen by executive members of the Committee. The risk related to the Clinical environment not being fit for purpose in many areas (number 3354) will be removed from the significant risk register as a result of the mitigatory actions taken. The Committee received assurance that the updating of risks was being actively managed and overseen. The Committee received assurance the Significant Risk Register is being kept up to date and that any corrective/mitigating actions are being monitored.
Review of FPC Board Assurance Framework (BAF) Risks	The Committee reviewed its BAF Risks as it does at each Committee, recognising the agenda had been framed with reference to the BAF. The digital data and technology steering group is set to conduct a preliminary scene setting at board development on Thursday. This will then be followed by a detailed scrutiny review by FPC in addition to the Board review. Subsequent reviews will be undertaken quarterly. The Director of Corporate Governance (DCG) advised there is no significant change from last month and that the Trust is in a fairly static place with regards to its BAF risk assessment.

We Care Integrated Performance Report (IPR) (M11): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee noted the IPR operational metrics and in particular noted the following key points: – Type 1 has dropped to 53.7% but still ahead of the 50% trajectory for the month of November. The position recovered in December and improved to 54.71%. – 12hrs in department is still a big challenge and currently being tracked at 9.5% against an IIP metric of 8% for Q3 and Q4. In December this went up to 10.2%, there are significant number of unplaced patients at William Harvey Hospital (WHH) this morning (7 January) which is the most challenged position the Trust has had. – Cancer performance remains in a good position for November for 28 days and 62 days which carried on into December. – There were 247 patients breaching 65-weeks, with 8 breached for 78 weeks. Both are an improvement on the metric for November. – DMO1 continues to do well and the Endoscopy backlog continues to reduce. Initial planning guidance was released yesterday which includes the target to achieve 65% RTT by the end of March 2026. At present there is no explicit reference about the 52-week wait numbers, however, this may become clearer when full guidance is released. The original plan was to eradicate them in 25/26. The national achievement of 65% for 52 weeks is still an expectation for all organisations. However, progress is being made on the 52-week plan with the goal of eliminating 52 weeks next year. This aligns with the Financial Sustainability Plan (FSP) activity increases. The challenge is if the Trust will be paid for the increased levels of Elective Recovery Fund (ERF) activity. Once the modelling has been done the Chief Operating Officer (COO) will share at this committee.
Patients no Longer Fitting the Criteria to Reside	The Committee noted the discussion in the We Care agenda item and the COO confirmed there has been a reduction over the past year and a reduction in numbers through the summer. The numbers had changed in recent weeks due to the introduction of the RTS referral form at WHH which went live in November. This has not been as successful as first thought and further work is underway to understand what can be done. There have been improvements in P1 discharges from Queen Elizabeth the Queen Mother Hospital (QEQM) and Kent & Canterbury Hospital (K&C) compared to WHH. However, P2s and P3s remain at similar levels at all sites. The reviews have mainly focused on P zero discharges. All sites are maintaining similar levels of discharges of P zero patients.
Cost Improvement Programme (CIP) Oversight and Assurance	The Committee Received an update of the CIP on the following two key sections: • 24/25 Performance;

	• Outlook on 25/26 pipeline development. At month end November, the Trust is forecasting to deliver £48.5m savings the against £49m. This is the first time the forecast has dipped from the £49m however additional mitigations are being developed. Year to date is slightly better than plan by 300k. The recurrent element remains strong against the full year target of 75%, with the year to date position at 73%. Specific high value schemes including Length of Stay (LOS), medical workforce and procurement contain relative risks of delivery for the remaining 4 months. Should these not deliver against their current forecast we would see an impact against the forecast target which we will be closely monitoring. Action plans are in place to bring them back on track. The next key milestone is the 24 January for development of 25-26 CIP schemes, with a target of £36m. These plans need to have robust decisions and planning agreements made with care groups, system, and capital-enabled schemes which will be focused on for next three weeks for the next committee update.
Month 8 Finance Report	The Committee received an update and noted the following in the report. The Chief Finance Officer (CFO) reported that we are on plan for month 8, highlighting risks that require careful management and highlighting the importance of focusing on the CIP initiatives in the second half of the year.
Financial Sustainability Plan Update (FSP)	The Committee received an update regarding the FSP. The CFO attended the Board meeting last month to seek approval for the work to date on FSP to be formally presented to the Integrated Care Board (ICB) and then to the national team, in line with NOF4 expectations that we will have a medium-term financial plan. The CFO also updated the Committee of her engagements with the ICB including attendance at the ICB's Productivity and Investment Committee on the 28 January to get ICB comments.
Business cases: over £1.75m Requiring Investment £2.5m for Self-Funding. Capital Business Cases Over £1m	The Committee noted there were no business cases to discuss.
Capital Investment Group (CIG) Assurance Report	The report was taken as read with nothing further to add.

East Kent Hospitals University NHS Foundation Trust

Business Case Scrutiny Group (BCSG) Assurance Report	There were no business cases to discuss.
Financial Improvement Programme Board (FIPB) Assurance Report	There was nothing further to add.
Feedback to Board of Directors	The Committee noted no feedback to Board Members
Referrals to Other Board Committees	The Committee noted no referrals to Board Members

Item	Purpose	Date
FPC asks the BoD to discuss and **NOTE** this FPC Chair Assurance Report.	Assurance	6 February 2025

East Kent Hospitals University NHS Foundation Trust

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

Committee: People & Culture Committee (P&CC)

Meeting date: 29 January 2025

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

Paper Author: Claudia Sykes

Quorate: Yes

Appendices: Appendix 1: Equality Delivery System (EDS) Report 2024

Declarations of interest made: None

Assurances received at the Committee meeting: See below

Agenda item	Summary
Board Assurance Framework (BAF) risk: recruitment and retention **Staff recruitment**	Overall vacancy levels remain low, at 8.8%, however, there are areas of concern in some specialties as reported previously. These are included on the Significant Risk Register. The Committee noted that some of these recruitment risks had been there for some time, and reflected national shortages in some positions. There was a discussion over the need to remain vigilant over these risks, and consider what action could be taken to move the dial.
BAF risk: recruitment and retention **Staff retention**	The Committee discussed the 2024 Staff Survey. The response rate was 63% which was fantastic, and well above the national average of 48%. The full detailed report was not yet available, but preliminary findings reflected similar staff comments and challenges as in 2023. It was noted that there was significant variation between departments, in some cases a 70% gap. The new Chief People Officer (CPO) stressed the importance of working with staff on actions immediately and not waiting another two months for all the details. He also commented on the need to highlight departments with positive results, and sharing best practice and learnings; and supporting those departments with worse results. Given the variation between departments, it was important not to average out scores when communicating messages to the wider staff base. This was supported by the Committee. The March Committee will review the full survey results in detail. The Committee also noted the appraisals completion rate was 80% for November and December, the first time it has met the target for many years. The Chair noted this was a good achievement, reflecting the focus on appraisals by all departments over the last 12 months. The Deputy CPO commented that work was ongoing to look at the quality of appraisals and to maintain the completion level.

	The Committee was ASSURED around appraisals. On reviewing the Integrated Performance Report (IPR), the Chief Executive Officer (CEO) advised that the Medical Job Planning rate was slipping and she would pick this up and report back to the next Committee.
BAF risk: culture and values **Culture and Leadership Programme (CLP)**	The Committee received a report which noted that limited progress had been made on the CLP since October. The CPO reported that the CLP work had now been integrated with the Organisational Development team, and an Interim Director of Culture, Learning and Organisational Development was in post. The Chair requested a fuller update at the March Committee, once the new roles had settled in, also to reflect on the CLP work over the last year and the successes and learnings to take into future CLP activities. The CPO noted that a lot of work was being done, also on the wider People Strategy, that could be shared at the next Committee meeting.
BAF risk: culture and values **Freedom to Speak Up (FTSU)**	The Committee reviewed the business case to outsource the FTSU programme. This would be cost-neutral, and ensure continuous and effective support to staff. Consultations had been undertaken with the current employed FTSU team. The Committee discussed the urgent need for a reliable and independent service, and that it was now a year since the Committee had received any assurance on the FTSU service and any reports on cases and themes. The new service would begin in March 2025. Regular assurance reporting should then be re-established to the Committee and Board.
BAF risk: culture and values **Equality, Diversity and Inclusion (EDI)**	The Committee reviewed the Annual report for EDI. Alongside the reports submitted for Workforce Disability Equality (WDES) and Workforce Racial Equality (WRES) which the Committee reviewed in November, this Annual report highlighted actions still required to improve the experience of Trust staff who have a disability or are from a Black, Asian and Minority Ethnic (BAME) background. A dashboard is being developed to enable data to be monitored more quickly across all Care Groups. The CPO advised that he had three priority areas for the next financial year: (1) Debiasing the recruitment processes, ensuring equity for applicants at every stage of the process. (2) Coaching and development provided for Band 7+ staff with protected characteristics. (3) Reduction in staff experiencing racism/harassment from patients. He will work with Executive colleagues to develop specific targets and action plans on these, to be reported at the next Committee. Other areas will continue to be worked on, some may have three year targets given the challenges of addressing some deep-seated cultural issues. The

	Committee noted the need to have Specific, Measurable, Achievable, Realistic, Time-based (SMART) targets to make real changes in the experience of staff with protected characteristics. The Chair also suggested working with other system colleagues, like Kent Community Health NHS Foundation Trust (KCHFT) and Kent & Medway NHS and Social Care Partnership Trust (KMPT), who have been developing some good activities in these areas, and had better staff outcomes on some of these metrics.
BAF risk: culture and values **Equality Delivery System (EDS)**	The Committee reviewed the annual EDS report. The EDS annual assessment requires us to look at access, experience, and outcomes for eight of the nine protected characteristics under the Equality Act 2010. The Trust has self-assessed itself at a score of 12. This is a slight improvement from last year but is still within the second-lowest "Developing" category. The Committee noted the work and improvements being made across the Trust, as documented in the detailed report. There is still a need for the Board and Board assurance committees to ensure that health inequalities are considered throughout all meetings, and there is more visible leadership on EDI and inequalities from all Board members. The NEDs and Head of EDI commented that many of our patients and staff are affected by health inequalities, and this is going to increase, and we need to understand and plan for this better as a Trust. This also has financial consequences due to the level of support needs many of our patients have. The Associate NED also offered to work with the Trust on supporting with research about health inequalities in the area. This was welcomed by the CEO and Chief Nursing & Midwifery Officer (CNMO). The Committee was ASSURED of the accuracy and completeness of the EDS report.
BAF risk: organisational development and resilience **Workforce planning**	The Committee reviewed the Transition Plan covering the next four months of the People and Culture activities. The Chair welcomed the new CPO and noted that substantive work was needed on the People Strategy, Organisational Development and aligning this to the other strategic and Finance Recovery Plans already prepared by the Trust.

Other items of business: None

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

East Kent Hospitals University NHS Foundation Trust

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

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

Items referred to the BoD or another Committee for approval, decision or action: None

Item	Purpose	Date
P&CC asks the BoD to discuss and **NOTE** this P&CC Chair Assurance Report.	Assurance	6 February 2025
P&CC asks the BoD to **APPROVE** the Equality Delivery System (EDS) Report 2024.	Approval	6 February 2025

East Kent Hospitals University NHS Foundation Trust

24/110.3 - APPENDIX 1

NHS Equality Delivery System (EDS)

EDS Report 2024

The Equality Delivery System Report gives an overview of the Trust's approach to addressing health inequalities and promoting inclusion.

30 December 2024

EDI team: ekhuft.edi@nhs.net

Patient Voice and Involvement team:

ekhuft.patientvoice@nhs.net

We care

Contents

About the NHS Equality Delivery System (EDS)

Implementation of the Equality Delivery System (EDS) is a requirement of both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance with the EDS guidance documents.

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

EDS rating and scores

The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure.

First, score each outcome out of 3.

- 0 = Undeveloped activity
- 1 = Developing activity
- 2 = Achieving activity
- 3 = Excelling activity

Then, add the scores of all outcomes together. This will provide you with your overall score, or your EDS organisation rating:

- total score under 7 = Undeveloped
- total score between 8 and 21 = Developing
- total score between 22 and 32 = Achieving
- total score 33 = Excelling

.

Section 1 – Your information

Name of organisation: **East Kent Hospitals University NHS Foundation Trust**

Organisation Board Sponsor/Lead: **Chief Medical Officer (Domain 1) / Chief Executive / Chief People Officer (Domains 2 and 3)**

Name of Integrated Care System: **Kent and Medway**

EDS Leads: **Associate Director of Patient Experience (Domain 1) / Head of EDI (Domains 2 and 3)**

EDS engagement date(s): **February 2024 to December 2024**

Which level has this EDS tool been completed at?

Individual organisation level

Completed actions/activity from previous year

Action 1: Put a process in place to gather evidence to assess and score all outcomes in Domains 1, 2 and 3 using the refreshed EDS 2022 process.

Related equality objective: Promote inclusion in both patient care and employment in line with our Public Sector Equality Duties.

Action 2: Engage with key stakeholders, both internal and external, and with patients and staff to help score each outcome under the three Domains.

Action 3: Friends and Family Test (FFT) survey responses now available by age, ethnicity, sex and Index of Multiple Deprivation.

Action 4: Easy Read patient experience survey now available.

Related equality objective: Involve people who receive healthcare, our staff and local communities in order to identify opportunities to tackle health inequalities and improve equity of access, experience and outcomes.

Section 2 – Outcomes and evidence

Domain 1 – Cancer services

Outcome	Evidence	Score / rating	Owner (Department/Lead)
1A: Patients (service users) have required levels of access to the service	**Diagnostics and waiting times:** There is national evidence that people who are Black, Asian or of an ethnic background other than White can experience longer waits for diagnosis and treatment. There has been an improvement in waiting times for some diagnostic tests (e.g. endoscopy). Locally there are some concerns about waiting times on the day for chemotherapy treatment. This can be due to several reasons, for example scheduling times not always accurately reflecting treatment time, patients becoming unwell or having complications during treatment. There have been improvements in waiting times for diagnostic tests, in particular endoscopy, and waiting for treatment to commence. The use of straight to test pathways (STT) for Upper Gastro-Intestinal (GI), Lower GI, Lung and Prostate at point of GP urgent suspected cancer referral have improved time frames for onward initial diagnostics either endoscopic assessment or diagnostic imaging. The STT nursing teams provide contact details for advice/guidance and support for early intervention of symptoms or concerns. The use of NHS England best practice timed pathways supports our improvement trajectory. The STT nursing teams also review the referral to identify additional support required by all our patient groups and type of appointment considered to meet their needs. **Data:** Local data on late presentation with cancer is limited. This is being reviewed both in the Trust and Kent and Medway Integrated Care Board (ICB). There is a planned Kent & Medway SACT (Systemic Anti-Cancer Therapy) capacity and demand review which will help inform improvements. **Interpreting:** There have been issues with getting face to face interpreters for Nepali, Slovak and Bulgarian to support patients' diagnostic tests and day treatments. This delays diagnosis and treatment.	1	Associate Director of Nursing, Cancer, Haematology and Haemophilia Associate Director of Patient Experience

Outcome	Evidence	Score / rating	Owner (Department/Lead)
1B: Individual patients (service users) health needs are met	The 2023 National Cancer Patient Experience Survey indicates that people with a pre-existing disability or health condition have a poorer experience when receiving treatment for cancer. The Friends and Family Test (FFT) survey: The top negative themes are waiting times to be seen / treated on site (small percentage, but top negative theme), communication and information, and medication, prescriptions and dispensing. The top positive themes are staff attitude, care given by staff and waiting time to be seen / treated on site, as most patients report they are seen promptly. FFT data indicates that 8.3% of respondents to the additional survey questions said that their family were not involved as much as they wanted to be. There is now a personalised care lead for cancer services. The services work closely with the Kent and Medway Care Alliance and Macmillan Cancer. Patient partnership work has started, with listening events held in November 2024 and a co-designed patient survey launched. Services have a Standard Operating Procedure (SOP) for the Accessible Information Standard (AIS) which is kept at each reception desk in addition to a Hospital. Most of our patients are regular attenders following their first appointment, their communication needs are usually well known by the teams. Patients are usually asked about their communication needs at first point of contact (Reception) and are asked if their needs have changed since their last visit at subsequent appointments. There is a Communication Book which we have devised as a guide and reference resource. The trust Outpatient Reception Toolkit is also available. We use PAS/Sunrise at our reception desks. Our main system has the correct AIS SNOMED (national) codes. These codes are also included in our hospital communication book and outpatient reception toolkit. In the Chemotherapy Service we also use the Maidstone and Tunbridge Wells NHS Trust (MTW) KOMS system for all chemotherapy activity which also has a field for communication needs. Patient communication needs are included in referral letters that both come into and out of our services. A recent review has indicated that when requests for reasonable adjustments around communication have been made there have been none that we have not been able to accommodate.	1	Associate Director of Nursing, Cancer, Haematology and Haemophilia

Outcome	Evidence	Score / rating	Owner (Department/Lead)
1C: When patients (service users) use the service, they are free from harm	Cancer Services hold a weekly Patient Safety Oversight Meeting to provide senior leadership oversight of patient safety incidents, complaints and risks and monitor progress of actions. There has been a recent focus on Learning disabilities following learning identified from an incident and a patient story with further improvement work planned. There is an established process for completing clinical harm reviews for patients on an active cancer pathway who reach 104 days and over. Each patient pathway is reviewed to establish if the patient has come to any clinical harm due to the delay in confirmation of a cancer diagnosis, understand and learn from delays and implement and share changes to improve patient experience and outcomes. Themes from delays are reviewed monthly with specialties and ensure the patient is supported through the delay in their pathway. Compliance and themes are reported to the service's quality meeting. Compliance with the completion of harm reviews is reported monthly to the Diagnostics, Cancer and Buckland Care Group Performance Review Meeting. Nursing Key Performance Indicators (KPIs) are reported monthly and include information on harms from falls and pressure ulcers. September 2024 training compliance data for Cancer services shows Oliver McGowan training has been completed by 83% of staff, Dementia by 81.4%, and Patient Safety Level 1 by 82% of staff.	1	Associate Director of Nursing, Cancer, Haematology and Haemophilia
1D: Patients (service users) report positive experiences of the service	Cancer services Friends and Family Test (FFT) satisfaction score from July 2023 to September 2024 was an average of 95.5%. Satisfaction levels by age groups shows the people aged 15-19 had a satisfaction level of 85.4%, and people aged 25-29 had a satisfaction score of 85%, in both cases over 10% lower than the average. Looking at ethnicity, white and black African people had a much lower satisfaction level at 81.8%, Pakistani people at 89.5% and Irish people at 93%. Caribbean and Chinese people scored higher satisfaction levels at 100% and 98.6% respectively. Men and women rate their overall satisfaction level with a similar score, but when looking at day treatment women score their satisfaction lower than men – 94.7% vs 96%. For inpatient care there was no significant difference.	2	Associate Director of Nursing, Cancer, Haematology and Haemophilia

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	When looking at the inpatient FFT satisfaction score for Cancer services by level of deprivation, people in group 2 (one of the most deprived) scored their experience at 93.7% satisfaction vs the average of 97.24%, but for day treatment people in group 9 scored lowest at 92.8% versus the average of 95.3%. People in group 1 scored their experience the highest overall at 97%. For outpatient satisfaction levels there was very little difference between the groups, although group 1 had the highest satisfaction score at 96.1% and group 9 the lowest at 94.4%. The 2023 National Cancer Patient Experience Survey (NCPES) for indicates that women and younger people have a slightly poorer experience of some aspects of care than men and older people. The survey indicates that people in quintile 1 (poorest) of the Indices of Multiple Deprivation report a better experience than those in quintile 5 (wealthiest). This is supported by analysis of Friends and Family Test (FFT) survey responses by age, sex and deprivation (see above). The NCPES did not have sufficient responses by ethnicity other than White patients to breakdown responses by different ethnicities. Cancer services have made several improvements over the last 12 months to ensure that patients have a better experience. This includes improvements in access to the chemotherapy out of hours helpline, improving patient information and patient involvement. Patient participation groups were set up in late 2024. Discussions have started on getting feedback from the Deaf community who use British Sign Language (BSL). There is a lack of feedback / involvement of people with learning disabilities. A new 'Ask, Listen. Do' Easy Read survey is now available for people to give feedback on any of our services.		Associate Director of Nursing, Cancer, Haematology and Haemophilia
Cancer services total score		**5**	

Domain 1 – Maternity services

Outcome	Evidence	Score / rating	Owner (Department/Lead)
1A: Patients (service users) have required levels of access to the service	The Maternity service developed an Equity & Equality dashboard to have sight of key service user access and service delivery metrics by ethnicity and the Index of Multiple Deprivation (IMD). Maternity can obtain from this dashboard that it has the ethnicity data of 98.1% of women and birthing people using the service (as of June 2024). The dashboard also includes the percentage of all women and birthing people using the service with recorded language or literacy support needs, which averages 4% of cases (Oct 2023-Sep 2024), and/or with recorded learning disabilities for which the average is 1%. Exploratory work is underway to establish if this is a true reflection through a local documentation audit to understand if these questions are asked and logged for every registered pregnancy. Maternity has updated its pregnancy self-referral form to capture people's communication needs, which is due for publication by the end of November 2024. All services are available to all service users but using this data enables Maternity to make adaptations based on local service user access needs to improve access to care and treatment. We do not currently have a way to record the gender identity of patients who are non-binary, intersex or gender diverse. This is an NHS wide issue that will continue until the national data set is updated. **Interpreting:** some languages prove hard to source for face-to-face interpreting. Use of video relay interpreting (VRI) on demand would improve access to spoken language interpreting, and this will require an investment in tablet devices by the service.	2	Director of Midwifery Associate Director of Patient Experience
1B: Individual patients (service users) health needs are met	The Maternity Service uses the data from its Equity & Equality dashboard to make targeted service improvements. For example, reasonable adjustments can be made including information in other formats, interpreters and additional communication support (e.g. British Sign Language - BSL). There are also clinical pathways such as smoking cessation services, and a pre-term clinic for		

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	high-risk pregnancies for which the service can view access rates by demographic (ethnicity and IMD) e.g. pre-term for ethnic minorities and IMD 1& 2 communities was 8.7% compared to a rate of 7.8% in the total service user population for September. Statistics are available to and shared with lead clinicians to identify how access can be improved for any disadvantaged service users such as the provision of a paid taxi to transport them to their appointments to cover the cost of travelling to these specialist clinics. There is more work to do which is constantly considered based on data trends and patient feedback. Involvement by family members at every stage of pregnancy and maternity is facilitated at every touch point/appointment. From Your Voice is Heard data in October 2024 for all service users, 86.2% of women felt they were included in decisions about their care, 82.6% said they were given choices about their care, and 80.5% felt listened to throughout their care. The approach from Maternity is to understand the 19.5% of women who did not feel listened to, to ensure care is consistently inclusive.	2	Director of Midwifery
1C: When patients (service users) use the service, they are free from harm	The Maternity Equity & Equality dashboard includes stillbirth data (currently at a rate of 1.63 per 1,000 over the period Oct 23 to Sept 24), which is significantly reduced from the 2010 rate of 5.7 per 1,000. In September 2024, the percentage of babies with an APGAR score of 0-6 at 5 minutes of birth was 2.2% for ethnic minority and socially deprived communities compared to 1.3% amongst the wider service user population, which was an upward trend from nine months of consistently being below the 0.9% threshold. The APGAR score is based on five criteria: appearance, pulse, grimace, activity, and respiration. Each criterion is scored from 0 to 2, and the total score ranges from 0 to 10. The number of c-section (caesarean) births in September 2024 was slightly over the 42% threshold. Figures for antenatal bookings indicated that 43.6% of women were booked by 10 weeks against a target of 52%, and 85% of people were booked by 13 weeks versus a target of 91%. Patient incidents all remain within defined parameters, including Maternity and Neonatal Serious Incident referrals of which there had been 0 reported in Quarter 2 (July-September 2024).	2	Director of Midwifery

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	The neonatal death data sadly shows an upward trend with cases rising from 1.25 per 1,000 births in Apr 2024 to 3.68 per 1,000 in Sept 2024; an external review has been commissioned with a particular focus on cases of extreme prematurity. The community midwifery teams are looking into causal factors for late antenatal bookings, so these can be reduced which in turn will support early identification of potential risk factors in pregnancy.		
1D: Patients (service users) report positive experiences of the service	Black, Asian and people of other ethnic backgrounds said they were given choices about their care (91.1% vs 83.8%). The Friends and Family Test (FFT) satisfaction score was highest for the delivery at 97.8%, lowest for antenatal at 91.7% and high for post-natal care at 97.1% in September 2024. This is echoed by feedback in the CQC Maternity Survey 2023, where the experience people had in antenatal care was generally poorer than for delivery and post-natal care. An area of significant improvement was birthing partners being able to stay with their partner as much as they wanted to. The themes from FFT feedback indicate some issues with communication and information at William Harvey Hospital, but there is overwhelming positive feedback about the care given by staff and the quality of treatment. FFT scores for Maternity – obstetrics using a bed - from July 2023 to September 2024 indicate that people aged 15 to 19 score their satisfaction level the lowest at 83.3% vs the average of 87.5%. People aged 25-29 score their satisfaction level lower at 85.9%. In terms of ethnicity, white and black Caribbean people score much lower satisfaction levels – 63.6% - than the average of 92.3%. Other groups to score lower are White and Asian people – 89.1% and 89.6% respectively. Looking at ethnicity, people of ‘any other white background’ have the lowest satisfaction score of 89.7%. People of unknown ethnicity score their satisfaction at 87.1%. Looking at levels of deprivation, people in group 3 score the lowest satisfaction level at 84.6%, where people in group 10, the least deprived, score their satisfaction level at 93.8%. Data from Your Voice is Heard in October 2024 indicated that the highest response rate was from White Non-British (94.6%) followed by Asian or Asian British (88.9%) and then Black, African, Caribbean, Black British (88.5%).	2	Director of Midwifery

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	Feedback by Indices of Multiple Deprivation (IMD) was highest from IMD 10 (100% of 97 women) followed by IMD 3 (93% of 568 women) and then IMD 5 (85.9% of 778 women). The highest percentage of deliveries was by women from IMD 2 (882) and the response rate from that cohort was 75%. Experiences of minority ethnic women were comparable with experiences of women of White ethnicity at approximately 60% positive, as was the experience of women from IMD 1 & 2. Negative comments about the buildings and facilities will hopefully be addressed with additional enhanced care suites in the Maternity units on both sites.		
Maternity total score		**8**	

Domain 1 – Renal services

Outcome	Evidence	Score / rating	Owner (Department/Lead)
1A: Patients (service users) have required levels of access to the service	Friends and Family Test (FFT) survey feedback shows that between April 2024 and October 2024, 57 patients felt they waited too long on site for a nephrology outpatient appointment. Of these 47 were at Kent and Canterbury. With accessibility and reasonable adjustments, this was mentioned as positive by 5 patients and negative by one patient across all renal services - all at Kent & Canterbury site. All other feedback is overwhelmingly positive. Renal out-patient services are offered on seven sites (six of those are within the dialysis units) across East and West Kent with the main central hub being at Canterbury. Out-patient clinics are held at Ashford, Dover, Folkestone, Maidstone, Margate, and Medway. Patients are offered an appointment at their closest site. If the referral is clinically urgent then they will be offered Canterbury if there is no capacity available at their nearest site. Our longest waiting time for clinics is mainly for general nephrology at Medway and specialist hypertension clinics. Renal dialysis services are offered within six sites across East and West Kent. The main dialysis unit is in Canterbury with five satellite units in Ashford, Dover, Margate, Maidstone and Medway. Patients will be offered a dialysis slot nearest to where they live whenever possible, but majority will start at Canterbury. Our longest waiting list is for Medway. Analysis of access to the service by ethnicity and IMD (deprivation) is needed to identify any disparities between local population and patient caseloads.	1	Director of Nursing, AHP and Quality, Kent and Canterbury Hospital and Royal Victoria Care Group
1B: Individual patients (service users) health needs are met	Friends and Family Test (FFT) survey feedback shows that only one patient felt that reasonable adjustments were not made. FFT feedback indicates that 20% of patients said their family were not involved as much as they wanted them to be. Accessible Information Standard (AIS): Renal document patient communication needs via their Renal SBAR and Renal plus however, there is not a dedicated platform to record this information. Renal nurses will update communication needs if needed at each appointment.	1	Director of Nursing, AHP and Quality, Kent and Canterbury Hospital and Royal Victoria Care Group

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	We have a high proportion of diabetics within our renal dialysis population so have support from the podiatrist service who see patients during their dialysis treatment at Canterbury. Nursing staff document patient's communication needs on the Renal SBAR which is used within our out-patient haemodialysis service. Communication needs are also documented within Renal plus, however there is not a dedicated place for this information to be recorded. Renal nurses will update communication needs as required.		
1C: When patients (service users) use the service, they are free from harm	Patient falls for renal services (inpatient) in 2023-24 shows that more men have falls than women, however there are more male patients on the wards. It is a similar picture for pressure ulcers. Many incidents relate to patients aged 60+. Diabetes is one of the leading causes of kidney disease. About 1 out of 3 adults with diabetes have kidney disease. Renal patients can be quite complex as they can have other comorbidities such as hypertension, heart problems, bone disease, vascular issues, and anaemia which can contribute to their being at a high risk of developing pressure ulcers in comparison to other patient groups. Renal patients are also at a higher risk of falls due to postural hypertension particularly those receiving haemodialysis or peritoneal dialysis as they will have fluid removed during their treatment, so their fluid status is monitored closely. Data on patient harms by ethnicity and deprivation is needed for renal services.	1	Director of Nursing, AHP and Quality, Kent and Canterbury Hospital and Royal Victoria Care Group
1D: Patients (service users) report positive experiences of the service	Friends and Family Test (FFT) survey data for July 2023 to September 2024 shows that the overall satisfaction level for renal patients is 97.4%. When this is looked at by age, those aged 20-24 have a satisfaction score of 88.24%, 9% less than the average. For ethnicity there is a lower score of 91.4% for people who are white and black Caribbean. All other ethnic groups score their satisfaction slightly higher than White patients. For men and women their overall satisfaction scores are similar, but where sex is recorded as 'unknown' satisfaction levels are 5% lower. Looking at data by deprivation, people who are the most deprived rate their overall satisfaction level as similar to the least deprived, with the exception being people in group 4 whose satisfaction level is the lowest.	2	Director of Nursing, AHP and Quality, Kent and Canterbury Hospital and Royal Victoria Care Group

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	For FFT Outpatients, white and black Caribbean patients score much lower than the average – 92.9% vs 97.6%. The FFT satisfaction scores for inpatient care show lower satisfaction scores for all ethnic groups, particularly for people of 'other white background' which would include people from European countries. For Renal patients receiving inpatient care, the age group 50-54 and 80-84 score their satisfaction levels 3% to 4% lower than the average. Men score their satisfaction level lower than women for inpatient care – 90.5% vs 96%. The scores for inpatient care by level of deprivation vary with the least and most deprived scoring 100% and patients from groups 6 and 7 scoring 86.9% and 85% satisfaction. For the FFT additional question about were their family involved as much as they wanted them to be in decisions about their care and treatment, the responses relate to Marlow ward, but some to the Kent and Medway Dialysis Unit (KMDU): Patients saying 'no': Marlow ward - 20.87% (43 patients), KMDU - 20.27% (15 patients) Patients saying 'yes': Marlowe ward - 40.29% (83 patients), KMDU - 22.97% (17 patients) Patients saying 'not applicable': Marlowe ward - 38.83% (80 patients), KMDU - 56.76% (42 patients) This is for 6 November 2023 to 4th November 2024		
Renal services total score		**5**	

Total score

Please total the scores from Domain 1 (average of the three services scored): **6**

Domain 2 – Workforce health and wellbeing

Outcome	Evidence	Score / rating	Owner (Department/Lead)
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	The organisation targets reading materials about the mentioned health conditions to staff about the mentioned conditions. The organisation promotes work-life balance. The organisation signposts to national support. The Trust provides a comprehensive occupational health and wellbeing service to staff including health checks, counselling, a benefits platform, resources and menopause clinics. All staff can access these services; however, sickness and absence data are not currently broken down by protected characteristic, therefore the organization is unlikely to identify groups or areas where focused support is needed. Training called “supporting staff with disabilities and long-term health conditions” has been rolled out across the organisation by occupational health. Equality, Diversity and Inclusion runs through the training as a golden thread. Engagement and feedback have been good. The organisation provides menopause support and advice to staff. The Trust has achieved menopause accreditation. The organisation has established wellbeing roles to support staff; wellbeing champions, Trauma Risk Management (TRIM) practitioners and Mental Health First Aiders. There are over 929 wellbeing advocates across the organization. However, the demographics of staff undertaking these roles is not currently collected so we do not know if the roles are representative of the workforce. The Wellbeing Team are working with the information team on a wellbeing tab for the SIP dashboard which will show the diversity of their advocates.	1	Occupational Health/Wellbeing Team

Outcome	Evidence	Score / rating	Owner (Department/Lead)
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	The organisation acts and supports staff who have been verbally and physically abused. The organisation acts to manage staff who abuse or bully other members of staff. Staff are supported to report patients who verbally or physically abuse them. Data from the 2023 National Staff Survey, Workforce Race and Disability Equality Standard (WRES and WDES) shows that Black, Asian, and staff of ethnic backgrounds and disabled staff experience higher levels of abuse, harassment and bullying than White and non-disabled staff: 31.35% of staff with a long-lasting condition or illness have experienced harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months. 29.11% of staff with a long-term health condition or illness who have experienced harassment, bullying or abuse from other colleagues. 31.24% of Black, Asian, and staff of ethnic backgrounds have experienced harassment, bullying or abuse from patients/service users their relatives or public. 30.67 % have experienced harassment, bullying or abuse from staff. Incident reporting is not currently broken down by protected characteristic on our reporting system (Datix) so it is not possible to get an accurate picture of incidents and who is impacted by them. However, Datix is being replaced by InPhase, the EDI Team will be working with the InPhase team to include protected characteristics on the reporting system. The Employee Relations Team have completed an analysis of grievances broken down by protected characteristics. This shows disproportionateness in formal processes in comparison to the trust headcount in the following; a) gender with 10% more male staff b) ethnicity with 8% more Black or Black British African staff	1	InPhase Team/Employee Relations/ EDI Team/ PV&I Team/ EDEN

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	c) ethnicity with 4% more Asian or Asian British Indian staff d) pay band with 20% more band 2 staff This needs further analysis and joint action planning with ER to address the disproportionality. East Kent Hospitals has been accredited as **Veteran Aware**, formally recognising the Trust's commitment to the armed forces community, including serving personnel, reservists, veterans and their families. The accreditation was confirmed by the national Veterans Covenant Healthcare Alliance (VCHA), which includes representatives from government and the NHS nationally as well as veterans. This is a result of work led by the Patient Voice and Involvement Team. The See Me First Anti-Racism campaign has been launched, this needs to be socialised with support from the Ethnic Diversity Engagement Staff Network (EDEN).		
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	There are a number of services available to support staff including; • the Hospital Independent Domestic Violence Advocate Team (HIDVA), this service supports staff and patients • Vivup platform that provides wellbeing and counselling service and resources • The Wellbeing Team • The EDI Team • Employee Relations Team • Freedom to Speak Guardians service • Resolution policy and toolkit for staff and managers. The Trust has five staff networks: Women's Network, Neurodiversity Network, Staff Disability Network, EDEN (Ethnic Diversity Engagement Network) and LGBTQIA+ (Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexual) Network. Staff Networks provide a safe space for staff	1	EDI Team/ Wellbeing Team/ Staff Networks

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	and support from those with lived experience. Staff Networks now have a published policy which includes protected time for staff network roles (chairs, co-chairs, admin etc.) and members. The staff network policy needs to be socialised. In collaboration with the staff network chairs/co-chairs, a Staff Network Inclusion Forum has been launched for the staff networks to share responsibility, work together to address gaps of inequality, with the support of executive sponsors.		
2D: Staff recommend the organisation as a place to work and receive treatment	Data from the 2023 National Staff Survey informs the Trust that 47.71% of staff feel the organisation takes positive action on health and wellbeing, this is an improvement from 2022 results in which it was 46.41% of staff. 43.79% of staff recommend this organisation as a place to work. 46.82% recommend this as a place to be treated: • 35.09% of staff with a disability or long-term condition recommend this organisation as a place to work. 39.17% recommend the organisation as a place to be treated. • 65.73% of Asian/Asian British staff would recommend this organisation as a place to work. 62.2% would recommend the organisation as a place to be treated. • 68.17% of Black/African/Caribbean/ Black British staff would recommend this organisation as a place to work. 71.25% would recommend this organisation as a place to be treated. • 43.62% of Mixed/Multiple ethnic groups staff would recommend this organisation as a place to work. 47.87% would recommend this organisation as a place to be treated.	0	Staff Experience Team/ EDI Team

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	• 56.9% of staff from other ethnic groups would recommend this organisation as a place to work. 56.9% would recommend this organisation as a place to receive treatment. (2024 Staff Survey data will be available early 2025). No data or evidence has been provided for Gender reassignment, Marriage and Civil partnership, Pregnancy and Maternity, Religion and Belief, Sexual Orientation. Exit interview data is not currently monitored by protected characteristics, which means we are less likely to identify if a disproportionate number of staff are leaving with protected characteristics e.g. disabled staff. The Staff Experience Team are exploring this and feedback to the stakeholder group. The reasonable adjustment working group created a workplace adjustment toolkit and policy to use alongside the NHS Health Passport, this is available on policy centre. This is to support staff who have disabilities and health conditions, and this toolkit needs to be socialised.		

Total score

Please total the scores for Domain 2**: 3 = undeveloped activity**

Domain 3 – Inclusive leadership

Outcome	Evidence	Score / rating	Owner (Department/Lead)
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• 1,052 managers attended the Introduction to EDI, 'Leading in the East Kent Way' sessions that were introduced. • 204 managers have completed a leadership programme delivered by the Organisational Development Team. This has an EDI module. A further 129 leaders are on target to complete a leadership programme. Equality and health inequalities is routinely discussed in the Patient Experience Committee that reports to Quality and Safety Committee but not Board and committee meetings.. • Not all Board members and senior leaders routinely engage with staff networks. Members of the Executive Team who are Executive sponsors of Staff Networks demonstrate some activity due to this role, for example attending network meetings and events and informal mentoring of network chairs. • Board members and senior leaders do not routinely engage in religious, cultural or local events and/or celebrations although some members of the Executive Team demonstrate some activity. An annual programme of events has been discussed with the Executive Team to increase this and plans are being developed with input from an advisory group of staff. • Board members and senior leaders engagement with, and/or communications to, staff about health inequalities, equality, diversity and/or inclusion is limited. Some examples include building EDI criteria into all of the Trust awards categories and ensuring representation on the developing Staff Council. • As part of the NHS England EDI Improvement Plan High Impact Action of Board and Executives requirement to have EDI objectives, the Executive Team and some non-executive directors have these in place as part of their appraisals.	1	Chief Executive Officer / Chief People Officer

Outcome	Evidence	Score / rating	Owner (Department/Lead)
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	As per the EDS guidance, a random sample of 5 board papers were requested and submitted to check whether EDI is meaningfully included or considered: 1. **Integrated Performance Report June 2024;** no mention of or reference to EDI 2. **Board committee assurance report to the board of directors September 2024;** EDI discussed as an agenda item, discussing that WRES and WDES are being deferred until November meeting so they can be reviewed by CEMG. Also referenced in discussion of Employee Relations, regarding the data around protected characteristics of people involved in grievances, disciplinaries and Tribunal activity. 3. **Board papers 24/58 - appendix 1 patient story;** patient story about a community of migrant women in Thanet involved in a project to hear the voices of migrant women about access to services including health services and some of the barriers they experience. Refers to health inequalities throughout. 4. **Report to board of directors on Journey to Exit NHS Oversight Framework 4 (NOF4) and Integrated Improvement Plan (IIP) June 2024; n**o mention of or reference to EDI 5. **Integrated Performance Report August 2024;** no mention of or reference to EDI • Equality and health inequalities are infrequently discussed in board and committee meetings. • EDI has been added as a confirmed standing agenda item on People and Culture Committee Papers, but not on any other papers.	1	Chief Executive Officer / Chief People Officer

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	• Actions associated with health inequalities are not recorded or reported on routinely (other than the EDS reports and Patient Experience Committee papers). • Equality and Health impact assessments (EHIAs) are not routinely completed for key decisions. • EHIAs were completed for the 2024-25 Cost Improvement Programme • EHIAs are regularly completed for new policies and policy updates		
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Board members, system and senior leaders ensure the implementation of the **relevant** below tools. Board members, system and senior leaders monitor the implementation of the below tools: WRES, WDES, EHI Impact Assessments, Gender Pay Gap reporting, Accessible Information Standard, and EDS 2022. The Trust can analyse Friends and Family Test (FFT) responses by age, ethnicity, sex and the Index of Multiple Deprivation (IMD).	1	Chief Executive Officer / Chief People Officer Chief Medical Officer

Total score

Please total the scores for Domain 3: **3 = undeveloped activity**

Third-party involvement in Domain 3 rating and review: **Staff Experience and Wellbeing, Staff Networks, International Recruitment (IR) / Pastoral support, Occupational Health, Standard Assurance Team (CQC), Chaplaincy Service, Risk Management, OD Business Partners, Site Heads of People and Culture, People and Culture Business Partners.**

Trade union reps: **Yes**

Independent Evaluator(s)/Peer Reviewer(s): **External NHS Organisation**

EDS organisation rating (overall rating)

Name of organisation(s): **East Kent Hospitals University NHS Foundation Trust**

Overall score and rating: 2024 score was 12 – Developing (a 4-point improvement compared to 2023).

Note: Organisations are required to provide an organisation rating, created by adding outcome scores together.

*Using the middle score out of the three services from Domain 1, domain scores are added together to provide the organisation rating.

Below is a key to support understanding of organisation rating:

Those who score **7 or under,** adding outcome scores **across domains**, are rated **Undeveloped**

Those who score **between 8 and 21,** adding outcome scores **across domains**, are rated **Developing**

Those who score **between 22 and 30,** adding outcome scores **across domains**, are rated **Achieving**

Those who score **31 and above,** adding outcome scores **across domains**, are rated **Excelling**

Section 3 – EDS action plan

EDS leads: **Associate Director of Patient Voice and Involvement (Domain 1) / Head of EDI (Domains 2 and 3)**

Years active: **April 2024 to March 2026 (note two year action plan, with actions updated in January 2025)**

EDS sponsor: **Chief Medical Officer / Chief People Officer**

Authorisation date: **Trust Board, 6 February 2025**

Domain 1 – Commissioned or provided service

Outcome	Objective	Action	Lead (s)	Completion date
1A: Patients (service users) have required levels of access to the service	Improve the collection and use of patient's demographic data to monitor uptake of services (including DNAs) and waiting times for diagnostics and treatment.	Patient caseload, waiting times and DNAs to be monitored by age, disability, ethnicity, gender identity, religion and belief, sexual orientation and Index of Multiple Deprivation.	Chief Analytics Officer, with support from the Business Information team and Care Group senior teams.	October 2025 (adjusted date)
	Consider the needs of the local population to improve equity of access, experience and outcomes.	Increase the number of Equality and Health Inequalities Impact Assessments (EHIAs) on service redesign and significant service or care pathway changes.	Care Groups and Programme leads	December 2025
	Video Relay Interpreting (VRI) on demand to support access to services for patients whose primary language is not English	Additional tablet devices needed to maximise use of VRI on demand.	Associate Director of Patient Experience / Care Groups	October 2025

Outcome	Objective	Action	Lead (s)	Completion date
1B: Individual patients (service users) health needs are met	Fully implement the Reasonable Adjustments Digital Flag (RADF). Build equality, diversity, inclusion and tackling health inequalities into service planning, improvement and performance reviews to help the Trust improve equity of access, experience and outcomes for patients.	Ensure the RADF SNOMED coding is on the main patient record systems, and the Patient Portal, with appropriate flags. EDI / health inequalities to be part of assurance reports, service performance reviews and service improvement plans.	I.T. teams Strategy and Development, Quality Governance, Care Group Governance, Operational leads	March 2025 (adjusted date) March 2026
1C: When patients (service users) use the service, they are free from harm	We can provide evidence that patients with protected characteristics of age, disability, and ethnicity, do not disproportionately experience harm.	Patient harms to be reported and monitored based on demographic data including age, disability, ethnicity, gender identity, religion and belief, sex and sexual orientation.	Care Group senior teams, corporate teams (falls, pressure ulcers, safeguarding), governance leads, Business Information teams	June 2025 (adjusted date)
1D: Patients (service users) report positive experiences of the service	Monitor and report patient experience by patients' protected characteristics.	Ensure we hear from people who are underserved, experience greater health inequalities and are less likely to get their voices heard. Pilot patient experience surveys in other languages.	Information team and Patient Voice and Involvement team IT and Patient Voice and Involvement team.	On-going March 2026

Domain 2 – Workforce health and wellbeing

Outcome	Objective	Action	Lead(s)	Completion date
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	To ensure that all staff access health and wellbeing support in proportion to their representation in the workforce. And that this support is culturally appropriate and inclusive.	a) System to be formulated to monitor sickness and absence data by protected characteristics, to identify groups or areas where focused support is needed. b) Survey demographics and protected characteristic of wellbeing champions, TRIM practitioners and Mental Health First Aiders. To assess whether staff in these roles are representative of the workforce.	a) Head of Staff Experience and Wellbeing b) Staff Wellbeing team	September 2025 March 2025
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	To reduce the abuse, harassment, and bullying that staff experience at work from colleagues, managers, patients, and their families, ensuring that staff who are disabled or of ethnic backgrounds do not experience this disproportionately to their representation in the workforce.	a) the EDI Team will be working with the InPhase (formerly Datix) team to include protected characteristics on the incident reporting system to give an informed picture of types of incidents and groups impacted. b) The EDI Team and ER further analyse the data of grievances by protected characteristics and joint action plan to identify the disproportionally identified c) The See Me First Anti-Racism campaign has been launched, this needs to be socialised with support from the Ethnic Diversity Engagement Staff Network (EDEN).	a) EDI team b) EDI team and Employee Relations c) EDI team	March 2025 May 2025 April 2025

Outcome	Objective	Action	Lead(s)	Completion date
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Staff Networks are supported and developed to provide a safe space for staff; to act as a voice for staff with protected characteristics; to be able to identify gaps in support for staff with protected characteristics	a) Formulate a plan to socialise/ raise awareness of the staff network policy.	EDI team with Communications team support.	April 2025
2D: Staff recommend the organisation as a place to work and receive treatment	To provide an inclusive work environment, free from discrimination, where staff's lived experience is seen as an asset and supports inclusive patient care.	a) Explore how to monitor exit interview data by protected characteristics, to provide an update. To identify if a disproportionate number of staff are leaving with protected characteristics. b) To socialise/ raise awareness of the workplace adjustment toolkit and policy to use alongside the NHS Health Passport, available on policy centre. This is to support staff who have disabilities and health conditions.	a) Staff Experience Team b) Employee Relations, Occupational Health, Staff Wellbeing team with Communications team support.	April 2025 June 2025

Domain 3 – Inclusive leadership

Outcome	Objective	Action	Lead(s)	Completion date
3A: Board members, senior leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	The Trust has Board members, senior leaders and managers who are culturally competent, inclusive and who demonstrate their understanding of, and commitment to workforce equality and reducing health inequalities for patients and their families.	a) As part of the NHS England EDI Improvement Plan High Impact Action of Board and Executives requirement to have EDI objectives, the Executive Team have these in place as part of their appraisals. The non-executive need to have these put these in place.	Chief Executive / Chief People Officer	May 2025
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	EDI to be part of the golden thread from Board to ward.	a) EDI to be an integral part of agenda items on Committee and Board Papers. Equality and Health inequalities Impact Assessment section to be added to every Board paper setting out the impact, mitigations, and risks in terms of people with protected characteristics.	Chief Executive / Director of Corporate Governance	September 2025

Outcome	Objective	Action	Lead(s)	Completion date
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	To identify inequalities and unwarranted variations in workforce representation and career progression and in patient access by protected characteristics and actions to reduce inequalities and monitor their impact to assess where there are positive changes taking place.	a) Board members and senior leaders to use the relevant EDI tools and regularly monitor their implementation: EDI High Impact Actions, Workforce Race Equality Standards, Workforce Disability Equality Standards, Equality and Health Impact Assessments, Gender Pay Gap reporting, Equality Delivery System.	Chief Executive / Chief Medical Officer / Chief People Officer	On-going