East Kent Hospitals University NHS
NHS Foundation Trust

BOARD OF DIRECTORS MEETING
FRIDAY 8 APRIL 2016

Please find attached the agenda for the next meeting of the Board of Directors. The meeting will take place in the **Board Room, Kent and Canterbury Hospital, Ethelbert Road, Canterbury, CT1 3NG,** commencing at **14:00.**

AGENDA

1	Chairman's Welcome			
2	Apologies for Absence			
3	Declaration of Interests			
4	Minutes of the previous meeting held on 5 February 2015			
5	Matters arising from the public minutes of 5 February 2015			
6	Staff Story	**Decision**	**BoD 21/16**	Ward Managers, WHH Chief Nurse and Director of Quality
7	Chief Executive's Report	**Discussion**	**BoD 22/16**	Chief Executive
8	2016/17 Annual Objectives	**Decision**	**BoD 23/16**	Chief Executive
9	Chair's Actions	**To Note**	**BoD 24/16**	Chair
10	Performance Reports			
	• Corporate Performance Reports	**Discussion**	**BoD 25/16**	Director of Finance and Performance
	• Clinical Quality and Patient Safety	**Discussion**	**BoD 26/16**	Chief Nurse and Director of Quality
	• Key National Performance Targets	**Discussion**	**BoD 27/16**	Chief Operating Officer
	• Strategic Workforce Report	**Discussion**	**BoD 28/16**	Director of HR
11	Trust Improvement Plans:			
	• Improvement Plan	**Discussion**	**BoD 29/16**	Chief Nurse and Director of Quality
	• Turnaround Programme Report	**Discussion**	**BoD 30/16**	Turnaround Director/ Director of Finance and Performance
	• Emergency Recovery Plan	**Discussion**	**BoD 31/16**	Chief Operating Officer
12	2015 Staff Survey Results	**Decision**	**BoD 32/16**	Director of Human Resources

13	Health and Safety KPI Update	**Decision**	**BoD 33/16**	Director of Strategic Development and Capital Planning
14	Corporate Risk Register – Top 10	**Discussion**	**BoD 34/16**	Chief Nurse and Director of Quality
15	Medical Director's Report	**Decision**	**BoD 35/16**	Medical Director
16	Board Committee Feedback:			Committee Chairs
	Finance and Investment Committee	**Decision**	**BoD 36/16**	
	Quality Committee	**Discussion**	**BoD 37/16**	
	Strategic Workforce Committee	**Discussion**	**BoD 38/16**	
	Remuneration Committee	**Approval**	**BoD 39/16**	
	Nominations Committee	**Discussion**	**BoD 40/16**	
17	Feedback from Council of Governors, to include: • Feedback from NEDs aligned to Governor Committees		**Verbal**	Chair and Non Executive Directors
18	Any Other Business			
19	**QUESTIONS FROM THE PUBLIC**			

Date of next meeting in public:
10 June 2016, 14:00, Lecture Theatre, QEQM Hospital

UNCONFIRMED MINUTES OF THE SEVENTY-FIRST MEETING OF THE BOARD OF DIRECTORS FRIDAY 5 FEBRUARY 2016, 2PM, BOARD ROOM, WILLIAM HARVEY HOSPITAL

PRESENT:

Mrs N Cole	Chair	NC
Mr R Earland	Deputy Chair/Non-Executive Director	RE
Mr B Wilding	Senior Independent Director	BW
Mrs G Gibb	Non-Executive Director	GG
Mr S Mathur	Non-Executive Director	SM
Mr S Adeusi	Non-Executive Director	SA
Mr C Tomson	Non-Executive Director	CT
Mr R Hoile	Non-Executive Director	RH
Mr M Kershaw	Chief Executive	MK
Mr N Gerrard	Director of Finance and Performance Management	NG
Dr S Smith	Chief Nurse and Director of Quality	SSm
Dr P Stevens	Medical Director	PS
Ms J Ely	Chief Operating Officer	JE
Ms L Shutler	Director of Strategic Development and Capital Planning	LS

IN ATTENDANCE:

Ms A Fox	Trust Secretary	AF
David Hargroves	Chair of Improvement Plan Delivery Board *(Min No 01-09)*	DH
Finbarr Murray	Director of Estates and Facilities *(Min No 11/16)*	FM

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mr and Mrs Smith
Andrew Scott

MINUTE NO.		ACTION
01/16	**CHAIRMAN'S WELCOME** NC welcomed the Board and members of the public to the meeting. NC extended a particular welcome to RH, his first Board meeting since appointment to the Board on 1 January 2016. NC informed the members of the public a private Board meeting was held in the morning for matters of a confidential nature. She provided assurance that important decisions would be reported to the public prior to implementation. Those in the public gallery would have an opportunity to ask questions about the topics of the day at the end of the Board Meeting. Any other questions could be raised either through the website or direct correspondence.	
02/16	**APOLOGIES FOR ABSENCE** Sue Lewis, Improvement Director Sandra Le Blanc, Director of Human Resources	

03/16 **DECLARATIONS OF INTEREST**

There were no declarations of interest declared in relation to the agenda.

04/16 **MINUTES OF THE PREVIOUS MEETING HELD ON 11 DECEMBER 2015**

The minutes of the previous meeting were agreed as an accurate record, subject to the following:

- Page 4, sixth paragraph should read '…the Trust was reporting breaches against the cap *and framework* on a weekly basis…..'

05/16 **MATTERS ARISING FROM THE PUBLIC MINUTES OF 11 DECEMBER 2015**

All actions were noted as closed, with exception to:

185/15 – CQC Draft Improvement Plan NC reported that SL had held discussions with Monitor but had not received an update on whether a letter had been sent to NHS England at this stage	Closed
186/15 – EKHUFT Performance Reports NC reported Governor involvement in exit interviews for staff was discussed at a Constitution committee. Governors felt this was not within their remit.	Closed

06/16 **PATIENT STORY**

SSm presented the report which described a positive patient experience posted on the NHS choices website.

Board of Directors discussion:

GG had met with SSm and was heartened by the level of personal attention given to information received from patients.

NG asked how messages from the story would be circulated more widely, particularly 'what good means'.

SSm responded that learning was shared with the teams involved and to wider staff through the Trust website and team brief.

RH asked if patient satisfaction was monitored for patients whose care had been outsourced.

SSm welcomed the challenge. The Trust received feedback internally from hand held tablets and friends and family tests. The Trust also monitored standards of care provided to patients in social care beds for assurance purposes.

The Non-Executive Directors had made an informal visit to the William Harvey Hospital Improvement Hub. GG commented on positive processes in place for staff to share feedback and experiences.

Board of Directors decision/agreed actions:

NOTED: The Board of Directors noted the report and the positive way the emergency eye clinic managed this particular patient's care, despite challenges at hand. Thanks were noted to all staff involved.

ACTION: SSm agreed to communicate positive learning from the story through the communications department. PS further suggested communication through the Swartz rounds. SSm

07/16 **CHIEF EXECUTIVE'S REPORT**

MK introduced his report which set out key priorities and issues, bringing the following to the Board's attention:

- The Trust's Improvement plan was comprehensive.
- Key priorities identified by the clinical strategy work.
- An update on industrial action. Emergency care cover would continue. The Trust would respond accordingly and negotiations would continue.

By way of an update he reported he attended a Performance Review Meeting with Monitor earlier this week (w/c 1/2/16). This was MK's first meeting since appointment. He felt the Board was connected and up to speed with all issues.

Board of Directors discussion:

BW referred to the mention of the need for demand and capacity planning which was fundamental.

MK recognised that significant work had been undertaken but more work was required in conjunction with partners. This was something Monitor had been pushing for and formed part of the Trust's plan for next year.

MK reported an appointment was not made to the East Kent Strategy Programme Manager. Discussions would take place with the CCG to finalise plans to fill the position.

CT asked if there was a timeline for reviewing the market forces factor.

MK responded there were no signs of this changing soon. However, there was no harm in flagging this as it did have an impact. NG added reference was made in the Trust's response to the Carter report last year.

Board of Directors decision/agreed actions:
NOTED: The Board of Directors noted the report.
ACTION: MK agreed to provide an update on the East Kent Strategy Programme Manager position at the next meeting. MK

08/16 **CHAIR'S ACTIONS**

NC reported two Chair's Actions:

- Approved procurement for IT solution for paperless board; and
- Q3 Submission to Monitor.

Board of Directors discussion:

BW referred to the Q3 Submission and asked how the Trust recorded patients referred on a cancer pathway, subsequently not requiring treatment. JE explained patients would be counted as routine within 18 week RTT.

GG referred to the Q3 submission which stated the Clinical Advisory Board reviewed compliance against criteria for meeting the needs of people with a learning disability in June 2015. She asked how regularly this was reviewed. PS advised six monthly reports were received by the Patient Safety Board. He added that flagging processes were in place on the Careflow system.

Board of Directors decision/agreed actions:
NOTED: The Board of Directors noted the report. Noted

09/16 **TRUST IMPROVEMENT PLANS**

- **CQC IMPROVEMENT PLAN**
- **TURNAROUND PROGRAMME REPORT**
- **EMERGENCY RECOVERY PLAN**

CQC Improvement Plan

DH reported the improvement plan had been refreshed included improvements in addition to those identified by the CQC and was subject to continuous monitoring by the Improvement Board. The plan was delivering on target and the Improvement Board were fully aware of the challenges.

Board of Director's discussion (Improvement Plan):

SA asked if the Trust would be conducting a mock CQC visit.

DH advised these were known as 'Improvement Visits' internally and one was planned w/c 8 February 2016.

BW referred to the risk management section of the report which he did not find user friendly. DH agreed to include specifics at the next meeting. SSm added that risks would be developed and included on the new risk management system.

CT asked for more detail around timely mental health assessments.

JE explained that the liaison service was commissioned by the CCG. Discussions were ongoing around an affordable model and recruitment of staff. Internally, the Trust was making sure all staff had been fully trained.

PS added the CQC would want to see the Trust providing an area of safety for mental health patients within our hospitals. William Harvey Hospital was better placed as there was a dedicated area. However, resources were tight.

JE commented that the three improvement plans presented were now aligned in terms of quality improvement and financial efficiency. Resources would be aligned to ensure much more integration.

RH referred to MD23 and plans to address resource issues in the pharmacy department. He asked if there were any risks.

DH explained the pharmacy function affected many disciplines. He had met with the Division to review the recruitment and retention plans. He provided assurance delivery of the plan would be closely monitored.

GG referred to MD13, ensuring sufficient equipment was in place to enable safe delivery of care. She reported the Charitable Funds Committee would be reviewing processes to ensure charitable funds were more accessible.

DH explained MD13 was related more to maintenance than equipment.

GG was keen to understand coaching of staff linked to behavioural changes.

DH informed the Board of Directors a number of initiatives were in place for staff to voice concerns which could be quickly addressed. The aim was to work towards a whole culture that 'listens and acts'.

GG felt this to be a positive approach.

DH left the meeting.

Turnaround Programme Report

NG presented the report. Financial turnaround was one element of the Trust's turnaround programme. The other dimension was the cost improvement programme.

The key priorities currently were focussed on implementing measures to improve the year end outturn position ready for 2016/17. Secondly, focus would be on plans to deliver savings in 2016/17.

Board of Director's discussion (Turnaround Programme Report):

RE referred to discussion at the Finance and Investment Committee where a concern was raised around the time taken to show a reduction in the run rate. Debate around analysis now needed to focus on a debate around trajectory. This would enable holding to account to be more positive and constructive.

NC asked SSm/JE if they had any particular thoughts on the pace of change.

SSm was closest to the workforce aspect supporting SLB. This area had been a particular challenge in terms of the vacancy factor with a steep trajectory set. Links needed to be made between the financial and cultural aspects to retain staff.

The Trust had secured external specialist support to look at productivity and JE reported feedback from staff had been positive. The Company had real expertise which was credible and the Trust was now seeing significant change at pace and strengthened staff engagement.

JE further added that significant work had been undertaken around demand and capacity planning but further work was required moving into 2016/17.

NG referred to key drivers behind the run rate position: agency spend 40% higher than the previous year; and implementation of additional safer staffing issues. He stressed firm decisions now needed to be made for improvements to realised.

JE reported that work was ongoing with theatres to identify additional measures for Q4. NG clarified this was process related and not clinically related.

JE reported challenges remain within the medical workforce. Monitoring of gaps was ongoing.

Following a question raised by SA, PS confirmed SLB was leading on the development of a workforce strategy.

Emergency Recovery Plan

JE presented the plan. Work would be undertaken to refresh the plan by removing those actions now embedded and leaving specific areas of focus around safe discharge, leadership and timely decision making.

A dashboard had been developed (included with board papers) and it was hoped the Trust's partners would input into this to provide a health economy view.

JE further reported community hospitals were also experiencing increased length of stay. The emergency care pathway was complex. Work was ongoing both internally and externally to improve processes.

GG recognised the risk to delivery of the plan related to the lack of clarity on the future commissioning of the current health and social care bed capacity from the 1st April. She asked if there had further output from the Newton Europe work.

JE was confident the Trust was aware of its long term plans, but the main risk was capacity. JE had written to commissioners to express the Trust's concern. The CCG had confirm funding for health and social care beds would continue until the review of the capacity plan concludes.

The Trust was in collaboration with KCC to understand assistance Newton Europe could provide.

GG commented current processes enabled systems to 'cherry pick' patients which caused more blockages around patient flow.

BW referred to the chart on page 4 of the report and the spike showing on the majors stream. JE clarified this was a patient at Buckland Hospital who had transferred out to another unit.

Board of Directors decision/agreed actions:
NOTED: The Trust noted progress against the emergency recovery plan. Noted

ACTION: DH agreed to expand the risk management section of the CQC Improvement Plan Report for the next meeting. DH

MK found the report to be comprehensive and the focus now was to concentrate on steady improvements. Reports demonstrated wider health economy issues but stressed there also improvements to be made within the Trust's control.

10/16 **EKHUFT PERFORMANCE REPORTS**

NC asked Executive Directors to present their reports by exception.

Corporate Performance Report

Financial performance was discussed earlier on the agenda under the turnaround programme report.

Board of Directors discussion (Corporate Performance Report):

BW found the commentary difficult to read due to the formatting.

NG reported the new integrated performance report was anticipated for April 2016. He referred to the Lord Carter Report mentioned the importance of providing Boards with top level data in a readable format which was easily accessible.

RE added a presentation had been received at the last Finance and Investment Committee on the development of the integrated report. He stressed that delivery by April was important as this had been discussed for some time.

Clinical Quality and Patient Safety Report

This report had been discussed at length at the last Quality Committee.

PS reported two never events which had been reported this week, both associated with low harm:

- A retained vaginal tampon following an episiotomy – this was being addressed with doctors and midwives
- A transfusion of blood group O plasma to a non-blood group O patient. There was a general misconception that this was acceptable because blood group O was widely known as the universal donor. Intensive investigation was underway in the Laboratory and supervision instigated, and the policy's shortcomings would be addressed immediately. The CQC would be notified. Duty of Candour would be undertaken when the patient was fit enough after surgery.

SSm provided assurance that data was triangulated within the organisation to identify and monitor trends.

Board of Directors discussion (Clinical Quality and Patient Safety Report):

RE commended PS and SSm with the speed at which the never events were first brought to the attention of the Quality Committee earlier in the week and then at a publically observed Board of Directors meeting. This was a further demonstration

of openness. The Quality Committee had received assurance that governance actions had been taken.

NC commended the news flash put out by PS after the incident.

RE added that further work was required in the medium term to strengthen the Trust's patient safety culture.

MK concurred with RE's statement about the speed of response. He added it was important to identify learning to prevent further issues. He had visited the Pathology Department to talk through the plasma incident, actions in place and and how it had affected individuals and the team. He would be referencing the incident in his next CEO brief.

CT referred to the summary report on page 4 which reported all CQUINS had been met in Quarter 1 and 2. The report referred to specific challenges in the Sepsis and Acute Kidney Injury pathway and asked for further details.

SSm reported a significant amount of work had been undertaken to improve the Sepsis pathway. The current hotspot was the Emergency Care Centre. A sepsis champion was in place and progress was being made but challenges remain.

RE referred to discussions at the Quality Committee around mortality. The Committee was proposing the Board receive a report at its next meeting to include issues the Board should be sighted on.

In terms of patient experience, GG referred to the improvement work to involve patients more in their care. She asked for more detail as to how this work was progressing.

SSm recognised the metric had remained static for some time. She regularly held Matrons Forums and Chief Nurse Forums where data was shared. A 'back to basics' campaign had been launched which provided the opportunity for patients to talk through issues with nursing staff and clinicians. This was fed back to ward managers.

NC/BW highlighted the scorecard on page 8 needed to be reviewed for clarity and completeness. SSm confirmed this would form part of the development of an Integrated Performance Report.

Following a question raised by CT, SSm reported approximately 2 compliments were received per 50 hospital episodes.

GG commented that this demonstrated a willingness to engage with the Trust.

Key National Performance Targets

The Board of Directors noted the report. The Emergency Recovery Plan was discussed earlier in the meeting.

JE referred to 18 week RTT, where challenges remain. The waiting list for

orthopaedic procedures was over 3,000. Discussions were taking place with CCGs to undertake an audit.

There was a shortage of capacity across the whole of East Kent and this would be reported on in the future.

Since writing the report, two locum doctors had been secured within gastroenterology.

The cancer target was still compromised. The 62 day target for January 2016 was still being validated but was unlikely to report compliance against the standard.

FM joined the meeting.

Strategic Workforce Report

In the absence of SLB, the report was taken as read.

Board of Directors discussion (Strategic Workforce Report):

The report had been discussed at the last Strategic Workforce Committee. CT drew attention to the development of a heat map (copy included in the board meeting pack).

It was recognised that the workforce agenda remained a challenge for the Trust. Overall, MK recognised there was a lot of work to do but he could see positive movement. As an example, the Trust's appraisal position reported favourably against its peers.

CT reported the appraisal procedure was being revised and a report would be received at the Strategic Workforce Committee. He stressed the importance of cascading high level objectives and would want to receive assurance that this was being taken forward.

SSm confirmed quality of appraisals was an objective in the quality improvement strategy. Nursing/midwifery was the largest workforce group. As part of the work to reduce agency spend, SSm and the Associate Deputy Chief Nurse were signing off 40 day rotas.

Board of Directors decisions/agreed actions (Performance Reports):

NOTED: The Board of Directors noted the reports and latest performance. SM welcomed the improvement in the quality and presentation of reports. — Noted

ACTION: PS agreed to present a mortality report to the next Board of Directors meeting. — PS

FM joined the meeting.

11/16 **SIX MONTHLY HEALTH AND SAFETY AND ESTATES STATUTORY COMPLIANCE REPORT**

LS presented the next six monthly report. The report had been presented to the

Integrated Audit and Governance Committee and a sub-set of the report had been taken to the Finance and Investment Committee. These Committees recognised progress had been made but further work was required. Feedback had been received around the format which had been incorporated into the next iteration. There were also comments around the need for inclusion of KPIs and the development of a dashboard which would be taken forward.

Board of Directors discussion:

GG welcomed the inclusion of costs and timescales in future iterations. She commented that behavioural issues should be linked to the wider cultural change programme.

LS referred to work to strengthen the governance structure within divisions. An audit had been commissioned to look at ensuring this was fully embedded.

A session with the Health and Safety Executive (HSE) had been held to develop further a culture of health and safety across the Trust. FM confirmed this was well received by staff who had attended and structures had started to build.

RE referred to past experiences of HSE enforcement notices being issued without prior knowledge of issues at Board level. He asked whether an unannounced visit remained a risk and how this fitted within a generalised safety culture.

LS felt the likelihood of a visit was possible. Staff were reporting off line which could potentially stimulate visits. This was an area of focus which would form part of the work to embed governance structures.

RE asked, in light of this response, what more did the Board of Directors needed to do to reduce the chance of enforcement notices.

LS stressed the importance of utilising reports to the Board of Directors and Board Committees to ensure reporting mechanisms were robust. She felt the Trust had strengthened its understanding of the residual risks. Managing these needed more focus.

PS reminded the Board of Directors that some areas of the Trust's estate were not fit for purpose. Staff stop reporting when no action is seen to be taken.

FM agreed more work was required to improve cultural behaviours. Over time staff had become disempowered to change working environments. A key message from the session with the HSE was that staff want to be involved in the decision making progress. Links would be made to the Trust's Improvement Hubs.

Following a question raised by SA, FM confirmed that two out of the ten trust wide RIDDORs were LTAs. The RIDDORs included all across the system rather than estates related. Noted

PS reported that the Trust had undertaken a detailed approach to legionella monitoring. All checks had been undertaken which reported the Trust's systems and processes to be robust.

Board of Directors decision/agreed actions:
NOTED: The Board of Directors noted the report and welcomed the review of format and reporting.
ACTION: NC requested near misses be included in future reports. LS/FM
DECISION: It was agreed that Health and Safety would remain an agenda item on the Board of Directors until further notice. It was agreed links needed to be made to the quality and patient safety agenda. Agreed

FM left the meeting.

12/16 **EMERGENCY PLANNING AND BUSINESS CONTINUITY**

- **ANNUAL REPORT**
- **NHS PREPAREDNESS FOR A MAJOR INCIDENT**

JE presented the paper and asked for the Board's view in terms of the format/content and future reporting requirements.

The Trust was now collaborating strongly with a highly reputable and accredited team at Maidstone and Tunbridge Wells NHS Trust.

Trust plans would be tested in a programme scheduled for the Summer.

The paper also provided the Trust's response following correspondence received from NHS England around NHS preparedness for a major incident.

Board of Directors discussion:

RE commended the work undertaken and the clarity in which the report was articulated.

RE referred to the paper which highlighted a risk around the Trust's switchboard. He asked for more detail around mitigating actions should the system fail.

JE confirmed a solution was in place. The Trust's system was digital and could be re-programmed elsewhere. This would form part of the programme of testing.

RE asked for assurance that urgent actions were being taken forward.

JE referred to staff training. The first 20 staff would be trained in the next month and then rolled out. Command and control training was delivered in December and March. Executive Directors would receive further training in May 2016. Kent wide training was also planned.

Following a question raised by CT, JE confirmed that Trust partners would be fully involved in the programme of testing.

SM felt it would be useful to identify typical scenarios in future papers, recognising some would need to remain confidential.

JE reported a full risk assessment would be undertaken. This would be

summarised in future reports, together with exercises planned.

GG asked if releasing staff remained a challenge. JE confirmed this had significantly improved. Staff were more engaged now the Trust had an accredited training in place to hold as an occupational standard.

Board of Directors decision/agreed actions:

DECISION: The Board of Directors noted the report and endorsed the positive approach taken by the Trust. The Board of Directors were content with the Trust's response to NHS England. — Agreed

ACTION: JE agreed to provide a further progress report (against urgent issues) to the next Board of Directors meeting. — JE

13/16 **FULL RISK REGISTER AND FORMAT**

SSm reported that a new IT solution was being implemented. The new system was currently being populated with risks from the Corporate Risk Register.

A copy of the full risk register was included in the Board packs. The Board is required to receive the full register twice per year.

Board of Directors discussion:

Following a question raised by BW, SSm confirmed that the new system included an assurance section.

BW asked if the individual lines could be RAG rated. AF confirmed this was the plan as the IT solution embeds. She added that the methodology would be brought to the Integrated Audit and Governance Committee for agreement.

Board of Directors decision/agreed actions:

NOTED: The Board of Directors noted the full risk register and work ongoing to move to a new IT solution. — Noted

14/16 **MEDICAL DIRECTOR'S REPORT**

PS presented the report and drew attention to:

- Actions taken to safeguard patient safety and medical trainees' experience in the Emergency Care Centre at Kent and Canterbury Hospital.
- An update on nasogastric tube assurance visit actions.
- An improved position relating to revalidation in quarter.
- Chemistry analyser software malfunction, resulting in errors in reporting of test results in diabetes. Three patients had been affected resulting in no harm.

Board of Directors discussion:

PS provided assurance there were no links between the chemistry analyser software malfunction and the never event reported earlier in the meeting.

Board of Directors decision/agreed actions:

NOTED: The Board of Directors noted the report. — Noted

15/16 **BOARD COMMITTEE FEEDBACK**

Finance and Investment Committee Report

SM presented the report and drew attention to the following:

Development of the Integrated Performance Report. The Committee endorsed the approach being taken and received assurance the development was on target.

NG confirmed the report would be delivered by the April Board if sufficient time was given to the Information Team to finalise.

DECISION: The Board of Directors approved the recommendation from the Finance and Investment for the sale of properties to KCC. Agreed

The Board of Directors emphasised the importance of the integrated performance report being available for April 2016.

Quality Committee Chair Report

The report provided feedback from two meetings which had taken place in January and February 2016. There was nothing additional to report to that discussed earlier in today's meeting.

Charitable Funds Committee

GG presented the report and referred to a number of decisions required of the Board of Directors:

DECISION: The Board of Directors approved the administration and fundraising budget of £164k for 2016/17. Agreed

DECISION: The Board of Directors approved the decision of the Committee to retain cash with commercial bank subject to review to utilise Government Banking Services if economically beneficial to do so. Agreed

DECISION: The Board of Directors approved the terms of reference. Agreed

DECISION: The Board of Directors ratified the scheme of delegation for the Committee. Agreed

DECISION: The Board of Driectors approved the Charity Reserves Policy. Agreed

MK reported he had met with the Charity's Fundraising Manager regarding the Dementia Campaign. MK would be meeting with dementia leads to see if there was any help he could bring to the campaign. GG welcomed this support.

Strategic Workforce Committee

CT drew attention to the following:

- The ongoing monitoring of the recruitment and retention strategy. Further work

was ongoing to develop an organisational development strategy, aligned to the quality strategy.
- The Ward Establishment Review was brought through as an appendix to the Chair Report. There was a requirement for the Board of Directors to receive the report at six monthly intervals. The Strategic Workforce Committee had discussed the report and found the level of detail, explanation and scrutiny to be clear.

SSM provided assurance that ward establishment was monitored on a daily basis.

Nominations Committee

The Board of Directors noted the report.

Integrated Audit and Governance Committee

BW drew attention to the following:
- The Committee received a helpful paper on the Trust's going concern position. The Committee agreed the Trust would prepare the accounts on a going concern basis. The Trust's auditors were comfortable with this position.

DECISION: The Board of Directors endorsed the recommendation from the Committee to approve the Risk Management Policy. — Agreed

SSm provided assurance to the Board the Policy reflected the work undertaken at a Board Development Day in November 2015.

DECISION: The Board of Directors endorsed the recommendation from the Committee to approve the Standing Financial Instructions. All comments from the Committee had been incorporated in the final version sent to Board. — Agreed

ACTION: NG would be undertaking a communication exercise to ensure all staff understand their responsibilities as outlined by the standing financial instructions. This was a key part of improving financial governance. — NG

16/16 **FEEDBACK FROM THE COUNCIL OF GOVERNORS**

The Council of Governors met on 18 January 2016, items discussed:

Public
- Reports from Board Committees
- Latest performance
- Annual Quality Report – arrangements for local indicator
- Formally noting the CEO appointment
- CoG Committee Reports
- Reports from Governors who sit on wider Committees

Closed
- NHS England Planning Guidance
- Update on the work of the Whole Systems Strategy Board and Vanguard

sites
- Receive the latest Monitor submissions
- Chairman's activity report

BW reported he attended the Governors' Constitution Committee which he found helpful. He was keen to strengthen Non Executive Director and Governor relations

AF reported she was working with Governors to review their Committee structure which would provide further opportunities for Board of Director and Governor working.

CT had attended the last Council of Governors Strategic Committee. Governors on this Committee had asked to be informed of the Board's decision around the Draft Financial Plans 2016/17 and Sustainability and Transformational Fund Offer. NG agreed to ensure they receive feedback.

MK had met with two/three Governors as part of his induction and found these to be constructive meetings.

NC reported that the election to the vacant Canterbury seat on the Council of Governors had now been concluded. Alan Holmes had joined the Council.

17/16 **ANY OTHER BUSINESS**

No further business was raised.

18/16 **QUESTIONS FROM THE PUBLIC**

Mr Smith relayed his positive personal experience of the Trust's CDU.

Mr Smith commented on the improving *C.difficile* performance. He noted that one case was waiting confirmation. SSm confirmed this would be reported in the next report.

Mr Smith referred to the 'bottoms up' pressure ulcers campaign which had achieved much progress. SSm was delighted with the results to date but was not complacent.

Mr Smith welcomed the addition to the CEO Report outlining the CEO activity. He particularly welcomed the increased visibility on each hospital site.

Mr Smith concluded his questions by expressing his appreciation of the work of the Board of Directors.

Date of next meeting in public:
8 April 2016, 14:00, Board Room, Kent and Canterbury Hospital

Signature _____

Date _____

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
BOARD OF DIRECTORS MEETING – 8 APRIL 2016

ACTION POINTS FROM THE PUBLIC MEETING OF THE BOARD OF DIRECTORS MEETING HELD ON 5 FEBRUARY 2016

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
OUTSTANDING ACTIONS FROM PREVIOUS MEETINGS					
		There were no issues outstanding from the previous meeting.			
ACTIONS FROM THE LAST MEETING HELD					
06/16	5.2.16	**PATIENT STORY** Communicate positive learning from the story through the communications department. Consider communication through the Schwartz rounds.	SSm SSm	Feb 2016 Feb 2016	Story emailed to the Comms team for inclusion in the Staff Zone This will be actioned when the next Rounds are scheduled.
07/16	5.2.16	**CHIEF EXECUTIVE'S REPORT** Provide an update on the East Kent Strategy Programme Manager position at the next meeting.	MK	Apr 2016	Included in CEO report on main agenda.
09/16	5.2.16	**TRUST IMPROVEMENT PLANS** • **CQC IMPROVEMENT PLAN** • **TURNAROUND PROGRAMME REPORT** • **EMERGENCY RECOVERY PLAN** Expand the risk management section of the CQC Improvement Plan Report for the next meeting.	DH	Apr 2016	Amended for the April Board report.
10/16	5.2.16	**EKHUFT PERFORMANCE REPORTS** Mortality report to the next Board of Directors meeting.	PS	Apr 2016	Agenda item for April Board.

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
11/16	5.2.16	**SIX MONTHLY HEALTH AND SAFETY AND ESTATES STATUTORY COMPLIANCE REPORT** Near misses to be included in future reports.	LS/FM		Noted for future reports.
12/16	5.2.16	**EMERGENCY PLANNING AND BUSINESS CONTINUITY** • **ANNUAL REPORT** • **NHS PREPAREDNESS FOR A MAJOR INCIDENT** Provide a further progress report (against urgent issues) to the next Board of Directors meeting.	JE	Apr 2016	Noted on Board planner.
15/16	5.2.16	**BOARD COMMITTEE FEEDBACK** Undertaking a communication exercise to ensure all staff understand their responsibilities as outlined by the standing financial instructions.	NG	Feb/Mch 2016	The programme has commenced with a screen saver, email to all staff, production of a 'do's and dont's' statement, and more specific policy related guidance to appropriate staff. The management board has approved mandatory roll out of the HFMA e-learning financial training modules.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**8 APRIL 2016**
SUBJECT:	**STAFF STORY – WINTER PRESSURES EXPERIENCE AT WILLIAM HARVEY HOSPITAL FROM THE WARD MANAGERS**
REPORT FROM:	**CHIEF NURSE & DIRECTOR OF QUALITY** **CHIEF OPERATING OFFICER**
PURPOSE:	**Decision**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

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. This month the Board of Directors are using a staff story to listen to the experiences of the staff caring for the patients and their families.

By listening and learning from our staff we can continually improve the quality of services and transform staff, patient and carer experience.

SUMMARY:

In April 2015 the William Harvey Hospital (WHH) Ward Managers attended the Board of Directors and described their concerns around how the winter pressures wards were being operationalised. They described their worries about not feeling part of the planning process and their concerns for the quality and safety of the patients and staff working in those areas. The Ward Managers have requested to attend the Board of Directors' meeting this month to provide an update.

Concerns remain regarding the pressure staff are working under across the wards. In particular, the Ward Managers are concerned about staffing levels due to opening an additional area and the impact this is having on staff and patients.

The Ward Managers will take the Board of Directors through their story at the meeting.

RECOMMENDATIONS:

The Board of Directors are invited to consider the Ward Managers' story and agree the next steps below.

NEXT STEPS:

The Board of Directors are invited to work with the Ward Managers, to listen to their story and the Executive Directors to progress any agreed actions together following further discussions with Divisional Management Teams.

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

SO4: Identify and exploit opportunities to optimise capacity and, where appropriate, extend the scope and range of service provision

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

AO3: Delivering Improvements in patient access performance to meet the standards expected by patients as outlined in the NHS Constitution and our Provider Licence with Monitor.

AO4: Improving the Trust's financial performance through delivery of the 2015/16 Cost Improvement Programme and effective cost control

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

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

Operational pressure during the winter months poses risks to a number of areas. These include;

- Achieving the Trust's operational performance standards;
- Delivering on the Quality Improvement Strategy;
- Delivering the CQC Improvement Plan and successfully getting the Trust out of Special Measures.

Improvement plans are in place to address each of the risks identified above and each of them are sighted by the Board of Directors at the Board Committees and Board meetings. Progress is also monitored by the CCGs and Monitor.

FINANCIAL AND RESOURCE IMPLICATIONS:

Examine the NHSP/agency spend for staffing the Winter Pressures Ward and allocate funding of two extra WTE for each ward in UCLTC (one registered and one unregistered).

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

None noted

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

None noted

ACTION REQUIRED:

(a) Discussion
(b) Approval

CONSEQUENCES OF NOT TAKING ACTION:

- Burnt out staff, increased sickness levels and continued poor retention;
- Inability to complete mandatory obligations;
- Patient safety cannot be maintained long term when the staffing/resource is unsustainable;
- A good patient experience not able to be achieved despite the best intentions of the staff.

Board of Directors
Staff Experience Story
April 2016

Introduction

In April 2015 the William Harvey Hospital (WHH) Ward Managers attended the Board of Directors and described their concerns around how the winter pressures wards were being operationalised. They described their worries about not feeling part of the planning process and their concerns for the quality and safety of the patients and staff working in those areas. The Ward Managers have requested to attend the Board of Directors' meeting this month to provide an update.

The Staff Story

Following the concerns raised by the Ward Managers in April 2015 a number of actions were put in place. These included:

- A Trust wide meeting with the Chief Nurse and Chief Operating Officer to hear in more detail the operational safety and quality concerns and agree actions;
- A Trust wide Ward Manager meeting with the Chief Nurse and Director of Human Resources to hear the concerns around staffing and agree actions. This meeting revealed delays in the recruitment process and difficulties in filling posts. Additional resource has been placed in HR to address some of these concerns. We also implemented the overseas recruitment drive, appointment of the Head of Resourcing and implemented numerous recruitment and retention initiatives. This latter challenge does however remain;
- The Chief Operating Officer ensured that the Ward Managers were included in the development of the winter planning process and that they were able to comment on the work as it evolved.

Every winter is very pressured, and the Trust always has to open additional capacity to manage the number and acuity of patients that require admission. Pressure exists external to the Trust and indeed this winter we have had a high number of patients whose discharge has been delayed thereby adding more pressure on the wards and departments. The Ward Managers have particular concern over:

- The temporary nature of Winter Pressures Ward – although it has funding it is does not have a permanent staffing establishment. This is the nature of winter pressures wards, such as St Lawrence which was able to be closed in February. The ward at WHH remains open;
- The increased dependency and acuity of the patients. This year has seen higher numbers who are frail, confused and needing a lot of clinical support;
- The number of medical versus surgical beds may not be right at the WHH. The Ward Managers feel they are being asked to concentrate on discharging patients rather than caring for them. They are concerned that they may need more resource to do both;
- They feel that there is no control over the numbers admitted and are concerned that the WHH never diverts elsewhere;
- There is not a full establishment for all of the beds excluding the Winter Pressures Ward. To staff the ward the Ward Managers suggested that each ward releases substantive staff rather than open the ward with temporary staff. This was learning from the previous winter. However, by definition, and for the duration of winter this leaves the wards with a staffing gap that requires reliance on a temporary workforce, or the ward is left short staffed;
- Concern is also expressed around the poor fill rates of NHSP resulting in the use of costly Agency staff to maintain safe staffing levels (which are still not always achieved);

- The impact of this is staff anxiety, morale and retention of staff. This was mentioned in the CQC report;
- The Ward Managers feel that staff are not encouraged to express opinion and possible solutions and they are often met with platitudes and apparent lack of concern. This results in them feeling undervalued and unappreciated and without job satisfaction;
- Because managing winter pressures results in constant "fire-fighting" and although patient safety might be maintained, there is insufficient time left to complete management/training. This bothers the Ward Managers as they are also held to account for this;
- We know from the Capacity and Escalation plan in 2015 that we went into winter short of around 59 extra medical beds at the WHH site;
- The team are concerned that Kings D Female (normally a surgical ward) remains open as the swing medical ward despite being identified as the swing ward for 6 weeks only.

During February and March the Ward Managers met with the Chief Nurse and Chief Operating Officer at one of their weekly 'Cluster' meetings. Although they agreed that this year had better planning; that the using of staff from every ward reduces the risk across the site and the winter pressures ward, they do believe that staff cannot sustain this level of working and that they are feeling very stressed. They agreed to work with their Divisions and the Chief Operating Officer, Chief Nurse and their teams to describe what good looks like for winter. The Chief Operating Officer met with the team during March.

Other actions in place to manage risk and maintain quality and safety include:

- Thrice daily formal Trust wide meetings to assess site status. There is always Divisional Director or Executive Director presence;
- Continual assessment of staffing by the Matrons with corrective actions taken on a daily basis;
- Some escalation areas have received funding for a permanent establishment;
- Focussed intensive work is in place via a number of improvement plans and steering groups to improve patient flow and reduce the number of beds. This includes the implementation of the SAFER bundle;
- Six-monthly establishment reviews are undertaken that take into account acuity and dependency. These are reported to the Board;
- Monthly 'safer staffing' reports are produced and are scrutinised by the Quality Committee and Board;
- External support from NHS Improvement – ECIP;
- External support from Monitor;
- Frequent whole systems meetings to mobilise all agencies to improve patient flow and reduce pressure on the wards and staff;
- Continued focus on recruitment initiatives;
- Continued focus on cultural change that should impact on staff morale and retention.

Considerations

The Ward Managers would like the Board of Directors to consider the following:

- Proper involvement of and engagement between the Board and frontline clinical staff – Directors to visit staff on the wards to experience the pressures (staff cannot be relieved from clinical duties due to staffing pressures);
- Funding added to every Urgent Care & Long Term Condition ward budget to over establish by one registered and one unregistered member of staff in order to mitigate short staffing as a result of substantive moves to the Winter Pressures Ward;

- The Recruitment Panel to be removed or streamlined as this process is currently making recruitment challenging and adding to the pressure. Ward Managers report that wards are left short for months whilst awaiting approval from the panel;
- A decision to be made about Cambridge M1 is needed as a fully funded general medical ward with a permanent establishment of nursing and administrative staff.

Summary

The Ward Managers would like to make the Board of Directors aware of the pressure the staff are working under and are present at the meeting to take the Board through this story. This meeting will enable feedback to the Board of the recent meetings held and suggestions for improvement.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS**

DATE: **8 APRIL 2016**

SUBJECT: **CHIEF EXECUTIVE'S REPORT**

REPORT FROM: **CHIEF EXECUTIVE**

PURPOSE: **Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

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

SUMMARY

The monthly report from the Chief Executive provides the Board of Directors with key issues related to:

- Improvement Journey
- Financial recovery
- Staff Engagement
- Emergency Department (ED) Recovery Plan
- Clinical Strategy Update
- Integrated Performance Report
- LGBT History Month
- Chief Executive Activity February 2016 to March 2016

RECOMMENDATIONS:

The Board of Directors is asked to discuss and note the report.

NEXT STEPS

N/A

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Compliance with notifications from regulatory bodies and policy changes all contribute towards achievement of strategic objectives.

LINKS TO THE BOARD ASSURANCE FRAMEWORK: To enable the Trust to respond in a timely fashion with appropriate information which may affect the Trust's rating with Monitor and the CQC.
IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS: None
FINANCIAL AND RESOURCE IMPLICATIONS: None
LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY: None.
PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES: None
BOARD ACTION REQUIRED: The Board of Directors is asked to discuss and note the report.
CONSEQUENCES OF NOT TAKING ACTION: Failure of the Trust to respond in a timely fashion with appropriate information may affect the Trusts rating with Monitor and the CQC.

CHIEF EXECUTIVE'S REPORT

1 EXECUTIVE SUMMARY

1.1 Improvement Journey/CQC

Progress continues to be made in implementing the Trust wide high level improvement plan (HLIP) overseen by the Improvement Plan Delivery Board. In February the four clinical divisions finalised supporting improvement plans and a reporting structure has been embedded. A tool has been developed which will be updated by the divisions monthly and is available on SharePoint to ensure that any member of staff across the organisation can review the plans and progress.

In February, the Improvement Team, launched the first of a monthly series of Improvement Visits. During February and March 35 clinical areas across all three acute sites have been visited led by 30 multidisciplinary members of staff. In addition we are encouraging teams to use the Improvement Visit tool as part of business as usual. Following the visits the Improvement Team have visited wards and departments to provide feedback and support further improvement. The visits have been well received and have provided an opportunity to gauge the temperature on the front line and assess staff awareness of local improvement plans and their role within them.

Following feedback from the Improvement Visits we have also launched a focused message of the fortnight ('Fortnightly Focus') – a brief message which can be promoted through existing communication channels and discussed face to face with teams. The topics, generated from the visits, are being supported by speakers and events in the Quality Improvement and Innovation Hubs on each site – and also promoted through existing communication channels.

It should be noted that there is some slippage against the high level plan which is being managed and is detailed within the CQC Agenda item.

1.2 Financial Recovery

As at the end of month 11 the Trust is reporting a deficit of £31.5m. This is in line with the updated projected forecast £36.4m at year end but subject to continuing operational performance risks, particularly in emergency and urgent care. Agency spend in month was £1.9m bringing the cumulative total for the first 11 months to £24.3m. This, and the heavy use of extra beds to respond to increases in activity, is contributing to maintaining the run rate.

The Trust has been able to maintain a positive cash balance through to the end of the year and is in active discussion with NHS Improvement over agreeing realistic plans for 2016/17.

The Trust is managing a large and complex turnaround and transformation programme that will take time to deliver. However, we are taking the right actions to deliver recurrent CIPs by focusing on a few key transformation schemes and engaging external support to develop its own delivery capability. The trust will ensure that the right balance of priorities between quality, operational performance and finance is maintained.

The CIPs savings in 2015/16 will deliver £16.3m but this has been achieved by compensating for the shortfall in recurrent savings by significant non-recurrent measures.

For 2016-17, the approach is to focus on 8 key transformation schemes with significant recurrent savings opportunities to deliver the £20m CIPs target.

A Clinical Engagement Steering Group (CESG) has been established to represent the voice of the clinical body and to ensure that our Turnaround and Transformation Programme and Innovation Improvement Programme are clinically-led and have the necessary clinical engagement.

1.3 Staff Engagement

The attached graphic (appendix 1) provides the first draft of our staff engagement framework which will be further developed over the coming months. It details channels being used for staff engagement at each level across the Trust.

At a Trust-wide level, the staff forums that were established last year for consultants, people managers and administrators, continue to be well attended and provide a vehicle for communicating key messages and gaining feedback. The two-way communication process, 'Let's talk…' is being rolled out across the Trust. It provides the opportunity for all people managers to brief their teams on important Trust and local news and then to provide feedback. The feedback is then responded to in the next 'Let's talk..' session.

The HR Business Partners are currently engaging staff in each of the divisions to develop *'Great Place to Work'* action plans. They are facilitating groups to focus on the divisional staff survey results, CQC action plans and workforce plans, and then to create an overall 'people' plan for the division. Progress against these plans will be monitored by a divisional *'Great Place to Work'* team, which will report into the Cultural Change Steering Group.

The site Quality Improvement Hubs continue to be important vehicles for staff engagement. The hubs are run by local teams who are supported by improvement facilitators. They run 'claims, concerns & issues' sessions for staff, which are followed up with 'You said, we did' displays.

1.4 Emergency Department (ED) Recovery Plan

Over the Easter weekend, the clocks went forward and we have all begun to think more about Spring. However, our teams in the Emergency Departments and on the wards have seen an increase in attendances as if it were mid-winter with more of patients attending (42%) classified as majors. This has not helped our performance against the four hour standard (deteriorated to around 80%). We continue to focus on our main priorities in terms of improving our processes within the emergency departments. We are also working hard to ensure that patients do not stay in hospital longer than is necessary and we are planning more "same day" ambulatory services so that patients do not have to attend the Emergency department.

The Trust has agreed a new realistic trajectory for delivering its recovery programme through the planning round with CCGs. There is a new focus on streaming at the front door which includes the new models of care, site management and SAFER roll out. In addition, a focus on internal capacity and improved support from the community to prevent admissions and expedite discharge.

1.5 Operation Carbine

On Tuesday 22nd March, almost 40 clinical and non-clinical staff took part in "Exercise Carbine" working alongside specialist staff from Kent Police and South East Coast Ambulance Service to test the response to a serious firearms incident. The

exercise allowed managers and clinicians to explore the role of the Trust in a major incident and how we would work together with partner agencies.

The exercise highlighted a number of key learning points and ideas which will be taken forward through the Trust's Resilience Committee led by Chief Operating Officer, Jane Ely.

It was poignant that this took place on the day that events in Belgium were unfolding and it highlighted how vital the Trust is in terms of being ready for a major incident. Exercises like this help our teams familiarise themselves with their roles and responsibilities and training needs.

1.6 Clinical Strategy Update

Clinical Strategy March event:

We held a three day clinical engagement event for around 100 members of staff working together to generate ideas on how we can work differently to provide better, more sustainable acute patient care. These ideas are vital input for shaping our future strategy and our contribution to the Sustainability and Transformation Plan. Dedicated workshops saw clinical colleagues sharing their ideas for working differently. A core team of people attended all three of the days and the emerging thinking was fed back in a session to conclude the event, with learnings and ideas reviewed and shared across the divisions.
Conclusions reached included the need to work ever more closely with colleagues to ensure we have the capacity to provide really effective care for all our patients; ensuring we address each patients' needs individually with better use of pre-assessments; and working towards a single electronic patient record and better use of technology to enable us deliver our vision for the future. Following this event we will agree our one and three year priorities; create a programme of work; feed this back to the East Kent Strategy Board and create our Sustainability and Transformation Plan ready for the end of June.

East Kent Strategy Board:

At the EKSB meeting in March it was confirmed that, in addition to taking a 'whole system approach' to designing health and care services, the Board will also be responsible for developing the east Kent chapter of the Kent and Medway Sustainability and Transformation Plan (STP). The Board asked the East Kent Clinical Forum, as the clinical leadership body for east Kent, to take forward the clinical aspects of the work programme. The Forum has agreed to create a number of 'task and finish' groups aligned to specific pathways. Organisations have been asked to nominate suitable clinicians to join these groups and help define a new model of care for east Kent.

The 'task and finish' groups are:
- Prevention and self-care
- Long term conditions and frailty
- End of life care
- Maternity and paediatrics
- Mental health
- learning disabilities
- Planned (elective) and specialist care
- Urgent and emergency care

A Patient and Public Engagement Group is being established as part of the programme's governance and the chair of the group will be a member of the EKSB. A

Programme Director has been appointed, on secondment from EKHUFT, and recruitment is underway for an Assistant Programme Director and a project officer.

Sustainability and Transformation Plan

The Development of the Sustainability and Transformation Plan document for Kent and Medway was discussed on the 23rd March by providers, commissioners and KCC. Governance processes and the work to be undertaken at both a Kent & Medway and local footprint level were agreed in principle. The paper has been redrafted and, subject to further comments and amendments, will be submitted on 15th April. The East Kent Strategy Board will oversee the East Kent chapter of the document which is due for submission at the end of June.

1.7 Integrated Performance Report

Key performance headlines can be found in the Performance Reports on the main agenda (Finance; Clinical Quality and Patient Safety; Key National Performance Targets; and Workforce KPIs).

The new Integrated Performance Report is planned to go live with April data which will be reported in May 2016. It reflects a re-alignment of the metrics that the Trust tracks each month into those domains recommended by the CQC and the Carter report. The report will be made available electronically to reduce the burden of paper reporting.

2 LGBT HISTORY MONTH FEBRUARY 2016

EKHUFT was proud to celebrate LGBT History Month again in February 2016. Rainbow flags were flown at QEQM, K&C and WHH throughout the month. EKHUFT are a Stonewall Diversity Champion organisation and were pleased to welcome Venu Dhupa , Senior Director Programmes at Stonewall who made a visit to Kent and Canterbury Hospital to meet with our of Diversity and Inclusion Team. She said,

"The visit was extremely important to us to get an overview of the Hospital Trust and the good work that has been done, as well as understand the challenges. It is gratifying to know that the Senior Management Team at EKHUFT is committed to recruiting and retaining the best talent as you move forward with your strategic improvements, including the development of your values and the behaviours that underpin them. "

Our Diversity and Inclusion Team also arranged a offsite meeting for LGBT staff and visited each of the Quality and Improvement Hubs at QEQM, K&C and WHH to listen and talk about Diversity and Inclusion at EKHUFT and LGBT History month. Nearly 100 members of staff visited the Hub at WHH.

It was disappointing to learn that a tiny minority of staff had chosen to make anonymous and inappropriate comments about our celebration of Lesbian, Gay, Bisexual and Transgender History Month and I hope the Board of Directors will join me in restating our commitment to being a Fair and Diverse organisation committed to combating discrimination in all its forms.

3 CHIEF EXECUTIVE ACTIVITY – FEBRUARY 2016 AND MARCH 2016

The following is an example of some of the meetings I as CEO have attended during February 2016 and March 2016 and their purpose:

- A number of press meetings as part of the induction process that also included separate meetings with local editors to build working relationships
- Health Overview and Scrutiny Committee
- Partnership meetings between EKHUFT and Kent County Council in addition to introductory meetings with key leaders from the Council
- A number of introductory meetings with CEOs from other Trust as well as the local MPs and external Stakeholders
- Various meetings with Monitor including PRM's and feedback meetings in addition to introductory meetings
- The Clinical Forum attended by a variety of external stakeholders
- Undertook with Human Resources the Director of Communications and Engagement recruitment process including shortlisting and interview panel
- The CEO Cancer Collaborative Meeting with CEOs from all Kent NHS Trusts
- The East Kent Strategy Board with external stakeholders
- The Improvement Plan Delivery Board
- The System Resilience Group meetings
- The Joint NED/CoG meeting partially facilitated by Freshwater providing a workshop around the communications within the Trust
- The EKHUFT Medical Forum which provided an opportunity for clinicians to meet with the new CEO as well as providing an update from the East Kent CCGs clinical chairs on the clinical strategy in addition to being provided with a demonstration from Allscripts Electronic Medical Records regarding moving to electronic patient records.
- Attended a roundtable discussion on the Development of NHS Improvement's Strategy in London
- Participated in the Trusts 3 day Strategy Event
- The Trusts Induction day, welcoming new starters to the Trust
- Held a meeting with Medway NHS Foundation Trust to facilitate discussions regarding vascular services in Kent
- The Kent Providers Forum where a number of topics such as Ambulance Services and Junior Doctors were discussed
- Met with Professor Graeme Dewhurst, the Post Graduate Dean ahead of the Trusts HEKSS visit that took place on the 14th March
- Escalation meeting with Monitor and NHS England
- Patient Safety Board

I have also attended the following Board Committees:

Nominations Committee
Remuneration Committee
Finance and Investment Committees
Quality Committee

I chair the following Executive meetings on a regular basis as part of the Trust's governance structure that ensures upward reporting through Board Committees to Board. I will be reviewing the purpose of each group and assessing how they work before making a judgement about any changes that are necessary as we move into the next stage of the Trust's development.

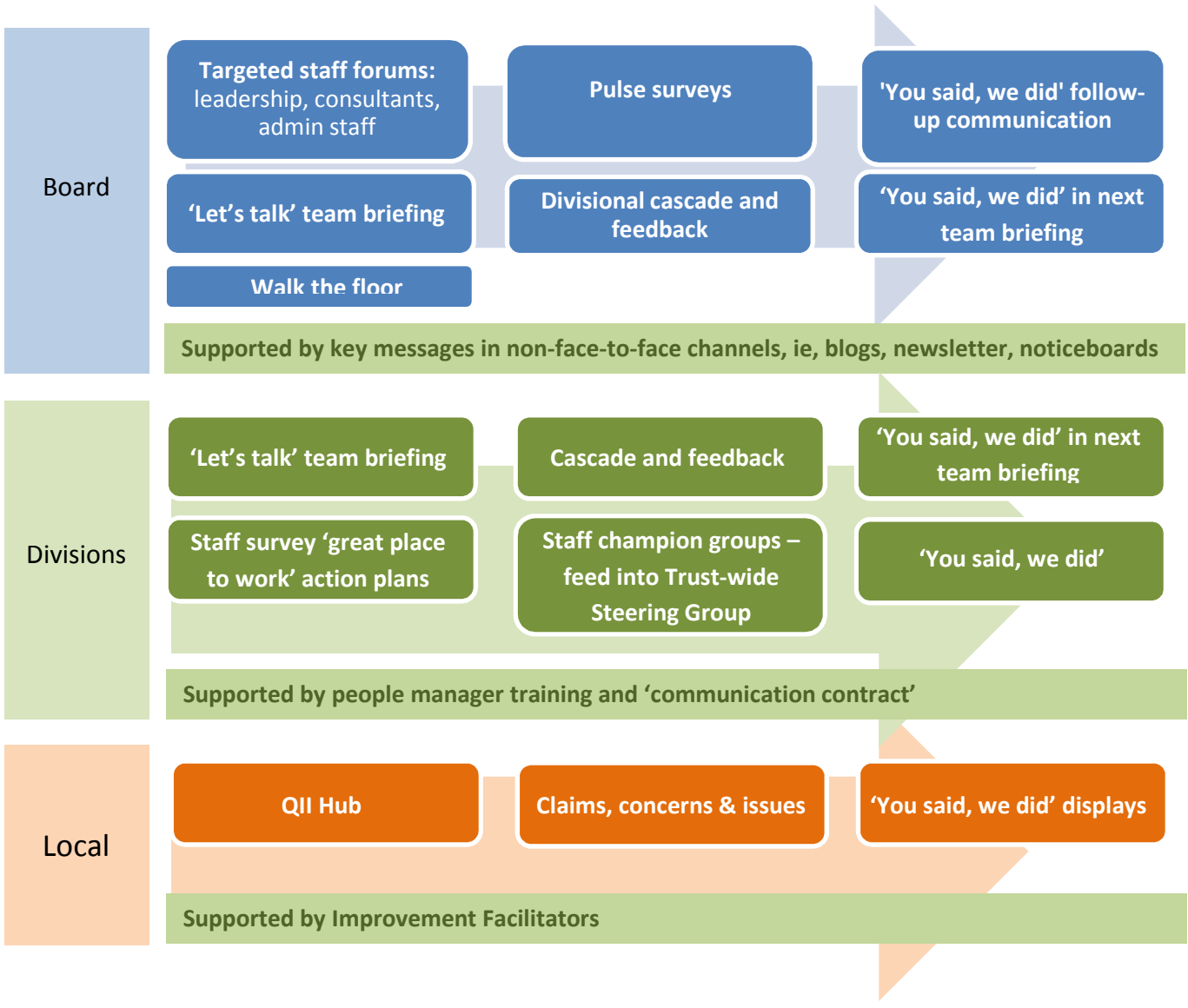
- Executive Team Meetings (weekly)
- Management Board (monthly)
- Trust Strategy Group (monthly)
- Turnaround Board (weekly)
- Key Metrics Reviews (monthly)
- Executive Performance Review Meetings (monthly)

Matthew Kershaw
Chief Executive

East Kent Hospitals University NHS
NHS Foundation Trust

Appendix 1

Staff engagement framework - draft



EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**8 APRIL 2016**
SUBJECT:	**2016/17 ANNUAL OBJECTIVES**
REPORT FROM:	**CHIEF EXECUTIVE**
PURPOSE:	**DECISION**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

The Trust has determined a number of annual objectives for 2016 / 17 that enable the delivery of the strategic objectives and support the Trust in achieving its vision, mission and values.

SUMMARY:

At its away day in January, the Board of Directors discussed the main strategic priorities for the Trust, alongside its annual objectives and some of the key risks associated with achieving these objectives. This was written up into a paper by the Chief Executive and was discussed again at the Board's February meeting. The paper was agreed, however a request was made that the language be looked at and a final paper, drawing together the Trust's vision, mission and values; annual objectives and any associated risks, be brought back to the Board for final agreement.

This paper sets out the four main elements of the Trust's strategic direction and also brings back the annual objectives that have been worked on further by the Executive team. In addition, it details the strategic risks associated with delivery of the annual objectives.

RECOMMENDATIONS:

The Board is asked to review, discuss and approve the Trust's annual objectives as detailed in the attached paper.

NEXT STEPS:

Progress against the annual objectives will be reviewed by the Board quarterly.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Not applicable – report is describing future strategic and annual objectives.

LINKS TO BOARD ASSURANCE FRAMEWORK:

The Board agreed five strategic risks at its November 2015 Board meeting which were aligned to the 2015/16 annual objectives. These are appended for reference. During discussions relating to the new strategic and annual objectives a number of possible risks / barriers were noted and have been worked up into new risks (detailed in the risk section below).

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

Three risks have either been added or substantially amended to those previously seen by the Board. The full list of strategic risks has been included in Appendix One, but in summary the changes are as follows:

Amended risk:

Strategic risk (SRR1) has been expanded to include additional causes which, if materialised would impact on delivery of the strategy. The additional causes are:

- Lack of clear commissioning intentions and possible changes in priority / inconsistent commitment;
- Lack of willingness to recognise the whole East Kent Health economy needs to change;
- Capability, capacity and ability to work in new ways within the Trust;
- Not being clear in the communication of our vision causing misinterpretation of our intentions.

New risks:

Risk Description: Due to the financial constraints on capital funding and therefore the ability of the Trust to invest in IT, there is a risk that the Trust will not be able to upgrade IT and take advantage of the opportunities afforded by new technology. This may result in inefficiencies in processes and poor patient and staff experience.

This risk is currently mitigated by: Continued investment in technology has been agreed at Strategic Investment Group as a priority. The replacement programme has been agreed to the level required to maintain good performance. The oversight of this programme is discharged through the Information Development Group with the Finance and Investment Committee having overall oversight of the capital programme.

Risk Description: Due to procurement processes not being consistently applied, there is a risk that purchases may be made that do not focus on the prioritised needs of healthcare and / or the Trust; have a lack of clinical or professional involvement; do not consider the deskilling of staff and the impact on motivation that would create; and create a supplier lock in with closed technology created by legacy acquisitions. This could result in IT not supporting the clinical strategy of the Trust and the consumption of additional effort and resources.

Current Mitigation: All technology purchases are reported to the Strategic Investment Group and scrutinised at the Information Development Group. The Director of Procurement is represented on those Groups to ensure proper processes are followed when purchasing new technology. The Architectural Standards of the Trust now favour solutions that are open. There is a process in place to ensure appropriate engagement in major system purchases.
FINANCIAL AND RESOURCE IMPLICATIONS: Costs have been included within annual planning.
LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY: As the Trust develops detailed plans to meet the strategic objectives any legal implications will identified and addressed.
PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES None
ACTION REQUIRED: **(a) Decision.**
CONSEQUENCES OF NOT TAKING ACTION:

Annual Objectives 2016/17

1. Introduction

1.1 The Trust's vision, mission and values are follows:

Our Vision Great Healthcare from great people

Our Mission Together we care – improving health and lives

Our Values We care so that:

- People feel cared for as individuals;
- People feel safe, reassured and involved;
- People fell teamwork, trust and respect sit at the heart of everything we do; and
- People feel confident we are making a difference.

1.2 At its away day in January, the Board of Directors discussed the main strategic priorities for the Trust, alongside its annual objectives and some of the key risks associated with achieving these objectives. This was written up into a paper by the Chief Executive and was discussed again at the Board's February meeting. The paper was agreed, however a request was made that the language be looked at and a final paper, drawing together the Trust's vision, mission and values; annual objectives and any associated risks, be brought back to the Board for final agreement.

1.3 This paper sets out the four main aspects of the Trust's strategic direction and also brings back the annual objectives that have been worked on further by the Executive team. In addition, it details the strategic risks associated with delivery of the annual objectives. These have been included at Appendix One.

1.4 The four aspects of the Trust's strategic direction previously agreed by the Board are:

1. Patients;
2. Partnerships;
3. People; and
4. Provision.

2. Strategic Direction / Annual Objectives

2.1 **Patients**. Enable all our patients (and clients who are not ill) to take control of all aspects of their healthcare by 2021. We will do this by:

- enabling self-management and understanding the importance of health status, exercise, dietary advice and well-being. We intend to offer 25% of our population the ability to self-manage their condition by 2019.

- working with our partners, we will pilot a single healthcare professional in each of each of four geographical localities, to act as information and advice integrators by 2018. These integrators will support and monitor self-management by patients.

- considering integration with European health systems, to create a wider population base post 2021.

Associated Annual Objectives for 2016/17:

1. Deliver the CQC and emergency care improvement plans to ensure Trust is removed from Special Measures at its next CQC re-inspection in 2016.

2. Deliver the agreed improvement trajectories (as submitted to and agreed with NHS Improvement) for the emergency care, RTT, cancer and diagnostic wait standards, by end of March 2017.

3. Transform care for people with learning disabilities with local providers as measured by self assessment against metrics by December 2016.

4. Deliver the following service quality improvements by March 2017:

    - 20% reduction in sepsis associated mortality;
    - 20% reduction in harm from poor handover of care/transfer of care;
    - 30% reduction in preventable venous thromboembolism events;
    - 30% reduction in medication errors;
    - 30% reduction in catheter associated urinary tract infection;
    - 30% reduction in falls with harm; and
    - 30% hospital acquired pressure ulcers.

5. Agree new pathways with commissioners for patients 'medically fit' and not requiring an acute bed to reduce delays by 5% by December 2016.

2.2 **Partnerships.** To define and deliver sustainable services and patient pathways together with our health and social care partners, by 2021. We will do this by:

- defining and agreeing with the East Kent Strategy Board specific KPIs for the priority patient pathways, by June 2016.

- working directly with the Vanguard to increase community capacity in Canterbury, Faversham and Whitstable to enable the transfer of acute activity to a community setting, by July 2017.

- ensuring the health economy has the right capacity and the required supporting infrastructure to deliver a sustainable model of care in East Kent, by 2021.

2.3 There are a set of underpinning principles that will need to be in place in order for these to be delivered. These are that:

- the health economy must take advantage of technology in order to drive effectiveness and efficiency wherever possible;

- wherever possible the patient pathways should be delivered close to home and be convenient to the patient;

- issues of loneliness and isolation should be addressed as part of the development of future models of care; and

- integration will only be successful when patient benefits are clearly identified and supported by all organisations.

Associated Annual Objectives for 2016/17:

1. Submit an agreed Sustainability and Transformation Plan (STP) by 30 June 2016 that would define and enable delivery of:

    - an agreed financial improvement trajectory;
    - a comprehensive clinical productivity improvement programme; and
    - a sustainable clinical model for the Trust.

2. To submit by June 2016, with partners, a single Local Digital Roadmap which will outline how we will use technology to provide improved patient services.

3. Working with CCGs commence formal consultation on a sustainable clinical configuration by December 2016

4. By working with the Vanguard, increase community provision to transfer the equivalent of 60 acute beds in patient activity, by March 2017.

5. To deliver an estates strategy that supports the Trust's clinical configurations by March 2017.

6. Continue to work with MTW on a joint pathology project, delivering a signed commercial agreement with external partners by June 2017. Report will be made back to the Board and FIC at key stages of the procurement process.

2.4 **People.** Identify, recruit, educate and develop a talent pipeline of clinicians, healthcare professionals and broader teams of leaders, skilled at delivering integrated care and designing and implementing innovative solutions for performance improvement. We will do this by:

- becoming the NHS employer of choice in Kent measured by the staff friends and family test, NHS staff survey and other metrics benchmarked to upper quartile performance against peers, by 2019;

- agreeing an appropriate measure of staff turnover to reflect positive benefit of improving the talent pool, whilst reducing high levels of staff leaving within first year of employment, by September 2016;

- improving the quality and quantity of applicants to the top 5 clinical and non-clinical posts, as measured by successful recruitment and delivery of objectives, by 2018; and

- increasing clinical productivity and reducing clinical variation.

2.5 There are two underpinning principles to achieving these which are maintaining the speed of adopting change and being a role model for the community.

Associated Annual Objectives for 2016/17:

1. Refresh and implement the recruitment and retention strategy to reduce the level of staff leaving by 2%, particularly in the first year of employment, by March 2017.

2. Achieve a staff turnover rate of 10%, by March 2017.

3. Roll out the Trust wide leadership and management development programme to another 200 staff, by September 2016

4. Continue with the implementation of the cultural change programme, incorporating divisional and corporate led plans into the programme, by June 2016

5. Continue to reduce agency and temporary staffing spend to £23m, as agreed with NHS Improvement, by March 2017

6. Improve the overall staff engagement score as measured by the staff survey, paying particular attention to those professional groups with lower levels of engagement, by March 2017.

2.6 **Provision**. Clearly identify 'what business we are in', 'what we want to be known for' and 'what our core services are'. We will do this by:

- engaging with staff and key external partners to define our core services. This work will be annually refreshed to ensure our service provision remains appropriate;

- continuing our improvement journey and ensuring the Trust is removed from Special Measures at its next CQC re-inspection in 2016;

- ensuring all staff groups can articulate and, are positive about, our overall strategic direction, December 2016;

- maintaining a net positive balance on press coverage as measured by press, Trust data and social media;

- being recognised as provider of high quality care and as a system leader by NHS, social care and other public sector partners, by March 2018;

- demonstrating our contribution to sustainability, corporate responsibility and our position as a major local employer and contributor to the local economy; and

- being identified as a paperless organisation, by 2020.

Associated Annual Objectives for 2016/17:

1. Implement a new Integrated Performance Report by May 2016.

2. Submit a financially sustainable plan for 2016 /17 and the following 4 years that meets the agreed control totals, by June 2016.

3. Agree core services and a timetable to review and refresh these services, by September 2016.

4. Be recognised as a provider of high quality care and as a system leader by NHS, social care and other public sector partners, as measured by 360 feedback from partners, by December 2017.

5. Achieve a net positive balance on press coverage as measured by press, Trust data and social media, by January 2017.

6. Develop and grow a number of whole system leaders, joint appointments that cross the boundaries of the whole health care economy and are designed around the patient pathway.

7. Delivery of £20m cash releasing, recurrent saving by March 2017.

8. Hit a year end deficit plan of £12.5m (after adjusting for any portion of STF funding not provided by Department of health), by March 2017.

9. Continue to progress improvements in 7 day services focussing on the implementation of priority schemes agreed following further work internally and benchmarked with other similar organisations.

3. Conclusion

3.1 Once adopted the whole package will be further communicated to leaders and then wider staff groups, then incorporated into staff objectives across the organisation and through the appraisal process ensure that this is what drives the improvement in a coordinated way across the Trust.

BAF

East Kent Hospitals University NHS
NHS Foundation Trust

Report Date	31 Mar 2016
Risk Status	Open
Risk Area	1. Strategic Risk Register

East Kent Hospitals University NHS
NHS Foundation Trust

Annual Objective 1 - Clinical Effectiveness - Delivering the improvements identified in the Quality Strategy in relation to patient safety, patient experience and clinical effectiveness.

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority	Reporting Committee
SRR 4	Estate Condition - Unable to source improvements in the Estate across the Trust to ensure long term quality of patient facilities **Risk Owner:** Liz Shutler **Delegated Risk Owner:** **Last Updated:** 29 Feb 2016 **Latest Review Date:** 25 Feb 2016 **Latest Review By:** Alison Fox **Latest Review Comments:** Risk reviewed by Trust Secretary (updated controls and assurances).	**Cause** - Backlog of work (£4-5 million); - The financial constraint on capital funding; - The sheer volume and extent of work required **Effect** resulting in poor patient and staff experience, potential breaches to health & safety standards and legislation, inefficiencies and difficulties in moving forward with providing services of the future.	I = 5 L = 5 Extreme (25)	Prioritisation exercise for capital spend has been completed to ensure resources are used in the most effective / efficient way **Control Owner:** Liz Shutler	Management Board receives reports from Director of Strategy and Capital Planning. Business cases are received on an ad-hoc basis - some of which require improvement to infrastructure	FIC receives quarterly reports on capital spend.		Adequate		I = 5 L = 4 Extreme (20)	**Person Responsible:** **To be implemented by:**			Quality Committee
				An assessment of the maintenance required has been undertaken to understand the overall position **Control Owner:** Liz Shutler	Deputy Director of Estates and Director of Capital receive information from all areas of the Trust regarding maintenance and undertake a first pass at prioritisation. Capital PLanning Group - review the prioritisation exercise	FIC receive reports about Backlog maintenance showing the risks.		Adequate						

Annual Objective 2 - Improvement Plan - Embedding the improvements in the High Level Improvement Plan to ensure the Trust provides care to its patients that exceeds the fundamental standards expected

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority	Reporting Committee

East Kent Hospitals University NHS
NHS Foundation Trust

Annual Objective 2 - Improvement Plan - Embedding the improvements in the High Level Improvement Plan to ensure the Trust provides care to its patients that exceeds the fundamental standards expected

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority	Reporting Committee
SRR 2	Adverse effects on Local services: Organisational Shape and Form **Risk Owner:** Liz Shutler **Delegated Risk Owner:** **Last Updated:** 25 Feb 2016 **Latest Review Date:** 25 Feb 2016 **Latest Review By:** Alison Fox **Latest Review Comments:** Controls and assurances updates with documentation	**Cause** Failure to action and deliver our regulatory requirements that may result in being taken over by another organisation **Effect** - Loss of autonomy; - Impact on staff morale; - Reputational problems; - Decline in pace and development of service.	I = 4 L = 4 Extreme (16)	Financial Recovery Plan - Monitor Undertaking (12/16) **Control Owner:** Nick Gerrard	Director of Finance and Chief Executive review of document prior to submission.	Plan circulated to Finance and Investment Committee members and thereafter all BoD members for input (12/16)		Adequate	Monitor feedback expected	I = 4 L = 3 Extreme (12)	Internal Audit to undertake a review of the CQC Improvement Plan **Person Responsible:** Sally Smith **To be implemented by:** 29 Apr 2016	**25 Feb 2016** **Alison Fox** Intelligencesuggests that the CQC revist will not take place until May / June 2016. Work on implementing the plan continues. The Hubs / staff have been involved in mock inspections (to be BAU).	I = 4 L = 2 High (8)	Quality Committee
				Emergency Department Recovery Plan (agreed with partners and submitted to Monitor) 12/2015 **Control Owner:** Jane Ely	ED Plan updated by Urgent Care and Long Term Conditions	- report to Executive Team on a weekly basis for information - UCLTC update on actions at Executive Performance Reviews - discussions at both Quality and Finance Committee in relation to impacts on safety, quality and finance - monthly BoD report showing progress against plans	Health Economy ED Recovery Meeting Monitor review of ED plan Improvement Director oversight of plan	Adequate	Clear understanding of the ED pathway and how the plans start to resolve the key issues.					
				Improvement Plan in place with supporting Divisional plans in place (01/2016) **Control Owner:** Sally Smith	Emma Kelly manages the updates to the Improvement Plan on at least a monthly basis.	Improvement Board monitor progress (meets monthly) BoD receives exception and progress reports (bi-monthly)	Monitor Progress Review meetings - provides challenge over progress of Trust in meeting deadlines Improvement Director - challenge to Trust CQC Inspection 07/15 - improved rating Internal Audit on data quality (11/15)	Adequate	Internal Audit on CQC (04/16) Internal Audit on Risk Management (04/16)		CQC re-visit plan to provide timeline and actions to ensure organisation readiness for CQC insepction due around April 2016 **Person Responsible:** Sally Smith **To be implemented by:** 08 Apr 2016	**25 Feb 2016** **Alison Fox** Intelligence suggests that the CQC visit is likely to take place in May / June 2017; work is on-going to implement the improvements required. **25 Feb 2016** **Alison Fox** Reviewing workload to confirm date of IA.		
											Emergency Department Board workshop to provide a good understanding of the issues and plan to address performance. **Person Responsible:** Jane Ely **To be implemented by:** 11 Mar 2016	**12 Mar 2016** **Jane Ely** Workshop completed with Board (Exec & Non-Exec) 11th March as planned. New Ed dashboard shared and the priority actions that would make a difference noted by all. Follow up action to review ED staffing at SWC and circulate to the Board. **29 Feb 2016** **Alison Fox** Planned for March 2016 BoD development session		

East Kent Hospitals University NHS
NHS Foundation Trust

Annual Objective 2 - Improvement Plan - Embedding the improvements in the High Level Improvement Plan to ensure the Trust provides care to its patients that exceeds the fundamental standards expected

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority	Reporting Committee
											Internal Audit to undertake review of the risk management systems and controls following output of Deloitte and PWC reviews **Person Responsible:** Helen Goodwin **To be implemented by:** 27 May 2016	**25 Feb 2016** **Alison Fox** Reviewing workload to programme in this review.		

Annual Objective 4 - Financial Performance - Improving the Trust's financial performance through delivery of the 2015/16 Cost Improvement Programme and effective cost control

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority	Reporting Committee
SRR 5	Failure to achieve financial stability **Risk Owner:** Nick Gerrard **Delegated Risk Owner:** **Last Updated:** 25 Feb 2016 **Latest Review Date:** 25 Feb 2016 **Latest Review By:** Alison Fox **Latest Review Comments:** Reviewed current status of controls; adding to assurances (Trust Secretary)	**Cause** due to: - poor planning - poor recurrent CIP delivery - - poor cash management and - gaps in financial governance **Effect** resulting in - potential breaches to the Trust's Monitor licence, - adverse impact on the Trust's ability to deliver all of its services and in the longer term clinical strategy, - poor reputation and - failure to be a going concern	I = 5 L = 5 Extreme (25)	Turnaround Director in post (10/15) **Control Owner:** Nick Gerrard	Direct line management by Chief Executive			Adequate		I = 5 L = 4 Extreme (20)	Implementation of finacial governance action plan **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2016	**25 Feb 2016** **Alison Fox** FIC to receive report on progress highlighting any areas for concern / risk to delivery. (to be scheduled).	I = 5 L = 3 Extreme (15)	Finance & Investment Committee
				Clinical Workstreams in place to ensure quality of care **Control Owner:** Nick Gerrard	Reports to Executive Team from workstream (weekly)	Feeds into Finance and Investment Committee	Feeds into BoD	Adequate			CIP deep dive - Report to FIC on reasons for slippage on Theatres, Outpatients and Workforce **Person Responsible:** Nick Gerrard **To be implemented by:** 08 Mar 2016	**25 Feb 2016** **Alison Fox** On FIC agenda in March 2016 **25 Feb 2016** **Alison Fox** On FIC agenda for March 2016		
				Financial govenance in place **Control Owner:** Nick Gerrard	Director of Finance oversees the governance	Integrated Audit Committee reviewed controls through reporting from Internal and External Audit	- Grant Thornton governance review (07/15)	Limited	Action plan development and requires full implementation					
				Cost Improvement Plan targets in place with workstream in support **Control Owner:** Nick Gerrard	Divisional Challenge meetings for Execs to challenge	- executive review weekly - Turnaround report to FIC - Exception reports to BoD	Monitor challenge at Progress Review meetings (6-8 weekly)	Limited						
				Financial Recovery Plan **Control Owner:** Nick Gerrard	Divisions report progress into Financial Recovery Group on a monthly basis.	- Exceptions reported into Finance and Investment Committee (monthly) - Board has final oversight (bi-monthly)	Monitor reviewed draft plan and discusses the financial position at Progress Review meetings (6-8 weekly)	Adequate	Reporting shows slow improvement; Monitor still to provide feedback on 2 year plan					

East Kent Hospitals University NHS
NHS Foundation Trust

Annual Objective 5 - Clinical Strategy - Developing, engaging and consulting on a clinically and commissioner supported strategy that achieves both medium and long terms clinical and financial stability

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority	Reporting Committee
SRR 1	Unable to deliver a clinical strategy that can be resourced **Risk Owner:** Liz Shutler **Delegated Risk Owner:** **Last Updated:** 25 Feb 2016 **Latest Review Date:** 25 Feb 2016 **Latest Review By:** Alison Fox **Latest Review Comments:** Reviewed controls and assurances 25/2/16	**Cause** - Four CCGs having differing agendas; - Lack of stakeholder agreement; - Lack of clear commissioning intentions; - Parliamentary timings may not be conjucive to timely implementation **Effect** - Patient care - Enforcement actions - Trust's Monitor licence.	I = 5 L = 4 Extreme (20)	Financial Recovery Plan **Control Owner:** Nick Gerrard	Divisional / Executive Transformation Meetings (held bi-weekly)	FIC and Board reporting from Turnaround Director	Monitor receive monthly reports on the Trusts finances as well as the quarterly returns and discussions at PRM's.	Adequate	Traction around clinical efficiencies - FIC requested an update on Theatre efficiencies / Outpatients and Workforce - scheduled for 03/2016	I = 5 L = 3 Extreme (15)	Agree for approval by EKSB a timeline for delivery of STP **Person Responsible:** Liz Shutler **To be implemented by:** 11 Mar 2016	**25 Feb 2016** **Alison Fox** Matthew Kershaw / Liz Shutler and Rachel Jones to produce this item for EKSB	I = 5 L = 2 Extreme (10)	Finance & Investment Committee
				Regular meetings with external partners / MP's and within the Trust **Control Owner:** Liz Shutler							Presentations on Outpatients / Theatres and Workforce CIP schemes to FIC to facilitate understanding of slippage. **Person Responsible:** Nick Gerrard **To be implemented by:** 08 Mar 2016	**25 Feb 2016** **Alison Fox** On FIC agenda for March 2016		
				East Kent Strategy Board **Control Owner:** Liz Shutler	Trust Secretary hold all copies of agendas / minutes East Kent Strategy Board	In attendance are all Health economy partners	Monitor received first submission of Annual Plan 2016/17 02/2016	Adequate			Agreement of final consultation document by all partners **Person Responsible:** Liz Shutler **To be implemented by:** 31 Mar 2016			
SRR 3	Loss of clinical specilaities and services that are Kent & Medway wide **Risk Owner:** Liz Shutler **Delegated Risk Owner:** **Last Updated:** 25 Feb 2016 **Latest Review Date:** 25 Feb 2016 **Latest Review By:** Alison Fox **Latest Review Comments:** Reviewed risk - actions due by end of March 2016. Added the delivery of a Sustainability & Transformation Plan to controls.	**Cause** due to the Networks in place / competition and decision-making across the CCGs **Effect** result in a loss to the Trust of some of the services that may adversley impact on the local population's expereince of care	I = 4 L = 3 Extreme (12)	East Kent Strategy Board (Health Economy wide) that drives the delivery of an agreed set of options for service reconfiguration to be consulted on **Control Owner:** Liz Shutler	Director of Strategy and Capital Planning has oversight of the progress made within the EKSB.	Minutes from EKBS to BoD meetings (02/16)		Adequate	Monitor / NHS England approval of transformation programme (07/16)	I = 4 L = 2 High (8)	Delivery of a Sustainability and Transformation Plan **Person Responsible:** Liz Shutler **To be implemented by:** 30 Jun 2016	**25 Feb 2016** **Alison Fox** Worth through the East Kent Strategy Board to support this. Meetings are monthly	I = 4 L = 2 High (8)	Finance & Investment Committee
											Awareness of external factors that may indicate commissioning (both local and specialist) intends to tender out services that the Trust currently provides **Person Responsible:** Matthew Kershaw **To be implemented by:** 31 Mar 2017	**25 Feb 2016** **Alison Fox** Local meeting to take place in relation to vascular services (26/2/16) Discussions on-going regarding pathology services		
											One year operational plan to set the ground work for delivery of the five year plan. **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2016	**25 Feb 2016** **Alison Fox** Draft Annual Plan to be reviewed at BoD in March 2016.		

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**8 APRIL 2016**
SUBJECT:	**CHAIR'S ACTIONS**
REPORT FROM:	**CHAIRMAN**
PURPOSE:	**To Note**

BACKGROUND:

External Board Governance Review:

The Board of Directors is required to undertake a further Board Governance Review to provide evidence of the improvements made following the Deloitte Board Governance Review. During "business as usual" an external Board Governance review is required every three years.

The purpose of the review is to evaluate the Board of Directors and make recommendations about its development and to increase the effectiveness of the Board as a team using Monitor's Well-Led Governance framework.

It is intended that the output will be used to further develop and enhance the current Board Development Programme. In addition the Trust has given a number of undertakings to Monitor and this review will provide an opportunity for the Trust to highlight the improvements made with a view to addressing these undertakings.

It will be necessary to undertake a procurement exercise to identify a suitable external organisation to facilitate this review.

A scope was agreed and a copy is attached for information. The contract is currently out to tender.

RECOMMENDATIONS:

To note the Chair's action.

NEXT STEPS:

The outcome of the review will be reported to the Board in June 2016.

ACTION REQUIRED:

(a) To note.

CONSEQUENCES OF NOT TAKING ACTION:

Monitor undertakings will remain in place and there would be a lost opportunity to improve the effectiveness of the Board..

EAST KENT UNIVERSITY HOSPITALS NHS FOUNDATION TRUST EXTERNAL GOVERNANCE REVIEW

SCOPE

1 Purpose of the review

1.1 The purpose of the review is to evaluate the Board of Directors and make recommendations about its development and to increase the effectiveness of the Board as a team using Monitor's Well-Led Governance framework.

1.2 It is intended that the output will be used to further develop and enhance the current Board Development Programme. In addition the Trust has given a number of undertakings to Monitor and this review will provide an opportunity for the Trust to highlight the improvements made with a view to addressing these undertakings. In order to provide Monitor with the required evidence, copies of the final draft and final reports will be provided to Monitor (following review for factual accuracy and redaction of personal data) by the external review provider at the same time as their submission to the Trust. Monitor will also discuss the findings of these reports with the external review provider.

2 Context

2.1 East Kent Hospitals University NHS Foundation Trust is one of the largest hospital trusts in England, with five hospitals serving a local population of around 759,000 people. The Trust delivers its services through c.8000 staff and has more than 1.2 million patient contacts a year.

2.2 The Trust runs three hospitals from which inpatient and outpatient services are provided: the Kent and Canterbury Hospital (Canterbury) which has an Emergency Care Centre (similar to a minor injuries units); the Queen Elizabeth the Queen Mother Hospital (Margate) with has an Emergency Department; and the William Harvey Hospital which has an Emergency Department and a Trauma Unit (Ashford).

2.3 The Buckland Hospital, Dover, and Royal Victoria Hospital, Folkestone, provide a variety of outpatient and minor injury services. The recent conclusion of a consultation on the Trust's Outpatients Strategy has reduced the number of sites services are provided on but increase the range of services and the times they are available.

2.4 The Trust also provides health services for other NHS facilities across East Kent including renal services in Medway and Maidstone. It has a national and international reputation for delivering high quality specialist care, particularly in cancer, kidney disease, stroke and vascular services.

2.5 As a teaching Trust it plays a vital role in the education and training of doctors, nurses and other healthcare professionals, working closely with local universities and Kings College University in London.

2.6 In July 2015 the Care Quality Commission (CQC) inspected all five of the Trust's sites with the final report being published on 18 November 2015. The overall rating given was "Requires Improvement" the individual hospital ratings are:

- Buckland – Good
- Kent and Canterbury – requires improvement
- Queen Elizabeth the Queen Mother – requires improvement
- Royal Victoria - Good
- WHH – requires improvement

2.7 Coming from a poor report in 2014 there has been good improvement made in services by the Trust. However the CQC and Monitor agreed that the Trust should remain in special measures until the next inspection to ensure the progress was maintained. The Trust has in place a detailed Improvement Plan monitored through a programme office led by a clinician who chairs the Improvement Board. He also reports to the Board of Directors.

2.8 A number of changes to the Board of Directors' has taken place over the last 12 months resulting in a fully substantive Board, completed in January 2016 with the addition of a permanent Chief Executive and a new Clinical Non-Executive Director.

3 Scope of the Review

The governance review should consist of a review of board governance and leadership,
including board effectiveness, capacity and capability, including the Trust's performance
against Monitor's Well-Led framework.

The review is to be undertaken during May 2016 and completed by observing a Board meeting during the first week of June with the report available within 5 working days of the Board meeting. We have agreed to make the final draft and final reports available to Monitor and we will agree with the supplier and Monitor how this should be shared.

Review of Board Effectiveness, Capacity and Capability

3.1 The review of Board effectiveness, capacity and capability should include but not be limited to:

3.1.1 Effectiveness of the Board's focus on achievement of all local and national targets, on quality assurance, clinical governance, financial plan, strategic planning and risk management;

3.1.2 Appropriateness of individual Board member's skill mix, knowledge and experience to deliver the Trust's agenda;

3.1.3 Effectiveness of the Board as a team, succession planning and the division of portfolios of responsibility;

3.1.4 The level and effectiveness of the Board's scrutiny and challenge of each other and of the wider organisation;

3.1.5 Development programmes for the Board;

3.1.6 Board capacity to provide leadership to deliver improvements required to ensure high quality, safer services are sustained across the Trust;

3.1.7 The effectiveness of Board's two way communication with direct reports, wider teams and front line staff;

3.1.8 Board's relationship with key external stakeholders (eg. Commissioners and governors) and the views of those stakeholders regarding the effectiveness of the Board.

It is expected that the review would include assessment of recent Board and Committee papers and a range of interviews and observations of the Board at committees and meetings.

Review of Board Governance

3.2 The scope of the quality governance review is to be based on Monitor's Well-Led Framework .

The review should contain an assessment and risk rating for the following 10 questions under the four domains of Monitor's Governance Framework. Relevant evidence should be provided for each element with recommendations made to address any gaps that are identified. The risk rating should follow the colour rating (RAG) system as set out in the Monitor guidance.

3.3 **Domain 1: Strategy and Planning**

3.3.1 Q1: Does the Board have a credible strategy to provide high quality, sustainable services to patients and is there a robust plan to deliver?

Outcomes to consider:

- There is a structured, effective strategic planning process in place.
- The planning process takes account of regular engagement with external and internal stakeholders
- The board understands the implications for the trust of all relevant local health economy factors, and incorporates these in the strategic plan.
- The board understands the internal factors affecting delivery of the plan.

- The senior management team and workforce have the capacity and capability to deliver the plan.
- Quality is embedded in the trust's overall strategy through discrete, well defined goals.
- Plans are designed to 'cascade' initiatives through the organisation.
- Strategic goals have been communicated across the trust and community.

3.3.2 Q2: Is the Board sufficiently aware of the potential risks to the quality, sustainability and delivery of current and future services?

Outcomes to consider:

- The main risks associated with current and future services are identified, with no significant control issues/gaps and clear responsibilities.
- There is an effective process in place to monitor, understand and address current and future quality risks.
- There is a robust framework to develop and assess the impact of initiatives on clinical quality, with clinical input.
- The impact of initiatives on quality and financial sustainability is effectively monitored on an ongoing basis.

3.4 Domain 2: Capability and Culture

3.4.1 Q3: Does the Board have the skills and capability to lead the organisation including the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?

Outcomes to consider:

- The board is assured that it has the experience, capability and capacity needed to lead the organisation and that governors are able to carry out their role.
- The board is assured that it recruits and maintains the appropriate experience and skills through effective selection, development and succession processes.
- Board members are knowledgeable about quality issues and priorities, quality metrics and quality governance processes and structures.

3.4.2 Q4: Does the Board shape an open, transparent and quality-focussed culture?

Outcomes to consider:

- The board communicates a clear set of values and behaviours which: support the delivery of the vision and strategy; have regard to the NHS Constitution.
- The board is aware of any cultural differences across the trust and takes these into account in managing the organisation.
- The board actively shapes the culture through effective engagement with internal and external stakeholders. Stakeholders to be considered include patients, staff, governors, commissioners & providers as well as other key stakeholders identified.

- The board is aware of the challenges a multi-site Trust has and ensures the communication reflects this.
- The board actively leads on clinical quality, promoting staff empowerment and a quality-focused culture.
- The board encourages open flow of information to and from staff

- The board listens to concerns and issued raised by staff so that risks are identified and addressed appropriately.

3.4.3 Q5: Does the Board help support continuous learning and development across the organisation?

Outcomes to consider:
- Quality information is used to improve quality performance.
- The board promotes a strong focus on continuous learning and improvement at all levels of the organisation.
- Staff use information to develop new and improved quality services for patients.

3.5 Domain 3: Process and structures

3.5.1 Q6: Are there clear roles and accountabilities in relation to Board governance (including quality governance)?

Outcomes to consider:
- There are clear structures and comprehensive procedures for the effective working of the board, the council of governors and how each should interact with the other.
- The structures support the multi-site nature of the Trust.
- The Trust uses clear, robust and effective structures, processes and systems of accountability that are tailored to the organisation.
- There are clear, well-understood structures and processes for the effective management of any partnerships, joint ventures and shared services.
- Quality receives sufficient coverage both in board meetings and in relevant committees/sub committees below board level.

3.5.2 Q7: Are there clear defined, well-understood processes for escalating and resolving issues and managing performance (including quality)?

Outcomes to consider:
- The processes provide the board with the insight and foresight to manage the performance of the trust now and into the future including finance, clinical and other operations, human resources and long term strategy.
- Processes for escalating performance issues to the board are clear and are working.
- There is a well functioning, impactful clinical and internal audit process in relation to quality governance, with clear evidence of action to resolve audit concerns.

- The processes for escalating and resolving issues and managing performance are suitable for a multi-site operation.

3.5.3 Q8: Does the Board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?

Outcomes to consider:

- Patients and the public feel that the board actively engages with them about the work of the trust, especially in relation to quality.
- Staff feel listened to by the board and are able to contribute their ideas about the direction and day-to-day work of the trust.
- The board is transparent and open with the council of governors and relevant stakeholders about the performance of the trust (eg staff, public, commissioners).

3.6 **Domain 4: Measurement**

3.6.1 Q9: Is appropriate information on quality, organisational and operational performance being analysed and challenged?

Outcomes to consider:

- The information the board receives supports effective decision-making.
- The board uses information effectively and to hold management to account for the delivery of the plan.

3.6.2 Q10 Is the Board assured of the robustness of all information, including quality?

Outcomes to consider:

- The board is assured that its decisions and reporting channels are based on robust information.

3.7 **Other points relevant to the scope**

3.7.1 The Trust has a number of key stakeholders but the focus of the review should be weighted towards internal stakeholders / staff engagement.

3.7.2 The Trust has engaged with a number of external consultancies over the past 18 months and the reviewer may wish to review this work:

- KPMG data quality audit (December 2014)
- PWC divisional governance review (January 2015)
- Deloitte well-led governance review (February 2015)
- Grant Thornton financial governance review (September 2015)
- David Amos Board effectiveness review (January 2016)

4 Methodology

The methodology should be outlined by the supplier in their documentation and should contain enough detail to enable the Trust to have a clear understanding of how the review will be undertaken. It should also include any risks to the timescales outlined in this document.

5 Selection Criteria

Reviewers should demonstrate the following:

5.1 A clear concise understanding of the purpose and objective of the review and its significance to the Trust; a solid understanding of how to carry out a rigorous governance review, covering the specific areas detailed in the scope; and an appropriate range of tools and approaches to carry out the work.

5.2 Relevant experience to carry out the work including:

- Credibility and experience in carrying out governance and quality reviews at healthcare providers; ideally a multi-disciplinary team with a broad range of skills relevant to all aspects of the board leadership and governance such as strategic planning, quality governance, cultural assessment, organisational development and management information and analysis.
- Named personnel (and CVs in the response), and clarity about their role and what they'll do during the review.
- Knowledge of the healthcare sector, and the internal and external challenges faced by trusts; and
- Knowledge of Monitor's licence, and the broader regulatory framework the Trust operates in.

5.3 The ability to manage the review process including:

- Project governance – reviewers should provide a credible and detailed plan of the proposed project governance regime which includes the approach to the quality of the work, risk management, reporting and escalation lines.
- Implementation/project plan – reviewers should provide a credible and detailed project plan to meet the requirements of the Trust.
- Capacity – reviewers must assure the Trust that they have the capacity to carry out the review.
- Conflicts of interest/independent perspective – reviewers should declare any factors that may, potentially, reduce the independence of the reviews e.g. if the firm has carried out any governance or board development review work with the Trust in the last three years.

5.4 Pricing: In order to ensure full transparency of costings we ask for each element of work to be broken down separately and stated in terms of time (man hours / daily rate) per level of consultant.

East Kent Hospitals University NHS

NHS Foundation Trust

Corporate Performance Report 2015/16

February 2016

OUR MISSION:	**To provide safe, patient focused and sustainable health services with and for the people of Kent. In achieving this we acknowledge our special responsibility for the most vulnerable members of the population we serve**

Contents

Jane Ely
Chief Operating Officer
Sally Smith
Chief Nurse, Director of Quality
Nick Gerrard
Director of Finance and Performance Management

Putting patients first

EKBI Business Intelligence Beautiful Information®

< February 16 >

RESET

SCORES

VALUES

Key National Targets

Monitor

Domain	Metric Name	MTD	QTD	YTD
Patient Safety	Cases of C.Diff (Cumulative)	28	28	28
Effectiveness	ED - 4hr Compliance (%)	79.99	82.47	87.02
Access & Productivity	Cancer: 2ww (All)	94.07	93.69	93.28
	Cancer: 2ww (Breast)	88.03	90.83	90.31
	Cancer: 31d (Diag - Treat)	97.02	95.88	94.92
	Cancer: 31d (2nd Treat - Surg)	97.37	96	92.96
	Cancer: 31d (Drug)	98.65	91.67	97.48
	Cancer: 62d (GP Ref)	77.89	74.87	72.32
	Cancer: 62d (Screening Ref)	91.67	92.86	91.35
	RTT: Admitted (%)	60.39	60.43	75.67
	RTT: Non-Admitted (%)	90.73	90.38	91.75
	RTT: Incompletes (%)	89.17	89.63	89.11
	DM01: Diagnostic Waits	99.65	99.73	99.82

Internally Monitored Indicators

Quality

Domain	Metric Name	MTD	QTD	YTD
Patient Safety	HSMR			91.42
	Crude Mortality EL (per 1,000)	0.22	0.17	0.24
	Crude Mortality NEL (per 1,000)	35.77	33.97	29.15
Effectiveness	Readmissions: EL dis. 30d (12M%)	3.2	3.21	3.14
	Readmissions: NEL dis. 30d (12M%)	16.31	16.32	16.3

Activity (% Variance to Plan)

Domain	Metric Name	MTD	QTD	YTD
Access & Productivity	DNA Rate: New	6.75	7.3	7.74
	DNA Rate: FUp	6.66	7.37	7.62

Efficiency

Domain	Metric Name	MTD	QTD	YTD
Valuing People	Clinical Time Worked (%)	69.3	69.8	69.05
	Unplanned Agency Expense	114.67	112.58	127.51
	Appraisal Quality			86.67
	Training Plans (Quarterly)			80.85
	Sickness (%)	3.41	3.56	3.6
Access & Productivity	BADS	107.7	108.2	103.87
	Theatres: Session Utilisation (%)	80.89	81.36	83.17
	Non-Clinical Cancellations (%)	0.32	0.38	0.31
	Non-Clinical Canx Breaches (%)	8.33	7.37	2.47

East Kent Hospitals University NHS
NHS Foundation Trust
Putting patients first

FINANCIAL COMMENTARY - FEBRUARY 2016

Overview of Trust Financial Performance

Trust Key Performance Indicators (£m)	Annual target	Year to Date Plan	Year to Date Actual
Total operating income	528.9	483.4	**484.7**
CIP savings	16.2	13.9	**15.2**
EBITDA	(1.2)	(5.3)	**(5.0)**
I&E net surplus	(32.2)	(32.6)	**(31.5)**
Cash balance	0.08	2.8	**8.2**

Monitor Financial Stability Risk Rating	Annual target	Year to date Plan	Year to Date Actual
Financial Stability Risk Rating	**1**	**1**	**2**

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 £1m favourable against a plan of £(32.5)m.
- The subsidiary company (Healthex Limited which runs the Spencer Wing at QEQMH) is reporting a YTD surplus of £0.1m, which is not included in the above position.

Improvement Programme
CIPs are showing a £(0.6)m adverse variance in Month 10 and £1.3m favourable variance YTD.

Statement of Financial Position (Balance Sheet)
The Trust Statement of Financial Position and Cash summary are set out on page 3.
Unconsolidated Cash increased by £3.9m to £8.2m in February 2016. The revised planned balance was £2.8m, therefore, the balance was £5.4m above plan.

Capital Expenditure Programme
The table on page 3 summarises £10.7m of expenditure on capital projects in the year so far.

Financial Performance Indicators
The Trust is achieving the rating of 2 under Monitor's Financial Stability 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.
Cash Management.

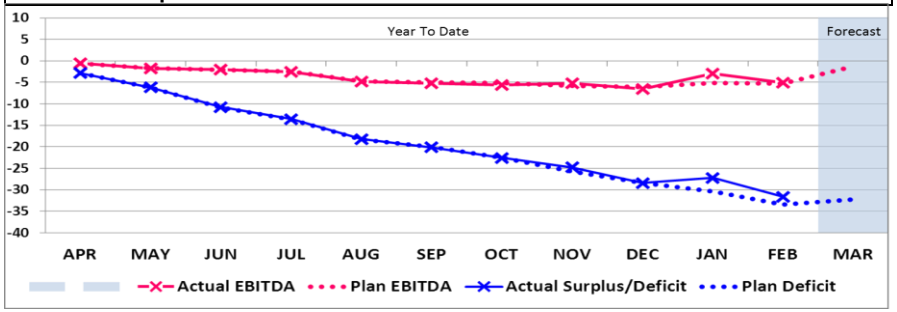
How financial risks are being addressed
The following actions are in place:
- The establishment of a Financial Recovery Group to develop and drive a robust Financial Recovery Plan chaired by the CEO.
- Continued HR drive to recruit to vacant posts in an effort to reduce Agency Staffing costs.

FINANCIAL PERFORMANCE FEBRUARY 2016

East Kent Hospitals University NHS
NHS Foundation Trust

Trust Statement of Comprehensive Income to 29th February 2016	Year to Date £000
SLAs & Corporate Income	357,222
Other Income	127,504
Total Income	**484,726**
Pay	301,333
Non-Pay	188,452
Total Expenditure	**489,785**
EBITDA	**(5,059)**
Depreciation	15,510
Dividend Payable	8,917
Other	2,085
Funds Available for Investment	**(31,571)**

Full Year - Surplus and EBITDA

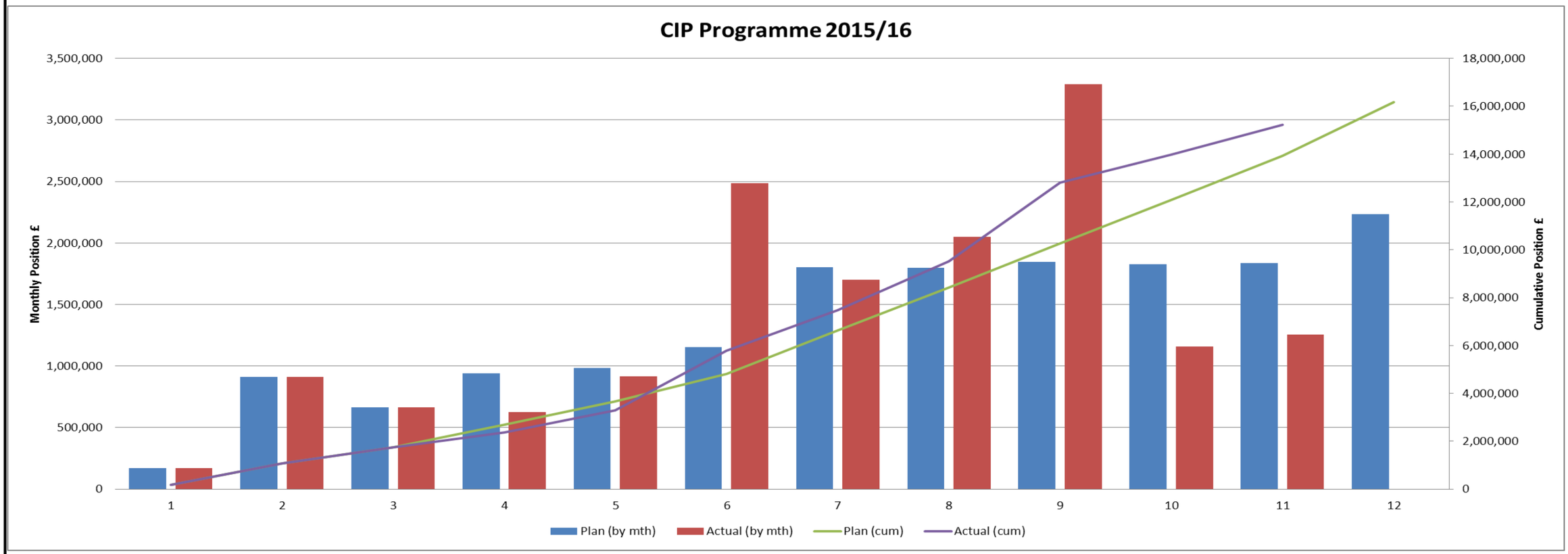


Trust Capital Expenditure to 29th February 2016	Year to Date		
	Budget £000	Actual £000	Variance £000
WHH A & E	894	890	4
WHH CT Scanner	2,026	1,544	482
Surgical Assessment Unit	2	24	(22)
Kent Pathology Partnership	51	107	(56)
Buckland Hospital	1,625	2,254	(629)
Outpatients	67	77	(10)
Replacement Medical Equipment	2,605	2,352	253
Patient Environment/Other Building Schemes	1,228	925	303
IT Strategy	2,851	2,851	(0)
All Other	448	(315)	763
Total Expenditure	**11,797**	**10,709**	**1,088**

Trust Statement of Financial Position as at 29th February 2016	Opening balance £000	Closing balance £000
Non-Current Assets	**316,625**	**316,036**
Current Assets		
Inventories	9,672	9,459
Trade and Other Receivables	29,527	21,560
Cash and Cash Equivalents	4,262	8,173
Total Current Assets	**43,461**	**39,191**
Current Liabilities		
Payables	(34,015)	(35,873)
Accruals and Deferred Income	(27,443)	(25,806)
Net Current Assets	**(17,996)**	**(22,487)**
Non-Current Liabilities	(2,670)	(2,670)
Total Assets Employed	**295,960**	**290,879**
Financed by Taxpayers Equity		
Public Dividend Capital	190,709	190,009
Revaluation Reserve	88,615	88,615
Retained Earnings	16,636	12,256
Total Taxpayers' Equity	**295,959**	**290,879**

Trust Cashflow Statement as at 29th February 2016	Current month £000
Opening Bank Balance	4,262
Receipts	
Main CCG SLAs	31,957
All Other NHS Organisations	10,208
Other receipts	5,469
Total Receipts	**47,634**
Payments	
Payroll	14,855
Creditor (including capital) payments	17,849
Other Payments	11,019
Total Payments	**43,722**
Closing Bank Balance	**8,173**

PROGRAMME OFFICE REPORT ON CIPs FEBRUARY 2016



The Trust's net financial efficiency target for 2015-16 financial year is £16.2m.

Savings delivered in the month of February were £0.6m below expected target, leaving a balance of £1m to achieve by year end.

PERFORMANCE REPORT - FEBRUARY 2016
GLOSSARY OF TERMS

Abbreviation	Definition
A&E in Dept <4 hrs	The percentage of A&E attendances who spent less than 4 hours from arrival at A&E to admission, transfer or discharge
Activity Data	Total Trust activity against the CaP Plan (a positive number shows the Trust had completed more activity than planned)
BADS	British Association of Day Surgery (Efficiency Score - actual v predicted overnight bed use)
CAMHS	Child and Adolescent Mental Health Services
IPM	Integrated Provider Management – A team providing local CCGs with financial and contract management in planning, negotiation and performance management of agreements with acute Trusts.
Cancer Targets	Specific cancer targets as identified in the Monitor Framework (2WW - 2 week wait, 31D - 31 days and 62D - 62 days)
CCG	Clinical Commissioning Group - CCGs have replaced PCTs
CDiff	Clostridium Difficile – A bacterium causing infection in the colon
CIP	Cost Improvement Programme – The programme to improve efficiency and productivity by reducing costs and/or increasing income
CoSRR	Continuity of Service Risk Rating - the way Monitor assesses the financial strength of FTs to sustain ongoing service provision (from 01/10/13). Scale of 1 to 4 (4 being the best).
CQC	Care Quality Commission – The body responsible for regulating and inspecting hospitals to ensure they are meeting government standards.
CQUINS	Commissioning for Quality and Innovation – Payment framework which makes a proportion of healthcare providers' income conditional on improvements in quality and innovation in specified areas of care.
CRU	Compensations Recovery Unit – The body which is responsible for liaising with insurance companies to recover the cost of treating RTA victims and pass the income to the Trust.
Crude Mortality	Number of in-hospital deaths per thousand discharged spells
Cum	Cumulative
CV's	Contract Variations
Diag.	Diagnosis
DM01	Reporting of Diagnostic waiting times less than six weeks - a key element towards monitoring waits from referral to treatment
DNA	Did Not Attend
DoH	Department of Health
DQ	Data Quality
EBITDA	Earnings(E) Before(B) Interest (I),Tax(T),Depreciation(D) and Amortisation on Donated Assets(A) ie Income less Operating expenses
eDN	Electronic Discharge Note
EL	Elective – Pre-arranged, non-emergency care
GUM	Genitourinary Medicine
HCOOP	Health Care of Older People
HD unit	High Dependency unit
HSMR	Hospital Standardised Mortality Ratios – This is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.
I&E	Income & Expenditure
LoS	Length of stay – Measurement of the duration of a single episode of hospitalisation.
Mth	Month
MRSA	Methicillin-Resistant Staphylococcus Aureus – A bacteria that is resistant to certain antibiotics.
MSSE	Medical Surgical Supplies and Equipment
NEL	Non Elective – Care which has not been pre arranged.
New to Follow Up Ratio	Ratio of attended follow up outpatient appointments compared to attended new outpatient appointments
Non Clinical Cancellations	Cancelled theatre procedures on the day of surgery for non-clinical cancellations as a percentage of total admitted patients
Non Clinical Cancellation breaches	Non-Clinical cancellations that were not rebooked within 28 days as a % of total admitted patients
PAS	Patient Administration System
PbR	Payment by Results – National pricing system designed to ensure Trusts get paid a standard price for each episode of patient care they provide.
PCT	Primary Care Trust – NHS bodies responsible for purchasing and providing healthcare for their local population.
PDC	Public Dividend Capital – Represents the funds provided by the DH since NHS Trusts were formed to enable them to own fixed assets.
POD	Point of Delivery
RAMI	Risk Adjusted Mortality Index
Readmissions	All Readmissions that are an emergency that occur within 30 days of any previous discharge (approved exclusions apply)
R&TC	Referral and Treatment Criteria – Criteria set to establish patient pathways.
RTT	Referral To Treatment
SHA	Strategic Health Authority
SLA	Service Level Agreement - Document describing the contract between the Trust and another public sector body for the provision of goods and/or services.
T&O	Trauma and Orthopaedics
Theatres Session Utilisation	Percentage of allocated time in theatre used, including turnaround time between cases, excluding early starts and over runs
UC&LTC	Urgent Care & Long Term Conditions
Uncoded Spells	Inpatient spells that either have no HRG code or a U-coded HRG as a % of total spells (including uncoded spells)
Var	Variance: the difference between budget and actual. A positive number is favourable.
VTE	Venous-Thromboembolism – A blood clot that forms within a vein.
WTE	Whole time equivalent - Expression of the number of staff based on the standard weekly hours for that staff group.
YTD	Year to date - The period from the start of the financial year (1 April) to the end of the month being reported on.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**8 APRIL 2016**
SUBJECT:	**CLINICAL QUALITY & PATIENT SAFETY**
REPORT FROM:	**CHIEF NURSE & DIRECTOR OF QUALITY** **MEDICAL DIRECTOR**
PURPOSE:	**Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

- The clinical metrics programme and annual and 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 Committee 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
- 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. Appendix 2 is a detailed complaint activity report and a heatmap of wards and departments in relation to quality indicators is included.

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.

The summary front sheet shows comparison in performance compared to one year ago. Of the 24 indicators, 9 report an improved or similar picture and 15 report a worsening picture to last year.

Key areas to note of this summary are:

- Mortality rates are slightly higher than this time last year and work is in progress to explain some differences noted in recent information from CHKS where mortality rates have worsened on our previous position;
- Readmission rates and the bed usage metrics show a poorer picture than this time last year. This reflects the operational pressure the Trust is under this year, and in particular the challenges the Trust is having in ensuring adequate emergency flow through the hospitals, although bed occupancy is lower than this time last year;
- Falls, pressure ulcers and the Safety Thermometer are discussed below, but the Trust is reporting slightly higher avoidable ulcers than this time last year;
- The old and new harms reported in the Safety Thermometer are higher than the national rate but Harms occurring in the Trust show a continued improvement and a lower harm rate than the national figure;
- The Trust StEIS reported 7 serious incidents during Feb-16 which are all subject to the root cause analysis process. This is slightly lower than the same time last year. The number of serious incidents that remain open is the same as in Feb-15, and the Divisions are working towards a trajectory to complete and close all breach cases. This is performance managed at the Divisional Executive Performance Reviews. The Surgical Division has made particular progress in this area. Learning is always shared as it emerges and while investigations are underway;
- The number of complaints received from February 2016 compared to February 2015 has decreased by 6% (66 compared to 70).
- The number of returner complaints received in Feb-16 compared to Feb-15 has increased by slightly (8 compared to 7).

The remaining metrics are discussed below and weave in the ward specific data depicted on the heatmap.

PATIENT SAFETY

- Harm Free Care – The Trust's 'Harm Free Care' performance remains lower than the national benchmark (91.8% vs 94.1% nationally), and performance has improved slightly since Jan-16's figure. With regard to new harms only, that we are able to influence, harm free care improved from 98.2% to 98.32% at WHH, from 98.2% to 98.24% at K&C and fell slightly from 98.01% to 97.99% at QEQM. Where on the heatmap wards are reporting less than 100% harm free care, it can be seen whether falls and pressure ulcer prevalence contributed to this. Analysis of the wards reporting harms shows that they are medical and surgical wards that admit patients as emergencies which is similar to last month. The relevance of this is that their workload can be very intense, and they also care for patients who are acutely unwell.

  The Tissue Viability Team is leading on a campaign entitled 'Bottoms-Up' following an increase in sacral sores. This commenced at the start of November and we are currently achieving against the trajectory of 25% reduction in deep ulcers and have reported no deep ulcers in Feb-16. The Trust remains above the trajectory to achieve a 25% reduction for category 2 pressure ulcers. The pressure ulcer panel remains in place in order to hold wards and departments to account and to enable the sharing of learning. Referring to the heatmap, it can be seen that the wards reporting avoidable pressure ulcers are largely the wards who admit patients as emergencies and these wards also report falls. These wards care for acutely ill and dependent patients whose mobility is reduced due to their clinical condition and who are often frail, some of whom are also living with dementia, such as on Kings C1, Harbledown, Mount McMaster and Kings D.

  The number of falls that our patients are experiencing was higher during Feb-

16 than in Jan-16. The highest number of falls occurred on Richard Stevens Stroke unit, Cambridge J, St Augustines (where patients are at particular risk due to frailty), CDU QEQM, Cheerful Sparrows Male ward and Clarke ward. Richard Stevens and Clarke ward experienced staffing difficulties this month and CDU QEQM, Cheerful Sparrows Male and Clarke wards utilise unfunded beds when the sites are under operational pressure which may contribute to the nursing staff's ability to monitor and supervise patients who are unsteady on their feet.

- HCAIs – There were no cases of MRSA bacteraemia in Feb-16. Two cases have occurred this year against the NHS England objective for 2015/16 of zero avoidable cases. C-Difficile rates remain significantly below national rates and the Trust is currently below the DH limit for 2015/16. MSSA bacteraemia rates are also below the national average. Trust wide mandatory Infection Prevention and Control training compliance continues to exceed the 85% standard.

- Mortality Rates – There has been no update on the Trust's HSMR and SHMI performance since last month, however crude non-elective and crude elective mortality rates are higher than last month. Analysis of the HSCIC website shows our SHMI for the period June 2014 – June 2015 as 1.03, which is at variance with that reported by CHKS (0.97). The Medical Director is exploring the specific conditions that are alerting to gain a greater understanding of the significance of the change. This involves a serial case note review of 30 consecutive deaths following abdominal hernia repair and a serial case note review of all cardiac arrests over the past year. The Divisional Medical Director for Urgent Care & Long Term Conditions Division is carrying out serial case note reviews of acute myocardial infarction, lung cancer and gastrointestinal haemorrhage. The findings of the reviews and actions taken will be reported to the Board of Directors once completed.

- Staffing – There was a fall in incidents recorded due to staffing levels in Feb-16 compared to Jan-16.

  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. An overall reduction in % shift hours filled has been seen since Nov-14 which reflects the national trend, linked to shortages of registered nurses. Reported data is derived from the E-Rostering and NHS-Professionals systems and aggregated fill rates in Feb-16 are over 94% at WHH, over 93% at QEQM and over 92% K&C which is slightly lower than that seen in Jan-16. The lower fill rates for registered nurse shifts during the day reflect the priority to ensure night shifts are properly covered. During the day Matrons and other RNs are able to assist on the wards to ensure safe staffing which is not always reflected on the E-Rostering system. Off framework agency bookings are partially reflected in the figures this month bookings have been linked into the NHSP system from mid Feb-16. This is reflected in particularly low % filled hours on St Augustines ward where off framework agency is used and Kingston ward.

  The fill rates this month reflect the vacancy position, sickness and maternity leave in some areas and annual leave at the higher end of permitted levels. Recruitment and retention initiatives are in progress and over 100 Registered Nurse posts have been filled between September and November including 38 newly qualified nurses. The remainder were EU nurses. 109 EU nurses have been recruited over the last year since Jan-15 and a further 31 will be joining us over the spring and early summer.

Analysis of the heatmap indicates that several of the wards flagging less than optimal staffing levels reported falls, and a lower level of patient satisfaction, or even no inpatient survey results this month. These wards include Cambridge K, Cambridge M2, Minster, Invicta, Cambridge L, Kingston and Richard Stevens stroke units, all wards with highly dependent and acutely unwell patients; and Clarke and Kings C2 ward. This is a similar picture to last 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 – Incident reporting continues to be high in the Trust reflecting a culture of risk awareness and a proactive approach to managing risk. All cases are thoroughly investigated with processes in place to share learning across the organisation. There were seven serious incidents reported in February. These comprised:

    - Three treatment delay meeting SI criteria (one urology, one ophthalmology, one ENT;
    - One child death;
    - One pressure ulcer category 3 (maternity – occurred in January);
    - One Never Event (retained foreign object (tampon) post-obstetric procedure);
    - One Never Event (ABO incompatible blood transfusion).

CLINICAL EFFECTIVENESS

- CQUINs – The 2015/16 CQUINs 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. Implementation of all quality initiatives are underway and all required milestones negotiated for Q1 & Q2 were met although Q3 milestones have identified particular challenges in the Sepsis and Acute Kidney Injury pathways and these were not fully achieved. Work is ongoing to ensure that improvement is sustained and improved upon for Q4 although it is likely that only partial CQUIN payment may be achieved.

PATIENT EXPERIENCE

- Mixed Sex Accommodation – There was 1 non-justifiable mixed sex breach reported this month and occurred in the QEQM CDU. Breaches (justifiable) that did occur were in the Kingston and Fordwich Stroke Units and Coronary Care unit at QEQM whilst the patients were receiving care at the hyper-acute phase of their illness. Privacy and dignity are maintained when this does occur.

- Compliments & Complaints – Appendix 2 contains the compliment, complaint and concerns analysis for Feb-16. The Trust continues to meet the 85% standard with 90% of the responses sent out within the date agreed with the client. However, the clinical Divisions are not achieving the Trust's stretch target of 85% of the responses being sent out within 30 working days. This month we have seen a sustained reduction in the number of returning complainants indicating an improvement in quality of response.

  Concerns about clinical management is the top theme in complaints, followed by delays and communication issues. The heatmap shows that no ward received in excess of 3 complaints, but the ED at William Harvey received 5 complaints and the ED at QEQM received 13 complaints. This correlates with

the lower satisfaction scores received via the friends and family test which is always lower in the EDs. Many wards were complaint free this month.

- Friends and Family Test – During Feb-16 we received 11,773 responses from our patients, an increase from 11,081 in Jan-16 and 8986 in Dec-15. This includes inpatients, A&E, maternity, outpatients and paediatrics. The satisfaction scores are depicted in the table below:

  Table 1 - Percentage Recommended – Feb-16

Department	Percentage recommended	
Inpatients*	95%	-
A&E	78%	↓
Maternity	95%	↓
Day Cases	94%	↓
Outpatients	91%	-

  * Now includes paediatrics.

  From the data we have received from Jan-16 all wards achieved a 92% or more satisfaction rate except Harvey ward (67%), the CDUs (79% & 76%) and Kings D (88%), with most achieving 100% recommendation. This can be seen on the heatmap and is similar to last month.

  Our real time inpatient feedback shows a continued high percentage of patients who felt their pain was managed as best it could. The heatmap shows that we have more improvement work to undertake in order to improve our care of patients by explaining their care and treatment in a way that they can understand, involving them more in their care and having time to allow patients to discuss their care with the staff. This month there does not appear to be a correlation with staffing and these metrics. These data are shared with the ward managers and Matrons.

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:

The metrics within this report will be continually monitored. However, particular focus is being applied to certain areas following this month's data. Actions for this month include:

1. Presentation of the Report at the Management Board for Divisions to share with their staff and work on the specific areas for improvement;
2. Discussion and agreement of actions at the Divisional Heads of Nursing meeting with regard to the Heat Map. Particular focus for this month is on the CDUs, CSM, Deal, Harvey, Richard Stevens, Kingston, Cambridge K Wards;
3. The Medical Director and colleagues are examining the mortality data and we will be required to introduce Trust wide mortality reviews of all deaths in April 2016. We are awaiting central guidance;
4. Improvements to the inpatient survey rates are expected and being taken forward by the Matrons and Divisional Heads of Nursing;
5. FFT data is being acted on, and the hotspot around ED feedback is

incorporated into the Emergency Pathway Improvement work across the Trust. Improvements in the pathway are expected to yield greater satisfaction scores;
6. Corrective action is in place to develop greater capacity within the Patient Experience Team in order to support the Divisions with complaint management;
7. Focussed work is in place to complete and close outstanding RCAs following serious incidents and ensure we meet the 60-day timeline consistently;
8. Actions around recruitment and retention continue with wards, departments and teams working closely with the HR teams and cultural change programmes;
9. All matters quality, safety and risk are performance managed through the monthly Executive Performance Meetings with the Divisions.

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.

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. The achievement of the stretch pressure ulcer reduction programme. The team are providing focussed improvements with the wards and the pressure ulcer panel interrogates avoidable ulcer RCAs for sharing and embedding learning and being aware of specific areas of work that need to be carried out;
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 ongoing 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 many months, the length of time complaints are open now needs focus to maintain our improvement journey. There is also a capacity issue in the Patent Experience Team that is requiring some additional corrective actions. This is around manpower. 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 and the internal inpatient survey. 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 ward staffing remains safe;
6. Successful delivery of the updated Improvement Plan following the outcome of the July-15 visit.

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) Discussion
(b) Information

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.

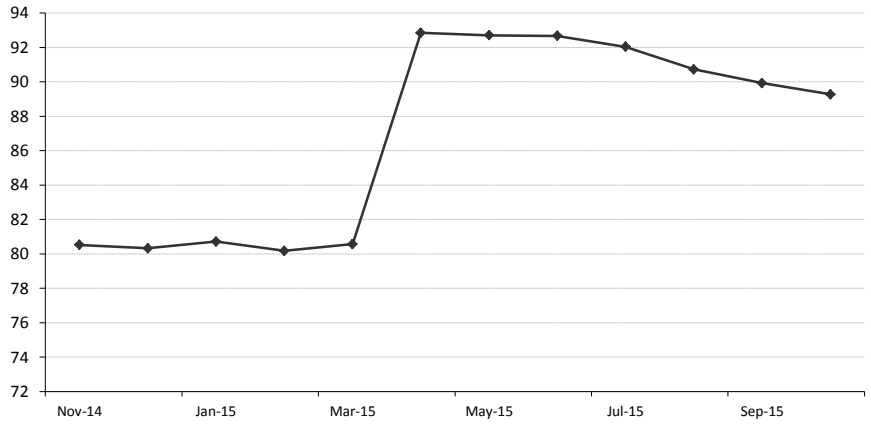
CLINICAL QUALITY & PATIENT SAFETY PERFORMANCE SUMMARY

	Measure	Improvement Metric		Target 15/16	Oct-15	Oct-14	vs Oct-14	YTD
Patient Safety	Mortality Rates	HSMR		-	89.3	80.3	↑	91.4
					Q2 14/15	Q2 13/14	vs Q2 13/14	YTD
		SHMI (%)		-	96.90%	94.51%	↑	-
					Feb-16	Feb-15	vs Feb-15	YTD
		Crude Mortality: All Ages (Per 1000)	Non-Elective	-	36.043	33.723	↑	29.179
			Elective	-	0.223	0.222	↑	0.243
	Risk Management	Serious Incidents (STEIS)	New Incidents	-	7	10	↓	-
			Open Incidents	-	68	68	↔	YTD
	HCAI	MRSA	Attributable	0	2	1	↑	YTD
		C. difficile	Post 72h	45	28	44	↓	YTD
	Infection Prevention				Feb-16	Feb-15	vs Feb-15	YTD
		Mandatory Training Compliance (%)		85.0%	86.9%	80.1%	↑	85.1%
	Harm Free Care (HFC)				Feb-16	Feb-15	vs Feb-15	YTD
		Safety Thermometer HFC (%) - Old & New Harm	EKHUFT	93.0%	91.8%	95.0%	↓	92.6%
			National	-	94.1%	93.8%	↑	-
	Nurse Sensitive Indicators	Pressure Ulcers: Category 2,3 and 4	Acquired	-	33	22	↑	287
			Avoidable	79	13	10	↑	86
		Pressure Ulcers	Unstageable	-	6	27	↓	45
		Falls		-	193	149	↑	1845
	Clinical Incidents	Total Clinical Incidents		-	1187	1036	↑	13268
Patient Experience	Experience	Friends and Family Test (Star Rating)		5.0	4.5	4.5	↔	-
		Adult Inpatient Experience (%)		80.00%	90.10%	89.76%	↑	-
		Mixed Sex Accommodation Occurrences		-	8	7	↑	124
Clinical Effectiveness	Readmission				Jan-16	Jan-15	vs Jan-15	YTD
		7 Day (%)		2.00%	4.44%	3.93%	↑	4.21%
		30 Day (%)		8.32%	8.63%	8.01%	↑	8.46%
	Bed Usage				Feb-16	Feb-15	vs Feb-15	YTD
		Bed Occupancy (%)		-	95.41%	97.27%	↓	-
		Extra Beds (%)		-	8.83%	7.53%	↑	0.00%
		Outliers		-	83	45	↑	0.00
		Delayed Transfers of Care (Average)		-	52.75	39.75	↑	41.72

NB: RAMI - Data sharing agreements with CHKS have now been resolved. An up to date RAMI position will be published in the near future.

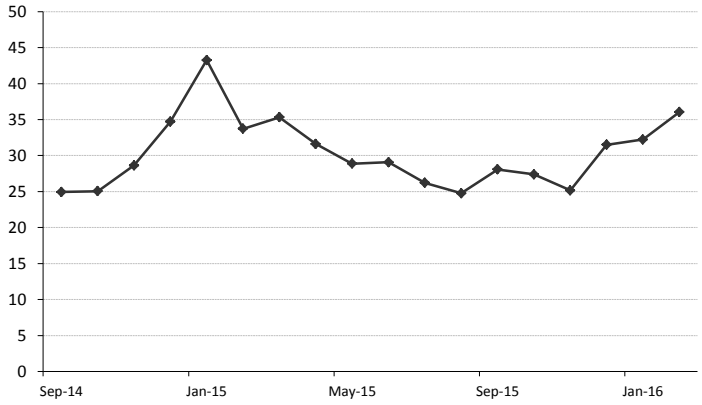
CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: MORTALITY RATES

Hospital Standardised Mortality Ratio (HSMR) - All Discharges



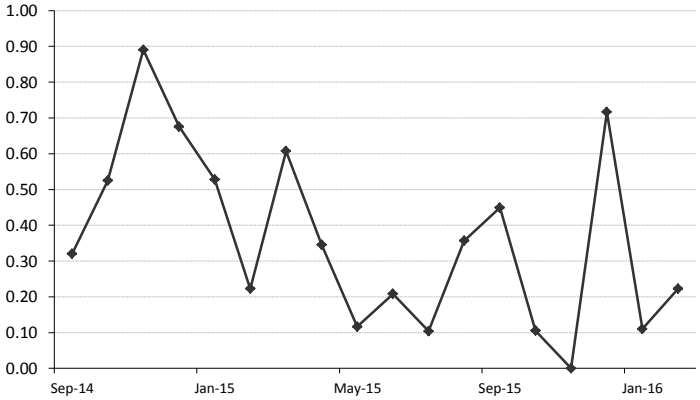
Hospital Standardised Mortality Ratios (HSMR) compare the number of expected deaths with the number of actual deaths, in hospital. The data are adjusted for factors statistically associated with hospital death rates. Severity of illness is an important factor on mortality and the methodology acknowledges this by using a measure of co-morbidity called the Charlson index, which looks at a number of secondary diagnoses and scores them according to severity.
HSMR saw a sharp increase in April 15 at 92.8 compared to 80.6 in March 15. HSMR has maintained much higher levels since April 15 with the most current figure being 89.3 for Oct-15. These increases could be a due to a change in methodology however this is to be confirmed by CHKS.

Crude Mortality - Non-Elective per 1000



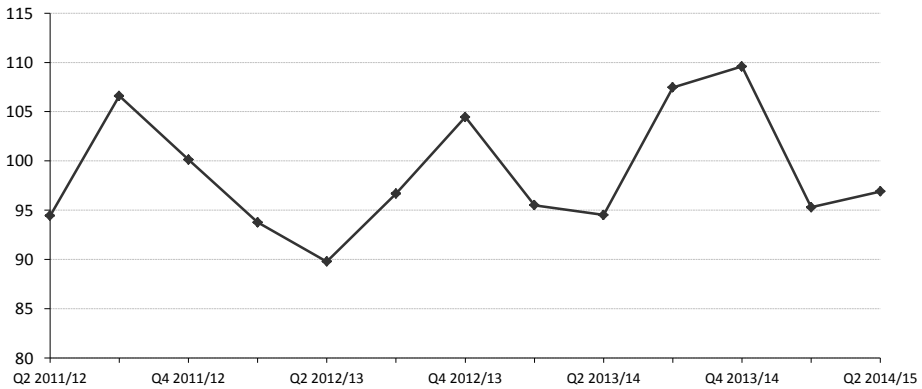
Non elective deaths per 1,000 increased in Feb-16 at 36.04 compared to 32.2 in Jan-16.

Crude Mortality - Elective per 1000

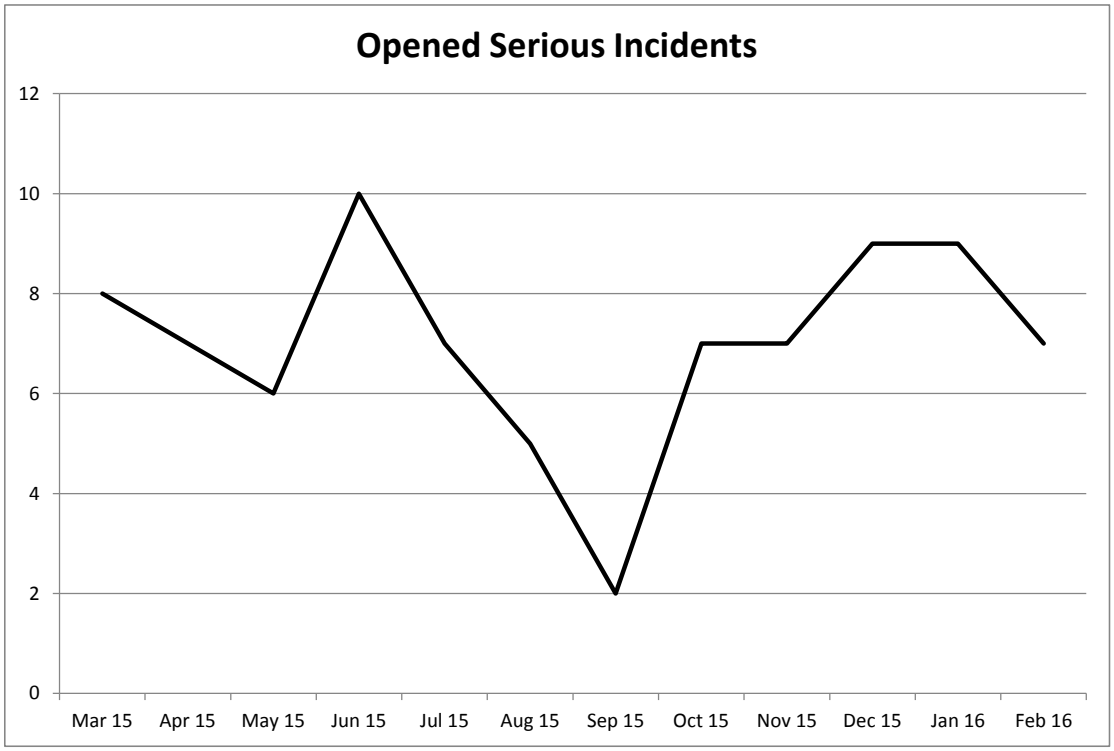


Elective deaths increased to 0.22 deaths per 1000 in Feb 16 compared to 0.11 deaths per 1000 in Jan-16. All elective deaths are reported on Datix and discussed at the Surgical Morbidity and Mortality meetings. Any points of learning are highlighted as part of this process.

Summary Hospital Mortality Indicator (SHMI)



The Summary Hospital Mortality Indicator (SHMI) includes "in hospital" and "out of hospital" deaths within 30 days of discharge. These data are supplied by an external party (CHKS) and are updated on a quarterly basis. The most recent data for Q2 2014/15 indicate a SHMI value of 96.9 which is higher than the position seen in Q1 2014/15 (95.30).

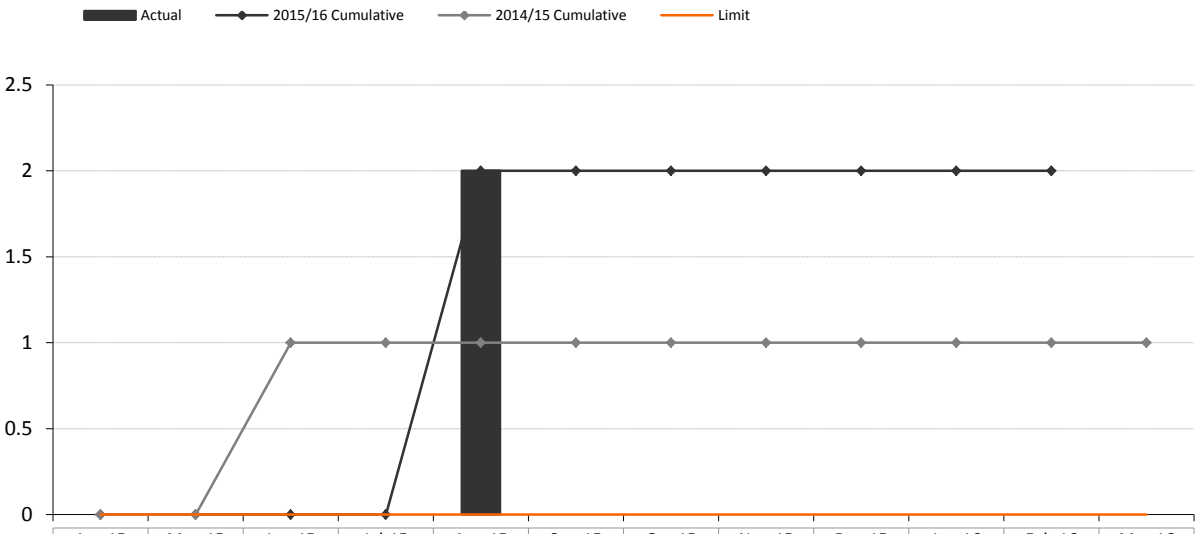


Total open SIs on STEIS Feb 2016: 68 (including 7 new)
SIs under investigation: 48
Breaches: 21
Non-breaches: 27

SIs awaiting closure: 20
Waiting CCG response: 16
Waiting EKHUFT non-closure response: 4
Supporting Narrative:
Work continues to take place within divisions, supported by the Clinical Risk Team, to improve the quality of the investigations, including meeting with the divisions, to enable RCA completion within the 60 day deadline. UCLTC continue to report difficulty in completing investigations due to medical involvement (current breach 11). Surgical Services have eight breached cases. There is also difficulty when completing investigations when clinicians differ in their opinions.

PATIENT SAFETY: HOSPITAL ACQUIRED INFECTIONS

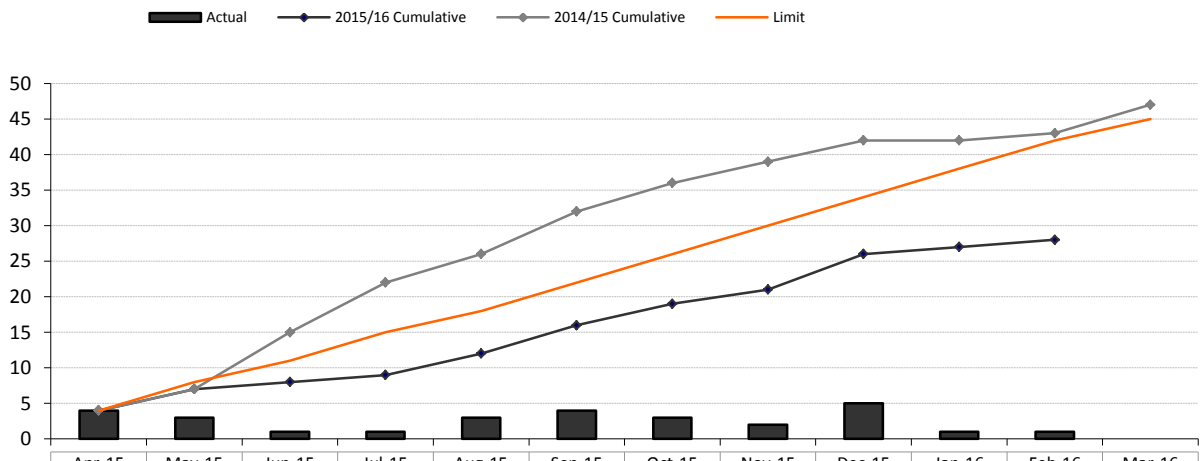
Trust Attributable MRSA Bacteraemia



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Actual	0	0	0	0	2	0	0	0	0	0	0	
2015/16 Cumulative	0	0	0	0	2	2	2	2	2	2	2	
2014/15 Cumulative	0	0	1	1	1	1	1	1	1	1	1	1
Limit	0	0	0	0	0	0	0	0	0	0	0	0

There were no cases of MRSA bacteraemia in February 2016. The NHS England objective for 2015/16 remains zero avoidable cases. The cumulative MRSA bacteraemia rate/100,000 occupied bed days for Apr 2015-Jan 2016 is 0.74 compared with 1.26 for KSS and 0.89 for England

Clostridium difficile - Incidents Post 72h



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Actual	4	3	1	1	3	4	3	2	5	1	1	
2015/16 Cumulative	4	7	8	9	12	16	19	21	26	27	28	
2014/15 Cumulative	4	7	15	22	26	32	36	39	42	42	43	47
Limit	4	8	11	15	18	22	26	30	34	38	42	45

There was 1 post 72hr C difficile case in Feb-2016. There were 28 cases at the end of Feb 2016 against a total DH limit of 45 cases. The monthly C difficile rate/100,000 occupied bed days for the April 2015 –Jan 2016 period is 9.93 compared with the national average of 15.34 and KSS rate of 12.31

PATIENT SAFETY: HOSPITAL ACQUIRED INFECTIONS

Escherichia coli Bacteraemia - Incidents Pre and Post 48h

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly Average	Total YTD
2015/16	Pre 48h	33	39	31	49	45	34	38	43	34	36	36		38.0	418
	Post 48h	6	5	5	3	4	8	5	7	9	7	11		6.4	70
2014/15	Pre 48h	32	36	32	37	25	39	40	35	29	30	30	35	33.3	400
	Post 48h	9	1	8	7	6	5	6	4	9	6	3	4	5.7	68

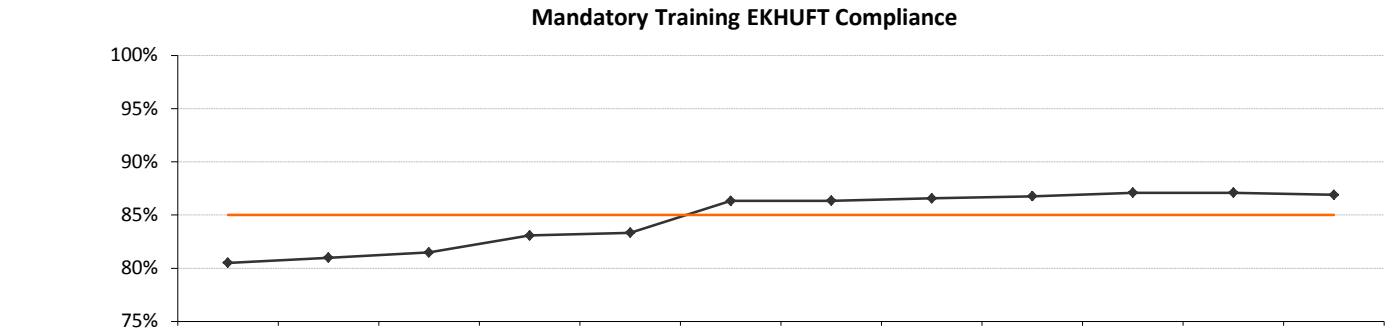
In Feb 2016 there were 47 cases of Ecoli bacteramia (36 pre 48 hour and 11 post 48 hour bacteraemia). Ecoli bacteramia rates are influenced by local demographic factors with the rate of Ecoli bacteraemia per 100,000 population ranging from 48.47 in Ashford CCG to, 65.22 in Canterbury & Coastal CCG , 70.72 in South Kent Coast CCG and 84.82 in Thanet CCG. The England population rate is 59.31 per 100,000 head of population. [Rates quoted for April 2015 –Jan 2016]

Meticillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly Average	Total YTD
2015/16	Pre 48h	13	13	3	8	14	9	5	8	6	14	16		9.9	109
	Post 48h	1	0	1	6	1	1	2	2	2	5	2		2.1	23

In February 2016 there were 18 MSSA cases (16 pre 48 hous cases and 2 post 48 hour cases). The cumulative rate per 100,000 occupied bed days is 7.72 compared with a KSS rate of 7.85 and an England rate of 8.38 . Given that the majority of cases are community acquired a rate per 100,000 head of population is probably a more relevant statisitic. Population rates are influnced by local demmographics and range through 8.22 for Ashford CCG, 14.82 for Canterbury & Coastal CCG, 22.2 for South Kent Coastal CCG and 20.47 for Thanet CCG . The England population rate is 16.3 per 100,000 head of population. [Rates quoted for April 2015 –Jan 2016]

PATIENT SAFETY: INFECTION PREVENTION & CONTROL



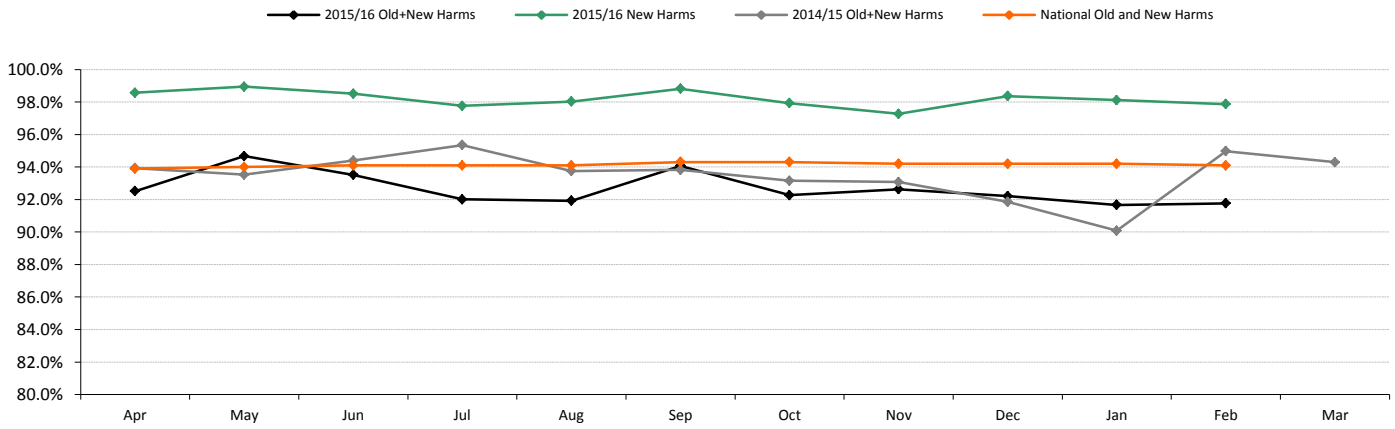
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Compliance	80.5%	81.0%	81.5%	83.1%	83.3%	86.3%	86.3%	86.6%	86.8%	87.1%	87.1%	86.9%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

	Feb-16								
	Target	Trust	Clinical Support Services	Corporate	Specialist Services	Strat Dev & Capt Pln	Surgical Services	UCLTC	Serco
Mandatory Comparative Data for Biennial Training Compliance	85%	86.9%	91.6%	86.6%	83.1%	86.1%	85.8%	87.1%	95.3%

Compliance Against Performance	
	Achieving or exceeding performance metric
	0-10% underperformance against metric
	10-20% underperformance against metric

Trust compliance decreased to 86.9% in February compared to 87.1% in January. A number of Divisions have seen positive increases including Surgical (85.5% to 85.8%), Corporate (85.7% to 86.6%) and Clinical Support Services (91.5% to 91.6%). Serco saw a decrease from 96% to 95.3%, Specialist from 83.3% to 83.1%, Urgent Care and Long Term Conditions from 87.7% to 87.1% and Strategic Development and Capital Planning from 90.1% to 86.1%.

Safety Thermometer Harm Free Care



The chart above shows the percentage of Harm Free Care expressed as a one-day snapshot in each month. It is known as the NHS Safety Thermometer and is a quick and simple method for surveying patient harms. The aim of the Safety Thermometer is to identify, through a monthly survey of all adult inpatients, the percentage of patients who receive Harm Free Care. Four areas of harm are currently measured:

- All categories of pressure ulcers whether acquired in hospital or before admission;
- All falls whether they occurred in hospital or before admission;
- Urinary tract infection (inpatients with a catheter);
- Venous thromboembolism, risk assessment and appropriate prevention.

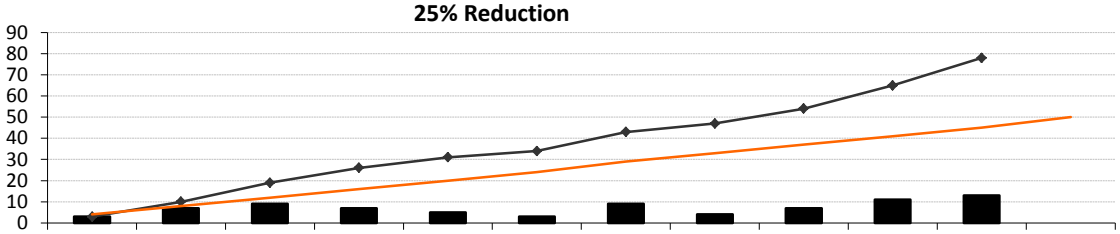
The strength of the NHS Safety Thermometer lies in allowing front line teams to measure how safe their services are and to deliver improvement locally. There are several different ways in which harm in healthcare is measured and there are strengths and limitations to the range of approaches available. The NHS Safety Thermometer measures prevalence of harms, rather than incidence, by surveying all appropriate patients on one day every month in order to count the occurrences of harms.

Harm Free Care includes both harms acquired in hospital ("new harms") and those acquired before admission to hospital ("old harms"). There is limited ability to influence "old harms" if a patient is admitted following a fall at home, or with a pressure ulcer, but these are included in the overall performance reported to the Health and Social Care Information Centre. "New harms only" are included separately when reporting performance to Divisional teams to enable success to be celebrated and to incentivise improvement. Harm Free Care performance is incorporated within the monthly ward quality dashboard and is triangulated with the existing funded establishment, acuity and dependency of patients, and effectiveness of rostering to enable analysis of influencing factors and thereby focusing improvement actions.

Those inpatients suffering from new and old harms remained stable at 91.8% in Feb-16. This figure includes those patients admitted with harms and those who suffered harm whilst with us. With regards to "New Harms Only" HFC, which we are able to influence, 97.9% were harm free, showing a slight decrease of 0.3% in comparison with Jan-16.

WHH demonstrated a slight decrease in Harm Free Care (''New Harms'' only) from 98.2% in Jan-16 to 97.7% in Feb-16. However, QEQM Harm Free Care (''New Harms'' Only) remained stable at 98% in Jan and Feb 16 and K&C decreased from 98.2% in Jan-16 to 97.9% in Feb-16.

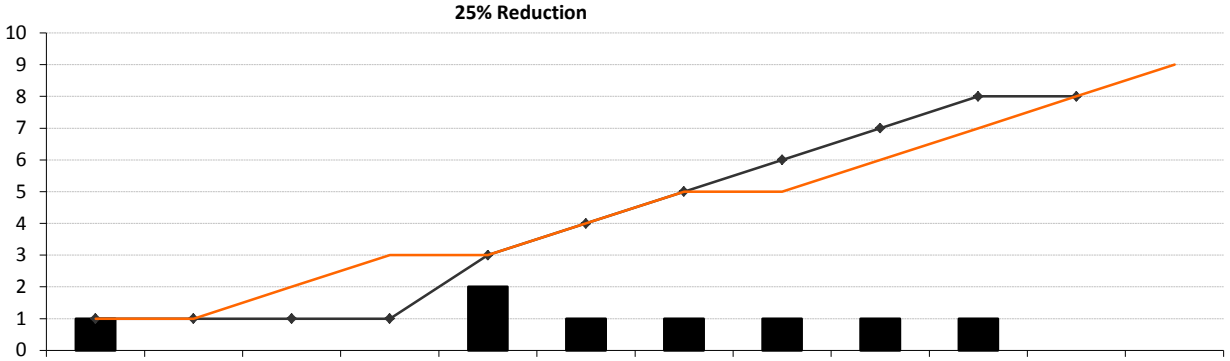
Category 2 Incidence Trajectory 2015/16
25% Reduction



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
2015/16 Avoidable	3	7	9	7	5	3	9	4	7	11	13	
2015/16Cum Avoidable	3	10	19	26	31	34	43	47	54	65	78	
2015/16Cum Trajectory	4	8	12	16	20	24	29	33	37	41	45	50
per 1000 bed days	0.10	0.23	0.30	0.23	0.16	0.10	0.28	0.13	0.22	0.33	0.40	

In Feb-16, a total of 32 acquired Category 2 pressure ulcers were reported and 13 were defined as avoidable due to learning in respect of aspectss of the SKINS bundle. Feedback to individual teams included improving early intervention and documentation; reminders to reduce chair sitting to shorter episodes at a time, react to red skin by obtaining active support surface and avoiding pressure by careful positioning; to include elbows and ensure thorough skin checks; compliance with repositioning regimes; correct risk assessment, obtaining appropriate equipment and correct use of anti-embolic stockings. Two incidents involved tubing from nasal cannula causing ear ulcers and staff were reminded to use protective dressings. All general wards participated in a Trust wide annual pressure ulcer prevalence audit in February which will demonstrate our progress in achievement quality standards as well pressure ulcer outcomes.

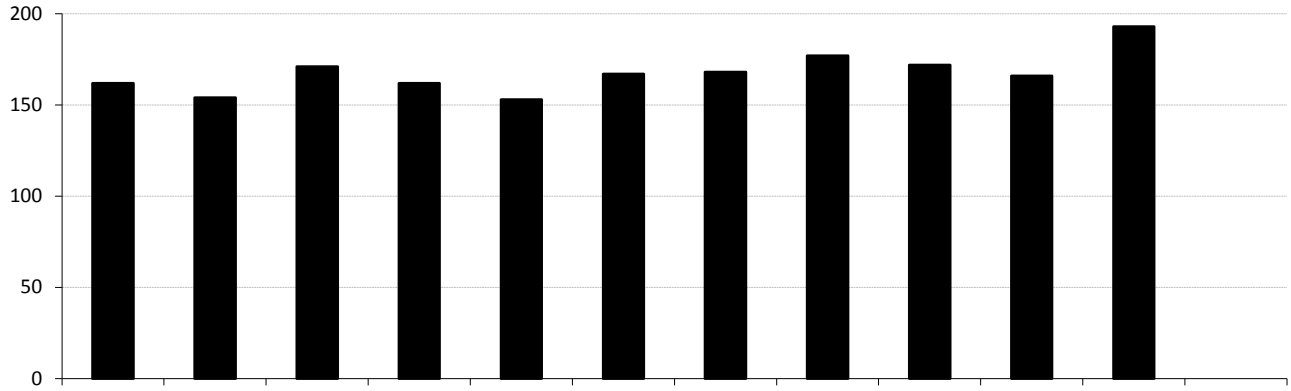
Category 3 and 4 Incidence Trajectory 2015/16
25% Reduction



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
2015/16 Avoidable	1	0	0	0	2	1	1	1	1	1	0	
2015/16Cum Avoidable	1	1	1	1	3	4	5	6	7	8	8	
2015/16Cum Trajectory	1	1	2	3	3	4	5	5	6	7	8	9
per 1000 bed days	0.03	0.00	0.00	0.00	0.06	0.03	0.03	0.03	0.03	0.03	0.00	

There were no avoidable confirmed category 3s or 4s in Feb-16. Even with full protection, one patient developed a category 3 pressure ulcer to the ankle on Kent ward. Ten potential deep ulcers occurred, of which four are suspected of being avoidable. Deeper investigations are required to fully understand this and identify any learning points. Currently work is being undertaken to raise awareness of the guidelines for correct use, application and monitoring of anti-embolic stockings (AES) following a cluster of incidents.

Patient Falls - Injurious and Non-Injurious



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
■2015/16	162	154	171	162	153	167	168	177	172	166	193	
2015/16 Cum	162	316	487	649	802	969	1137	1314	1486	1652	1845	
per 1000 bed days	5.37	4.97	5.71	5.29	4.94	5.38	5.29	5.66	5.49	4.96	5.91	

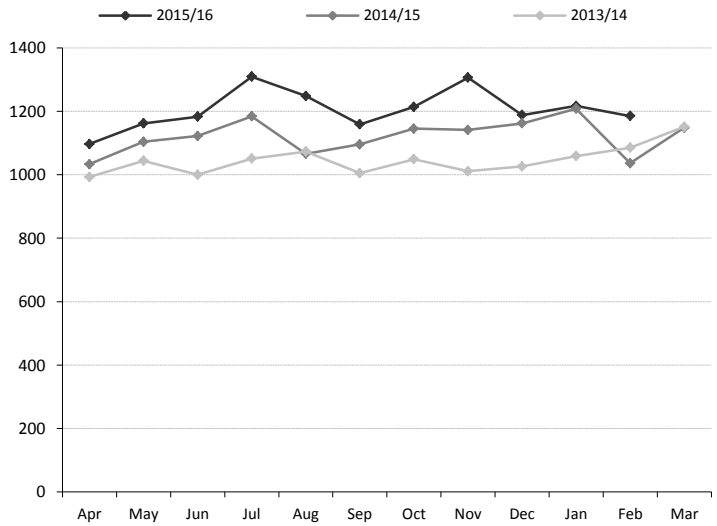
Of the 193 patient falls recorded for February (166 in Jan-16 and 152 in Feb-15), no incidents have been graded as death or severe harm. One incident has been graded as moderate, which resulted in a head injury. There were 100 falls resulting in no injury and 92 in low harm. The top reporting wards were Richard Stevens stroke unit with 14 falls; Cambridge J (WHH), Cheerful Sparrows male (QEH), Clarke ward (K&CH), Mount/McMaster ward (K&CH), CDU (QEH), CDU (WHH), Cambridge K ward (WHH) and Cambridge M2 ward (WHH).

Our team is currently running with only 2 CNS's and a Nurse Consultant, therefore Ward Based Falls Link Workers have been given the responsibility of ensuring all staff have been trained in the completion of the Falls Risk Assessment & Care Plan (FRACP) and that risks are being managed appropriately. We have recently developed a "Falls" specific RCA template to address moderate to severe harms in a specific and more robust way. The 1st draft has been sent out for approval. Working with Head of Information Development & Data Architecture, Information Team Richard Ewins and Senior Information Analyst, Nikhaela Wicks we are looking to formulate a functional database to capture all information relevant to moderate/severe harm injuries to aid with ensure more effective monitoring and pooling of Trust wide data. It will help identify key themes and actions. We will be recruiting to our 2 vacant band 6 posts. 5 candidates were successfully shortlisted and interviews are planned for 21st March 2016. The focus of the new Band 6 members of our team will be to have a more prominent presence on the wards with the focus on staff training, embedding the culture of harm prevention and audit with associated action plans. We have approval to launch a "FallStop" programme and the Band 6's will be instrumental in embedding this Trust wide with support from senior members of the team.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: CLINICAL INCIDENTS

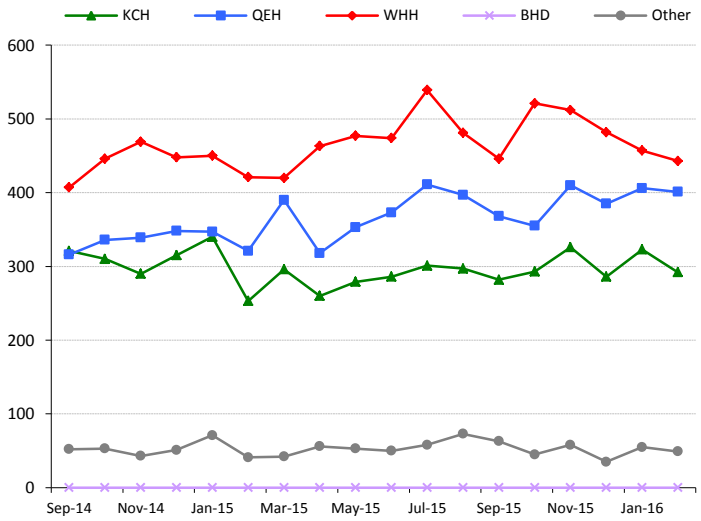
In Feb-16 a total of 1187 clinical incidents (excluding duplicates) were reported. Three incidents have been graded as death and one as severe harm. In addition, 21 incidents have been escalated as a serious near miss, of which 18 are still under investigation. The number of moderate harm incidents reported during Feb-16 is on a par with previous months [Feb-16: 50 compared with Jan-16: 53 and Feb-15: 33].
Seven serious incidents were required to be reported on STEIS in February. Four cases have been closed in February; there remain 68 serious incidents open at the end of February.

Overall Incident Rates by Year



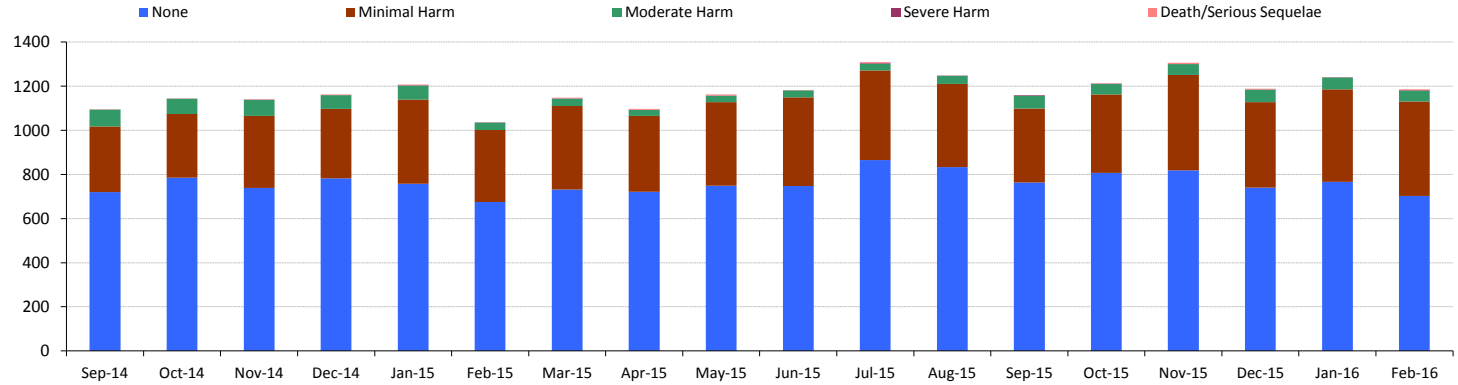
A total of 1187 clinical incidents have been logged as occurring in Feb-16 compared with 1241 recorded for Jan-16 and 1036 in Feb-15.

Overall Incident Rates by Site



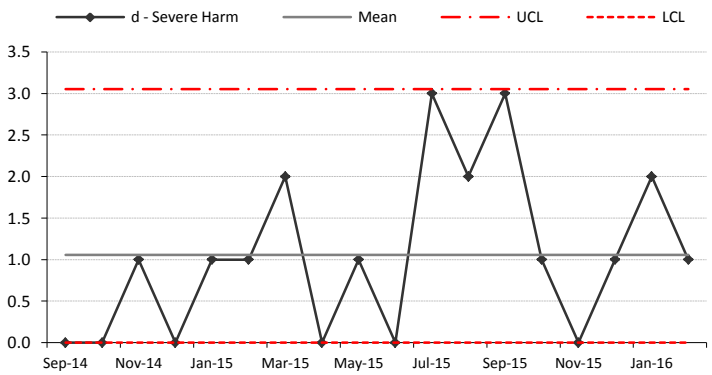
Over the last 12 months incident reporting has increased at all three main sites.

Clinical Incidents by Severity

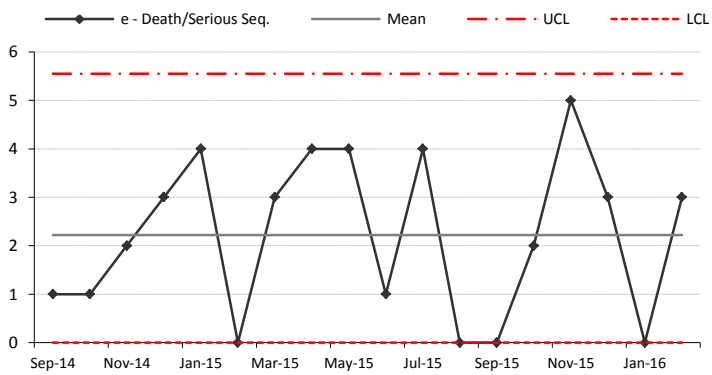


The incidents graded as moderate, serious and death have all been subject to review in order to confirm the consistency of the grading of harm across the Trust. The Board of Directors may see a change in this report to reflect the re-categorisation process undertaken. This is consistent with the data presented in the Quality Account and Quality Report.

Severe Harm

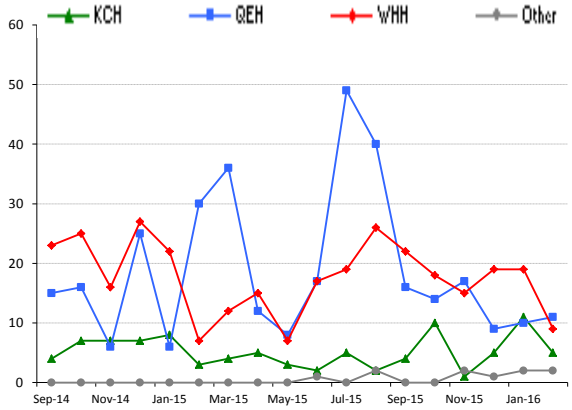


Death/Serious Sequelae



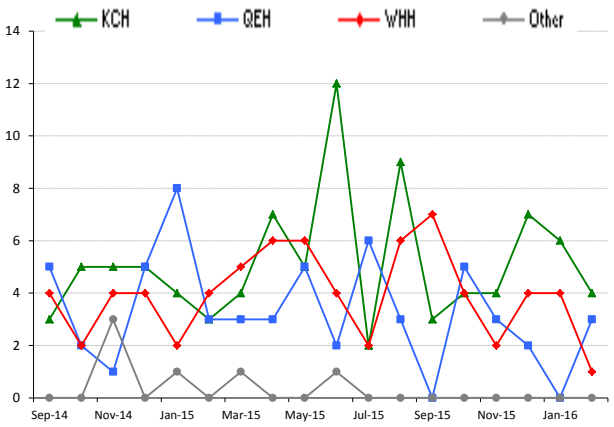
The number of death/serious and severe harm incidents reported in Feb-16 remains subject to the usual RCA investigation and review. It is possible that the severity of these cases will be downgraded once the investigation process is completed in line with national guidance to ensure the actual harm caused by any act or omission is recorded. In Feb-16, the number of incidents graded as death or severe is on a par with previous months.

Staffing Level Difficulties



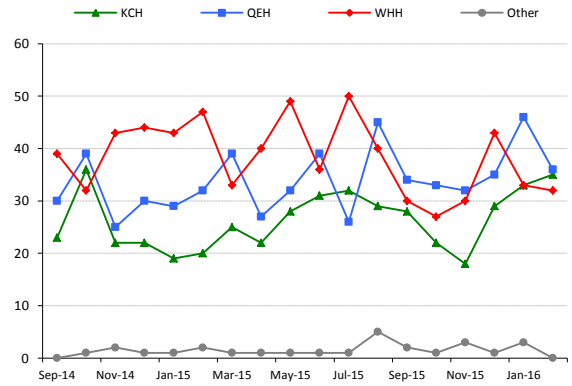
There were 27 incidents recorded in Feb-16 (42 in Jan-16 and 40 in Feb-15). These included 10 general staffing level difficulties, 10 incidents relating to insufficient nurses, three to inadequate skill mix and three to insufficient doctors and nurses. Top reporting locations were Deal ward (QEH) with five incidents each; ECC (K&CH), CDU (QEH), Seabathing unit (QEH), ITU (WHH) and Folkestone ward (WHH) with two incidents each; 12 other areas reported one incident.
Five incidents occurred at K&CH, 11 at QEH, nine at WHH and two at BHD. Eighteen incidents have been graded as no harm and nine as low harm.

Blood Transfusion Errors



In February, there were eight blood transfusion errors reported (10 in Jan-16 and 10 in Feb-15). No themes were apparent. All nine incidents were graded no harm.
Reporting by site: one at WHH, three at QEH and four at K&CH.

Medicines Management



Category	Feb-16
Drug error- Prescribing	23
Drug error- Dispensing	14
Drug error- Administering	44
Drug shortage (not available or in stock)	1
Drug missing (stock discrepancy or lost between wards/pharmacy)	15
Adverse drug reaction	3
Infusion injury - extravasation	1
Infusion problems - medication related	4
Totals	**105**

There were 105 medication incidents reported as occurring in February (115 in Jan-16 and 101 in Feb-15). Over the last 12 months there has been a gradual increase in reporting of medication incidents at QEH and K&CH. A downward trend is showing for WHH.
Of the 105 reported, 78 were graded as no harm including four serious near misses and 24 as low harm. There were three incidents graded moderate harm: 1) patient became breathless and unresponsive following an infusion, 2) patient prescribed excessive dose of actrapid (5 times correct dose) which was administered resulting in a hypoglycaemic episode and 3) patient given the wrong drug and suffered a likely rhabdomyolysis episode (muscle injury); all three incidents are under investigation. Top reporting areas were: Aseptics (K&CH), Cathedral day unit (K&CH), Thomas Beckett dialysis unit (K&CH), Cheerful Sparrows male ward (QEH), Deal ward (QEH), A&E (WHH) and Pharmacy (WHH) with four incidents each; Harbledown ward (K&CH), ITU (K&CH), Kent ward (K&CH), CDU (QEH), Cheerful Sparrows female (QEH), Fordwich stroke unit (QEH), Kings C1 (WHH), NICU (WHH) and Padua ward (WHH) with three each; other areas reported 2 incidents or fewer. Thirty-six incidents occurred at QEH, 35 at K&CH and 33 at WHH.
*Missing Drugs are broken down as follows: 11 incidents relating to stock control, 2 incidents of medication missing between wards and departments, 1 delay in dispensing due to missing drug chart and 1 incident of medication stored in the wrong box.

Friends and Family Test (FFT)

The Friends and Family Test asks the patient how likely they are to recommend the ward, A&E department, Maternity Services, Day Case Services and Outpatient Departments to their friends or family. The scoring ranges from:

- Extremely likely;
- Likely;
- Neither likely nor unlikely;
- Unlikely;
- Extremely unlikely;
- Don't Know.

The percentage measures for patients that would and would not recommend our services are then calculated.

The FFT does not provide results that can be used to directly compare providers because of the flexibility of the data collection methods and the variation in local populations. This means it is not possible to compare like with like with other trusts. There are other robust mechanisms for that, such as national patient surveys and outcome measures. The real strength of the FFT lies in the follow up questions that are attached to the initial question, and a rich source of patient views can be used locally to highlight and address concerns much faster than more traditional survey methods.

During February we received 11,773 responses in total which shows an increase from 11,081 in Jan-16 and 8986 in Dec-15. The total number of inpatients, including paediatrics who would recommend our services was 95% (the same as in Jan-16). For A&E it was 78% (81% in Jan-16), maternity 95% (99% in Jan-16), outpatients 91% (the same as Jan-16) and day cases 94% (95% in Jan-16). The Trust star rating in February is 4.51 (4.55 in Jan-16 and 4.53 in Dec-15).

The response rate for inpatients was 31% (36% in Jan-16), A&E 27%, (21% in Jan-16), maternity 30% (36% in Jan-16). (Please note as per DH guidelines only Q2 Birth is given a response rate, the other 3 questions reponses are not calculated or required nationally). The response rate for outpatients was 27% (20% in Jan-16) and 37% for day cases (29% Jan-16).

All areas receive their individual reports to display each month, containing the feedback left by our patients which will assist staff in identifying areas for further improvement. This is monitored and actioned by the Division Governance Teams.

Our staff FFT has shown a 7% increase over the past 6 months in those staff who would recommend the Trust as a place to work (45% - 52%), and a 4% rise in recommending the Trust for treatment (72% - 76%).

CLINICAL QUALITY & PATIENT SAFETY

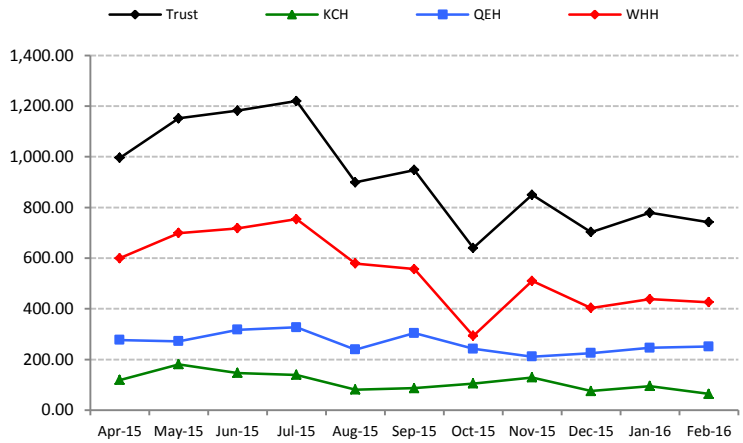
PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

Real time patient experience monitoring using iPads have captured data since 1 Apr-13. Since 1st November the trust is using an internal system to collect the data from our patients instead of using an out side provider. This has many benefits including financial, performance and reporting of the data. Further work to embed this continues in order to improve response rates which have fallen since Aug-15. 742 responses were received from patients during Feb-16.

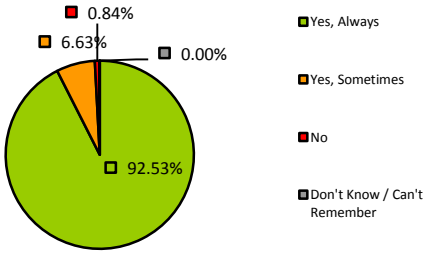
Overall Adult Inpatient Experience February 2016

Experience (%)	No. of Responses
90.10	742

Number of Adult Inpatient Survey Responses

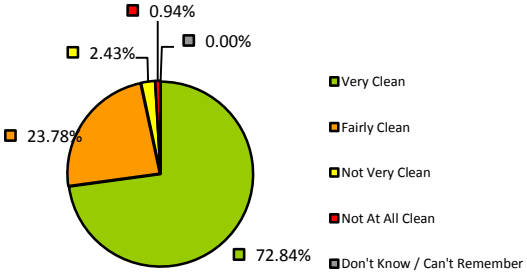


Overall, did you feel you were treated with respect and dignity while you were in hospital?



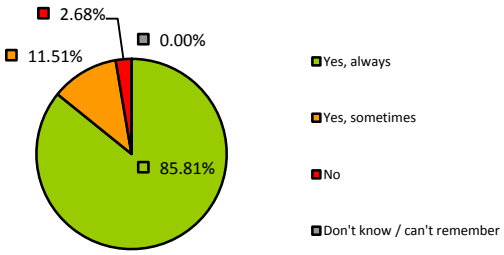
Green and amber overall score:
99.16%

In your opinion, how clean was the hospital room or ward that you were in?



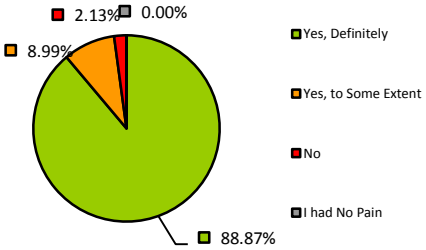
Green and amber overall score:
96.62%

Was your care or treatment explained to you in a way you could understand?



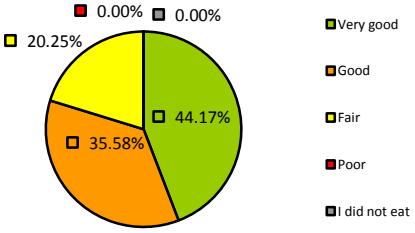
Green and amber overall score:
97.32%

Do you think the hospital staff did everything they could to help control your pain?



Green and amber overall score:
97.87%

How would you rate the hospital food?



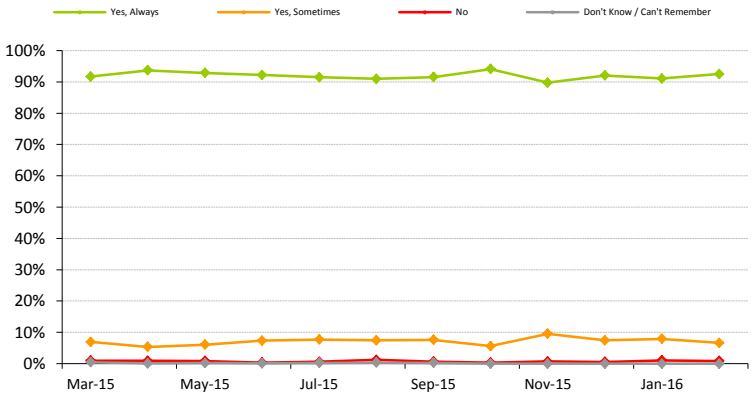
Green and amber overall score:
79.75%

Each ward reviews their real-time monitoring data regularly. This data is available via the ward dashboard and is updated frequently to ensure a valuable real time tool to capture patient experience and satisfaction feedback, to assist to identify any areas of concern and any areas of praise instantly and action can be demonstrated as needed. In Dec-15 the questions within the survey were updated to reflect the issues highlighted in the national inpatient survey to enable closer monitoring of improvement. Questions related to involvement in care decisons, staff availability to discuss concerns and privacy in discussing treatement have been substituted for questions on explanation of care / treatment and pain control as they are areas where we perform less well.

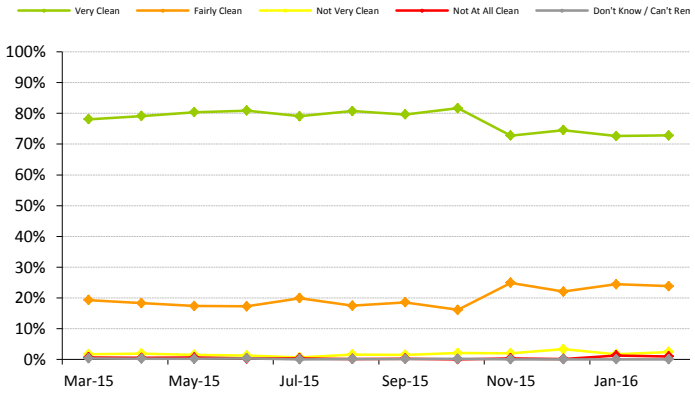
This information is also shared as "heat maps" with other teams. From this actions are taken to address the themes which are considered with the Friends and Family Test feedback, and compliments and complaint information. This is monitored and actioned by the divisional governance teams.

PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

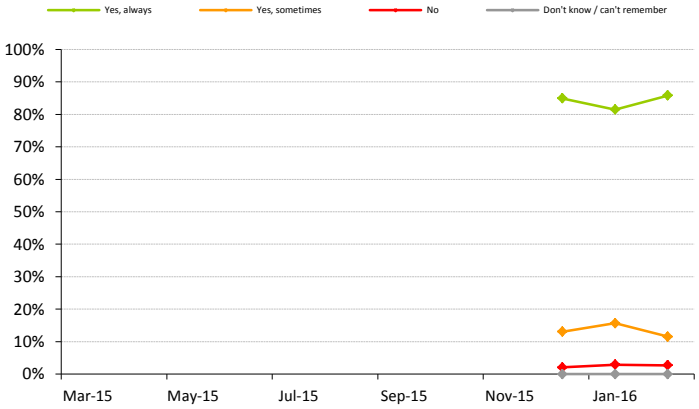
Overall, did you feel you were treated with respect and dignity while you were in hospital?



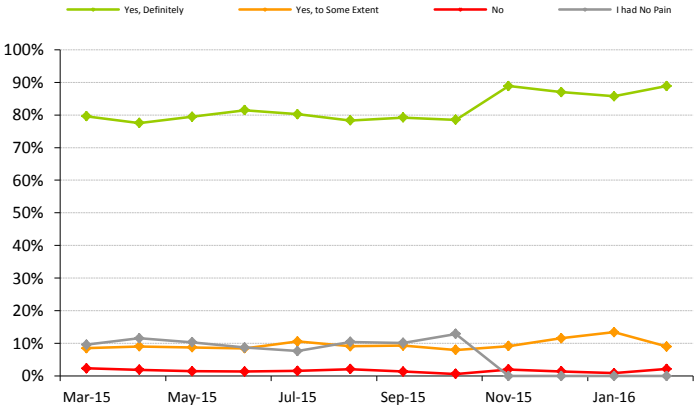
In your opinion, how clean was the hospital room or ward that you were in?



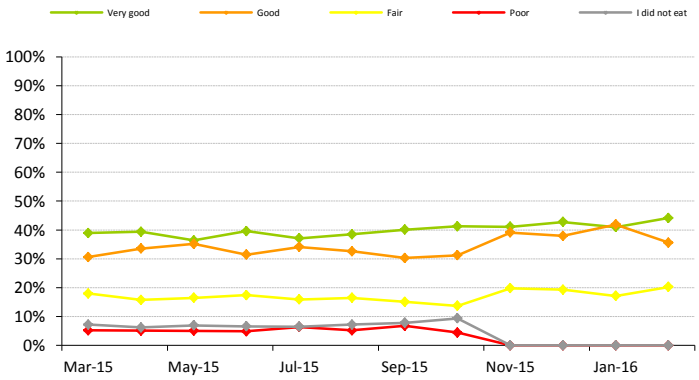
Was your care or treatment explained to you in a way you could understand?



Do you think the hospital staff did everything they could to help control your pain?



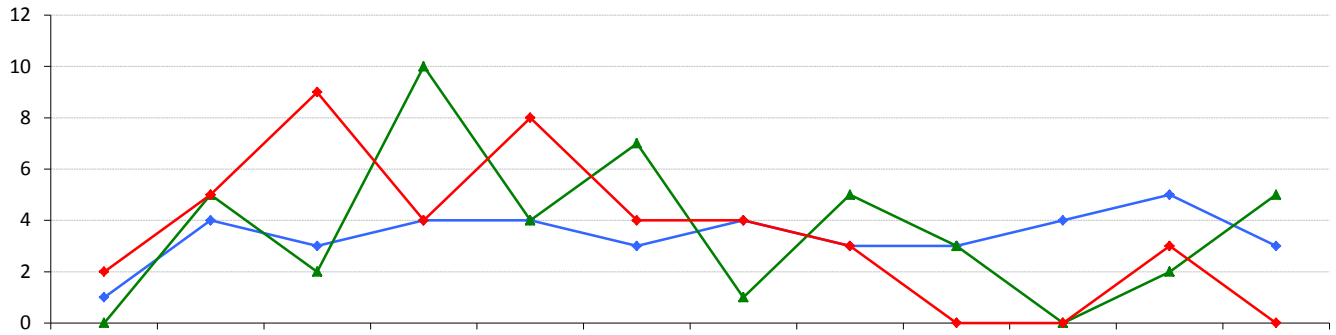
How would you rate the hospital food?



Wards have received their own results and are being asked to address the issue of ensuring that care and treatment is explained to patients in a way that they can understand. Improvement in patient feedback related to whether staff did all they could to help control pain appears to be sustained. The remaining metrics are similar to last month. Improvements are being led by the senior matrons using the data from the survey and the data they receive from the Friends and Family Test to ensure it is all triangulated.

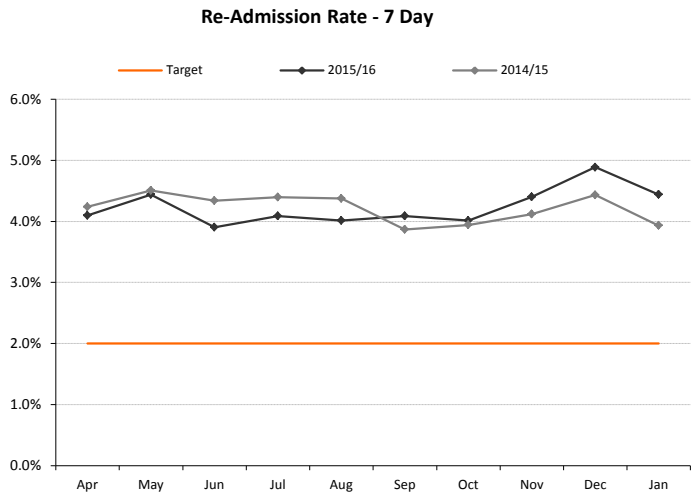
CLINICAL QUALITY & PATIENT SAFETY
PATIENT EXPERIENCE: MIXED SEX ACCOMMODATION

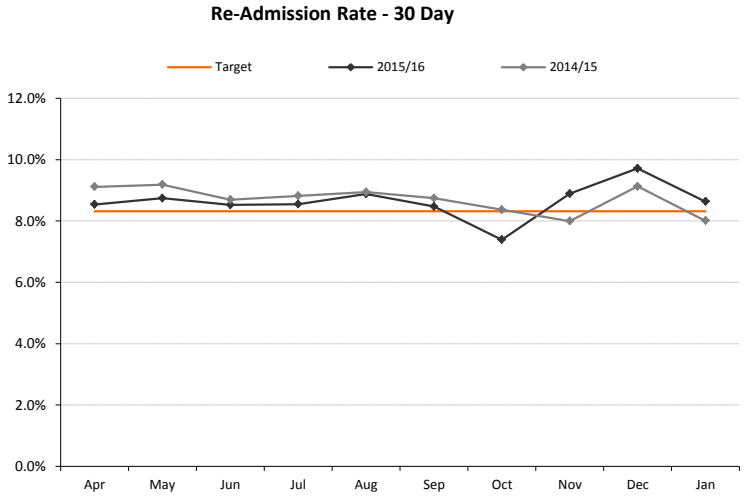
Number of Episodes of Mixed Sex Occurrence



	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
KCH	1	4	3	4	4	3	4	3	3	4	5	3
QEH	0	5	2	10	4	7	1	5	3	0	2	5
WHH	2	5	9	4	8	4	4	3	0	0	3	0

During Feb-16, 1 non-justifiable incidents of mixed sex accommodation breaches occurred. This information has been reported to NHS England via the Unify2 system. The remaining incidents occurred in the Stroke Units and Coronary Care Units which is a justifiable mix based on clinical need. There were 8 mixed sex accommodation occurrences in total, affecting 32 patients. (Last month there were a total of 10 occurrences affecting 54 patients). A review of bathroom mixed sex compliance has been performed and is being taken forward by the Trust.





Unplanned readmissions for both 7 days and 30 days remained higher than the same period last year (for 3 consecutive months).

Whilst pressure on inpatient beds has been consistent, there were national initiatives in both December (80% bed occupancy by 24/12/15) and January (SAFER start week) which did not occur last year. This may have had some impact, although a similar picture was not seen as a result of the Trust undertaking a 'Perfect Week' in Jan 2015.

However, the 30 day Readmission rate for the Trust is only slightly above the internally agreed standard of 8.32% and remains within the national average of between 5-11%.

East Kent Hospitals University NHS Foundation Trust CQUINS performance 2015/16

			CQUIN	2014/15 Baseline	2015/16 Target	YTD Status	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Q1	Q2	Q3	Q4	Year End Position
			National CQUINS - approved Schedules received by Trust on 10/11/15																				
Performance	Acute Kidney injury (AKI)	1a	Implementation methodology to be developed including EDN changes (Q1)	N/A	Develop implementation methodology (10% whole year payment)		Nil Return																
		1b	Audit established and results used a baseline for improvement (Q2)	N/A	Baseline established based on Q2 audit performance (30% whole year payment)		Nil Return																
		1c	Achieve improvement target for AKI measures in discharge summary from Q2 baseline (Q3)	N/A	Locally agreed improvement target reached - TBA (from Q2 baseline) (20% of whole year payment)		Nil Return																
		1d	Achieve improvement target for AKI measures in discharge summary (Q4)	N/A	90% (40% whole year payment based on agreed thresholds)		Nil Return									47.0%	52.0%						
	Sepsis	2a	Develop and pilot a local sepsis protocol and screening tool, pilot on 1 site (Q1)	N/A	Local sepsis protocol and screening tool is developed and piloted (10% whole year payment)		Nil Return																
		2a	Appropriate tool implemented (in EDs, ECC, SEAC and Paed Assessment) and baseline screening data collection established (Q2)	N/A	Implementation of appropriate screening tool in all appropriate areas and baseline data established (10% whole year payment)		Nil Return																
		2a	Achieve improvement target for screening from Q2 baseline (Q3).	N/A	Locally agreed improvement target reached - can be based on Q1 or Q2 performance (10% of whole year payment)		Nil Return																
		2a	Achieve improvement target for screening (Q4).*reporting one month retrospectively.	N/A	Threshold values based on screening coverage - maximum 90% or above screened (20% of whole year payment)		Nil Return									48.33%	*see note (2a)						
		2b	Sepsis Antibiotic Administration. No Q1 requirements.	N/A	N/A		Nil Return																
		2b	Baseline data collection established for antibiotic administration (Q2)	N/A	Baseline established based on Q2 audit performance (10% of whole year payment)		Nil Return																
		2b	Achieve improvement target for antibiotic administration from Q2 baseline (Q3).	N/A	Locally agreed improvement target reached from Q2 baseline (20% of whole year payment)		Nil Return																
		2b	Achieve improvement target for an antibiotic administration (Q4). *reporting one month retrospectively.	N/A	Threshold values based on administration coverage - maximum 90% or above (10% of whole year payment)											51.28%	*see note (2b)						
		2b	Develop, pilot and implement an e-CAS card to include auto calculation of VIEWS EWS and enhanced escalation (one site)	N/A	Develop, pilot and implement on one site by Q4 (10% of whole year payment)		Nil Return																
	Improving Diagnosis of Dementia	3a	Proportion of patients 75 years and over to whom case finding is applied	N/A	Develop and agree care plan and method of implementation (Q1 - 25% whole year payment). Implement improved care plan and monitor progress. Report data to CCGs to enable upload to Unify 2 (Q2 - 25% whole year payment). Embed use of care plan and monitor progress (Q3 - 25% whole year payment). 90% FAIRI by Q4 (25% whole year payment)		98.72%	98.95%	99.30%	99.24%	99.38%	99.12%	99.08%	99.2%	99.6%	98.6%	98.96%						
		3a	Proportion of those identified as having dementia or delirium who are appropriately assessed	N/A			90.48%	92.86%	90.72%	98.6%	92.86%	93.68%	93.18%	93.7%	93.4%	93.2%	92.22%						
			Proportion identified, assessed and referred who have a written care plan on discharge shared with GP	N/A																			
		3b	To ensure that appropriate dementia training is available through a locally determined training programme	36.0%	Maintain current training levels above 35% TBC. Implement Virtual Dementia training and train all staff in frailty wards by end of Q4 (25% whole year payment each quarter)		35.9%	37.0%	36.9%	37.0%	37.0%	40.8%	41.6%	41.7%	43.4%	38.4%	43.6%						
		3c	Ensure carers of people with dementia feel adequately supported (carer survey)	N/A	Report quarterly and provide comparison with patient feedback from inpatient survey (25% whole year payment each quarter)		Nil Return																

Compliance Against Performance		
		On target
		Monthly target missed; quarterly/annual target at risk
		Monthly target missed; annual target at risk

National CQUINS - Have not yet been fully agreed and will therefore not yet be reported on (continued)				
Commentary	Acute Kidney Injury (AKI)	1a	Implementation methodology to be developed including EDN changes (Q1)	EDN changes are being progressed by PAS team in conjunction with clinical lead for CQUIN (Dr Ian John). Final version planned to go live on 1st November 2015. Go live has been delayed by a few weeks as we requested GP feedback via Ashford CCG Practice Liaison Manager. This has not been forthcoming and as such we will continue but add contact details at the bottom of the EDN so that GPs can feedback on the new format as required.
		1b	Audit established and results used a baseline for improvement (Q2)	90 patients were audited in Q2. There was an average compliance of 23% (key data items present in reviewed discharge summaries). The new EDN will go live on the 16th November 16. Our Q3 target for improvement against the baseline is 40%. This will be measured following implementation of revised EDN. Due to technical delays December 15 will be the first reportable month. The EDN went live on Friday 4th December. We have notified CCG quality leads of this improvement target. To be signed off at the next Quality Meeting.
		1c	Achieve improvement target for AKI measures in discharge summary from Q2 baseline (Q3)	The December target was 40% compliance (following agreement that Q3 compliance would be monitored on December as this was the month the new EDN went live). In December 15 compliance was 37% and as such this indicator was not achieved. When the EDN was intially developed, the intention was for the AKI fields to be mandatory. Due to the total number of patients with AKI vs total inpatient population this was not possible. At present, where a patient has any stage of AKI (as identified by pathology results), a message alerts the doctor to complete the AKI section of the EDN. There has been education of the doctors around this but further work is required to improve completion rates. The CQUIN covers all stages of AKI - the vast majority being AKIN 1. This subset will be over represented in the random audited sample. We know that compliance is much better for patients with more severe AKI - who will often have specialty team involvement - than those patients who have AKIN 1 where it may habe been mild and transient. The CQUIN target covers all categories of AKI and as such further work is ongoing to improve overall compliance.
		1d	Achieve improvement target for AKI measures in discharge summary (Q4)	Achievement of indicator at risk hence amber rating. The target is 90% for maximum payment with incremental payments for 50% compliance and above. Despite this work continues to increase compliance as per project plan. January 16 achievement was 47% increased to 52% for February 16. A minimum of 51% will need to be achieved for March to ensure minimum payment for Q4 (10% whole value). Named leads are being targetted where the information is incomplete - with further education ongoing about the importance of the indicator.
	Sepsis	2a	Develop and pilot a local sepsis protocol and screening tool, pilot on 1 site (Q1)	Achieved - local sepsis protocol and screening tool developed and trialled at the A&E at the WHH on 4-5 May 15 and the A&E at QEQM on 20th and 21st May 15. 300 patients were audited.
		2a	Appropriate tool implemented (in EDs, ECC, SEAC and Paed Assessment) and baseline screening data collection established (Q2)	Achieved - The screening tool was successfully implemented on the 1st July 15 across the Emergency Departments and also ECC at K&C, Paediatric Units at QEQM and WHH and Surgical Admissions Unit at WHH. Baseline screening data has been collected for July 2015. This was based on a random sample of 50 sets of notes (as per CQUINS guidance). Only 5 patients met the requirement to be screened and 4 patients were screened. A larger sample of patients (x100) has been pulled for Month 5 and Month 6 (in progress) to ensure the baseline is representative of current practice. In Sept 15 (to mark World Sepsis Day), 'credit cards' for staff lanyards were distributed with condensed visual aid of protocol. During w/c 5th Oct 15, 'Sock it to Sepsis' events were held on all sites to raise awareness, train staff and ensure that staff were provided with the lanyard. These events were very successful.
		2a	Achieve improvement target for screening from Q2 baseline (Q3)	The Q2 baseline is 40% for screening. Our Q3 improvement target based on this baseline is 50%. CCG quality leads have been notified of this improvement target. To be signed off at the next Quality Meeting. Q3 finalised quarterly performance is 40.58% (October-December) and as such we have not achieved this target. Despite this there has been significant improvement against the target, with two of the three acute sites achieving over 50% and with the December average 48.14% which is an improvement on November. The tool has been re-launched at K&C site with enhanced support from the clinical lead for the scheme.
		2a	Achieve improvement target for screening (Q4)	Achievement of indicator at risk. The target is 90% for maximum payment with incremental payments for 50% compliance and above. Despite this work continue via the Sepsis Collaborative to increase compliance as per the work plan. Audit data is one month retrospective. In January 16 48.33% achieved. Q4 compliance based on average.
		2b	Sepsis Antibiotic Administration. No Q1 requirements.	No requirements. Data collection process discussed and established.
		2b	Baseline data collection established for antibiotic administration (Q2)	Achieved- baseline audit completed. Training has also been given to coders to ensure accuracy of identifying primary diagnosis of sepsis. A secondary audit will be undertaken looking at antibiotic administration within 60 minutes where sepsis was primary diagnosis. The current Q2 average baseline for antibiotic administration is 58.18% although as above a larger sample is being pulled to ensure that it is representative of practice. The improvement target will be shared with the CCG quality leads.
		2b	Achieve improvement target for antibiotic administration from Q2 baseline (Q3)	Based on the Q2 baseline, the Q3 target for 2b (antibiotic administration) is proposed to be 65%. This has been shared with CCG quality leads and will be signed off at the next Quality Meeting. Q3 finalised quarterly performance is 59.17% (October-December) and as such we have not achieved this target. There has been significant improvements in antibiotic administration rates with 72% achieved in November. Work is ongoing to ensure that improvement is sustained and improved upon for Q4.
		2b	Achieve improvement target for an antibiotic administration (Q4).	Data is reported one month retrospectively. January 16 data shows compliance of 51.28%. The Q4 target is 90% with incremental achievement over 50%. Work ongoing to ensure achievement of over 50% on average by the end of Q4.
		2b	Develop, pilot and implement an e-CAS card to include auto calculation of VIEWS EWS and enhanced escalation (one site)	In progress for implementation during Q4. Marked amber as some risks to delivery.
	Improving Diagnosis of Dementia	3a	Proportion of patients 75 years and over to whom case finding is applied	98.96% of eligible patients benefitted from case finding in M11.
			Proportion of those identified as having dementia or delirium who are appropriately assessed	For M11 92.22% of patients were appropriately assessed.
			Proportion identified, assessed and referred who have a written care plan on discharge shared with GP	Revised national guidance was issued in July 2015 detailing that 3a part c (refer and care plan on discharge) is only relevant for providers that diagnosis dementia/delirium. It was confirmed at the internal Dementia Strategy Group in July that we do not do this. A revised schedule has been sent to the quality leads at the CCG (w/c 1st Sept) for sign off to this affect. The approved finalised 1516 Schedule was returned by the CSU on 10th November 2015 reflecting that this element of the CQUIN is not applicable.
		3b	To ensure that appropriate dementia training is available through a locally determined training programme	43.6% of staff have received training for February 2016. In addition cumulatively 546 members of staff YTD have undertaken the training who were not identified in the training needs analysis who will benefit in their interaction with patients. This includes non clinical staff who have contact with patients.
		3c	Ensure carers of people with dementia feel adequately supported (carer survey)	The ability to survey carers of dementia sufferers via the Meridian web based system was launched (paper based) in October 2014 and will continue in 15/16. Carers Support are now assisting with completing questionnaires prior to discharge as the postal response rate has been low. Carers questionnaire will also be embedded on PAS/EDN with reminder to print and give to carer for completion. As at M10 the response rate has improved. The associated action plan is overseen by the Dementia Strategy Group.

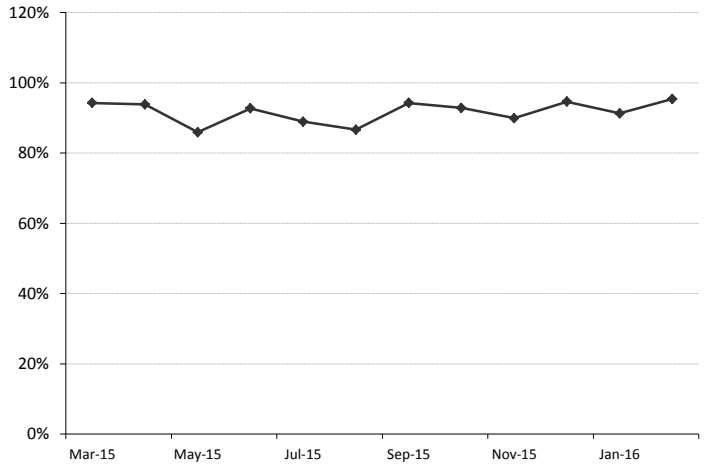
Local CQUINS - approved Schedule received by Trust on 10/11/15

				2014/15 Baseline	2015/16 Target	YTD Status	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Q1	Q2	Q3	Q4	Year End Position
Performance	COPD	4a	Establish baseline performance EQ data if available and participate in CCG led pathway development group (Q1)	N/A	Establish baseline performance EQ data and implement integrated pathway (25% full year weighting)		Nil Return																
		4b	Participate in CCG led pathway development group meeting on 28.7.15. (Q2)	N/A	Participate in CCG led pathway development group (25% full year weighting)		Nil Return																
		4c	Participate in CCG led pathway development group (Q3)	N/A	Participate in CCG led pathway development group (25% full year weighting)	TBA	Nil Return																
		4b	Implement relevant elements of integrated pathway following agreement with all stakeholders. Agree audit criteria, methodology and sample size with commissioning lead (Q4).	TBC in Q1	Achieve COPD ACS (Appropriate Care Score) target set by EQ team for the period January-December 2015 (25% full year weighting)		Nil Return																
	Diabetes	5a	Audit of implementation of Integrated Care Pathway (Q3). Identify areas of improvement and contribute to action plan.	N/A	Audit report in Qtr 3 (50% weighting)		Nil Return																
		5b	Audit of implementation of Integrated Care Pathway (Q4)		Audit report in Qtr 4 (50% weighting)		Nil Return																
	Heart Failure	6a	Participate in CCG led integrated HF pathway working group. Publish HF pathways ACS (EQ measures) (Q1)	TBC in Q1	Publish HF pathway ACS (25% weighting)		Nil Return																
		6b	Participate in CCG led integrated HF pathway working group (Q2)	TBC in Q1	Achieve Heart Failure Pathway ACS target published by Central EQ team (25% weighting)		Nil Return																
		6c	Participate in CCG led integrated HF pathway working group. Publish HF pathways ACS (EQ measures) (Q3)	TBC in Q1	Achieve Heart Failure Pathway ACS target published by Central EQ team (25% weighting)		Nil Return																
		6d	Participate in CCG led integrated HF pathway working group. Achieve HF pathway ACS for the period Jan-Dec 2015 (EQ Programme Team) (Q4)	N/A	Achieve Heart Failure Pathway ACS target published by Central EQ team (25% weighting)		Nil Return																
	Over 75s Frailty Pathway	7a	Finalise business case and agree through Systems Operational Group 22nd June 15. Identify systems and processes to record use of PRISMA 7 and full frailty assessment tool (Q1)	N/A	Contribute to business case for pilot pathway (25% weighting)		Nil Return																
		7b	Pre implementation of pathway (recruitment of staff, training, communication etc.) (Q2)	N/A	Pre implementation (no target) 25% weighting.		Nil Return																
		7c	Complete implementation of pilot of pathway and conduct audit and action plan (Q3)	N/A	Audit as agreed (25% weighting).		Nil Return																
		7d	Progress report on action plan implementation (Q4)	N/A	Action plan report as agreed (25% weighting)		Nil Return																

Compliance Against Performance		On target
		Monthly target missed; quarterly/annual target at risk
		Monthly target missed; annual target at risk

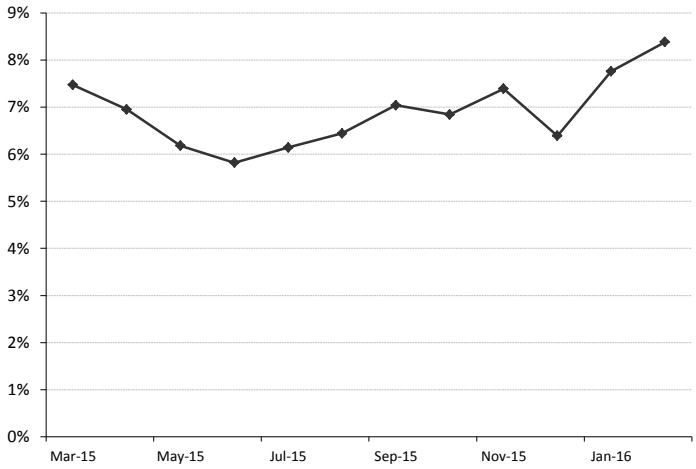
	Local CQUINS - Have not yet been fully agreed and will therefore not yet be reported on (continued)			
Commentary	**COPD**	**4a**	Establish baseline performance EQ data if available and participate in CCG led pathway development group (Q1)	As there had been little progress with the COPD Task and Finish Group and no meeting for a long period of time a meeting was scheduled with the CCGs on 28th July 15 which EKHUFT managerial and clinical representatives attended but was cancelled on the day. Internal meetings continue. The EQ team have not yet set an Appropriate Care Score (ACS) Target and unlikely to be in place for 1516. This is due to coding differences between participating provider sites. EKHUFT are fully involved in EQ meetings and providing monthly data.
		4b	Participate in CCG led pathway development group meeting on 28.7.15. (Q2)	Meeting on 28.07.15 was cancelled by the CCG on the day despite EKHUFT managerial and clinical representation. There was full representation at the last COPD Task & Finish Group on 15th September 2015. Despite delay to the EQ ACS target being established the internal COPD working group continues to progress developments. The admission and discharge bundle was launched on 2nd November 2015 and there has been associated teaching and communications across all sites. Monthly compliance with the EQ measures is reviewed monthly and data submitted to the EQ Programme. Work in ongoing to improve uptake of the bundles facilitated through teaching and link nurse programmes on the wards.
		4c	Participate in CCG led pathway development group (Q3)	As above. EKHUFT have been present at CCG meetings. There have been no further requirements requested in terms of contribution to the integrated pathway. EKHUFT will seek clarity from the CCG Chief Nurses as to the current performance against the local CQUIN schemes as part of the Quality Meetings.
		4b	Implement relevant elements of integrated pathway following agreement with all stakeholders. Agree audit criteria, methodology and sample size with commissioning lead (Q4).	As above there is at present no EQ ACS Target set. This is due to differences in coding between provider sites which is making establishing a comparative baseline problematic. EKHUFT are involved in all EQ meetings and have put the EQ Improvement Facilitators in touch with our own Clinical Coding Department to establish potential solutions. The EQ Respiratory Collaborative was on the 12th Nov 15 and there was full representation. There havn't been any CCG led COPD meetings since October and no further actions for EKHUFT to take forward in respect to the integrated pathway. Patient documentation has been rolled out and work is ongoing to further promote use of the Admission and Discharge Bundle and COPD EDN.
	Diabetes	**5a**	Audit of implementation of Integrated Care Pathway (Q3). Identify areas of improvement and contribute to action plan.	A CCG led Project group has been developing an Integrated Diabetes Pathway. The Single Point of Access has gone live for Thanet CCG patients. We are awaiting confirmation of when the other CCGS will go live but likely by the end of the financial year. Awaiting confirmation about whether business case has been signed off by CCGs for additional resource. There has been full EKHUFT representation at Mobilisation and Implementation Group Meetings.
		5b	Audit of implementation of Integrated Care Pathway (Q4)	The audit of the proposed pathway has yet to be agreed with CCGs and is only at present live for Thanet CCG. Further information was requested at the last Mobilisation Group on the 8th October 2015 as to the content of the audit and confirmation of when the pathway will go live for the other CCGs. No further update re CCG led group - request for information resent Dec 15. Further request relating to content of the audit sent to Commissioning Lead on 11th January 16. At present only Thanet CCG has gone live with the SPA and GPs are not in the main using it for acute referrals. As such it is not possible to audit the integrated pathway at this time. Data relating to EKHUFT referrals has been shared with the commissioners as agreed.
	Heart Failure	**6a**	Participate in CCG led integrated HF pathway working group. Publish HF pathways ACS (EQ measures) (Q1)	A collaborative Cardiology Task & Finish Group is in place. An audit is underway looking at cardiology referrals (CCG lead and EKHUFT). Once this data is available a further Task and Finish Group will be established (Oct 15) to agree next steps. Q1 HF EQ data not yet received from EQ team. The EQ audit has been merged with the National HF Survey and as such a new baseline is being captured. Likely that 1516 target will be continued performance of 90%. 1415 finalised data just received from EQ Team - 93.25% ACS achieved (with 99.6% data completeness) Highest performing Trust in the area and designated 'Excellent' in 'Achieving Excellence in Quality Award'.
		6b	Participate in CCG led integrated HF pathway working group (Q2)	An Appropriate Care Score (ACS) has yet to be established due to the merger of the standards with the National HF Survey. Monthly data continues to be submitted and April and May 15 data has been received back from the EQ team.
		6c	Participate in CCG led integrated HF pathway working group. Publish HF pathways ACS (EQ measures) (Q3)	As above - ACS target has yet to be established by the EQ Team. A target may not be set for 1516. There have been no CCG led pathway groups since Q2 although Trust reps have kept in regular contact with the commissioning lead and have assisted in an audit of current patients. The commissioning lead has been contacted again to confirm arrangements for further CCG working groups. We have been informed that this is not a CCG priority at this time and no meetings have been set.
		6d	Participate in CCG led integrated HF pathway working group. Achieve HF pathway ACS for the period Jan-Dec 2015 (EQ Programme Team) (Q4)	As above - ACS target has yet to be established by the EQ Team.
	Over 75s Frailty Pathway	**7a**	Finalise business case and agree through Systems Operational Group 22nd June 15. Identify systems and processes to record use of PRISMA 7 and full frailty assessment tool (Q1)	A proposal for a pilot across NHS Ashford CCG for screening and frailty assessment for patients attending ED following a fall has been agreed by the CCGs. The pilot is planned w/c 5th October 2015. An Over 75s Group is set up (led by Ashford CCG) and is meeting regularly to oversee this work. An internal weekly mobilisation meeting has been established to oversee implementation of internal project plan and monitor any associated risks. It has been confirmed by the CCG lead that we have met Q1 requirements.
		7b	Pre implementation of pathway (recruitment of staff, training, communication etc.) (Q2)	The pilot pathway went live on the 5th October 2015. CCG meetings continue to happen face to face fortnightly (with a conference call every other week during the initial pilot stages). At present the numbers of patients being Prisma screened in ED is low. This is due to the fact the CCG would only like Ashford patients who have fell (over 75 years) to be screened. This has made embedding practice in a busy ED problematic. In addition there are delays to the recruitment of the ED Majors Clerks who will be central to the administrative process. At present a number of workarounds have been put in place to ensure we are following the new pathway. All key staff are trained on Share my Care. MDTs have yet to be established in the community. The geriatrician input is being confirmed at present. Audit data and patient case studies are being collected. It has been confirmed by the CCG lead that we have met Q2 requirements which all related to pre-go live mobilisation.
		7c	Complete implementation of pilot of pathway and conduct audit and action plan (Q3)	As above. Baseline data has been collected and KPIs have been established which are to be collected for the duration of the pilot. Compliance with completing Prismas has continued to be low but there has been an increase recently. Strategies are in place to increase compliance - with support from IDT, CDU (for admitted patients) and ED leads. Data is being reviewed daily and overseen by a weekly operational group. Improvement trajectory has been set to increase Prisma compliance for the last quarter to ensure that the pilot can be affectively evaluated. Regular data has been provided via the Over 75s Meeting. No agreement from commissioning leads as to the 'audit requrements' but re admission data to be shared.
		7b	Progress report on action plan implementation (Q4)	As above. This all forms part of the pathway project plan overseen by the Over 75s Group. Commissioning lead to agree evaluation criteria and plan required.

Bed Occupancy



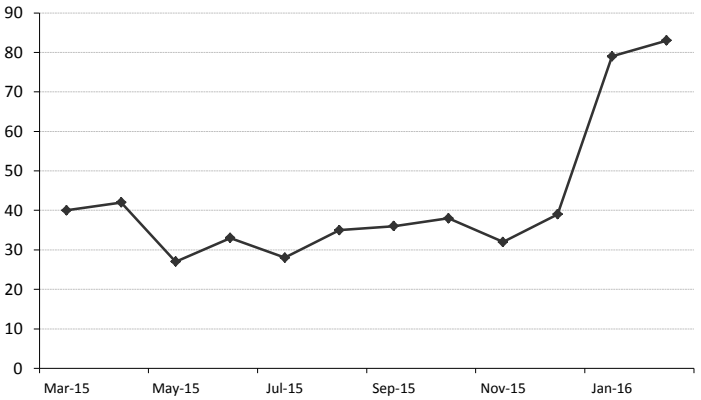
The bed occupancy metric looks only at adult inpatient beds and excludes any ring fenced wards such as Maternity. The position in Feb-16 (95.40%) is higher than that seen in Jan-16 (91.30%).
NB: Data are sourced from the Trust's Balanced Scorecard.

Extra Beds



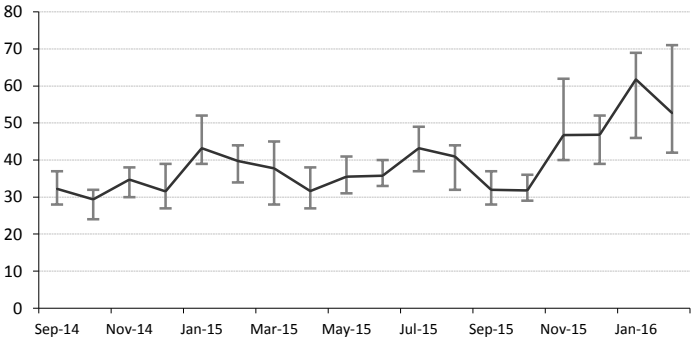
This metric is built up using the number of funded beds on each ward and reviewing those occupied on a daily basis. Where the number of occupied beds exceeds the funded bed base for the ward these are classified as "extra". The degree of extra beds used within the Trust has continually risen from Dec-15 at 6.39% to 8.38% in Feb-16.

Outliers



The outliers data show the average number of patients bedded in a ward outside of the relevant Division over a given month. The outlier position has continued to rise following a large peak from Dec-15 onwards, standing at 83 in Feb-16.

Average Delayed Transfers of Care



Following a steep rise in the average number of patients on Delayed Transfers of care between Sept 15 (32) and Jan 16 (61.75), a decrease was seen in Feb-16 with the figure standing at 52.75. The primary issues for DToC remain, that is, continuing health care pending assessment by Social Services and community resources.

CLINICAL QUALITY & PATIENT SAFETY PERFORMANCE HEAT MAP

Ward/Site	Patient Safety									Patient Experience						Clinical Effectiveness	
	Risk Management		HCAI		Harm Free Care	Nurse Sensitive Indicators				Experience						Nurse Staffing	
	Complaints	Compliments	MRSA	C. diff	Safety Thermometer HFC - New Harms (%)	Pressure Ulcers: Category 2, 3 and 4		Falls	Cardiac Arrests	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Did you get the care that matters to you?	Were you treated with respect and dignity while in hospital?	Was your care or treatment explained to you in a way you could understand?	Day - Staff Fill Rate (%)	Night - Staff Fill Rate (%)
						Unavoidable	Avoidable										
Cambridge J2 Ward - WHH	3	1	0	0	100.0%	1	0	9	0	15%	100%		50%	100%	100%	92%	121%
Cambridge K Ward - WHH	0	1	0	0	100.0%	1	0	8	1	71%	96%		33%	33%	50%	72%	97%
Cambridge M2 Ward - WHH	1	93	0	0	94.7%	0	0	8	1	61%	94%		50%	50%	100%	77%	87%
Coronary Care Unit (Taylor) - KCH	0	0	0	0	100.0%	0	0	0	0	73%	100%		50%	100%	100%	70%	124%
Coronary Care Unit - QEH	0	0	0	0	100.0%	0	0	3	0	100%	100%		100%	100%	100%	76%	76%
Coronary Care Unit - WHH	0	0	0	0	100.0%	0	0	0	0	53%	95%					96%	85%
Minster Ward - QEH	0	68	0	0	100.0%	1	0	4	0	41%	96%					74%	97%
Oxford Ward - WHH	0	4	0	0	92.9%	0	0	2	0	41%	100%					93%	103%
Sandwich Bay Ward - QEH	0	0	0	0	100.0%	0	0	1	1	31%	100%		50%	100%	33%	90%	99%
St Margaret's Ward - QEH	0	6	0	0	100.0%	0	0	6	1	25%	100%					106%	103%
Deal Ward - QEH	0	31	0	0	96.4%	0	0	6	0	18%	93%	7%	50%	100%	50%	97%	84%
Harvey Ward - KCH	0	0	0	0	100.0%	0	0	2	0	60%	67%	33%				77%	88%
Invicta Ward - KCH	1	152	0	0	100.0%	0	0	1	2	13%	100%		33%	50%	50%	72%	93%
Cambridge L Ward - WHH	2	14	0	0	100.0%	2	0	7	0	44%	100%		50%	100%	33%	73%	93%
Treble Ward - KCH	0	30	0	0	93.8%	0	0	1	0	38%	100%		100%	100%	100%	91%	107%
Mount & McMaster Ward - KCH	0	1	0	0	100.0%	0	1	8	0	17%	100%					91%	93%
Fordwich Stroke Unit - QEH	0	1	0	0	100.0%	0	0	2	0	27%	100%		100%	100%	100%	105%	135%
Kingston Stroke Unit - KCH	1	1	0	0	100.0%	0	0	4	0	20%	100%					59%	82%
RSU Unit - WHH	1	1	0	0	87.5%	0	0	14	0	65%	100%		50%	50%	50%	77%	69%
Harbledown Ward - KCH	0	0	0	0	100.0%	1	1	6	0	16%	100%		100%	100%	50%	108%	100%
St Augustine's Rehab Ward - QEH	0	0	0	0	96.4%	0	0	8	0				100%	100%	100%	51%	33%
CDU - QEH	3	63	0	0	100.0%	0	0	8	0	18%	79%	17%	25%	50%	50%	83%	112%
CDU - WHH	0	41	0	0	100.0%	0	0	0	0	21%	76%	15%				103%	99%
Emergency Care Centre - KCH (CDU only)	0	3	0	0	100.0%	0	0	0	0	19%	85%	7%	100%	100%	100%	101%	100%
Rotary Suite - WHH	0	30	0	0	100.0%	0	0	1	0	46%	97%		50%	100%	33%	101%	97%
Cheerful Sparrows Ward Female - QEH	1	0	0	0	100.0%	0	0	5	0	45%	96%		50%	50%	50%	118%	167%
Clarke Ward - KCH	1	87	0	0	95.5%	1	2	8	0	16%	96%					68%	81%
Cheerful Sparrows Ward Male - QEH	3	0	0	1	85.7%	1	0	9	0	36%	95%		50%	50%	50%	90%	139%
Kent Ward - KCH	1	0	0	0	90.5%	3	2	3	0	35%	97%		50%	50%	50%	113%	100%
Kings B Ward - WHH	1	169	0	0	100.0%	1	0	0	0	39%	100%		50%	50%	50%	89%	98%
Kings A2 Ward - WHH	0	135	0	0	90.0%	1	0	1	0	63%	100%		50%	50%	50%	106%	112%
Kings C1 Ward - WHH	3	179	0	0	96.2%	0	1	3	0	17%	100%		100%	50%	50%	85%	99%
Kings C2 Ward - WHH	2	0	0	0	100.0%	0	0	1	0	61%	100%		33%	33%	33%	65%	86%
Kings D Ward Male - WHH	0	156	0	0	100.0%	0	0	3	0	49%	88%		50%	50%	50%	84%	90%
Kings D Ward Female - WHH	1	54	0	0	100.0%	0	1	3	1	36%	95%		50%	100%	50%		
Quex Ward - QEH	1	45	0	0	100.0%	1	0	2	0	75%	100%		33%	50%	33%	101%	98%
Bishopstone Ward - QEH	0	0	0	0	90.5%	1	0	3	0	51%	95%					86%	89%
Seabathing Ward - QEH	0	0	0	0	100.0%	0	0	0	0	26%	92%	8%					
Critical Care - WHH	1	4	0	0	100.0%	0	0	0	0							121%	110%
Critical Care - KCH	0	1	0	0	100.0%	0	0	1	0							93%	109%
Critical Care - QEH	1	51	0	0	100.0%	2	0	0	0							82%	96%
Marlowe Ward - KCH	0	0	0	0	97.0%	0	0	3	0	35%	100%					91%	107%
Neonatal Intensive Care Unit - WHH	0	24	0	0	100.0%	0	0	0	0							84%	84%
Padua Ward - WHH	0	1	0	0	100.0%	1	0	1	0	8%	100%					96%	99%
Rainbow Ward - QEH	2	0	0	0	100.0%	0	0	0	0	11%	97%	3%				92%	100%
Birchington Ward - QEH	1	154	0	0	94.1%	0	0	0	0				50%	100%	50%	83%	98%
Kennington Ward - WHH	0	0	0	0	100.0%	0	0	1	0	22%	96%					95%	110%
Brabourne Ward - KCH	0	1	0	0	100.0%	0	0	2	0	54%	100%					82%	104%
Folkestone Maternity & Labour Ward - WHH	0	0	0	0	100.0%	0	0	0	0							95%	94%
Kingsgate Maternity & Labour Ward - QEH	0	89	0	0	100.0%	0	0	0	0							100%	87%
Hospital at Home - QEH	0	0	0	0	100.0%	0	0	0	0								
Hospital at Home - WHH	0	0	0	0	91.7%	0	0	0	0								
Special Care Baby Unit - QEH	0	0	0	0	100.0%	0	0	0	0							84%	98%
A&E Department - QEH	13	0	0	0		0	0	2	0								
A&E Department - WHH	5	0	0	0		0	0	3	0								

Criteria

The Heat Map uses February-16 data.

Data are sourced from the Ward Dashboard* and therefore only relate to Inpatient Care, not Trust-wide numbers which the Clinical Quality and Patient Safety Report will include.
* With the exception of FFT data, sourced from the FFT Dashboard, and Safe Staffing data, taken from the CQC Action Dashboard.

Where applicable, RAG ratings are assigned to the data using thresholds taken from the Ward Dashboard and the CQC Action Plan. FFT threshold for Recommended % taken from the NHS England average. Where complaints are over 1, the RAG is marked red.
For the purposes of this Heat Map, the RAG is either red or green, to help with simplified alerting and emerging patterns.

Appendix 1 - The Publication of Nurse staffing Data – February 2016

Introduction

In accordance with National Quality Board requirements to provide assurance on safe staffing the Trust is now publishing staffing data in the following ways:

- Information about nurses, midwives and care staff deployed, by shift, against planned levels has been displayed at ward level since April 2014. The levels are displayed using a red, amber green status; green depicts staffing levels are as planned; amber depicts that the ward is slightly short staffed but not compromised; red rag rating depicts an acute shortage for that shift. The display allows staff to explain the reasons for any shortage and also what actions they have taken to mitigate the situation, thereby offering assurance to patients and visitors.
- Ward staffing reviews are repeated every 6 months and the October review was reported to the Trust Board in February 2016.
- Monthly reports detailing planned and actual staffing on a shift by shift basis for the previous month has been presented monthly to the Board since May 2014. This report is also published on the Trust website and to the relevant hospital webpage on NHS choices.

Planned and actual staffing

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, by day and by night, and by individual hospital site. Reported data is derived from the E-Rostering and NHS-Professionals systems and aggregated fill rates in February are over 94% at WHH, over 93% at QEQM and over 92% K&C, shown in Figure 1.

Figure 1. % hours filled planned against actual by site during Feb-16

	% Hours filled - planned against actual Feb 2016				
	DAY		NIGHT		
Hospital site	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Overall % hours filled
Kent & Canterbury	84.2%	86.8%	100.3%	126.1%	92.61
Queen Elizabeth the Queen Mother	91.4%	84.2%	103.0%	99.2%	93.20
William Harvey	90.5%	97.1%	96.3%	96.6%	94.10

It should be possible to fill 100% of hours if:

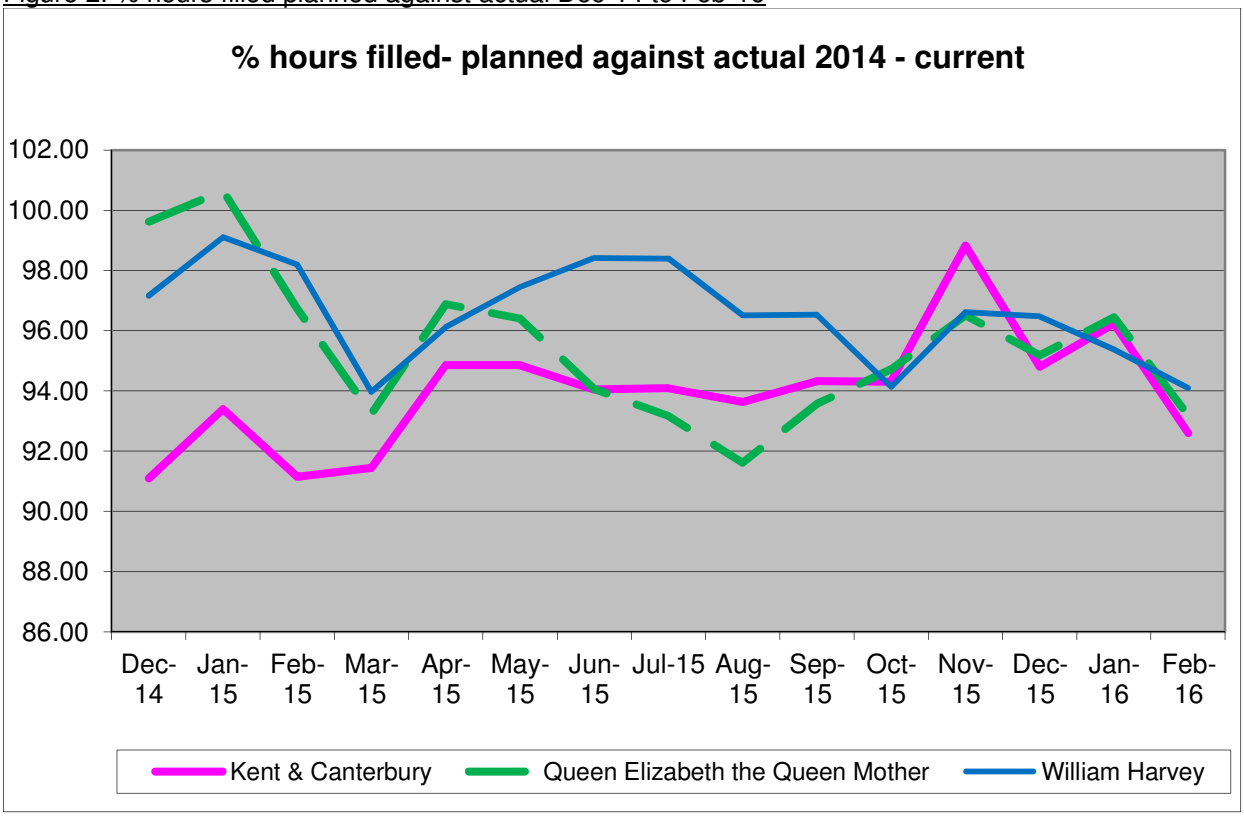
- There are no vacant posts
- All vacant planned shifts are covered by overtime or NHS-P shifts
- Annual leave, sickness and study leave is managed within an overall 22%

Figure 2 shows the slight reductions seen in % shift hours filled from Dec-14 to Mar-15 repeated in Dec-15 to Feb-16 which reflects the requirement for additional shifts during winter pressures not always being filled by NHSP. The reduction in March and August also reflects periods of higher annual leave. Work to ensure that roster templates closely reflect the budgeted establishments and include shifts necessary for additional beds has supported the increased fill rates seen over time.

This trend in performance over time reflects the analysis of safe staffing levels reported by 225 acute trusts, reported in the Health Service Journal recently, which shows a gradually worsening

position for nurse staffing during 2015 with 85% trusts missing staffing targets for day nursing hours in January and 92% in August.

Figure 2. % hours filled planned against actual Dec-14 to Feb-16



Senior nursing leaders have reported that:

- It is not possible to say which organisations have concerning levels of staffing using this data;
- Some Trusts may achieve high % fill rates but have planned for what are already sub-optimal levels;
- Many Trusts reporting the lowest fill rates have invested in to nursing in the last year;
- There may be inconsistencies in the methodology as those Trusts using E-Rostering tend to report lower fill rates.

Figure 3 shows total monthly hours actual against planned and % fill during February by ward. Work has been undertaken to explore the reasons for the gap, the impact and the actions being taken to address the gap. Some wards achieve higher than 100% due to additional shifts worked through NHS-P during times of increased demand and additional bed use.

No national RAG rating tolerances have been determined, but wards achieving under 80% have been RAG rated Red, in Figure 3. Comments relating to the main root cause of <80% fill rates are provided and detail on annual leave, sickness and parenting rates by ward. The RAG rating for these elements are provided below. Detail on key quality indicators are included by ward within the heat map within the main report.

Annual Leave	<11.0%
	>17.0%
Sickness	>2.5%
Parenting	>3.0%

Data validation and sign-off steps have been implemented and the data will be reported externally via Unify/NHS Choices on 14th March. The national data will be published representing each hospital site on the NHS Choices website.

Figure 3. Total monthly hours actual against planned and % fill by ward during Feb-16

Division / Ward	DAY		NIGHT			Unavailability %					
						A/L		Sickness		Parenting	
Urgent Care & LongTerm Conditions	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Comments	Registered	Unregistered	Registered	Unregistered	Registered	Unregistered
Cambridge J	92.42	159.81	120.51	157.83		20.6%	13.6%	2.9%	8.7%	0.0%	0.0%
Cambridge K	72.19	117.46	97.00	86.51	RN AL & Parenting	21.9%	20.6%	2.1%	3.2%	4.4%	0.0%
Cambridge M2	77.26	71.49	87.32	79.07	RN and HCA Sickness & Parenting.	14.5%	17.6%	8.3%	13.7%	18.9%	7.9%
Coronary Care Unit (K&C)	69.61	N/A	123.46	N/A	RN Sickness	14.9%		9.1%		0.0%	
Coronary Care Unit (QEQMH)	75.72	103.59	76.21	72.41	RN and HCA Sickness	16.2%	15.6%	14.9%	8.4%	0.0%	0.0%
Coronary Care Unit (WHH)	95.69	116.52	84.90	55.77	HCA impact of sickness when small WTE	19.2%	11.7%	4.0%	4.4%	2.6%	0.0%
Minster	74.06	99.42	97.02	97.69	RN Parenting	17.5%	15.0%	2.2%	1.2%	7.7%	0.0%
Oxford	92.59	69.37	103.37	98.95	HCA AL & Sickness	20.7%	31.5%	4.6%	15.2%	2.9%	0.0%
Sandwich Bay	89.57	101.61	99.22	137.70		19.9%	18.0%	3.6%	9.0%	0.0%	8.6%
St Margarets	105.68	65.18	103.44	124.96	HCA Sickness	16.6%	13.0%	8.0%	5.2%	0.0%	0.0%
Deal	96.52	67.61	83.58	107.28	HCA Sickness	22.8%	17.8%	2.8%	15.4%	0.6%	0.0%
Harvey	77.08	89.84	87.93	144.98	RN Sickness	14.6%	14.2%	16.0%	7.3%	0.0%	0.0%
Invicta	72.32	104.41	93.39	144.11	RN AL, Sickness & Parenting	21.8%	19.9%	5.1%	3.4%	4.2%	0.0%
Cambridge L	72.83	101.36	93.25	140.33	RN Sickness	16.7%	18.5%	3.5%	5.0%	0.0%	3.2%
Treble	90.77	86.60	107.05	271.06		14.8%	18.6%	2.5%	7.6%	0.0%	0.0%
Mount/McMaster	91.34	79.89	93.10	164.08	HCA Sickness	14.6%	15.2%	1.8%	4.9%	7.4%	0.0%
Fordwich Stroke Unit	104.64	84.00	135.03	102.59		14.8%	11.4%	6.5%	19.6%	4.6%	0.0%
Kingston Stroke Unit	59.37	90.36	81.58	101.87	RN Sickness & Parenting	17.9%	14.7%	10.3%	13.8%	8.0%	0.0%
Richard Stevens Stroke Unit	76.74	93.31	69.07	100.10	RN Parenting	11.8%	17.6%	1.9%	16.6%	5.6%	0.0%
Harbledown	108.06	98.94	99.78	103.16		17.2%	16.7%	2.8%	11.8%	0.0%	0.0%
QE St Augustine Contingency Ward	50.49	116.56	32.68	121.71	RN Parenting	15.3%	14.7%	1.1%	1.7%	17.0%	0.0%
QE CDU	83.14	110.75	111.81	173.09		15.2%	8.4%	6.7%	13.1%	5.1%	13.6%
WH CDU/Bethersden	103.41	82.16	99.04	81.11		19.2%	21.9%	3.9%	9.3%	10.6%	3.8%
KC ECC	101.34	84.27	99.82	97.02		13.9%	11.5%	10.7%	2.7%	2.3%	0.0%
Surgical Services											
Rotary Suite	101.42	96.27	96.55	127.59		14.9%	13.0%	6.2%	0.0%	0.0%	0.0%
Cheerful Sparrows Female	118.26	115.33	166.81	88.33		20.7%	9.6%	4.8%	23.6%	8.8%	0.0%
Clarke	67.79	82.22	81.11	93.30	RN Sickness	16.0%	15.9%	7.8%	5.3%	0.3%	0.0%
Cheerful Sparrows Male	90.17	124.50	139.15	96.10		17.2%	12.4%	5.0%	8.1%	0.0%	0.0%
Kent	112.97	92.06	100.30	89.34		16.6%	13.8%	12.4%	19.2%	10.5%	0.0%
Kings B Ward - WHH	88.55	98.81	98.43	181.11		16.2%	11.0%	2.1%	12.5%	0.0%	0.0%
Kings A2	105.98	98.34	111.81	72.41	HCA Sickness	25.4%	18.2%	5.9%	8.2%	0.0%	0.0%
Kings C1	85.06	132.32	98.58	98.13		20.2%	10.5%	3.1%	8.8%	0.0%	0.0%
Kings C2	65.27	96.99	86.17	93.10	RN Sickness	17.6%	11.6%	7.2%	2.7%	0.0%	13.2%
Kings D Female	83.48	116.13	89.72	112.41		19.4%	12.0%	1.0%	4.5%	2.5%	3.3%
Quex	100.65	75.39	98.28	100.00	HCA AL & Sickness	21.1%	30.8%	1.9%	4.6%	6.3%	0.0%
Bishopstone - split	86.36	74.80	88.48	95.25	HCA Sickness	22.5%	16.6%	6.9%	15.4%	3.9%	0.0%
Critical Care - WHH -	121.24	90.22	109.74	83.78		17.8%	20.0%	4.8%	4.7%	0.0%	0.0%
Critical Care - KCH	92.86	71.11	109.33	N/A	HCA impact of AL when small WTE	17.6%	34.3%	5.8%	0.0%	0.0%	0.0%
Critical Care - QMH	82.26	86.09	96.24	N/A		17.9%	10.8%	1.6%	7.9%	4.6%	0.0%
Specialist Services											
KC Marlowe Ward	90.76	85.59	107.30	119.86		16.5%	13.2%	9.2%	7.6%	4.0%	10.8%
WH NICU	84.02	72.42	83.78	N/A	HCA Sickness	18.0%	16.2%	8.2%	5.8%	2.0%	0.0%
WH Padua Ward	95.74	70.56	99.29	37.93	HCA Sickness & Parenting	14.7%	15.3%	3.0%	12.4%	0.0%	10.0%
QE Rainbow Ward	91.93	75.84	100.00	N/A	HCA Sickness	17.0%	14.4%	4.4%	5.4%	0.0%	0.0%
QE Birchington Ward	83.03	110.62	98.35	108.20		22.7%	18.5%	5.5%	0.0%	4.0%	0.0%
WH Kennington Ward	94.50	91.33	110.39	N/A		19.0%		4.6%		4.1%	
KC Brabourne Haematology Ward	81.98	50.41	103.77	N/A	HCA impact of sickness when small WTE	20.2%	13.5%	1.3%	66.7%	0.0%	0.0%
WH Maternity Labour and Folkestone+	94.84	60.93	94.24	53.45	HCA Parenting	21.4%	18.6%	5.4%	0.6%	5.3%	7.5%
MLU WHH	105.60	72.02	93.74	75.86	HCA impact of AL when small WTE	16.3%	17.3%	8.6%	0.0%	0.0%	0.0%
QE Maternity Wards + MCA	99.67	64.02	87.33	94.56	HCA Sickness & Parenting	18.1%	20.5%	4.7%	4.8%	4.4%	4.6%
QE MLU	84.10	84.00	189.91	65.52	HCA Sickness	17.9%	12.2%	2.5%	15.9%	0.0%	0.0%
QE SCBU	84.17	92.54	97.70	N/A		16.2%	22.1%	3.1%	0.0%	0.0%	0.0%

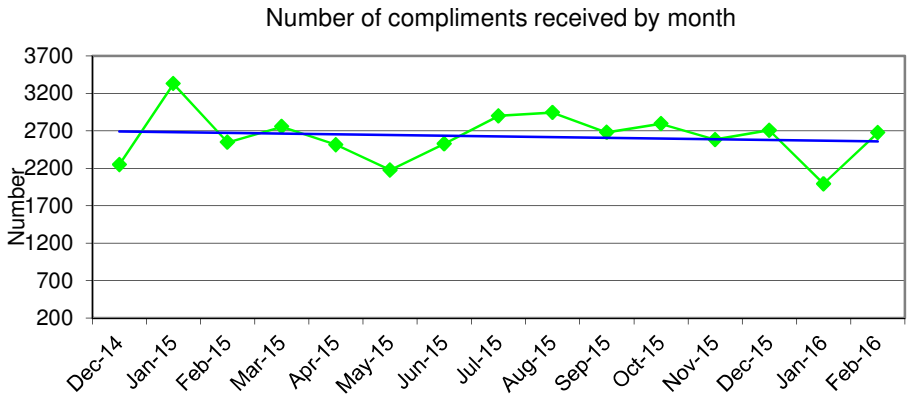
Appendix 2 - Patient Experience Report

This report provides the Board of Directors with activity and performance information about the complaints, concerns, comments and compliments during February 2016. The information reported is for cases received in February 2016.

Activity

Complaints received for February: 66
Concerns for February: 53
PALS contacts for February: 154 at the time of writing
Compliments for February: 2674
There are 15 contacts received in February 2016 that are still awaiting consent from the client. Once consent is received, these will be triaged as either a complaint or concern.

The charts below show the number of complaints and compliments received on a monthly basis since December 2014. The total number of recorded episodes of care for February 2016 was 79446 which means that, one formal complaint has been received for every 1204 recorded spells of care in comparison to January's figures where one formal complaint was received for every 1319 recorded spells of care.

Figure 1: Number of compliments received	
	The number of compliments received has increased by 34% compared to the previous month. The ratio of compliments to formal complaints received for the month is 41:1. There has been one compliment being received for every 30 recorded spells of care.

Examples of Compliments received in February 2016

Mr Ben Eddy and team - Urology

Since the end of 2015, I have been under the care of Mr Eddy and the Urology team for Prostate Cancer, having been admitted for Robotic Surgery on November 17th. I feel the need to write to you to express my heartfelt thanks, to Mr Eddy and the entire team on Clark ward. The care I received was fantastic and very professional and I could not have asked for better.

The Nurses on the unit are under obvious pressure, which I was aware of on my day of admission, bed shortages which they overcame, and Mr Eddy following a hectic morning Clinic was on the ward to see me at 14.30 having not even had his lunch, but was there to operate on me soon after 15.00.

The support and reassurance I received from Mr Eddy and the team was invaluable to me at very worrying time in my life, together with the Group Meeting, the whole package was excellent preparation for the operation.

The Public are always hearing the negative things about the NHS and Hospital Trusts, but my experience was totally positive, and I can't praise the Urology team and Kent and Canterbury Hospital enough, for everything.

Mr Lau and team – Fracture Clinic WHH.

For the last five months I've been a patient in your Fracture Clinic under Mr Lau and his team attending to my broken neck.

I would like to place on record my grateful thanks for the efficient manner I have been dealt with. The staff including Frankie, Pat and the nurses together with the very helpful receptionist, have always been most caring, attentive and cheerful during my weekly visits to the Clinic during the past very traumatic five months.

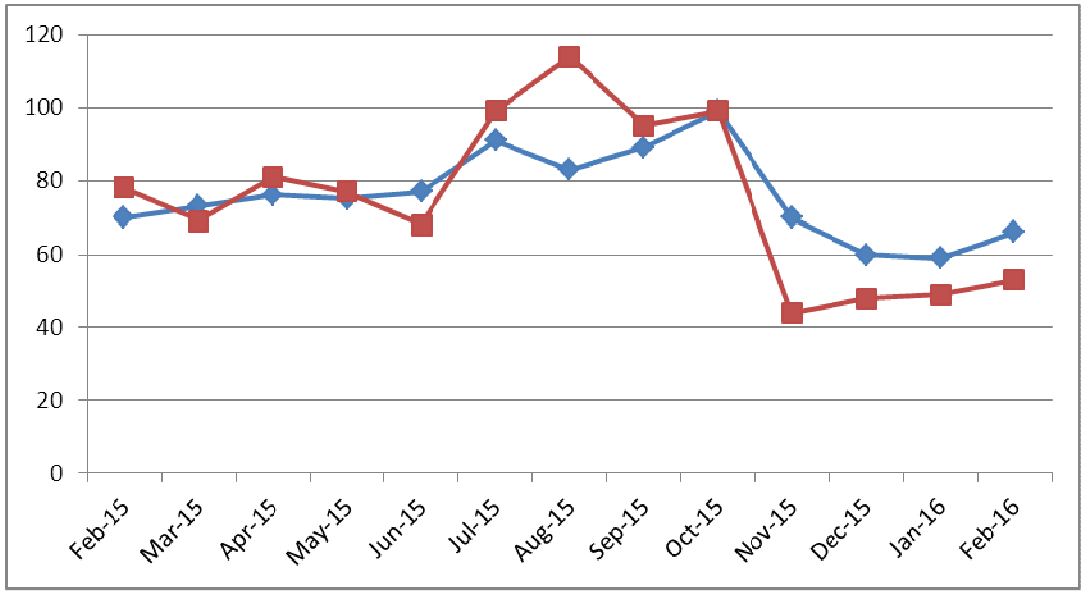
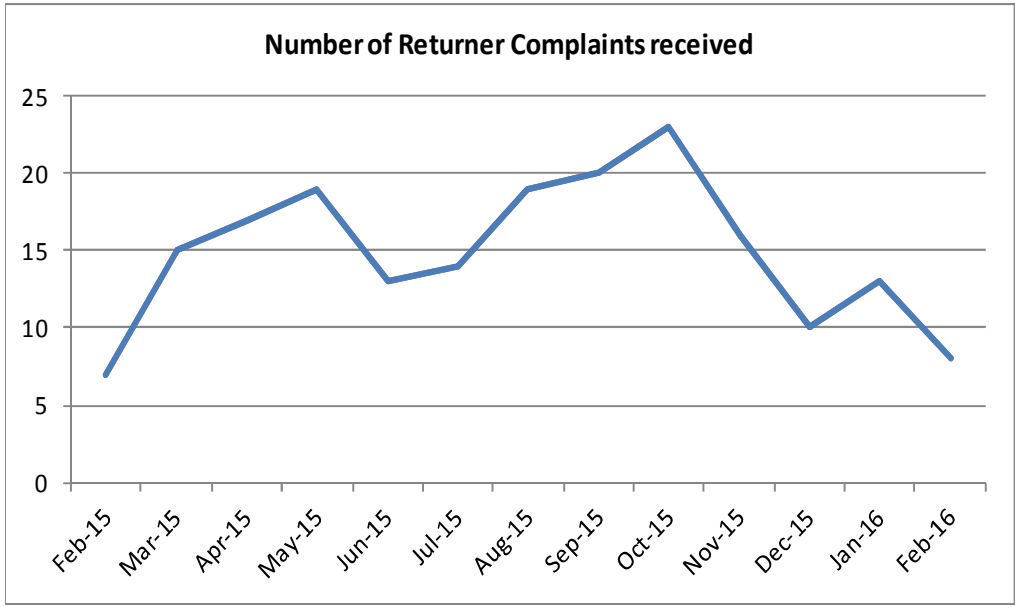
CDU – K&CH

I recently had cause to spend time on your ward and I just wanted to thank you and all the team for the wonderful care, support and understanding I received during my stay. All the staff played a part in my care be it physically or mentally and I really can't thank you enough. You have a fantastic team; it really was apparent that it is what you are a team that, support each other by working together to the benefit of the patients. There is so much in the media about the failings of the NHS however from the treatment I received I cannot find fault.

I would like to say that the ward facilities were spotless; your attention to detail in respect of infection control outstanding. Having always worked in the food industry I would also like to say that the meals were nutritious, tasty, well presented and ample. Keep up the wonderful work you are doing.

Emma in A&E - WHH

On the evening of Tuesday 9th February I attended the A&E Department at the hospital because I had fallen in the cinema car park and my spectacles had cut open my right cheek quite badly. The cut was cleaned up, glued etc. by Emma. She did an excellent job and my cheek is almost back to normal. I found all the staff at A&E both helpful and efficient. At a time when the NHS tends to receive, in my view, unjustified adverse criticism, I would like to extend my sincere thanks to those who attended to me that evening.

Figure 2: Number of Complaints and Concerns Received	Figure 3: Number of Returner Complaints received
	
The number of complaints (blue line) received has increased by 12% compared to January 2016 (66 compared to 59). The number of complaints received from February 2016 compared to February 2015 has decreased by 6% (66 compared to 70). The number of concerns (brown line) has slightly increased by 8% compared to last month (53 compared to 49). Compared with February 2015 there has been a 32% reduction (78 then; 53 now).	The number of returner complaints received has decreased by 5 compared to January 2016 (8 compared to 13). The number of returner complaints received in February 2016 compared to February 2015 has increased by 1 (8 compared to 7).

Themes and Trends in February 2016 – PALS Contacts

The top five subjects raised within PALS in February are detailed in the table opposite.

Table 1: Top Five Themes for PALS: February 2016

Delays	41
Problems with Appointments	30
Enquiry clarification or admin query	25
Problems with Communications	25
DISC / CLAIMS	5

Themes and Trends in February 2016 – Concerns

The top five subjects raised within concerns in February are detailed in the table opposite (NB a joint fifth place):

Table 2: Top Five Themes for Concerns : February 2016

Delays	20
Problems with communication	20
Problems with Appointments	9
Problems with Attitude	6
Site Problems/discharge arrangements	4/4

Themes and Trends in February 2016 – Complaints for all of Trust

Table 3: Complaints

The breakdown of the top five issues by sub-subject are below and opposite:

Concern about Clinical Management	**39**
Unhappy with treatment	17
Incomplete examination carried out	5
Lack of / Inappropriate pain management	4
Unexpected outcome/post op complication	5
End-of-life/palliative care issues	2
Difficulty during procedure	3
Scans/ x-rays not taken	2
Blood tests not carried out	1
Delays	**22**
Delays in receiving treatment	11
Delays in allocation of outpatients appointment	3
Delays in being seen in Outpatients department	2
Delay in receiving x-ray results	1
Delay in emergency admission	1
Delay in referral	3
Delays in being seen in AandE	1
Problems with Communication	**17**
Doctor communication issues	8
Lack of information / explanation of how procedure went	4
Misleading or contradictory information given	4
Other communication issues (i.e. old literature, phones not working	1
Problems with Attitude	
Problems with Nurse's attitude	7
Problems with doctor's attitude	9
Problems with other staff attitude	1
Problems with Nursing Care	**16**
Problems with Nursing Care	9
Inappropriate physical handling	2
Nutrition	1
Delay in receiving treatment	1
Pressure ulcer care	3

The highest recurring subjects raised within complaints for February 2016 are:

Concern about Clinical Management,
Delays
Problems with Communication,
Problems with Attitude
Problems with Nursing Care,

Concerns about clinical management continues as the top reason for complaint. Problems with communication, nursing care and delays remain in the top five.

Table 4: Themes and Trends by Division.
The breakdown of the top five issues for complaint received in February by Division are opposite:

Concern about Clinical Management	UCLTC	Surgical	Specialist	Clinical	Corporate
Unhappy with treatment	4	7	4	1	0
Incomplete examination carried out	2	1	1	0	0
Lack of / Inappropriate pain management	3	1	0	0	0
Blood tests not carried out	0	0	0	1	0
End-of-life/palliative care issues	1	0	0	0	0
Inappropriate ward	0	0	0	0	0
Scans/ x-rays not taken	0	1	0	1	0
Difficulties during procedure	0	0		0	0
Delays					
Delays in receiving treatment	4	2	5	0	0
Delays in allocation of outpatients appointment	0	2	0	1	0
Delays in being seen in Outpatients department	0	1	1	0	0
Delay in receiving x-ray results	1	1	0	0	0
Delay in emergency admission	0	0	0	0	0
Delay in referral	0	3	0	0	0
Delay in sending/receiving copies of medical records	0	0	0	0	0
Problems with Nursing Care					
Problems with Nursing Care	2	2	5	0	0
Pressure ulcer care	2	1	0	0	0
Inappropriate physical handling	0	2	0	0	0
Nutrition	0	1	0	0	0
Delay in receiving treatment	0	0	1	0	0
Lack of response to call button	1	0	0	0	0
Problems with Communication					
Doctor communication issues	5	2	1	0	0
Unhappy with info on medical records	0	0	0	0	0
Lack of information / explanation of how procedure went	1	1	2	0	0
Misleading or contradictory information given	1	2	1	0	0
AandC staff communication issues	0	0	0	0	0
Other communication issues (i.e. old literature, phones not working	0	0	0	1	0
Problems with Attitude					
Problems with Nurse's attitude	4	1	2	1	0
Problems with doctor's attitude	3	5	2	0	0
Problems with other staff attitude		0		1	0

Performance

Table 5: Current Open Cases by Division

Division	Complaints	Concerns	Total
Urgent Care and Long Term Conditions	82	33	115
Surgical Services	70	29	99
Specialist Services	33	12	45
Clinical Support	10	10	20
Corporate	4	1	5
TOTAL	**199**	**85**	**284**

Tables 6 and 7 below show the monthly divisional activity and performance for February 2016.

Table 6: Divisional Performance

	Divisional activity in February 2016					Divisional performance in February 2016		
Division	**Complaints**	**Compliments**	**Concerns**	**PALS Contacts**	**Compliments: Complaints ratio**	**First response target met (within agreed timescales)**	**First response target met (30 working days)**	**No. of returning complaints**
UCLTC	23	564	17	38	25:1	13 of 16 (81%)	4 of 10 (50%)	1
Surgical Services	23	1506	23	73	65:1	23 of 24 (96%)	8 of 24 (33%)	7
Specialist Services	14	445	6	10	32:1	9 of 10 (90%)	7 of 10 (70%)	0
Clinical Support	3	156	3	22	52:1	-		0
Corporate	3	3	4	9	1:1	-	-	0
Other	0	0	0	2	-	-	-	0
TOTAL	**66**	**2674**	**53**	**154**	**41:1**	**45 of 50 (90%)**	**19 of 50 (38%)**	**8**

Rating	% of first responses met
	85 – 100%
	75-84%
	< 75%

The breakdown by Division is given in the table above. Performance by Division has been given a red, amber or green indicator for the month (see key above). The data shows 90% of responses sent out to clients in February were sent out on target compared to 88% last month

The PET implemented a new process from April 2015 whereby the target response date relates to the number of complaints responded to within 30 working days (as set out in the Complaints Policy) rather than 'within agreed timescales' which we consider to be more meaningful data. The table above also includes the average number of working days to respond to complaints for each division to gain a better understanding of the time being taken by each division to respond to complaints.

The data shows 38% of responses sent out the clients in February were sent out on target (within 30 working days) compared to 20% last month, which is a significant improvement.

Table 7: Site Performance

Table 7 below shows the monthly Site activity and performance for February 2016.

	Site activity in February 2016					**Site Performance in February 2016**		
Site	**Complaints**	Compliments	**Concerns**	**PALS Contacts**	**Compliments: Complaints ratio**	**First response target met (within agreed timescales)**	**First response target met (30 working days)**	**No. of returning complaints**
KCH	14	301	18	59	21.5	15 of 15 (100%	6 of 15 (33)	2
WHH	29	1026	19	49	35:1	17 of 20 (85%)	7 of 20 (35%)	2
QEQM	20	1039	14	35	52:1	12 of 14 (86%)	6 of 14 (43%)	4
BHD	0	40	0	6		-		0
RVHF	0	0	2	3		1 of 1 (100%)	0 of 1 (0%)	0
Other (non-site specific)	3	268	0	2				0
TOTAL	**66**	2674	**53**	**154**	**41:1**	**45 of 50 (90%)**	**19 of 50 (38%)**	**8**

Rating	% of first responses met
	85 – 100%
	75-84%
	< 75%

The breakdown by Site is given in the table above. Performance by Site has been given a red, amber or green indicator for the month (see key above). None of the Sites achieved higher than the 75%.

Key Outcomes and Service Improvements as a Result of Complaints

Table 8: Outcome of Complaints Closed in February 2016

Upheld	Partly Upheld	Not Upheld	Withdrawn or consent not received	Meeting held and awaiting outcome	Comments sent to another organisation
29	13	17	2	2	2

Key Improvements as a result of Complaints in February 2016:

Trauma and orthopaedics QEQMH

Concerns that subchondral fracture was not picked up from the x-ray taken on attending the ED. The patient was treated for soft tissue injury, including painful physiotherapy. The physiotherapist decided to check the x-ray and informed the fracture was clearly visible. Also there were concerns over the diagnosis of Perthes Disease for the patient.

ACTIONS
Although it appears that the relevant clinical process was followed, the patient's x-ray report was not reviewed as it had not been uploaded to the system. This could have saved some time. Actions have been taken within the department to avoid this in the future. The abnormality was not seen on the x-ray. Despite the delay in diagnosis the treatment path remains the same. This was presented as a Patient Story to a recent Board of Directors meeting.

Trauma and orthopaedics WHH

Concerns raised by client that there were poor arrangements in place for the patient's discharge: dressings were not provided; a cannula was left in; no physiotherapy had been arranged to prepare for discharge; and the discharge notes were poor with no explanation of the medication.

ACTIONS:
The patient was not adequately discharged and the cannula should have been checked. It was unacceptable that it was left in. There were communication problems and the complainant and patient were not kept fully informed. It was acknowledged that there were problems with the community nursing being properly in place.

Neonatal (QEQM)

Concerns over the length of the waiting list for a simple operation for a tongue tied baby born at the beginning of November. The client was informed this would not be performed until January, due to the waiting list and therefore went privately as the baby having constant colic and the mother experiencing severely cracked nipples due to this; further impeding the feeding process.

ACTIONS:
Service is not adequate for the local population. Actions taken are:

1. Plans have been made to double the capacity of the current tongue tie service;
2. A midwife is currently being trained to undertake tongue tie division, with the plan being that the procedure can be undertaken on the ward before discharge;
3. A further midwife will subsequently be trained, hopefully later this year.

Gastroenterology (WHH)

Concerns raised regarding poor patient care; lack of information from the nursing staff to the family; not being introduced to the new consultant and poor communication with the consultant following patient's diagnostic results; poor communication due to ethnic language difficulties with Sister and nursing staff; poor discharge planning and lack of support for family in having to deal with their loved one who is a cancer patient.

ACTIONS:
Meeting held - poor patient care and communication; not told results of scans, endoscopy cancelled. Actions taken are:

1. Put measures in place regarding the triaging process to ensure that when they speak to members of staff on the ward it is documented who they have spoken to and that any decisions made during the triage are communicated back to the requesting clinician by the Endoscopy Department.
2. All nursing staff have been reminded to answer any questions or queries by relatives when they are not present during ward rounds.
3. Taken forward to the Clinical Nurse Specialist and Trust meetings to ensure contact cards are given out to enable patients' relatives to contact them and request further reviews.
4. Reiterated to all nursing staff any drugs that are required from Pharmacy on the EDN should be sent as soon as possible to ensure a timely discharge.
5. Reminders to all nursing staff to complete a discharge checklist.

Feedback Received via the Patient Opinion and NHS Choices Websites

Table 9 - Compliments and Concerns Received in February 2016

Site:	WHH	KCH	QEQM	RVHF	BHD	TOTAL
Compliments	9	4	4	2	0	19
Complaints	6	3	2	0	1	12

Examples of Compliments received on the Patient Opinion and NHS Choices Website in February 2016 :

- "I was in hospital from 10th Feb and came home on the 12th Feb.....I would like to say a big thank you to all the staff from domestic's to nurses that looked after me. My independence was not taken from me and I was given the respect and dignity that anyone should receive. I pushed myself so I could go home sooner and the nurses, healthcare assistances and OT's worked with me so I was able to, Once again a thank you to you all". [QEQM - Orthopaedics] (Visited in Feb 2016. Posted on 12 Feb 2016)
- "From start to finish I was dealt with care, humour and great professionalism". [K&C - Dermatology] (Visited in Jan 2016. Posted on 29 Feb 2016)
- "I have attended the warfarin clinic and phlebotomy many times over the last few years and I can't fault them in any way, friendly, cheerful and helpful staff, sometimes it's a long wait, but its not their fault, very hard working". [RVHF - Phlebotomy] (Visited in Jan 2016. Posted on 29 Feb 2016)
- "I can honestly say I was extremely impressed with the fantastic service I received. Every member of staff was professionall, kind and seemed genuinely interested in helping me. I was treated quickly with dignity and respect and felt like an individual. I wish to thank everyone involved from the receptionist to the staff in minors to the radiographers to the Maxillo-facial SHO who saw me. You are a brilliant team and your managers should be proud of your hard work. I am very grateful". [WHH – AED/Radiology] (Visited in Feb 2016. Posted on 02 Feb 2016)

Examples of Complaints received on the Patient Opinion and NHS Choices Website in February 2016 :

- "I was sent for an Urgent MRI on 29.01.16. I was told to go to the GP within a few days to get the results... however I did this to find no results and Dr said they would telephone and chase them. Today I ring the surgery to be told my results are not available. I then ring the hospital to fingers that my urgent MRI is still waiting on the Radiologist desk and is still not reported on. I have spent the last 6 wks in agony and on high doses of morphine. That even as urgent your MRI scan can sit on a desk waiting for someone to look at it and report on it... but I can go to the hospital and purchase a copy of my MRI on a disk. It seems a joke. And the pain increases the longer I wait". [KCH - Diagnostic Physiological Measurement] (Visited in Jan 2016. Posted on 10 Feb 2016)
- "I had an appointment yesterday 4th February and it is a real challenge getting to the hospital from Deal on public transport so I was very unhappy when I got to the hospital on time and had a long wait which ended up with me being referred back to my GP! The staff are rude and very unhelpful and the place just seems totally disorganised. Not Happy". [BHD - Dermatology] (Visited in Feb 2016. Posted on 05 Feb 2016)
- "You can see why this place is in special measures. Toilets don't work, patient services operate 5 minutes a day, reception staff are rude, there's the usual pre clinic checks of being told what's going to be done to you, rather than asked, I'm sure I've heard 'patient choice' somewhere. Outpatients consultations aren't done in private. Complaints procedures are useless, online forms ignored and PALS here as soft, fluffy and intangible as elsewhere. Clinics are booked, then rearranged, latest no less than 4 times, when I asked why, there were no clinics on the date I was booked!!! Outpatient letters don't have the phone number for the department, just the generic outpatients line. As to letters, if I DNA I get kicked out, if the Trust cancels an appointment, the letter should tell you why. My last, excellent, hospital did this, patients, the most important person in the deal surely, got copies of clinic letters, not here. Anti patient information culture, on the a little knowledge is a dangerous thing theme no doubt. [WHH - Orthopaedics] (Visited in Feb 2016. Posted on 24 Feb 2016)

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**8 APRIL 2016**
SUBJECT:	**KEY NATIONAL PERFORMANCE TARGETS**
REPORT FROM:	**CHIEF OPERATING OFFICER**
PURPOSE:	**Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

This paper provides an update to the Board on the performance around the key performance indicators in the previous month.

SUMMARY:

This paper outlines performance against some of the key standards in the 2014/15 National Operating Framework & Monitor Risk Assessment Framework.

The Trust was non-compliant with the A&E 4 hour standard

The Trust was non-compliant for all RTT standards

The Trust is compliant with the six week diagnostic target

The Trust is non-compliant against the 2ww symptomatic breast and 62 day GP standards.

All information contained in this report is complete and accurate at the time of reporting.

RECOMMENDATIONS:

- The Board is asked to note the content of this report and seek further assurance if required.

NEXT STEPS:

Recovery trajectories are in place for the A&E, RTT and Cancer standards. Achievement of these standards is being monitored daily, however operational pressures are significant.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

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

These targets are key to the achievement of access and financial objectives and contribute significantly to the patient experience and choice.

LINKS TO BOARD ASSURANCE FRAMEWORK:

These standards form part of the reporting mechanism to The Management Board (previously CPMT) and also the Clinical Advisory Board (CAB).

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:
All these standards are being closely monitored and mitigating actions are being taken where appropriate (in collaboration with the whole health economy)

FINANCIAL AND RESOURCE IMPLICATIONS:

There is a financial penalty for not achieving these targets when in a PbR contract – the current managed contract does not hold this financial risk.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

None

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

N/A

ACTION REQUIRED:

(a) Discuss and agree recommendations.
(b) To note the content of the report

CONSEQUENCES OF NOT TAKING ACTION:
Potential risk of failing the required standards which has an impact on our Monitor rating and Trust reputation.

Performance Report February 2016 – key national indicators

1. Introduction

This report summarises the Trust's performance and position for the following key national targets:

- A&E Performance
- Referral to Treatment waiting times for admitted care, non-admitted care and incomplete pathways
- 52+ week
- Cancellation of an urgent operation for the second time
- 6 week standard for diagnostics
- Cancer Waiting Time Standards

2. A&E Performance

The Trust was non-compliant with the 4 hour emergency access standard in February at 80.0%.

This shows a decline from the previous month (84.8%), and the previous year's February position (Feb-15 88.2%).

As noted last month, the previous year saw performance holding relatively stable, with a small decline in performance over the Winter period to a low of 87.5% in March 2015. This year has shown a sharper and more notable drop in compliance against the 4 hour target, and the Trust is below 85% for a second month.

QEH continues to show the lowest level of compliance against the 4 hour standard with 72.0% within the 4 hour standard (62.4% in majors, 91.1% in minors). The site achieved a compliance of 86.1% last year. This site has also run with the highest number of Delayed Transfers of Care which has increased the length of stay of patients on a supported discharge pathway.

The WHH had an overall monthly compliance of 77.7%, with performance lower than the previous year (82.8%).

During February, the WHH achieved 2 days of performance above 90%, and 10 days below 75%. The QEH site did not achieve a single day with above 90% compliance (2 in January), and had 4 days of above 80% compliance, as the site struggled.

Activity levels compared to the previous year and performance against the emergency 4 hour KPI is broken down by site in the following table:

A&E Performance	Trustwide	QEH	WHH	K&C	BHD
Total A&E Attendances	16,633	5,889	5,943	3,718	1,083
Variance to Previous Year	10.9%	12.3%	9.5%	6.4%	31.4%
Breaches of 4 hr Standard	3,324	1,648	1,323	352	1
% Compliance	80.0%	72.0%	77.7%	90.5%	99.9%
Age Profile (attendances)	**Trustwide**	**QEH**	**WHH**	**K&C**	**BHD**
Numbers of 20-30 year olds	2,516	792	867	713	144
	15.1%	13.5%	14.6%	19.2%	13.3%
Numbers of 75+	2,902	1,058	997	762	85
	17.5%	18.0%	16.8%	20.5%	7.9%

Continuing from January, the activity levels in A&E were above the phased plan by 7.0%, and markedly higher than the previous year (+1,639, +7.1%).

Breach Analysis

The breakdown of breaches for February grouped by breach area is shown below;

Reason for Breach	Total	% of Breaches
Bed Management	839	25.0%
Waiting for Diagnostics	167	5.0%
Waiting for Specialist Opinion - Acute	459	14.0%
Waiting for Specialist Opinion - MH	48	1.0%
Wait for First Clinician (not triage)	996	30.0%
A&E Assessment	45	1.0%
Clinical	105	3.0%
Treatment Decision	618	19.0%
Primary Care Assessment/Streaming	-	0.0%
Patient Transport	34	1.0%
Unknown / Other	13	0.0%
Total	**3,324**	**100.0%**

The main reasons for failure of the 4 hour access standard were:

- Bed management breaches – Breaches allocated to these reasons continued to increase in February, with high numbers of breaches attributed to this reason (839, from 671 last month). The WHH site experienced 532 of these breaches in month (40% of the site's breaches), reflective of the difficulties in bed flow experienced.

- Delays to be seen by clinicians in ED. This breach category had the largest proportion of breaches in month, relatively unchanged at 30% of all breach reasons. The volume of breaches was especially high in February, with 996 breaches seen (+275 on January).

- Delays in treatment decision, such as late referral to specialty also impacted on congestion in the ED. This remains relatively unchanged as a proportion of the total number of breaches, around 20% of all breaches.

Most notable is the sheer volume of breaches experienced by the Trust across its sites, with 114 breaches per day on average (57 per day was required to hit 90% compliance).

EMERGENCY ACCESS RECOVERY PLAN

PROGRESS UPDATE

ED WORKSTREAM

- The Emergency Department Standard Operating Procedure (ED SOP) was approved at the Management Board on the 4 March 2016.
- A roll out programme for the ED SOP has been implemented.
- A meeting has been organised for early April with the senior ED clinicians to develop a protocol as to when the Emergency Department is unsafe and requires senior consultant attendance.
- The middle grade medical rota is still in the final stages of development following concerns raised by the substantive Doctors regarding the weekend commitment. Adjustments are being made to the rota in collaborative with the substantive middle grade doctors.
- The nursing skill mix review has been completed using the BEST tool, NICE guidance and professional judgement.
- Delays in patients receiving mental health assessments and in particular delays in being transferred to a mental health bed continue to put pressure on the ED departments. This issue continues to be escalated externally at Chief Executive level and is managed at Executive and Divisional Director level on a daily basis.

ALTERNATIVE PATHWAYS.

- The Frailty Ambulatory Pathway is being aligned to the review of the Acute Medical Model at QEQMH and with phase one due to be implementated mid Aprill 2016.

SAFER CARE BUNDLE

- The project has been commenced across all the medical wards at QEQMH and WHH with ongoing work to embed best practice.
- Discharge Lounge utilisation continues to increase on all sites.

SITE MANAGEMENT & LEADERSHIP

- The Operational Control Centres have been established.
- A larger and more appropriate location for the WHH OCC has been identified with a plan to relocate on 1st April 2016.

INFORMATION & REPORTING

- QEQMH has gone live with the E-Cascard project in the minors area of the department and operational issues with the system are being actioned with user engagement.

ESTATES

- The new minors area at WHH has successfully opened
- Phase two - which is the new paediatric area is progressing to timescales.

WORKFORCE

- The recruitment programme to ED specialty and core level doctor posts has confirmed that 9 middle grade doctors have accepted substantive posts.

KEY ACTIONS TAKEN IN FEBRUARY :

- Continue with proactive management and progression of the action plan.
- An internal restructure has identified a dedicated Head of Nursing for QEQMH and WHH to lead on Acute and Emergency Medicine and ensure that there is a senior clinical focus on embedding the principles of SAFER.
- Job planning and review of on call arrangements for ED Doctors and physicians is progressing.

Referral to Treatment waiting time performance

The 2014/15 National Operating Framework, 'Everyone Counts' measures the following RTT standards;

- **non-admitted patients = 95%**
- **admitted patients = 90%**
- **incomplete pathways = 92%**
- **52 week waiters = zero tolerance**

(Incomplete pathways are a measure of all patients still waiting for their first definitive treatment regardless of where they are on their pathway, i.e. this measure combines both admitted and non-admitted patients waiting for treatment.)

On the 4th June 2015, NHS England announced that the admitted and non-admitted measures relating to 18 weeks Referral to Treatment Times (RTT) would be abolished and the incomplete standard will become the sole measure of patients' constitutional right to start treatment within 18 weeks." For completeness this paper will continue to report performance across all four standards to the end of the financial year.

February performance against the 2015/16 standards was; non-admitted care 90.7%, admitted care 60.4%, **incomplete pathways 89.2%** and there were only three patients who were waiting 52+ weeks as at the end of the month.

Pathway	< 18 Weeks	>18 Weeks	Total	% Compliance	52 Week waiters
Non-Admitted Pathway	7,251	741	7,992	90.7%	
Admitted Pathway	1,622	1,064	2,686	60.4%	
Incomplete Pathways	38,157	4,634	42,791	89.2%	5

Table 3.1 – RTT Position Compliance by Pathway (February 2016)

As at the end of February the total number of Incomplete Pathways grew and now stands at 47,791.

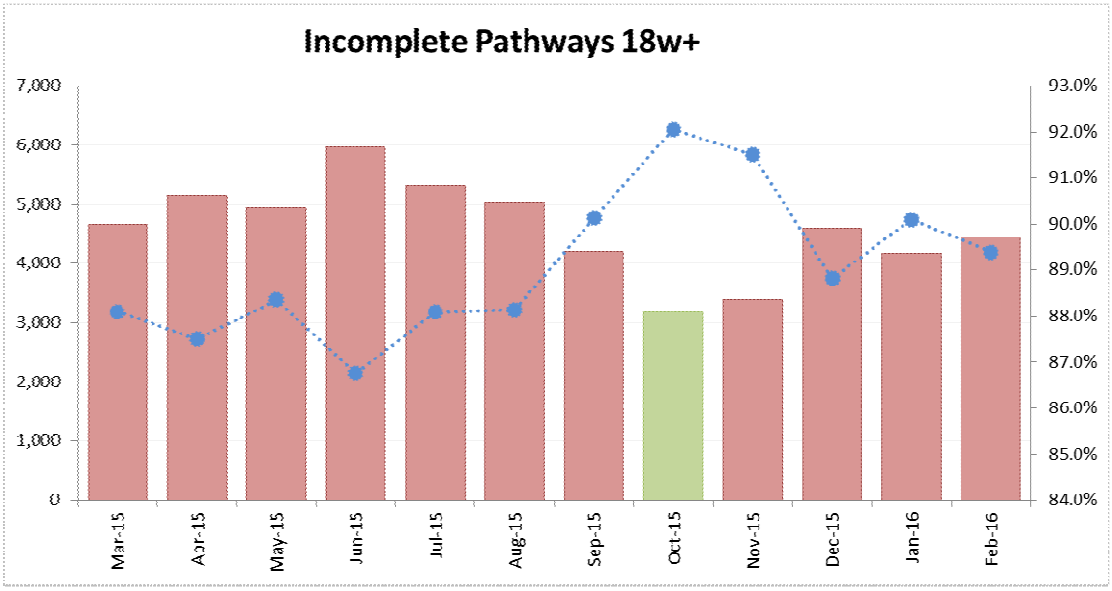


Chart 3.1: 18+ wk Incompletes Position by Month

	Still waiting	Backlog	52w +	OPA Still Ticking	Backlog	52w +	Elective WL	Backlog	52w +	Total Income.	Backlog	52w +	%
⊞100 - General Surgery	2,404	115		2,198	301	3	1,184	417	5	5,786	833	8	85.6%
⊞110 - Trauma & Orthopaedics	1,757	7		909	90		3,143	681		5,809	778		86.6%
⊞120 - Ear, Nose & Throat	1,696	54		1,274	351		904	297	1	3,874	702	1	81.9%
⊞130 - Ophthalmology	3,177	140		884	87		1,269	240	1	5,330	467	1	91.2%
⊞301 - Gastroenterology	1,596	92		938	326	1				2,534	418	1	83.5%
⊞330 - Dermatology	2,143	47		278	49		742	286		3,163	382		87.9%
⊞502 - Gynaecology	1,644	75		790	95	1	619	175		3,053	345	1	88.7%
⊞X01 - Other Specs	2,652	89	1	425	84	2	141	51		3,218	224	3	93.0%
⊞140 - Maxillo Facial	1,721	65		501	48		351	88		2,573	201		92.2%
⊞400 - Neurology	1,140	37		268	115					1,408	152		89.2%
⊞101 - Urology	953	10		729	53	1	898	47		2,580	110	1	95.7%
⊞320 - Cardiology	898	4		743	71	1	380	3		2,021	78	1	96.1%
⊞340 - Thoracic Medicine	745	13		407	59					1,152	72		93.8%
⊞410 - Rheumatology	601	20		164	26		10	0		775	46		94.1%
⊞300 - General Medicine	351	8		61	16					412	24		94.2%
⊞430 - HCOOP	367	4		112	5					479	9		98.1%
Grand Total	23,845	780	1	10,681	1,776	9	9,641	2,285	7	44,167	4,841	17	89.0%

At the 28th February 2016 the Trust has 44,167 open pathways with 4,841 patients currently breaching the 18 week standard. As such current performance is at 89.0%. The Trust aggregate position is 1.2% behind the submitted recovery trajectory; the Trust is planning for a high productivity month in March, plus a regime of targeted validation of breaching pathways, to attempt to reach the 91.2% target.

Significant Issues Affecting our Current Position

- General Surgery – Capacity constraints within our Endoscopy service are stretching the waiting time to the decision to treat, this is generating an unachievable 18 week pathway for surgical interventions following Endoscopy. Following an in depth analysis, we have identified a reduction in the number of general surgery theatre sessions used since November 2015, this reduction in productivity has meant elective capacity is no longer aligned with demand. This is isolated on one particular site and is as a direct result in the middle grade tier no longer utilising sessions dropped for consultant annual leave due to perceived governance issues.
- Ophthalmology – Loss of cataract surgeon due to unplanned long term sickness.
- Gynaecology – We have identified a loss of productivity within outpatients due to the current booking process which is now resolved.

- Other Specialties – We are yet to achieve the expected gains from the validation of smaller specialties paediatrics and vascular.
- Elective Cancellations – The Trust has had to cancel 124 elective cases due a shortage of beds and the junior doctor's strikes since 1st January 2016.

Recovery Plan Initiatives

- Four Eyes Insight – The theatre productivity work stream is now moving to Operational phase which is expected to yield significant additional cases through established theatre sessions.
- General Surgery – The Trust intends to remove fire breaks within annual jobs plans currently lost to on call rotas. This will increase the number of weeks a consultant provides theatre surgery to 42.
- Ophthalmology – The service has now returned to capacity and has added a number of additional theatre and outpatient procedure sessions in an attempt to recover the position by the end of the financial year.
- Endoscopy in the Independent Sector – The Trust is finalising plans to work collaboratively with our local MCP Vanguard, Whitstable Medical Practice. Unfortunately this is unlikely to be in place by the end of the financial year.
- Gynaecology – A trajectory to return the waiting time to first outpatient appointment to the local milestone 8-10 weeks by the end of April. The Trust is actively searching for additional theatre capacity to align demand and capacity.
- Targeted Validation Programme – It is believed a number of specialties can still benefit from targeted validation, in line with National RTT Validation programme, we are expecting to make good progress in a number of specialties including ENT, Breast Surgery, Ophthalmology, Acute and Community Paediatrics and Vascular Surgery.

4. Cancelled Operations (Non-Clinical)

The 2014/15 Operating Framework maintains the zero tolerance on urgent operations that are cancelled by the Trust for non-clinical reasons, which have already been previously cancelled once for non-clinical reasons.

The definition of 'urgent operation' is one that should be agreed locally in the light of clinical and patient need. However, it is recommended that the guidance as suggested by the National Confidential Enquiry into Peri-operative Deaths (NCEPOD) should be followed.

In February there were zero second or subsequent cancellations of any urgent operations.

5. 6 week target for diagnostics

The 2014/15 Operating Framework has retained the six week maximum wait for all diagnostic tests as outlined in the national DM01 return. The framework states that 99% of all patients should wait a maximum of six weeks for their diagnostic test. This standard is measured at aggregate Trust level and not by individual diagnostic test.

The Trust has maintained its compliant position in February, closing the month with 99.7% patients waiting six weeks or less for a diagnostic test.

There were three non-compliant areas, Audiology, Cardiology and Urodynamics.

The amount of work being undertaken to maintain this position is significant. Endoscopy services are trying to source additional capacity and the risk to DM01 moving forward is being quantified.

Table 5.1 below shows the breakdown of waiters' vs breaches by diagnostic test.

Service	Test	0 to 6 Weeks	06 < 13 plus Weeks	Total WL	% within 6wks
Imaging	Magnetic Resonance Imaging	3,410	-	3,410	100.0%
	Computed Tomography	1,775	-	1,775	100.0%
	Non-obstetric ultrasound	4,083	4	4,087	99.9%
	Barium Enema	76	-	76	100.0%
	DEXA Scan	240	-	240	100.0%
Physiological	Audiology - Audiology Assessments	90	6	96	93.8%
Measurement	Cardiology - echocardiography	740	20	760	97.4%
	Cardiology - electrophysiology	-	-	-	100.0%
	Neurophysiology - peripheral neurophysiology	348	1	349	99.7%
	Respiratory physiology - sleep studies	252	-	252	100.0%
	Urodynamics - pressures & flows	3	3	6	50.0%
Endoscopy	Colonoscopy	705	6	711	99.2%
	Flexi sigmoidoscopy	239	2	241	99.2%
	Cystoscopy	349	-	349	100.0%
	Gastroscopy	638	3	641	99.5%
Total		**12,948**	**45**	**12,993**	**99.7%**

Table 5.1 – Diagnostic DM01 (February 2016)

6. Cancer Waiting Time Performance

Standard	2ww All Cancers	2ww Breast Symptomatic	31 Day Diag to First Treat	31 Day Sub Surg	31 Day Sub Drug	62 Day GP	62 Day Screening
Target %	93.0%	93.0%	96.0%	94.0%	98.0%	85.0%	90.0%
Q4 14/15	93.88%	95.29%	97.52%	96.62%	98.88%	75.18%	86.72%
Q1 15/16	93.37%	91.04%	94.41%	89.57%	100.00%	74.27%	96.83%
Q2 15/16	91.62%	88.09%	91.27%	88.79%	100.00%	67.28%	92.11%
Q3 15/16	94.66%	93.21%	97.33%	95.28%	98.82%	73.31%	85.25%
Jan-16	93.20%	94.06%	94.94%	94.29%	87.91%	72.22%	93.55%
Feb-16	94.07%	88.03%	97.03%	97.37%	98.63%	79.25%	91.67%

Table 6.1: Cancer Performance Standards

2ww, 31 day, 31 day subsequent surgery, Drug and 62 day screening standards have been achieved by the Trust. Breast symptomatic and 62 day standards have not been achieved. We will continue to validate the information to the national submission date as some cancer pathways involve other providers and validation continues between organisations which can take up to 24 working days from month end.

Breast Symptomatic

The Breast Symptomatic referral standard has not been met. 14 patients have breached this target from a total of 117 seen in month.

Breach reasons include;

Capacity issues – 4,
Patient unavailable to attended within 14 days – 1
Patient cancelled a booked appointment - 9

Analysis of 1st appointment offered to patients, indicates that available capacity is late in the two weeks pathway.

Day in pathway of 1st offered appointment	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 18	Day 21
Number of referrals	2	1	3	4	4	10	21	**31**	**36**	4	1

Table 6.2: Breast Symptomatic day in pathway of 1st offered appointment

This trend is also amongst all tumour sites as the majority of patient are offered on Day 14 of the 14 day target.

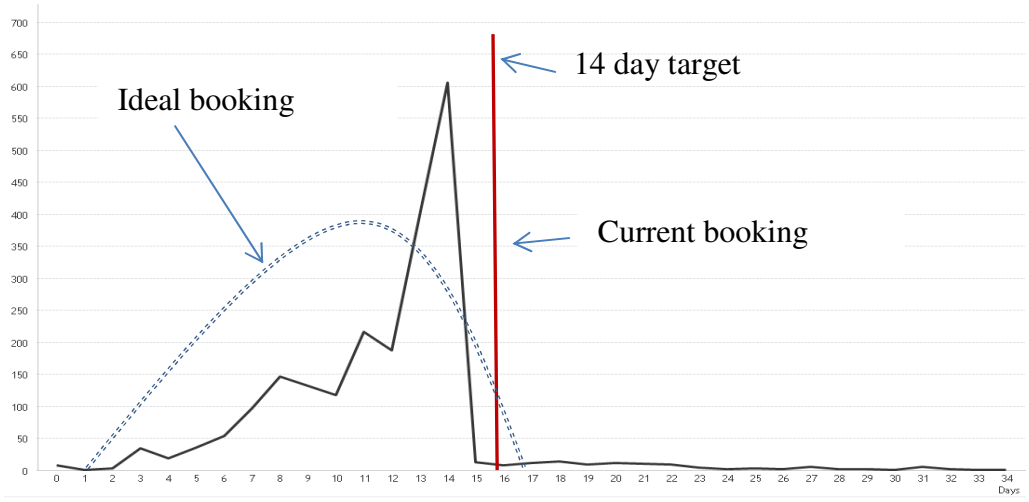


Chart 6.1: 2ww Booking profile for Trust Feb 16

Therefore, risk of non-compliance remains high.

Tumour sites are being asked, through the Cancer Recovery group, to explore what will be needed to deliver an average 1st seen appointment of 10 days and 7 days, which will give clinicians more time to diagnose and treat within the 62 day pathway.

62 day performance

Although performance has improved in Jan 16, it has been another challenging month for the Trust. A significant concern is failure for Breast 62 day (81%) for the second month. Some of the 62 day breaches are due to complex diagnostic pathways, other delays along the pathway diagnostics, reporting turnaround times and treatments, have also contributed to delays and failure of this target. A task and finish group is exploring what is required to offer every breast patient a 'One Stop'

clinic appointment, which will reduce the time to diagnosis and deliver quicker treatment planning within the 62 day pathway.

These issues have been mirrored within the other tumour sites, notably Skin, where we have seen 4 breaches in month, primary reason for this is capacity within Head and Neck for treatment of skin cancers. The performance of both skin and breast is significant for the delivery of 62 day target (85%) as they have high treatment and ordinarily perform at a very high level of compliance, i.e. 0- 1 breach per month.

Patient choice within the pathway for diagnostics and other key events remains a challenge. Better communication with patients through the pathway is required. From GP's through to our own clinicians and admin staff are fearful of informing patients they are on a cancer pathway. The Cancer Compliance Team is working with the CCG partners on getting the message out to GP practices and a letter from the Trust Cancer Clinical Lead will be going out to every clinician within the trust to remind them of firstly the standards, but also the responsibility of informing patients that they are being investigated to exclude cancer.

Urology continues to make good progress. The tumour site has improved month on month since August 15 and has achieved 81% in Feb, its highest compliance since Dec 14 (85.19%). There currently there no issue with capacity for the Da Vinci Robot. This element of the service is evidencing sustained performance through staff changes, new theatre support worker and clinical fellow. The Blood in Pee awareness campaign is currently under way and this must be monitored closely to ensure that there are not capacity issues with the bladder pathway if referral numbers begin to increase.

Urology PTL meeting has been highlighted as working very well. This is CNS nurse lead and supported with operational staff and Cancer tracking and coordinator staff. The information which is need to make a decision to plan the patients pathway is available at the meeting (OPD capacity and Theatre slots) from the operational staff. Other tumour site PTL meeting are look adopted this practice.

Chemotherapy is delivering treatments within 20 days of decision to treat. Although there are delays and cancellations, close work with the team continues to improve processes within the chemotherapy department and Asceptics.

Endoscopy capacity remains a challenge for the Trust and continues to impact on the Lower GI pathway.

62d Treatments (Target 85%)

Tumour	Total	Brch	%	
Breast	22	4	81.82%	🔴
Lung	12	4	66.67%	🔴
Haemat.	4	1	75.00%	🔴
Upper GI	8.5	2	76.47%	🔴
Lower GI	10	4.5	55.00%	🔴
Skin	34	3.5	89.71%	🟢
Gynae.	6	2	66.67%	🔴
Urological	44	8	81.82%	🔴
Head & Nk.	4.5	2	55.56%	🔴
Sarcoma	1.5	1.5	0.00%	🔴
Other	0.5	0	100.00%	🟢
	147	**32.5**	**77.89%**	🔴

Table 6.3: Un-validated 62 day position February 2016

>100 days

The number of patients who are over 100 day on the 62 day pathway is at its lowest number at 46 patients.

On a weekly basis the MDT leads are sent a report detailing the patients who have entered the 100 day cohort. The clinicians are required to review the pathway and comment as to whether the patient has come to harm or not. Patients are also removed from pathway if appropriate. The Clinical Leads are now expected to deliver a report to the Cancer Board about their findings. This process is now reported via DATIX.
Lower GI has the largest cohort of patients past 100 days. This is due to pathway length being extended as a result of Endoscopy capacity issues.
As a result of the reviews a number of factors have been identified that extend pathways past 100 days. These include delays and capacity issues to key treatment events, tests and reporting, patient co-morbidities, patient choice and complex diagnostic pathway where patients have been referred under one suspected tumour group to then be ruled out, but another cancer type has been investigated and /or found. The Trust will continue to review and reduce this cohort of patients.

Tumour site	Number of patient 100 days in pathway or greater	With a Diagnosis	With a Decision to Treat (DTT)	With no Diagnosis or DTT
Urology	8	1	4	4
H&N	4	1	1	3
Thyroid	5		3	2
Lung	2	1	2	0
Haematology	4	4	2	0
Upper GI	1			1
Lower GI	21	7	6	15
Skin	2		2	0
Total	47	14	20	25

Table 6.4: >100 day break down as of 16th March 16

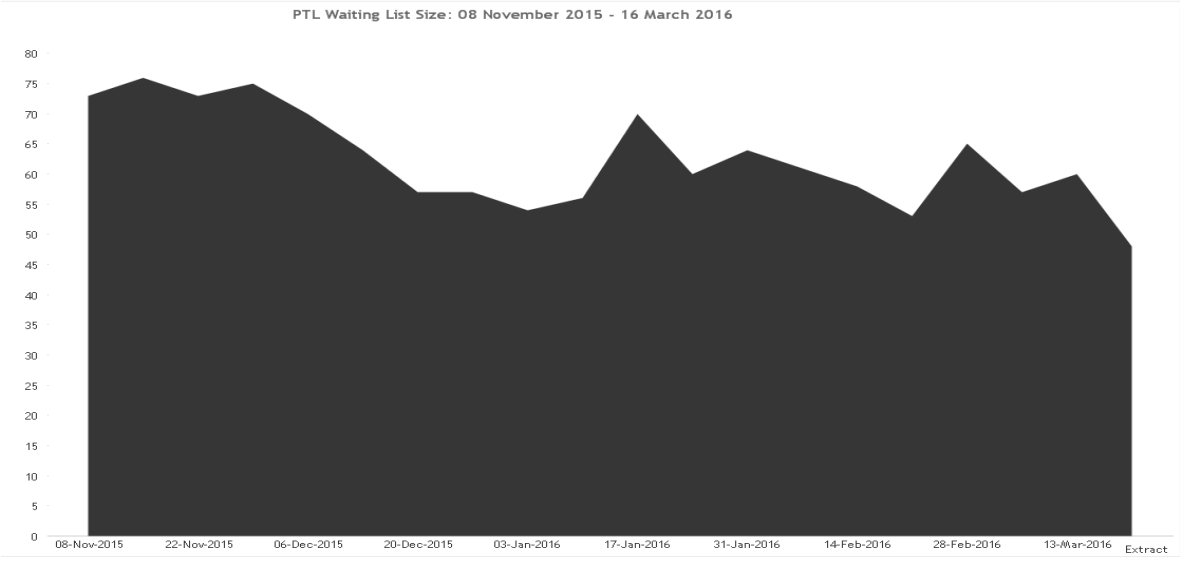


Chart 6.2: PTL size >100 days Nov to March

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**8 APRIL 2016**
SUBJECT:	**STRATEGIC WORKFORCE REPORT**
REPORT FROM:	**DIRECTOR OF HUMAN RESOURCES**
PURPOSE:	**Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

This workforce report has been developed on an interim basis to provide information to the Board and Strategic Workforce Committee on key workforce markers whilst work continues on the development of the integrated performance report.

This month's report includes a workforce "heat map", displaying a number of workforce metrics in a RAG rated table. This report shows January data and reports the discussions and actions that have been taken at a Divisional level at executive performance reviews

SUMMARY:

The Board are asked to review and discuss the workforce data within this report.

The key points to note are:

- A significant risk has been identified in regard to statutory training; the report provides the numbers of staff who have never completed one or more statutory training courses required by the Trust. Details shown on page 23.
- Agency trajectories which have been provided by the Divisions are included in this report. The Divisions are working on trajectories for 2016/17 which are expected to be a consistent format.
- Sickness absence in January 2016, when compared with January 2015 has decreased from 4.33% to 4.19%. The data is showing the seasonal pattern we would expect to see based on previous years.
- A graph showing sickness by staff group has been included. In line with the findings of Lord Carter in his February 2016 report, sickness levels for support to clinical staff are the highest in the Trust. Similarly, in line with the report findings, the sickness rates for the medical staff are the lowest in the Trust.
- The Trust appraisal rate has improved in January and is now at 86%, although below the target rate of 90%.
- The Statutory Training Compliance Rate has remains at 85% - the Trust target rate.
- In this report turnover has been analysed by site and staff group, turnover is highest for community based staff in January and in the Allied Health Professional group
- January shows an increase in % of pay bill being used to support temporary staffing when compared to December 2015. We have limited data for comparison but this may reflect that annual leave for nursing staff is restricted over the Christmas period due to the difficulties in arranging temporary staff cover. Agency spend as a proportion decreased.

Head of Human Resources and Head of HR Systems are continuing to work with the Information team to implement a single reporting platform, via Qlikview, for all workforce reporting (at Divisional and Board level).

RECOMMENDATIONS:

To note and discuss the content of this report.

NEXT STEPS:
n/a

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:
This report enables the Board of Directors to review the workforce as part of the Trusts strategic objectives.

LINKS TO BOARD ASSURANCE FRAMEWORK:
A010

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:
N/A

FINANCIAL AND RESOURCE IMPLICATIONS:
Key workforce decisions and actions may be taken on the basis of this report.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:
Relevant to compliance with Foundation Trust licence.

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

ACTION REQUIRED:

(a) Discuss
(b) To note

CONSEQUENCES OF NOT TAKING ACTION:
Insufficient scrutiny of the workforce position and overall workforce performance indicators. Insufficient awareness at Board level of risks to achievement of objectives and remedial/mitigating actions to be taken in relation to workforce.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Workforce Report

Submitted March 2016

January 2016 data

Jacqui Siggers

Head of Human Resources

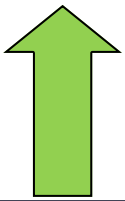
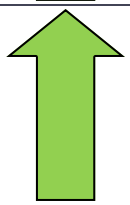
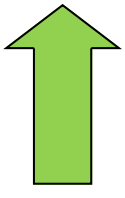
Putting patients first

Introduction and High Level Summary

This workforce report has been developed on an interim basis to provide information to the Board and Strategic Workforce Committee on key workforce markers whilst work continues on the development of the integrated performance report and workforce "heat" map.

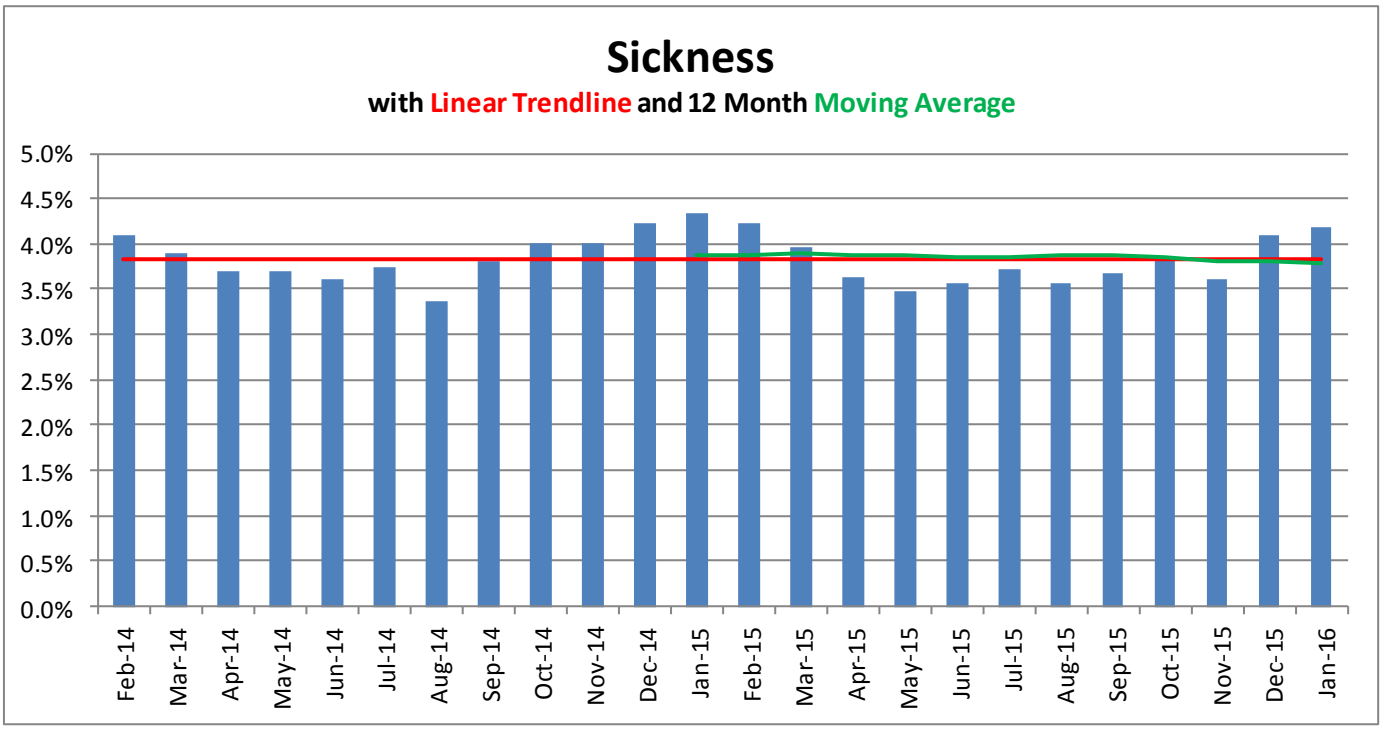
This months report contains a workforce 'heat map', displaying a number of workforce metrics in a RAG rated table.

This report includes January 2016 data for all measures except those obtained from i-view, for benchmarking purposes, which are reporting data for December 2015.

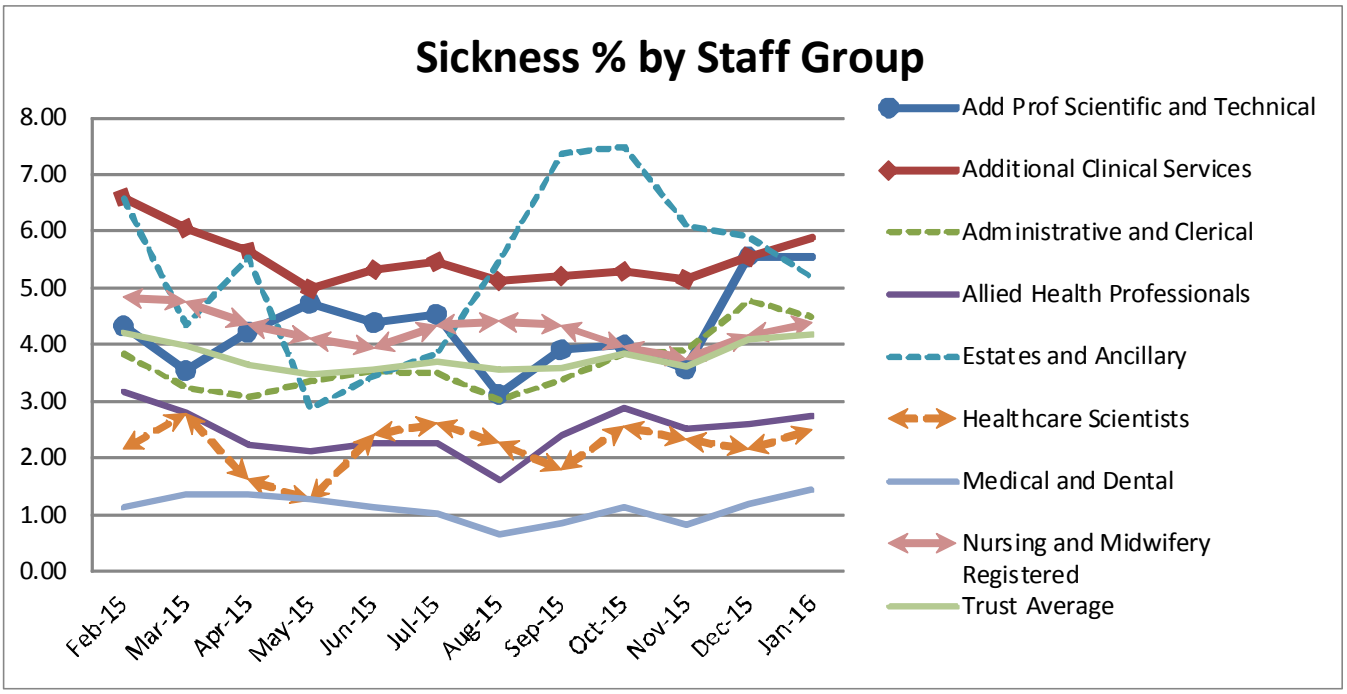
	Metric	Target	Current Position
	Sickness Absence	3.5 %	**4.19%**
	Turnover Rate	7.5%	**14.9%**
	Statutory Training	85%	**85%**
	Appraisal Rate	90%	**86%**

- Sickness absence in January 2016, when compared with January 2015 has decreased from 4.33% to 4.19%. The data is showing the seasonal pattern we would expect to see based on previous years.
- A graph showing sickness by staff group has been included. In line with the findings of Lord Carter in his February 2016 report, sickness levels for support to clinical staff are the highest in the Trust. Similarly, in line with the report findings, the sickness rates for the medical staff are the lowest in the Trust.
- The Trust appraisal rate has improved in January 2016 and is now at 86%, although below the target rate of 90%.
- The Statutory Training Compliance Rate remains at 85% - the Trust target rate.
- The turnover rate for January 2016 is 14.9% - a slight increase on last months figure of 14.7% Please note that the Turnover figure has been brought into line with that reported nationally and now includes staff leaving the Trust due to TUPE and Junior Doctors rotations.
- Turnover has also been reported by staff group and by site—again including and excluding junior doctors.
- There is a significant risk in regard to statutory training compliance, shown on page 23. In January 2016 911 staff were identified as not completing one or more of the statutory training courses required.

Trust Sickness

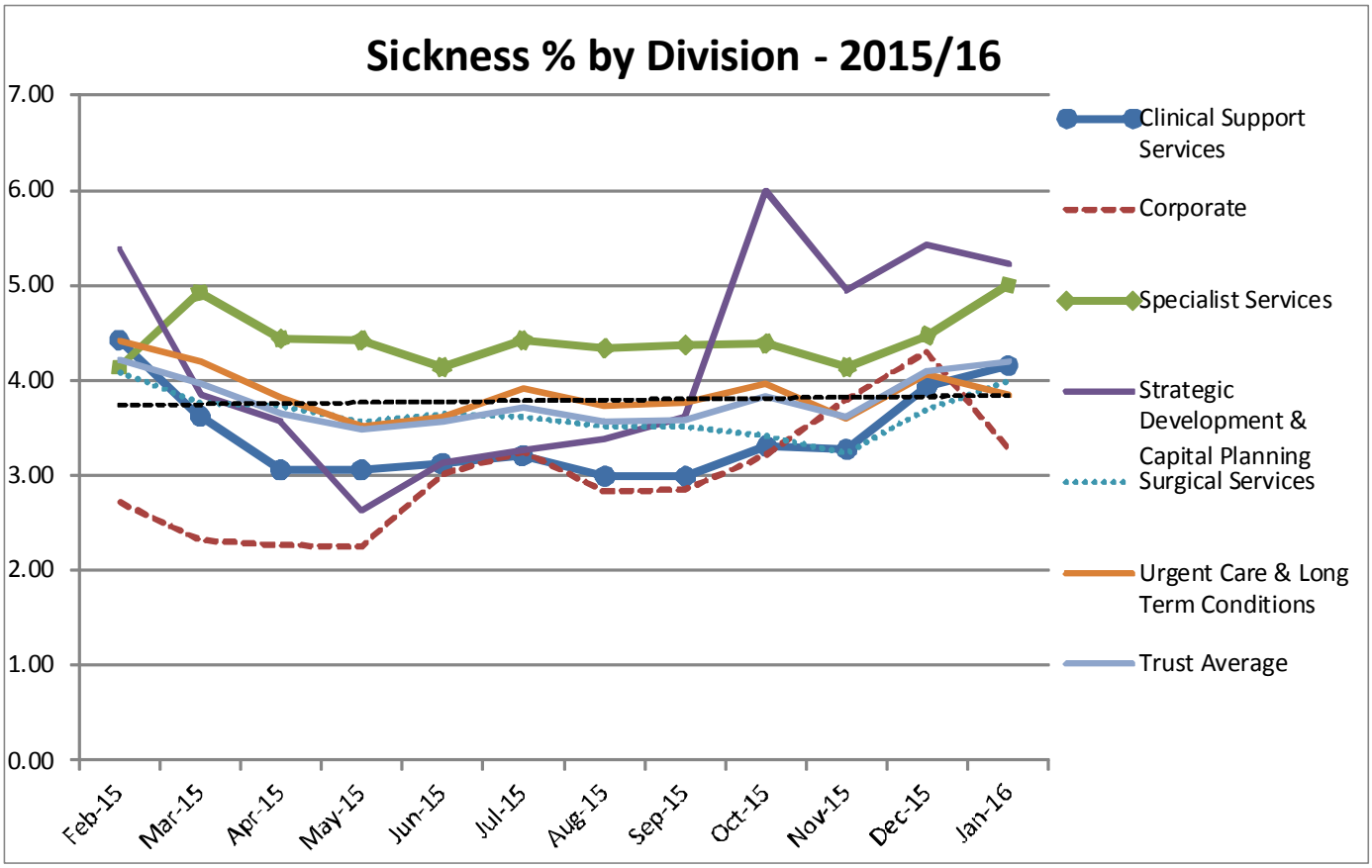


The sickness rate in January 16 is 4.19%, which is lower than it was in January last year. Overall, there has been a slight downward trend in the Sickness rate over the last couple of years, which is evident from the trend line on the graph above.



The Estates and Ancillary staff group has shown an increase in sickness rates in the second half of 2015, but has started to decline. Medical and Dental staff have consistently had the lowest sickness % *Source: ESR*

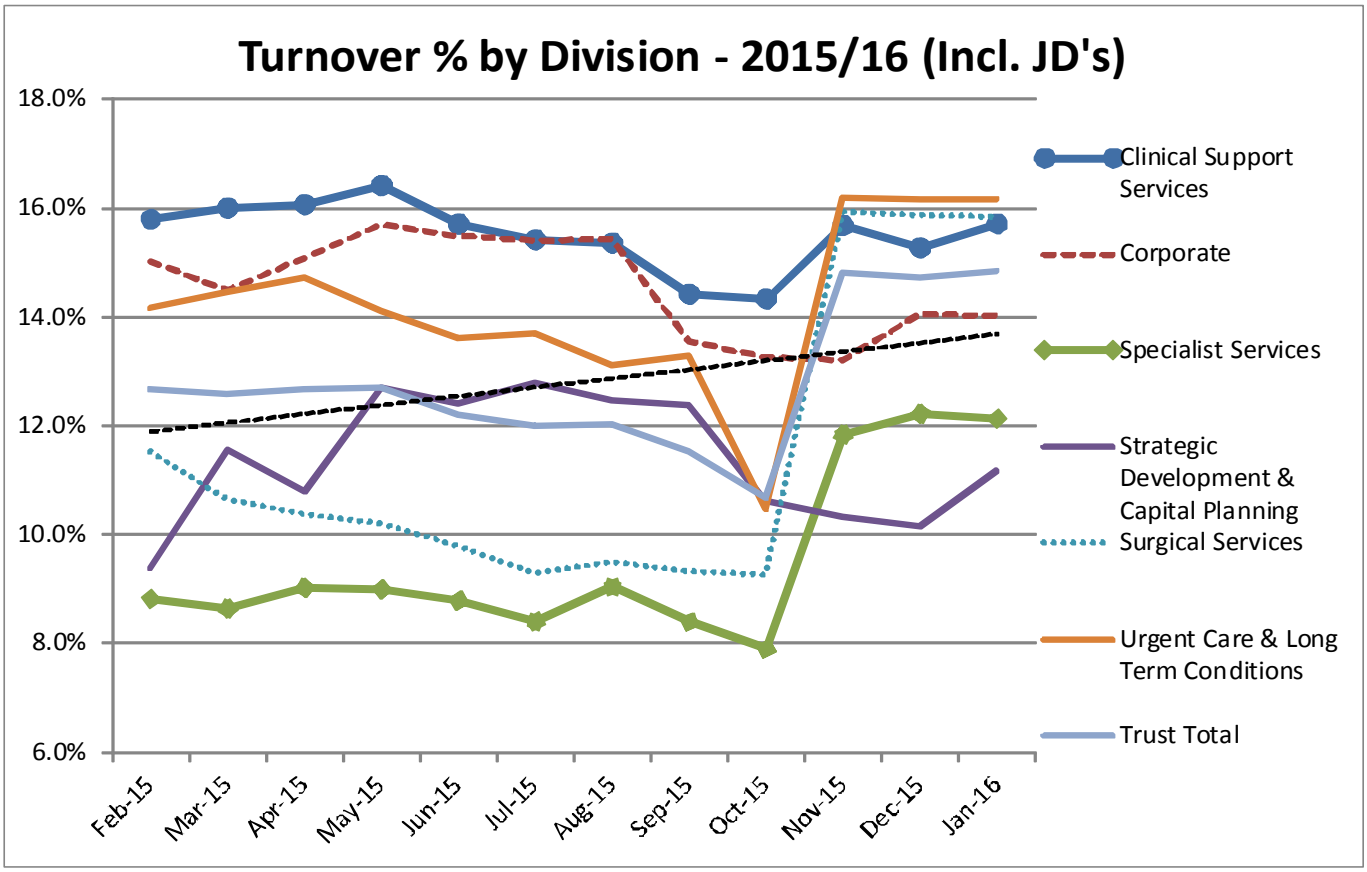
Trust Sickness

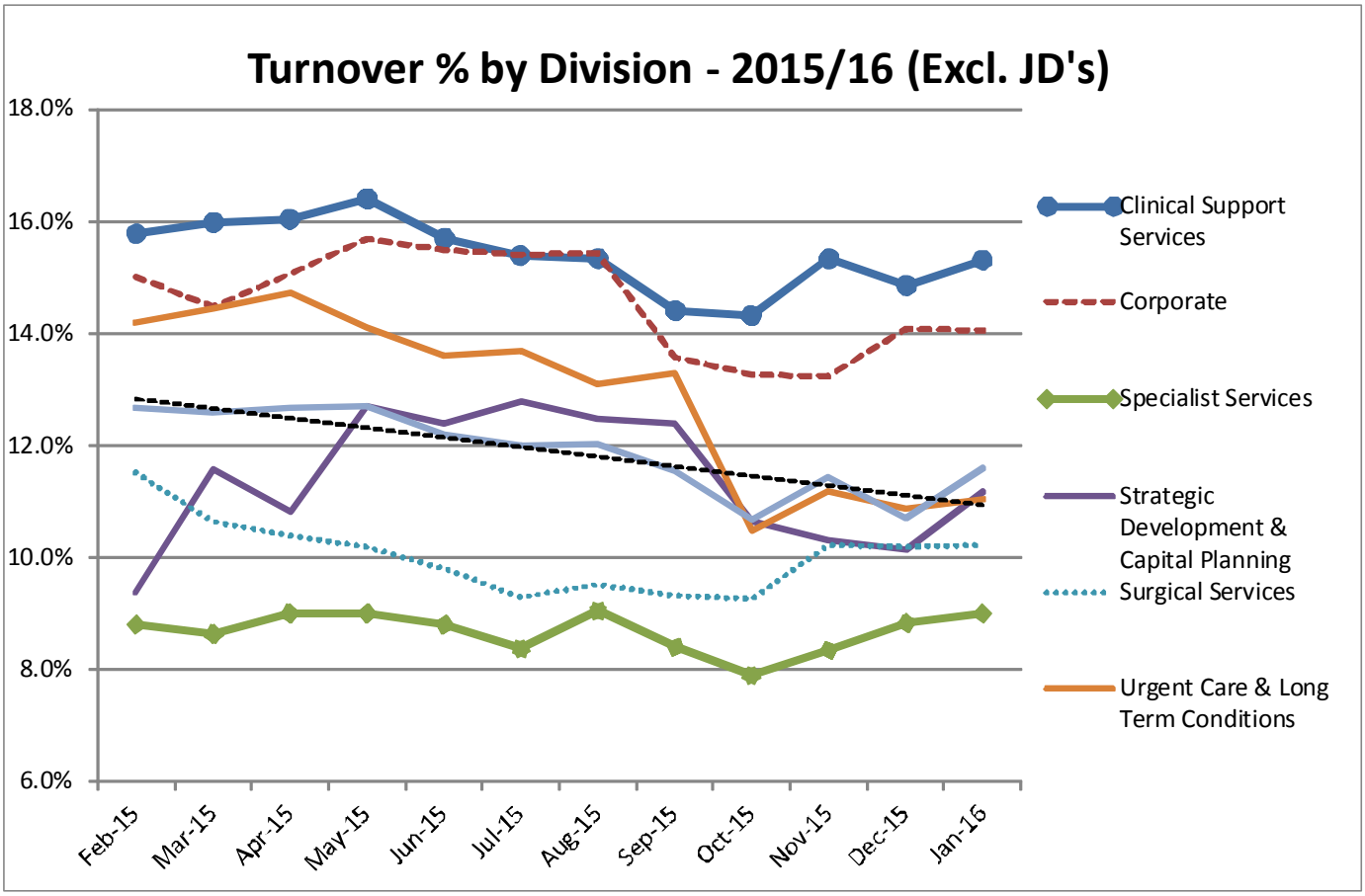


The Trust sickness absence rate for January 2016 is 4.19%. This is lower than the same period in 2014/15 when the rate was 4.33%. *Source : ESR*

The HRBPs have provided a commentary on these statistics later in the document.

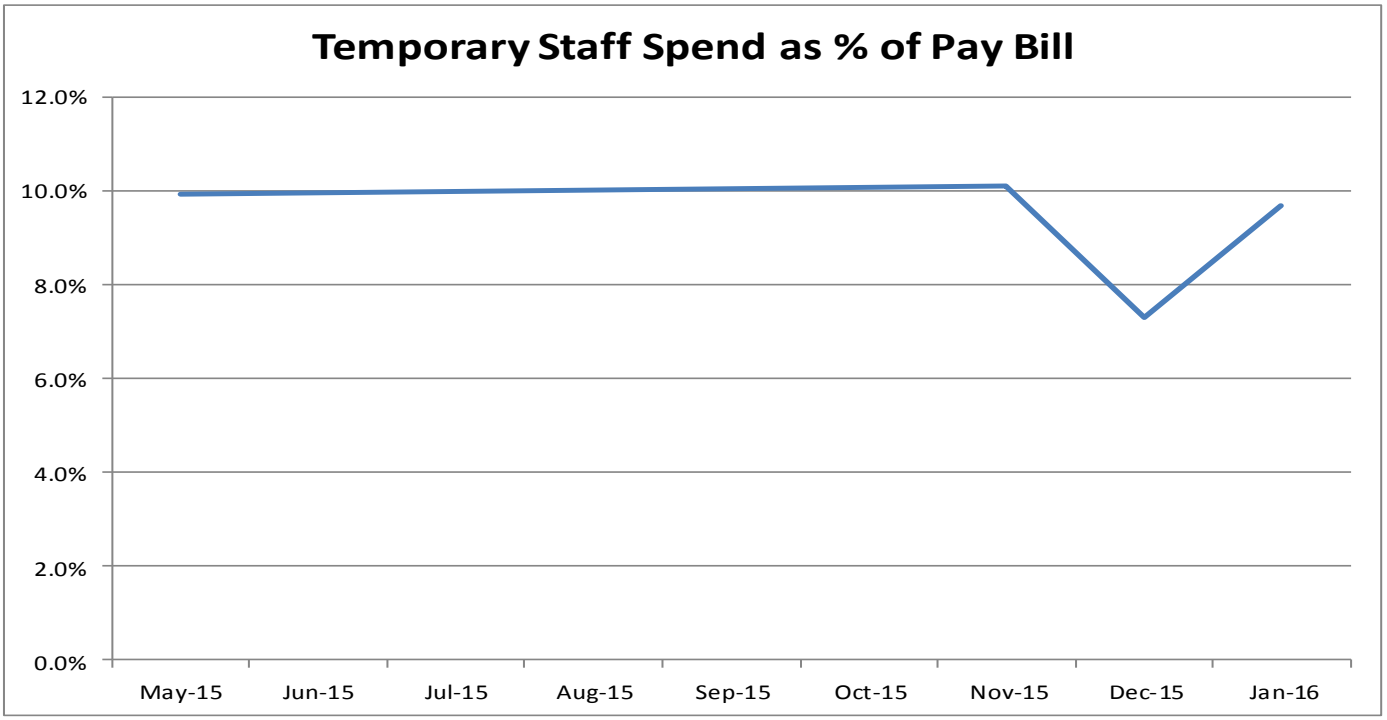
Turnover % by Division



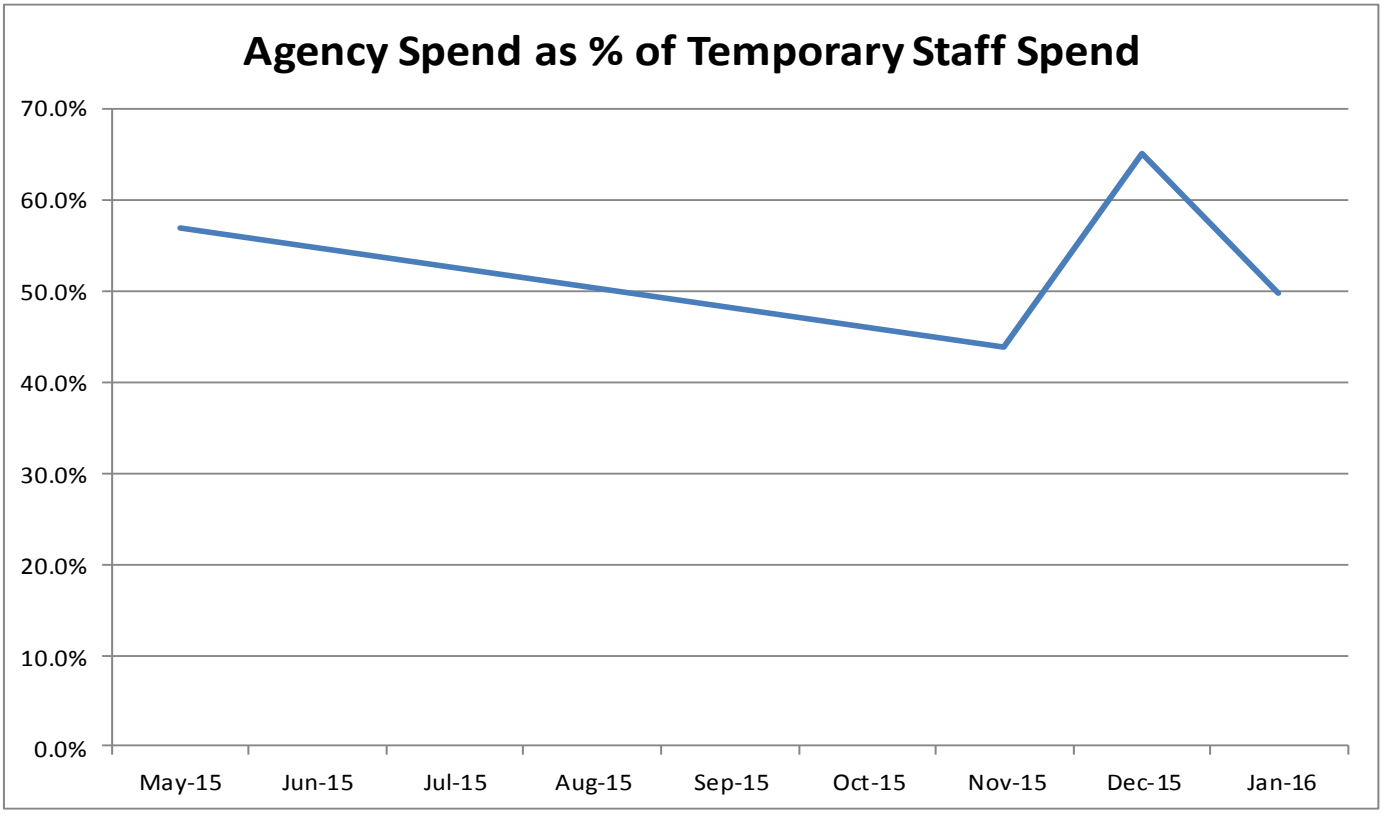


Source : ESR

Temporary Staffing

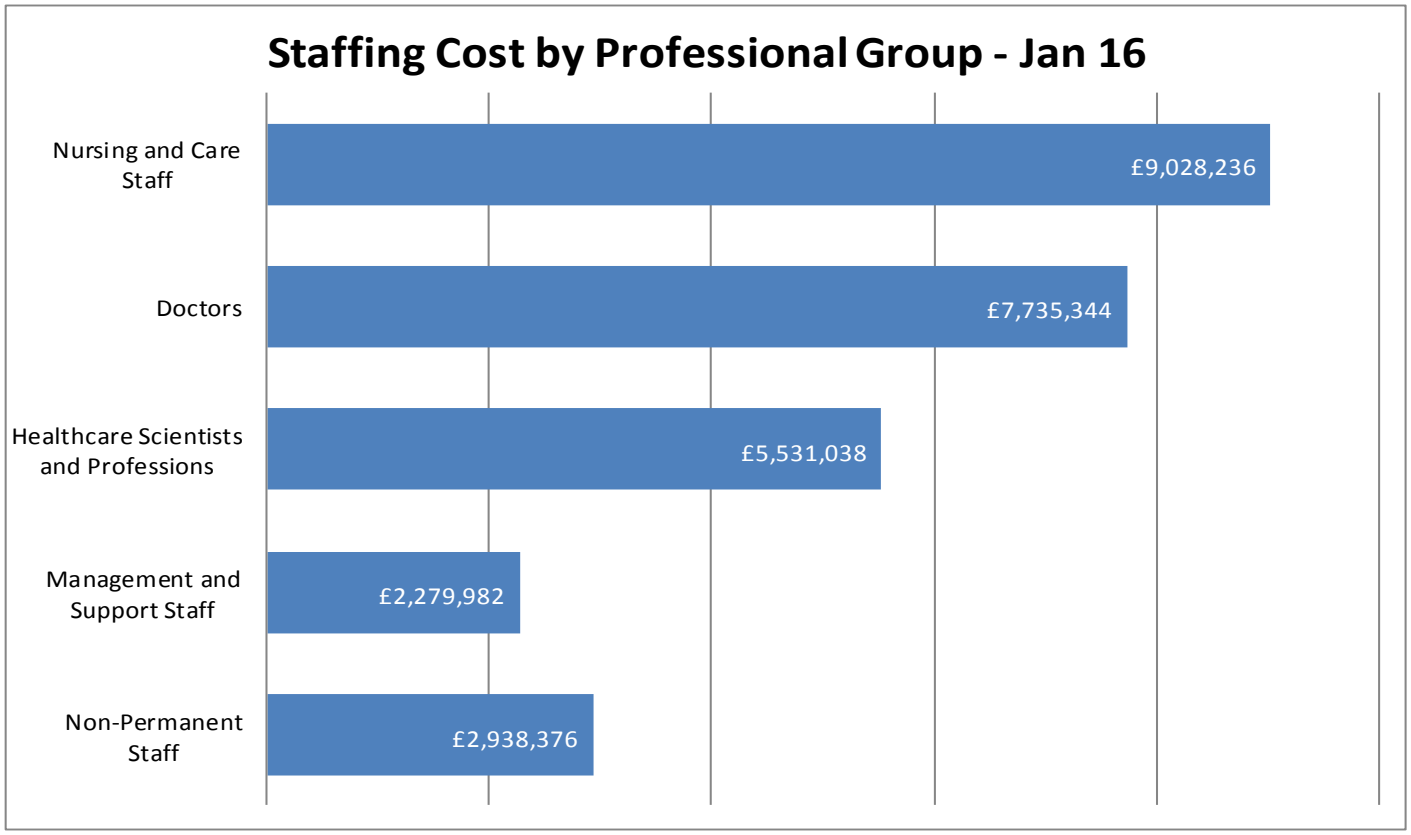


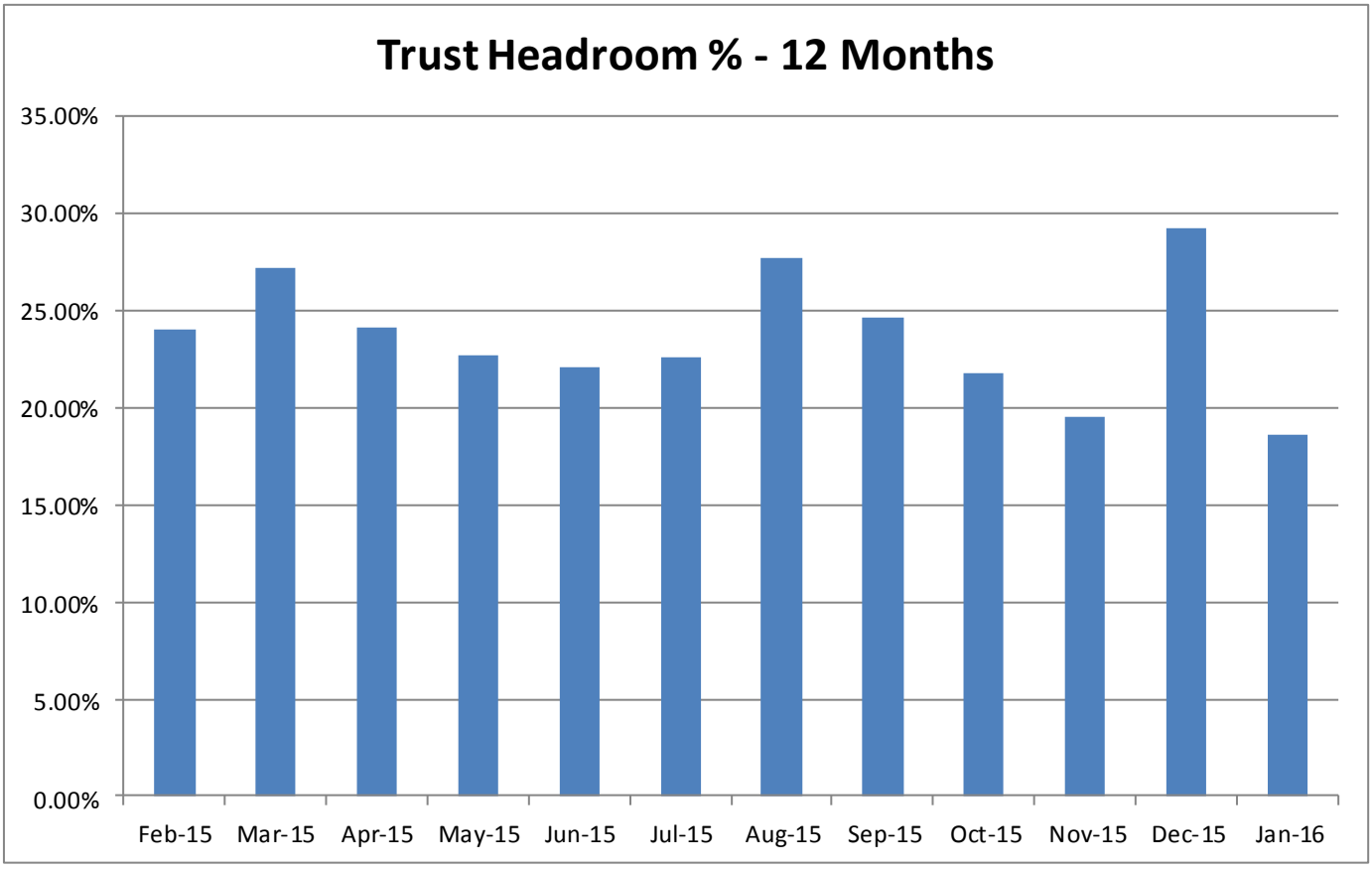
December saw a significant reduction in the % of the Pay Bill that is made up of Temporary Staffing costs, however, this trend has reversed for January 2016. There are currently only 4 data points on this graph, which limits the trend analysis that is possible.



January has seen a decrease in the % of the Temporary Staff bill that is made up of Agency Staffing Spend. As with the graph above, we only currently have 4 data points and as the data set expands we should be in a better position to identify trends.

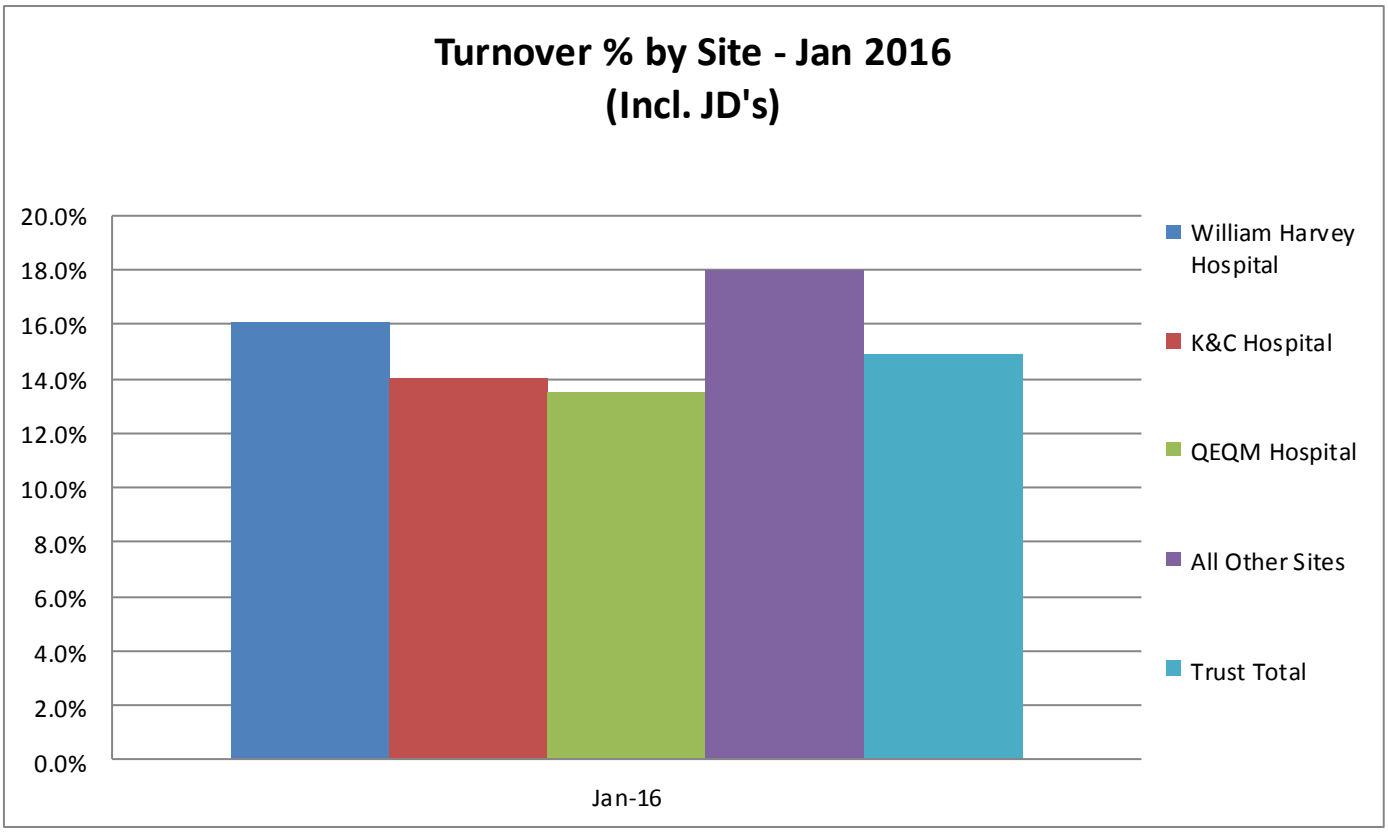
Staffing Cost and Headroom



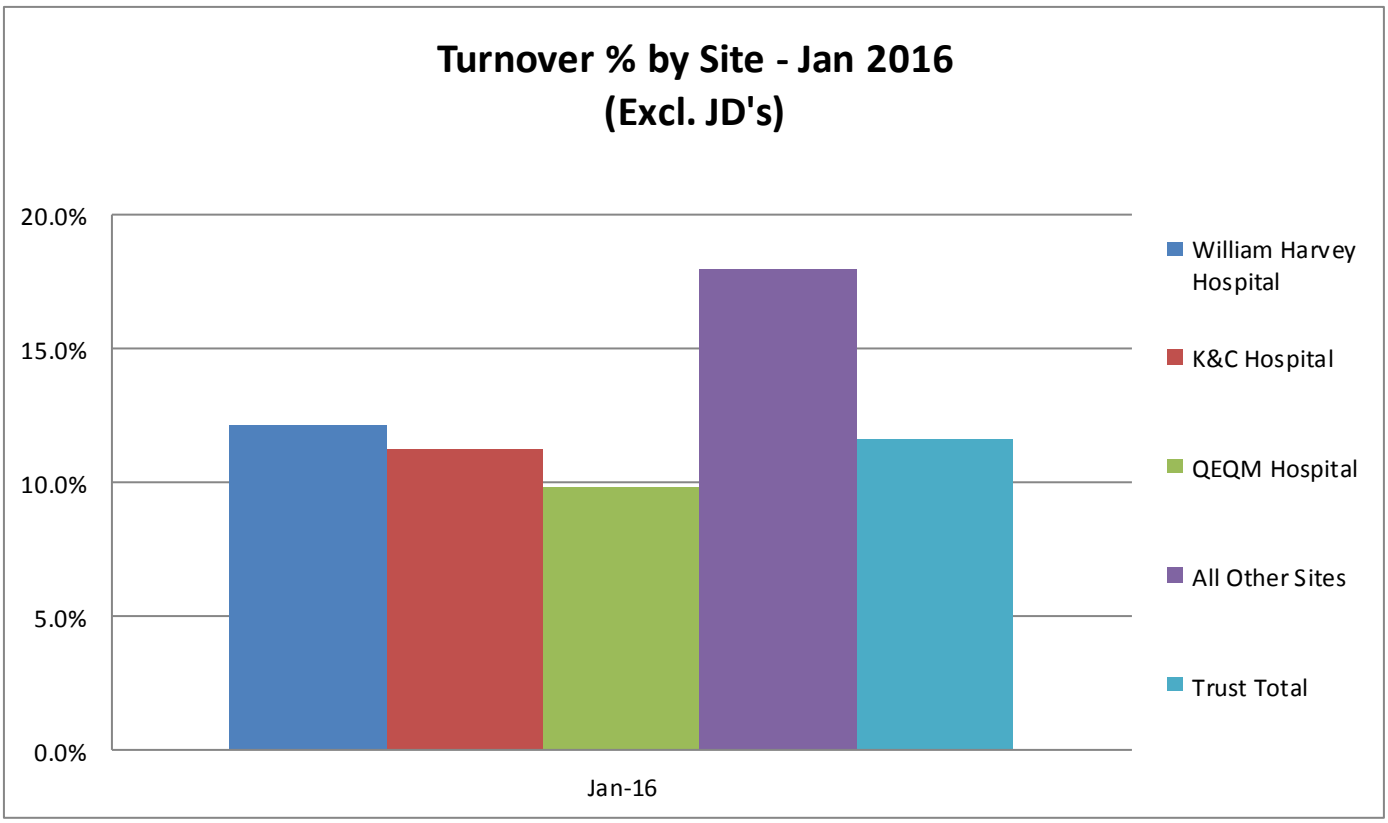


The graph above shows the Headroom % for the Trust for the 12 months up to and including January 2016. The headroom represents the total % of staff who are unavailable to work each month due to planned and unplanned absence. *Source: ESR*

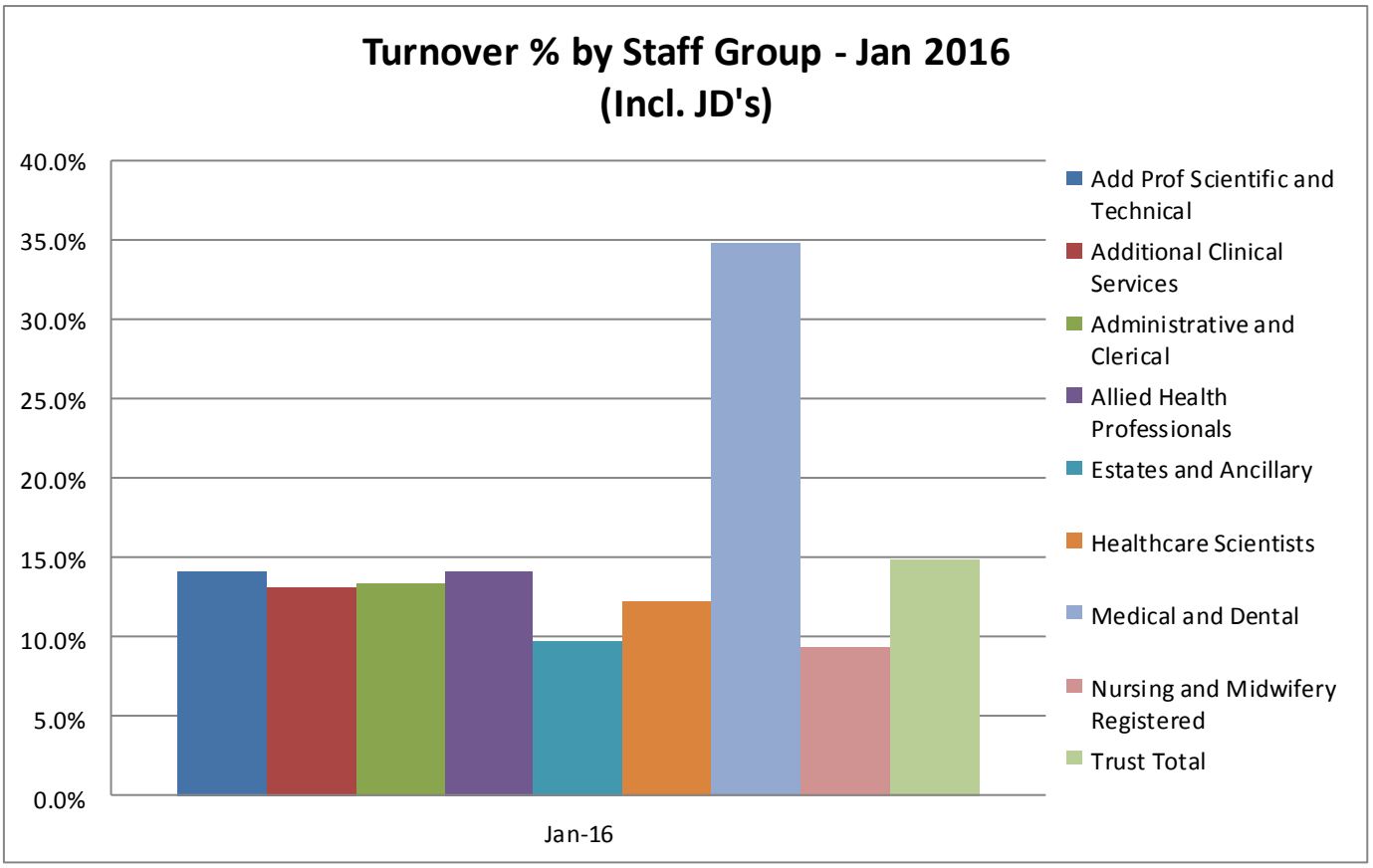
Turnover % by Site

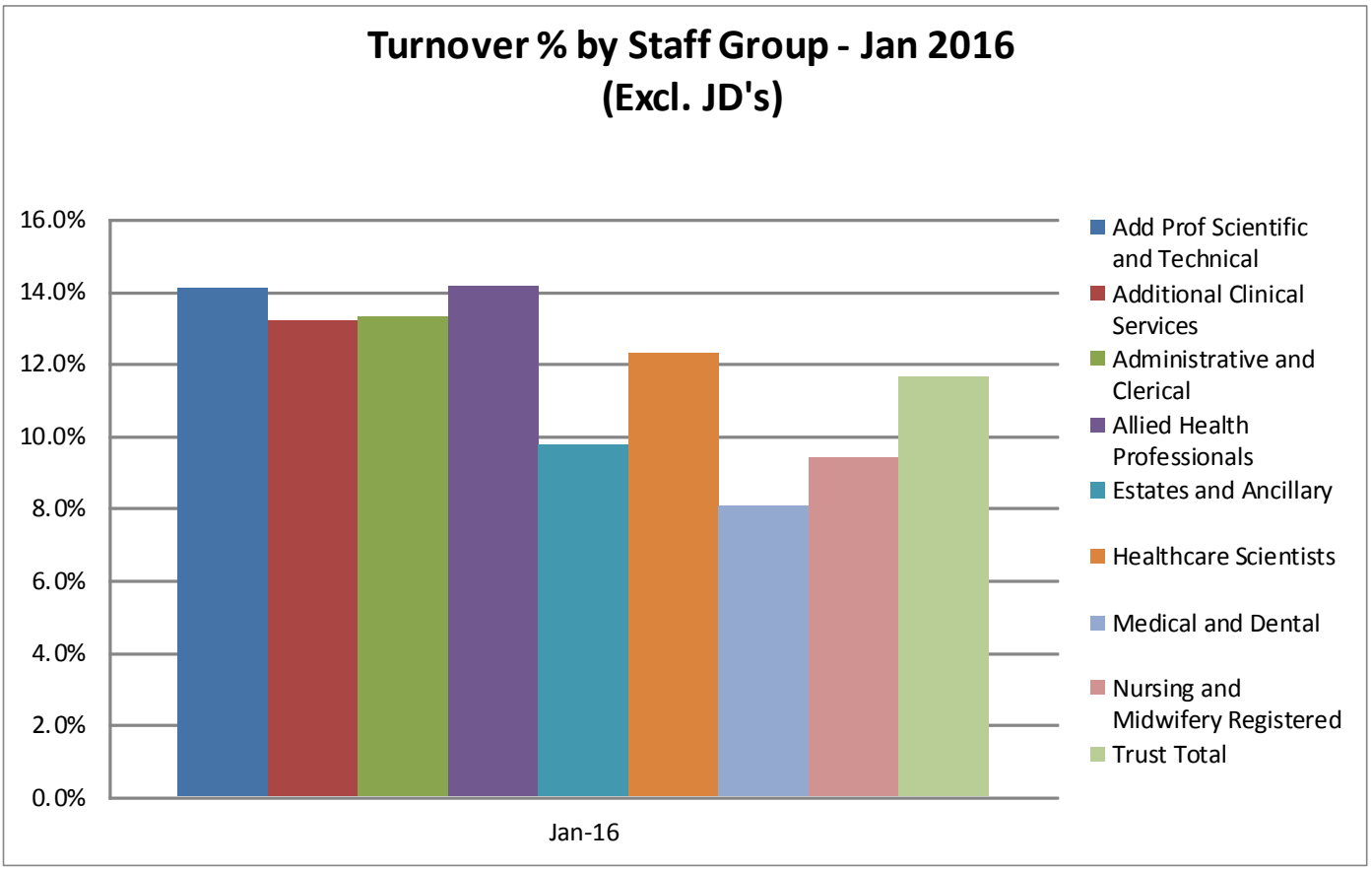


Please note that the 'other' category includes for example: Buckland Hospital, Royal Victoria Hospital, renal satellite units and any employee who has their site recorded as 'Home'. This would include community based midwives and hospital-at-home nurses. *Source: ESR*



Turnover % by Staff Group





Source : ESR

Turnover % by Division and Directorate

The graphs on the previous 2 pages show turnover rates by Division and month, for the last 12 months, and turnover by site and staff group in January 2016.

We are now calculating Turnover in two different ways—both inclusive and exclusive of Junior Doctors. Both sets of figures include staff who have TUPE'd out of the organisation. The figure which includes Junior Doctors has been provided so as to offer a better comparison with other Trust's and to try and eliminate the disparity between Turnover rate we report internally and that which is reported nationally through HSCIC iView. It is this change in the method of calculating turnover which is largely responsible for the large increase between October and November.

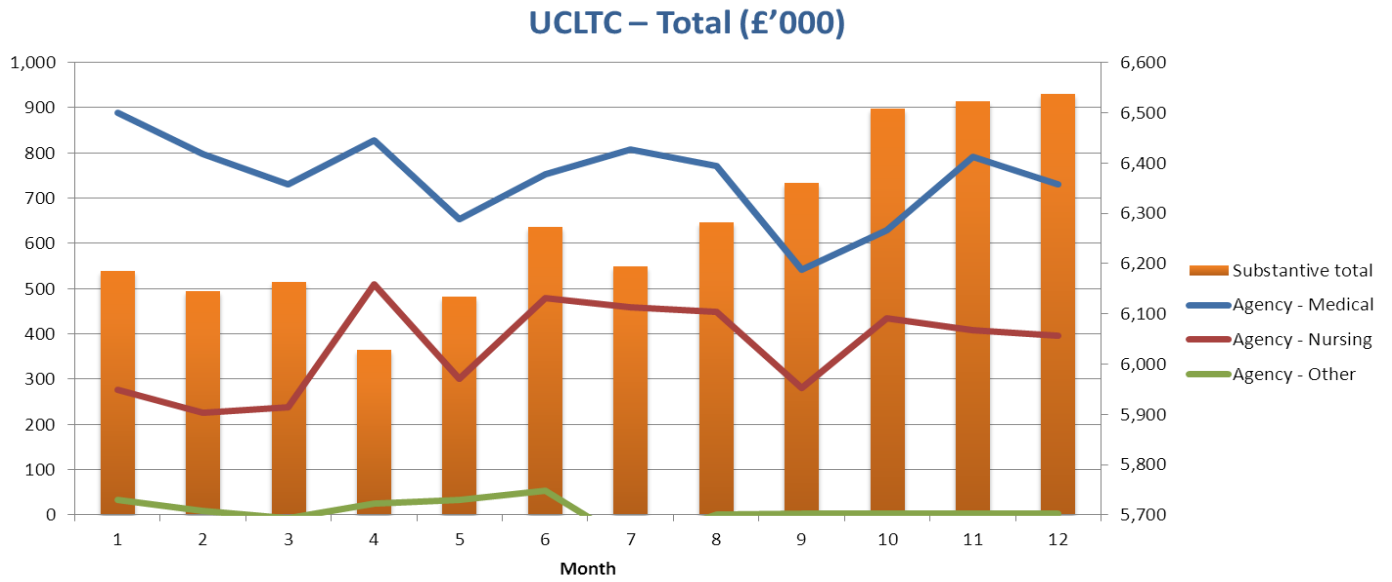
Comparison with local Trusts shared with the Board previously showed our turnover was within the range for NHS organisations in Kent, Surrey and Sussex. However the average for all large acute Trusts in December was 12.54%.

Source : ESR and iView

Agency Trajectories

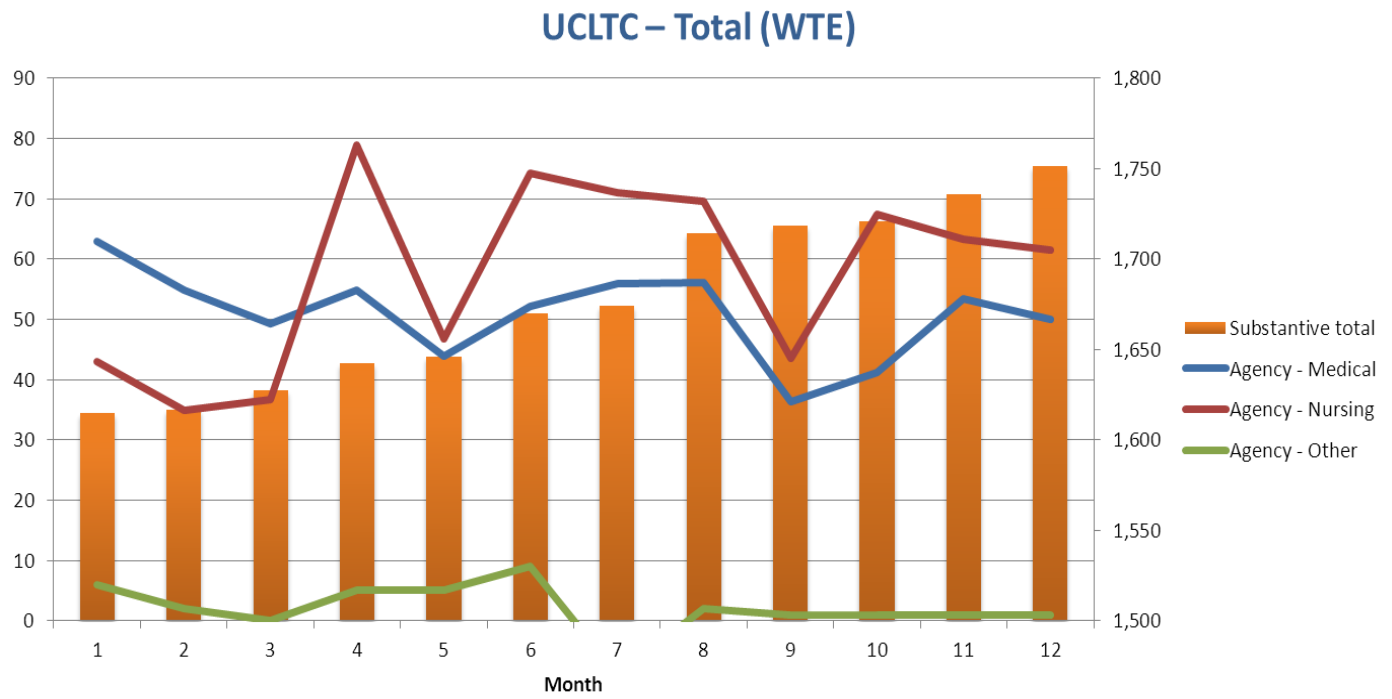
The Divisions have shared 15/16 agency trajectories at the regular Divisional Challenge Turnaround meetings. The trajectories based on January data are overleaf. These will shortly be updated with February data. UCLTC have designed an agency tracker which they are in the process of completing, which is also to be shared with the other Divisions to enable a common format for 16/17 agency trajectories to be published.

2015/16 Agency Trajectories—UCLTC



£'000	April	May	June	July	August	September	October	November	December	January	February	March
Substantive total	**6,185**	**6,146**	**6,164**	**6,028**	**6,135**	**6,272**	**6,195**	**6,282**	**6,360**	**6,508**	**6,523**	**6,538**
Agency - Medical	890	797	730	828	653	753	807	772	542	629	792	731
Agency - Nursing	277	226	237	509	301	478	458	449	281	435	408	397
Agency - Other	32	10	-7	25	34	53	-62	0	3	2	2	2
Agency - Total	**1,199**	**1,033**	**961**	**1,362**	**988**	**1,285**	**1,203**	**1,220**	**825**	**1,067**	**1,202**	**1,129**
TOTAL PAY	**8,583**	**8,211**	**8,086**	**8,752**	**8,111**	**8,842**	**8,600**	**8,723**	**8,010**	**8,642**	**8,927**	**8,797**

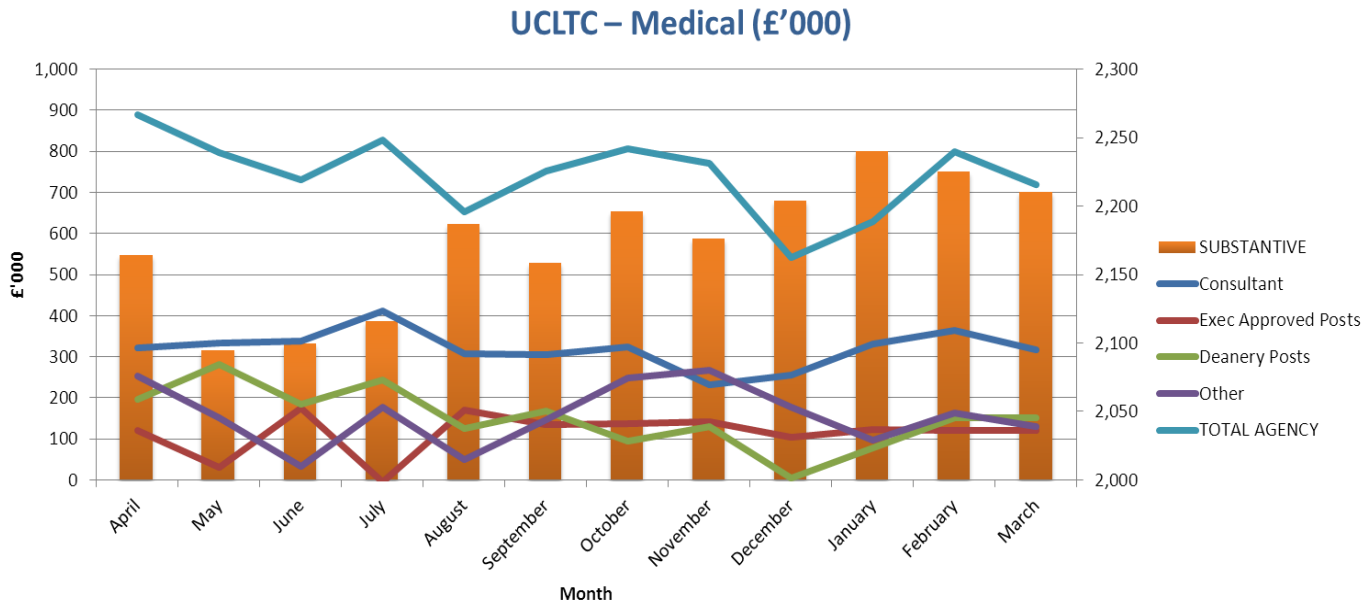
MOVEMENT	**0**	**-372**	**-125**	**666**	**-641**	**731**	**-241**	**122**	**-712**	**631**	**286**	**-130**



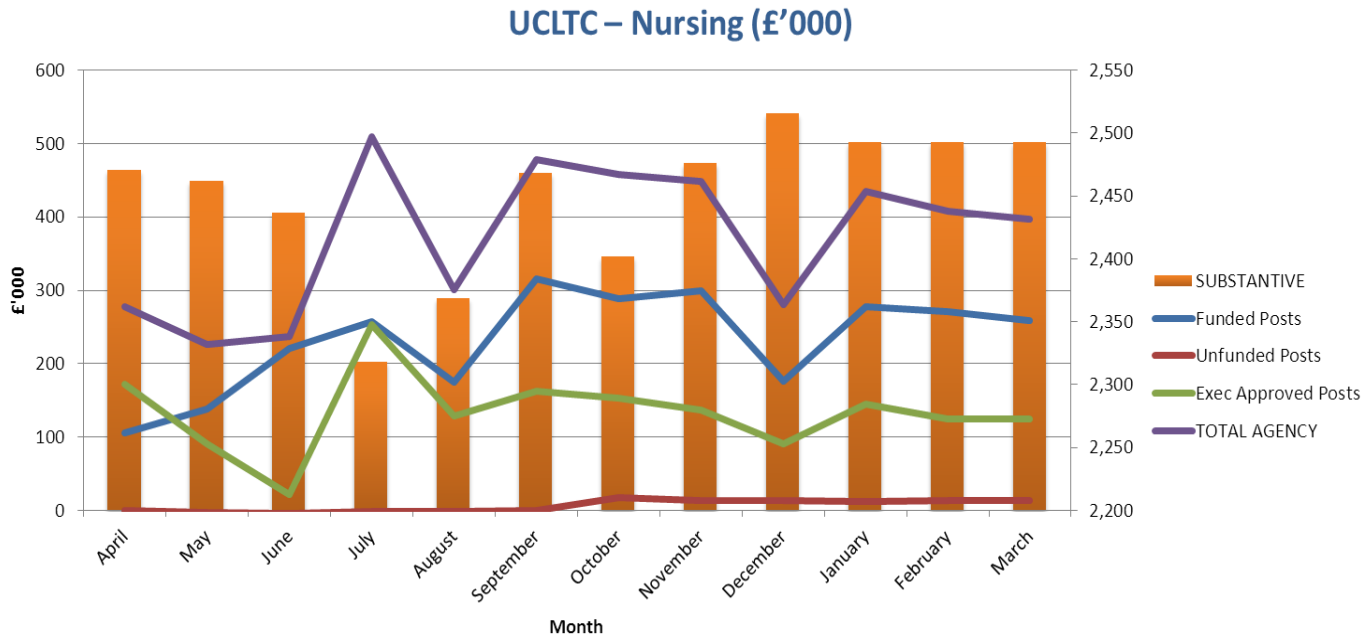
WTE	April	May	June	July	August	September	October	November	December	January	February	March
Substantive total	**1,615**	**1,617**	**1,628**	**1,642**	**1,646**	**1,670**	**1,675**	**1,714**	**1,719**	**1,721**	**1,736**	**1,751**
Agency - Medical	63	55	49	55	44	52	56	56	36	41	53	50
Agency - Nursing	43	35	37	79	47	74	71	70	44	67	63	61
Agency - Other	6	2	0	5	5	9	-9	2	1	1	1	1
Agency - Total	**112**	**92**	**86**	**139**	**96**	**135**	**118**	**128**	**81**	**110**	**118**	**112**
TOTAL WTE	**1,839**	**1,800**	**1,800**	**1,920**	**1,837**	**1,941**	**1,911**	**1,970**	**1,881**	**1,940**	**1,972**	**1,976**

MOVEMENT	**0**	**-39**	**-1**	**120**	**-83**	**104**	**-30**	**59**	**-89**	**60**	**31**	**4**

2015/16 Agency Trajectories—UCLTC

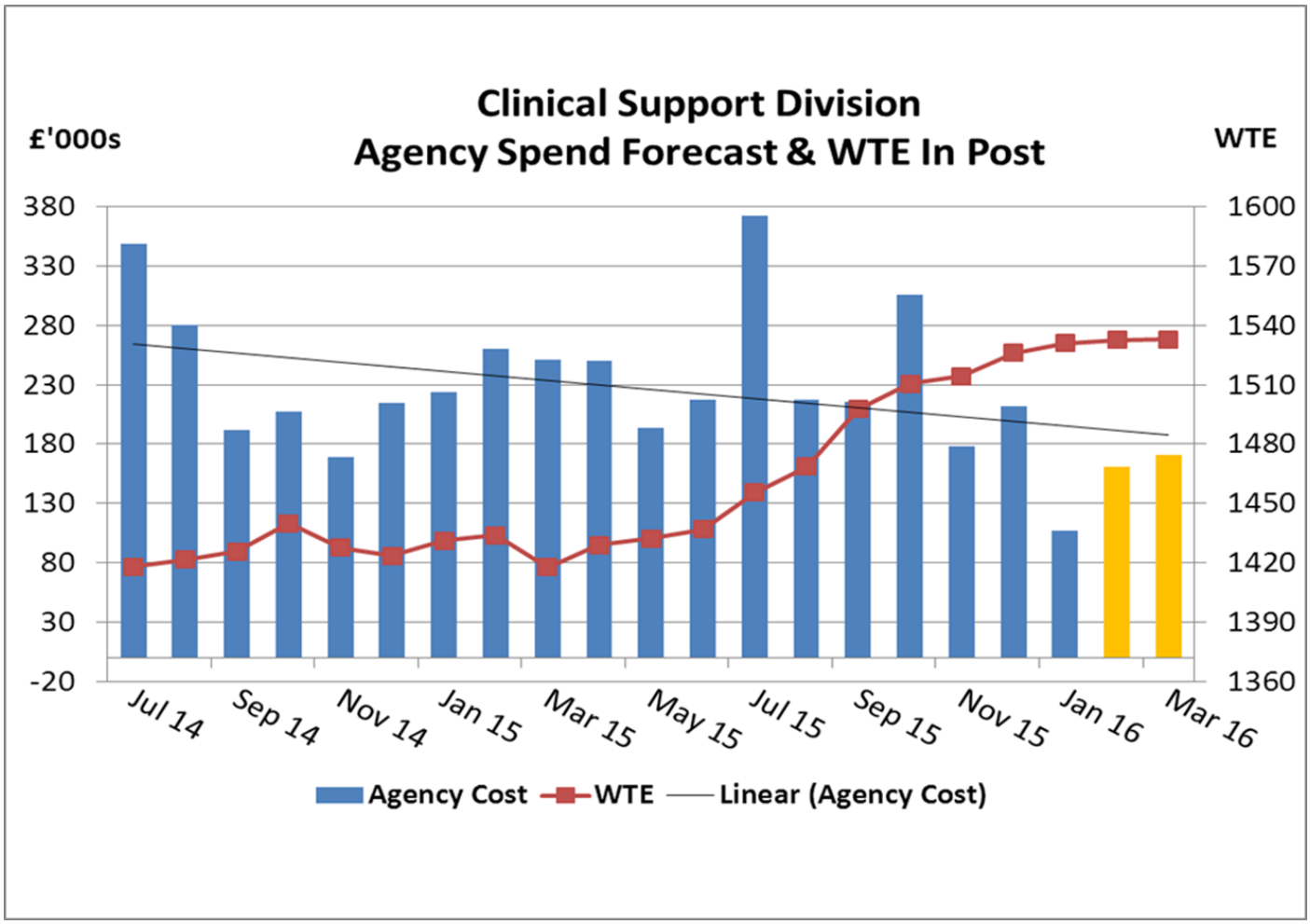


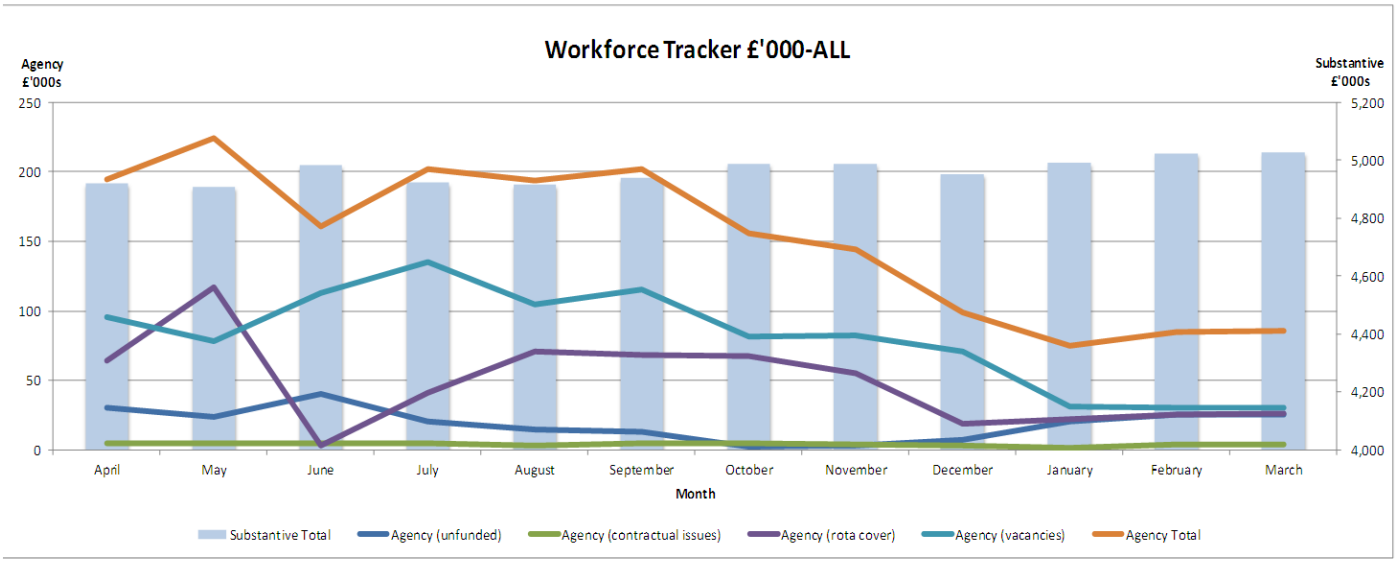
£'000	April	May	June	July	August	September	October	November	December	January	February	March
Consultant	321	334	338	411	308	305	324	233	255	331	363	318
Exec Approved Posts	121	31	174	-6	170	136	138	141	104	122	121	121
Deanery Posts	195	281	184	244	126	167	96	130	5	79	151	151
Other	252	151	34	178	49	146	249	268	176	97	157	141
TOTAL AGENCY	890	797	730	828	653	753	807	772	542	629	792	731
SUBSTANTIVE	2,164	2,095	2,100	2,116	2,187	2,159	2,196	2,176	2,204	2,240	2,225	2,210



£'000	April	May	June	July	August	September	October	November	December	January	February	March
Funded Posts	106	138	220	257	174	316	288	299	176	278	271	259
Unfunded Posts	0	-3	-5	-1	-2	0	18	13	14	12	13	13
Exec Approved	171	90	21	253	129	162	152	137	91	145	124	124
TOTAL AGENCY	277	226	237	509	301	478	458	449	281	435	408	397
SUBSTANTIVE	2,471	2,462	2,437	2,318	2,369	2,469	2,402	2,476	2,516	2,493	2,493	2,493

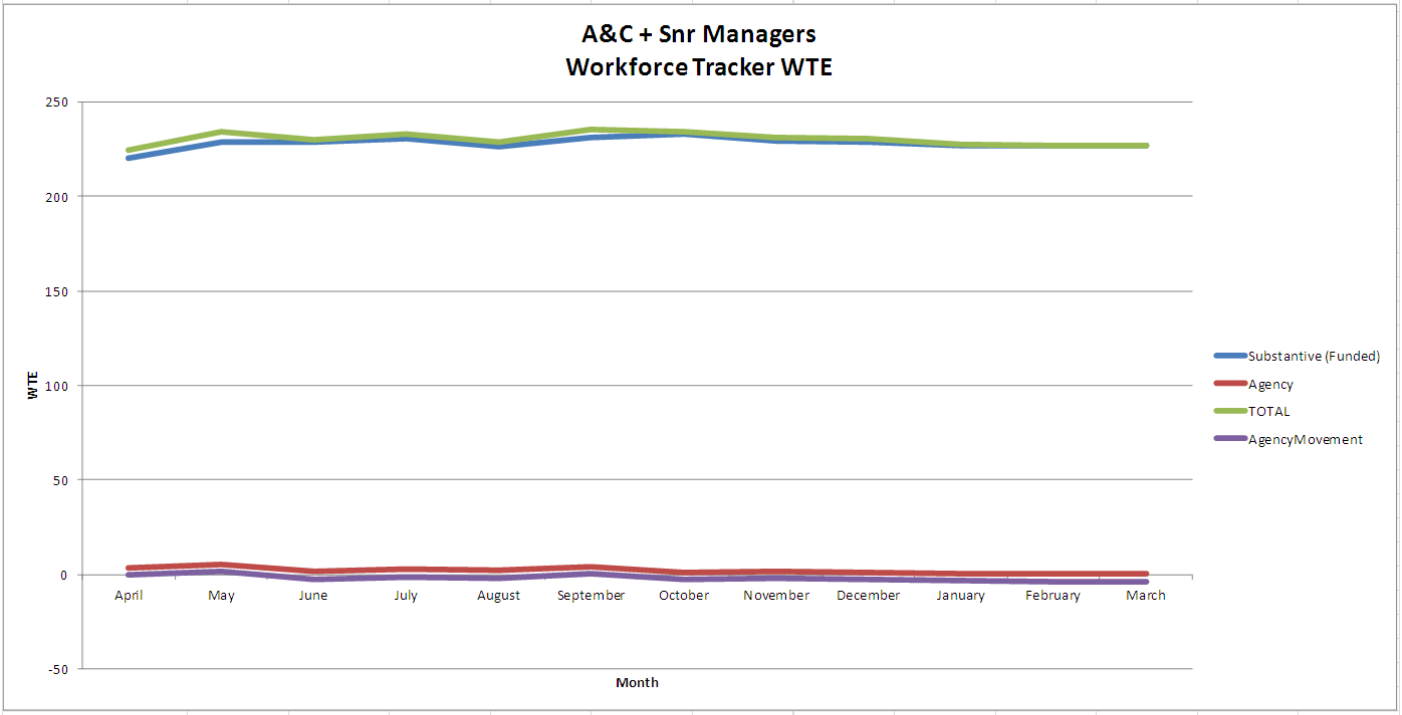
2015/16 Agency Trajectories—Clinical Support and Specialist Services



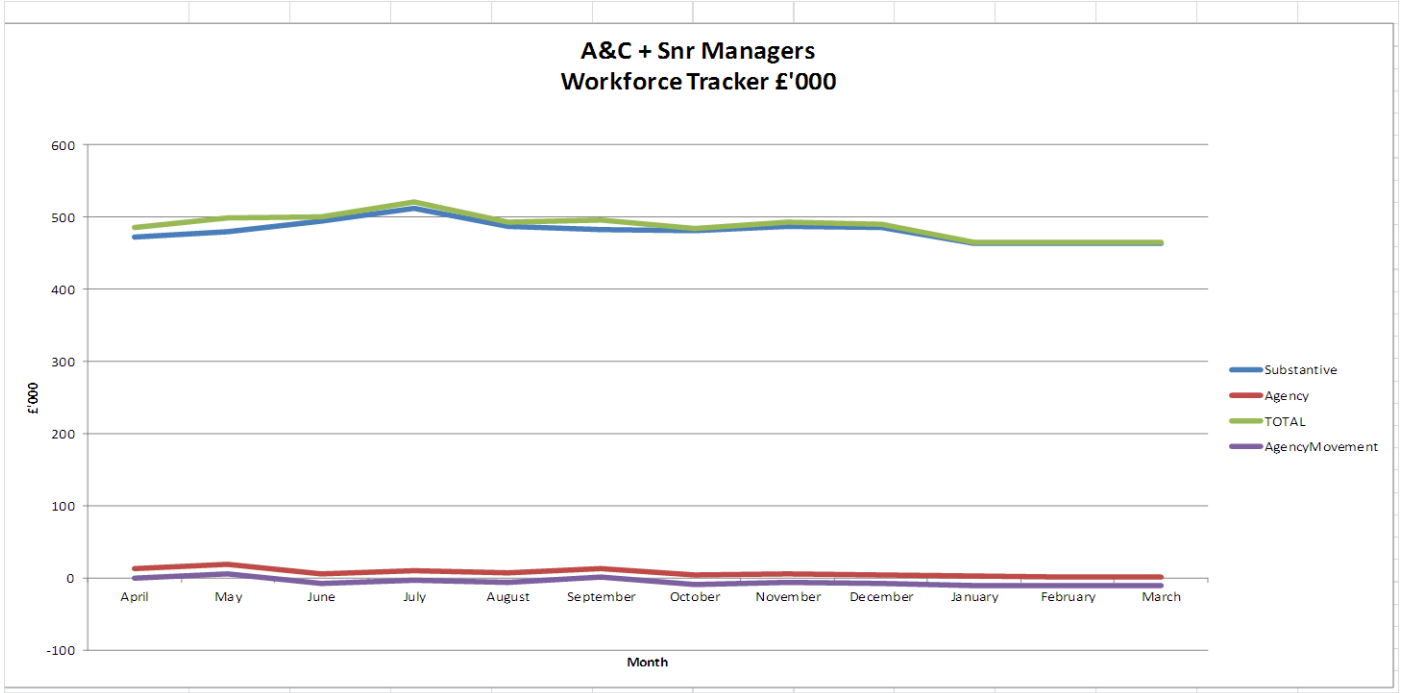


£'000	April	May	June	July	August	September	October	November	December	January	February	March
Substantive Total	4,919	4,907	4,981	4,921	4,914	4,937	4,988	4,986	4,952	4,990	5,023	5,026
Agency (unfunded)	30	24	41	21	15	13	2	3	7	20	25	25
Agency (contractual issues)	5	5	5	5	3	5	5	4	3	2	4	4
Agency (rota cover)	64	117	3	41	71	68	67	55	19	22	25	27
Agency (vacancies)	95	79	113	135	105	116	81	82	70	31	31	31
Agency Total	195	224	161	202	194	202	156	144	99	75	85	86
Total Pay	5,114	5,131	5,142	5,123	5,108	5,138	5,144	5,130	5,051	5,065	5,108	5,112
Agency Movement	0	30	-34	7	0	7	-38	-50	-95	-120	-110	-109

2015/16 Agency Trajectories—Surgical Services

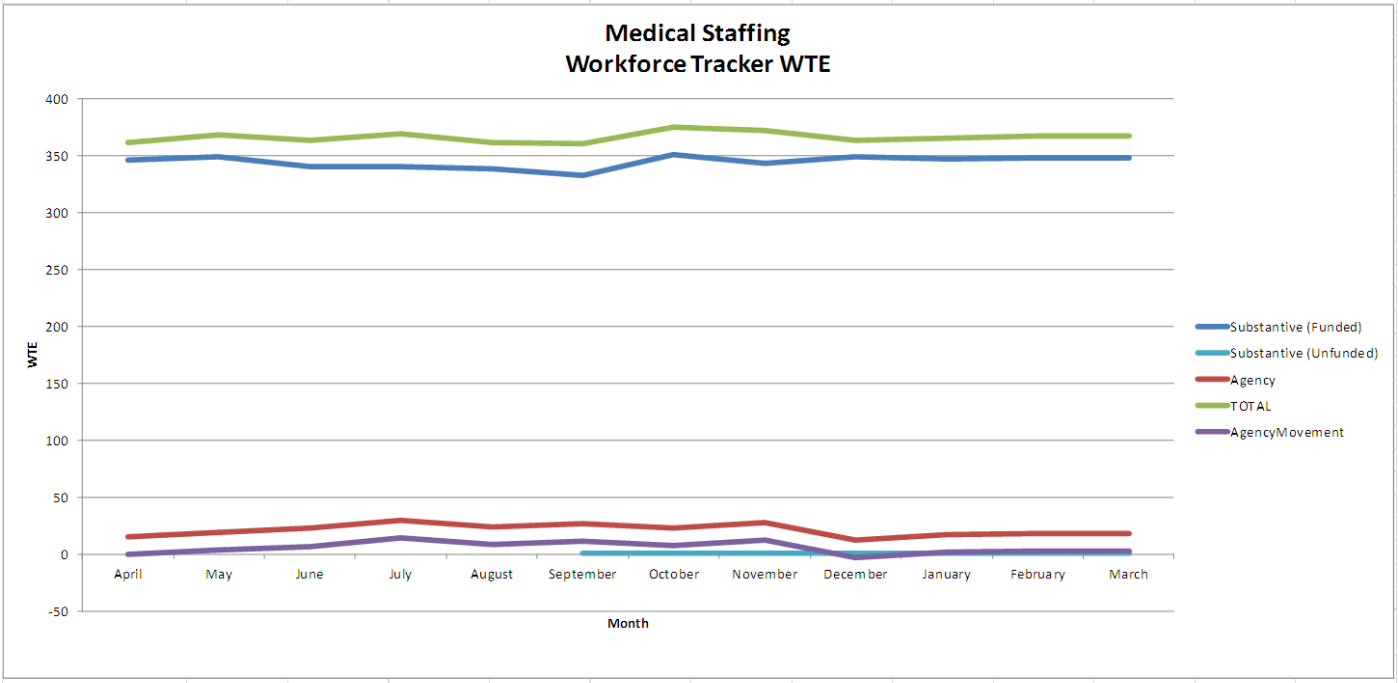


WTE	April	May	June	July	August	September	October	November	December	January	February	March
Substantive (Funded)	220	229	229	230	226	231	233	230	229	227	227	227
Substantive (Unfunded)	0	0	0	0	0	0	0	0	0	0	0	0
Agency	4	6	1	3	2	4	1	2	1	1	0	0
TOTAL	224	234	230	233	229	236	234	231	230	227	227	227
AgencyMovement	0	2	-2	-1	-2	0	-3	-2	-2	-3	-4	-4

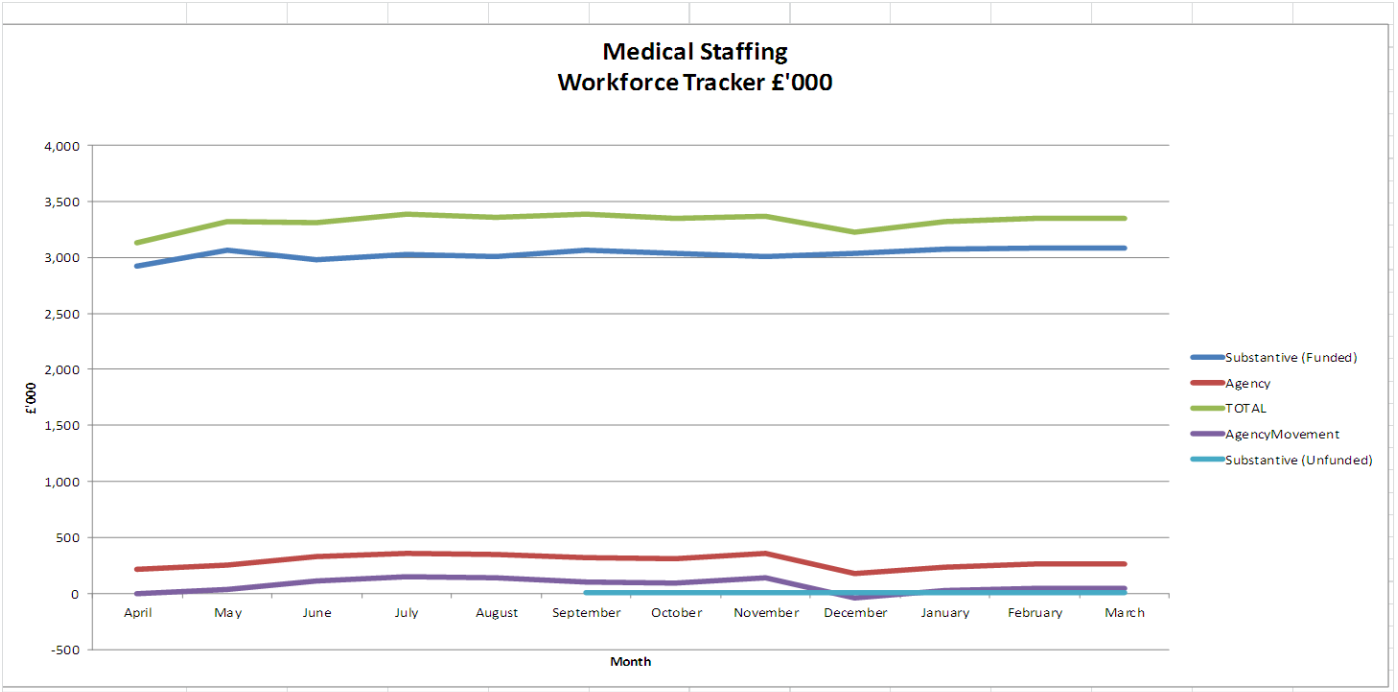


£'000	April	May	June	July	August	September	October	November	December	January	February	March
Substantive	473	480	495	512	487	483	481	487	486	463	463	463
Substantive (Unfunded)	0	0	0	0	0	0	0	0	0	0	0	0
Agency	13	18	5	9	7	13	3	6	5	2	1	1
TOTAL	485	498	500	521	493	496	485	493	490	465	464	464
AgencyMovement	0	6	-8	-3	-6	1	-9	-7	-8	-11	-12	-12

2015/16 Agency Trajectories—Surgical Services

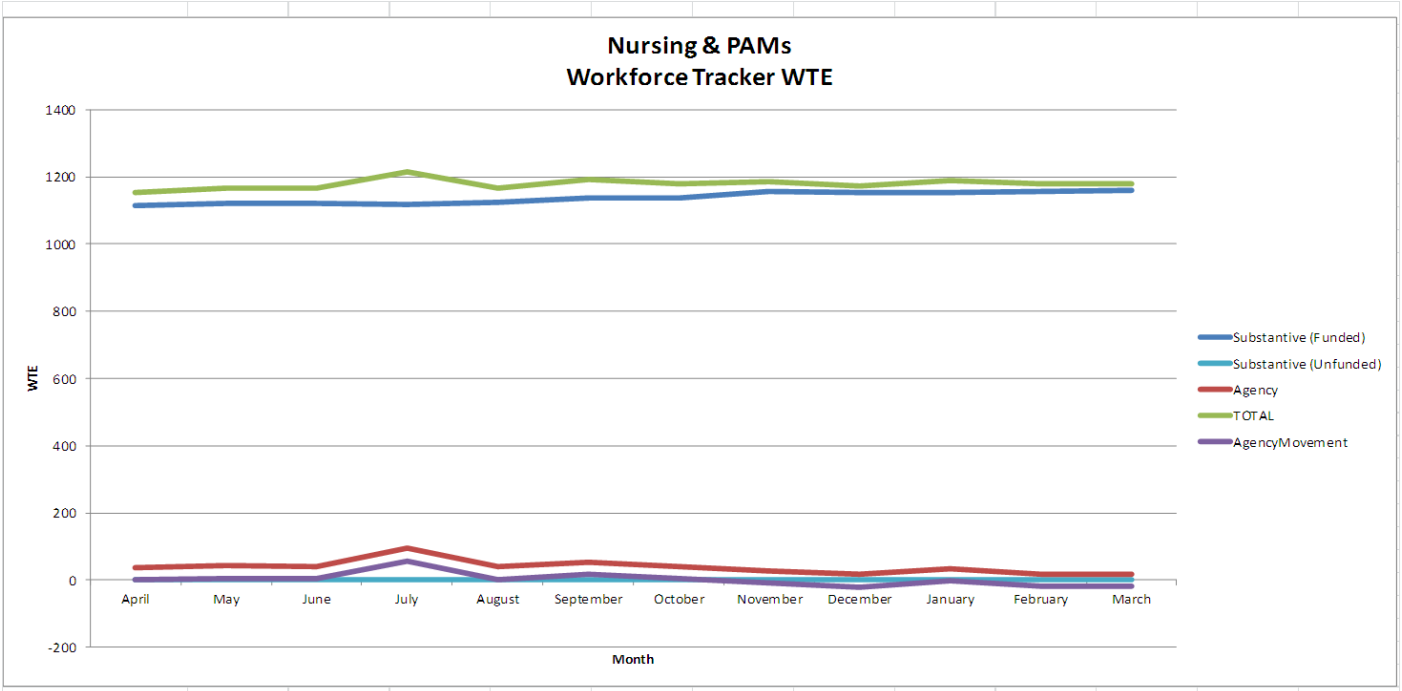


WTE	April	May	June	July	August	September	October	November	December	January	February	March
Substantive (Funded)	347	349	341	340	338	333	351	344	349	347	348	348
Substantive (Unfunded)						1	1	1	1	1	1	1
Agency	15	19	23	29	24	27	23	28	13	17	19	19
TOTAL	362	368	363	370	362	361	375	373	363	365	368	368
AgencyMovement	0	4	7	14	8	11	8	13	-3	2	3	3

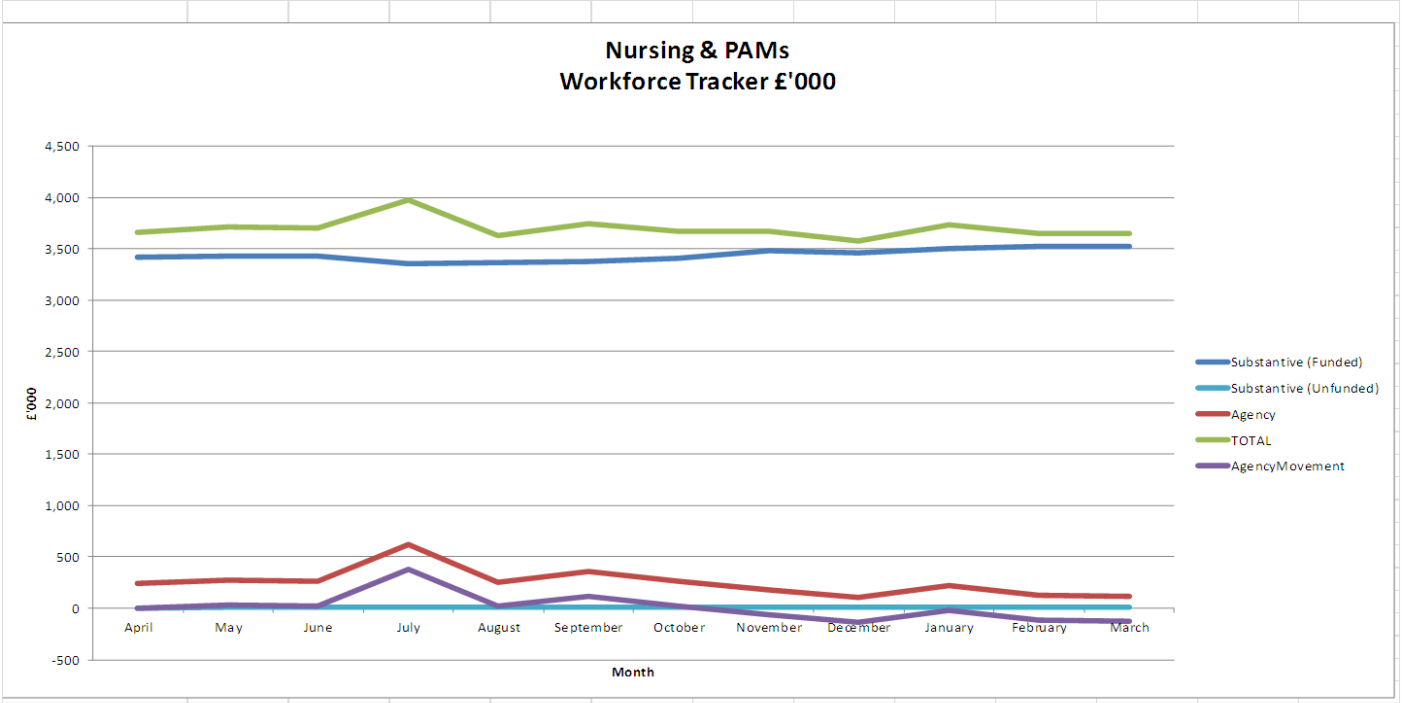


£'000	April	May	June	July	August	September	October	November	December	January	February	March
Substantive (Funded)	2,920	3,069	2,982	3,028	3,004	3,062	3,032	3,005	3,039	3,073	3,081	3,081
Substantive (Unfunded)						6	8	8	8	8	8	8
Agency	215	253	325	362	352	317	308	356	174	237	262	262
TOTAL	3,135	3,322	3,307	3,390	3,356	3,384	3,348	3,368	3,221	3,318	3,351	3,351
AgencyMovement	0	38	110	146	137	101	93	140	-41	22	47	47

2015/16 Agency Trajectories—Surgical Services



WTE	April	May	June	July	August	September	October	November	December	January	February	March
Substantive (Funded)	1116	1122	1122	1117	1126	1136	1137	1156	1155	1152	1156	1159
Substantive (Unfunded)	0	3	3	3	3	3	3	3	3	3	3	3
Agency	37	42	41	95	39	54	40	28	16	33	19	18
TOTAL	1153	1167	1165	1215	1168	1193	1180	1187	1174	1188	1178	1180
AgencyMovement	0	5	4	58	3	17	3	-9	-20	-3	-18	-19



£'000	April	May	June	July	August	September	October	November	December	January	February	March
Substantive (Funded)	3,418	3,430	3,432	3,352	3,362	3,379	3,405	3,479	3,462	3,506	3,519	3,529
Substantive (Unfunded)	0	14	8	7	7	7	8	8	8	8	8	8
Agency	239	273	264	617	257	353	260	181	106	218	125	115
TOTAL	3,657	3,717	3,704	3,977	3,626	3,740	3,673	3,667	3,576	3,731	3,651	3,651
AgencyMovement	0	34	25	378	18	114	21	-58	-133	-21	-114	-124

Divisional Commentary— UCLTC

Urgent Care & Long Term Conditions

Sickness Absence

The Division saw a notable increase in sickness absence in January 2016 to 4.07%. Some areas of increased absence have been identified, with further analysis underway to continue the identification of those areas contributing to the increase. A number of actions have been agreed by the Division to mitigate and reduce the risk including; building capacity of managers to effectively manage sickness absence through coaching and master classes, addressing short term sickness absence as a priority, agree a sickness absence reduction trajectory for 2016/17 which the Division is committed to achieve.

Mandatory Training & Appraisals

The Division has seen a continued upward trend in Appraisal and Mandatory training compliance. Following a 10% improvement in appraisal compliance over the last 12 months, the Division will be focusing on ensuring that appraisals are of a high quality, including the implementation of the new Appraisal policy and paperwork. To improve mandatory training performance the Division will focus on staff who have one or more mandatory training module which they have never completed.

Recruitment

Positive progress continues to be made to recruit doctors in hard to fill specialties including A&E, Respiratory, Acute Medicine and Neurology.

Whist further cohorts of overseas nurses are anticipated to join the Division in March and again in the summer, the Division is still challenged in recruiting experienced nurses, particularly to wards at QEQM. Work is underway with the Head of Strategic Resourcing to identify recruitment interventions specifically for QEQM.

Where significant recruitment challenges continue, the Division is engaged in identifying opportunities for new roles including Science Graduate roles to develop our own Cardio physiologists, Physicians Associates, Advanced Nurse Practitioners, wider use of Nurse Consultants and Apprentices in administrative roles.

Job planning

The Division is currently an outlier in its progress of job planning. There is commitment to have 50% of job plans in cohort 1 signed off by Clinical Leads by the end of March 2016 and work is underway to develop a trajectory for completion of the remaining 50%.

Culture

The Division aspires to have one Great Place to Work Action Plan which covers recruitment and retention actions, workforce planning actions and staff survey actions. A Divisional steering group is being established to lead on staff engagement of the plan, ensuring input from staff at all levels across the Division so they are involved in the development and delivery of the plan.

Carolyn Apps, HRBP – Urgent Care & Long Term Conditions

Divisional Commentary—CSSD

Overall as a division our workforce indicators are good, there are some areas that show a pattern and interlink with overall performance and culture within certain teams.

Sickness % has increased to 3.9% - hotspots are outpatients and pharmacy. Absence cost now published as part of the HR KPIs on a monthly basis. Teams have been asked to focus on the policy and identifying colleagues who are at the trigger and how we are managing those. Continuation of coaching and masterclasses

Turnover remains high as a Division, continued work on exit interviews and understanding why colleagues are leaving still taking place. This is now being transitioned into the Great Place to Work plan for the Division – which will include information from HR KPIs, Staff Survey and CQC (workforce actions). By having the one action plan it will simplify the process but should ensure focus on the key areas. A recruitment and retention strategy is currently being written for pathology following a SWOT session understanding the service and its risks. Jaz Mallan is engaged with HRBP to take this forward.

Mandatory training and appraisals remain strong with mandatory training green and appraisal rate at 90%. Teams understand the colleagues who are at risk by not completing mandatory training and have a plan in place to deliver this. The key challenge for the division is to ensure that managers are trained and understand the new appraisal paperwork and that we use this in a meaningful way from day one. This will also support us in building our talent plan and pipeline.

The workforce information that was produced in the last month was cost focused alongside the standard HR KPIs, we had paid sick costs and also expenses – ensuring that managers are understanding and able to make judgement overall as a workforce.

A weekly recruitment panel within the division continues and focuses on recruitment of new colleagues, planned agency spend, overtime and change forms.

Staff survey conversations are planned and we will be having an approach which involves all levels within a team and this will feed into a CSSD overall plan.

Louise Goldup—HRBP, CSSD

Divisional Commentary—Surgical Services

Sickness Absence continues to track lower than last year, as the Division continues to monitor sickness absence very closely and is effectively using Employee Relations and Occ Health to support when necessary. The Division remains below Trust average and all other Divisions.

Appraisal rates remain static, but continue to be above Trust average. Under reporting in General Surgery, and an additional 35 appraisal dates for Gen Surg were sent through to be recorded earlier this week. This should put General Surgery above 80%.

Mandatory Training rates also remain static, and the Division is now targeting those people who have never completed mandatory training subject areas.

The Division continues to focus on retention of staff, and the Divisional Turnover rate remains below the levels for the last three years. With the large amount of overseas and newly qualified nurses joining the Division in the last six months, and into the new financial year, the retention of these staff is vital to sustain quality and patient experience, and reduce agency spend.

Our vacancy rate in the Division has dropped from 10% a year ago to approx 6.5% now, mostly due to targeted recruitment of nursing staff. Nursing vacancies within the Division have dropped by almost 40 WTE in the last 8 months. Our use of temporary staff and overtime has continued to fall as the newly appointed nursing staff join.

Karl Woods—HRBP, Surgical Services

Divisional Commentary—Specialist Services

Vacancies

Dermatology vacancies and activity was discussed in detail. Confirmed that 2 Consultant posts and 1 Spec Dr post had been authorised through the panel and that General Manager and HRBP were working on options to recruit to these posts. They will be advertised in BMJ and also put to international framework agencies.

NICU and Chemotherapy Nursing vacancies and agency use were discussed and it was confirmed that Lead Nurse and HRBP were drafting a recruitment and retention strategy for the hard to recruit posts with long term and short term actions to enable exit dates to be agreed.

Sickness

Sickness rate overall has increased from 4.14% to 4.46% this month. This is above Trust average which is 4.10%. The Division agreed at EPR that trajectories need to be set for the Division overall and the particular areas of concern. These will be presented at the March EPR. There is a mix of long term and short term sickness absence which will take some time to manage down. The hotspot areas for December data are:

- Cancer Clinical Haematology moved from amber to red at 6.04% this month. Highest areas are Cathedral, Brabourne and Compliance. Sickness master classes delivered by Corporate HR set up in for 02/03/16.
- Women's Health sickness continues in red at 5.21%. Sickness absence master class delivered to Midwifery Matrons on 27/01/16. All sickness cases and management plans are reviewed by Head of Midwifery and HR Business Partner monthly, with one to one coaching taking place to support moving cases forward.
- Renal have also moved into red at 4.56%.The highest area was Thomas Beckett and Marlowe Ward at K&C. Sickness absence masterclass set up for 02/03/2016.

Work being completed now would not take effect until March/April figures which will be reported in May/June.

Mandatory Training

It was agreed that the Division needed to focus on the information governance metric which is currently at 67% as a Division. There were problems with this recording but as this is now resolved the Division need to concentrate on increasing this.

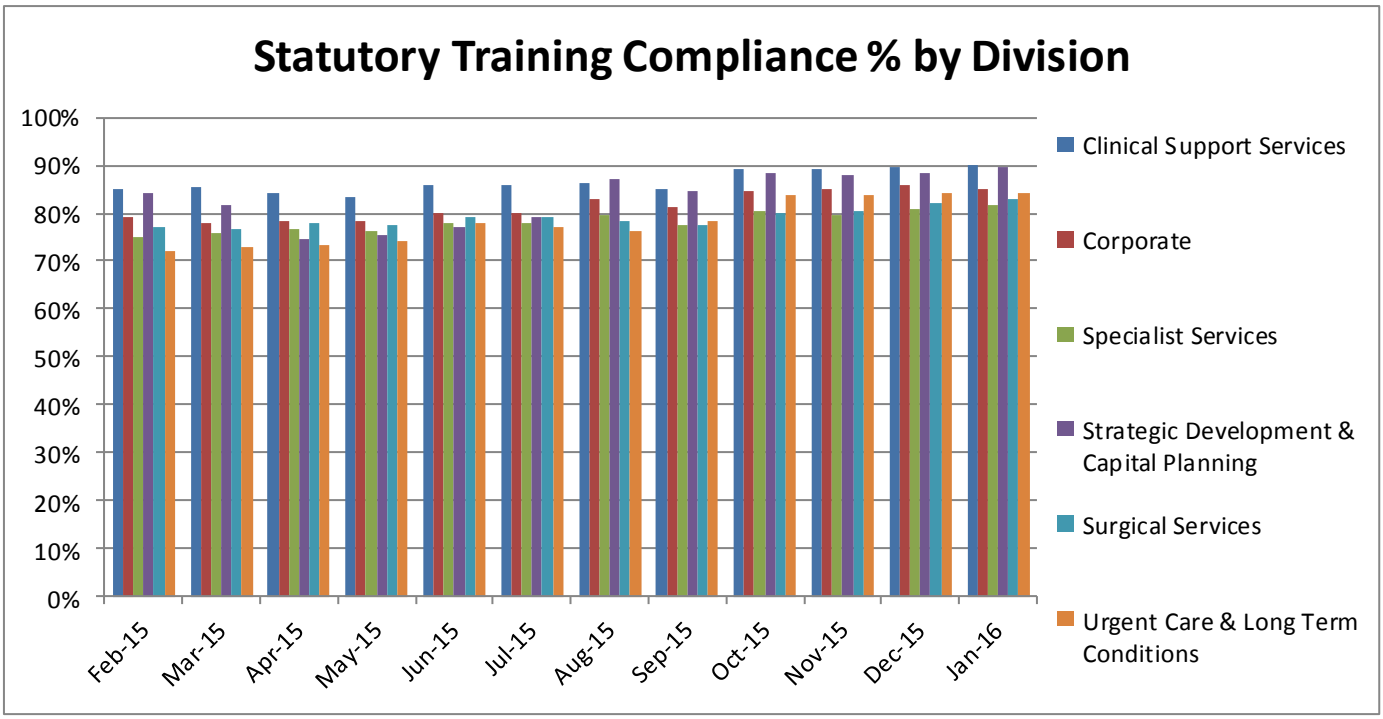
The Mandatory training never completed was raised and HRBP confirmed that this would be discussed with DD and those staff written to.

Appraisals

Appraisals increased this month to 80%. Division looking at getting all Managers onto appraisal update training to support appraisal quality.

Claire Berry—HRBP, Specialist Services

Statutory Training Compliance



The graph above shows the Trust statutory training compliance by Division, for a rolling 12 month period starting February 2015. The Trust compliance rate in January 2016 was 85%.

(These figures are an average of the compliance rates for all of the Statutory Training courses, and do not include employees currently on Maternity, adoption leave, or career breaks). *Source: ESR*

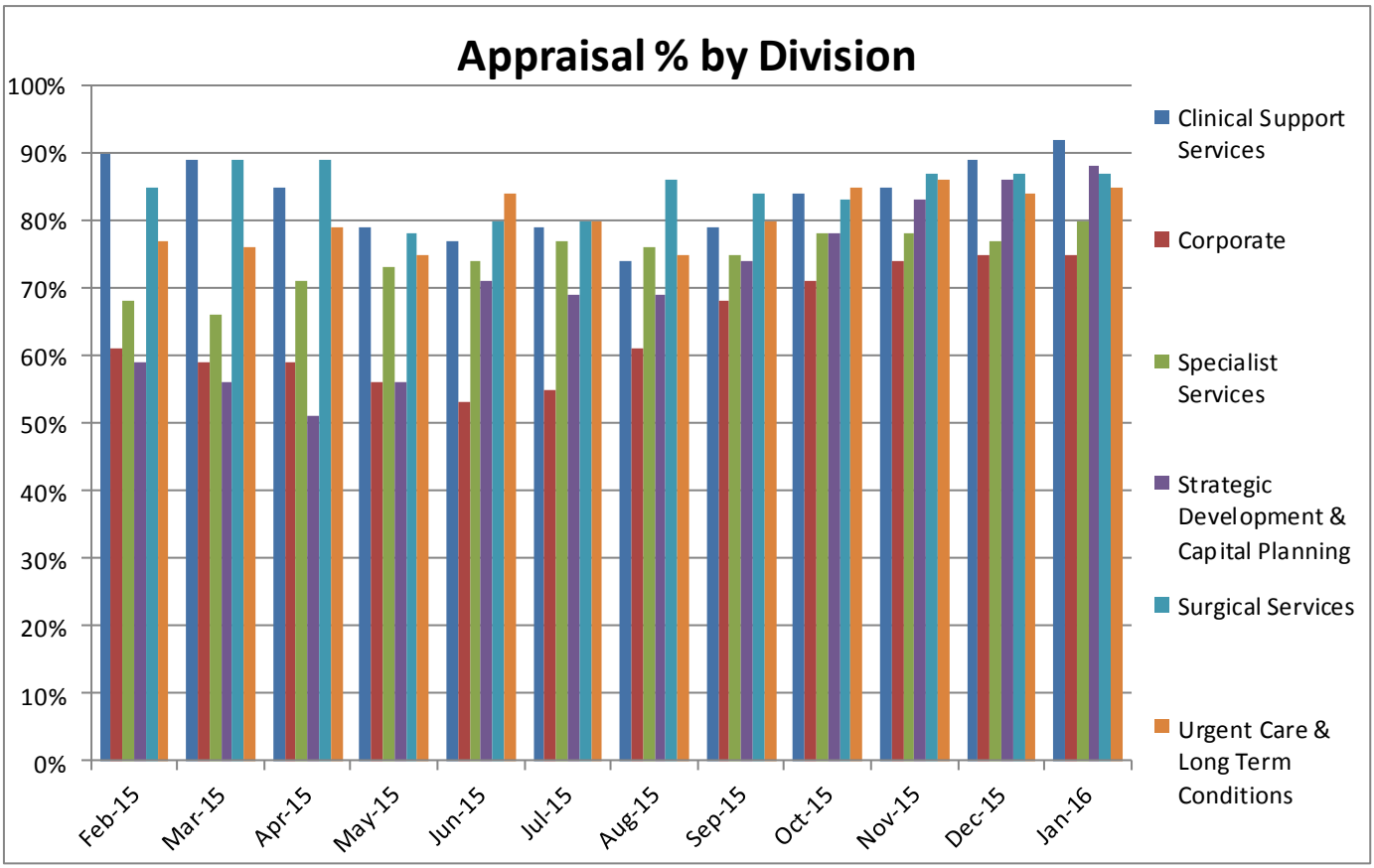
Statutory Training Non Compliance Risk - Head Count by Division

January 2016

Division	Numbers of staff who have never completed one or more Statutory Training Course
344 Urgent Care & Long Term Conditions Division	295
344 Clinical Support Services Division	117
344 Surgical Services Division	260
344 Specialist Services Division	177
344 Strategic Development & Capital Planning Division	23
344 Corporate Division	39
Trustwide	**911**

The table above shows the number of employees, by Division, who have never attempted one or more of the courses that are defined as statutory for all employees.
Source: QlikView

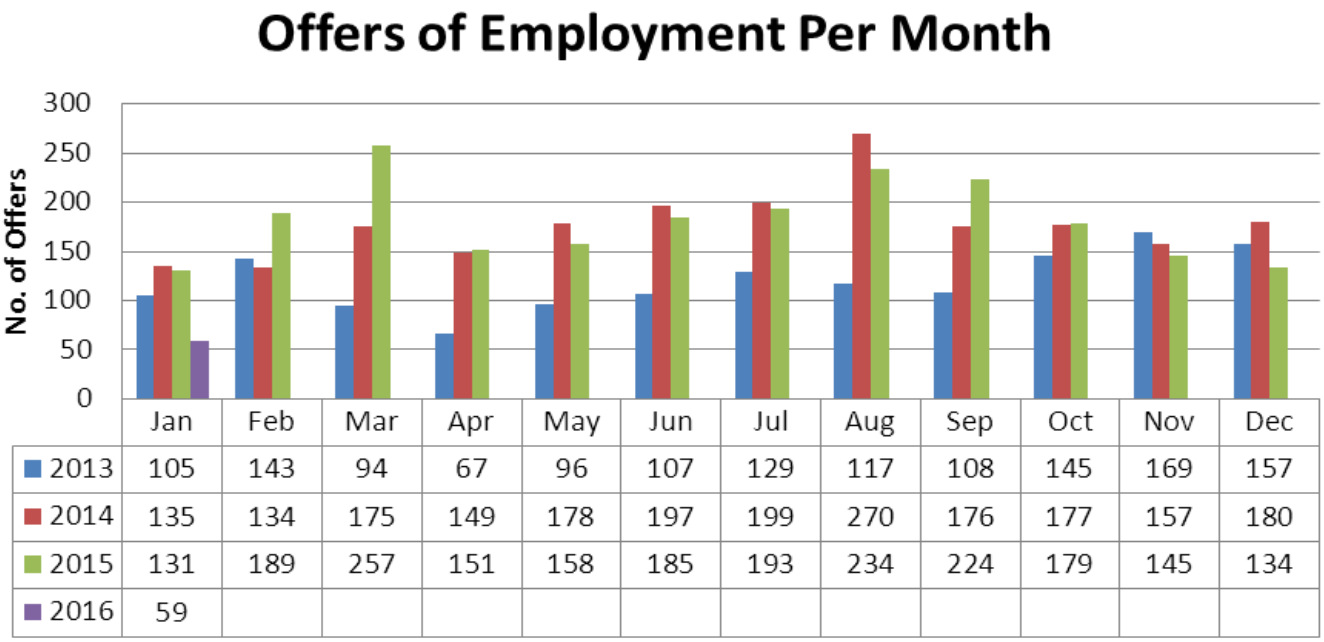
Appraisal %



There is an upward trend in the number of appraisals completed for all Divisions, going into January 2016. This is supported by the Trust Average appraisal figure, which is at it's highest for the past 12 months at 86%.

Source: ESR

Resourcing —Offers of Employment



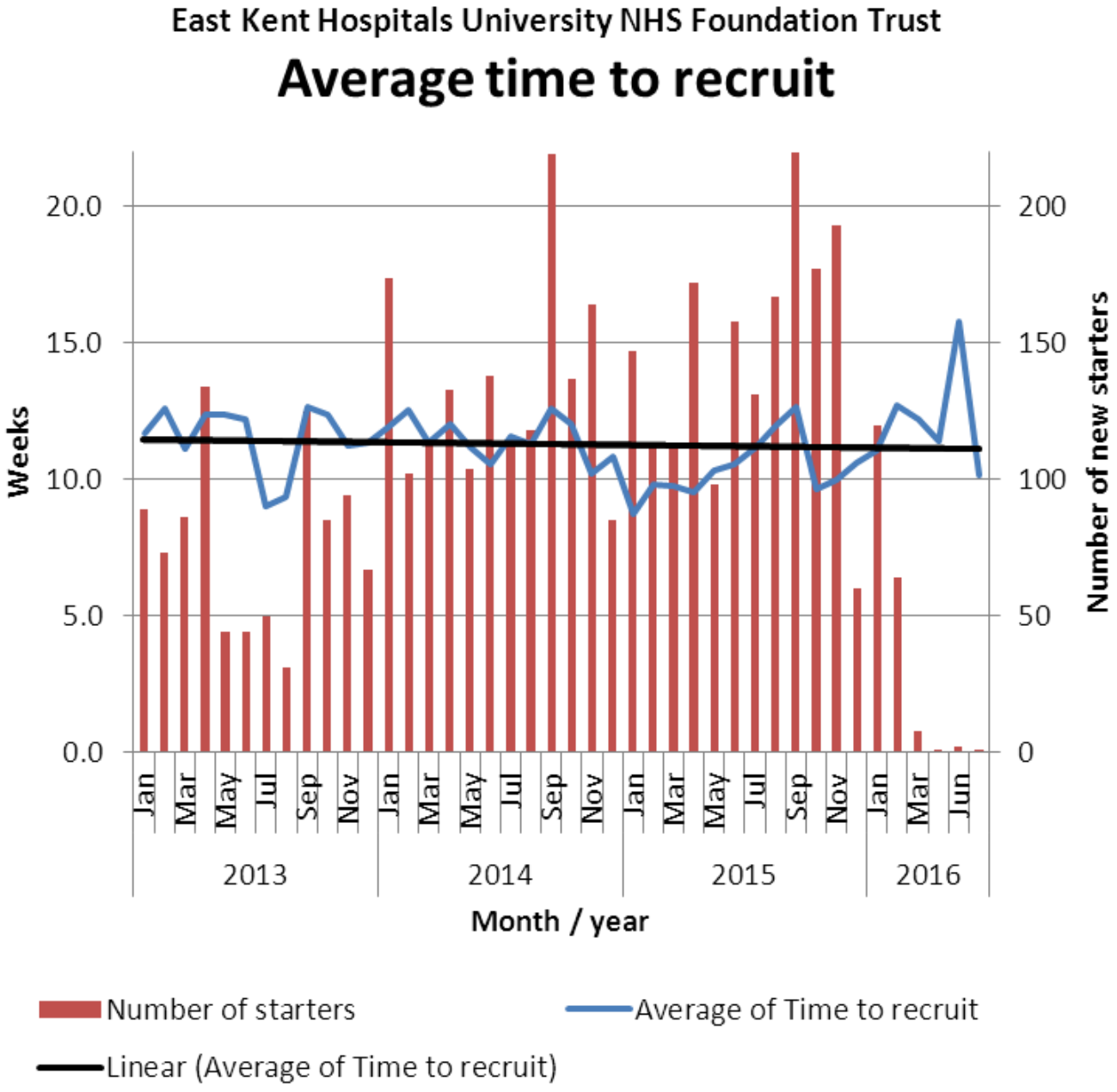
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2013	105	143	94	67	96	107	129	117	108	145	169	157
2014	135	134	175	149	178	197	199	270	176	177	157	180
2015	131	189	257	151	158	185	193	234	224	179	145	134
2016	59											

In conjunction with the vacancy review panel being implemented the numbers of offers for the month of January 2016 are at an all time low in comparison to the previous three years. Many vacancies have been placed on hold or been rejected.

As of 12th February 2016, there are 298 candidates going through the recruitment pipeline:

***Please note, that the numbers quoted above are a snapshot in time as this is a constant moving figure.**

January 2016	Total	Surgical Services	UC&LTC	Clinical Support Services	Specialist Services	Corporate Functions
Additional Clinical Services	68	29	3	27	9	0
Admin & Clerical	43	0	7	12	9	15
Allied Health Professionals	45	3	14	18	5	5
Estates & Ancillary	4	0	0	3	0	1
Healthcare Scientists	0	0	0	0	0	0
Medical & Dental	34	14	8	0	12	0
Nursing & Midwifery Registered	97	28	22	0	14	33
Scientific and Professional	7	0	0	6	1	0
TOTAL	298	74	54	66	50	54



The time to recruit has increased in the month of January 2016 and is considerably higher than the previous year. The implementation of the vacancy review panel would have an impact on the final time to recruit figures.

Source : ATS