EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**9 JULY 2015**
SUBJECT:	**CEO AND PERFORMANCE UPDATE**
REPORT FROM:	**CHIEF EXECUTIVE**
PURPOSE:	**Information / Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

Performance metrics relevant to the Trust's licence and Monitor's Risk Assessment Framework (principally governance and finance) are distributed monthly to the Council of Governors at the same time as they are received by the Board of Directors. (Reports are also published on the Trust's website.)

SUMMARY:

Governors will therefore already have received the latest performance reports which were issued in June 2015.

The attached summaries are taken from the: Clinical Quality and Patient Safety Report; Key National Targets Report; and Corporate Performance Reports.

The report also includes an introduction from the Interim Chief Executive.

RECOMMENDATIONS:

The Council of Governors are invited to note and discuss the report.

NEXT STEPS:

None. The metrics within this report will be continually monitored.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Clinical quality, the patient safety programme and patient experience underpin many of the Trust's strategic and annual objectives. Continuous improvements in quality and patient safety will strengthen the confidence of commissioners, patients and the public.

Governance AO10: Maintain strong governance structures and respond to external regulatory reports and guidance.

LINKS TO BOARD ASSURANCE FRAMEWORK:

This report links to AO1 of the BAF: Implement the third year of the Trust's Quality

Strategy demonstrating improvements in Patient Safety, Clinical Outcomes and Patient Experience / Person Centred Care.

Governance AO10: Maintain strong governance structures and respond to external regulatory reports and guidance - Maintain a Governance Rating with Monitor of Green

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

Identified clinical quality and patient safety risks are summarised in the attached report.

Standards are being closely monitored and mitigating actions are being taken where appropriate (in collaboration with the whole health economy).

FINANCIAL AND RESOURCE IMPLICATIONS:

Continuous improvement in quality and patient safety will make a contribution to the effective and efficient use of resources.

There is a financial penalty for not achieving targets.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

Reduction in clinical quality and patient safety will impact on NHSLA activity and litigation costs.

Most of the patient outcomes are assessed against the nine protected characteristics in the Equality & Diversity report that is prepared for the Board of Directors annually. The CQC embed Equality & Diversity as part of their standards when compiling the Quality Risk Profile.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

None

ACTION REQUIRED:

(a) Discuss and agree recommendations.
(b) To note

EXECUTIVE SUMMARY

1 EXECUTIVE SUMMARY

1.1 Cultural change programme

The cultural change programme continues to be a priority for the trust and remains critical in ensuring that the trust is a great place to work and that we can recruit to the large number of vacancies we currently have. Recruitment remains a significant challenge for us as it does across the NHS and getting out of Special Measures will also contribute to making us a more attractive employer. The training programme for people managers has started and the second medical engagement workshop is scheduled for the 2 July. There has also been a number of management actions that have been aimed at tackling poor behaviour in individuals reinforcing the zero tolerance the board has for bullying and harassment.

1.2 CQC

Preparation continues for the July CQC inspection as part of the long term 'improvement programme', including the production of a staff handbook, the development of our 'improvement hubs' and significant activity by the site improvement teams. Please be clear, the CQC inspection in July is not the end but the beginning of a long term journey of improvement for all the trust's hospitals.

1.3 Quality

I am pleased to report in May 2015 we achieved over 98% for harm free care. In particular, QEQM reported 99% and William Harvey Hospital achieved 99.3%.

No deep pressure ulcers were reported in May 2015, this being the second consecutive month. There had also been a decrease in the number of falls reported.

The Friends and Family Test reported an increase in the number of patients recommending the Trust.

Full details of performance against all quality metrics can be found in the Clinical Quality and Patient Safety report.

1.4 Strategy - 'delivering our future'

The trust's 'improvement programme' whilst initially aimed at addressing the issues brought into focus by the CQC, also has to encompass ensuring we tackle head on the other challenges we and the rest of the NHS face, including the shortage of clinical workforce that is leading to difficulties in delivering safe and effective emergency care; demographic challenges eg the growing elderly population; the opportunities presented by the changing world of technology, pharmaceuticals and emerging new models of healthcare including developing a truly seven day service. All of these issues will require more fundamental change in the way we deliver healthcare across east Kent if patients are to continue to receive the very best in healthcare. The board will be aware that the strategic work programme has continued to attract media and political interest.

The executive team are developing a structured work programme for consideration by the board that will take us through the coming months to the point where we will undertake a full public consultation on proposed changes in the new calendar year. The medical engagement workshop mentioned above will focus on the development of strategic options as will a chief executive led strategy board that will include the trust's senior clinical leaders. Importantly, we have commenced a programme of public engagement, supported by Healthwatch, to ensure the public have an opportunity to understand the case for change and shape potential options. We have also been working with our commissioners on how the strategic work programme can ensure that we take a wider whole systems approach to the challenges and opportunities the NHS in East Kent faces.

1.5 Finance

Like many parts of the NHS the board recognises that we face very tough financial challenges with the trust moving into deficit last year for the first time since 2006 and deficits forecasts for this and future years. This challenge has been discussed at the recent Chief Executive staff forums. Over the coming weeks a three to four year financial recovery plan will be developed based on a current review of the existing 2015/16 plan including a review of the proposed cost improvement plans (CIPs) and the outcome of this review will be reported to the board at its July meeting, however the challenge we face is likely to be significantly greater than first forecasted. The month two financial results are cause for serious concern and means that improving our financial performance requires increased capacity and capability over and above the existing 'business as usual' capacity the trust currently can deploy and the Chief Executive and Finance Director are considering this with Monitor. We have increased our focus on our high agency/locum spend and an action plan has now been established that complies with the recent guidance issued by the Department of Health (see 4.2). Patients will remain central to our financial recovery remembering that getting things right for our patients and improving quality reduces cost for example reducing agency/locum usage both improves quality and reduces costs. The board should not under estimate that this will be challenging for the organisation but for our hospitals to be able to invest and develop in the future we need to return to financial strength as soon as possible.

1.6 Performance

As can be seen from the performance report our A&E waiting time performance remains a challenge. We have now received the recommendations following the ESIST review and these have been included in the existing whole system recovery plan. We have also strengthen management and clinical service transformation capacity and made changes to the acute physician model at the William Harvey (see 5.4).

Full details of performance against all national standards can be found in the Key National Performance Targets report.

1.7 Monitor Performance review meeting

A performance review with monitor took place on 17 June and a verbal update will be given at the board.

1.8 New Buckland Hospital Dover

Staff began moving in to the new Buckland hospital on Saturday 6th June and all staff that currently offer service in the old building and at Deal Hospital, have now moved in to the new building. The building has been delivered to an extremely high specification and offers the Trust a unique opportunity to deliver high quality services from modern, fit for purpose facilities. Perhaps more importantly the Trust will be able to challenge current models of care and be at the forefront of delivering new models of care to local people on the south Kent coast. The challenge for the organisation is to focus on service improvement and redesign and utilise to capacity this exciting new opportunity. The original business case describes these opportunities and quantifies the quality and efficiency benefits, now is the time to focus on delivery.

The press and general media covered the opening of the new hospital extensively including “walk throughs” and interviews with trust staff and the local MP on 12th June. A more formal opening date will be set in the future, once services have bedded in.

SUMMARY OF PERFORMANCE

KEY NATIONAL INDICATORS

A&E Indicators

Monitor Indicator and threshold:

	Threshold	Monitoring Period
Maximum of four hours from arrival to admission/ transfer/ discharge	95%	Quarterly

EKHUFT Performance 2015/16:

	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mch
Compliance	89.3%	88.3%										

Activity levels and performance against the emergency 4 hour access standard for May is broken down by site in the table below:

	Trustwide	QEH	WHH	K&C	BHD
Total Numbers attending A&E	17,248	5,842	6,351	3,953	1,102
Change from Previous Year	-4.77%	-3.18%	-1.63%	-8.90%	-14.11%
Breaches (Numbers Not Seen within 4 Hrs)	2,010	868	1079	63	0
% met	88.35%	85.14%	83.01%	98.41%	100.00%
Numbers of 20-30 year olds	2,645 (15.34%)	818 (14.00%)	913 (14.38%)	727 (18.39%)	187 (16.97%)
Numbers of 75+	2,847 (16.51%)	988 (16.91%)	1,081 (17.02%)	691 (17.48%)	87 (7.89%)
Nursing vacancies	31	B5 x12 B3x10 B4 x6	X1 B5 RSCN X1 B6 RGN	B5 x1	B6 x 0.5 B2 x 0.5
ED Middle Grades vacancies	12	7	5	N/A	N/A
ED Consultants vacancies	11.5	7	4.5	N/A	N/A

Referral to Treatment Waiting Time Performance

Monitor Indicator and threshold:

	Threshold	Monitoring Period
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted.	90%	Quarterly
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted.	95%	Quarterly
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	Quarterly

EKHUFT Performance:

Pathway	< 18 Weeks	>18 Weeks	Total	% Compliance	52 Week waiters	Backlog Position
Non-Admitted Pathway	5,883	369	6,252	94.1%		
Admitted Pathway	2,218	519	2,737	81.0%		1,145
Incomplete Pathways	37,569	4,950	42,519	88.4%	5	

Table 3.1 – RTT Position Compliance by Pathway (May 2015)

Cancer Performance

Monitor Indicator and threshold:

	Threshold	Monitoring Period
All cancers: 62 day wait for first treatment from: • Urgent GP referral for suspected cancer • NHS cancer screening service referral	85% 90%	Quarterly
All cancers: 31 day wait for second or subsequent treatment comprising: • Surgery • Anti-cancer drug treatments • Radiotherapy	94% 98% 94%	Quarterly
All cancers: 31 day wait from diagnostics to first treatment	96%	Quarterly
Cancer: two week wait from referral to date first seen comprising: • All urgent referrals (cancer suspected) • For symptomatic breast patients (cancer not initially suspected)	93% 93%	Quarterly

EKHUFT Performance: Cancer targets – May 2015

	2ww 93%	Breast Symptomatic 93%	31 day 96%	31 day Sub Surg 94%	31 day Sub Drug 98%	62 day GP 85%	62 day Screening 90%
Q2 14/15	93.47%	81.90%	98.69%	94.50%	100%	81.68%	86.03%
Q3 14/15	93.36%	86.43%	98.06%	93.08%	100%	81.99%	93.06%
Q4 14/15	93.88%	95.29%	97.52%	96.62%	98.88%	75.18%	86.72%
Mar-15	95.41%	96.18%	96.54%	97.83%	100%	70.83%	91.49%
Apr-15	94.00%	93.55%	95.28%	88.57%	100%	80.53%	95.00%
May-15	93.75%	93.08%	92.54%	87.81%	98.70%	68.47%	90.00%

Quality Performance

A copy of the performance summary is attached.

Financial Performance

A copy of the latest scorecard is attached.

May 2015

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**9 JULY 2015**
SUBJECT:	**CLINICAL QUALITY & PATIENT SAFETY RECEIVED BY THE BOARD OF DIRECTORS IN JUNE 2015**
REPORT FROM:	**ACTING CHIEF NURSE & DIRECTOR OF QUALITY MEDICAL DIRECTOR**
PURPOSE:	**To note**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

- The clinical metrics programme was agreed by the Trust Board in May 2008; the strategic objectives were reviewed as part of the business planning cycle in January 2015. Alignment with the corporate and divisional balanced scorecards has been reviewed.

- Performance is monitored via the Quality Assurance Board, Clinical Advisory Board and the Integrated Audit and Governance Committee.

- This report covers

    - Patient Safety
        - Harm Free Care
        - Nurse Sensitive Indicators
        - Infection Control
        - Mortality Rates
        - Risk Management
    - Clinical Effectiveness
        - Bed Occupancy
        - Readmission Rates
        - CQUINS
    - Patient Experience
        - Mixed Sex Accommodation
        - Compliments and Complaints
        - Friends and Family Test
    - Care Quality Commission
        - CQC Intelligent Monitoring Report.

- This report also appends data relating to nurse staffing, which is a requirement to report planned staffing versus actual staffing levels to the Board of Directors; an appendix outlining detailed complaints themes and trends and a heatmap of wards and departments in relation to quality indicators.

SUMMARY:
A summary of key trends and actions of the Trust's performance against clinical quality and patient safety indicators in 2015/16 is provided in the dashboard and supporting narrative.

PATIENT SAFETY

- Harm Free Care – This month 94.4% of our inpatients were deemed 'harm free' which is a 2% improvement on last month but meets the national figure which is 94%. This figure includes those patients admitted with harms and those who suffered harm whilst with us. The percentage of patients receiving harm free care during their admission with us (which we are able to influence) is 98.9%, similar to last month (98.5%). Further analysis of these data show that the prevalence of patients who had developed a new VTE had slightly increased this month, the remaining indicators similar this month.

- Nurse Sensitive Indicators – In May there were 32 reported incidents of pressure ulcers developing in hospital (27 in April). These include 27 Category 2 pressure ulcers and 4 ulcers categorised as unstageable, and 1 deep tissue injury. Six of the Category 2 ulcers have been assessed as avoidable. The unstageable ulcers will be categorised when they are debrided and the depth may be fully established. This is in line with new national and local recommendations. The Pressure Ulcer Steering group will be targeting sacral ulcers to make further reduction in incidents during the forthcoming financial year, and further analysis is required to update the Trust Action Plan.

- There were 150 patient falls recorded for May (160 in April) of which 81 resulted in no injury. None were graded as severe or death, the remaining were reported as low or moderate harm. The top reporting wards were Cambridge M2 ward (WHH) with 9 falls; CDU (WHH) with 8 falls. Harbledown Ward continues to make good progress with falls reduction for the second month running. The Falls Team have undertaken some focused work with this team.

- Infection Prevention and Control –Trust wide mandatory Infection Prevention and Control training compliance for May was 78.5% and 81% for April. The online training link is now active and staff are being advised to complete this as soon as possible.

- HCAI – There were no cases of MRSA bacteraemias in May, and 3 cases of C. difficile occurring within the Trust during the month (against a trajectory of four). The earlier cases reported on Harbledown Ward identified lapses of care that may have contributed to the development of the cases. The Ward remains on special measures around infection prevention and control practices, supported by the Infection, Prevention and Control Team. There were 44 cases of E.coli bacteraemia in May. Thirty nine cases occurred pre-48h and 5 occurred post-48h. There were 13 cases of MSSA bacteraemia in May. All cases occurred pre-48h.

- Mortality Rates – The most recent HSMR performance was reported in December 2014 and equalled 78.6 compared to 83.7 in December 2013. Next month we are hoping to have the full 14/15 data up to March. Crude mortality for non-elective patients continues to show a reduction on January's elevated position. Elective crude mortality has decreased returning to expected seasonal levels. All elective deaths are reported on Datix and discussed at the Morbidity and Mortality meetings. Any points of learning are highlighted as part of this process. The most recent data for Q1 2014/15 indicate a SHMI value of 95.3 lower than the position reported in Q4 2013/14.

- Staffing – There was a reduction in incidents recorded due to staffing levels in May. The revised National Quality Board guidance published in May 2014 outlined the requirement for % fill of planned and actual hours to be identified by registered nurse and care staff. This is expressed by day and by night,

and also by individual hospital site. Gradual improvement was seen over the first months of reporting, then slight reductions seen in December to March that reflected the requirement for additional shifts during winter pressures not always being filled by NHSP, and due to annual leave being taken at the end of the financial year. Fill rates improved during April and are similar this month in May. This correlates with a reduction of incident reporting around staffing difficulties reported this month. Please see the attached appendix for greater detail on nursing staffing and the 'heatmap' for correlation of patient safety and quality of care against the fill rates.

- Risk Management – In May a total of 1101 clinical incidents were reported. Five serious incidents were required to be reported on STEIS in May. Eight cases have been closed since the last report. There remain 71 serious incidents open at the end of May. Incidents may be re-graded following investigation. The team are working closely with the CCGs and the Divisions to complete the investigations and share the learning as soon as possible.

CLINICAL EFFECTIVENESS

- Bed Occupancy – The bed occupancy metric looks only at adult inpatient beds and excludes any ring fenced wards such as Maternity. In May a further reduction in bed occupancy was reported, including a reduction in the number of extra unfunded beds in use, and patients bedded in a ward outside of their Division (Outliers).

- Readmission Rates – Readmission rates are reported 2 months in arrears. The 7 day and 30 day readmission rates for April-15 continues to show an improved position from the same period last year.

- CQUINs – The 2015/16 CQUINs have yet to be finalised with our CCG colleagues but will include national quality improvements for Sepsis, Acute Kidney Injury and dementia. Development of the integrated Heart Failure, COPD, Diabetes and Over 75s pathways continue into 2015/16 as local CQUINs.

PATIENT EXPERIENCE

- Mixed Sex Accommodation – The Trust has been working closely with the CCG Chief Nurses to agree the new Delivering Same Sex Accommodation Policy. A key area was to refresh the justifiable agreed clinical scenarios that were previously agreed with the PCT. Reporting to date has been in line with this policy. During May there were 9 reportable mixed sex accommodation breaches to NHS England via the Unify2 system, occurring in the CDU at WHH. The remaining cases occurred in the Stroke Units which is a justifiable mixing based on clinical need.

- Compliments & Complaints – During May we received 75 complaints, which is similar to April. One formal complaint has been received for every 1010 recorded spells of care similar to April. During May there were 77 informal concerns (81 in April), 231 PALS contacts (similar to last month) and 2175 compliments (compared to 2513 in April). This represents a ratio of compliments to formal complaints of 29:1, and one compliment being received for every 29 recorded spells of care.

  The number of returning clients seeking further resolution of their concerns during April was 19 (17 in April). Surgical Services Division recorded the highest number of returning clients. This is being addressed through the Complaints Management Steering Group where performance is discussed

and managed.

This month the Trust achieved the standard of responding to 85% of formal complaints within the agreed date with the client. We sent 97% of the responses out on time to clients during May (95% in April). Every Division achieved the required standard this month with this being the third consecutive month we have achieved this standard. From April we are also monitoring response rates against the Trust Policy of 30 working days as part of our improvement work to reduce the length of time complaints remain open. Compliance to this local standard is 40% with the average length of time a complaint was open during May as 39 days. UC&LTC is the only Division who achieved the 30 day standard. Focussed work continues with the teams to address themes, reduce the number of complaints and ensure compliance to the response time standard. This is performance managed through the Complaints Management Steering Group.

Themes remain similar to previous months and are being triangulated with other patient feedback data and addressed at Divisional level. With regards to formal complaints, the highest recurring subjects raised in May were, problems with communication, concerns about clinical management and problems with attitude.

Appended is a more detailed review of complaints and offers the Board of Directors a detailed overview of the complaints performance as of the end of Q4 14/15, and pulls through current hotspots and trends as of May-15.

- Friends and Family Test – During May we received 14597 responses from our patients. This includes inpatients, A&E, maternity, outpatients, day cases and paediatrics. The response rates and satisfaction scores are depicted in the table below:

  Table 1 - Response Rates and Percentage Recommended – May 2015

Department	Response Rate		Percentage recommended	
Inpatients*	54%	↑	95%	↑
A&E	29%	↑	84%	↑
Maternity	20%	↓	98%	↑
Day Cases**	39%	-	39%	-
Outpa□i□n□s	27%	↑	94%	↑

  * Now includes paediatrics.
  ** Was included last month in the inpatient total.

  It is encouraging to see that satisfaction rates have improved in all areas that we are able to compare to last month. Our star rating for this month equals 4.7 out of 5.0, improving on last month. We await the detailed satisfaction scores for each area but these will be shared with the wards and departments where the individual comments are being scrutinised so that we can make improvements in response to the feedback. The A&Es continue to be an area where improvement work continues. The key theme for the lower scores in the feedback is the length of time patients are waiting to be seen in the Depts. Local action plans are in place across all areas.

  The Staff FFT takes place during June and we are hoping for an improved score given the cultural change and staff engagement work that is in progress. The previous score showed a 2% improvement with 47% of staff recommending the Trust as a place to work and 72% said they would

recommend the Trust to friends and family as a place to be treated.

CARE QUALITY COMMISSION

The latest Intelligent Monitoring Report (IMR) was received on the 21st May 2015. The draft has been released and will be reported next month. This report shows four elevated risks in areas which have not previously flagged and which will remain in the IMR until the results of national surveys improve. The staff survey is flagged as an elevated risk along with our Monitor governance rating and snapshot of whistleblowing.

The Trust's Improvement Director Sue Lewis has been appointed by Monitor to provide us with advice, to observe progress on the implementation and embedding of the improvements, and to liaise with the Monitor Regional Team as part of the performance review requirements. Monthly reports on progress are submitted to NHS Choices and are published on our website. In the meantime the Trust is preparing for our re-inspection on the 13th July 2015.

RECOMMENDATIONS:

The Board of Directors are invited to note the report and the actions in place to continue patient safety and quality improvement.

NEXT STEPS:

None. The metrics within this report will be continually monitored.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Clinical quality, the patient safety programme and patient experience underpin many of the Trust's strategic and annual objectives. Continuous improvements in quality and patient safety will strengthen the confidence of commissioners, patients and the public.

LINKS TO BOARD ASSURANCE FRAMEWORK:

This report links to AO1 of the BAF: AO1: Deliver the improvements identified in the Quality and Improvement Strategy in relation to patient safety, patient experience and clinical effectiveness.

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

Identified risks include:

1. Ability to maintain continuous improvement in the reduction of HCAIs in particular C-difficile although we are currently meeting the limit set by NHS England. An action plan is in place which is being monitored via the Infection Prevention and Control Committee;
2. The delivery of same sex accommodation in all clinical areas in the Trust given the change in reporting due to CCG concerns of the previously agreed justifiable criteria based on clinical need. Work is in progress within the

Divisions to ensure we meet these standards;

3. The consistent achievement of the response rate standard for formal complaints. Although we have achieved this for 3 consecutive months, the length of time complaints are open now needs focus to maintain our improvement journey. The Complaints Management Steering Group oversees the delivery of the Improvement Plan;
4. The maintenance of the improvement in patient satisfaction as depicted by the FFT. Divisions are addressing specifically the feedback and developing plans to address patients' concerns;
5. The maintenance of safe staffing levels given the vacancy factors and occasions where extra beds are opened due to operational pressures. A robust recruitment and retention action plan is in place including an overseas recruitment drive to ensure our war staffing remains safe;
6. Successful delivery of the CQC Improvement Plan. Divisions are progressing the actions and monthly meetings with Monitor are in place.

FINANCIAL AND RESOURCE IMPLICATIONS:

Continuous improvement in quality and patient safety will make a contribution to the effective and efficient use of resources.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

Reduction in clinical quality and patient safety will impact on NHSLA activity and litigation costs.

Most of the patient outcomes are assessed against the nine protected characteristics in the Equality & Diversity report that is prepared for the Board of Directors annually.

The CQC embed Equality & Diversity as part of their standards when compiling the Quality Risk Profile.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

None

ACTION REQUIRED:

(a) Discuss and agree recommendations.
(b) To note

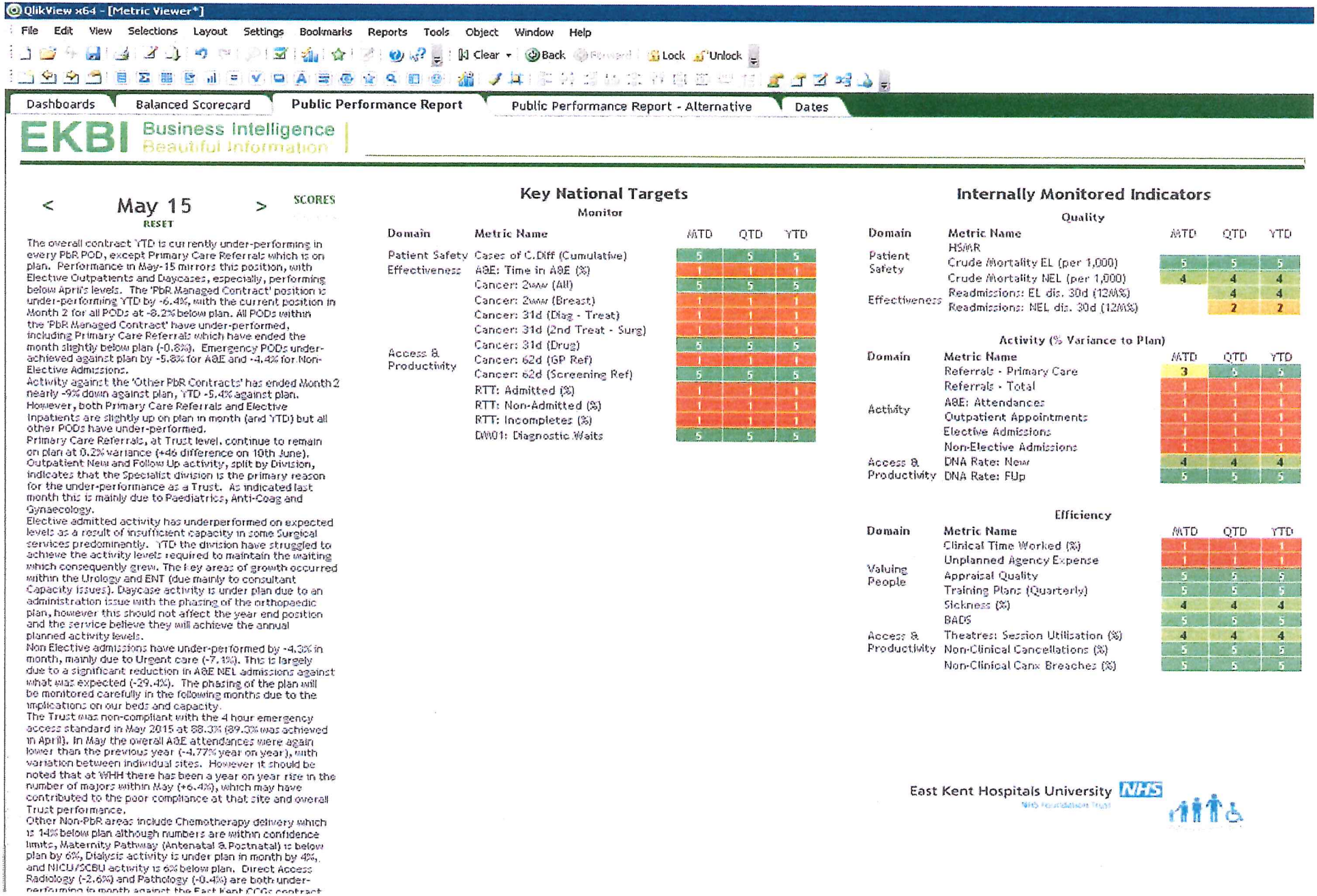
CONSEQUENCES OF NOT TAKING ACTION:

Pace of change and improvement around the patient safety programme and patient experience will be slower. Inability to deliver a safe, high quality service has the potential to affect detrimentally the Trust's reputation with its patients and within the wider health economy.

Introduction

A summary of key trends and actions of the Trust's performance against the clinical quality and patient safety indicators is provided together with supporting narrative. The report is structured around the key themes of the annually published Quality Report/Account; Patient Safety, Patient Experience and Clinical Effectiveness.

	Measure	Improvement Metric		Target 15/16	Dec-14	Dec-13	vs Dec-13	YTD
Patient Safety	Mortality Rates	HSMR		-	80.1	83.3	↓	
					Q1 14/15	Q1 13/14	vs Q1 13/14	YTD
		SHMI (%)		-	95.30%	95.51%	↓	-
					May-15	May-14	vs May-14	YTD
		Crude Mortality: All Ages (Per 1000)	Non-Elective	-	28.940	26.365	↑	30.244
			Elective	-	0.117	0.117	↓	0.232
	Risk Management	Serious Incidents (STEIS)	New Incidents	-	6	8	↓	-
			Open Incidents	-	71	47	↑	Cumul.
	HCAI	MRSA	Attributable	0	0	0	↔	Cumul.
		C. difficile	Post 72h	45	7	7	↔	Cumul.
	Infection Prevention				Apr-15	Apr-14	vs Apr-14	YTD
		Mandatory Training Compliance (%)		95.0%	81.0%	82.6%	↓	81.0%
					May-15	May-14	vs May-14	YTD
		Mandatory Training Compliance (%)		95.0%	78.5%	83.3%	↓	79.9%
	Harm Free Care (HFC)				May-15	May-14	vs May-14	YTD
		Safety Thermometer HFC (%) - Old & New Harm	EKHUFT	93.0%	94.4%	93.5%	↑	93.4%
			National	-	94.0%	93.6%	↑	-
	Nurse Sensitive Indicators	Pressure Ulcers: Category 2,3 and 4	Acquired	-	26	22	↑	56
			Avoidable	79	7	10	↓	10
		Falls		-	150	172	↓	313
	Clinical Incidents	Total Clinical Incidents		-	1101	1102	↓	2172
Patient Experience	Compliments and Complaints	Compliments:Complaints		-	29:1	21:1	↑	-
		No. Care Spells per Formal Complaint		-	1010	864	↑	-
	Experience	Friends and Family Test (Star Rating)		5.0	4.7	4.4	↑	-
		Adult Inpatient Experience (%)		80.00%	89.20%	88.92%	↑	-
		Mixed Sex Accommodation Occurrences		-	14	7	↑	28
Clinical Effectiveness	Readmission				Apr-15	Apr-14	vs Apr-14	YTD
		7 Day (%)		2.00%	4.06%	4.24%	↓	4.06%
		30 Day (%)		8.32%	8.42%	9.12%	↓	8.42%
	CQUIN				May-15	May-14	vs May-14	YTD
		Standard Contract CQUIN		Multiple			↔	
		Specialist CQUIN		Multiple			↔	
	Bed Usage	Bed Occupancy (%)		-	81.77%	98.30%	↓	-
		Extra Beds (%)		-	5.35%	6.04%	↓	5.85%
		Outliers		-	22.42	30.26	↓	60.95
		Delayed Transfers of Care (Average)		-	35.50	39.80	↓	33.55
Care Quality Commission	Intelligent Monitoring Report	Outcome Measures	Risks	-	3	4	↓	-
			Elevated Risks	-	6	1	↑	-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Dashboards
Balanced Scorecard
Public Performance Report
Public Performance Report - Alternative
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RESET
SCORES
The overall contract YTD is currently under-performing in every PbR POD, except Primary Care Referrals which is on plan. Performance in May-15 mirrors this position, with Elective Outpatients and Daycases, especially, performing below April's levels. The 'PbR Managed Contract' position is under-performing YTD by -6.4%, with the current position in Month 2 for all PODs at -8.2% below plan. All PODs within the 'PbR Managed Contract' have under-performed, including Primary Care Referrals which have ended the month slightly below plan (-0.8%). Emergency PODs under-achieved against plan by -5.8% for A&E and -4.4% for Non-Elective Admissions.
Activity against the 'Other PbR Contracts' has ended Month 2 nearly -9% down against plan, YTD -5.4% against plan. However, both Primary Care Referrals and Elective Inpatients are slightly up on plan in month (and YTD) but all other PODs have under-performed.
Primary Care Referrals, at Trust level, continue to remain on plan at 0.2% variance (+46 difference on 10th June). Outpatient New and Follow Up activity, split by Division, indicates that the Specialist division is the primary reason for the under-performance as a Trust. As indicated last month this is mainly due to Paediatrics, Anti-Coag and Gynaecology.
Elective admitted activity has underperformed on expected levels as a result of insufficient capacity in some Surgical services predominantly. YTD the division have struggled to achieve the activity levels required to maintain the waiting which consequently grew. The key areas of growth occurred within the Urology and ENT (due mainly to consultant Capacity issues). Daycase activity is under plan due to an administration issue with the phasing of the orthopaedic plan, however this should not affect the year end position and the service believe they will achieve the annual planned activity levels.
Non Elective admissions have under-performed by -4.3% in month, mainly due to Urgent care (-7.1%). This is largely due to a significant reduction in A&E NEL admissions against what was expected (-29.4%). The phasing of the plan will be monitored carefully in the following months due to the implications on our beds and capacity.
The Trust was non-compliant with the 4 hour emergency access standard in May 2015 at 88.3% (89.3% was achieved in April). In May the overall A&E attendances were again lower than the previous year (-4.77% year on year), with variation between individual sites. However it should be noted that at WHH there has been a year on year rise in the number of majors within May (+6.4%), which may have contributed to the poor compliance at that site and overall Trust performance.
Other Non-PbR areas include Chemotherapy delivery which is 14% below plan although numbers are within confidence limits, Maternity Pathway (Antenatal & Postnatal) is below plan by 6%, Dialysis activity is under plan in month by 4%, and NICU/SCBU activity is 6% below plan. Direct Access Radiology (-2.6%) and Pathology (-0.4%) are both under-performing in month against the East Kent CCGs contract
Key National Targets
Monitor
Domain Metric Name MTD QTD YTD
Patient Safety Cases of C.Diff (Cumulative) 5 5 5
Effectiveness A&E: Time in A&E (%) 1 1 1
Cancer: 2WW (All) 5 5 5
Cancer: 2WW (Breast) 1 1 1
Cancer: 31d (Diag - Treat) 1 1 1
Cancer: 31d (2nd Treat - Surg) 1 1 1
Cancer: 31d (Drug) 5 5 5
Access & Productivity Cancer: 62d (GP Ref) 1 1 1
Cancer: 62d (Screening Ref) 5 5 5
RTT: Admitted (%) 1 1 1
RTT: Non-Admitted (%) 1 1 1
RTT: Incompletes (%) 1 1 1
DM01: Diagnostic Waits 5 5 5
Internally Monitored Indicators
Quality
Domain Metric Name MTD QTD YTD
Patient Safety HSMR
Crude Mortality EL (per 1,000) 5 5 5
Crude Mortality NEL (per 1,000) 4 4 4
Effectiveness Readmissions: EL dis. 30d (12M%) 4 4
Readmissions: NEL dis. 30d (12M%) 2 2
Activity (% Variance to Plan)
Domain Metric Name MTD QTD YTD
Activity Referrals - Primary Care 3 5 5
Referrals - Total 1 1 1
A&E: Attendances 1 1 1
Outpatient Appointments 1 1 1
Elective Admissions 1 1 1
Non-Elective Admissions 1 1 1
Access & Productivity DNA Rate: New 4 4 4
DNA Rate: FUp 5 5 5
Efficiency
Domain Metric Name MTD QTD YTD
Valuing People Clinical Time Worked (%) 1 1 1
Unplanned Agency Expense 1 1 1
Appraisal Quality 5 5 5
Training Plans (Quarterly) 5 5 5
Sickness (%) 4 4 4
BADS 5 5 5
Access & Productivity Theatres: Session Utilisation (%) 4 4 4
Non-Clinical Cancellations (%) 5 5 5
Non-Clinical Canx Breaches (%) 5 5 5
East Kent Hospitals University NHS

FINANCIAL COMMENTARY - MAY 2015

East Kent Hospitals University NHS
NHS Foundation Trust

Overview of Trust Financial Performance

Trust Key Performance Indicators (£m)	Annual target	Year to Date Plan	Year to Date Actual
Total operating income	541.9	88.4	86.6
CIP savings	25.2	3.4	1.1
EBITDA	14.7	0.7	(1.7)
I&E net surplus	(17.3)	(3.9)	(6.2)
Cash balance	11.0	19.8	25.7

Monitor Continuity of Service Risk Rating	Annual target	Year to date Plan	Year to Date Actual
Continuity of Service Risk Rating	2.5	2	2.0

The financial statements and summaries in this report are prepared for internal performance monitoring purposes and have not been audited. The Trust accepts no liability for any decisions made by persons external to the Trust based on this information.

Note: Detailed financial tables are on page 3

Statement of Comprehensive Income (Income and Expenditure)
The Income and Expenditure YTD position is £(2.3)m adverse against a plan of £(3.8)m.
- The subsidiary company (Healthex Limited which runs the Spencer Wing at QEQMH) is reporting a YTD deficit of £(0.1)m which is below plan by £(0.1)m and not included in the above position.

Improvement Programme
The Trust's net financial efficiency target for 2015-16 financial year is £25.2m. Savings delivered in the month of May were £(624k) below expected target. The full year delivery now stands at £(14.8)m below plan and £(24.1)m below target. (see page 4).

Statement of Financial Position (Balance Sheet)
The Trust Statement of Financial Position and Cash summary are set out on page 3. Trade and Other Receivables have decreased in month by £10m mainly due to NHS England Commissioning Hub, South East & Wessex overperformance 2014/15 contract totalling £7.6m. Also credit notes issued to Maidstone & Tunbridge Wells £0.9m and prepayments increased by £1.5m following receipt of Maintenance and other invoices covering full year. Accruals increased by £0.6m in month and Deferred Income decreased by £2.5m.

Capital Expenditure Programme
The table on page 3 summarises £2.24m of expenditure on capital projects in the year so far.

Financial Performance Indicators
The Trust is achieving the rating of 2 under Monitor's Continuity of Service Risk Rating.

Identified Financial Risks
The risk of ongoing adverse performance in the delivery of the CIP target.
Final agreement and managing within the Winter Funding envelope for 2015/16.
The risk of overspends on Agency Staff and non-delivery of CIP targets could result in cash shortaes
Month 3 plan is for a siginificant surplus which will require a much improved financial performance. Failure to achieve this plan will inevitably impact our year end forecast

How financial risks are being addressed
The following actions are in place:
- The establishment of a Financial Recovery Group to develop and drive a robust Financial Recovery Plan.
- Reduction in the use of Agency staff and delivery of CIP's

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS**

DATE: **9 JULY 2015**

SUBJECT: **CQC ACTION PLAN**

REPORT FROM: **CHAIR OF IMPROVEMENT PLAN DELIVERY BOARD**

PURPOSE: **Discussion**
Information

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

- The Trust was put into special measures following a CQC inspection in March 2014.
- In response the Trust developed an action plan based on the 21 Key Findings and 26 Must Do areas that were identified in the CQC report.
- Detailed action plans were developed at Divisional level. These feed into the High Level Improvement Plan (HLIP) to give an overall picture of progress.
- The Improvement Plan Delivery Board (IPDB) monitors progress against the HLIP and associated action plans. The IPDB is chaired by David Hargroves, Consultant Physician (who commenced in December). It has met monthly since 29 Oct 2014. The terms of reference for the IPDB were approved by the Board on 30 October 2014.
- A Programme Management Office has been established to oversee delivery of the action plans.
- Sue Lewis has been appointed by Monitor as the Improvement Director.
- Progress towards achievement of the HLIP is recorded monthly in the Special Measures Action Plan. This is submitted to Monitor via Sue Lewis. It is then uploaded to the NHS Choices website and EKHUFT staff and public websites.
- CQC have announced that that the Trust will be re-inspected in the w/c July 13th 2015. This will be a full re-inspection with around 30 inspectors.
- The inspection is expected to cover the following services: urgent and emergency services, medical care (including older people's care), surgery, critical care, maternity and gynaecology, services for children and young people, end of life care, outpatients and radiology.
- In the week prior to the visit, CQC will run focus groups on each site. On Tuesday 7th July they will visit WHH, on Wednesday 8th July they will visit K&C and on Thursday 9th July they will visit QEQM. There will be 7 focus groups on each site, covering all staff groups.
- The CoG will have the opportunity to speak to Alan Thorne, Head of Hospital Inspectors CQC, at their meeting on 9th July.

PROGRESS TO DATE

Progress towards achievement of the Improvement Plan is recorded monthly in the Special Measures Action Plan. This is submitted to Monitor and is then uploaded to the NHS Choices website and EKHUFT staff and public websites.

The submission made on 11th June is attached.

Monthly meetings, chaired by Monitor, take place to review performance against the Improvement Plan. The agenda covers both achievements and areas of risk.

Achievements shared with Monitor at the last two meetings, which took place on 20th May and 17th June, included:

- The very successful nurse, midwife and allied health care professionals conference which celebrated innovation and best practice. The conference attracted over 200 staff and focussed on our trust values of caring, safe and making a difference. Many of the sessions were captured on video so that they can be shared more widely.

- The running of a fourth Schwartz round at WHH. This was a meeting to provide an opportunity for staff from all disciplines to reflect on the emotional aspects of their work. These events have proved to be very successful with over 100 staff attending each event.

- That we have introduced a very successful forum for consultants. The first forum, held in May, attracted over 120 consultants. The next forum will take place in early July. Forums are now being established for other staff groups.

- That we are piloting a new style of Team Brief in the UCLTC Division to improve engagement with staff.

- That we have been named as one of 25 organisations to be welcomed to NHS Employers 'Equality and Diversity Partners Programme after successfully demonstrating that we have achieved six measurable criteria including, 'empowering, engaging and supporting staff''.

- That we held an Ophthalmology Nursing forum, attended by delegates from across South England, to share experiences and showcase work done at EKHUFT.

- That EKHUFT was named as the best performer in a recent European audit of andrology laboratories.

- That we have launched 'Hello my name is..' campaign which commits staff to introducing themselves to patients, visitors and staff.

- That we have opened Improvement and Innovation Hubs to give staff the opportunity to learn about and to contribute to Our Improvement Journey.

- That fifty members of staff have volunteered to be workplace buddies and to provide support to the 'Respect each other' programme.

- That we have run face to face e-learning clinics on the three main sites to support staff who have difficulty accessing the e-Learning.

- That laboratory medicine have turned paperless with all internal reports now being generated electronically so that test results are made available more quickly.

- That we have held conferences on the Mental Capacity Act and on Deprivation of Liberty Safeguards and run training on Safeguarding Children

and Sepsis Awareness.

- That we have received praise from Ashford CCG about the systems we have put in place to manage infection rates. (We have had a 50% reduction in rates of C. difficile in the last 6 months.)

- That we have increased the format and frequency of the CEO forums for staff; they are now held monthly and on as many sites as possible.

- That we have developed a staff charter from staff feedback on what a good working environment feels like to encourage people to become more aware of the way they behave.

Areas of risk that were discussed at the last meetings Included:

- recruitment and retention of staff (A&E, paediatrics, general);
- outpatient booking system;
- mandatory training;
- storage of medications;
- patient flow; and
- cleaning at K&CH.

PREPARATION FOR CQC RE-VISIT

Preparations are now well underway for the CQC re-inspection which will take place w/c 13 July 2015.

The re-inspection will be a full inspection covering K&CH, QEQM, WHH and Dover. It is expected that there will be around 30 inspectors in total.

In addition there will be unannounced visits - probably in the two weeks prior to 13 July 2015.

The focus for the preparation will be the key lines of enquiry associated with the domains of safe, effective, caring, responsive and well-led for each of the services to be visited.

A short-term multi-disciplinary steering group has been set up to oversee preparations for the CQC re-inspection. The membership of the group is very wide and includes staff from all Divisions and all sites. This group meets weekly and reports into the Improvement Plan Delivery Board chaired by David Hargroves. The preparation for the inspection, and the inspection itself, is seen as a key milestone in our improvement journey which is going to take much longer to ensure that effective clinical leadership and cultural change is fully embedded.

The steering group has agreed the approach to preparing for inspection and has focussed efforts on developing site based teams and on developing materials to support the site-based hospital teams in preparing for inspection.

The site-based teams are now well established and meet weekly in a designated 'Improvement Hub' room. The teams undertake mini-inspections, hold focus groups and keep staff informed of Our Improvement Journey. A handbook has been produced to help staff understand the inspection process and this was issued to all staff with the May payslips.

On Friday 8 May we held a mock inspection of QEQM, K&C and WHH; over 60 staff, patients, carers and external colleagues participated in the event. Using the CQC's key lines of enquiry (KLOEs), visits were undertaken to inspect our progress against the improvement plan and the five domains of safe, effective, caring, responsive and well-led. In addition, three focus groups took place, and a separate group reviewed our data and information packs.

Feedback was given on the day and clarification and queries discussed. There were celebrations around the way some of our services are delivered and, in particular, around the compassion and caring displayed by our staff. There were a number of improvement points identified including: cleanliness, information governance compliance and medicines management compliance.

On Monday 11 May the Improvement Plan Delivery Board held an away day where each Executive and Director was asked to provide an update on their actions from the CQC action plan. This was a useful meeting as it enabled full discussion of issues that remain outstanding including:

- Staffing issues;
- Medicines management;
- Mixed sex accommodation compliance;
- Out of hours paediatric cover in A&E;
- Staff training.

We are now liaising with the CQC officers to ensure all necessary preparations are in place to support the CQC inspection which is expected to take place as follows:

14th July – WHH
15th July – K&C
16th July – QEQM.

We have already submitted all requested data to the CQC. This was a large quantity of data that was sourced from both Divisions and the Information Department. CQC will review the data pack and use it to inform their visit.

We are now working on logistical arrangements including setting up the focus groups (planned for July 7th, 8th and 9th), booking rooms, ordering car parking permits, arranging admin support, obtaining access to IT systems, checking transport arrangements, pulling together a Welcome Pack for the CQC inspectors, producing a briefing pack for the Executive Team to ensure that they have immediate access to the latest facts and figures when in meetings with the CQC, ordering refreshments etc.

Risks in respect of re-inspection

The key risks that have been identified in respect of the re-inspection are:

- Funded establishment may not be reflected in ward staffing due to vacancies, sickness and outcome of ward staffing review not being fully implemented yet.

- Staff not being able to articulate consistently any changes following a complaint, incident or other investigation and not being aware of the recent changes to NHS England guidance on never events and SIs. Their statutory responsibilities for duty of candour may not be well embedded. The understanding of some medical staff in reporting incidents does not align well with their professional responsibilities.

- Mandatory training reporting contains inaccuracies leading to lower compliance being reported than is true. Inability of workforce information to provide up to date information on training compliance.

- Non-compliance with mixed sex accommodation requirements.

- SharePoint not holding all up-to-date policies.

- Staff whistle-blowing directly to the CQC. Staff not aware of communication around the re-visit schedule or the progress towards the action plan

- '5 question' audits to assess staff knowledge still need to be developed using a stable platform on an Apple format.

- End of Life Care pathway - staff not consistently aware of the how to describe the current pathway, pain relief and decision-making issues.

- Segregation of paediatric areas within Day Case Surgery, A&E and out-patient areas is not yet completed. Resuscitation trolleys not always segregated for paediatrics in areas where adults, children and young people are cared for in co-located environments.

- Routine checking of drugs, fridge temperature, fridge locking and resuscitation trolleys in clinical areas not being undertaken on a daily basis.

- The risk that staff will express concern or uncertainty around the clinical strategy for the Trust if communication is unclear. There is a possibility that discussion of the proposals for the clinical strategy, which are not in line with the required local consultations, may result in a Judicial Review of the entire process.

- Inconsistent levels of awareness amongst staff regarding the statutory duty of candour responsibilities.

- Inconsistent and out of date information leaflets available for patients at ward and departmental level.

The mitigation of the risks is being discussed and addressed through the steering group and the overall improvement plan delivery board

ENGAGEMENT WITH GOVERNORS

The support of the governor's - both now, as we prepare for the CQC inspection next week, and in the longer term, as we continue our improvement journey - is vital.

The Chief Nurse, Director of Quality and the Clinical Lead for the CQC Improvement Programme wrote to all governors on Monday 20th April inviting them to support preparations for the re-inspection by joining one of the site based teams. Two governors responded: Jane Burnett (who volunteered to join the WHH team) and Sarah Andrews (who volunteered to join the K&C team). In addition David Bogard (staff governor) volunteered to be part of the site based team at K&C.

RECOMMENDATIONS:

The Council of Governors is invited to note the report and the progress to date.

NEXT STEPS:

We will welcome the CQC inspectors next week (w/c July 13th). On the first day the inspectors will have a 30 minute presentation from Chris Bown, they are then expected to spend the rest of the day planning their visit and then the remainder of the week on site visits.

East Kent Hospitals University NHS
NHS Foundation Trust

Special Measures Action Plan

East Kent Hospitals University NHS Foundation Trust

11 JUNE 2015

KEY
Delivered
On Track to deliver
Some issues – narrative disclosure
Not on track to deliver

East Kent Hospitals University NHS Foundation Trust – Our improvement plan & our progress

What are we doing?

- The Trust was put into special measures following a CQC inspection with reports that identified two of the three main sites as "inadequate" and the Trust rated overall as "inadequate". The sites rated as inadequate were the Kent and Canterbury Hospital and the William Harvey Hospital. The Trust was also rated "inadequate" in the safety and well-led domains.
- This is the ninth NHS Choices Action Plan report since the Trust was put into special measures on 29 August 2014.
- The Trust was given a number of recommendations, some of which have already been actioned. Issues of organisational culture ran throughout the reports and we envisage that improvements to address these issues fully will be long term actions, however, we are undertaking a diagnostic programme to signpost the most immediate concerns and prioritise these areas. It is likely that the timeframe to embed organisational cultural change will be long term and we have set out a detailed programme supporting our High Level Improvement Plan. The Trust agreed a summary action plan to deal with the 21 key findings and 26 must do areas for action. We recognised all of the recommendations and are addressing them through current actions being taken to improve the quality of services. The Trust will set out a longer-term plan to maintain progress and ensure that the actions lead to measurable improvements in the quality and safety of care for patients when the Trust is re-inspected.
- The key themes of these recommendations, which underpin our Improvement Plan, recognising that some of them overlap, are summarised by the headings below:
  - Trust leadership overall and at the individual sites inspected;
  - Staff engagement and organisational culture to address the gap between frontline staff and senior managers;
  - Safe staffing in nursing, midwifery, consultant and middle grade medical staff and some administrative roles;
  - Staff training and development, specifically around mandatory training;
  - Data accuracy and validation of information used by the Board, specifically A&E 4-hourly wait performance and compliance with the WHO safer surgical checklist and mixed-sex accommodation reporting;
  - Demand and capacity pressures on patient experience, specifically within the emergency pathway and out-patient areas;
  - Following national best practice and policy consistently; specifically staff awareness of the Trust's Incidence Response Plan in A&E:
  - Caring for children and young people outside dedicated paediatric areas;
  - Estate and equipment maintenance and replacement programme concerns.

Since the last report:

- We have been named as one of 25 organisations to be welcomed to NHS Employers 'Equality and Diversity Partners Programme after successfully demonstrating that we have achieved six measurable criteria including, 'empowering, engaging and supporting staff''.
- We held a very successful nurse, midwife and allied health care professionals conference, to celebrate innovation and best practice. The conference attracted over 200 staff and focussed on our trust values of caring, safe and making a difference. Many of the sessions were captured on video so that they can be shared more widely.
- We held an Ophthalmology Nursing forum, attended by delegates from across South England, to share experiences and showcase work done at EKHUFT.
- We have held conferences on the Mental Capacity Act and on Deprivation of Liberty Safeguards and run training on Safeguarding Children and Sepsis Awareness.
- EKHUFT was named as the best performer in a recent European audit of andrology laboratories.
- We have undertaken a mock inspection in preparation for the CQC re-inspection in July.
- We have opened Improvement and Innovation Hubs to give staff the opportunity to learn about and to contribute to Our Improvement Journey.
- We have received praise from Ashford CCG about the systems we have put in place to manage infection rates. (We have had a 50% reduction in rates of C. difficile in the last 6 months.)
- We have increased the format and frequency of the CEO forums for staff; they are now held monthly and on as many sites as possible.
- We have developed a staff charter from staff feedback on what a good working environment feels like to encourage people to become more aware of the way they behave. We have held a 'Respecting each other' campaign to encourage staff to sign up to the Staff Charter.
- We have received 170 comment cards from staff on how we can make this a better place to work and are now looking at how the suggestions can be implemented.
- UCLTC have introduced a monthly staff recognition programme, 'You made a difference', to recognise staff that 'have gone the extra mile'.
- We have launched 'hello my name is..' campaign which commits staff to introducing themselves to patients, visitors and staff.

This document shows our plan for making the required improvements and demonstrates our progress against the plan. While we take forward our plans to address the 47 recommendations, the Trust is in 'special measures'. This document builds on the summary of actions identified at the Quality Summit with our partners, external stakeholders and the CQC.

- Oversight and improvement arrangements have been put in place to support changes required; this is being led at Executive and Divisional Leadership level to ensure successful implementation. The programme of improvement has a structured approach with a Programme Management Office directly responsible to the CEO.

East Kent Hospitals University NHS Foundation Trust – Our improvement plan & our progress

Who is responsible?

- Our actions to address the recommendations have been agreed by the Trust Board and shared with our staff.
- Our Interim Chief Executive, Chris Bown, is ultimately responsible for implementing actions in this document. Other key staff are the Interim Chief Nurse, Director of Quality and the Medical Director, who provide the executive leadership for quality, patient safety and patient experience.
- The Board welcomed a new chair (Nikki Cole), two new Non-Executive Directors (Colin Thompson and Barry Wilding) and a new Finance Director (Nick Gerrard) in May.
- The Improvement Director assigned to East Kent Hospitals University NHS Foundation Trust is Susan Lewis, who will be acting on behalf of Monitor and in concert with the relevant Regional Team of Monitor to oversee the implementation of the action plan overleaf and ensure delivery of the improvements. Should you require any further information on this role please contact specialmeasures@monitor.gov.uk
- Ultimately, our success in implementing the recommendations of the Trust's High Level Improvement Plan (HLIP) will be assessed by the Chief Inspector of Hospitals, upon re-inspection of our Trust. The CQC have indicated that this inspection will take place in the week commencing 13th July 2015.
- If you have any questions about how we're doing, contact our Trust Secretary, Alison Fox on 01227 766877 (ext 722 2518) or by email at alison.fox4@nhs.net

How we will communicate our progress to you

- We will update this progress report every month while we are in special measures, which will be reviewed by the Board and published on our website. This section of the Board meeting will be held in public. We will continue to share regular updates with our staff through team meetings, staff newsletters and the CE Forum.
- There will be monthly updates on NHS Choices and subsequent longer term actions may be included as part of a continuous process of improvement.
- The Trust has scheduled a monthly progress meeting with the four CCGs. In addition the Trust has held several engagement events with external stakeholders including Kent County Council, East Kent Association of Senior Citizens' Forums and Ashford CCG PPG.

Chair / Chief Executive Approval (on behalf of the Board):

Chair Name: Nikki Cole	Signature: 	Date: 11/06/2015
Interim Chief Executive Name: Chris Bown	Signature: 	Date: 11/06/2015

East Kent Hospitals University NHS Foundation Trust – How our progress is being monitored and supported

Summary of Main Concerns	Summary of Urgent Actions Required	Agreed timescale	Revised deadline (if required)	Progress against original time scale	External Support/ Assurance
Safe	Ensure there is a sufficient number and mix of suitably qualified, skilled and experienced staff across the Trust, including A&E, on wards at night and in areas where children are treated.	Sept 2015	N/A	We have launched a new, more co-ordinated induction process for all new staff. This will help ensure that new starters enjoy a more positive working experience from their very first day with the Trust and will provide them with immediate access to all necessary IT systems so that they will be able to hit the ground running when they report for work. The 'Welcome Day' will be run twice a month with all new starters attending on the first day that they start work. We are also working hard to retain staff and have introduced exit interviews so that we can better understand why staff leave the Trust.	HEKSS for workforce redesign
	Ensure that there is a Board level lead for children and young people (and that staff know who this is) and that, in all areas where children are treated, equipment is safe and there are appropriately trained paediatric staff.	March 2015 and on-going	N/A	We have appointed a new Board level lead for children as the previous lead has now left the Trust. All staff have been notified through: the Chief Executive's Blog and through Team Brief. Paediatric trained staff are available in A&E, but only between 8am and 8pm - which is when the majority of children attend A&E. We are recruiting to fill vacancies but with limited success. From September paediatric training will be started for 'adult' nurses, but this will not be completed until April 2016. In the meantime, paediatric staff from wards provide support if children arrive in A&E at night.	N/A
	Ensure staff are up to date with mandatory training.	March 2015	Sept 2015	All mandatory training is provided through e-learning but some staff had difficulty accessing the training due to incompatibility of IT systems. The access issues are expected to be resolved by the end of June when the new training App is made available. This will be accessed via an icon on each desktop computer. In the meantime, staff who have difficulty accessing the e-learning modules, may drop into one of the 2 hour e-Learning clinics where they will be able to complete their e-Learning with face to face support. We have also reviewed the quality of training provided and, as a result, have revised the content of the e-learning training in 5 of the 7 statutory subjects.	N/A
	Ensure that an effective system is in place for reporting incidents and never events and that Trust wide, all patient safety incidents are identified and recorded.	June 2015	August 2015	We are continuing to see incident rates improving. We are testing how well learning is embedded through regular testing using the 5 question approach. We have revised the adverse incident and serious incident policy. These have both been approved at QAB. We are completing the final testing of Datix v12.3 and expect it to be ready for roll out mid June. This version will give us the ability to provide feedback to staff who report incidents once the incident is closed. We have trained more staff in incident investigation and RCA analysis and have trained over 150 staff in Duty of Candour requirements.	External review
	Ensure patient treatments, needs and observations are routinely documented and that any risks are identified and acted on in a timely manner.	Sept 2015	N/A	Patient observations are undertaken with VitalPac, an electronic system that automatically uploads patient observations. We have fully addressed the WiFi issues and have a robust plan in place to ensure the system operates smoothly, including the provision of 24 hour support. Regular audits are now being undertaken to check that staff know what to do if patient observations are not uploaded or the action to take if a device is not working. This work is now continuing as business as usual.	N/A
	Ensure that the environment in which patients are cared for and that equipment used to deliver care is well maintained and fit for purpose.	June 2015	March 2016	We have introduced an electronic system for logging of all estates issues. This will make it easier for staff to report and then monitor progress of works. We have started the work to create a paediatric specific minor injury area in the Emergency Department at WHH. We are also making improvements to the observation section of the majors area. We expect this work to be completed within 6 months. We have set up equipment libraries on all three main sites. These are now well established and have proved very successful.	N/A

East Kent Hospitals University NHS Foundation Trust – How our progress is being monitored and supported

Summary of Main Concerns	Summary of Urgent Actions Required	Agreed timescale	Revised deadline (if required)	Progress against original time scale	External Support/ Assurance
Safe	Ensure that protective clothing for staff is in good supply and that cleaning schedules are in place across the hospital and that in-depth cleaning audits take place.	Dec 2014	March 2015	Both QEQM and WHH show consistently good, audited levels of cleaning. Maintaining sustainable standards at KCH, however, remains a challenge. Weekly review meetings take place between providers and matrons. The recruitment of additional supervisors at KCH is well underway but training is taking some time so temporary supervisors have been brought in from other sites to provide support during this 'on-boarding' phase.	N/A
	Ensure that evidence from clinical audits is used to improve patient care.	April 2015 and on-going	N/A	Each Division has produced and presented clinical audit plans to the Clinical Audit Committee These plans were signed off by the Quality Committee in April. The plans have the backing of all four Divisional Medical Directors and will ensure we have a robust audit programme in 2015/16. Moving forward, we have reviewed the structure of the clinical audit team and have identified a Lead to work more closely with the Divisions to provide support: - in the development of robust audit plans with a focus on implementing changes to practice that will lead to improvements in patient care and - to ensure better recording of clinical audit projects. This work is now continuing as business as usual.	CHKS
	Ensure medications are stored safely and that the administration of all controlled drugs is recorded	Feb 2015	N/A	There is a detailed bi-annual audit undertaken in November and May each year. (The results of the May audit are currently being analysed and will be reported next month.) In addition there are focussed monthly audits covering five key areas: % of medicine fridges that are locked, % of drug cabinets that are locked, % of medicine fridges at correct temperature, that the correct pharmaceutical waste bins are used and that oral liquids have not been administered intravenously in error. These audits have not have shown any significant improvement in compliance. The estates team have now ben asked to check that all fridges can be locked, the Quality Assurance Pharmacist has been asked to check systems for monitoring fridge temperatures and Heads of Nursing have been asked to remind staff to lock fridges. The controlled drugs policy has been rewritten and this details two person sign off for all controlled drugs. A monthly audit is now undertaken to test compliance . This is showing a steady improvement in compliance from 59% in month 1 to over 80% compliance in month 3.	N/A
Effective	Ensure that all paper and electronic policies, procedures and guidance are up to date and reflect evidence-based best practice	March 2015	July 2015	A Task and Finish Group meets regularly to oversee delivery of this action and to ensure that the existing electronic storage system is fit for purpose. All Divisions have action plans in place to review and update all policies by July 2015. The Task and Finish Group reviews the Divisional action plans on a monthly basis to ensure that all are on track for delivery and to assesses risk in relation to policies that still require updating.	N/A
	Ensure that all relevant policies and procedures for children reflect best practice / NICE quality standards	April 2015	N/A	All Trust policies and guidance for children have been reviewed and updated. A full audit is being planned and spot checks and face to face audits will be completed to ensure all staff are fulfilling their roles in accordance with current guidelines. This work is now continuing as business as usual.	N/A

East Kent Hospitals University NHS Foundation Trust – How our progress is being monitored and supported

Summary of Main Concerns	Summary of Urgent Actions Required	Agreed timescale for implementation	Revised timeline	Progress against original time scale	External Support/ Assurance
Effective	• Ensure the flow of patients through the hospital is effective and responsive, that patients are not moved unnecessarily and that patients leave hospital, with their medications, when well enough.	March 2015	October 2015	There is an approved process for transferring patients out of hours. During the day, we are working towards a live bed state using VitalPac; this is being trialled on Cambridge ward. Overall, the number of times we move patients is reducing. In addition we are introducing a new acute model that will hopefully prevent patients being admitted to a ward and we are re-launching 'ticket home' so that patients, carers and staff are aware of the patient's planned date of discharge. We are also working with CCGs on best practice models such as 'discharge to assess' where patients are discharged once they are medically fit and have an assessment with the appropriate members of the social care and community intermediate care teams in their own home.	CCGs
	• Ensure that staff are fulfilling their roles in accordance with current clinical guidelines and also that children's services audit their practice against national standards.	March 2015	N/A	A framework of action is now in place; this includes reviewing all current clinical guidance and undertaking a gap analysis and ensuring all Divisions (including Specialist Services which covers children) have a detailed clinical audit programme in place for 2015/16. This work is now continuing as business as usual.	N/A
	• Improve staff awareness of the Trust's Incident Response Plan and ensure all necessary staff are appropriately trained	March 2015	Dec 2015	Following Board of Directors approval on 27th March 2015, the Trust's Major Incident Plan, was widely communicated throughout the Trust using both paper and electronic means. Hard copies of the policy have been issued to 114 area, 170 posters have been put up across the Trust and an electronic copy is available through SharePoint. A Training Needs Analysis has been undertaken to establish the core staff groups who require role essential training. A revised training programme started in April 2015. A&E front line staff have received their training and a schedule of training dates organised for other staff. All relevant staff are being actively encouraged to book a place on the training programme. For remaining staff, awareness training is being provided through DVD or New Starter Induction. In addition to table top exercises, there are two live exercises planned for this year (in June & October 2015).	N/A
Caring	• Review the provision of end of life care and make certain that staff are clear about the care of patients at the end of life and that all procedures, including the involvement of patients, relatives and the multidisciplinary team, are fully documented to ensure the effective and responsive provision of safe care.	March 2015 and on-going	N/A	We have reviewed the provision of end of life care to ensure staff are clear about the care of patients at the end of life and the procedures that must be followed. An audit has been undertaken to assess use of End of Life forms and the results were discussed at the April End of life board meeting and will feed into the on-going work plan which is overseen by the End of Life Board. This work is now continuing as business as usual.	N/A

East Kent Hospitals University NHS Foundation Trust – How our progress is being monitored and supported

Summary of Main Concerns	Summary of Urgent Actions Required	Agreed timescale for implementation	Revised timeline	Progress against original time scale	External Support/ Assurance
Responsive	• Review the complaints process and timeliness of response, ensuring compliance with regulations.	January 2015	N/A	The new complaints policy is now fully operational; it has been out for consultation, approved by the Clinical Advisory Group and ratified by the Quality Assurance Board (QAB). We have also made it easier for patients and relatives to contact us whether in person, by phone, by email or in writing. This work is now continuing as business as usual.	HealthWatch SEAP (Support, Empower, Advocate and Promote)
	• Improve the patient experience within outpatients by reviewing the Trust communication processes, reducing outpatient clinic waiting times and delays in follow up appointments.	September 2015	N/A	We have implemented partial booking of follow up appointments in ophthalmology and cardiology. The service improvement team is now reviewing benchmarked data around new to follow up ratios and DNA rates and working with clinicians on plans to roll out to other specialties in the year ahead.	Local commissioners to support with demand management
	• Ensure waiting times in pre-assessment clinics are not too long.	April 2015	July 2015	Following discussions with the consultants it has been agreed to revise the pre-assessments process. All patients, at point of listing, will receive a one-stop pre-assessment that will be valid for 3 months. If the patient's surgery does not take place within 6 weeks they will then receive a short nurse led pre-assessment to re-do bloods and swabs - at this point the consultant may also see the patient to do the consent or to review any special requirements such as equipment. The revised process will reduce patient waiting times in pre-assessment clinics and will give the service flexibility to better manage capacity.	N/A
Well-led	• Improve communication between senior management and frontline staff and address the cultural issues identified in the staff survey	Diagnostic undertaken by February 2015 and fully embedded by March 2017	N/A	Following the work with The Hay Group, a leadership development programme has been developed for all people managers The Executive team started the development programme on 5th May and divisional management teams will start the programme in early July. A one-day people manager programme has also been developed, focusing on increasing staff engagement. This programme is being delivered to all middle managers (Band 8) between May-July and will then be cascaded to front line managers from September. The first Consultant's forum was held in early May, with over one third of EKHUFT consultants attending, to deliver the results of a recent Medical Engagement survey. A second consultant forum will take place in July. Forums are also being set up for other staff groups including people managers and administrative staff.	External support to deliver programme
	• Ensure the governance and assurance of the organisation is robust by March 2015 • Implement the action plans from the governance reviews by September 2015	September 2015	N/A	External reviews have been undertaken. All final reports have now been received and responses to recommendations are now being actioned.	External review
	• Ensure that all clinical services are led by a clinician with leadership skills.	March 2016	N/A	We are launching a Leadership Academy on June 15th for all staff who have completed the Clinical Leadership Programme, the Aspiring Consultant Programme, the Medical Clinical Leadership Programme or equivalent. The Leadership Academy will enable the growing band of skilled clinical and systems leaders to work together as a critical community, to support the cultural change programme and to provide a test-bed for innovation.	N/A

East Kent Hospitals University NHS Foundation Trust – How our progress is being monitored and supported

Oversight and improvement action	Agreed Timescale for Implementation	Action owner	Progress
Appoint Improvement Director	September 2014	Monitor	Delivered – Susan Lewis appointed.
Independent reviews of data quality, divisional governance and safety systems at the Trust will be commissioned and have been completed within the next four months	September 2014 to January 2015	Trust Chief Executive	Data quality review - The final report has been received and an action plan drawn up based on the recommendations. Divisional governance review – The final report has been received and an action plan drawn up based on the recommendations. The actions are being monitored by the Improvement Plan Delivery Board (IPDB).
External quality governance review to look at how the Trust Board is performing, provide assurance it is operating effectively and identify further opportunities for improvement	October 2014 to January 2015	Chairman	Board governance review – The final report has been received and the Board of Directors has drawn up an action plan based on the recommendations. The actions are being monitored by the Improvement Plan Delivery Board (IPDB).
Regular conversations and monthly accountability meetings with Monitor to track delivery of action plan	September 2014 onwards	Trust Chief Executive/Monitor	Monthly accountability meetings are held with Monitor and key stakeholders.
Monthly meetings of the Trust Board will review evidence about how the Trust action plan is improving our services in line with the Chief Inspector of Hospitals recommendations	Throughout special measures	Chair of Improvement Plan Delivery Board	Monthly reports, detailing progress towards achievement of the action plan, are reviewed at each Board meeting.
Weekly Executive oversight meeting to drive the delivery of our plan	September 2014 onwards	Trust Chief Executive	The Executive Team meets weekly to review progress.
Local economy level consideration of whether the trust is delivering its action plan and improvements in quality of services by a Quality Surveillance Group (QSG) composed of NHS England Area Team, Clinical Commissioning Groups, Monitor, Care Quality Commission, Local Authority and Healthwatch	October 2014 onwards	Quality Surveillance Group	Monthly accountability meetings are held with Monitor and key stakeholders.
Monthly updates of this report will be published on our website	August 2014 onwards	Trust Chief Executive	The report is published on the Trust website, the staff intranet and is also emailed to key stakeholders
Establish an Improvement Plan Delivery Board (IPDB) chaired by a clinical lead	October 2014 onwards	Trust Chief Executive	The IPDB meets monthly, chaired by a clinical lead.
Inception of a Programme Management Office function for the entire programme IPDB	November 2014	Trust Chief Executive	The Programme Management Office, led by a senior clinician, is now fully established.
The Chief Inspection of Hospitals will undertake a full inspection of the Trust	July 2015	CQC	We are now preparing for the re-inspection which will take place in July this year.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS MEETING**

DATE: **9 JULY 2015**

SUBJECT: **PWC REVIEW UPDATE**

REPORT FROM: **INTERIM CHIEF EXECUTIVE**

PURPOSE: **Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

Following receipt of the draft CQC Report in July 2014, the then Chief Nurse and Director of Quality (on behalf of the Executive Team) commissioned a Divisional Governance review through PWC. The purpose of the review is to inform the on-going improvements to governance and quality assurance arrangements which are being made by the Trust.

PWC reported on 30 January 2015 and an action plan was put together by the sponsor and circulated to the Executive team for their input. The resultant action plan is shown as Appendix 1.

The Acting Chief Nurse and Director of Quality is taking a leading role to ensure the actions are being addressed. Many of the recommendations were discussed and addressed at the Divisional and Executive Team Away-day on 29 May 2015. The Trust Secretary is now holding and managing the action plan which is reviewed monthly by the Executive Team before being presented at the Improvement Plan Delivery Board. No actions will be closed until sufficient and relevant evidence is received.

SUMMARY:

- Many of the overdue actions are in relation to the governance structures and achieving consistency. Work is taking place and much of it completed in terms of design but implementation will be through July and August 2015. It is felt that the deadlines were overly ambitious but more could have been done to progress some of the actions.
- The Deloitte LLP Review also had recommendations about the structure and these are now being dealt with in parallel;
- The PWC actions are linked to the Deloitte review (final column) for ease.

RECOMMENDATIONS:

Discuss the recommendations is the PWC report and ensure that the proposed actions are robust enough to make the required change.

NEXT STEPS:

The report will be presented to the Improvement Plan Delivery Board on 24 June for challenge and onwards to the Council of Governors on 9 July. Monthly review by the Executive Team / Divisional Teams will continue.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

SO1: Deliver excellence in the quality of care and experience of every person, every time they access our services

SO2: Ensure comprehensive communication and engagement with our workforce, patients, carers, members GPs and the public in the planning and delivery of healthcare

LINKS TO BOARD ASSURANCE FRAMEWORK:

AO1: Delivering the improvements identified in the Quality Strategy in relation to patient safety, patient experience and clinical effectiveness

AO2:Embedding the improvements in the High Level Improvement Plan to ensure the Trust provides care to its patients that exceeds the fundamental standards expected

AO5: Developing, engaging and consulting on a clinically and commissioner supported strategy that achieves both medium and long terms clinical and financial stability

AO6: Delivering the cultural change programme to increase staff engagement and satisfaction

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

Risk Number	Summary
57	Quality, safety, financial & reputational consequences associated with the CQC's published report
3	Patient safety, experience & effectiveness compromised through inefficient clinical pathways/patient flow
59	Poor staff survey results and evidence of staff engagement

FINANCIAL AND RESOURCE IMPLICATIONS:

None directly in terms of implementing the recommendations. Cost involved in PWC's review.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

None

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES
N/A

ACTION REQUIRED:

(a) To note this report which was discussed by the Board on 26 June 2015.

CONSEQUENCES OF NOT TAKING ACTION:
Failure to move out of special measures / enforcement action.