REGISTER OF DIRECTOR INTERESTS – 2018/2019 FROM AUGUST 2018

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ACOTT, SUSAN	Chief Executive	Advisory Council of The Staff College (leadership development body for the NHS/Military) **(4)** Substantive Chief Executive at Dartford and Gravesham NHS Trust (DGT). A memorandum of understanding has been signed to mitigate the risks with the substantive role and the interim role. No longer a Board member at DGT. Discussed and accepted at the Board meeting held on 6 October 2017 **(5)**	Appointed 1 April 2018
COOKSON, WENDY	Non Executive Director	Managing Director of IdeasFourHealth Ltd, a consultancy for the healthcare industry **(2)** Sole Shareholder for IdeasFourHealth Ltd **(3)** Trustee of Bede House Charity, a local community charity in Bermondsey, London, from January 2017 **(4)** Member of Health Advisory Board for OCS Group UK **(5)** Non Executive Director of Medway Community Healthcare **(1)**	6 January 2017 (First Term)
ADEUSI, SUNNY	Non Executive Director	None	1 November 2015 (First term)
CAVE, PHILIP	Director of Finance and Performance Management	Wife works as a Senior Manager for Optum, who run the Commissioning Support Unit (CSU) in Kent, which supports the Clinical Commissioning Group's (CCG's) of East Kent in their contracting **(5)**	Appointed 9 October 2017
LE BLANC, SANDRA	Director of HR	Justice of Peace (East Kent) and I am a specialist advisor for the CQC **(4)** Member – Scheme Advisory Board for the NHS Pension Scheme **(4)**	1 September 2014

REGISTER OF DIRECTOR INTERESTS – 2018/2019 FROM AUGUST 2018

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
MANSLEY, NIGEL	Non Executive Director	Jeris Associates Ltd **(1) (2) (3)** Chair, Diocesan Board of Finance (Diocese of Canterbury) **(1)**	(First term) 1 July 2017
MARTIN, LEE	Chief Operating Officer	None	Interim from May 2018 Substantive from August 2018
OLLIS, JANE	Non Executive Director	Quvium UK **(1)** The Heating Hub **(1)** Board Member of the Kent Surrey Sussex Academic Health Science Network (AHSN) **(1)**	8 May 2017 (First term)
PALMER, KEITH	Non Executive Director	Managing Director of Silverfox Consultancy Ltd **(1)** Sole shareholder of Silverfox Consultancy Ltd **(3)** Non Executive Director of EKMS **(1)** Non Executive Director of 2Gether Support Solutions **(1)**	1 January 2017 (First term)
SHUTLER, LIZ	Director of Strategic Development and Capital Planning/Deputy Chief Executive	Nil	January 2004
SMITH, SALLY	Chief Nurse and Director of Quality	Nil	Interim from 1 April 2015 Substantive from 28 July 2015

REGISTER OF DIRECTOR INTERESTS – 2018/2019 FROM AUGUST 2018

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
SMITH, STEPHEN	Chair	Non Executive Director of NetScientific Plc **(1)** Chairman of Biotechspert Ltd **(1)** Non Executive Director of uMed Ltd **(1)** Non Executive Director of Draper and Dash **(1)** Chairman of Signum Health Ltd **(1)** Trustee of Pancreatic Cancer UK **(1)** Stephen Smith Ltd **(1)** Chair of Scientific Advisory Board **(4)** Pancreatic Cancer UK **(4)** Non Executive Director of Great Ormond Street Hospital **(1)** (overlap agreed by NHS Improvement until the end of May 2018)	1 March 2018
STEVENS, PAUL	Medical Director	CQC Adviser **(4)** NICE Chair, Chair of the Kidney Disease Guideline and Quality Standards Groups **(4)** Executive Member of Kidney Disease Improving Global Outcomes **(4)**	June 2013
TOMSON, COLIN	Non Executive Director	Nil	11 May 2015 (First term)
WILDING, BARRY	Senior Independent Director	Trustee of CXK, a Charity in Ashford inspiring people to thrive **(4)**	11 May 2015 (First term)

Footnote: All members of the Board of Directors are Trustees of East Kent Hospitals Charity
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 EIGHTY-FIFTH MEETING OF THE BOARD OF DIRECTORS FRIDAY 8 JUNE 2018 AT 9.30 AM IN THE LECTURE THEATRE, EDUCATION CENTRE, QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL, MARGATE

PRESENT:

Professor S Smith	Chair	StS
Ms S Acott	Chief Executive	SAc
Mr S Adeusi	Non-Executive Director	SA
Mr P Cave	Director of Finance and Performance Management	PC
Ms W Cookson	Non-Executive Director	WC
Ms S Le Blanc	Director of Human Resources	SLB
Mr N Mansley	Non-Executive Director	NM
Mr L Martin	Interim Chief Operating Officer	LM
Ms J Ollis	Non-Executive Director	JO
Mr K Palmer	Non-Executive Director	KP
Ms L Shutler	Director of Strategic Development and Capital Planning/Deputy Chief Executive	LS
Dr S Smith	Chief Nurse and Director of Quality	SSm
Dr P Stevens	Medical Director	PS
Mr C Tomson	Non-Executive Director	CT
Mr B Wilding	Non-Executive Director	BW

IN ATTENDANCE:

Ms J Adam	Clinical Support Assistant (Minute Number 37/18)	JA
Dr P Bandipalyam	Director of Medical Education (Minute Number 37/18)	PB
Mr C Crowe	Education Research Fellow (Minute Number 37/18)	CC
Mrs A Fox	Trust Secretary	AF
Ms C Judge	Specialist Matron (Minute Number 40/18)	CJ
Dr D Merriott	Lead for Medical Student and TTF1 Teaching/F1 Doctor (Minute Number 37/18)	DM
Mr F Murray	Director of Estates and Facilities (Minute Number 51/18)	FM
Dr T Newson	Undergraduate Lead (Minute Number 37/18)	TN
Dr J Purday	Deputy Medical Director	JP
Ms S Robson	Board Support Secretary (Minutes)	SR
Ms N Yost	Director of Communications	NY

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mrs S Andrews
Ms C Gregory
Mrs C Heggie
Mr C Jeeves
Ms C Jeffrey
Miss S Landers
Mr C Morley
Dr J Sewell
Mr J Smith
Mrs M Smith
Mrs M Warburton
Mrs J Whorwell

MINUTE NO.		ACTION
32/18	**CHAIRMAN'S WELCOME**	
	The Chair welcomed the attendees to the meeting.	
33/18	**APOLOGIES FOR ABSENCE**	
	There were no apologies for absence received.	
34/18	**DECLARATION OF INTERESTS**	
	There were no further declarations of interest.	
35/18	**MINUTES OF THE PREVIOUS MEETING HELD ON 6 APRIL 2018**	
	The minutes of the previous meeting were **APPROVED** as a true record.	
36/18	**MATTERS ARISING FROM THE MINUTES ON 6 APRIL 2018**	
	The action 22/18 - Annual Staff Survey Results: for the staff survey action to be updated was noted as closed.	
37/18	**MEDICAL EDUCATION ANNUAL REPORT**	
	PB presented the key initiatives. An education fellow post had been created. The clinical support administrator role supported junior doctors in the Clinical Decision Unit (CDU). She highlighted that funding had been sought from Health Education Kent Surrey and Sussex (HEKSS) to develop the first Continuing Professional Development (CPD) framework for Specialty and Associate Specialist (SAS) doctors, which it was hoped would prove beneficial for recruitment.	
	JA highlighted that her role as Clinical Support Assistant (CSA) was to support junior doctors with tasks that facilitated patient flow. DM highlighted that F1 doctors had been able to design and run their own teaching courses. CC highlighted the East Kent maternity transformation programme, which aimed to change culture through training and development. Noting that training was at the heart of improving safety.	
	TN noted that the Trust had over 500 medical students attending for clinical training. The Trust's main partner was King's College London, although the new Kent and Medway Medical School was an exciting opportunity. The Trust also now had a lead for undergraduate simulation.	
	TN highlighted that the Medical School for Clinical Medicine was the way forward. Students had rated the Trust highly in feedback, although investment would be key in maintaining the Trust's success. The TTF1 module saw the transition from doctors into their F1 years and was very innovative. He highlighted that education should be at the heart of all managerial areas and that there was great opportunities in the future for the Trust particularly with the new Kent and Medway Medical School.	

KP asked for further detail on the emergency medicine app. PB noted that the idea of the app had been put forward by the junior doctors to ensure that all the guidelines were held and accessible in one area. SSm noted there was a significant opportunity for interdisciplinary work. DM agreed the benefits of this with nursing staff; SSm agreed to follow this up outside of the meeting. CC highlighted the midwifery medical student body scheme to support medical students and further understanding.

CT noted that the doctor training around behaviour and values was hugely important and the Trust had an opportunity to become outstanding in that area.

PS highlighted that the presentation had contained only a small part of the medical training that was being undertaken. The Board acknowledged the strong CPD framework set out in the report.

The Board discussed and **NOTED** the report.

38/18 **CHAIR'S REPORT**

The Chair highlighted that the Board meetings would move to monthly meetings to increase supervision of the Trust's transformation programme and operational performance. There would be 10 meetings each year. This would result in changes to the Board Committees, with a clearer definition of the relationship between the Board and the Board Committees.

There would be quarterly meetings between the Non-Executive Directors and Governors to increase communication and improve the dissemination of information. There would be an extended programme of Governors and Non-Executive Directors visiting parts of the hospital sites to increase visibility. There would be formal feedback on these visits to the Board.

NM highlighted that the Buckland Hospital in Dover visit had been valuable in terms of building the relationship between Governors and Non-Executive Directors. The actions arising from the visit would be reported to the Board. AF noted that the actions would also be presented to the Council of Governors.

The Board discussed and **NOTED** the report.

39/18 **CHIEF EXECUTIVE'S REPORT**

SAc highlighted that LM had started as the Trust's Interim Chief Operating Officer and would lead the Emergency Department (ED) improvement work and refresh the workstreams. There was ongoing improvement to the A&E 4 hour wait performance, which was positive and encouraging to the staff.

The Care Quality Commission (CQC) well-led inspection was underway with a particular focus on maternity, surgery, A&E, and palliative care. It was likely that the CQC would return for further reviews and consultations, and had already requested 350 items of evidence. The initial feedback received had been that staff were 'unstintingly caring' and hospitable.

NHS Improvement's (NHSI) review of the Trust's financial position had provided the

Trust with a strategy to exit Financial Special Measures (FSM). NHSI had requested financial plans for the next three years, but was confident that the Trust's financial control was good albeit still in deficit.

Cleaning, catering and portering services currently run by Serco would be transferred to a new NHS-owned organisation, providing the opportunity to bring the services back into an NHS subsidiary. Allowing the organisation to have more dynamic services that were not contractually orientated.

The Archbishop of Canterbury had visited the Trust. There had also been success for the Trust around recruitment to midwifery along with a national profile around the Trust's work within midwifery.

The Board discussed and **NOTED** the report.

40/18 **STAFF EXPERIENCE STORY**

SSm highlighted that this story related to unconscious bias. CJ recounted the story of a patient undergoing haemodialysis who had become very aggressive with nurses, following an episode during treatment when their blood pressure dropped and the nurse caring for them administered a bolus of fluid, which is the correct treatment. This had made the nursing team feel vulnerable and prevented them from interacting with them closely. The patient had complained that they had been given saline during dialysis against their wishes. The learning enabled nurses to receive further language training where appropriate in order to improve negotiation skills, and to understand that patients with capacity were able to make unwise decisions or unusual wishes. CJ noted that the learning had been beneficial for all staff.

WC noted that consent was complicated, and assumed consent could be taken for granted, although the patient had clearly articulated his non-consent. The aggression had stemmed from staff missing important elements of his communication. The learning was being shared across specialist services.

SLB noted that it was part of the clinical strategy to recruit staff from overseas, and that the experience in this case could be useful to other overseas staff. PS requested that the language training be extended to doctors. The Chair noted that it was important to highlight that patient stories had an effect on the way the Trust practised.

CJ confirmed that the learning from the incident had changed the way that handovers were conducted. SAc noted that staff had a high tolerance to patient aggression and that this was not necessarily a good thing.

SA enquired whether the relationship had improved with the patient in question. CJ highlighted that the relationship had improved once the patient had felt that they had been listened to. LM noted that the incident had been addressed in a sophisticated way.

The Board discussed and **NOTED** the report.

41/18 **QUALITY COMMITTEE – CHAIR REPORT**

BW highlighted that the Quality Committee had received an update from LM on how ED performance would be improved. The Committee had been assured that the improvement plan was both robust and realistic. The principal quality risks on the Risk Register had been reviewed, and the Committee had noted improvements in the reporting of progress against the risks. There were process control limits on the quality metrics data, which enabled the Committee to review these more objectively. He highlighted that the Committee had reviewed and approved the revised Quality Strategy 2018-2021, which was recommended to the Board for approval.

The Chair highlighted that the friends and family test inpatient satisfaction rate was at 97%, and the overall patient experience was rated green at 91.6%. The Trust had entered its third month without a never event. The pressure ulcer rate showed substantive improvement, and was an indicator of good quality care. The falls rate was reducing.

SAc agreed that the Quality Strategy was good, and highlighted that the Board needed to consider how it would be sighted on the implementation of the strategy. AF noted that the update on the implementation of the strategy presented quarterly to the Committee could be appended to the Quality Committee report presented to the Board.

ACTION: Quarterly Quality Strategy update report to be appended to future Quality Committee Chair reports presented to the Board. SR

The Board discussed and **NOTED** the report.

42/18 **MEDICAL DIRECTOR'S REPORT**

PS highlighted infection prevention and control, in particular C. diff where historically the Trust had performed better. While the Trust could not eradicate C. diff there were basic elements that staff were not getting right in terms of hand hygiene. PS noted that the report contained actions to close the gaps in antimicrobial stewardship and antibiotic prescribing. SAc noted that antimicrobial stewardship was very complex and might require external review.

PS noted that the performance in sepsis screening and delivery of intravenous antibiotics within an hour of screening was potentially driving the C. diff issue. SAc noted the clash between trying to treat sepsis quickly and the campaign against the overuse of antibiotics. If blood cultures confirmed that there was no sepsis the antibiotics should be stopped immediately.

The Board discussed and **NOTED** the report.

43/18 **STRATEGIC WORKFORCE COMMITTEE – CHAIR REPORT**

CT highlighted that the Trust was being affected by the Government's refusal to issue visas for overseas doctors. The Guardian of Safe Working report regarding the operation of the junior doctors' contract, had indicated that the Trust was technically in breach due to not all of the exception reports being reviewed by a

supervisor within seven days. PS noted that the issue with the exception reports had been dealt with.

The Board would need to reflect on the governance and support required for the Kent and Medway Medical School programme. PS highlighted that a working group had been set up to plan how to move forward with the programme. CT noted that it would be appropriate to consider an agenda item for a future Board meeting to look at emerging themes from the working group. The Chair had met with the Vice Chancellors and noted that all parties were anxious to move forward the programme. The Dean for the new Medical School was being recruited.

DECISION: The Board discussed the report and **APPROVED** the revised Terms of Reference (TOR) for the Strategic Workforce Committee.

44/18 **NURSING RECRUITMENT**

SLB highlighted that there was a national shortage of nurses. The Trust was looking to recruit alongside other Trusts in Kent & Medway. The recruitment improvement process would reduce the time to recruit to eight weeks. She highlighted that the new IT recruitment system, Trac, had provided a cost saving and there had been positive feedback from HR and recruiting managers regarding this system. SLB highlighted that the central vacancy control panel had been removed, devolving responsibility to Divisions, making the recruiting process faster.

JO queried whether the Trust was taking the best learning from the Royal College of Nursing (RCN) work on enabling technology to support nurses. It was noted that the IT and AI elements of the RCN would be helpful to the Trust.

NM noted the Trust's ageing workforce, and asked what work was being done to address that issue in terms of longer-term workforce planning. SLB highlighted that each Division had been provided with the age profiles of their clinical staff. Flexible working for staff nearing the end of their careers and new roles were being considered. SAc noted the need to ensure that workforce strategies were skills based, not role based, and were suitably blended.

SA asked for further information on the retention of the 100 recently recruited overseas nurses. SLB highlighted that there would be a phased start, so that not all of those recruited joined the organisation at the same time. The overseas staff had received a specialist induction and all new entrants were supported through a buddy arrangement over their first year. The Trust was investigating the potential to conduct rotations with a Trust in London.

The Board discussed and **NOTED** the report.

45/18 **MEDICAL REVALIDATION REPORT**

PS highlighted that the Trust was at the beginning of the second cycle of revalidation. The annual appraisal was a condition of a doctor's licence to practise and the Trust's appraisal rate for 2017 was 95%. The Trust provided revalidation services for the Pilgrim's Hospice.

The Board discussed and **NOTED** the report.

46/18 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR REPORT**

The Board **NOTED** the report.

47/18 **FINANCE AND PERFORMANCE COMMITTEE – CHAIR REPORT**

The Trust had met with NHSI around FSM and had been advised that NHSI's expectations were: that the Trust deliver on Q1 income and expenditure run rates; produce a three-year operational plan showing improvement in run rates, and to improve on constitutional standards. The Committee had received a detailed and robust plan around ED, which was data driven. LM would produce similar improvement plans for Referral to Treatment (RTT) and cancer standards for the July Committee meeting.

SA requested that the Board consider the Financial Year (FY)19 capital plan of £16m. LS highlighted that £9m of the capital plan was allocated to the standing items around maintenance, replacement equipment and IT. The remaining allocations were around high-cost equipment replacement, with £2m still to be allocated through a prioritisation exercise. It was noted that funding to meet the remaining capital costs for the dementia village were being loaned from Kent County Council (KCC).

DECISION: The Board discussed the report and **APPROVED** the £16m (including the Dementia Village) 20181/9 capital plan.

48/18 **MANAGEMENT BOARD – CHAIR REPORT**

The Management Board had focused on preparation for 2018/19, ensuring that the improvement plans to achieve the RTT, cancer standards and A&E performance were in place. There was a particular focus around planning for winter and the Commissioning for Quality and Innovation (CQUIN) targets. At any one time there were up to 180 patients who did not need to be in an acute bed. The Trust was working with partners to focus effort on accommodating these patients in the community.

The Board discussed and **NOTED** the report.

49/18 **INTEGRATED PERFORMANCE REPORT (IPR)**

The IPR was presented in statistical process control format as far as possible, with particular attention given to movement above or below the control limits and the actions to rectify adverse movement.

PS highlighted his main areas of concern as C. diff and Venous Thromboembolism (VTE).

SAc highlighted that the Executive Team was focused on ensuring the organisation was prepared for winter.

LM highlighted that the ED trajectory for April 2018 had been 78%, but the ED had performed at 81%. In May the trajectory was 77%, and the ED had achieved 80%. It was noted that the last few days had been extremely good. The work in ED had focused on the pathway, the physical environment, models of care and workforce.

There was a plan to ensure that as patients moved through the ED zones staff had the appropriate space to treat patients in the target time. Work was underway with partners to tackle re-attendances, with good engagement. An extra 17 medically well patients had been moved out of hospital, some of whom had complex social care needs. The improvement in ED would continue with the trajectory to reach 84% in July.

BW highlighted that the process control limits would allow an objective assessment of whether things were improving or deteriorating. The Chair noted that the figures would be reviewed by the Board at the future monthly Board meetings.

JO asked for further clarity on the GP streaming model. LM noted that the physical capacity and correct staffing complement had not been in place. The number of treatment rooms had now increased from three to six, and a joint dovetail staffing model had been agreed with the Clinical Commissioning Group (CCG).

There were nine cancer targets and current performance was at 65.4% against 78% trajectory. The cancer action plan would be divided into four areas: a dedicated cancer leadership team; the cancer steering committee and co-ordination relating to work with external providers; the timed pathways and using the Patient Tracking Lists (PTLs); pathways for complex patients utilising multiple specialties. The Chair highlighted that improvement was expected with the Board's support. There were 31 104-day patients that were reviewed daily, half of whom were extremely complex. Work was underway with GPs to ensure that there were better referral pathways.

LM highlighted that the Referral to Treatment (RTT) indicator would go down as the Trust improved. The trajectory was 77.3%, with the Trust performing at 76%. There were 222 patients at 52 weeks, with trajectory at 250. The work around pre-admission flow and bed stock was important to move admitted patients through the pathway, with bed capacity being relieved in the next few months. The early indication for May was that the Trust had achieved against trajectory.

SA enquired how bed stock would be reconfigured to ensure that there were no outliers. SAc highlighted the need for regular review to ensure that each specialty had the right capacity. The Trust had achieved 99.3% on the diagnostic national standards and was reviewing the number of referrals weekly to ensure capacity was in the correct place. The numbers of Delayed Transfers of Care (DTOC) patients was high with 63 on average per day. LM highlighted that there was work to ensure that the hospital and community teams were aligned with patient need.

LM noted that mental health provision from Kent and Medway NHS and Social Care Partnership Trust (KMPT) was now at 24 hours in ED, and the focus was on ensuring that the model was right for future need.

The Board discussed and **NOTED** the report.

50/18 **FULL CORPORATE/HIGHEST MITIGATED STRATEGIC RISKS REPORT**

The Trust's highest risks were around patient flow, funding and workforce. KP noted that CRR55 - sharing of medical records was a longstanding problem that appeared to be worsening. The Trust had been responding to GP requests for records, but in the future records would stay with the hospital.

NM requested an update on SRR16 in relation to the transformation programme. SAc noted that the current programme had stemmed from the 2014 CQC report, and was likely to be re-focussed when the current CQC inspection report was received.

CT noted that CRR19 relating to delays in the cancer pathway stated that no patient had been harmed due to treatment delay and asked how the Trust could be confident that was the case. SSm highlighted that there was a methodology in place to review patients.

JO requested further information on whether the staff leadership programme had been approved. SLB noted that the NHSI panel had not supported the business case in April due to the lack of improvement in the A&E performance. The Trust was working with EY to develop an option to deliver the programme internally. The Board discussed and **NOTED** the report.

51/18 **SIX MONTHLY ESTATES STATUTORY COMPLIANCE AND HEALTH AND SAFETY REPORT**

LS highlighted that the report detailed work around legionella, asbestos and fire management. There had been improvements in health and safety compliance in all Divisions. The Integrated Audit and Governance Committee had conducted deep dives on health and safety.

KP noted that with regards to the internal audits, 56 departments out of 181 were red, which was poor. LS noted that governance within the Divisions had been slow to improve. FM highlighted that there had been significant improvement since the deep dives had been conducted. The Chair noted that the Board expected an improvement in the health and safety requirements. SAc noted that a higher frequency of reporting to the Board would ensure that health and safety had the same prominence as patient safety.

FM noted that the Trust's 11 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reports was a low number for the headcount, and the increase in April was due to backdated reporting.

ACTION: Present reports on a quarterly basis to the Board, and include in future reports comparable data on how the Trust is performing against other Trusts. LS

The Board discussed and **NOTED** the report.

52/18 **TRANSFORMATION BOARD – CHAIR REPORT**

PC highlighted that the healthier finances piece on the transformation was about ensuring that staff within the organisation were given the right level of training. The Trust was ahead of plan in month 1. SAc highlighted that the 'getting it right first time' programme would see national clinical experts conduct deep dives on the effectiveness of the Trust's clinical services.

The Board discussed and **NOTED** the report.

53/18 **CHARITABLE FUNDS COMMITTEE – CHAIR REPORT**

KP thanked Gill Gibb, the Charity Adviser, for her support to the Committee, who had recently stood down from this role. The Committee had asked the Strategic Investment Group to present a list of the equipment and projects that should be considered for future purchase. The dementia appeal target was £500,000 with £122,400 raised so far. He requested the Board's approval of the Terms of Reference.

WC enquired, with reference to the Trust Staff Awards, whether it had been ascertained that donations had not been earmarked for staff. KP noted that the Committee acknowledged the importance of the Awards and saw this as a Trust cost rather than for the Charity. The Committee had decided it was not appropriate to fund the Awards for a second year. BW highlighted that the decision had been taken after considerable due diligence.

DECISION: The Board discussed the report and **APPROVED** the Charitable Funds Committee TOR.

54/18 **ANY OTHER BUSINESS**

There were no further items of business.

55/18 **QUESTIONS FROM THE PUBLIC**

A comment was made highlighting the improvement in infection control policies and practices.

A question was raised about how the CCG's deficit impacted on the commissioning of the Trust's services. PC noted that it was not a good position for both commissioner and provider to be in deficit. The CCG's plan for 2018/19 was break-even; and the Trust's plan was £30m deficit.

A question was raised about whether the space in A&E was the main issue the department was facing. LM highlighted that there had not been insufficient consulting rooms to move the minor injury patients through more quickly. For A&E to be successful it required the right workforce, and the processes and systems to treat patients. PS noted that the hospital had been built for half of the current A&E attendance.

A question was asked for clarity on the number of staff employed in the ED at Queen Elizabeth the Queen Mother Hospital (QEQMH) and the number of staff shortfall for consultants and nurses. It was noted there was a shortfall in both doctors and nurses.

ACTION: Confirm the number of staff employed in the ED at Queen Elizabeth the Queen Mother Hospital (QEQMH) and the number of staff shortfall for consultants and nurses. SLB

A question was raised about where people in Ashford would go after 6.30 pm and on weekends for x-rays with reference to the minor injuries leaflet. NY noted that the leaflet was designed to provide more information on the minor injury units, and

that further information on the Trust's website would steer patients to the right service for their needs.

A question was raised about when the monthly public Board meetings would start. The Chair noted this would begin in September.

A question was raised as to whether the consultation on acute care would be discussed at the next Board meeting. It was noted that the consultation process was the remit of the CCGs and was currently not for the Trust to discuss. It was noted that the Board could only answer questions based on the content of the meeting agenda and that factual questions should be emailed to the Trust's Secretary.

A question was raised around whether the Trust had the capacity to conduct repeat breast screening for ladies under 72 and whether ladies over 72 should self-refer through their GPs. It was asked whether breast screening was sent to Texas for analysis. PS highlighted that the breast screening incident was an IT issue within Public Health screening and was not for the Trust. Public Health England had been identifying the women who had not been screened and had asked the Kent & Medway service to provide extra appointments for those women. The service had found appointments for everyone to date, although it might become more difficult when reaching the over-72 age group.

A question was raised as to whether the health and safety policy covered staff lone working in the community. SAc noted that lone working was subject to particular legal requirements, and that the Trust valued the safety of the environment for staff.

A question was raised about how metrics would be agreed on the impact of local care agreements. SAc noted that the CCG had to balance two elements in terms of reducing the demand on acute hospitals and ensuring that patients had support in the community to be discharged from hospital. LM highlighted that there was a lot of work being undertaken currently around discharge planning.

A question was raised as to whether the health and safety risks would transfer to a risk register in the new subsidiary company. It was noted that the new company would have its own risk register. SLB noted that Serco and the Trust continued to recruit, current terms and conditions would be offered and the individuals would be TUPE to the new company.

A request was raised that there be an open channel of communication to EKHUFT regarding the consultation. SAc noted that the consultation process would be highly structured. SA noted that the CCG would hold a set of events via which the Trust would respond. The Chair noted that there would be statutory responsibilities on the Trust, but the process of consultation was the responsibility of the CCGs. It was advised that contact be made with the Trust's Secretary regarding this query.

The Chair closed the meeting at 1.00 pm.

Date of next meeting in public: Friday 10 August 2018, 09:30 in Seminar Rooms 1 & 2, Buckland Hospital, Dover.

CHAIR'S INITIALS ……

Signature _____

Date _____

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
BOARD OF DIRECTORS MEETING – 10 AUGUST 2018

ACTION POINTS FROM THE PUBLIC MEETING OF THE BOARD OF DIRECTORS MEETING HELD ON 8 JUNE 2018

ACTION NUMBER	DATE OF MEETING	MINUTE NUMBER	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
B/001/18	08.06.18	41/18 Quality Committee – Chair Report	Quarterly Quality Strategy update report to be appended to future Quality Committee reports presented to the Board.	SR	October 2018	Noted on the work programme for the quarterly report to be appended to the Quality Committee Chair's report when presented to the Board. **Action for future Board meeting.**
B/002/18	08.06.18	51/18 Six Monthly Estates Statutory Compliance and Health and Safety Report	Present reports on a quarterly basis to the Board, and include in future reports comparable data on how the Trust is performing against other Trusts.	LS	September 2018	Noted on the work programme for reports to be presented to the Board on a quarterly basis. **Action for future Board meeting.**
B/003/18	08.06.18	55/18 Questions from the Public	Confirm the number of staff employed in the Emergency Department (ED) at Queen Elizabeth the Queen Mother Hospital (QEQMH) and the number of staff shortfall for consultants and nurses.	SLB	August 2018	A&E QEQMH 156.36 whole time equivalent (WTE) staff 6.00 WTE consultant 17.32 WTE nursing staff (Data as at June 2018). **Action closed.**

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**10 AUGUST 2018**
SUBJECT:	**CHAIR'S REPORT**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX A: 70 NHS YEARS – A CELEBRATION OF 70 INFLUENTIAL NURSES AND MIDWIVES FROM 1948 TO 2018** **APPENDIX B: PROPOSED CHANGES TO THE TRUST'S CONSTITUTION**

BACKGROUND AND EXECUTIVE SUMMARY

Introduction

The purpose of this report is to:

- Report any decisions taken by the Board of Directors outside of its meeting cycle;
- Update the Board on the activities of the Council of Governors;
- To bring any other significant items to note to the Board's attention.

70 NHS Years – A celebration of 70 influential nurses and midwives from 1948 to 2018
A member of EKHUFT's staff was one of the seventy most influential nurses and midwives acknowledged in the attached document (Appendix A). Kim Manley, Associate Director Transformational Research and Practice Development's summarised profile reflects on her life and the contribution she has made to nursing. Along with her continued inspirational and professionalism in shaping the NHS and supporting others in meeting the current challenges. On behalf of the Board and EKHUFT congratulations to Kim in receiving this highest of accolade, and thanks for all her hard work and continued support to the Trust, her colleagues, peers, and the NHS.

Council of Governors Update
A meeting of the Council of Governors took place on 3 August 2018. This meeting was the first since the introduction of a new agenda structure to provide better opportunities for the Council to hold the Non-Executive Directors to account.

The plan is that at each meeting the Chairs of two of the Board Committees will present to the Committee on their recent meetings. This provides the Council the opportunity to question the NEDs in greater depth, using the information that they have gathered from different sources to inform their questions. This includes intelligence from their constituents and the public, Joint Site Visits and the content of Board papers.

As this was the first meeting, there were presentations from all four Board Committees to give the Council a complete update. The Council challenged the NEDs to provide assurance on a wide range of issues including;

- Delivery of Cost Improvement Programmes
- Delivery of the ED, Cancer and RTT targets and the metrics used to monitor performance
- Does the Trust have a well embedded safety Culture
- Reporting on health and safety issues
- Freedom to speak up
- Staff recruitment and retention

- Organisation culture and the Listening into Action programme
- Resilience training for doctors
- The role of the Integrated Audit and governance committee in the Trust's governance structure.
- Risk management: resilience and tolerance

I agreed to bring two specific issues to this meeting of the Board.

A suggestion was made that the Trust should consider undertaking some work to gauge public perception of the Trust and its services. This would be different from the Friends and Family test as the aim would be to reach the public as a whole, not just those who use the services or are linked to the Trust in some way.

The second issue is the Trust's use of single use plastics and what steps are being taken to ensure that this is controlled.

The Council received a report from the Task and Finish Group they set up to look at the Trust's constitution and the information provided to Governors to assist them to fulfil their role. The Group proposed several changes to the Trust's constitution, which the Council approved. The paper taken to the Council meeting is appended to this report (Appendix B). As changes to the Constitution also need to be approved by the Board, I am seeking that approval at this meeting.

The Trust's new subsidiary company, 2gether Support Solutions, was discussed in both the closed and private sessions. I agreed with the Council that the second phase of the programme, moving a number of Trust support services such as Estates, is more complex and will be working with Alison Fox to ensure proper involvement of the Council in the process.

I updated the Council on the progress with the introduction of the programme of joint site visits. Six had already taken place and were well received by the trust staff; feedback from the teams was also positive, showing the value that the programme is going to deliver. The reports on the visits have highlighted areas for attention and these will be taken to the Executive Team meetings for consideration. Any actions which need immediate attention, because they relate to patient or staff safety, will be taken forward immediately with the Chief Executive. There will be quarterly reporting on the Joint Site Visits to both the Board and Council.

I agreed with the view expressed by the Council that it is essential that the staff who are visited receive feedback from that process and that action is seen to happen. A system will be put in place, and embedded, to ensure that action is taken swiftly after the visit report is received and there is a full feedback loop to the staff involved, the Board and the Governors.

In addition the Executive Directors regularly visit the Trust hospital sites carrying out visits and walkabouts to the wards and departments as well as attending staff meetings and briefings. Noted below is a brief outline of these visits by the Executive Directors.

Medical Director	23 May – Clinical Leadership Meeting with Chief Executive Officer (CEO) and Clinicians at Kent and Canterbury Hospital (K&CH) 1 June – Nutrition Round at Queen Elizabeth the Queen Mother Hospital (QEQMH) 4 June – Obstetrics Leadership Team Meeting with at K&CH 8 June – Nutrition Round at QEQM 15 June – Nutrition Round at QEQM 21 June - Never Event workshop (held at external location) 29 June – Nutrition Round at QEQM 6 July – Nutrition Round at QEQM 13 July – Quality Meeting, Minster Ward at QEQM

	13 July – Team Talk at QEQM 23 July – Joint Governor, NED and Executive Director Hospital Visit at K&CH
Chief Nurse and Director of Quality	21 June - Never Event Workshop (held at external location) 2 July - Senior Leadership Forum (video conferenced across the three main hospital sites) 9 July - Team Talk at William Harvey Hospital (WHH) 13 July - Ward Visits at Kent and Canterbury Hospital (K&CH) 13 July - Quality Meeting, Minster Ward at Queen Elizabeth the Queen Mother Hospital (QEQMH) 20 July - Ward Visits at QEQMH 3 August - Ward Visits at QEQM
Director of Strategic Development and Capital Planning	6 June – Managers' Briefing (WHH) 6 June – Managers' Briefing (K&CH) 6 June – Managers' Briefing (QEQMH) 11 June – Visit to Radiology Physics to talk about the Trust's Winter Plan (K&CH) 12 June – Staff Listening Sessions x 2 (QEQMH) 13 June - Staff Listening Sessions x 2 (K&CH) 14 June - Staff Listening Sessions x 2 (WHH) 19 June – Staff Forum (K&CH) 2 July – Joint Board/Governor Visit (QEQM) 4 July – Ward Buddying (K&CH) 9 July – Team Talk (Royal Victoria Hospital (RVH)) 9 July – Team Talk (WHH) 10 July – Walk the Floor (K&CH and WHH) 16 July – Trust Induction 30 July – Ward Buddying (QEQMH)
Director of Finance and Performance	4 July – Ward Buddying at Marlowe Ward (K&CH) 5 July – Ward Buddying at Cheerful Sparrows Ward (QEQM) 5 July – NHS70 Tea Party (Royal Victoria Hospital (RVH))
Chief Operating Officer	4 June – Walk the Floor in ED Department (WHH)
Director of HR	11 June – Team Talk (Buckland Hospital, Dover (BHD)) 19 June – K&CH Staff Forum (K&CH) 17 July – Team Talk (BHD) 20 July – Ward Buddying, Birchington Ward (QEQM) 27 July – Ward Buddying, Day Surgery (K&CH)

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	N/A
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	By ensuring continuation of supply of essential goods and services.
RESOURCE IMPLICATIONS:	N/A

COMMITTEES WHO HAVE CONSIDERED THIS REPORT	N/A

PRIVACY IMPACT ASSESSMENT: *NO*	**EQUALITY IMPACT ASSESSMENT:** *NO*

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to:

a) discuss and note the report;

b) discuss the suggestions made at the Council of Governors meeting about ways to engage public perception of the Trust and the Trust's use of single use plastics;

c) approve the proposed changes to the Trust's Constitution.

RCNi

70 NHS YEARS

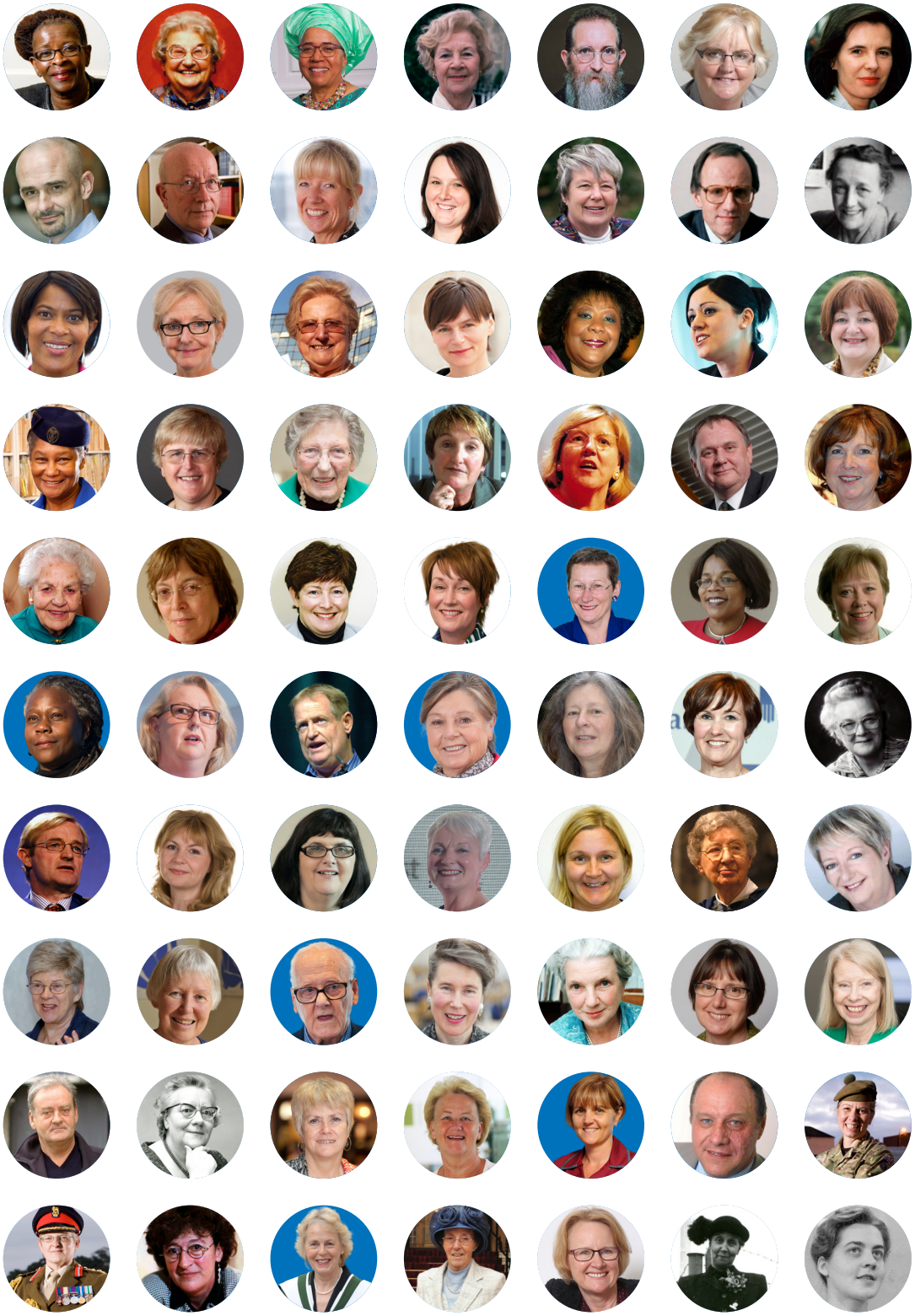
A celebration of 70 influential nurses and midwives from 1948 to 2018

In partnership with

NHS 70

Nursing Standard

70 YEARS OF THE NHS 1948 - 2018



Seventy of the most influential nurses and midwives: 1948-2018

Inspirational nurses and midwives who helped to shape the NHS

Jane Cummings
chief nursing officer
for England

Jane Cummings reflects on the lives of 70 remarkable figures whose contributions to nursing and midwifery are summarised in the following profiles, and on the inspiration they provide as the profession meets today's challenges

As a nurse, when I visit front-line services and meet with staff and colleagues across the country I regularly reflect on a powerful quote from the American author and management expert Ken Blanchard: 'The key to successful leadership today is influence, not authority.'

I am a firm believer that everyone in our profession, whatever their role, wherever they work, has the ability to influence and be influenced by the people they care for and work with.

Nursing and midwifery has a rich, diverse history. We continue to grow and adapt as a result of people who do amazing things across a whole spectrum of activities.

Individuals and teams leading and shaping education, research, innovation, clinical practice and many other important areas highlight the influence of nursing, midwifery and care staff across the health and care system.

Our huge impact on people's lives

As the NHS turns 70 it is important that we reflect on the past 70 years, recognising and celebrating all that we have achieved, individually and collectively, and the huge impact we have had and will continue to have on people's lives.

As chief nursing officer for England, I am delighted to have contributed to this publication on behalf of the CNOs in Northern Ireland, Scotland and Wales, identifying some of the most influential nurses and midwives who have made a significant impact across the UK and beyond.

I would like to give special thanks to the RCNi and Nursing Standard, who we have worked in partnership with to produce this important reflection of our history over the past 70 years, and to its sponsor Impelsys.

Tireless work to shape a profession

Here you will find profiles of 70 extraordinary nursing and midwifery leaders. Many of them have helped shape our NHS.

While it's not possible to capture every significant event and list every notable individual, I hope their stories help encapsulate the huge contribution of nursing and midwifery across the seven decades of the NHS.

I would like to thank CNO for Wales Jean White, CNO for Northern Ireland Charlotte McArdle and CNO for Scotland Fiona McQueen, who together with myself and others nominated outstanding nurses and midwives from across the UK – many more than could eventually be included in the final list of 70.

As we celebrate 70 years of the NHS, it is important to take this opportunity to pay tribute to some of the inspirational and groundbreaking leaders who have worked tirelessly to shape nursing and midwifery over many years.

Why nurses are respected and appreciated

Florence Nightingale, considered to be the founder of modern nursing, turned it into a strong profession, raising standards by incorporating education and responsibilities into the job. Thanks to her, nurses were no longer looked down on but became respected and appreciated.

Edith Cavell's pioneering work helped to develop one of the first nursing journals, L'infirmiere, which documented strong nursing practice and basic standards.

And then there is Mary Seacole, an iconic figure who made significant contributions to nursing. Her hands-on approach continues to be recognised today.

Core values that never change

There are so many more leaders and iconic figures who could be mentioned, but a striking similarity between nurses and midwives of the past and those today is in the values they adopt.

I am pleased to be able to say that the 6Cs – care, compassion, competence, communication, courage and commitment – as a value base for nursing, midwifery and care staff, continue to underpin the work of all staff.

I am delighted that they remain as relevant today as they have been for many decades, ensuring that patients and those we care for will never forget what we do for them and how we make them feel.

I am truly delighted and honoured to provide the introduction to this publication and would like to pay tribute to all those included here for the inspiration they still give to us today.

Identifying 70 nursing and midwifery leaders was challenging – but exciting

The challenge issued by Jane Cummings was as daunting as it was exciting: could we identify the 70 most influential nurses and midwives from the past 70 years, and so celebrate the NHS turning 70? So a judging panel was convened, nominations received and the debate began.

The panel tried to strike a balance between recognising the women and men who have helped forge the NHS, and those who are better known to us because their impact has been felt more recently.

We wanted to reflect the diversity of nursing and midwifery in every respect, including ethnicity, gender, geography and specialty. We strived to ensure that nurses and midwives' contribution to all 70 years of the NHS was acknowledged. And we tried to avoid a list comprising only the 'great and the good', while giving appropriate recognition to the professional leaders who have shaped modern nursing and healthcare.

There are many great nurses and midwives who missed the cut, and doubtless there are many whose names have not been discussed because their work has never received the recognition it deserves. Nevertheless, the impressive achievements of the final 70 serve as a suitable celebration of nursing and midwifery over the past seven decades, and hopefully will inspire today's students and schoolchildren to achieve even great heights than their predecessors.

Graham Scott is Nursing Standard editor and RCNi editorial director

Cecilia Akrisie Anim

Cecilia Akrisie Anim is serving her second term as RCN president. She is the first black and minority ethnic nurse to be elected to the position and previously served as deputy president.

A member of the RCN for over 30 years, in 2017 she was awarded a CBE in recognition of her role as a nurse and as RCN president, and for her contribution to her community.

Born in Ghana, Ms Akrisie Anim completed her midwifery training there before moving to the UK in the 1970s. She gained a UK nursing qualification at Hull Royal Infirmary.

In 1979 she took up a post at London's Margaret Pyke Centre, a family planning and sexual health clinic, where she continues to work as a clinical nurse specialist in sexual and reproductive health, combining her work there with the RCN presidency.

Annie Altschul

Fleeing Austria after its annexation by Nazi Germany in 1938, Annie Altschul arrived in Britain with her sister, nephew, widowed mother and a single possession – a painting of a rural Austrian scene.

A student of mathematics in Vienna, in London she became a nurse, one of the few jobs then open to refugees. And so began the career of one of the most indomitable and pioneering figures in psychiatric nursing.

By 1957 she had published her first book, and in the early 1960s, with a degree in psychology, she was appointed lecturer in the burgeoning nursing studies department at the University of Edinburgh. She remained there until her retirement as professor of nursing in 1983.

Dame Elizabeth Nneka Anionwu

Dame Elizabeth Nneka Anionwu was shy as a nursing student, she told Nursing Standard in 2016 – to the extent that she would feel sick at the prospect of having to move to a different ward. She attributed her horror of change to her upbringing, when short-lived periods of relative stability would end in disruption. For much of her childhood she was cared for by nuns.

Her early experiences of stigma and racism, and the complexities of her Irish-Nigerian heritage, are vividly described in her memoir Mixed Blessings from a Cambridge Union. She overcame low expectations to build a distinguished reputation as a nurse, health visitor, academic and campaigner.

Professor Anionwu has been a trailblazer throughout her professional life. A politically aware 'radical health visitor' in the 1970s, at the end of the decade she became the first sickle cell and thalassaemia nurse counsellor in the UK. The service she pioneered in London led to nationwide screening of babies.

A prominent leader of the successful campaign to honour Mary Seacole, a black nurse who became a heroine by helping soldiers during the Crimean War, she has been recognised with a damehood and a CBE. Currently emeritus professor of nursing at the University of West London, she has campaigned tirelessly to reduce inequalities facing black and minority ethnic nurses and their patients.

1948

Aneurin Bevan, health minister and lifelong campaigner for social justice, launches the National Health Service on 5 July. It is the culmination of an ambitious plan to bring good healthcare to everyone, free at the point of delivery. Mr Bevan says: 'No society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means.'

1949

The Nurses Act offers a new framework for the role of nursing within the NHS.

Monica Baly

After her death in 1998, one newspaper characterised Monica Baly as displaying a 'genteel rebelliousness' throughout her career.

Born at the outbreak of the first world war, she served with great distinction in the 1939-45 conflict as a member of Princess Mary's RAF Nursing Service.

Later she began a campaign for better pay and conditions for nurses and through the RCN's Raise the Roof campaign in 1970 helped secure an astonishing 22% pay rise.

In retirement she focused on charting nursing's history, completing a PhD at the age of 70. Her thesis on Britain's most famous nurse was later turned into a book, Florence Nightingale and the Nursing Legacy, published in 1986.

She was the first chair of what would become the RCN History of Nursing Society and did much to record the profession's development. The RCN Foundation's Monica Baly Bursary is awarded annually for the promotion of scholarship in nursing history.

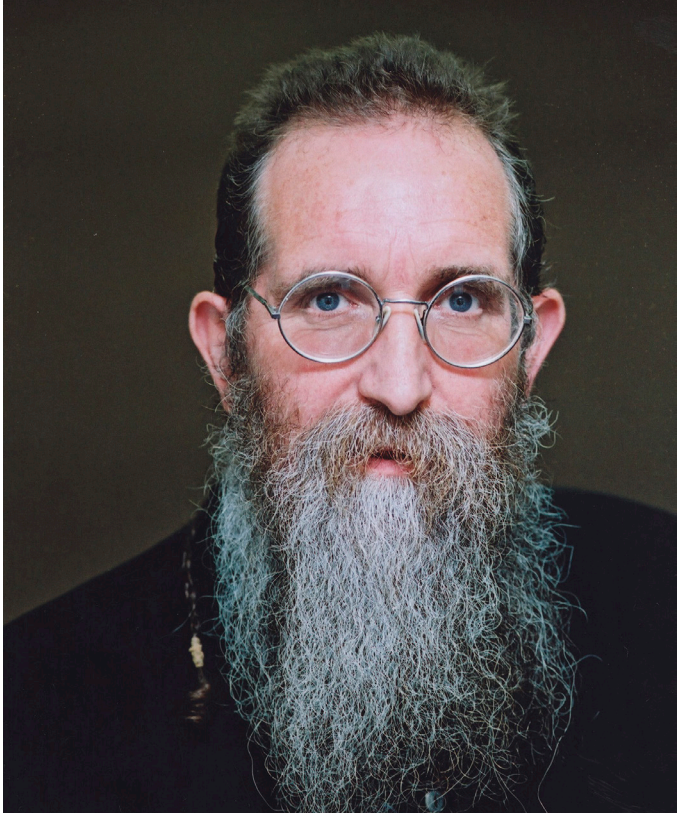
Phil Barker

'It is folly to try to control our lives,' says Phil Barker in an online video. 'What we need to do is work out how we navigate our way through all the storms and challenges that life presents to us.'

He is explaining the philosophy behind the Tidal Model of mental health practice, developed by him and his colleagues as an approach focused on recovery. The Tidal Model became hugely influential as a prism through which mental health problems can be seen and understood.

Professor Barker's career in healthcare began when he took a job as a nursing assistant in the 1960s. He had previously worked as a railway porter and as a labourer in an iron foundry.

Innovative, nonconformist and a champion of psychoanalytic thinking, he became the UK's first professor of psychiatric nursing practice at Newcastle University, and later worked in Australia, Japan and Ireland. The author of numerous books, chapters and academic papers, he is also an award-winning artist.



Dame Christine Beasley

'I have always tried – and believe most of the time have succeeded – to include the people I am leading in thinking about where we are going,' Dame Christine Beasley told The Times in 2011 when she was about to step down as England's chief nursing officer (CNO).

She had been appointed chief nurse in 2004. Tackling hospital-acquired infections was a high priority for the new CNO, and by the time she left her post the Department of Health said there had been a 78% reduction in MRSA and a 53% decrease in C difficile.

Her achievements as CNO were wide-ranging and include moves towards ending mixed-sex wards and promotion of the importance of patients' experience.

On her retirement, then health secretary Andrew Lansley, now Lord Lansley, said of Dame Christine: 'Her ease of manner and depth of knowledge have given her an unrivalled reputation as an accessible and effective nursing leader.'

1952

A charge of 1 shilling (5p) is introduced for prescriptions.
Prescription charges were abolished in 1963 but reintroduced five years later.

1953

The Nuffield Provincial Hospitals Trust publishes The Work of Nurses in Hospital Wards: Report of a Job Analysis. It showed that many questions about training, staffing and general organisation needed addressing.

Queen Elizabeth II becomes patron of the RCN following the death of Queen Mary.

Alison Binnie

Freedom to Practise: The Development of Patient-centred Nursing by Alison Binnie and Angie Titchen was published in 1999. The book drew on research and real-life examples to identify strategies for improving patient care, irrespective of setting.

It was a significant contribution to the literature on approaches to nursing care. Even now, many years after its publication, the themes discussed in the book retain their currency.

In a foreword to Freedom to Practise, Marie Manthey, the American nurse and author who is recognised as an originator of primary nursing, wrote: 'Within the context of my thirty-plus years of experience in this particular field, I have never read a more thorough, more interesting, or more practical discussion of the practice development process.'

Ms Binnie was made a fellow of the RCN in the same year the book was published.

Neil Brimblecombe

Well-known and highly regarded in mental health nursing and beyond, Neil Brimblecombe is a professor of mental health at London South Bank University.

Formerly director of nursing at South London and Maudsley NHS Foundation Trust, Professor Brimblecombe has helped develop mental health policy and practice through various senior leadership roles across the NHS, including as director of mental health nursing at the Department of Health.

His PhD focused on crisis and home treatment services and his research interests include violence in mental health care, the history of mental health nursing and he introduction of e-technology

Early in his academic career he wrote an article for Nurse Researcher journal describing how he came to realise that 'stubbornness and resilience' are important characteristics for all nurse researchers.

Tony Butterworth

Tony Butterworth once said that if he had not become a nurse he would have been a farmer. Mental health nursing would have been the poorer if he had.

Professor Butterworth qualified as a mental health nurse in 1965 and rose to become inaugural Queen's Nursing Institute professor of community nursing at the University of Manchester.

He became a national figure in the 1980s due to his groundbreaking work on clinical supervision in nursing and his highly influential contribution to education for people with schizophrenia.He led a government review of mental health nursing in 1994 and was involved in the last review in 2006.

Professor Butterworth has held many senior roles in education and the NHS, including chair of the Council of Deans of Health and director of a research centre at the University of Lincoln, where he is emeritus professor. Awarded a CBE in recognition of his achievements, he is also a fellow of the RCN.

Dame Hilary Chapman

Dame Hilary Chapman is chief nurse at Sheffield Teaching Hospitals NHS Foundation Trust. She has spent her entire working life in the NHS and the vast majority of it in nursing.

Her career began with nurse training at Sheffield's Northern General Hospital, where she later worked as a sister in cardiothoracic care and then in critical care.

She has made important contributions to health policy and system reform, including co-development of the Safer Nursing Care Tool to determine safe nurse staffing levels.

In 2012 she was awarded a CBE for services to nursing and in 2018 was made a dame in the new year's honours list, as well as a fellow of the RCN.

After the awards ceremony at Buckingham Palace, Dame Hilary said: 'I have only been able to achieve the things I have because I have worked with incredible teams throughout my career.'

1954

Sir Richard Doll, who had been studying lung cancer in patients in London hospitals, publishes research linking the disease with smoking.

1958

Polio and diphtheria vaccinations begin, in line with one of the main aims of the NHS – to promote good health.

Teresa Chinn

Nurses exert their influence in many ways and often from a lofty position in the healthcare hierarchy. But Teresa Chinn made her name by using social media to connect and share ideas.

In a recent online post, she wrote: 'The most important reason why I find so much value in blogging and tweeting is the people you meet – it's such a fantastic way in which to surround yourself with the very best of nursing and midwifery.'

Teresa Chinn qualified as a nurse in the 1990s and practised at different levels in various settings. More recently, as an agency nurse, she felt professionally isolated and reached out through social media to connect with other nurses. WeNurses – a weekly Twitter chat covering topics as diverse as protected mealtimes and learning from serious incidents – grew from that experience.

A social media specialist, she received an MBE for services to nursing in 2015.

Dame June Clark

Dame June Clark has always been an activist in that she has sought to promote the nursing profession and to optimise the care nurses deliver.

She trained and worked as a nurse and health visitor, but has also been a manager, author, teacher and political advocate.

She established the school of nursing at Middlesex University and was professor of nursing at Swansea University, where she remains an emeritus professor.

On the international stage, Professor Clark has worked with the International Council of Nurses and the World Health Organization.

As a former president of the RCN she gave much to the college, although in her memoir Nursing: An Exquisite Obsession, published in 2015, she described 'the end of the love affair'. She also acknowledged her debt to the 'hundreds, maybe thousands' of nurses in the UK and beyond.

Trevor Clay

Trevor Clay was a hugely experienced nurse and manager by the time he became RCN general secretary in 1982. Ill health curtailed his tenure but when he left the college after seven years his legacy was secure.

When he was appointed general secretary a staff nurse could expect to earn less than £6,000 a year. Mr Clay was thrust into a pay dispute with the government that ended with an improved offer and establishment of the independent pay review body.

Emphysema, diagnosed when he was 37, left him dependent on oxygen for hours every day. It limited his RCN career and ultimately his life, but having left the college he worked hard to promote nursing nationally and internationally.

An obituary in The Independent after his death in 1994 at the age of 57 quoted a remark he had made two years earlier: 'Life's too short not to take the opportunities it offers.'

Dame Elizabeth Cockayne

Dame Elizabeth Cockayne was chief nursing officer of the NHS from its inception in 1948. An energetic and progressive leader, she was determined to promote nursing at the highest level.

Dame Elizabeth contracted smallpox as a child, an experience that first led her to consider nursing as a career. She trained in Plymouth and Sheffield before taking up numerous roles in many places, including midwifery in Birmingham and matron of the Royal Free Hospital in London for 12 years from 1936.

In 1945 she was appointed to a working party on the recruitment and training of nurses that recommended a move away from the routine, repetitive and often domestic functions that featured heavily in a nurse's workload at the time.

Committed to nurses' well-being and high standards of care, she was chief nursing officer until her retirement in 1958. She died in 1988.

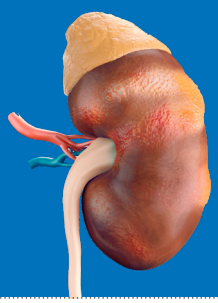
1959

The new Mental Health Act replaces existing legislation on 'lunacy' and brings mental health service provision into the NHS for the first time.

1960

The first UK kidney transplant takes place at Edinburgh Royal Infirmary.

RCN membership is opened up to men.



Yvonne Coghill

Yvonne Coghill is director of implementation for the workforce race equality standard for NHS England. She is passionate about increasing the diversity of the NHS workforce.

She was awarded an OBE for services to healthcare in 2010. In 2013 she was voted one of the top 50 most inspirational nurse leaders, and for two years in a row was among the top 50 black and minority ethnic pioneers. This year she was awarded a CBE and an RCN fellowship.

Ms Coghill's nurse training began at Central Middlesex Hospital in 1977. She went on to qualify in mental health nursing and health visiting, and was later appointed to various operational and leadership roles.

In three years at the Department of Health she held several strategic posts and led the Breaking Through initiative, which supports black and minority ethnic staff to realise their potential and move into leadership roles.

Dame Jessica Corner

Dame Jessica Corner's reputation is founded on her work to improve the care of people with cancer. She was among the first students to graduate with a degree in nursing from London University and went on to specialise in cancer nursing at the Royal Marsden Hospital.

After gaining a PhD at King's College London she became the first nurse to be appointed to a chair at the Institute of Cancer Research.

She is a former chair of the Council of Deans of Health, and is pro-vice chancellor for research and knowledge exchange at the University of Nottingham. In 2015, Professor Corner was elected a fellow of the Academy of Medical Sciences.

Dame Sarah Cowley

Jersey-born Sarah Cowley first came to the public's attention in the 1940s when she was nine weeks old. Her father, a lighthouse keeper, bundled her up in a cot and sent her to stay with an aunt in the UK until her mother recovered from illness. He had to send her unaccompanied on a mail plane, prompting coverage in a local newspaper.

After practising and teaching in Eastbourne, she joined the academic staff of King's College London in 1992, having completed her doctorate. At King's she led a dual health visiting and district nursing programme for five years and was later appointed professor of community practice development

She has been an adviser on needs assessment studies in Brazil, Australia, Japan and New Zealand, and her own research on the subject is known internationally.

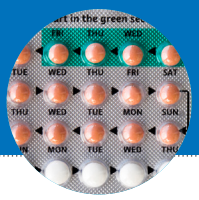
A fellow of the Queen's Nursing Institute and a former chair of the Community Practitioners and Health Visitors Association, she completed a large research workstream at King's to support the government's health visitor implementation plan, published in 2011.

She was made a dame in 2013 for services to health visiting.

1961

Minister of health **Enoch Powell** proposes the closure of large asylums and more local mental health care.

The contraceptive pill is made widely available on the NHS, initially only to married women until the law is relaxed in 1967.



1962

The first full hip replacement is carried out at Wrightington Hospital in Wigan. The surgeon, Professor **John Charnley,** asks his patients if he can remove the replacement joints post mortem to aid research into wear and tear.

Karen Cox

A registered nurse and professor of cancer and palliative care, Karen Cox graduated from King's College London and held a number of clinical posts in oncology and community health.

She completed her PhD at the University of Nottingham and was successively a lecturer, senior lecturer and professor there.

She was appointed deputy vice chancellor at Nottingham in 2013 and in August last year took up a post as vice chancellor of the University of Kent, a hugely significant role.

A reviewer for a number of grant-giving bodies and academic journals, Professor Cox is also a council member of the Nursing and Midwifery Council.

Dame Karlene Davis

The first black female trade union leader, Dame Karlene Davis is a vociferous champion of midwives.

Born in Jamaica, she came to the UK in 1967 and began a remarkable career that would influence the working lives of midwives as well as the care of childbearing women.

She joined the Royal College of Midwives (RCM) in 1994 as deputy general secretary, having made her mark in midwifery education and health services management.

She led the RCM's international collaborations, and served as president of the International Confederation of Midwives and director of the World Health Organization's Collaborating Centre for Midwifery.

She was made a dame for services to midwifery in 2001.

Helene Donnelly

Helene Donnelly blew the whistle and when no one listened she blew it again. She persevered, in the face of hostility, until finally the authorities heeded her concerns and the scandal of poor care at Stafford Hospital was exposed and an investigation began.

Working in the emergency department at the hospital, Ms Donnelly raised more than 100 concerns about patient care. She described a culture of fear and said she suspected similar system failures were common elsewhere in the NHS. But senior colleagues reacted with threats and bullying.

Eventually she would become a key witness in the inquiry into Mid Staffordshire NHS Foundation Trust led by Sir Robert Francis QC, and in 2014 she was awarded an OBE.

The following year Ms Donnelly was appointed ambassador for cultural change at Staffordshire and Stoke-on-Trent Partnership NHS Trust. Interviewed last year by Nursing Standard she was asked what career advice she would have given her younger self. She replied: 'Trust yourself and be true to your values.'

1967

The Salmon report is published, with recommendations about nursing's structure and the status of the profession.

The Abortion Act is introduced and becomes law the following year. It makes abortion legal up to 28 weeks.

1968

The Ministry of Health and the Ministry of Social Security merge to become the Department of Health and Social Security.

Tina Donnelly

Tina Donnelly CBE has been director of the RCN in Wales since 2004. A registered nurse who also trained as a midwife, she completed specialist training in cardiac care, palliative care and clinical teaching.

She has held senior management posts in the NHS in England and Northern Ireland, and senior academic posts in England and Wales. She also completed more than 20 years' service as a reservist in the Army Medical Services, including two tours of Afghanistan.

'I'm in civilian and military life because I want to make things better,' she once said.

As head of the RCN in Wales she has worked on behalf of college members, representing them at the highest levels. She led RCN members and staff in their campaign for safe staffing, and when the Nurse Staffing Levels (Wales) Act was passed in 2016 she said: 'I am delighted to have witnessed this momentous occasion, a truly historic moment for Wales and the UK.'

Zena Edmund-Charles

The father of Zena Edmund-Charles advised her against a nursing career. He suggested teaching or dressmaking instead, she writes on the Queen's Nursing Institute's heritage website. She chose to ignore his advice.

After training as a midwife in Kingston, Jamaica, she moved to England in 1956 to pursue her career.

After a decade in community midwifery she became a district nurse, working 48 hours a week for £10 a month. But she said of those days: 'Everyone concerned was interested in 100% proper care and attention for whoever was in need of help.'

Ms Edmund-Charles, who has an MBE for services to community nursing, featured in a 2016 BBC documentary called Black Nurses: The Women Who Saved the NHS, in which she said: 'All I wanted ever was to be a nurse.'

Judith Ellis

Children and those who care for them have a powerful and long-standing advocate in Judith Ellis, the first nurse to be appointed chief executive of the Royal College of Paediatrics and Child Health (RCPCH).

Formerly dean of the faculty of health and social care at London South Bank University, she worked for three years as a nursing officer at the Department of Health and for eight years as director of nursing and workforce development at Great Ormond Street Hospital in London.

When the RCPCH's State of Child Health report was published last year, Professor Ellis wrote in Nursing Standard: 'Austerity measures that undermine services aimed at improving child health will have a long-term impact on the health of our nation.'

Professor Ellis was awarded an MBE in 1998 for services to paediatrics, a reflection of her tireless work to improve the health of children and young people.

Baroness Audrey Emerton

Dame Audrey Emerton is a crossbench member of the House of Lords and an indefatigable champion of the nursing profession.

Interviewed by Nursing Standard in 2013, she said: 'I wanted to be a nurse from the age of four – and I did not change that view despite several bouts of hospitalisation during my schooling and opposition from my headmistress.'

During a distinguished career that began more than 60 years ago, she has held many leadership posts, including chair of the UK Central Council, and chief commander of St John Ambulance.

Appointed a dame in 1989, she was made a life peer in 1997. In the 1980s she led the programme to close Darenth Park Hospital in Kent, an institution for people with learning disabilities, and find its residents new homes. In 2011 she led nursing opposition to the government's plans to reorganise the NHS in England.

1971

Following a surprise Conservative victory in the general election of 1970, secretary of state for social services **Keith Joseph** publishes a consultative document on reorganising the NHS, with responsibility for planning and spending given to new regional health authorities.

1973

The NHS Reorganisation Act is finally published after years of debate.

Jean Faugier

'Patients are not protected by simple answers or quick and easy fixes,' Jean Faugier once wrote in Nursing Standard. As a highly experienced and knowledgeable practitioner herself, Professor Faugier, now retired, was well-qualified to make such a comment.

Beside the many clinical and leadership issues she covered in her published articles, she also reflected on more abstract concepts such as intimacy in nursing, why managers 'go bad', intuition, and the pursuit of happiness.

As director of the National Nursing Leadership Project, she did much to promote imaginative, dynamic and intelligent leadership. She encouraged nurses to reflect on their role as leaders in creating a modern and flexible workforce, responsive to the needs of patients.

'Leadership affects everyone and is therefore available to everyone,' she once wrote. 'Thus everyone has the potential to be a leader.'

Ainna Fawcett-Henesy

Born in Ireland, Ainna Fawcett-Henesy trained in England and was later appointed to an array of influential roles including primary care adviser at the RCN and regional adviser on nursing and midwifery at the World Health Organization (WHO).

She spent ten years with the WHO in Copenhagen, where her many accomplishments included organising the first European ministerial conference on nursing. Illness intervened in the form of aggressive cancer. Her gruelling treatment left her unable to work and she returned to Ireland 'determined not to give up on life'. She rekindled her love of reading and completed a master's degree in creative writing.

Bob Gates

Everyone in learning disabilities nursing knows of Bob Gates. In a career spanning more than 40 years he has built a reputation as a fierce advocate for an often-marginalised group.

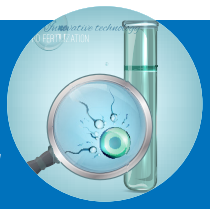
Professor Gates is active in many aspects of the specialty, from academia to the performing arts. He is professor of learning disabilities at the University of West London, emeritus professor at the University of Hertfordshire and visiting professor at the University of Derby. He is also a patron of Friendly Bombs Theatre Company in Slough, which aims to provide theatre activities for people with learning disabilities.

He is a member of numerous editorial boards, and his extensive publication record covers textbooks, peer-reviewed papers, commissioned research reports and commentaries.

Interviewed by Learning Disability Practice journal, Professor Gates said of his chosen profession: 'Learning disabilities appeals to people who want to do new and innovative things. When I was a student you could work in a hospital – that was it. Nowadays there is such breadth and depth. It still excites me today.'

1978

Louise Brown, the world's first test-tube baby, is born, following the introduction of a technique to fertilise an egg outside a woman's body.



The 'winter of discontent' sees widespread strikes across Britain after attempts to introduce a pay freeze to control inflation. The NHS's financial problems worsen.

1980

The Black report on health inequalities highlights differences in mortality between social classes.

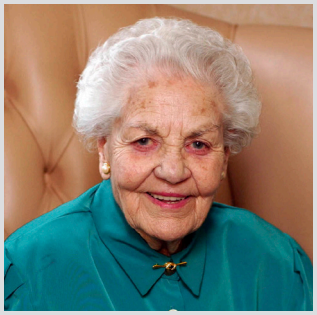
Margaret Graham

Three years ago in the Belfast Telegraph, Margaret Graham recalled life as a nurse at the city's Royal Victoria Hospital during the Troubles in Northern Ireland.

'We were stepping over guns, there were armed guards,' she said. 'But in those times you didn't know any different until peacetime came.'

The experiences of nurses who lived through those dark days were later collated in a book Ms Graham co-edited with Jean Orr, who also appears in this list. Nurses' Voices from the Northern Ireland Troubles contains personal accounts from all grades and disciplines of nursing who tended casualties of three decades of civil unrest with compassion and fortitude.

Ms Graham spent most of her nursing career in public health. She also worked for the Northern Ireland Department of Health, commissioning nurse education, and later became a leading light in the RCN History of Nursing Network.



Mona Grey

Born in 1910, the daughter of missionaries in Rawalpindi in what is now Pakistan, Mona Grey was headmistress of a small school by the age of 18.

She left for England in the 1930s to become a nurse and then a midwife. During the second world war she nursed patients as bombs fell on and around the Royal London Hospital, where she was night superintendent.

In 1946 the RCN asked her to set up a Northern Ireland office, and she became its first salaried secretary. Later she was appointed Northern Ireland's first chief nursing officer.

Dr Grey – she received an honorary doctorate from Ulster University – retired in 1975 but continued to play an active role in promoting the nursing profession.

She was awarded an OBE in 1972 and in 2002 she was the first recipient of the RCN Northern Ireland lifetime achievement award.

She was made an RCN fellow in 2004.

Christine Hancock

General secretary of the RCN from 1989 to 2001, Christine Hancock was described by PR Week magazine in 1997 as 'probably the strongest weapon in the RCN's formidable armoury'.

Ms Hancock began nursing at King's College Hospital, London. After various clinical nursing posts she worked as a midwife and a mental health nurse, and later as a nurse manager and chief executive.

She led the RCN through some turbulent years, when the battle for fair pay and conditions was as intense as it is now.

In 2001 she was elected president of the International Council of Nurses and in 2009 she established C3 Collaborating for Health, a charity with a global vision of preventing chronic disease.

She has said: 'I work to cast light on new and effective ways that enable people to quit smoking tobacco, eat and drink less and better, and be more physically active.'

Mary Hanratty

Mary Hanratty's influence on nursing regulation has been strong.

She was vice-president of the regulatory body, the UK Central Council for Nursing, Midwifery and Health Visiting, when it was superseded by the Nursing and Midwifery Council (NMC) in 2002 and she was elected to the same role in the new organisation.

Professor Hanratty qualified as a state registered nurse at Lurgan Hospital in Northern Ireland, and gained extensive senior management experience in health and social care.

She was appointed a visiting professor at Ulster University in 2002 and won the Outstanding Achievement Award in the RCN Northern Ireland Nurse of the Year Awards in 2006.

In 2003, when she was head of nursing and midwifery education at Beeches Management Centre in Belfast, now the HSC Leadership Centre, she was awarded a CBE for services to nursing.

1981

The new decade has seen continued improvement in babies' health. Twenty years earlier, only 20% of infants born weighing less than 1kg survived. Now the figure is nearer to 80%.

1983

The Griffiths report heralds a new management culture in the NHS. The report says: 'If Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge.'

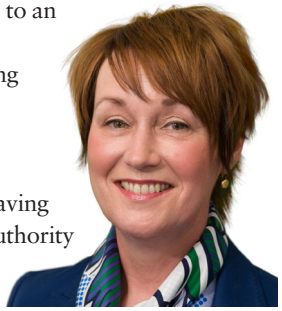
A new Mental Health Act is published in England and Wales, introducing the concept of patient consent.

Ann Holmes

Chief midwifery adviser and associate chief nursing officer for the Scottish Government, Ann Holmes exerts a major influence on the direction of midwifery policy and practice across Scotland.

The first consultant midwife in Scotland, working across NHS Greater Glasgow and Clyde for ten years, she has been an innovative clinical leader throughout her career.

She has led key maternity strategies and various service redesigns. When supervision of midwives was removed from statute, she provided outstanding leadership to guide and steer the Scottish response to an employer-led model.



A member of the Nursing and Midwifery Council's midwifery panel, she has significant experience in professional regulation, having been a local supervising authority midwifery officer for six years.

Debra Humphris

Passionate about equality and diversity, Debra Humphris is an openly LGBT senior leader in higher education. Her career began as a nursing student in Chichester. A master's degree followed, then a PhD at the University of London.

She joined the University of Brighton from London's Imperial College, where she had effected real change in the college's position on teaching and learning. Before that, she held roles, including pro-vice chancellor, at the University of Southampton.

In April this year, Professor Humphris was elected a fellow of the Royal College of Physicians. She said she was 'delighted and humbled' by the award, particularly as it is unusual for a fellowship to be granted to a professional outside medicine.

Nola Ishmael

Nola Ishmael has the rare distinction for a nurse of having her portrait displayed in the National Gallery.

She came to England from Barbados in 1963 to train as a nurse and within 18 months of qualifying was a sister on the neurological unit at the Maudsley Hospital in London.

After training as a health visitor, she became in turn a community manager, an assistant director of nursing and then London's first black and minority ethnic director of nursing.

A six-month post at the Department of Health became a ten-year tenure, working closely with ministers and chief nursing officers.

She set up mentoring and development programmes for NHS staff and collaborated on the establishment of the Mary Seacole Awards, named after a black nurse who became a heroine in Victorian England by helping soldiers during the Crimean War.

Awarded an OBE in 2000, Dr Ishmael has inspired many other black and minority ethnic nurses and has been described as 'one of the all-time BME greats of the NHS'.

In 2016 she was recognised by the Barbados government as one of 50 Barbadians who have contributed significantly to services in the UK.

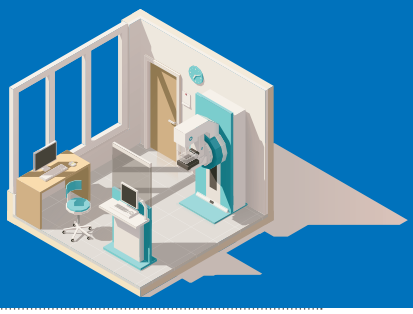
1986

Project 2000 introduces radical changes to pre-registration nursing courses and aims to increase the professional status of nurses. The Cumberlege report on community nursing is published and proposes limited prescribing for nurses.

The world's first heart, lung and liver transplant is carried out at Papworth Hospital in Cambridge.

1988

Breast screening is introduced for women over 50 in an attempt to reduce breast cancer deaths.



Rosemary Kennedy

A leader and mentor for much of her long career, Rosemary Kennedy CBE trained as a nurse in London and has held many senior posts.

Professor Kennedy was appointed chief nursing officer for Wales in 1999 and produced several key nursing strategies, including Free to Lead, Free to Care, which empowered ward sisters and charge nurses to improve the ward environment for patients.

She had a distinguished career in the Territorial Army, gaining a commission in the Queen Alexandra's Royal Army Nursing Corps in 1984. She was appointed colonel commandant of the corps in 2008, the first time the post had been held by a TA officer. She became honorary visiting professor at Cardiff University in 2012.

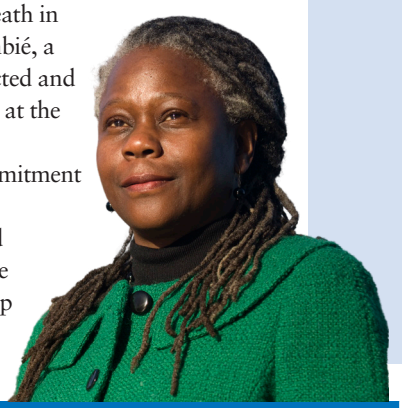
Dame Donna Kinnair

Dame Donna Kinnair is the RCN's director of nursing policy and practice, and took up her post at the college with an impressive range of NHS roles behind her.

Early in her career she was a trainee manager with Marks & Spencer when a consultation with an occupational nurse rekindled her childhood interest in nursing.

Health visiting led to a passion for child protection and to a role as nurse adviser to the inquiry into the death in London of Victoria Climbié, a girl who had been neglected and abused and died in 2000 at the age of eight.

From that grew a commitment to the importance of partnership working and communication to ensure other children did not slip through the net.



Alison Leary

Alison Leary has three degrees, three postgraduate degrees, a background in nursing, natural sciences and medicine – and is clinical lead for match day medical services at Millwall Football Club in south east London.

Professor Leary is recognised as a role model and leader, and the accolades she has garnered are numerous – her fellowships, for example, include the RCN, the Queen's Nursing Institute and the Royal Society of Medicine.

She has had a remarkable career trajectory. Currently chair of healthcare and workforce modelling at London South Bank University, she qualified as a nurse in 1996 after ten years in science and engineering. She holds a master's in biomedical sciences and a PhD in clinical medicine.

On becoming an RCN fellow in 2015 she said: 'One of the things I love about my current work is learning about the wonderful and innovative things nurses are doing.

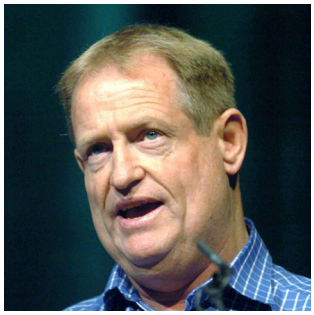
Nurses are such a creative group of people and I feel it's an honour to help them show the value of their work and benefits to patients and families.'

1990

The NHS and Community Care Act introduces an 'internal market' in healthcare.

1991

The Patient's Charter outlines what people should expect of NHS care and treatment.



Paul Lewis

Male midwives are a rarity today but when Paul Lewis qualified nearly 40 years ago they were so unusual he would sign job applications 'P Lewis' rather than 'Paul Lewis'. When he arrived for one interview, he told the BBC last year, the panel, expecting a 'Miss Lewis' had 'freaked'. He was offered a job but in neo-natal intensive care, not maternity.

Since those pioneering days, Professor Lewis has built an illustrious career, making an outstanding contribution to the profession and to the care and support of women.

He went on to become professor of midwifery at Bournemouth University, and along the way held numerous influential posts, including vice chair of the governing council of the Royal College of Midwives.

Awarded an OBE in 2015, Professor Lewis has worked internationally and across professional boundaries, highlighting midwives' unique contribution to mothers and communities.

Dame Jill Macleod Clark

Dame Jill Macleod Clark agreed to lead the development of the Nursing and Midwifery Council's new education standards because 'it's not much good complaining about things if you are not prepared to improve the situation'. It was 'probably a once in a lifetime opportunity for the profession to recalibrate itself,' she told Nursing Standard earlier this year. The new standards focus on outcomes rather than process.

Professor Macleod Clark trained at University College Hospital in London and completed a doctorate on nurse-patient communication at King's College London. The scale of her impact on nursing, education and research is evident in her long CV.

There are the leadership and advisory roles – she is a former chair of the UK Council of Deans of Health – contributions to key policy initiatives such as embedding undergraduate nursing education in universities, coaching and mentoring work, and trustee roles with a number of charities supporting people with health challenges.

Her publications list on the University of Southampton website, where she is emeritus professor of nursing and former head of the health faculty, is extensive, varied and international.

She was made a dame in 2000 for services to nursing education. She has said: 'The key to providing the very best care to patients and their families lies in ensuring that every aspect of nursing practice is underpinned by robust research evidence.'

Kim Manley

Kim Manley is an expert in practice development, with an international reputation for the development of effective workplace cultures that put patients at the centre of care.

Her work is not 'ivory tower research', she has said. Rather, it's 'swampy lowlands research', striving to define the conditions that enable people to thrive.

With long experience as a practitioner, educator, developer and nurse training programme director, she is currently associate director of the England Centre for Practice Development at Canterbury Christ Church University.

She has published extensively, from books to journal articles and has served as an examiner of PhD theses all over the world.

The centre's director, Carrie Jackson, describes Professor Manley as 'a true icon'.

1992

The Health of the Nation, a government white paper, identifies areas for improvement in health, including cancer, coronary heart disease and mental health.

1994

The NHS Organ Donor Register is set up.

Tanya McCance

For two decades, the focus of Tanya McCance's research has been person-centred care, and the theoretical framework that developed out of her work has become an internationally recognised model for nursing.

'The framework shines a light on practice and moves person-centredness from a policy position to a standard achievable across healthcare settings,' she told Nursing Older People journal in 2017.

She was being interviewed after winning the outstanding achievement category in last year's RCN Northern Ireland Nurse of the Year Awards for her exceptional contribution to nursing research.

Professor McCance is research director of the Institute of Nursing and Health Research at Ulster University. A registered nurse since 1990, she studied for a nursing degree at a time when graduate programmes were still uncommon pathways into the profession.

'Never lose sight of people as individuals,' she advised new nurses in her interview with Nursing Older People. 'Be curious about them, listen to their stories. Don't be afraid to ask them important questions and always show them compassion.'

Baroness Jean McFarlane

Jean McFarlane was born in Cardiff in 1926 and while studying chemistry in London worked at a mission for homeless people – an experience that would leave a lasting impression.

Later, as a nurse, midwife, health visitor and tutor, she was appointed RCN director of education but soon afterwards joined the staff at Manchester University.

Under her leadership, the university's department of nursing was established in 1973. She became England's first professor of nursing and developed a nursing degree course.

The first ever recipient of an RCN fellowship, she was awarded a life peerage in 1979, becoming the first nurse peer.

Guided always by her strong faith, she served for several years as a member of the general synod, the national assembly of the Church of England. Baroness McFarlane died in 2012.

1997

Labour wins power and publishes a white paper titled The New NHS: Modern, Dependable.

1998

NHS Direct is launched, heralding the start of a drive to provide alternatives to traditional GP services. At its peak, NHS Direct will handle 500,000 calls a month.

The Acheson report, published by the Department of Health, highlights continuing inequalities in health by socioeconomic and ethnic groups and gender.

Hugh McKenna

As Ulster University's dean of medical school development, Professor Hugh McKenna has more than 250 publications to his name, including 11 books. His published work has been cited more than 10,000 times, and he has secured more than £4 million in research grants. His research interests include mental health care and interdisciplinary research.

He has received a host of awards, including fellowships of the RCN, the European Academy of Nursing and the Royal College of Surgeons in Ireland, an RCN lifetime achievement award and an honorary degree from Edinburgh Napier University. He was awarded a CBE in 2008 for services to healthcare and to the community in Northern Ireland.

In 2009 he was made an international fellow of the American Academy of Nursing – only the third person in Europe to be given the honour and the 15th worldwide.

Michelle McLoughlin

Michelle McLoughlin chose nursing for several reasons, but mainly because of her grandfather. She was 14 and he was dying, being cared for at home by his family. 'I wanted to help but did not know how,' she told Nursing Children and Young People journal earlier this year. 'This made me want to learn what to do.'

Now chief nurse at Birmingham Women's and Children's NHS Foundation Trust, she combines her extensive clinical and leadership skills to ensure the trust focuses on the needs of patients and families.

She first joined Birmingham Children's Hospital in 1991 as a specialist liaison nurse and became chief nurse after the hospital gained foundation trust status in 2007.

Asked by Nursing Children and Young People what she enjoys most about nursing, she said: 'Working with and helping children and young people. Their bravery and tenacity never ceases to amaze me.'

Donna Mead

After a 40-year career in nursing, education and research, Donna Mead is still ready for new challenges. Earlier this year she was appointed chair of Velindre NHS Trust in Cardiff.

Professor Mead's achievements since she began training at Merthyr school of nursing include writing and delivering the first undergraduate nursing degree programme at Swansea University, obtaining funding to develop a master's degree in disaster nursing, professor of nursing at the University of Glamorgan, an OBE in 2009 and writing an RCN Wales strategy on the future of nurse education, published in 2016.

In an article in Nurse Researcher journal she once explained how apparently insoluble patient problems fired her interest in nursing research.

'I approach each research question with an open mind about how to go about investigating it,' she wrote.

Heather Monteverde

Heather Monteverde MBE has described herself as an 'accidental nurse'. Although her mother was a Marie Curie nurse and an inspiring role model, as a child Ms Monteverde had intended to read English at university. But in her last year at school she changed her mind.

'I really don't know why,' she told the Belfast Telegraph earlier this year. 'But one day I just knew it was the right thing to do.'

The eldest of six children and raised on the family farm, she trained in general and children's nursing. She described how that training shaped her career: 'I remember vividly a man dying of cancer when I was a student nurse and thinking there has to be some better care than this.'

She had found her niche and went on to specialise in oncology, becoming Northern Ireland's first specialist breast care nurse and eventually head of services for Macmillan Cancer Support in Northern Ireland.

1999

The National Service Framework for Mental Health is published with the aim of ensuring higher levels of competence and good practice among professionals.

2000

NHS walk-in centres are introduced.

The NHS Plan, the biggest change to healthcare in England since the founding of the NHS, sets out a programme of major investment and reform.

Pippa Nightingale

Pippa Nightingale's first post when she joined the NHS in 1994 was as a maternity support worker.

Four years later she qualified as a midwife and then worked in clinical practice for ten years.

After earning a master's degree taking a clinical academic role at the University of Hertfordshire she moved back into the acute sector, first as a matron and later as a consultant midwife.

She has undertaken numerous professional leadership roles, including large-scale, complex service re-organisations. She led the transition of maternity services in north west London and ensured safe care was provided to more than 33,000 women by standardising midwifery services across six acute providers.

After 18 months as director of midwifery and clinical director at Chelsea and Westminster Hospital NHS Foundation Trust, she was appointed the trust's chief nurse last year.

Doreen Norton

Doreen Norton devoted herself to the care of older people, in particular the management and prevention of pressure ulcers.

Ms Norton built an international reputation based on a simple premise: reduce the risk of pressure ulcers by removing the pressure. She showed that regularly moving or turning a patient was more effective than anything tried before.

The book that resulted from her research, An Investigation of Geriatric Nursing Problems in Hospital, published in 1962, established her pressure sore scale as an invaluable aid to care. Later, as a nursing research officer, she helped develop the so-called King's Fund bed, designed to maximise patient comfort, nurse efficiency and cost-effectiveness.

Ms Norton was in 1976 one of the first recipients of an RCN fellowship, and in the following year she was awarded an OBE.

Jean Orr

When Jean Orr was awarded a CBE in 2004 she said such honours were usually regarded as a reward for the individual, but she considered hers as much a tribute to colleagues in the school of nursing and midwifery at Queen's University Belfast as recognition of her own achievements.

Yet it was Professor Orr who founded the school and who worked tirelessly to ensure that nursing and midwifery were integrated into university life there. Among her contributions to the profession is Nurses' Voices from the Northern Ireland Troubles, an extraordinary book she co-edited with Margaret Graham, who also appears in this list. Published in 2013, it revealed the unimaginable horror faced by Northern Ireland's nurses over three decades of violence, and captured brilliantly the human aspect of nursing.

Last year saw the inaugural Professor Jean Orr lecture at Queen's to recognise women in leadership.

Lesley Page

Lesley Page has an international reputation as an academic, advocate and activist for midwives, mothers and babies.

The UK's first professor of midwifery, she has had a long and distinguished career in clinical practice, management, academia and policy work.

Professor Page is a former president of the Royal College of Midwives (RCM) and was involved in the landmark 1993 report Changing Childbirth, which advocated that 'the power should be with a woman and her family'.

Interviewed by New Statesman magazine last year when she stood down as RCM president, she said there should be a single primary carer for each pregnant woman. 'I would like to see every woman have the possibility of a midwife she can get to know over time,' she said. 'I would like midwives to know the joy of birth, not just the fear.'

Midwifery, she added, is 'the most meaningful work you can imagine doing'.

2002

The first successful gene therapy is carried out at Great Ormond Street Hospital in London, curing 18-month-old 'bubble boy' Rhys Evans of severe combined immunodeficiency. Rhys spent months in a sterile 'bubble' at the hospital.

2003

In June, the NHS Agenda for Change pay system is introduced at 12 test sites in England.

Susan Pembrey

Sue Pembrey was an outstanding nurse leader who promoted the academic development of clinical nursing, patient-centred care and the leadership role of ward sisters.

A product of the Nightingale school of nursing at St Thomas' Hospital in London, she later returned to the hospital as ward sister, implementing a system in which nurses are responsible for small groups of patients. She explored this approach for her PhD thesis, later published by the RCN as The Ward Sister: Key to Nursing.

The nursing development unit at the Radcliffe Infirmary in Oxford encouraged nurses to practise in innovative, patient-centred ways. She secured funding to establish the city's Institute of Nursing, which developed these models further.

Dr Pembrey was appointed a fellow of the RCN in 1979 and awarded an OBE in 1990. Her death in 2013 at the age of 71 was mourned by many who had known her as a friend, colleague, mentor and inspiration.

Graham Pink

For those who have come more recently to nursing, the name of Graham Pink may not resonate. But for a while in the early 1990s he was among the best-known nurses in Britain.

Mr Pink worked as a charge nurse at Stepping Hill Hospital in Stockport, caring for older people, and he became increasingly concerned about standards of care.

When the letters he wrote to managers failed to effect change, he went public. The Guardian published extracts from a dossier he had compiled and almost overnight he became famous. His bosses deemed that he had breached confidentiality and he was sacked. The case was settled shortly before an employment tribunal and he received compensation.

Mr Pink considered himself a 'truth-teller' rather than a whistleblower, the Guardian said, and he never sought the limelight. But his actions led eventually to greater protection for the truth-tellers who succeeded him.

Anne Marie Rafferty

Among the best-known of contemporary nurse researchers, Anne Marie Rafferty is professor of nursing policy at King's College London and a former dean of its Florence Nightingale school of nursing and midwifery.

She holds a doctorate in modern history as well as a degree in nursing studies and a master's in clinical research. She won a fellowship to study at the University of Pennsylvania in the US, where she worked on the role of nursing in the Clinton administration's healthcare reform agenda.

Professor Rafferty holds fellowships from the RCN and the American Academy of Nursing, and was awarded a CBE in 2008.

Her research has shown how nurses can make a profound difference to patients and their recovery. In 2014 she told the Guardian: 'We need to stop treating nurses as a soft target in times of austerity, as there is so much potential to be unlocked in the nursing workforce.'

Dame Kathleen Raven

'Her diminutive size belied the force of her character,' said the Guardian's obituary of Dame Kathleen Raven following her death in 1999.

'A sharp brain, wit and insatiable appetite for hard work made her a power in the hospital ward and corridors of Whitehall.'

Born in 1910 in the Lake District and growing up with three brothers, she went into nurse training at St Bartholomew's Hospital in London, qualifying in 1936. She rose through the ranks at Bart's and in 1949 was appointed assistant matron at Leeds General Infirmary.

A member of the RCN's ruling council, she moved to the Ministry of Health in the late 1950s, first as deputy then as chief nursing officer, where her achievements included establishing the right of matrons to attend hospital management meetings.

Shortly before her death she endowed the Kathleen Raven chair of clinical nursing at Leeds University, which still continues.

2004

The first ten NHS foundation trusts are established, with greater control over their own budgets and services.

2005

The four-hour target for Accident and Emergency departments becomes operational.

Mary Renfrew

The Royal Society of Edinburgh, Scotland's national academy of science and letters, has only ever elected one fellow from a nursing or midwifery background: Mary Renfrew, professor of mother and infant health at the University of Dundee.

Professor Renfrew is a leading health researcher and midwife. Her research over 30 years into maternity care and infant feeding has informed and shaped policy and practice across the UK and internationally.

After gaining a degree in social sciences and nursing at the University of Edinburgh and a PhD at the city's MRC Reproductive Biology Unit, she went on to work at the universities of Oxford, Leeds and York, as well as Alberta in Canada, where she founded the Alberta Association of Midwives in the 1980s.

A study she co-authored last year highlighted the ongoing societal barriers that make it difficult for women to breastfeed.

Elizabeth Robb

In May 2015 Elizabeth Robb received a letter marked 'Private and Confidential (On Her Majesty's Service)'. Her first thought, in 'typical nurse fashion', was to assume she had made some 'enormous transgression'.

When the truth dawned – she was being awarded an OBE – she felt 'overwhelmed with pride, humbled to have been chosen'.

She realised 'this was all about the patients I had nursed… the marvellous organisations I had worked in and the people there'.

A nurse, midwife and academic, Professor Robb spent seven successful years at the Florence Nightingale Foundation before stepping down in 2017.

Among her many achievements was a substantial increase in the number and diversity of the foundation's leadership scholars, who receive bespoke training in the skills needed to represent nursing at the highest levels.

Ray Rowden

Ray Rowden was a one-off: colourful, iconoclastic and influential, he was often a thorn in the side of the establishment and one of the first openly gay nurse leaders.

He was appointed to many influential positions during his career, always driven by a zeal to improve care and treatment.

He was making waves from the outset of his mental health nursing training at St Augustine's Hospital in Kent, where he became a whistle-blower and helped expose poor standards of care.

He trained as a general nurse, too, and held many senior posts, including director of nursing at the Royal Marsden Hospital in Surrey and director of high secure services for the Department of Health.

When he died of pancreatitis in 2014, at the age of 62, Nursing Standard described him as charismatic and a consummate networker who was 'always ambitious for his patients'.

Juanita Rule

Juanita Rule was said to be 'fundamentally nonconformist' and found the RCN old-fashioned and 'relentlessly female' when she joined the staff in 1948.

But when she returned there in 1971 as director of the RCN Institute of Advanced Nursing Education, her strong views on education cemented her reputation as an innovator.

She later trained as a teacher of nursing because she felt it would make her a better ward sister, and in 1959 won a World Health Organization scholarship to investigate the development of nursing degree courses in the US and Canada.

Her position at the Institute of Advanced Nursing Education allowed her the resources to investigate her concerns that government opposition to nursing degrees was founded on cost rather than patient welfare.

She was awarded an OBE in 1976 and was elected RCN deputy president the same year. She died in 2008 aged 93.

2007

NHS Choices website is launched.

Smoking is banned in workplaces, pubs, restaurants and other public places.

2008

Local events across the country mark the 60th anniversary of the NHS.

The Improving Access to Psychological Therapies programme begins, allowing easier access to talking therapies on the NHS for people with anxiety and depression.

Jane Salvage

'Jane Salvage is a hugely influential nurse leader who has contributed to advancing nursing in a wide number of roles throughout her career.' So read the citation when Professor Salvage was awarded an honorary doctorate in 2011 by Kingston University and St George's, University of London.

A nurse since the late 1970s whose first degree was in English literature, Professor Salvage has a long track record as a respected adviser, consultant, writer, leader and policy activist.

She has held senior positions with the World Health Organization, the King's Fund think tank and in publishing. Her 1985 book, The Politics of Nursing, resonates to this day.

Susan Semple

Seventy years on from the birth of the NHS, Susan Semple's work with homeless people in Belfast reflects its founding principles. Indeed, four years ago she won the Bevan Prize for Health and Wellbeing, named after the founding father of the health service, Aneurin Bevan.

As a healthcare coordinator based at Belfast Health and Social Care Trust, Ms Semple led a project that sought to provide evidence-based care for the city's diverse homeless population.

The organisers of the Bevan Prize noted that she had managed to get 98% of the people using the service registered with family doctors.

The Bevan Prize is one of several awards that Ms Semple has won during a nursing career that began in the 1970s. In 2011 she was recognised by the RCN in Northern Ireland for outstanding achievements in nursing. The following year she was awarded an MBE for services to healthcare in Northern Ireland.

Dame Eileen Sills

In a film put on YouTube by Guy's and St Thomas' NHS Foundation Trust, its chief nurse Dame Eileen Sills says: 'You can't go far wrong by choosing to come and work at Guy's and St Thomas.'

With its long history and record of medical breakthroughs, the London trust is attractive to many nurses. And those who go there will witness for themselves Dame Eileen's transformational leadership.

Appointed chief nurse at the trust in 2005, she has become known for strong, visible management. Clinical Fridays, her initiative to take senior nurses back to the bedside, has gained a national reputation.

She was the driving force behind the award-winning Barbara's Story, a film to raise staff awareness of dementia.

The trust's central London location means she and her staff have had to cope with major incidents in the capital.

After the 2017 Westminster terrorist attack, yards from St Thomas', which left six people including the attacker dead and 50 injured, Dame Eileen told Nursing Standard: 'You can't help but be completely humbled by our staff in terms of responding in the way they did.'

2009

The NHS Constitution sets outs rights and responsibilities for patients and staff.

The Care Quality Commission is established to better regulate health and social care.

2010

The first landmark report of the independent Francis inquiry into care failings at Mid-Staffordshire NHS Foundation Trust is published. It highlights nursing shortages and a bullying culture at Stafford Hospital.

David Sines

David Sines has been influential in nursing circles for decades. He was awarded a fellowship of the RCN in 1989 for pioneering work in advancing the art and science of nursing and community care.

He has held four secretary of state appointments with the former regulatory body, the UK Central Council for Nursing, Midwifery and Health Visiting, and with its successor, the Nursing and Midwifery Council. He has been a governor of three London trusts, was executive dean of the health faculty at London South Bank University and head of the school of health sciences at the University of Ulster.

He is a former pro-vice chancellor and executive dean of Buckinghamshire New University, where he was appointed emeritus professor in 2014.

Professor Sines was awarded a CBE in 2010 for services to healthcare.

Helen Singh

In a newspaper interview in 2016, Colonel Helen Singh described the reality of being an army reservist deployed to Camp Bastion in Afghanistan at the height of the conflict, when she was matron of 205 (Scottish) Field Hospital of the Royal Army Medical Corps.

'Although we trained very hard and were prepared for the type of injuries we would have to treat, the number of casualties and the magnitude of their multiple wounds was still shocking,' she recalled.

'We had a lot of very bad days but we got very good at dealing with what arose.'

So good in fact that she became the first female commanding officer of 205 Field Hospital and was recognised with an MBE in 2011.

Currently an advanced critical care nurse practitioner at NHS Lothian, Colonel Singh once told a parliamentary reception that joining the army reserves, deploying on operations and nursing soldiers had been the highlight of her career, saying: 'It was an absolute privilege to treat them.'

Colonel Wendy Spencer

'When the chips are down, someone has to make difficult decisions,' Colonel Wendy Spencer told Nursing Standard in 2011 on the eve of her retirement. And often she was the one to do it.

As director of army nursing services, in charge of about 1,000 nurses and healthcare assistants, Colonel Spencer had an illustrious military career, serving with distinction all over the world.

Commissioned into the army after nurse training in Bristol, she first saw front-line action in the Gulf war in 1990, running a high-dependency unit.

In 1996, she was decorated for exceptional service after the bombing of the army's headquarters in Northern Ireland, where she served as matron.

After a posting to South Africa and gaining a master's degree in disaster healthcare, she undertook a placement with a health charity in Sierra Leone, west Africa.

2012

Publication of the Health and Social Care Act proposing NHS reorganisation. During its passage through parliament, the draft legislation has met with opposition, leading prime minister David Cameron to announce a 'listening exercise'.

The opening ceremony of the London Olympic Games pays tribute to the NHS. More than 600 nurses and other healthcare workers take part.

2013

The second report of the Francis inquiry is published. The public inquiry identifies wider failings in the healthcare system, which contributed to poor care at Stafford Hospital.

The NHS Friends and Family Test allows patients to give feedback on the care they are given.

Barbara Stilwell

Nurse, teacher, researcher and influencer, Barbara Stilwell was instrumental in establishing nurse practitioners in the UK.

The concept of autonomous practitioners who could assess, treat and refer or discharge was inspired by her experiences as a health visitor in inner-city Birmingham, often working with women who wanted to discuss sensitive issues such as screening or family planning.

She established a clinical trial and wrote it up for a nursing journal. As a consequence, she was offered a scholarship to study on a nurse practitioner programme in the US state of North Carolina.

Her work since then has taken her all over the world, but it was those early experiences in Birmingham that proved the game changer.

Alison Tierney

Planning and managing a research project, Alison Tierney once wrote in Nurse Researcher journal, requires a range of intellectual and practical skills. But her top tip for those seeking to follow in her footsteps was simply this: when in doubt, ask.

'It it is the very thing I do more of, the more research I carry out,' she said.

Professor Tierney's name is familiar to countless nurses whose practice has been shaped by the nursing model that bears her name.

She and colleagues Nancy Roper and Winifred Logan were inspired by the work of US pioneering nurse and theorist Virginia Henderson, and the model they developed became hugely influential in the UK and beyond.

But there have been many other accomplishments in Professor Tierney's career, including ten years as director of Edinburgh University's nursing research unit.

When she stood down as editor-in-chief of the Journal of Advanced Nursing in 2011, she reflected on the marked improvement she had witnessed in the quality of research reporting over the previous decade.

Her strong leadership in international research undoubtedly contributed to that.

Judy Waterlow

Judy Waterlow was working as a clinical nurse teacher when she began developing the pressure ulcer risk assessment tool, the Waterlow tool, that was to become the most widely known method of risk assessment and prevention of pressure ulcers.

Ms Waterlow officially retired on medical grounds in 1998 because of rheumatoid arthritis but she continued to work towards improved patient care and nurse education.

For 13 years she served on the committee of the Tissue Viability Society.

She also worked on the NHS programme Challenging Arthritis, which teaches patient self-management, and with Musgrove Partners, an award-winning group of volunteers at Musgrove Park Hospital in Taunton.

Her dedication to the nursing profession was recognised in 2008 when she was awarded an MBE.

2014

NHS 111 free helpline is launched, allowing people to access healthcare when they need medical help fast.

The NHS Five Year Forward View is published, setting out 'a vision of a better NHS'.

2016

The RCN celebrates its centenary.

Royal College of Nursing

Baroness Mary Watkins

In an interview with Nursing Standard in April 2018, Baroness Mary Watkins revealed her concern that younger people were becoming disillusioned with an NHS that seemed under chronic strain. 'We have to fund the NHS better so that society keeps on wanting it. And that will also make working in the NHS more attractive again.'

Her career dates back to 1976, when she qualified as a general nurse from Wolfson School of Nursing at Westminster Hospital. She went on to train in mental health and held posts in community, inpatient mental health and acute settings.

After working as a clinical teacher she studied for a doctorate at King's College London and was later appointed dean of the then faculty of health and social work at the University of Plymouth. She was appointed deputy vice-chancellor of the university in 2007.

Widely published in nursing education and leadership, she has represented nursing on several Department of Health working parties and is a leader of the Nursing Now campaign, which aims to strengthen nurses' role globally.

Professor Watkins joined the House of Lords in 2015 as a crossbench peer. Her position gives her 'influence not power' but that influence does make a difference, she told Nursing Standard. She was 'thrilled' that her efforts helped to secure up to 500 new district nursing training places.

Dame Katherine Watt

A butcher's daughter from Glasgow born in 1886, Katherine Christie Watt trained in general nursing in Glasgow and midwifery in London before being posted to a field hospital in Flanders in the first world war.

She served as matron-in-chief in the Air Ministry until 1938, when she moved to the civil service, remaining there for the rest of her working life. As chief nursing officer from 1941 to 1948 she was involved in plans for the nascent National Health Service. Later, she became chief nursing adviser, travelling as the government's representative to Commonwealth countries, advising them on the role of nursing in the NHS.

The first nurse to be given a permanent post in the civil service, she received many honours and was made a dame in 1945.

Jennifer Worth

When Call the Midwife was first screened in 2012 it was the most successful drama series on BBC1 for ten years. The series is based on the memoirs of Jennifer Worth, who described her experiences practising in the poverty-stricken East End of London during the 1950s.

Born in 1935, she trained first as a nurse at the Royal Berkshire Hospital in Reading then as a midwife, and lived with a community of nuns who worked with impoverished families in the Whitechapel district of east London. She was also an accomplished musician.

When she died in 2011, one obituary said: 'Worth's powers of description, authenticity of detail and richness of characterisation evoke from the start an unforgettable milieu.'

2018

Prime minister Theresa May announces the NHS budget for England will increase by 3.4% year over the next five years, meaning it will be £20bn higher than it is now by 2023. Work begins on a 10-year plan covering productivity and staffing and key areas such as mental health and cancer.

The NHS turns 70.

NHS 70

Meet the judges

Hilary Garratt (chair), director of nursing and deputy chief nursing officer, NHS England

Jane Cummings, chief nursing officer, England, and executive director, NHS England

Katerina Kolyva, executive director, Council of Deans of Health

Charlotte McArdle, chief nursing officer, Department of Health, Northern Ireland

Fiona McQueen, chief nursing officer, The Scottish Government

Graham Scott, editorial director, RCNi

Jean White, chief nursing officer and nurse director, NHS Wales

Paul Labourne, nursing officer, NHS Wales

Carmel Lloyd, head of education and learning, Royal College of Midwives

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Nuffield Trust
Nurse Researcher
Nursing Children and Young People
Nursing Management
Nursing and Midwifery Council
Nursing Older People
Nursing Standard
Oxford Dictionary of National Biography
PR Week
Queen's Nursing Institute
RCN Bulletin
Royal College of Midwives
Royal College of Nursing
Royal College of Paediatrics and Child Health
The Guardian
The Independent
The Scotsman
The Times
Twitter
Royal Society of Edinburgh
Scottish Government
YouTube
Wikipedia
World Health Organization
www.parliament.uk

Subjects' employing trust, health board, charity and university websites
Subjects' personal websites

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REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**3 AUGUST 2018**
SUBJECT:	**TASK AND FINISH GROUP – CONSTITUTION REVIEW AND GOVERNOR ROLE DOCUMENT**
REPORT FROM:	**TRUST SECRETARY** **ALISON FOX**
PURPOSE:	**APPROVAL**

BACKGROUND AND EXECUTIVE SUMMARY

This report updates the Council on the work of the Task and Finish group set up to review the Trust's Constitution and consider whether the Code of Conduct and the Role of the Governor documents should be combined within the constitution.

LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.

RECOMMENDATIONS AND ACTION REQUIRED:

The Council is asked to:

a) agree the proposed changes to the Constitution; and
b) note the plans to replace the Roles of a Governor document with a Council Responsibilities Pack and a revised Code of Conduct.

Background

At the Joint Governor and NED meeting on 15 February it was requested that consideration be given to whether the following documents should be combined:

- Trust Constitution
- Code of Conduct
- Role of a Governor.

This question arose as a result of the amount of overlap identified between these documents during the discussion on setting up the task and finish group. It is also recognised that the purpose of the Role of a Governor document is to assist the Council to understand its role; the complexity of the document does not support this purpose.

A draft terms of reference (Annex A) and scoping paper (Annex B) were circulated to the group in preparation for a meeting to be held on 24 June. A formal meeting did not take place due to constraints of time, however the group agreed that the course of action laid out in the scoping paper was appropriate and that the group would meet formally on 11 July 2018.

Position Update

The Task and Finish group agreed that the terms of reference would best be met by following two work streams.

Work stream A – Constitutional Changes

Agree the changes to be proposed to Council at the 11 July meeting, take these to the Council meeting on 3 August. The Council approved changes would then be taken to the Board meeting on 10 August for approval. These can then be taken to the Annual Members' meeting on 10 September.

The changes being proposed by the Task and Finish Group are listed below.

Work stream B – Council Responsibilities Document

The Task and Finish group looked at a proposal for the content of the Council Responsibilities pack – Annex C. They considered that would provide a useful induction and reference document for Council. In developing the document various policies relating to the Council's work would be reviewed and revised or updated.

It was agreed that a first draft of the full document would be produced by the Governor and Membership Lead for consideration at a meeting of the Task and Finish Group in October. A final draft would be completed in time for an item to go to the Council meeting on 6 November to approve the document. The final draft would include a proposal for a revised Code of Conduct cross referenced to the Council Responsibilities Pack.

Changes proposed to the Trust's Constitution

A. Page 21 section 49.3 under Mergers etc and significant transactions

Diagram 1, Significant transaction frame work (below) to be replaced with the wording:
'A significant transaction is one which is deemed to be a significant transaction by NHS Improvements.'

Ratio	Description	Reporting requirements: Non-healthcare/ International	Reporting requirements: UK Healthcare
Assets	The gross assets* subject to the Transaction, divided by the gross assets of the foundation trust	> 5%	> 10%
Income	The income attributable to: • the assets; or • the contract associated with the Transaction, divided by the income of the foundation trust	> 5%	> 10%
Consideration to total foundation trust capital	The gross capital** or consideration associated with the Transaction divided by the total capital*** of the foundation trust following completion, or the effects on the total capital of the foundation trust resulting from a Transaction	> 5%	> 10%

* Gross assets is the total of fixed assets and current assets
** Gross capital equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets
*** Total capital of the foundation trust equals taxpayers' equity

B. Page 26 Composition of Council.

Replacing Thanet District Council with Folkestone and Hythe District Council following the formal renaming of the district council.

C. Page 81 Annex 7 2.1 Composition of the Council

It is proposed that the following paragraph:

> If a Governor resigns from office as Lead Governor then the Council of Governors shall thereupon elect another Governor as the Lead Governor without delay. Any such Governor shall serve as the Lead Governor for one year from the date at which he/she is elected by the Council of Governors.

be changed to:

> If a Governor resigns from office as Lead Governor, or dies in service, then the Council of Governors shall thereupon elect another Governor as the Lead Governor without delay. Any such Governor shall complete the term of office of the lead Governor they suceeed.

This will ensure that the election of the Lead Governor stays within the same timeframe as the Governor elections.

D. Page 82 Annex 7 section 3.1 Calling meetings

The section currently reads:

> The Chairman may call meetings of the Council of Governors. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of governors including at least two elected and two appointed governors, has been presented to him/her, or if, without so refusing, the Chairman does not call a meeting within 14 days after such requisition has been presented to him/her, at the Trust's Headquarters, such one third or more governors may forthwith call a meeting of the Board.

It is proposed that the number of appointed governors be reduced to 'at least one' given that the size of the Council has been reduced from 26 to 19 and there are now only 3 appointed governors.

E. Page 87 Annex 7 section 3.12 Virtual voting

The section:

> In the event that a decision is required ahead of the next Council of Governors meeting a virtual vote will be proposed. The vote will be passed if 65% of Governors vote for the motion and at least 50% of the elected and appointed Governors has voted. The decision will be ratified at the next public Council of Governors meeting.

To be changed to

> In the event that a decision is required ahead of the next Council of Governors meeting a virtual vote will be proposed. The vote will be passed if 65% of Governors vote for the motion and at least 70% of all governors able to vote. The decision will be ratified at the next public Council of Governors meeting.

F. page 97 Appendix 1 to Council of Governors Standing Orders

The index provides links to internal and external documents relevant to the Council of Governors. It is proposed to delete this appendix as the information contained in

the index will be included in the Council Responsibilities Pack – which can more easily be kept up to date.

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 AUGUST 2018**
SUBJECT:	**CHIEF EXECUTIVE'S REPORT**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**ASSISTANT TRUST SECRETARY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: LATEST PUBICATIONS**

BACKGROUND AND EXECUTIVE SUMMARY

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

This month's report covers the following:

- Emergency Department (ED) Improvement
- Care Quality Commission (CQC) Unannounced Visit
- Financial Special Measures (FSM)
- East Kent Medical Services (EKMS)
- We are the NHS Recruitment Campaign
- Retained Accreditation for Haematology, Blood transfusion and Phlebotomy Services
- Listening Into Action
- Trust Seal Activity
- Making A Difference
- Latest Publications and Policy Developments of Note

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risks around ED, Financial Recovery are covered in more detail elsewhere on the Board agenda.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	ED, Financial Recovery, clinical strategy all link to the strategic risk register.
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Executive Management Team have reviewed the Board Governance Review Action Plan

PRIVACY IMPACT ASSESSMENT: *NO*	**EQUALITY IMPACT ASSESSMENT:** *NO*

RECOMMENDATIONS AND ACTION REQUIRED:

To discuss and note the report.

CHIEF EXECUTIVE'S REPORT

0 Introduction

0.1 July marked a significant milestone of the NHS, celebrating the 70th anniversary of one of our most remarkable and beloved institutions in our country. There were many celebrations up and down the country, but locally we celebrated and held a tea party on all our sites. Colin Tomson and I were privileged to accompany some of our longest serving staff to a celebration of thanksgiving at Westminster Abbey and York Minster. The BBC ran their news and briefings live from the Queen Elizabeth the Queen Mother (QEQM) at Margate and our staff and many patients got to voice the positive experiences and impact the NHS has had on them.

0.2 Our focussed work on improving standards for patients coming to our Emergency Departments (EDs) is progressing, although we recognise there is much more work to do internally and externally with our partners. For the fifth month in a row we have seen an improvement in waiting times and we have remained on our improvement trajectory. The number of medical outliers has fallen and there have been consistent numbers of available empty beds on the Canterbury site.

0.3 Access for patients with cancer is another priority for us. Clinician engagement is improving as we review all pathways and Multi-Disciplinary Team (MDT) working. We also plan to give all of our longest waiting patients a personal treatment plan to eliminate excessive waits. Our last priority for our access targets is to reduce treatment waiting times and to eliminate long waits by the end of the year. Focussed chronological booking, additional clinics and procedure lists, use of the private sector as well as data cleansing is all contributing to a reduction in long waits.

0.5 The Board of Directors remains committed to ensuring certainty and a strong vision and strategy for the Trust going forward.

2 Emergency Department Improvement

2.1 Our emergency department teams continue to experience significant challenges. June performance for the A&E 4 hour standard reported at 82.6%. This represents a further improvement in performance compared to the previous month.

2.2 Planning for winter commenced both internally and for the East Kent system.

2.3 Measures we have put in place or planned include:

- Overseas recruitment to nursing and consultants posts
- Improved site management support for clinical teams
- Building work to improve the environment in the ED
- A number of improvement projects aimed at improving different elements of the patient journey through ED, the wards and back home or to a community setting.
- Carrying out more planned surgery at Canterbury

2.4 More detailed information regarding the current performance and improvements underway and key highlights for June are included in the Trust's Integrated Performance Report.

3 Care Quality Commission (CQC) Review – May 2018

3.1 At the time of my last report to Board, the CQC had completed their visit to our Trust on 16 and 17 May 2018 as part of their latest inspection of our hospitals.

3.2 During June 2018, the CQC completed the targeted and well-led elements of their scheduled inspection.

3.3 Throughout the inspection they commented on how overwhelmingly caring staff were and proud to share the good practice in their areas. Following the well-led section of the review, and following a further visit to surgery at the William Harvey, they gave us some further early feedback.

3.4 There was recognition of the significant challenges faced by the Trust and the NHS during the last year and recognition of the amount of pressure our staff have been under with the demand on our services. Despite this, coupled by the uncertainty created by not getting to public consultation on our future clinical strategy, the CQC has said there was a clear focus on improving the quality of care we provide to our patients.

3.5 The CQC also praised the way the Trust responded to complaints with compassion and asked us to focus more on how we can share learning across the organisation.

3.6 They were impressed with our use of data and information, how we are improving engagement within the Trust and how communications focussed on supporting improvements in patient care.

3.7 The CQC's report will not be published until the autumn but we are already responding to the suggestions they have made for improvement and will continue to do so.

4 Financial Special Measures (FSM)

4,1 Our core financial challenges continue to be well managed and shepherded by the financial and operational teams. The Trust has a financial plan of a £30m deficit for 2018/19; because the Trust rejected its control total it does not qualify for Provider Sustainability Funding. The cost improvement plan for the year is £30m.

4.2 Our Executive Team continue to be committed to maintaining quality and patient safety whilst working to sustain our financial improvements. At the end of June (M3), the Trust has delivered a deficit of £9.9m which is on plan; this is a positive position however the Trust has significant challenges to deliver the full year plan. The key financial challenges relate to ensuring we deliver our clinical activity plan and ensure we recruit to our vacancies across the Trust.

5 East Kent Medical Services (EKMS)

5.1 On 12 July 2018, I, along with our Chairman and Finance Director, met with EKMS who were represented by their Chairman (Geoff Benn) and Chief Executive (Di Daw). We called the meeting to improve our management of subsidiary businesses. We highlighted our governance plans for all our subsidiaries and the working arrangements going forward. EKMS have been asked to present their forward looking business plan along with their annual report and quality account at the Trust Board in September (previously August); in addition EKMS and the Trust will schedule quarterly meetings to review performance against the key targets for the organisation. I felt this was a positive meeting and there are many benefits of having our own wholly owned subsidiary delivering private health care. We will restate the advantages – patient choice; consultant access and incentives; a profit line in support of NHS activity; a contribution to the overheads.

6 NHS-owned social enterprise to run hospital support services

6.1 2gether Support Solutions, the Trust's wholly owned subsidiary, created to provide support services such as cleaning and portering to our patients will 'go-live' on Wednesday 1 August.

6.2 As part of the first phase of the company's existence, staff from EKHUFT's Procurement Services and staff previously employed by Serco will transfer into 2gether.

6.3 The contract covers cleaning, catering, portering, retail, switchboard and staff accommodation for the Trust.

6.4 Our aim is to have an organisation with a social purpose that is rooted in its local community and, as the company will have a 25-year contract to provide services for the NHS in east Kent, it will also provide stability.

6.5 Transferring services into the NHS wholly-owned company will allow support services to remain in the NHS family and enable the teams currently employed by different organisations to work together more efficiently.

7 We are the NHS Recruitment Campaign

7.1 Staff and patients from across East Kent Hospitals are the feature of the biggest NHS recruitment drive in its 70 year history. The 'We are the NHS' campaign highlights the extraordinary work that staff across EKHUFT do every single day.

7.2 The campaign aims to increase the total number of applications into the NHS by 22,000 as well as double the numbers of nurses returning to practice and improve retention of staff in all sectors. It will recognise the incredible contribution and impact of NHS staff who treat over one million patients every 24 hours across the country in GP surgeries, hospitals and at home.

8 Retained Accreditation for Haematology, Blood transfusion and Phlebotomy Services

8.1 I am pleased to report that our haematology, blood transfusion and phlebotomy services have retained their prestigious United Kingdom Accreditation Service (UKAS) ISO15189 accreditation, after a week-long inspection. The teams were highly commended for their commitment, hard work, professionalism, and dedication to the service.

9 Listening into Action

9.1` As part of the Trust's response to the staff survey, we are using a Listening into Action methodology, taking staff ideas and suggestions and putting them into action. The purpose is to increase staff engagement and improve patients safety. The first part of this process has been completed and having gathered many ideas, suggestions and feedback, we will start to implement the ideas and enable the improvements

10 Trust Seal Activity

10.1 The following summarises Trust Seal Activity since my last report to the Board:

- Lease – The PET-CT Centre at William Harvey Hospital (WHH) (EKHUFT and Alliance Medical Ltd).
- Vehicle Contract – Zenith Vehicle Contract Ltd and 2Gether Solutions.

- Licence to Assign and vary – Between EKHUFT and EE Ltd and Hutchinson 3G UK Limited to Arriva Limited.
- Contract – between Costa Limited and 2Gether Support Solutions.

10 Making A Difference

10.1 One of our Orthodontic Consultants, has been awarded membership of the Angle Society of Europe. This exclusive society, made up of the brightest and best orthodontists from across Europe, has a membership of just 80. They are one of only three consultants in the UK to become a member, having had to present 10 cases treated to highest clinical standards and two lectures on original research. The whole process has taken five years from application to becoming a full member.

10.2 The Alcohol and Substance Misuse Team at QEQM was presented with an NHS70 'Local Heroes Award' by local MP Sir Roger Gale in July, in recognition for the fantastic work they do to help people who arrive at the hospital dependent on alcohol or drugs.

10.3 Dr Chi Davies, Consultant Anaesthetist was shortlisted for a national lifetime achievement award. The NHS 70 Windrush Awards celebrated the contributions and diversity of Black , Asian and Minority Ethnic (BAME) people at the NHS, from the Windrush generation of 1948, the south Asian arrivals in the 1960s and 70s, to today's workforce, represented by 202 nationalities.

10.4 Out of 1.7 million people employed in the NHS, our Director for the Neuro-rehabilitation Service in East Kent was awarded recognition for being a Top 70 NHS Star Leader.

10.5 The Trust has been shortlisted in the National Nursing Times Awards, for our Clinical Research Nursing. The judging day will be take place in September, with the award being announced on 31 October 2018.

10.6 Prof Kim Manley has been named as one of the 70 most influential nurses in the history of the NHS.

11 Publications and Policy Developments of Note

Appendix 1 provides a list of resources available (new and a reminder of those available).

Susan Acott
Chief Executive

APPENDIX 1

LATEST PUBLICATIONS / RESOURCES

Securing the future: Funding health and social care to the 2030s
The NHS Confederation published a report which we commissioned from the Institute for Fiscal Studies and the Health Foundation which explores the demand pressures and funding requirements which will face the NHS and social care over the next fifteen years. It argues that the system will require a significant increase in funding in order to deliver a truly 21st health and care service and it explores how the Government might fund such investment. It provides a clear analysis of the scale of the challenge and a consideration of all available options open to the current and future Governments.It concludes that it is almost inevitable that enhanced investment will have to be funded from increased taxation.

Integrated care: organisations, partnerships and systems
The Health and Social Care Select Committee has published a report following its inquiry into the development of new integrated ways of planning and delivering integrated health and care services. This inquiry focusses on sustainability and transformation partnerships (STPs) integrated care systems (ICSs) and accountable care organisations (ACOs).

NHSI Publications

Making Data Count
This practical, interactive guide is suitable for those working at all levels in the NHS, from ward to board, and will show you how to make better use of your data.

Improving delivery of the 62-day cancer waiting-time standard
A guide and data measurements to help you to deliver and sustain the 62-day cancer standard and improve waiting times for patients.

Demand and Capacity models
A suite of demand and capacity models to help you estimate the capacity needed to run your elective care service.

Delayed Transfers of Care
This tool has been developed to enable trusts, clinical commissioning groups and local authorities to understand where delayed transfers of care are in their area or system.

Corporate Services Productivity Toolkit
To help NHS providers implement their corporate services transformation and to enable the NHS to share best practice, we are developing a toolkit of 'how to' guides and templates.

Two Week Wait Demand and Capacity Tool
A model to help you understand your two week wait demand and estimate the capacity you may need to meet it.

Patient Experience Improvement Framework
An evidence-based framework centred around Care Quality Commission key themes to enable board and senior teams in providers to continuously improve the experience of patients.

Guide to reducing long stays
Our 'how-to' guide offers practical steps and tactics to support the NHS and partners to use an optimal approach to managing hospital length of stay.

Learning Disability Standards
We have developed new standards to help NHS trusts measure the quality of care they provide to people with learning disabilities, autism or both.

Pressure ulcers: revised definition and measurement framework
An evidence-based framework to enable board and senior leaders to consistently define and measure pressure ulcers.

Ambulatory emergency care guide: same day emergency care — clinical definition, patient selection and metrics
This guide offers guidance on emergency patient flow to identify a large cohort of patients who can safely be treated on the same day, reducing admissions and improving the patient experience.

Ambulatory emergency care guide: same day acute frailty services
This guide helps trusts to improve quality, effectiveness and productivity across same day emergency care and acute frailty care service provision.

Managing increased demand from winter illness
This guide outlines some key approaches to avoid unnecessary admissions, reduce length of stay and promote efficient patient flow in emergency care.

The long-stays dashboard
NHSI has developed a dashboard to help providers, clinical commissioning groups and local authorities to monitor and manage hospital length of stay in acute hospitals.

Safe, sustainable and productive staffing in urgent and emergency care
An improvement resource to help standardise safe, sustainable and productive staffing decisions in urgent and emergency care.

Safe, sustainable and productive staffing for neonatal care and children and young people's services
Improvement resources to help standardise safe, sustainable and productive staffing decisions in neonatal care and children and young people's services.

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 AUGUST 2018**
SUBJECT:	**PATIENT AND STAFF EXPERIENCE STORY**
BOARD SPONSOR:	**CHIEF NURSE & DIRECTOR OF QUALITY**
PAPER AUTHOR:	**CHIEF NURSE & DIRECTOR OF QUALITY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The Board of Directors have been using patient stories to understand from the perspective of a patient and/or a carer about the experiences of using our services. Patient stories provide a focus on how, through listening and learning from the patient voice, we can continually improve the quality of services and transform patient and carer experience. The Board more recently have requested staff stories to come to the meeting so that the Board can gain an understanding of what our staff also experience.

This month the Board of Directors are invited to hear the story of a patient who benefitted from a bedside assessment and intervention by the Speech and Language Therapy Team. The team have begun to use an innovative method to assess swallowing difficulties in some of our patients, including those who have suffered a stroke. This means that the patient is able to eat and drink normally far more quickly than conventional methods traditionally used in practice. The team will bring the equipment to the meeting so that the Board can appreciate its quality and safety benefits to our patients. The story also enables the Board to learn how technology can help us when caring for our patients and their families.

The key items for the Board of Directors to note are:

- The timely assessment and care that this patient received by the specialist speech and language therapists;
- The benefits that technology has on outcomes as well as efficiency and effectiveness in our work.

Thanks are extended to the Speech and Language Team for attending the Board of Directors meeting to tell the story.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	If we do not learn from the feedback from patients and their families there is a risk that we do not continue to make improvements to patient experience and outcomes.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR2 - Failure to maintain the quality and standards of patient care. CRR 16 - Poor complaints management.
RESOURCE IMPLICATIONS:	None

COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

PRIVACY IMPACT ASSESSMENT: NO	**EQUALITY IMPACT ASSESSMENT:** NO

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors are invited to note the key themes of these experiences and the learning outlined.

Board of Directors
Patient and Staff Experience Story
August 2018

Introduction

This month the Board of Directors are invited to hear the story of a patient who benefitted from a bedside assessment and intervention by the Speech and Language Therapy Team. The team have begun to use an innovative method to assess swallowing difficulties in some of our patients, including those who have suffered a stroke. This means that the patient is able to eat and drink normally far more quickly than conventional methods traditionally used in practice. The team will bring the equipment to the meeting so that the Board can appreciate its quality and safety benefits to our patients. The story also enables the Board to learn how technology can help us when caring for our patients and their families.

The Story

Mrs A was admitted to hospital on a Thursday night following a stroke. She failed the nurse swallow screen on admission, meaning that there was a risk that food and drink might go into her lungs instead of her stomach. Apart from the discomfort of this, aspirating food and drink can cause chest infections and complications for patients. Mrs A was therefore referred to the Speech and Language Therapy Team (SLT Team).

The SLT team saw her on Friday morning for a clinical bedside swallowing assessment which showed that there was a risk aspiration therefore the team recommended that she did not eat or drink anything. In other words she remained 'nil by mouth' (NBM). Not being able to eat or drink for a period of time is also detrimental to our patients. Often a feeding tube is inserted, but ideally we like to enable patients to eat and drink normally for their comfort, health, nutritional needs and well-being.

Swallowing difficulties (dysphagia) is one of the roles of the SLT team. The team use specialist skills to assess this and treat it. Dysphagia is common in people with strokes, dementia, critical care settings, head and neck cancer, Chronic Obstructive Pulmonary Disease and progressive neurological conditions. The team undertake the clinical bedside examination and clinical judgement to assess patients, but this has a low sensitivity to aspiration. In addition this is a subjective and not an objective measurement. It predicts risk in the absence of instrumental assessment. The team can use videofluoroscopy, (video x-ray of swallowing) but not all patients are able to access this. Mrs A suffered from kyphosis, excessive curvature of her back, which precluded her from being able to tolerate the positioning required for a videofluoroscopy. Also, due to availability in x-ray there were no videofluoroscopy slots until the following Tuesday. This meant that Mrs A would have to wait several days before she could possibly eat or drink.

However, the SLT team are trialling a new technique that can be undertaken at the bedside which is of great benefit to our patients. The technique is called Fibreoptic Endoscopic Evaluation of Swallow (FEES).

Fibreoptic Endoscopic Evaluation of Swallow is a recognised objective tool for the assessment and management of dysphagia. FEES involves passing a nasendoscope through the nose and observing the throat whilst the person is swallowing. It improves accuracy in identifying the presence and cause of dysphagia. It is important to remember that appropriate management of dysphagia can reduce complications and associated costs.

FEES has many benefits for the patient. It is a safer and more accurate assessment than clinical bedside assessment alone. It reduces risk of morbidity and mortality, it reduces length of stay and dependency on tube feeding meaning our patients can eat and drink normally much sooner. It reduces cost and exposure to radiation (compared with videofluoroscopy). FEES results in reduced re-admissions, reduced risk of dehydration and malnutrition and enables immediate feedback and improved engagement in care. It results in improved quality of life and overall outcomes.

Mrs A had her FEES assessment completed on Friday afternoon. She was able to start eating pureed food and drinking syrup thick fluids. This meant the team were able to avoid Mrs A remaining nil by mouth over the weekend and also avoided tube feeding which is also uncomfortable. Mrs A was discharged from the acute stroke ward on the Monday.

For the SLT department the benefits of a FEES service is that the team's time is used more efficiently. It enables them to provide high quality evidence-based care and also improves recruitment and retention of specialist staffing as the innovation is attractive for staff to use and learn how to use.

The benefits of a FEES service for the Trust is an assurance of best practice quality service to meet patient needs, it improves patient flow, reduces length of stay, reduces cost of care associated with non-oral feeding, pneumonia, tracheostomy dependency, extended hospital stays, and it releases capacity for SLT staff to see other patients. Other neighbouring Trusts and the London Teaching Hospitals also use FEES.

The team carried out an unmet needs assessment by looking at the speech therapy caseloads across the three acute Trust sites during three separate weeks between February, March and April last year. They identified a high percentage of our patients who would have had a significant benefit from access to FEES.

Summary

This story describes the care of a patient with swallowing difficulties. It describes the impact of new technology on comfort, nutritional requirements and also on efficiency and effectiveness. The team will demonstrate the equipment for the Board of Directors.

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 AUGUST 2018**
SUBJECT:	**QUALITY COMMITTEE (QC) CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF THE QUALITY COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE QUALITY COMMITTEE**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

The following provides feedback from the July 2018 Quality Committee meeting. The report seeks to answer the following questions in relation to the quality and safety performance:

1. What went well over the period reported?
2. What concerns were highlighted?
3. What action has the Committee taken?

MEETING HELD ON 4 JULY 2018

1. The following went well over the period:

1.1. The Committee received and discussed the report from the Patient Safety Board.

1.1.1 Noted the continued improvement in relation to the Medication Safety Thermometer, that showed 6.1% of the Trust's percentage of patients with a missed dose of a critical medicine had fallen further and was now in line with other organisations. The percentage of patients with a missed dose of any medication is slowly falling and was at 21.7%;

1.1.2 Duty of Candour (DoC) completion remains a challenge, particularly in Urgent Care & Long Term Conditions (UC&LTCs) Division. There is focussed work within all Divisions to achieve improved compliance in this area. UC&LTCs are reviewing their process as these are currently not fit for purpose.

1.2. The Committee received and discussed the report from the Patient Experience Group (PEG).

1.2.1 Response time to formal complaints has improved and is maintained above 90% within the timescale agreed with the client;

1.2.2 The End of Life (EoL) working groups are well established and include medical representation. There had been no complaints during the reporting period regarding EoL.

1.3 The Committee received and discussed a highlight report on the National Constitutional Standards for Emergency Department (ED), Referral to Treatment (RTT) and Cancer.

1.3.1 There has been good progress against the ED trajectory, that had been exceeded by 3.3% with a performance of 80%;

1.3.2 RTT should improve by the end of August, for the period reported 213 patients had waited over 52 weeks, 105 had agreed dates and 108 did not;

1.3.3 There should be improvements in the cancer standards by September, and for the period reported 28 patients had waited over 104 days;
1.3.4 The Committee was assured that there are robust plans in place and that these plans are on track.

1.4 A Learning from Deaths Report was discussed and noted.
1.4.1 The Committee was assured that mortality structured judgement reviews are taking place and investigated and that these are being acted on.

1.5 The Committee noted improved performance in the following areas:
1.5.1 The Friends and Family Test (FTT) inpatient satisfaction rate remains positive at 97% recommended, and 1.8% would not (registering green);
1.5.2 Overall patient experience remains green and reported at 91.4%;
1.5.3 Complaint responses are reporting green, with a rise from 84.8% to a 94.4% achievement at the highest reported point for this year, and was currently reporting 91.4%;
1.5.4 The Trust falls rate has decreased, reporting green (4.93 per thousand bed days). This is below national rates;
1.5.5 The Trust category 2 Pressure Ulcer (PU) rate reported in line with the Trust limit, registering 0.1512 per 1000 bed days, compared with 0.124 per 1000 bed days reported the previous month. There was one confirmed category 3 PU that has been investigated and identified as unavoidable, and the Trust remains below the Trust limit for avoidable category 3 and 4 PUs;
1.5.6 There needs to be sustained action to achieve the Trust and National target of greater than 95% with regards to Venous Thromboembolism (VTE) risk assessment.

1.6 The Committee received and discussed the principal mitigated quality risks and took assurance from the progress updates reported.
1.6.1 There remained risks around the National Operational Standards, i.e. ED, RTT and cancer and these are being reviewed and improvement plans in place.

1.7 The Committee received and discussed a report on Human Tissue Authority (HTA) Compliance.
1.7.1 The Committee congratulated the HTA lead and team for their hard work, especially during the winter period and the successful accreditation received;
1.7.2 The Trust's mortuary was one of the best in the County.

2. Concerns highlighted over the reporting period:

2.1. The Committee received and discussed a Clinical Quality and Patient Safety Report, which for the month reported showed that performance in some areas showed some challenge.
2.1.1 There had been a never event reported;
2.1.2 Eighteen Mixed Sex Accommodation (MSA) breaches had been reported affecting 139 patients, and recovery actions are in place;
2.1.3 Clostridium difficile infections (CDIs) and MRSA reported red, representing a deterioration from the green position reported the previous month;
2.1.4 Thirteen Serious Incidents (SIs) were reported that represented an upward trend since January, with 12 breached SIs compared with the 11 reported in the previous month.

3. Other topics discussed:

3.1. The Committee noted that the inaugural meeting of the NICE/Clinical Audit and Effectiveness Committee had been cancelled due to the CQC 'well led' visit, and a report will be presented to the next Committee meeting.

3.2. The Committee received and noted a Care Quality Commission (CQC) update report. Providing an update on the CQC engagement work, inspection updates and monthly insight report.

3.3. The Committee received and discussed a Learning from SIs (Root Cause Analysis (RCA)) report.

3.4.1 It was acknowledged that the Trust needed to make changes in the way it learned from incidents, an action plan was requested with a proposed method in taking this forward.

3.4. The Committee received and noted a report on the recent Never Event workshop held.

3.5.1 This was around exploring learning and themes with the purpose of embedding quality and safety improvement and shared learning;

3.5.2 This was a positive and helpful event;

3.5.3 The learning and actions arising out of the workshop are being analysed and once completed will be presented to the Committee.

3.5. The Committee received and noted the Governance Board minutes.

24 July 2018 Briefing

The QC Chair, Chief Nurse & Director of Quality and Medical Director reviewed the following matters:

4.1 An RCA is being carried out following a never event in relation to a retained swab. The Trust has had a number of never events in the past 3 years (18 during the years 2015 – 2018) with repeat never events in certain areas. To address this the Trust has enlisted an expert from the CQC to review its policies around supporting sustainable learning being embedded in the organisation. The CCG will be undertaking an action review, which will be reported to the Trust once completed.

4.2 An updated mortality report will be presented to the August Board meeting incorporated in the Medical Director's report, providing an update from the report previously presented to the QC. This will include details of the Mothers and Babies: Reducing Risk Through Adults and Confidential Enquiries Across the UK (MBRRACE-UK) perinatal mortality report published in June 2018, together with a review of 18 neonatal deaths undertaken in response to that report.

4.3 In relation to infection prevention and control, performance is improving around the MRSA trajectory. There are actions to be implemented by Occupational Health following a recent measles incident, around ensuring awareness of the immunisation of staff to be employed by the Trust.

4.4 All metrics regarding patient experience are registering green for patients that would recommend the Trust. MSA breaches are still being reported. There has been an increase in the number of attendees of patients with mental health illness. Harm free care remains positive for the low percentage of new harms which are registering green, along with falls. Performance against PUs remains good.

4.5 Performance in ED over the last couple of weeks had been challenging, with significant increase in attendances impacting on patient flow.

4.6 The Chief Operating Officer has presented and outlined his proposed improvement plan for cancer to the Clinical Leads, which has been positively received.

4.7 The Patient Experience Group received the 2017 inpatient survey results and the Trust had improved in 11 areas. The Trust compares favourably across Kent and Medway in terms of patient experience overall, with a satisfaction of 80%, against the other Trusts in Kent and Medway that were the same or slightly below.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss and accept the report for approval from the Quality Committee.

REPORT TO:	BOARD OF DIRECTORS (BoD)
DATE:	10 AUGUST 2018
SUBJECT:	MEDICAL DIRECTOR'S REPORT
BOARD SPONSOR:	MEDICAL DIRECTOR
PAPER AUTHOR:	MEDICAL DIRECTOR
PURPOSE:	DISCUSSION
APPENDICES:	APPENDIX A: GENERAL MEDICAL COUNCIL (GMC) TRAINING SURVEY 2018

BACKGROUND AND EXECUTIVE SUMMARY

This report encompasses the following areas:

1. National Breast Screening update
   Since the error in the Public Health England (PHE) system was identified an additional 1,497 clients of all age groups have been seen by the Kent Breast Screening Programme. Of these 10 patients have been diagnosed with breast cancer, 3 of which are from East Kent.

2. Quarterly Mortality Update
   East Kent Hospitals University NHS Foundation Trust's crude and risk-adjusted mortality rates, and the work-streams being undertaken to review and improve these, are overseen by the Trust's Mortality Information Group (MIG), chaired by the Medical Director.

   The 2 year trend shows the Trust to follow the peer trend but consistently at a higher crude rate. The peer distribution showed the Trust rate of 1.4% to be 0.1% higher than the peer rate for the 2 year period.

   The Hospital Standardised Mortality Ratio (HSMR) is in the 25th percentile of Acute Trust Peers and in the latest dataset period (June 2017 to May 2018) was 85.6.

   The latest risk associated mortality index (RAMI) of 90.2 for this reporting period (June 2017 to May 2018) remains at the peer 50th percentile.

   The latest summary hospital mortality index (SHMI) reported on NHS Digital is from the January 2017 to December 2017 period and was 1.02 (0.90-1.12, 95% over dispersion control limits).

   Diagnostic conditions significantly contributing to mortality are detailed in the report.

   From December 2017 one of the Learning from Deaths requirements is for Trusts to submit data nationally and publish mortality data to the Trust Board on a quarterly basis, including the number of deaths reviewed and/or investigated, and the number of those found to be more than likely due to problems in care. The report reviews the Trust's progress to date and the methods of reporting together with details of structured judgement reviews.

The final section of the report details the Mothers and Babies: Reducing Risk Through Adults and Confidential Enquiries Across the UK (MBRRACE-UK) perinatal mortality report published in June 2018, together with a review of 18 neonatal deaths undertaken in response to that report. In the MBRRACE report adjusted and standardised neonatal mortality in 2016 was 10% higher in East Kent, the review of neonatal deaths concludes that this was related to a large proportion of expected deaths in 2016. The MBRRACE-UK 2016 Full Report and Executive Summary can be found via the link https://www.npeu.ox.ac.uk/mbrrace-uk/reports.

3. Infection Prevention and Control (IP&C)
   This continues to be an area where more work and focus is required. In this report the Healthcare Associated Infection (HCAI) data is presented in terms of the rate of each HCAI per 100,000 bed days with national comparisons to enable some comparability of performance. However, it should be noted that these data are crude rates and are not corrected for demography and co-morbid conditions.

   Also detailed in the report is a measles incident. Measles is a highly contagious disease and in recent months several cases of measles have emerged both nationally and internationally. Although predominantly viewed as a childhood disease measles causes complications in 1 in 5 children and the complication rate, and severity, is greater in adults. As a consequence of the concerns raised several years ago around the MMR vaccine a significant proportion of adults have not been immunised against measles, this includes healthcare workers as well as the general public.

4. GMC training survey
   The GMC training survey is an annual subjective review of medical postgraduate training and the impact on trainees and trainers. The survey highlights workload and burn out as those factors most affecting doctors' training experience and their personal wellbeing.

5. Never Events and Never Event Workshop
   The Trust has had a number of never events in the past 3 years (18 during the years 2015 - 2018) with repeat never events in certain areas despite analysis and identified learning, suggesting that learning has not been sustainably embedded. The purpose of the workshop was to explore what we need to do differently in the future to address this.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risks: 1. Risk of delayed diagnosis from the National Breast Screening incident. 2. Reputational risk from MBRRACE-UK 2016. 3. Patient safety risks from poor safety culture (infection prevention and control and never event incidents). 4. Risk to staff health and well being from lack of immunity to measles. 5. Risk to future training from deterioration in GMC training survey feedback. Actions: 1. Review of neonatal deaths by the Designated

	Doctor for Child Death Review to address the MBRRACE-UK report. 2. Continued communication campaign surrounding bare below the elbows and hand hygiene Trust wide, together with communication around good anti-microbial stewardship. 3. Revision of occupational health process with respect to pre-employment health screening and in particular staff measles immune status. 4. Collate and embed across the organisation the outputs from the Never Event workshop.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR 2 - Failure to maintain the quality and standards of patient care. CRR 47 - Inability to prevent deterioration in the number of healthcare associated infection metrics. CRR 48 - Challenges in embedding a mature and developed Patient safety culture across Obstetrics and Maternity. CRR 62 - Failure to comply with standards for medical education and training in particular areas.
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Quality Committee have received part of the mortality report not including MBRRACE and neonatal mortality.

PRIVACY IMPACT ASSESSMENT: *NO*	**EQUALITY IMPACT ASSESSMENT:** *NO*

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to note, review and discuss the report.

The Board is also asked to acknowledge and thank the Kent Breast Screening service for the enormous amount of extra work incurred by the error in the PHE system.

1. National Breast Screening Update

The NHS Breast Screening Service Specification states that women are eligible for breast screening until they reach their 71st birthday. An IT problem in Public Health England (PHE) was identified in January 2018 whilst reviewing progress of the age extension trial (AgeX) which indicated that some women had not been called forward for breast screening. While exploring this it became apparent that a similar impact has resulted from long term problems with the routine programme as well. In addition, some local services have not invited everyone for a final screen in the three years before their 71st birthday. For Kent the total number of clients affected was determined to be 7,413.

The main batch of clients aged <72 years were all booked for appointment between June and July (1,662 clients). Of these, 1,054 have attended and in 8 patients breast cancer has been diagnosed.

Of the >72 years age group affected (5,751) 970 clients have requested an appointment. Of these 443 so far have attended and 2 have been diagnosed with breast cancer.

Of the total of 10 patients diagnosed with breast cancer 3 are from East Kent, 2 are from the Medway area and 5 from the Maidstone and Tunbridge Wells catchment.

This Public Health incident obviously has far reaching consequences for the patients involved but has also had a major impact on our staff at all levels from Administrative & Clerical (A&C) staff through changing all the appointments and additional clinic preparation, to mammographers and film readers through screening all the extra clients and reading additional films, and to nurses and doctors through additional assessments and difficult conversations with all the clients recalled and those with cancer.

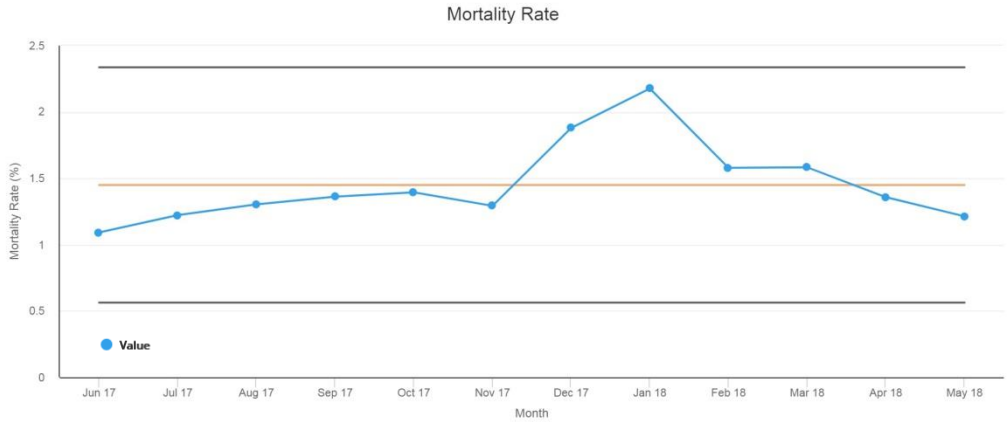
Agreement has yet to be reached with PHE concerning reimbursement for the additional work.

2. Quarterly Mortality Update

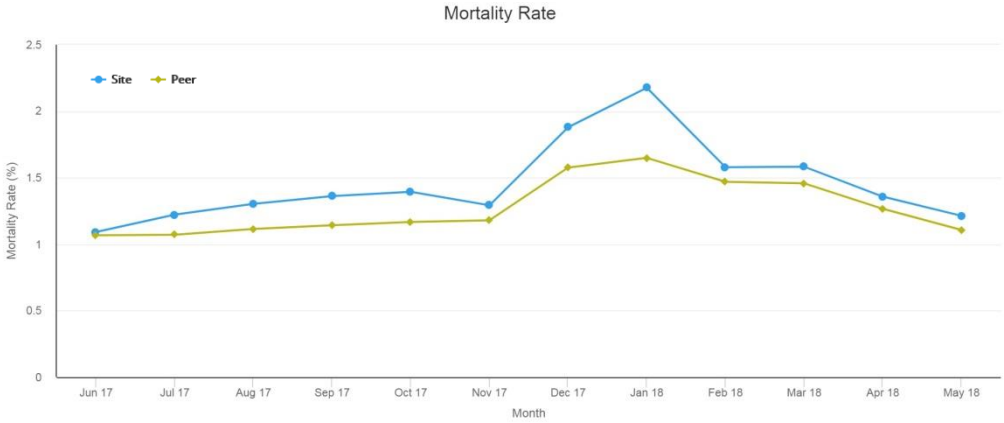
2.1 EKHUFT mortality rates and what the data are telling us.

2.1.1 Crude Mortality (proportion of discharges where death is the outcome).

Crude mortality for the period June 2017 to May 2018 was 1.45% and is within the 50th to 75th peer percentile of the Hospital Episode Statistics (HES) for Acute Trusts. How the Trust's crude mortality rate has varied over the 12 month period is shown below.



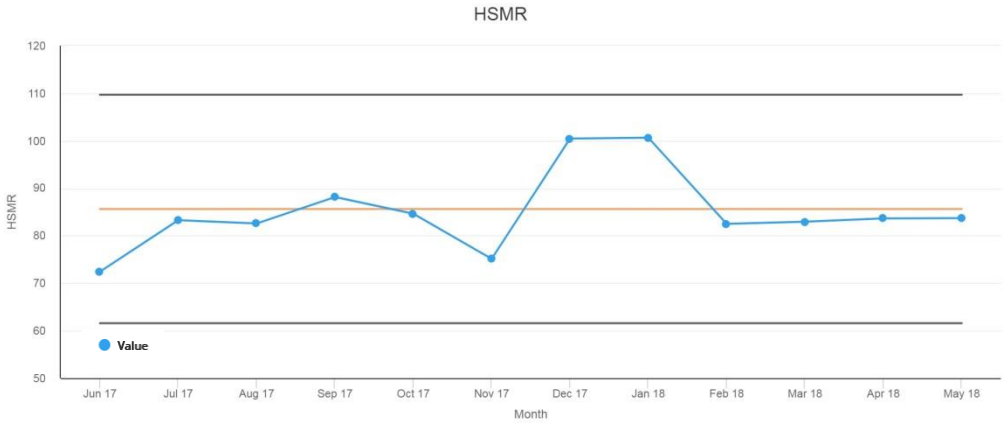
The seasonal variation in crude mortality described in the last quarterly mortality report can be clearly seen with an increase in mortality rates from November through to January/February and this is a constant feature in National data too, although a less marked rise.



However, crude mortality is simply the number of deaths occurring per unit of time and reflects underlying demographics and associated comorbidity.

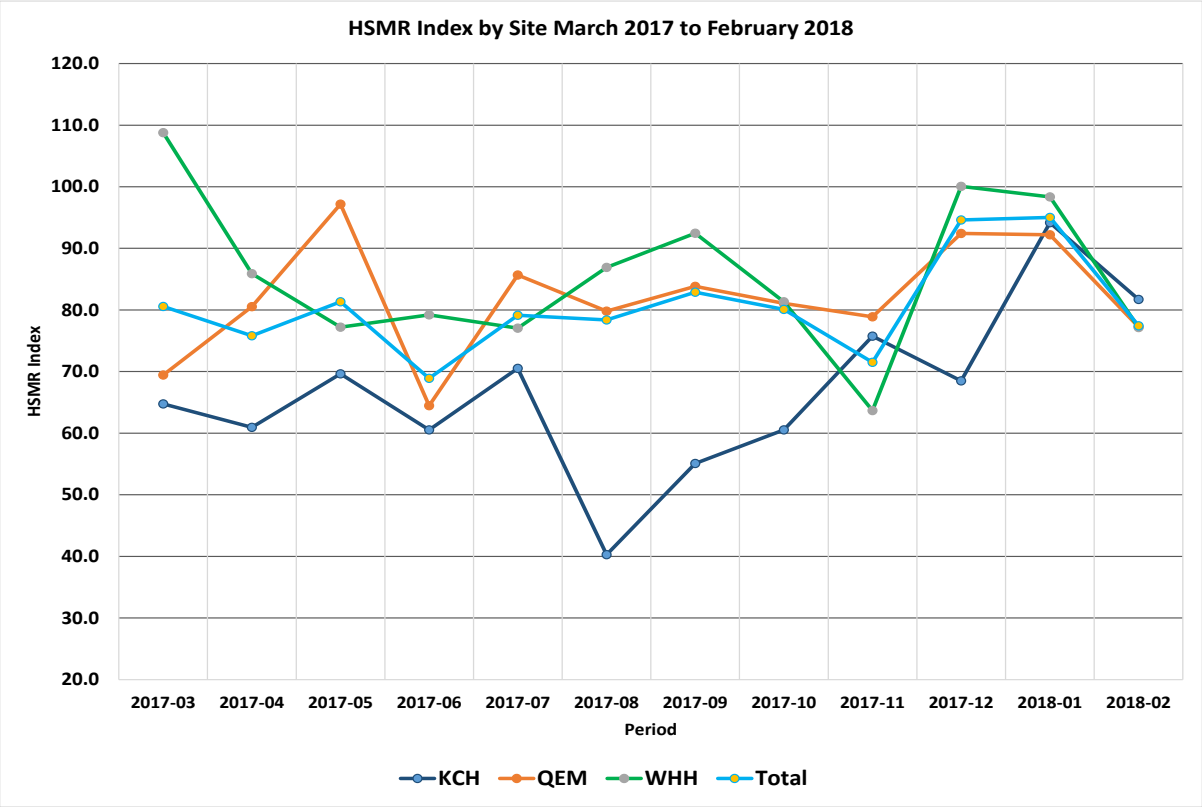
2.1.2 Hospital Standardised Mortality Ratio (risk adjusted mortality where patients die in hospital over a 12 month period within 56 diagnostic groups covering at least 80% of deaths).

The hospital standardised mortality ratio (HSMR) for the latest period (June 2017 to May 2018) was 85.6 and continues to be in the lower quartile of the HES Acute Peer.



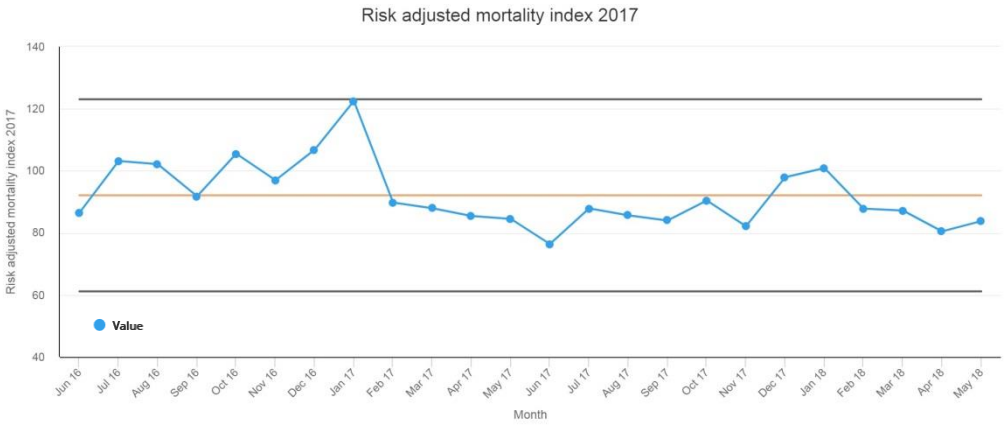
HSMR also varies throughout the year and follows the same pattern as crude mortality. The diagnostic groups are chosen to cover over 80% of in hospital deaths and during this reporting period covered 87.2% of in hospital deaths.

For the 2 year outcome the Trust index was 88.7 in comparison with the National Peer of 93.8. The site variation that previously existed, chiefly because of differences in casemix, has now disappeared.

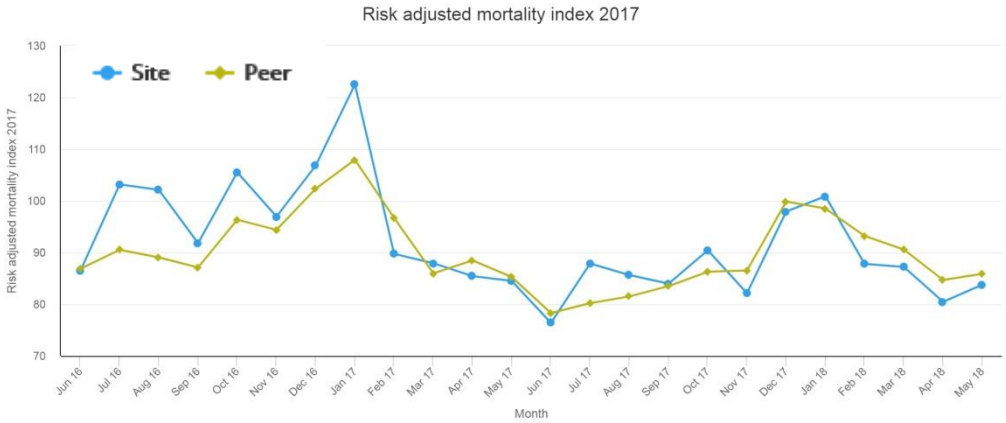


2.1.3 Risk Adjusted Mortality Index (Includes all activity including well babies and palliative care).

The latest risk associated mortality index (RAMI) of 92.1 for this reporting period (June 2017 to May 2018) is on the peer 50th percentile.



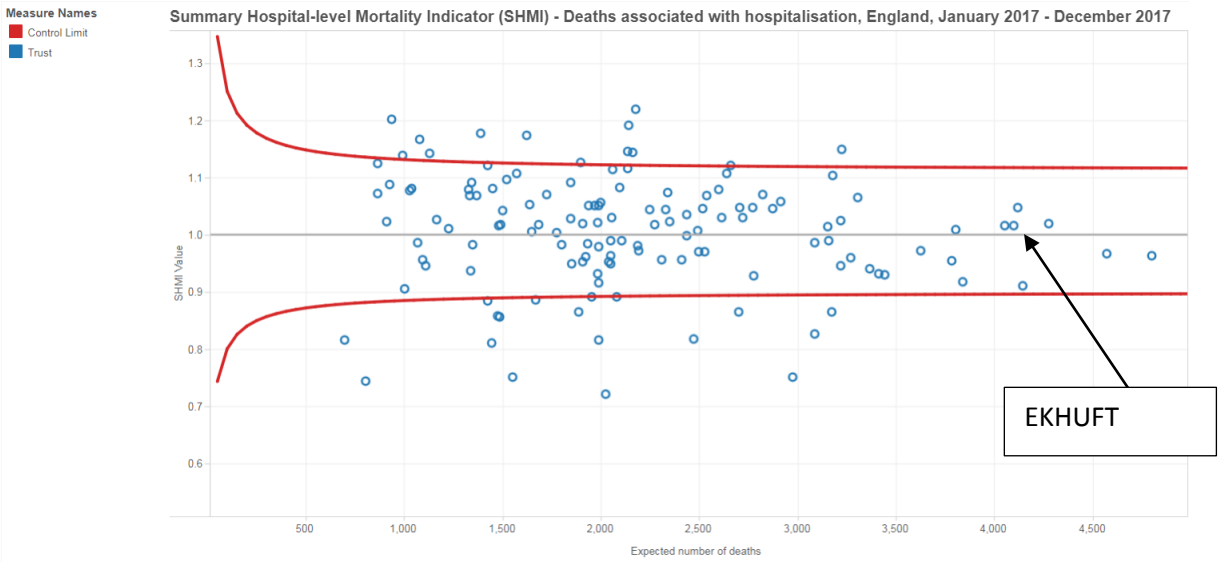
Again there is variation within year for both our Trust and the HES Acute Peers.



2.1.4 Summary Hospital Mortality Index (risk adjusted mortality including both within hospital deaths and deaths within 30 days of discharge).

The latest summary hospital mortality index (SHMI) reported on NHS Digital is from the January 2017 to December 2017 period and was 1.02 (0.90-1.12, 95% over dispersion control limits).

A SHMI of 1.02 is categorised 'as expected' and how this compares with all other Acute Trusts is shown in the funnel plot below. For the period January 2017 to December 2017 there were 106,295 admission spells, 4,100 deaths expected both in hospital and within 30 days of discharge and 4,164 deaths observed. Overall 65.75% of deaths contributing to the SHMI occurred in hospital and 34.25% within the 30 days of discharge, these percentages have remained very consistent since October 2015.

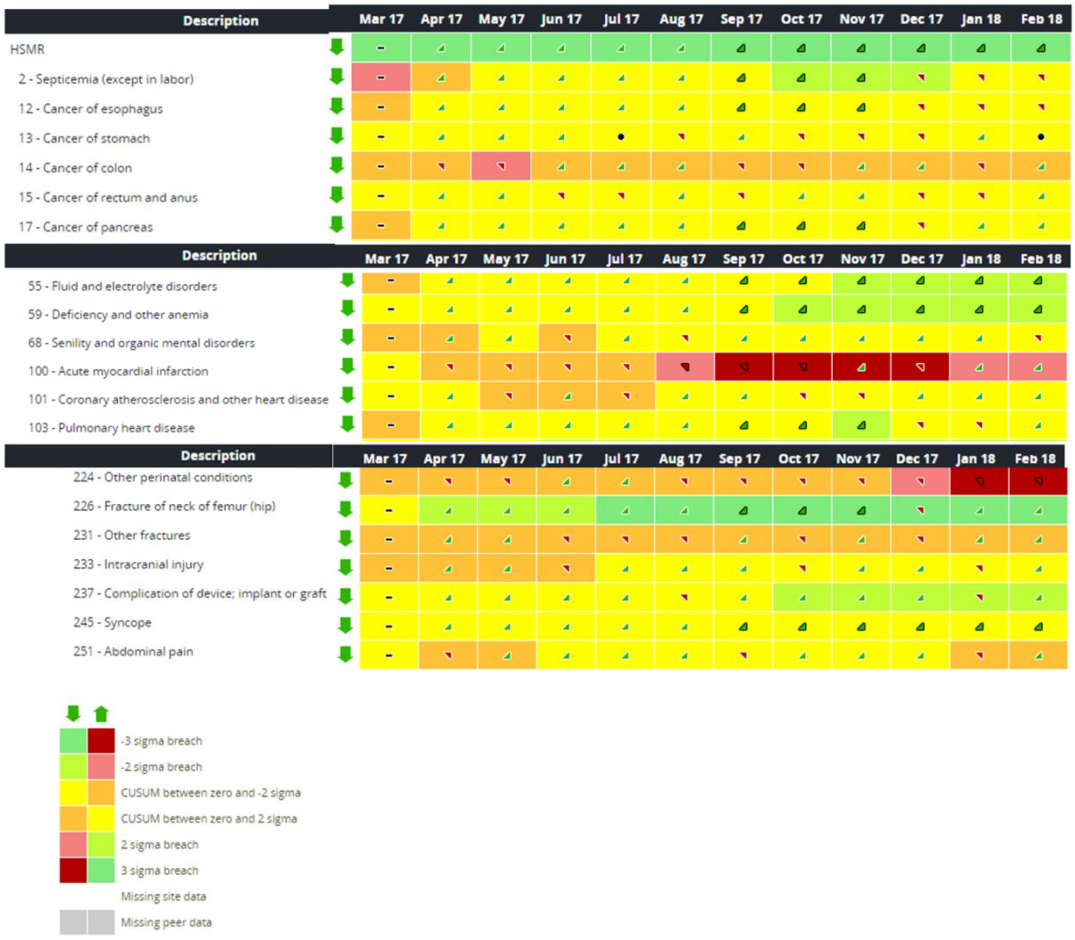


2.2 Which are the diagnostic groups most contributing to our mortality rates?

There are 140 diagnostic codes that contribute to the SHMI analysis and we look at both these and the diagnostic codes contributing to the RAMI and HSMR to identify conditions potentially alerting for increased mortality. From the latest SHMI data those conditions triangulating with RAMI and HSMR are acute myocardial infarction and perinatal mortality (although the latter does not appear in the SHMI list). The full list of conditions, number of spells and observed versus expected deaths where observed deaths are more than 20 are detailed in the table below.

Diagnostic group	Spells	Observed	Expected
Acute Stroke	1,215	237	215.9
Acute Myocardial Infarction	1,511	150	112.0
Cancer of the lung	251	124	96.6
Cancer of the colon	310	34	28.1
Cancer of the oesophagus	105	30	25.5
Chronic obstructive airways dis.	1,872	123	114.6
Gastrointestinal haemorrhage	826	64	57.5
Alcohol related liver disease	161	38	28.6
Other gastrointestinal disorders	985	46	33.3
Intestinal obstruction, no hernia	451	53	45.0
Joint disorders, trauma related	1,028	36	28.8
Septicaemia (except in labour)	3,016	762	647

Diagnostic codes alerting in the SHMI, RAMI and HSMR data are triangulated through CHKS monitoring and reviewed by the mortality information group to assess trends. In the example HSMR heat maps below red = above 75th percentile, amber = 50th - 75th percentile, yellow = 25th - 50th percentile and green = below 25th percentile compared with Acute Trust Peer). Arrowheads represent either an improving or deteriorating trend compared with the previous period.

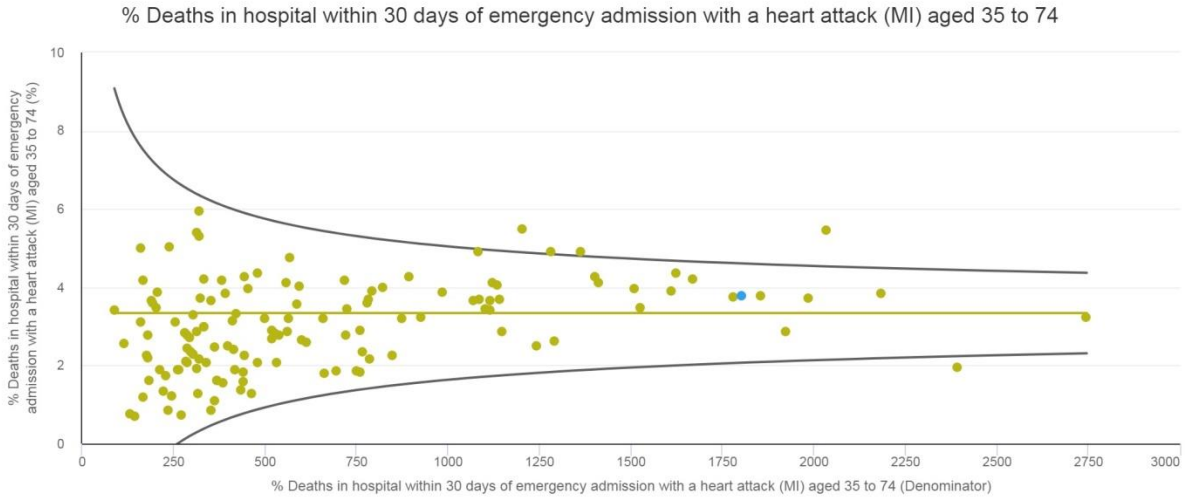


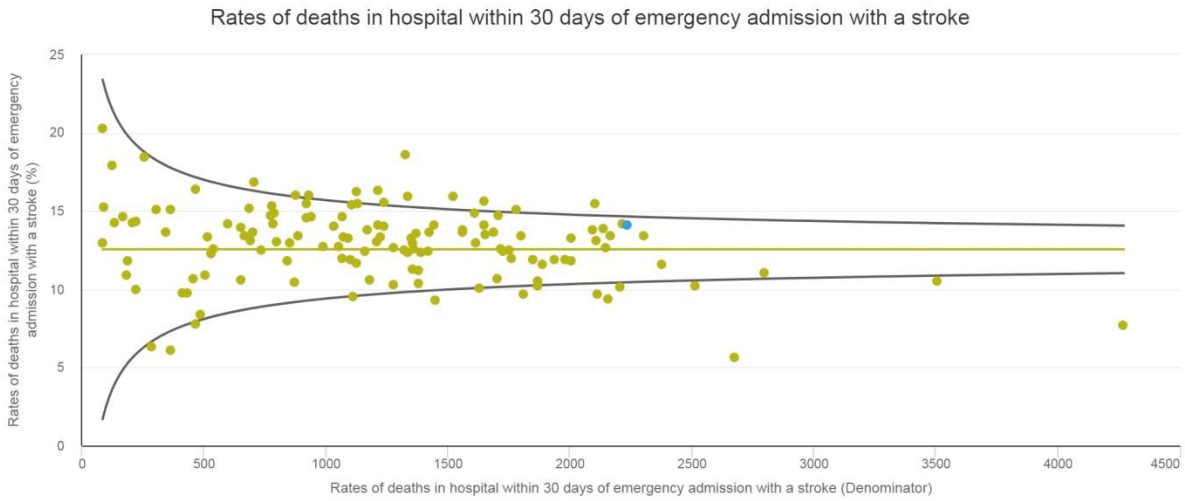
Finally, we look at RAMI cumulative sum control chart alerts to guide which areas require additional information.

Description	Observed deaths	Expected Deaths	RAMI Index	Excess deaths	Alert
Risk adjusted mortality index 2017	2743	3112.5	88.1	-369.5	
109 - Acute cerebrovascular disease	195	172.5	113.1	22.5	Amber
100 - Acute myocardial infarction	130	106.6	122	23.4	Amber
233 - Intracranial injury	44	45.1	97.5	-1.1	Amber

Of note are the diagnostic groups 100 Acute Myocardial Infarction and 109 Acute Cerebrovascular Disease.

Further information can also be acquired by looking in greater depth at these conditions using existing data, for example the funnel plots below compare EKHUFT with peers for both myocardial infarction (MI) and stroke demonstrating that any potential problem for MI mortality does not appear to lie in the age group 35 to 74 and that stroke is not a significant outlier for the period under consideration (June 2017 to May 2018).





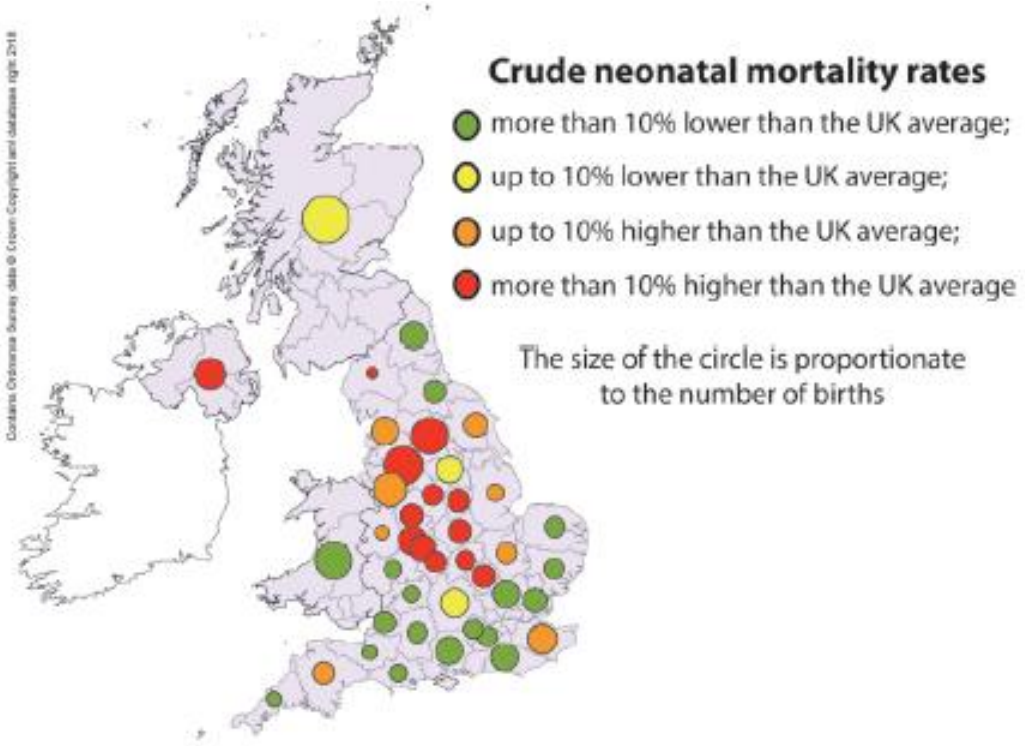
Having identified potential problem areas further information may be required in order to understand exactly what is contributing to the alerts and this ties in with the selection criteria for structured judgement reviews of potentially avoidable death. For both of the above diagnostic groups the next steps are to review a cohort of randomly selected 30 patient deaths from the period of interest for further investigation and analysis. Data collected includes demographics, details of the admission pathway and diagnoses and details of medical reviews and interventions.

2.3 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2016

This report details the fourth year of MBRRACE-UK perinatal mortality surveillance data. As can be seen in the table below although East Kent stillbirth rates are comparable nationally neonatal mortality rates are higher than the average and so too are the extended perinatal mortality rates (stillbirth or neonatal death).

Total Births	Death Rate per 1000 births					
	Stillbirth		Neonatal		Extended perinatal	
	crude	adjusted	crude	adjusted	crude	adjusted
7,029 (EKHUFT)	3.70	4.12 (3.38-4.98)	2.57	2.53 (1.72-3.75)	6.26	6.63 (5.79-8.45)
Average for comparator group		4.11	-	2.10	-	6.20

The reasons for the differences are not immediately apparent and given some of the deprivation in certain parts of East Kent it could reasonably have been expected that adjusted rates would be lower than crude across the board. It is also apparent that there is considerable national variation, as seen below.



In response to this report the designated doctor for child death review undertook a review of 18 neonatal deaths and identified that a high proportion of deaths (two thirds) were expected. Pathologies included congenital malformations incompatible with life and babies born with no signs of life and needing extensive resuscitation. A similar pattern was also noticed in deaths in 2017. Around one third of deaths were due to complications associated with prematurity and the majority of them did not get the full benefit of antenatal steroids. The review also looked at survival rates for extremely preterm babies admitted for intensive care from 2014 - 2017, the survival of these babies is better than published survival data for preterm babies.

Gestation at birth (weeks)	EKHUFT Survival rate (%)	[1]EPICURE 2 (2006) Survival rate (%)	[2]NDAU 2014 Survival rate (%)
23	56.5	29	35.9
24	60.0	46	58.6
25	78.1	69	74.0
26	87.9	78	83.5

1 Population based studies of survival and later health status in extremely premature infants

2 Neonatal Data Analysis Unit

The designated doctor for child death's review concludes that whilst the adjusted and standardised neonatal mortality rate in the MBRRACE 2016 report was 10% higher than the England comparator this was related to a large proportion of expected deaths in 2016.

Actions following on from the MBRRACE report and the review of deaths are to identify/address avoidable factors in neonatal deaths:

- All perinatal death reviews will be conducted using the National Perinatal Mortality Review Tool (PMRT) to support a systematic and standardised review of care. This is in addition to the mortality review undertaken by the neonatal multi-disciplinary team and the Regional Child Death Overview Panel.

- Continued participation in the Royal College of Obstetricians & Gynaecologists national quality improvement programme, each baby counts, to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

2.4 Learning from Avoidable Deaths

2.4.1 What does "Learning from Deaths" involve?

The National Guidance on Learning from Deaths includes a requirement for Acute Trusts to publish on a quarterly basis via Trust Board papers and in the annual Quality Accounts:

- the total numbers of in-hospital deaths.
- the numbers of deaths fully reviewed as part of the relevant Specialty morbidity and mortality (M&M) process using the Structured Judgement Review tool (SJR) which is part of the National Mortality Case Record Review programme.
- the number of deaths assessed as having been more likely than not to have been caused by problems in care.
- evidence of learning and action that is happening as a consequence of this information.

There are certain categories of deaths where a full review is automatically expected (i.e. children; patients with Learning Disabilities, Severe Mental Illness, following an elective procedure). Full reviews should also be undertaken where family, carers or staff have raised a concern about the quality of care provision; where there is the potential for learning and

improvement; and where there is a CUSUM (cumulative sum control chart) alert for a diagnosis group or a Quality Improvement initiative.

Case record review can identify problems with the quality of care so that common themes and trends can be seen, which can help focus organisations' quality improvement work. Review also identifies good practice that can be spread. Investigation (root cause analysis and after action review) is more in-depth than case record review as it gathers information from many additional sources. The investigation process provides a structure for considering how and why problems in care occurred so that actions can be developed that target the causes and prevent similar incidents from happening again.

Death due to a problem in care is one that has been clinically assessed using a recognised method of case record review, where the reviewers feel the death is more likely than not to have resulted from problems in care delivery/service provision.

2.4.2 What progress have we made to date?

The Trust's policy governing Learning from Avoidable Deaths was published in September 2017 and the structured judgement review tool produced nationally has been adapted to use on an electronic platform to enable data capture and analysis. Alongside this a dashboard has been developed for reporting (see below) which remains under review through the mortality information group in terms of its final format.

Four members of the Trust underwent a 'training the trainers' programme in the structured judgement review methodology in October 2017. They in turn have since trained a further 79 reviewers across the Trust.

2.4.3 Learning From Avoidable Deaths Dashboard

As of June 2018 the dashboard records the first 176 structured judgement reviews that have been completed on the electronic platform. It should be noted that the majority of these reviews have been completed in areas where we expected to see some problems in the care provided. Of these 176 cases, in 5 the reviewers opinion was that death was more likely than not to have resulted from a problem in care, in 6 there were problems in care identified which may have contributed to death, and in 36 there were problems in care identified but these were very unlikely to have contributed to death.

The structured judgement review process also allows assessment and categorisation of problems in healthcare, some cases will have had more than one problem with care identified throughout the inpatient episode. Overall 103 of 176 cases reviewed had a problem with care identified and these were categorised as follows:

Problem	Led to Harm?		
	No	Probably	Yes
Assessment, Investigation or Diagnosis (including assessment of pressure ulcer, Venous Thromboembolism (VTE) or falls risk	22	2	8
Medication/IV fluids/electrolytes/oxygen	15	4	7
Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)	21	3	3
Infection control	3	1	3
Related to operation/invasive procedure (other than infection control)	14	1	1
Clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)	12	0	7
Resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR))	3	0	0
Any other problem not fitting the categories above	31	4	2

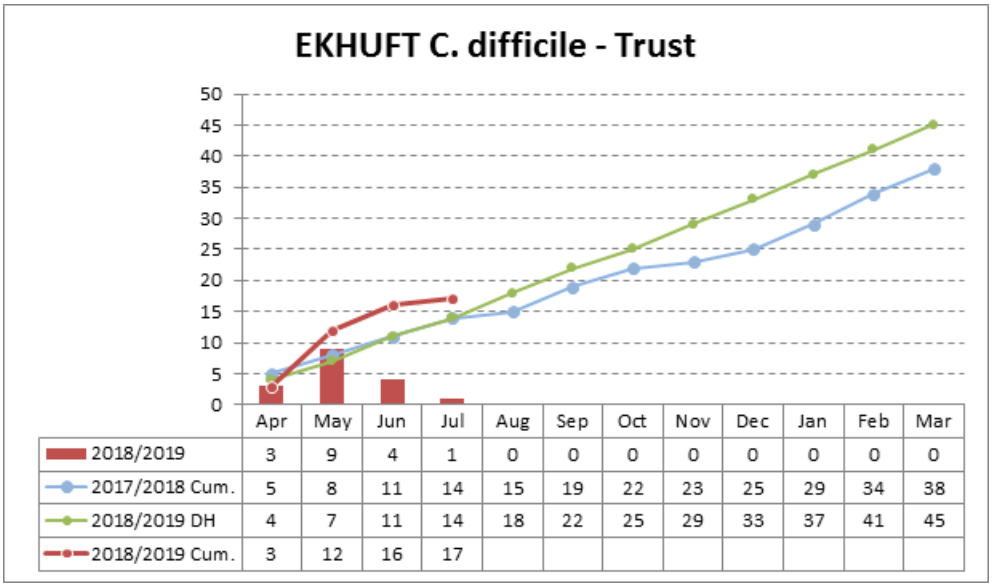
2.4.4 Next Steps

As the number of clinicians trained in the methodology increases and once the process has been embedded in each departmental mortality review meeting, supported by the appointment of clinician leads across the Trust the proportion of all deaths reviewed should increase to the desired level driven by those clinician leads. Coupled with this work further development of the dashboard will assist in extraction of key learning themes for dissemination across the Trust.

3. Infection Prevention and Control (IP&C)

3.1 C. difficile

The beginning of this New Year, in which our Department of Health (DH) trajectory is 45 cases, was hugely disappointing with 16 cases in the first quarter. The year-to-date total is now 17 cases but the trajectory is beginning to suggest that this is being turned around.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/2019	3	9	4	1	0	0	0	0	0	0	0	0
2017/2018 Cum.	5	8	11	14	15	19	22	23	25	29	34	38
2018/2019 DH	4	7	11	14	18	22	25	29	33	37	41	45
2018/2019 Cum.	3	12	16	17								

All of the cases to date have been in either the Urgent Care & Long Term Conditions (UC&LTCs) Division (12 cases) or Surgical Division (5 cases).

The Trust rate of C.difficile per 100,000 bed days is currently 19.3, significantly higher than our average over the preceding 8 years (14.4, range 8.5-25.0) and the current England average of 12.7/100,000 bed days.

3.2 MRSA

From April 2018, all post 48 hour MRSA bacteraemias have been automatically assigned to the Trust and all pre 48 hour cases to the Clinical Commissioning Group (CCG.)

In the last 8 years our rate of MRSA per 100,000 bed days was 1.84 (range 0.0 - 3.1) and by virtue of 2 assigned bacteraemias year to date our rate per 100,000 bed days is 2.41, this compares with national rate of 0.86 and a Kent and Medway rate of 2.89/100,000 bed days.

3.3 MSSA

In the last 8 years our rate of MSSA per 100,000 bed days was 7.53 (range 6.12-11.02). Our current rate is 7.22, below that for Kent and Medway and below the national rate (9.10 and 9.59/100,000 bed days respectively).

3.4 E.coli

In the last 7 years our rate of E.coli per 100,000 bed days was 22.6 (range 14.6-28.2). Our current rate is 27.7, exactly the same as the Kent and Medway rate but below the national rate of 22.4/100,000 bed days.

3.5 Infection control incidents

3.5.1 Measles

Two cases of measles in adults presented to the Trust in June prompting a thorough review of staff immunity to measles.

There have recently been national and international reports of increased laboratory confirmed cases of measles and other hospitals have reported similar incidents including one hospital outbreak of measles involving more than 20 cases, including some healthcare workers. Measles presents with non-specific upper respiratory tract symptoms and is highly infectious, the period of high infectivity precedes the development of rash and there are frequently delays in diagnosis increasing the risk of non-immune staff exposure to risk of infection.

We know that:

- Awareness of measles in healthcare settings is low, particularly in services for adults.
- The isolation of patients with rashes (and suspected measles) is often delayed.

- Even where a measles diagnosis is suspected, there are often delays in reporting (whilst awaiting confirmation) and, once reported, delays in identifying and contacting those exposed.

All of these factors contribute to onward spread and increased workload.

3.6 Actions taken

The following actions have been taken as a result of the above:

- Continued communication campaign surrounding bare below the elbows and hand hygiene Trust wide.
- Ward review summits for those wards experiencing high numbers of HCAIs.
- Tightening of the anti-microbial policy and a renewed communication campaign at induction regarding compliance with the Trust's antimicrobial prescribing policy.
- Targeted testing and vaccination of measles non-immune frontline staff.
- Series of measles communications Trust wide to raise awareness and to offer testing and vaccination.
- Review of occupational health process with respect to pre-employment health screening and in particular measles immune status screening.

4. General Medical Council (GMC) Training Survey

Each year the GMC surveys trainees to gather their experience of training and to identify areas for improvement. The results of this year's survey nationally are stark. Long and intense working hours, heavy workloads and the challenges of frontline medical practice are affecting doctors' training experience and their personal wellbeing. Nearly a quarter of doctors in training and just over a fifth of trainers reported that they felt burnt out because of their work. Almost a third of trainees said that they are often or always exhausted at the thought of another shift. Well over a half of trainees, and just under a half of trainers, reported that they often or always feel worn out at the end of their working day. A fifth of doctors in training and trainers told the GMC they feel short of sleep when at work. Two in five trainees and two thirds of trainers rated the intensity of their work as very heavy or heavy; and nearly half of trainees reported that they work beyond their rostered hours on a daily or weekly basis.

The full survey results for our Trust are available in Appendix B. Headline messages for us are that the major areas of concern are Gastroenterology (on both sites), surgery (especially Foundation Year 1 on both sites), Geriatrics at Queen Elizabeth the Queen Mother Hospital (QEQMH) at Margate and Respiratory at QEQMH at Margate. Acute Internal Medicine (at QEQMH at Margate) has many green flags and Core Medical Training on both sites has improved with green flags at QEQMH. At Trust level, there are no red or pink flags and overall satisfaction is slightly better than last year.

5. Never Events and Never Event workshop

Staff from EKHUFT and external guests from NHS Improvement (NHSI) and CCGs attended a Never Event Learning Workshop in June to share learning about the Trust's never events across a number of specialities. Never events are serious incidents which although defined as 'wholly preventable, where guidance or safety recommendations that provide strong systematic protective barriers are available at a national level and should have been implemented by healthcare providers' nevertheless, continue to happen in all hospitals. Never events have the potential to cause serious patient harm or death, however serious harm or death is not required to have happened for the incident to be classified as a never event.

The revised never event list published by NHS Improvement from January 2018 includes:

- Wrong site surgery.
- Wrong implant/prosthesis.
- Retained foreign object post procedure.
- Mis-selection of a strong potassium containing solution.
- Administration of medication by wrong route.
- Overdose of insulin due to abbreviations or incorrect device.
- Overdose of methotrexate for non-cancer treatment.
- Mis-selection of high strength midazolam during conscious sedation.
- Failure to install functional collapsible shower or curtain rails (mental health providers only).
- Falls from poorly restricted windows.
- Chest or neck entrapment in bedrails.
- Misplaced naso-or oro-gastric tubes.
- Scalding of patients.
- Unintentional connection of a patient requiring oxygen to an air flowmeter.
- Undetected oesophageal intubation (temporarily suspended).

The current national picture for 2016 - 2018 is shown in the table below, those numbers in brackets are events that have happened in the Trust in the last 3 years during which time we had a total of 18 never events prior to the workshop.

	2016/17, n = 445	2017/18, n = 469
Wrong site surgery (4)	189	202
Wrong site block (4)	30	38
Wrong tooth removed (1)	46	32
Retained foreign object (1)	114	113
Retained central line wire (1)	13	11
Retained vaginal swab (3)	32	23
Wrong implant/prosthesis (2)	53	65
Wrong lens (1)	21	22
Misplaced nasogastric tubes (1)	26	26

Regrettably, we have reported a number of these incidents over the past year, and what does not appear to be happening following investigation and analysis of these events is sharing and sustainably embedding the learning.

The function of the workshop was to share experiences, improve understanding of the impact of never events, and explore what we can do to deliver safe care at all times. The workshop reviewed not just what went wrong, but also what learning and positives we were able to draw from these incidents. It also enabled staff to explore how it felt to be part of a Never Event incident from a patient's point of view.

Outputs from the workshop are being collated for sharing across the organisation and serving as a template for further learning events on all sites.

NHS
Health Education England

GMC NATIONAL TRAINEE SURVEY 2018

Understanding the GMC National Trainee Survey Outliers

In line with previous years the GMC National Trainee Survey reporting tool continues to RAG rate each indicator on the basis of outliers (a score that is distant, positively or negatively, from the average) and a colour rating is applied dependent on how far from the average the responses are - which is shown in the below table:

Red	Strong negative outlier	**Pink**	Negative in comparison to the average but not quite a negative outlier.
Green	Strong positive outlier	**Light Green**	Positive in comparison to the average but not quite a positive outlier.
White	Within the range of the average	**Grey**	Less than three trainees
Yellow	No trainees responded to questions relating to this indicator		

Help & Support

All queries with regards to the National Trainee Survey and the process of action planning should be sent to the Regulation, Intelligence and Patient Safety Team (London and Kent, Surrey and Sussex) via the Quality Inbox: Quality.lase@hee.nhs.uk

Support from the GMC on using the Public Reporting Tool can be found at this link: http://www.gmc-

Local Office	Programme Group	Trust / Board	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Reporting systems	Work Load	Teamwork	Handover	Supportive environment	Induction	Adequate Experience	Curriculum Coverage	Educational Governance	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Rota Design	Number of Red	Number of Pink	Number of Green
KSS	ACCS	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	0	0	0
KSS	Anaesthetics	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	0	0	0
KSS	Anaesthetics F1	East Kent Hospitals University NHS Foundation Trust	#	#		#	#	#		#	#	#	#	#	#	#				#	0	0	6
KSS	CMT	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	0	1	0
KSS	CST	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	1	0	0
KSS	Cardiology	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	0	0	0
KSS	Clinical radiology	East Kent Hospitals University NHS Foundation Trust	#	#		#	#	#		#	#	#	#	#	#	#	#	#	#		0	2	1
KSS	Core Anaesthetics	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	0	1	0
KSS	Emergency Medicine F2	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#			#	#	0	0	1
KSS	Emergency medicine	East Kent Hospitals University NHS Foundation Trust	#	#		#	#	#	#	#	#	#	#	#	#		#	#	#	#	0	0	0
KSS	GP Prog - Emergency Medicine	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	0	2	0
KSS	GP Prog - Medicine	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	2	2	0
KSS	GP Prog - Obstetrics and Gynaecology	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	1	4	0
KSS	GP Prog - Paediatrics and Child Health	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	0	1	1
KSS	Gastroenterology	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	9	7	0
KSS	General Practice F2	East Kent Hospitals University NHS Foundation Trust	#	#		#	#	#		#	#	#	#	#	#	#			#		0	0	1
KSS	General surgery	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	0	2	0
KSS	Geriatric medicine	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	2	5	0
KSS	Haematology	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#		#	#	#	#	#	#		#	#	#	#	1	4	1
KSS	Medicine F1	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#		#	#	#	#	#	#	#				#	0	1	0
KSS	Medicine F2	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#			#	#	0	0	0
KSS	Neurology	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	1	1	1
KSS	Obstetrics and Gynaecology F2	East Kent Hospitals University NHS Foundation Trust	#	#			#	#	#	#	#	#	#	#	#	#			#	#	0	1	0
KSS	Obstetrics and gynaecology	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	0	4	0
KSS	Paediatrics	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	1	0	1
KSS	Psychiatry F1	East Kent Hospitals University NHS Foundation Trust	#	#		#	#	#		#	#	#	#	#	#	#				#	2	1	1
KSS	Psychiatry F2	East Kent Hospitals University NHS Foundation Trust	#	#		#	#	#	#	#	#	#	#	#	#	#			#	#	0	2	1
KSS	Renal medicine	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#		#	#	#	#	#	#	#	#	#	#	#	1	2	0
KSS	Surgery F1	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#		#	#	#	#	#	#	#				#	6	1	0
KSS	Surgery F2	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#			#	#	1	0	0
KSS	Trauma and orthopaedic surgery	East Kent Hospitals University NHS Foundation Trust	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	1	1	0

URGENT CARE AND LONG TERM CONDITIONS (UC&LTCs) WORKFORCE DEVELOPMENT PROGRAMME – REPORT AND FORWARD PLAN **BOD 53/18**

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 AUGUST 2018**
SUBJECT:	**URGENT CARE AND LONG TERM CONDITIONS (UC&LTCs) WORKFORCE DEVELOPMENT PROGRAMME – REPORT AND FORWARD PLAN**
BOARD SPONSOR:	**DIRECTOR OF HUMAN RESOURCES**
PAPER AUTHOR:	**WORKFORCE PROGRAMME DIRECTOR**
PURPOSE:	**TO NOTE**
APPENDICES:	**APPENDIX A: UC&LTCs WORKFORCE DEVELOPMENT PROGRAMME**

BACKGROUND AND EXECUTIVE SUMMARY

This paper outlines the twelve month UC&LTC workforce development programme to support the achievement of the ED improvement plan and to help create a sustainable workforce for the East Kent health and social care system. Rationale for the programme and progress and impact in the first five months are summarised; with risks and mitigation identified.

In summary:

- Recruitment is the top short-term priority whilst workforce redesign, leadership and staff engagement are essential for a sustainable workforce.
- Role clarity at senior level and development opportunities to fulfil requirements of the role are key – the proposed development is an opportunity to strengthen this.
- Planning establishment and staffing to demand whilst ensuring staff work at the top of their licence and skill mix meets patient need.
- Time out for teams to work on shared objectives and review their effectiveness is key.
- The workforce solution is broader than EKHUFT and needs to be integrated with primary care, community and social care.

Key issues:

Agency spend is currently above trajectory and recruitment below trajectory for the business cases that were recently approved.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risk of not meeting recruitment trajectory will make it difficult to achieve Cost Improvement Programme (CIP) target on agency spend and puts additional pressure on existing staff increasing risk of turnover and impact on patient care. Mitigation includes proactive recruitment marketing, rolling adverts and interviews, weekly monitoring of recruitment.
LINKS TO STRATEGIC OBJECTIVES:	**People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	CRR61 – Failure to achieve the A&E improvement plan and evidence sustainable improvement to the emergency care pathway.

	SRR8 – Failure to recruit and retain high calibre staff (substantive) to the Trust.
RESOURCE IMPLICATIONS:	Contributes to achievement of CIP for agency staff.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

PRIVACY IMPACT ASSESSMENT: *NO*	**EQUALITY IMPACT ASSESSMENT:** *NO*

RECOMMENDATIONS AND ACTION REQUIRED:

(a) To note the programme report.

URGENT CARE AND LONG TERM CONDITIONS (UC&LTCs) WORKFORCE DEVELOPMENT PROGRAMME – REPORT AND FORWARD PLAN **BOD 53/18**

UC&LTC Workforce Development Programme

A. Background and Programme Overview

At the end of February 2018, Amanda Price was seconded from her role as Associate Director of Education, Training and Development at Guy's and St Thomas' NHS Foundation Trust for a year to lead a Workforce Development Programme in Urgent Care and Long Term Conditions, with a focus on the Emergency Departments (ED).

The aims of the programme are to support the achievement of the emergency care 4 hour waiting time standard and meet the proposed performance trajectory; and to support the delivery of the East Kent Accident and Emergency Plan.

The objectives are to improve staffing levels and competence as part of the Emergency Department Improvement Plan, and to build a sustainable and affordable workforce across East Kent local care.

The programme comprises six work-streams. Three are focused on outcomes needed now in support for divisional and department leadership; safe for care including safe staffing, governance, competency and health and wellbeing; and recruitment. The activity in these work-streams is centred on the emergency departments. The other three are focused on future outcomes in culture and leadership, future workforce and local care and covers the wider division, particularly ED, acute medicine and elderly care. The local care work-stream is in partnership with community, primary care, social care and mental health colleagues.

The workforce development programme reports to the Divisional Management Group, Quality Board and the Trust-wide transformation programme steering groups for Great Place to Work (GPTW) and Right Skills, Right Place, Right Time. The ED aspects are reported through the ED business meeting and ED Improvement Plan Steering Group. governance; and into the Trust-wide transformation programme steering groups for Great Place to Work and Right Skills, Right Place, Right Time. The Workforce Programme Director reports to the HR Director, Sandra Le Blanc, and is a member of the senior HR team, whilst working closely with the Divisional Director and divisional and ED leadership teams.

B. Workstream Progress

1. Divisional and Speciality Leadership

The aim of this work-stream is to support the capacity, capability and confidence of the divisional leadership team and speciality leadership team.

Progress to date includes:

- coaching individuals in senior teams at divisional and ED level
- identifying and clarifying roles, responsibilities and accountability with divisional and speciality leadership teams
- joining ED joint triumvirate team to support workforce and OD elements of the ED Improvement plan
- testing out the emerging Trust Leadership Framework with the divisional and speciality leadership teams

The key risk associated with this work-stream was time for the ED general managers to engage in team and service development which is now helped by appointment of silver command managers. The temporary nature of divisional leadership pending organisational restructure is also a risk to sustainable team development and performance.

2. Safe for Care

The aim of this work-stream is to ensure safe staffing, competence, governance and health and wellbeing in the ED's.

Progress includes:

- Reviewing consultant and middle grade rotas to ensure consistency, fairness and adequate cover
- Reviewing divisional and speciality governance
- Healthroster training and roster completion improvement for nursing
- Rolling out Royal College of Nursing (RCN) nursing competences
- Coaching at health and wellbeing days
- Aligning rotas and rosters with demand as part of the ED Improvement Plan
- Approval to recruit and develop full business case for prospective cover of the middle grade rota

Risks include operational pressures preventing engagement in governance or in education and training. This will be mitigated against through rationalising governance meetings and including study time in staffing plans.

3. Recruitment

The aim of this work-stream is to attract and recruit sufficient substantive staff across staff groups to the ED's across EKHUFT.

Progress includes:

- Divisional engagement in the Trust-wide resourcing improvement plan, particularly around streamlining processes and recruitment marketing.
- Recruitment trajectories for ED and the medical wards monitored weekly at the divisional recruitment meeting and fortnightly at matrons' meeting with the Financial Improvement Director.
- The new Standard Operating Procedures for resourcing will be rolled out through divisional governance as soon as they are signed off.
- Standard descriptors for ED departments and roles and standard advert copy
- Presence at local and international job fairs
- Plan for proactive recruitment of returners with Canterbury Christ Church University,
- Identifying and supporting overseas trained nurses already working in the Trust as support staff
- Engagement of Espirita recruitment agency for doctors at all grades and Veredus for ED consultants
- Standardising and streamlining shortlisting and interview process for medical staff. Standard questions for medical recruitment
- Fortnightly rolling advert and interviews for ED nursing
- 'We are EKHUFT' campaign launched and 'We are the NHS' filmed at EKHUFT

The key risk is the sheer scale of the recruitment challenge compared to availability of staff. This requires a fresh look at the make-up of the ED workforce, which will be addressed by the Future Workforce work-stream (see section 5.). The Resourcing improvement plan needs to be fully implemented in order to improve efficiency and effectiveness.

4. Culture and Leadership

The aim of this work-stream is to build a culture of compassion and continuous improvement.

Progress includes:

- Thirty-one Listening into Action Conversations in teams and open forums to build on the staff survey results and identify what helps create a good working experience now, and what would help create a great working experience all of the time
- Three site wide meetings to play back the findings of the Listening into Action Conversations
- Survey of staff who have left ED or Clinical Decision Unit (CDU) in the last year
- Follow up meeting and action plan with Royal College of Nursing and ED staff
- Pop-up coaching

- Division-wide task and finish group developing, implementing and evaluating a divisional Great Place to Work action plan. Divisional actions are mapped against the ten domains of A Great Place to Work. Actions within divisional GPTW action plan have been passed to the relevant leads.
- ED Great Place to Work task and finish group launched to focus on ED specific actions. An ED Great Place to Work Listening into Action report and actions has been produced.
- Team development with all nursing teams in William Harvey Hospital (WHH) ED using the Aston Real Team Plus profile

These activities have gleaned a rich set of data based on the experiences of a range of staff across the department. There are positives to build on around team and colleague support and learning opportunities; plus improvements to be made around staffing, facilities, management support and effective team working.

The key risk related to this work-stream is the long-term nature of culture change which will require sustained effort and consistent upholding of Trust values and behaviours at all levels.

5. and 6. Future workforce and Local Care

The aim of these work-streams is to ensure a sustainable workforce for the East Kent Health and Social Care System in the future.

Progress includes:

- Scoping current and pipeline workforce
- Recruitment of second cohort of trainee Advanced Clinical Practitioners into the ED/acute medicine workforce
- Posts developed for medical fellows working across ED and elderly care and ITU
- Skill mix review plan for medical wards using the Shelford safer care tool and competency framework
- Engagement of the Sustainability and Transformation Partnership (STP) workforce team around workforce modelling tools
- Design of workshops for new models of care
- Development of the Kent and Medway Emergency Care education collaborative
- Launch of an inter-professional emergency medicine and acute medicine faculty to share learning, maximise on internal expertise and open up learning opportunities to all
- HR business partner support for stroke reconfiguration and patient flow 3
- Competences for Silver Command, Nurse in charge and Doctor in Charge in ED
- Bid to Health Education Kent, Surrey and Sussex (HEKSS) for practice development in EDs
- Work experience working group

Risks to these work-streams include reduction in funding for education, requiring more in-house solutions and collaboration across Kent and Medway partners; and the complexity of the health and social care system requiring relationship management and partnership workforce planning.

C. Programme Impact

At the start of the programme, a number of key performance indicators were identified and baseline measures recorded. The table below shows baseline and current (end of June) data. It must be recognised that agency spend, vacancies and recruitment have been impacted by approval of business cases extending services and opening new wards.

Key Performance Indicator (KPI)	Baseline division (Feb)	Current (June) divisional position	Baseline ED (Feb)	Current (June) ED position	Note
Appraisals % Over previous 12 months	73%	53%	82.5% Queen Elizabeth the Queen Mother (QEQM) 36% WHH	45% QEQM 19% WHH	ED appraisals booked over summer; approx. 80 carried out not reported
Joiners (n) over previous 12 months	394	441	94	117	Includes doctors in training
Leavers (n) over previous 12 months	343	348	82	77	Includes doctors in training
Turnover % Over previous 12 months	13.5%	13.4%	15.6%	15.5%	
Vacancies % In month	14.3%	18%	14.95% QEQM 33% WHH	16.94% QEQM 29% WHH	Includes new posts funded through business cases
Agency spend £000's In month	2,000	2,100	325 medical 333 nursing	243 medical 425 nursing	Includes new posts funded through business cases
Sickness % In month	4.27%	3.25%	2.39% QEQM 8.4% WHH	5.8% QEQM 11.9% WHH	Needs further investigation
Staff engagement (0-5)	3.57	n/a	3.43	n/a	Calculated from staff Friends and Family Test (FFT), ability to make a difference and motivation
e-roster sign- off	55% (05/02/18)	81%			

It should be noted that achievements in the programme are due to a number of individuals working in the division, the HR business partner and other HR colleagues, in addition to the Workforce Programme Director. The approach of the Workforce Programme Director is coaching with a balance of support and challenge, and facilitation - aiming to retain ownership for achievement with the division.

D. Outline Programme Plan August 2018 – February 2019

The Workforce Programme Director is supporting a number of Trust-wide initiatives; including the Improving Clinical Leadership and Organisational Effectiveness programme, Education Strategy including Medical School partnership, and the Leadership Development Framework. A more detailed work-plan will be developed balancing divisional and Trust-wide work according to requirement.

Work-stream	Planned activity for August 2018 - February 2019
Divisional and speciality leadership	Coaching support for those in transition to new roles Roll out Trust-wide organisational development programme including leadership and triumvirate development
Safe for Care	Competency and development frameworks for ED in line with new models of care Health and wellbeing days for ED staff off-site Review and support divisional governance in line with new organisational structure and clinical leadership
Recruitment	Recruitment plan for new medical wards Build and launch ED web pages including staff stories Consistency in advertising jobs on Take a Different View website Recruitment and Retention Premium (RRP) and reward package tailored to individual needs whilst ensuring consistency and fairness Standard operating procedures for recruitment for the division once Trust Service Level Agreement (SLA) and Standard Operating Procedures (SOPs) have been signed off Joint academic appointment and partnership plan for Kent and Medway Medical School (KMMS) Targeted international recruitment campaigns
Culture and leadership	Roll out Trust-wide organisational development programme including leadership and triumvirate development Quarterly hubs for Great Place to Work shared learning

Future workforce and local care	Career pathways for nursing, medicine and admin/managerial staff in ED Workforce redesign assessing what skills and competence are required at each stage of the patient journey, before deciding which roles can demonstrate those skills. Dynamic workforce model with STP workforce team Five year EKHUFT workforce plan, taking account of workforce supply, and influencing education providers to provide the right training and education. East Kent workforce plan in line with clinical strategy and in partnership across health and social care

The KPIs reported above in Section C will continue to be tracked over the last six months. Other measures of change will be reported at the end of the year including staff survey metrics and performance and quality measures that can be linked to the programme. The report will also include an impact and return on investment assessment from Trust, divisional and speciality leadership, and from external partners.