BOARD OF DIRECTORS MEETING
FRIDAY 7 October 2016

Please find attached the agenda for the next meeting of the Board of Directors. The meeting will take place in the **Board Room, William Harvey Hospital, Ashford,** commencing at **09:30**

AGENDA

1	Chairman's Welcome			
2	Apologies for Absence			
3	Declaration of Interests			
4	Minutes of the previous meeting held on 9 September 2016			
5	Matters arising from the public minutes of 9 September 2016			
6	Patient Story	**Discussion**	**BoD 78/16**	Chief Nurse and Director of Quality
7	Chief Executive's Report	**Discussion**	**BoD 79/16**	Chief Executive
8	Highest Mitigated Risks	**Discussion**	**BoD 80/16**	Chief Nurse and Director of Quality
9	Board Committee Feedback:			Board Committee Chairs
	10.1 Finance and Investment Committee	**Approval**	**BoD 81/16 To Follow**	
	10.2 Quality Committee	**Discussion**	**BoD 82/16 To Follow**	
	10.3 Strategic Workforce Committee • People Strategy	**Approval**	**BoD 83/16**	
10	Integrated Performance Report		**BoD 84/16**	Director of Finance and Performance Chief Nurse and Director of Quality Chief Operating Officer Director of HR

11	Trust Improvement Plans:			
	• Improvement Plan		**BoD 85/16**	Chief Nurse and Director of Quality
	• Emergency Recovery Plan		**BoD 86/16**	Chief Operating Officer
12	Communications and Engagement Strategy		**BoD 87/16**	Chief Executive / Director of Communications
13	Research and Development Annual Report and Strategy		**BoD 88/16**	Director of R&D
14	Medical Director's Report		**BoD 89/16**	
15	Feedback from Council of Governors, to include: • Feedback from the Annual Members' Meeting	**Discussion**	**Verbal**	Chair
16	Any Other Business			
17	**QUESTIONS FROM THE PUBLIC**			

Date of next meeting in public: 9 December 2016, Board Room, KCH

UNCONFIRMED MINUTES OF THE SEVENTY-FOURTH MEETING OF THE BOARD OF DIRECTORS
FRIDAY 9 SEPTEMBER 2016, 09:30
LECTURE THEATRE, POST GRAD, QEQM HOSPITAL, MARGATE

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 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
Mrs 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
Ms S Le Blanc	Director of Human Resources	SLB

IN ATTENDANCE:

Ms N Yost	Director of Communications and Engagement	NY
Ms A Bedford	Governor and Membership Lead	AB
Claire Longden	Temporary Secretary (Minutes)	CL

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mr David East
Mr John Smith
Marcella Warburton
Paula Evans
Mr Edel
Sarah Andrews
Caroline Heggie
Frank Macklin
Michèle Low
Kallie Heyburn

MINUTE NO.		ACTION
60/16	**CHAIRMAN'S WELCOME** NC welcomed members of the Board and members of the public gallery. 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.	

NC advised there would be no private Board meeting today.

The Trust's Communications and Engagement Strategy was scheduled for the October Board meeting for the Directors' approval. Members were asked to provide feedback on the draft document by 23 September 2016.

61/16 **APOLOGIES FOR ABSENCE**

Alison Fox Trust Secretary
Satish Mathur Non-Executive Director

62/16 **DECLARATIONS OF INTEREST**

SA declared his interest in RSM and NC declared her interest in ST2.

63/16 **MINUTES OF THE PREVIOUS MEETING HELD ON 10 JUNE 2016**

The minutes of the previous meeting were agreed as an accurate record.

64/16 **MATTERS ARISING FROM THE PUBLIC MINUTES OF 10 JUNE 2016**

An update on actions from the last meeting was noted. The following verbal updates were provided at the meeting:

Min No 43/16:
- SSm reported that the Patient Experience Group would meet later in September. The Dementia Strategy Update and feedback were on the agenda and would be discussed and brought back to the October Board meeting.
- MK reported that the Trust was still waiting to hear whether European funding had been obtained.

Min No 50/16:
LS reported that Serco had rectified all of the issues found following swabs taken by the Environmental Health Team at the William Harvey. Serco had subsequently commissioned separate laboratory tests which had returned negative results. The situation would be revisited in the next few months.

The following matters arising were noted:

NC reported that the BAF and Risk Register had been updated and they were reviewed on a monthly basis. The BAF would be updated to provide progress against the Trust objectives as well as the risks. A complete review would be undertaken at the next Board meeting.

NC reported that comprehensive notes had been written in terms of the high-risk areas ahead of the CQC visit. This would be discussed as an item on the agenda.

NY reported that there was a new Kent and Medway communication group that would report into the STP Steering Group and a communications sub-group of the East Kent Strategy Board. The Trust Communications and Engagement team would support both the East Kent Strategy Board and the STP steering group to

identify what was required from different partners.

CT asked whether the positions of the governors could be considered, as they were often looked to for commentary around matters concerning the Trust. NY replied that the governors involved would be well briefed, well prepared, and supported.

MK advised that a conversation had been held with the governors around their roles and responsibilities and how the Trust could assist them in fulfilling their duties. There would be a specific role for the governors to assist with the communication and engagement work being undertaken within the Trust.

Improvement on the historical data presentation and Trust metrics would be looked at as the report was developed.

All other actions were noted as closed or on the agenda.

65/16 **CHIEF EXECUTIVE'S REPORT, TO INCLUDE:**
- **EXTERNAL BOARD GOVERNANCE REVIEW ACTION PLAN**

MK thanked the staff for the work they had achieved over the two years of the improvement journey, in preparation for the CQC inspection, and recognised that high-quality services to patients had been maintained throughout that time.

MK reported that the CQC inspection had taken place last week, and noted that some brief initial feedback had been received. The CQC had focused on end of life care, maternity, emergency care and medicine, and had noted positive changes in those areas. There were still areas for improvement, and the Trust would receive formal notification in the coming weeks of where those improvements should be directed.

The formal report from the CQC was expected in December.

NC noted that NHSI would make its decision from the CQC report, on whether the Trust would remain in special measures.

MK drew attention to key discussion points:

The Emergency Care Pathway was a key area where performance issues needed to be addressed. The Board needed to be assured that improvement work was ongoing in all areas where performance issues existed.

Public consultation around clinical strategy across the East Kent Trust Board would likely occur in January 2017.

MK requested that the Board Governance Review be supported by the Board.

Board of Directors' discussion:

PS noted that Recommendation Ten, from the draft Board Governance Review, recommended combining the Serious Incidents Group and the Root Cause Analysis Group, using the Patient Safety Board to gain assurance on the process.

PS advised that he had concerns with this recommendation. He advised that the Serious Incident meeting ensured serious incidents had been reported and assigned the right provision to investigate any serious incident and the right person to lead those investigations. The RCA meeting reviewed RCAs, in the midst of the RCA, to ensure the right things were being looked at, to find out if any help was needed so that when the RCA was completed, it was fit for purpose.

MK advised that the recommendation was only for consideration, and the Board could take those concerns back if it were decided that was not the right approach.

GG referred to the various papers presented on the financial position and expressed concern that the information did not clearly convey the financial position of the Trust. NG therefore provided an explanation of the current financial position, for clarity.

GG noted that NG had presented a clear explanation and added that it was unfortunate that was not reflected in the papers. GG suggested that the CEO's report provide a clear summary of the financial position which would be beneficial in communicating more generally to the members of the public. MK accepted the suggestion and would ensure that featured in future reports.

GG suggested that the Non Executives' Board Reports could also be summarised in the interest of clarity.

NC noted that she was delighted that the Friends of William Harvey had funded the quiet room on Kings Ward. MK advised that the ward manager had identified that there was a gap in the provision on that ward and had approached the Friends of William Harvey who provided assistance.

Gill noted that funds were available from the Charitable Funds Committee and the Friends to undertake developments such as the Quiet Room.

Board of Directors decision/agreed actions:
NOTED: The Board of Directors noted the report.
DECISION: NC asked the Board of Directors to endorse the position taken by PS, that the recommendation to combine the Serious Incident and the Root Cause Analysis for the purpose of gaining assurance was not the correct approach. The Board of Directors endorsed this position.
DECISION: The Board of Directors approved the Grant Thornton Action Plan.
ACTION: CEO's report to include a detailed summary of the Trust's financial position, for future meetings. MK

66/16 **HIGHEST MITIGATED RISKS**

SSm provided an update to the Strategic Risk Register, and the Corporate Risk Register reports. The risks were presented in themes and were current to 31st August.

SSm noted that several new risks had been discussed at Management Board and they were yet to be placed on the register

Board of Directors discussion:

BW advised he was pleased with the progress that had been made with the registers. He was disappointed that many of the risks had not been updated for some time. BW pointed out it was the responsibility of the individual executives who owned the risks to ensure the actions were updated on the registers.

RE noted that the action on the Strategic Risk Register indicated what was being done to mitigate risk, and those actions were not there. He drew attention to two risks on the Corporate Risk Register and noted that the comments should reflect the details around how the mitigation of the risks would be managed.

SSm and NG provided brief updates to the risks mentioned by RE.

MK noted that any action to be taken on a risk needed to be described so it was clear that work was occurring to ensure the risk was mitigated. SA agreed and advised that any movement made to those risks considered high risks needed to be clearly visible.

SSm drew attention to the history tab and noted that it provided an audit trail which showed when information had been updated.

CT suggested the Board revisit the Grant Thornton risk around Governance and Safety Culture at a future Board meeting.

ACTION: SSm will investigate changes to the risk register that would provide clarity to the mitigation process. — SSm

67/16 **CHAIR'S ACTIONS**

The report was noted, which confirmed the Trust had submitted its Quarter 1 return to Monitor (copy attached to the report).

Board of Directors decision/agreed actions:
NOTED: The Board of Directors noted the report.
NOTED: The Board of Directors had previously endorsed the recommendation from the Strategic Workforce Committee to implement the new Junior Doctors contract. The New Junior Doctors contract would be implemented in October.

68/16 **BOARD COMMITTEE FEEDBACK**

Finance and Performance Committee

RE drew attention to the following points:

- IQR assurance would be looked at in terms of performance.
- In terms of finance, the Trust was broadly where it had been predicted it would be at this point in the year. It was important to be mindful of the trajectory around performance and the financial consequences.
- The critical relationship between Strategic Workforce and the Finance and Performance Committee is at least starting. Many of the cost drivers were around agency and locum medic spend, and Strategic Workforce would discuss

how that was progressing, but the financial consequences of that were discussed in the FPC.

Board of Directors discussion:

NC asked whether the Trust was looking for £20m worth of CIPs as well as one-off savings or was it purely CIPs savings. NG replied the £20m was purely cash releasing recurrent savings.

SA asked how the Trust planned to reach the gap in CIPs, and what the control totals currently were.

NG replied the Trust had a £612k surplus control total set by NHSI and the internal plan was a £10m £12m deficit. Under the current criteria if the control total were not achieved the Trust would become ineligible to secure transformation sustainability fund monies. That control total plan was achieved for Quarter 1, and the Trust received £4m cash. The expectation now, pending further discussion with NHSI and built into the forecast, is that Quarters 2, 3 and 4 would not be received. That would increase the Trust deficit to around £24m. If the Trust starts to achieve some of the performance trajectories, and a clear improvement is seen, part or all of the sustainability fund money may become available.

NG advised that in terms of closing the CIP gap, agency spend was still around £2m a month. The ceiling that was placed on the Trust would be breached, and NG reminded the Board that an increase in the ceiling was negotiated to £23m. On current trajectory agency spend would be £25.5m - £26m. Sixty percent of that was related to medical staffing so the clinical divisions needed to look at whether spend in agency could be further eroded.

NG explained that all areas across the Trust were being looked at to reduce spend. In particular, there was a strategy regarding workforce and recruitment, and more productive measures to activity and how it was delivered were being investigated. The intention was to refine the current list of possibilities and provide that to the full Board for discussion.

MK noted that the issues were connected to performance as well as quality.

NC asked whether the pathology risk was a performance issue. NG replied the risk was not related to performance; it was related to a programme of work with Maidstone and Tunbridge Wells Trust to jointly take forward a modernisation programme in pathology. A steering group would be held next Tuesday, and a business case was with NHSI. The Trusts would meet with NHSI in the next few weeks to ascertain what information they would require for the business case to be approved. Once approval was gained, the Trust would go out to market to secure a third party for pathology services which would leverage resources and expertise and would allow improved services and financial savings to be generated.

Quality Committee

- Infection Control Annual Report 2015/16

RH asked the Board to approve the Infection Control Annual Report.

Board of Directors discussion:

PS noted there was a significant problem on the wards at the moment, relating to MRSA carriers and dementia and wandering patients. He advised that, as staff were not able to physically restrain wandering patients, the risk of infection was far greater. The Trust needed to work with its partners to get people out of hospital which would alleviate that risk. PS was also concerned that as the Trust had a good performance on infection control in recent years' staff were becoming complacent.

NC asked whether the source of the Legionella was identified. LS replied that testing occurred every week on all Trust sites. Levels of Legionella were monitored in the water systems each week, and those reports were also viewed by Infection Control.

Board of Directors decision/agreed actions:
DECISION: The Board of Directors approved the Infection Control Annual Report.

Strategic Workforce Committee
- **Ward Establishment Review**

CT drew attention to the following points:
- A detailed deep dive was undertaken into agency performance costs, and one focus to reinforce was that if there was a consistent collaborative approach by all NHS employers in Kent, that might assist with efficiency pressures.
- The Ward Establishment Review had reported the turnover of registered nurses and midwives fell from 12.8 percent in 2014/15 to 8.9 percent in 2015/16.

Board of Directors discussion:

NC noted that the draft People Strategy had been discussed at the Strategic Workforce Committee and wondered when the report would be ready. SLB advised there were some concerns about the draft of the People Strategy so it would be discussed at the Staff Side Committee next week. Once the strategy had been endorsed it would go back to the Strategic Workforce Committee and then on to this Board in October. SLB noted the strategy had not greatly changed, the issue was with how it had been presented.

SLB advised that collaboration with Acute Trusts in Kent had already begun. A meeting had been held this week and hopefully there would be some output from that.

BW noted that statutory training compliance had been above target for the last two months.

Integrated Audit and Governance Committee
- **Risk Management Policy**
- **Risk Management Handbook**

BW noted the report was taken as read.

BW advised the revised Risk Management Policy would require approval and noted the changes had been minor. He advised that he highly commended the new Risk Management Handbook.

Board of Directors discussion:

RE asked whether the Raising Concerns route had been utilised, and what evidence there was that the route by which people raised concerns was appropriate.

SLB advised that staff had various routes in which concerns could be raised, and Raising Concerns through the policy was just one way of doing that. Another route was through a Freedom to Speak Up Guardian. Each Trust was required to have one within their organisation, and a recruitment process was currently being undertaken. SLB advised that the report RE had seen was the formal process the staff used to raise concerns through the policy.

RE noted that in previous years there had been just one or two users which was a clear indication that the process was not working. He recommended that more needed to be done to ensure that staff were aware there was a policy, but there were also other routes.

SLB advised that she would arrange for a report to be circulated which demonstrated that the number of users had increased.

MK advised that he had dealt with four issues raised through the policy in the past month. He noted the report would be productive, and the Freedom to Speak Up Guardian would be helpful, however, attention would need to be paid to staff feedback.

NC suggested all the routes be investigated around how they were used and whether some were better than others.

GG noted that the need to speak up leads would be voted on by the staff on each site, which was important in terms of accessibility.

Board of Directors decision/agreed actions:
DECISION: The Board of Directors approved the Risk Management Policy.
DECISION: The Board of Directors approved the Risk Management Handbook.
ACTION: SLB to circulate 'Raising Concerns' report to Board members and look into all available routes for staff to raise concerns and the frequency of their use. SLB

Remuneration Committee

There were no comments for the Remuneration Committee. The report was noted.

Nominations Committee

There were no comments for Nominations Committee. The report was noted.

Charitable Funds Committee

GG advised that the staff presentations at the last meeting had been excellent and noted it was fantastic to see staff so engaged with some new technology. She requested the continuation of the current investment policy as it had not been looked at since 2012 so was very out of date. GG assured the quality of the document could be improved before the next charitable funds committee for agreement, and then to the Board for approval.

NC confirmed that GG was asking for continuation for another quarter. GG confirmed that was the case.

BW noted that the presentations for funds at the last Charitable Funds Committee were exactly the sort of thing the Committee should be considering for funding.

Board of Directors decision/agreed actions:
DECISION: The Board of Directors approved the continuation of the current investment policy for one-quarter.

69/16 **INTEGRATED PERFORMANCE REPORT (IPR)**

Assurance was provided by JE that work was being done with the CCG in the Community Trust, with regard to referral management. CCG would put more choice navigators into their referral management centres, particularly in trauma orthopaedics.

Cancer was highlighted in the report this month, and neurology, gastroenterology, colorectal and gynaecology were still the most challenging pathways.

RE noted that the Quality Committee had agreed to have a deep dive on the one hundred days plus cancer targets.

Board of Directors discussion:

PS reported that the latest position for C.Diff was 19, against a trajectory of 46. The national SHMI had come down below one for the first time in a long time. On a monthly basis, 140 conditions behind the SHMI score were looked at to see where the problem areas were. Areas currently being concentrated on were Sepsis, cardiovascular areas including stroke, MI and heart failure.

SA asked JE what new plans were being established to recall the trajectory of RTT.

JE replied that it was not a case of doing anything new, it was about following the plans in place. She advised that the demand seen in the first quarter, particularly in trauma orthopaedics, was beyond the plan. JE suggested that the new plan might be to investigate the demands. CCG had put in some referral management systems, however, they had recognised that choice had not been offered at that point. JE advised conversations had been held about whether choice navigators would come into the hospital, as well as those referrals that were still within the system to see if they had a choice. The accuracy of referral and choice element were being acted on at the moment. More work was going on, and JE would be

able to report back to the Board in more detail with any recommendations in the future.

SA asked when the Trust might be on track to hit the trajectory.

JE replied that the target and the standard that was being worked towards now was a measure of those that were still in a pathway. The trajectory that was provided had to be recalculated so the doctor strikes could be taken into account and the trajectory was not close to meeting 92 percent this financial year.

GG thanked JE for her explanation and wondered if there was anything more that could be done from a communications point of view with the public about the choice navigators and to help the Trust.

JE noted that the Trust needed to ensure people were aware what the waiting times were. NY advised that there were now more opportunities to get that message across due to the improved communication channels the Trust had.

RE thanked Jane for her explanation. He advised there were a series of trajectories that the Trust were not meeting. He asked to what extent JE had used dynamic, demand and capacity modelling.

JE replied that the principles were there, however, it varied greatly. Several teams monitored the situation well, but other teams required further guidance. A substantive workforce was being recruited to ensure outsourcing was reduced. It was a learning and development situation for our teams on how that performance would be delivered.

RE advised that it was not clear that what was being done would deliver the required performance.

MK noted that the performance dashboard was a connected piece, and issues in one area meant other areas were impacted. He advised that a piece of work had begun and an update on the trajectories would be provided at the Board in the future.

RE asked if an action could be captured with a response date. MK advised it was a big piece of work, and he preferred not to confirm a date until discussions were held with JE.

BW noted the idea was an improvement on what the Trust had before. He wondered whether there was enough financial data provided. BW noted that staff turnover/sickness on page 33 was getting worse and asked how that would be improved, and when an improvement could be expected.

SLB replied that a deep dive had been done on sickness/absence/turnover at the Strategic Workforce Committee and they had looked at where those things were mostly occurring. Urgent care and long-term conditions was the division that was causing the most concern, and the executive team had challenged the division on that at the last EPR. The Division Director was working closely with the HR Business Partner, and some of that was to do with having the right leaders and

manager within the division. SLB advised there were plans and trajectories in place and that had been examined at the strategic level.

BW noted that, on page 36, local induction compliance was at 15 percent and asked if that figure was correct. SLB advised that figure indicated induction for temporary staff and that the inductions were taking place, but the recording of those inductions had not occurred. The head of HR was working with the business partners in the Divisions to encourage them to use the process in place. SLB noted that she was concerned the data was not being recorded because that was a risk.

BW noted that, on page 37, in July acuity was only 1 percent higher than planned in A & E, which did not strike him as being much higher. JE advised that, when there were 150 patients a day, 1 percent would make a difference to people if they arrived at certain times of the day. The number had dipped slightly in August, however, it was the acuity, and it was the non-elective. JE noted the issue was ongoing and advised the CCGs had devised an action plan to try and direct the public away from A & E unless it was an emergency.

NG noted that the Trust had a lot to do to improve how services were delivered. There had been 700 A & E attendances in one day from an average of 600 however only an 85 percent trajectory had been delivered. The current RTT numbers were not greatly above the numbers of 12 months ago. NG advised that the internal productivity piece was essential for the Trust to say to NHSI that everything possible was being done. External pressures should be recognised, provided it was recognised that there were things that could be done internally to ensure the necessary improvements were made.

CT asked if there was a standard in the world of health. MK replied there was a standard, there were best practices, and they were embedded in the plans. The key was to ensure that the Trust and the partners did their part to implement those things that would make a difference.

CT advised it would be easier as a Board if there was a way of reporting that indicated compliance with standards and systems. MK advised the problem was not with the metrics, it was ensuring that once the metrics were provided they were the ones that demonstrated what the Trust wanted.

NC asked that the conversation be taken up at the Workforce Committee.

Board of Directors decision/agreed actions:
NOTED: The Board of Directors noted the Integrated Performance Report.

70/16 **TRUST IMPROVEMENT PLANS**

- **Improvement Plan**

There were no comments for the Improvement Plan.

- **Emergency Recovery Plan**

JE advised that there was a huge amount of work occurring and a lot of that work related to the workforce in emergency and recovery. JE noted that she could

provide a metric to indicate how many shifts had doctors down and link that to performance. JE noted that William Harvey had started their emergency severity index, a new system that had every patient assessed in the reception and screened at the front door. The system went live on 22nd August. The staff loved it, and the patient feedback has been positive. That had been seen on the dashboard, and that would be where we could show that there was a real improvement, and there would be a lot more confidence that we were getting that front end right. The issue was now about discharge and site management as a whole, bed availability and the SAFER which had been implemented as a project at William Harvey and was about 50 percent rolled out, while other sites had rolled out a proportion of it. JE advised she was involved in external work to look at the home first element which was the external pathways of capacity that was crucial for us through the winter.

GG thanked JE for the update and advised that the Non-Executive Directors had visited William Harvey the week before the new process had been implemented and staff were anticipating it. It was great to hear that it was working because the queues were significant. The table top exercise in September had been discussed, and it would be good to hear how that went at the October Board. GG advised the Non-Executive Directors had seen the new system that was in place and noted it seemed very manual. She asked whether that was going to remain and whether it would be automated at any point.

JE replied that best practice indicated that having that dynamic live element was what the staff responded to, and that would be what they were looking at, to see whether they could have the status electronically on every ward.

GG noted that the delay in transfers of care could be clearly seen and suggested she would like to see more trajectories.

SA asked why SAFER had not been rolled out to 80 or 100 percent. SA also asked whether an issue still existed in the recruitment of consultants and if so what was being done around trying to recruit abroad from developing countries.

JE replied that the SAFER project would roll out, and that was expected to be at 100 percent by December. She noted the weekly reviews needed to be embedded of those patients that stayed in a bed longer. A matching exercise had been undertaken with those that were required to go to the capacity outside, and that was successful, but now the external capacity was trying to move those patients on so there was many dynamics in that. JE advised that two more consultants would join in the next month or so, and there was one other who seemed interested, however, consultants were a key issue. Middle-grade doctors were beginning to join from overseas recruitment.

SLB advised that recruitment was challenging at the moment, particularly for Urgent Care and Long Term conditions which currently had 17 or 18 locums, making it difficult to deliver a sustainable service. Two agencies that supported recruits had been engaged from overseas, so that was both ED consultants, consultants in medicine, and middle-grade doctors. The Trust had been successful but the lead time onboarding these doctors was long. The biggest issue was around the visas and being able to get those visas. Staff were coming through the process, but that would continue to be a challenge. SLB noted that one of the

discussions she had raised with the Division was around perhaps delivering the service in a different way, because the Trust would always be on that treadmill to try and recruit doctors, so it needed to look at how services could be provided differently.

ACTION: Whole Health Economy half day exercise to take place in September; outcomes to be brought to Board in October. JE

71/16 **MEDICAL DIRECTOR'S REPORT**

PS noted that the September Junior Doctors strike had been cancelled.

PS asked the Trust Board if they would write and express their thanks to the people who had worked so hard in the ECC while PS was at Kent & Canterbury.

MK advised that should the Junior Doctor Strikes continue in October the Trust would cancel patient appointments for that week as well as elective surgery to ensure there were enough senior doctors working in the emergency service. The contingency plan in place to ensure that process could be implemented in plenty of time if required.

Board of Directors decision/agreed actions:
DECISION: The Board of Directors agreed to write a letter of thanks to the people who had worked in the ECC.

72/16 **FEEDBACK FROM COUNCIL OF GOVERNORS TO INCLUDE:**

- **Feedback from NEDs aligned to Governor Committees**

NC asked the Board to send congratulations to Michèle Low who had been appointed as the lead governor.

NC recommended that members of the Board read the Membership and Member Engagement Strategy that had been written by a governor of the governing body, as it was a good report and would be helpful to where the Trust needed to go next.

BW noted a good long discussion had taken place, and it was a good roadmap and a good session.

73/16 **ANY OTHER BUSINESS**

SSm advised that the executives who had presented to staff had made a promise to continue the Improvement Day incentive, whether or not the Trust came out of special measures. SSm noted the CQC had asked whether the Board Directors had agreed to that formally and had had it formally minuted. SSm sought agreement from the Board Directors that they pledged to continually improve in the engagement undertaken with staff in cultural change and good things going forward, coming out of special measures.

PS advised that Dr Neil Goldsack had just been appointed as a Freedom to Speak Up Guardian.

RE advised that the Trauma Board report would be released to the Trust today to consider for accuracy. RE noted that he thought it appropriate to report to the Board that the data he had reviewed on the performance of the Trust, regarding trauma services, was first class. He advised that a lot of work had been done by many people to continue to drive trauma services, and he would like, through the Board, to express thanks to Matt Jones who had handed over the leadership to Natasha Newton. Matt had done an enormous amount of work.

NG asked if the Board could have an item on the Safe Data Safe Care document that was published, at the next meeting; new proposals had also been published around consent. Perhaps that could go alongside the 2018 Implementation of General Data Requirement.

NC advised that was a good idea.

Board of Directors decision/agreed actions:
ACTION: The Safe Data Safe Care document would be discussed alongside the 2018 Implementation of General Data Requirements item. For a future Agenda. NG
DECISION: The Board of Directors pledged to engage in continual improvement with staff after the Trust had come out of special measures.
DECISION: The Board of Directors thanked Matt Jones for his work with the Trust Trauma Board.

74/16 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

Mr Smith asked what risks had been identified in the clinical strategy around the commissioners from the CCG's who had different agendas, considering the priorities of the strategy was very much partnership working

MK replied that the partnership working was essential to the clinical strategy work and advised that the partnership working was going positively on the basis that there was an East Kent Strategy Board which incorporated the Trust, the local authority, community organisations, Community Trust, Mental Health Trust and the commissioners. MK advised that the Strategy Board had set a strong ownership of the issues collectively, across the organisations, in understanding that changes could not be made by one organisation without other organisations also changing how they worked. MK noted that the relationships were there, they were strong and positive, and he hoped that was what was demonstrated to members of the public.

Mr Edel requested clarification be provided around the abbreviations used in the Board documentation, considering those documents were in the public domain.

NC advised that would be taken on board. NC

Mr Edel asked why there were no details around the Estates and Asset Management Board workshop.

NC responded that the workshop would help the Board understand the risks associated with the Trust Estate so the Board could put together a coherent strategy. NC advised that a procurement exercise had been undertaken and noted she would investigate why the details of the workshop had not been made public.

Mr Edel asked why job titles were not mentioned in the Remuneration Committee report. He noted that Trust salaries were public money, and that was meant to be transparent.

RE responded that, as a public organisation, salaries of the executives were published in the annual report. RE added that it was completely appropriate for a remuneration committee to discuss ongoing adjustments to salaries in the year, in confidence. RE noted that to do otherwise would be inappropriate and would not conform to the normal codes of governance of the Remuneration Committee.

Mr Edel asked why the Quality Report had failed to highlight the dismal waiting time in A & E. He advised that he had waited for almost four hours before someone approached him and let him know what was happening.

NC advised that would be taken on board, and she would consider communication to A&E patients. NC

Meeting closed at 11:35 am

Date of next meeting in public:
7 October, 09:30, Board Room, WHH

Signature _____

Date _____

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
BOARD OF DIRECTORS MEETING – 7 OCTOBER 2016

ACTION POINTS FROM THE PUBLIC MEETING OF THE BOARD OF DIRECTORS MEETING HELD ON 9 SEPTEMBER 2016

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
OUTSTANDING ACTIONS FROM PREVIOUS MEETINGS					
43/16	10.6.16	**STAFF STORY** Reflect and report back on what more could be done in terms of integrating doctor and nursing teams or providing holistic support to dementia patients and their families.	SSm	October 2016	Patient Experience Group to take place later in September – SSm will then report back.
59/16	10.6.16	**QUESTIONS FROM MEMBERS OF THE PUBLIC** Improve on historical data presentation for the Trust metrics within the Integrated Performance Report.	NG	Ongoing	Will be considered as part of the report's ongoing development.
ACTIONS FROM THE LAST MEETING HELD					
63/16	9.9.16	**CEO'S REPORT** CEO's report to include a detailed summary of the Trust's financial position, for future meetings.	MK	October 2016	Closed. Noted for future reports.
64/16	9.9.16	**HIGHEST MITIGATED RISKS** Consideration to be given to how best to demonstrate the movement of data that occurs between Board meetings, in reports. SS to link with HG/DO about the presentation of data.	SSm	October 2016	Completed. HG & DO have agreed to work with risk owners to make visible the updates and changes in the risk registers to enable an audit trail
69/16	9.9.16	**INTEGRATED AUDIT AND GOVERNANCE COMMITTEE** SLB to circulate 'Raising Concerns' report to Board members and look into all available routes for staff to raise concerns and the frequency of their use.	SLB	October 2016	Closed. Report has been circulated.

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
75/16	9.9.16	**TRUST IMPROVEMENT PLAN – EMERGENCY RECOVERY PLAN** Whole Health Economy half day exercise to take place in September; outcomes to be brought to Board in October.	JE	October 2016	Due to timing of the exercise, a verbal update will be provided as part of the CEO Report. The Board will receive the Trust's Demand and Capacity Plans at the December Board. The exercise will inform these plans.
73/16	9.9.16	**ANY OTHER BUSINESS** The Safe Data Safe Care document would be discussed alongside the 2018 Implementation of General Data Requirements item. For a future Agenda.	NG	October & December	This is being considered by the IAGC at its October meeting and will be reported to the Board through the Chair report.
74/16	9.9.16	**QUESTIONS FROM THE PUBLIC** Re Trust Reports, request for better explanation of the abbreviations used in Trust reports. Re Nominations and Remuneration Committee Reports – the public to be advised of the costs involved in commissioning consultants to conduct reviews. NC agreed to give the matter consideration. Re A&E, Mr Edel asked that the issue of better systems of communication with patients waiting in A&E be looked at. NC agreed to consider.	All NC NC	Ongoing October 2016 October 2016	Noted. The Trust publishes where it has used consultancy within its Annual Report. The Trust publishes on a quarterly basis all expenditure on its website. Current waiting time information is made available on the Trust website. Screens displaying this information have also been recently installed within A&E Departments.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 OCTOBER 16**
SUBJECT:	**PATIENT EXPERIENCE STORY**
BOARD SPONSOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY

The Board of Directors have been using patient stories to understand from the perspective of a patient and/or a carer about the experiences of using our services.

Patient stories are a key feature of our ambition to revolutionise patient and customer experience. Capturing and triangulating intelligence pertaining to patient and carer experience from a variety of different sources will enable us to better understand the experiences of those who use our services.

Patient stories provide a focus on how, through listening and learning from the patient voice, we can continually improve the quality of services and transform patient and carer experience.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Identified risks include: If we do not learn from the feedback from patients and their families there is a risk that we do not continue to make improvements to patient experience and outcomes. The management actions are detailed in the paper.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **Provision:** Provide the services people need and do it well.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	CRR 16 – Complaints Management
RESOURCE IMPLICATIONS:	Nothing additional
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

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

SUMMARY:

This story this month reflects a current complaint that has been investigated during August and early September 16. The Board are invited to receive and consider a recent complaint theme rather than a historic complaint that has been fully resolved. Consequently, some of

the actions and learning that arise from this patient story are still being developed, confirmed and being shared.

The Board of Directors are privileged to hear the story first hand from the patient himself Mr MV. The issues that have arisen will be taken away and resolved by the Division with learning that spans across the Trust shared and implemented.

The story relates to a largely satisfactory experience, but reflects disorganisation and silo working of differing departments that left Mr V feeling anxious and also concerned that joined up care was not in place. In addition a breach of his confidentiality took place.

RECOMMENDATIONS:

The Board of Directors are invited to discuss the story and seek any further assurances that may be required.

Board of Directors
Patient Experience Story
October 2016

Introduction

This month's story was received via email directly to the Chief Nurse & Director of Quality during August 16. The client, Mr MV was telephoned by the Chief Nurse & Director of Quality before the Division was asked to investigate and respond to Mr V's concerns. This gentleman has kindly agreed to attend Board of Directors to share his story in person. This paper therefore, is a short summary of Mr V's experience in order to allow him to explain in full at the meeting.

The Patient Story

The episode of care took place during June 16. Although the story is written in the third person, it is told in the client's own words as outlined in his email to the Trust.

On the 8th June Mr V collapsed in the street and was subsequently admitted to the Emergency Department at William Harvey Hospital with a suspected seizure. He had his bloods taken and a CT scan performed. He was admitted to the Clinical Decision Unit after spending 4 hours in the ED for an overnight stay for observation as he had been found unconscious. Mr V was given a snack, but did comment that the nurses did not offer him pyjamas to sleep in and left him fully clothed all night.

The next day Mr V was discharged with a letter from the Consultant to attend again for an Electroencephalogram (EEG) at Kent & Canterbury Hospital, plus an Echo Cardiogram and also to have cardiac monitor fitted. The letter also stated that he should attend the Ambulatory Unit (Celia Blakey Centre) on the 8th August for his results review.

On the 4th July 16 he attended Kent & Canterbury Hospital for his EEG. He was pleased that the appointment was on time, and everyone was very efficient and very friendly. However, when he asked for the results or an overview he was told that this would be done by the Consultant who ordered the referral.

On the 20th July 16 Mr V attended William Harvey for the Echo and the fitting of the cardiac monitor. Although the appointments were 3 hours apart the staff managed to fit them back to back so he had no waiting. He was told to wear the monitor for 6 days and then bring it back between 10:00 and 12:30 along with his patient activity diary. This he duly did on the 28th July 16.

On the 8th August 16 Mr V attended Celia Blakey Centre at the correct time. The Unit was empty. He waited for 10 minutes before a member of staff (who did not introduce themselves) asked if they could help. He told them that he had been instructed to attend for his results. They asked him to wait and they went off. After about 10 minutes they returned and said they knew nothing about it and did he know why he was there. He said he thought he was supposed to see a Consultant to review his results post seizure, they said "OK" and went off again. They returned after 5 minutes or so and said he should go round to the Ambulatory Unit and take a seat and someone would see him. By this time he was getting quite annoyed; he was nervous enough waiting for his results but now he got the impression he was almost a hindrance.

The senior sister came round and said she needed to take his blood pressure (BP). He asked why as he was only there for his results, she said it what standard procedure and took his BP. She said it was a little high, he said jokingly '*After the start I've had I'm not surprised! I have to say that throughout the wait the Sister and*

Student Nurse were coming round at regular intervals offering tea and coffee between treating patients which was a nice touch'.

When Mr V finally got to see the Doctor, he had to repeat the entire story again and tell her every test he had had. After each test that he explained, the Doctor asked what the results were; he had to keep repeating that he was there for the results, none of which she seemed to have. She asked if he could wait outside and that she would ring Kent & Canterbury. Whilst waiting the Sister asked Mr V to go to a cubicle, as she had been told to do an ECG. He said that he had already had one done but she said the doctor had requested another, which put him even more on edge as he assumed there must have been an anomaly.

Mr V went back to see the Doctor who gave him his results which were all normal and no epilepsy suspected. Because he had noticed that his heart does skip a beat every now and then he asked if this had been picked up on the 24-hour tape and the Doctor said yes. He went out to tell his girlfriend that it was all clear. She asked if the 24-hour tape had picked up an irregular rhythm, he said it picked up a missed beat, but she said that is not the same thing and that she was surprised it hadn't been picked up. (His girlfriend is a Senior Sister on a Coronary Care Unit).

On the 11th August 16 Mr V's girlfriend came home from a day out and said she had news for him. The William Harvey had called her mobile. They did not have Mr V's correct number, they had called his GP who also did not have his correct number and so they had called her. Rather than ask her for the number they proceeded to tell her that they had in fact not told me the results of the 24-hour tape as they did not yet have them, and that they would send them to his GP in 6-8 weeks' time, and in the meantime could she tell him not to drive a car.

Mr V was not best pleased with this breach of patient confidentiality. His personal view is that firstly they had no right to discuss his condition or treatment with anyone bar himself, and moreover, what could have the consequences have potentially been had he not told his girlfriend that he was undergoing these tests and this was the first she had heard of it. Mr V stated that this is clearly not acceptable. Whilst he understood that this was done with the best intentions and no harm was actually done on this occasion, he felt it needed to be investigated in order to prevent recurrence.

Summary of the Issues

A number of issues are evident in Mr V's story that are common themes in many of the concerns and complaints the Trust receives. These include:

- Staff attitude, resulting in Mr V feeling like a hindrance;
- Poor manners by failing to introduce themself to Mr V;
- Lack of explanation leaving Mr V feeling anxious and worried;
- Confusion regarding his clinical history, why he was attending the hospital at all, and the staff not having all of the information ready for Mr V's appointment;
- A breach of confidentiality that could have been far more serious.

The Division have investigated Mr V's complaint and the Consultant in charge of his care has written a letter of apology for not fully explaining his results properly to him; for not having all the results ready, given that was the purpose of his appointment and also for the confidentiality breach. The member of staff has been cautioned and asked to reflect on the whole consultation. This person has also been advised of the General Medical Guidance on confidentiality. The Division in the meantime are looking at their administrative processes to see how they can improve communication with patients.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 OCTOBER 2016**
SUBJECT:	**CHIEF EXECUTIVE'S REPORT**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**ASSISTANT TRUST SECRETARY**
PURPOSE:	**Approval**

BACKGROUND AND EXECUTIVE SUMMARY

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

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

- **Improvement Journey / CQC**
- **Emergency Department (ED) Recovery Plan**
- **Financial Recovery**
- **Operational and Contracting Planning Guidance & Single Oversight Framework**
- **Clinical Strategy Update**
- **William Harvey Hospital Trauma Review**
- **Letter of Declaration' and Self-Assessment against NHS Core Standard for Emergency Preparedness, Resilience and Response (EPRR)**
- **Demand and Capacity Planning**
- **Good News Stories**
- **Chief Executive Activity**

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

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

RECOMMENDATIONS AND ACTION REQUIRED:

To note the report.

CHIEF EXECUTIVE'S REPORT

1 EXECUTIVE SUMMARY

1.1 CQC Visit Update/Improvement Journey

This report provides an update of progress against the CQC Improvement Plan, the monthly NHS Choices Return, and initial feedback from the re-inspection that took place 5th-7th September 2016.

- Following the inspection of July 2015, the Trust was re inspected 5th-7th September 2016.
- Initial feedback was positive, with staff being described as "Positive, open and enthusiastic". Particular emphasis was placed upon the exemplary caring displayed from staff during the re inspection. There were no immediate safety concerns raised nor enforcement notices applied – this remains the position following two follow up unannounced inspection.
- The priority is for the Trust to come out of Special Measures following this re-inspection – the outcome is not expected before December 2016; and to continue the improvement journey and delivery upon outstanding actions and produce an interim improvement plan following the re inspection.

Following the re inspection, a brief verbal summary was received on the 7th September followed by a formal letter to the CEO on the 9th September 2016. To summarise the conversation and letter:

The CQC asked that the trust thank the staff for the openness with which they discussed issues with the CQC team.

They highlighted the caring and compassionate nature of all observed interactions between staff, patients and carers.

They commended the Alcohol Support Team in the Emergency Department, the learning sessions in the Emergency Department, the Stroke Unit's approach to falls and ulcer prevention and the Integrated Discharge Team.

The CQC advised that the maternity MDT working, maternity bereavement support, CNS support from SPCT towards wards and the EOLC facilitator were viewed as impressive.

The CQC outlined some areas of concern. These included:-

- Paediatric nursing cover in the Emergency Department at QEQM.
- The working hours of middle grade doctors in the Emergency Departments.
- The review of notes for safeguarding purposes in the Emergency Department.
- The matching of nursing skill mix to patient acuity on medical wards.
- The levels of midwifery staffing and impact on birth ratio and 1:1 care in labour.
- The variable levels of implementation of new EOLC and MCA documentation and process across the Trust.
- The lack of fast track discharge processes for EOLC patients.

The CQC did advise that this initial feedback should be viewed as immediate headlines and that the feedback could provide no guidance regarding the decision to exit Special Measures, as this would be subject to the standard CQC processes of report quality assurance.

Since the re inspection, we have canvassed the following feedback from staff via the improvement hubs regarding the inspection:

- An overall positive experience.
- The was a "can do" attitude towards the inspection.
- Staff felt prepared and pre inspection and intra inspection communication was appropriate, with the weekly steering group (IPsG) providing an appropriate bi directional transfer of information.
- Inspectors were approachable and staff felt engaged and less anxious than in previous inspections.
- The improvement visits prior to the re inspection were cited as a possible contributory factor in relieving anxiety and enabled teams to appreciate other clinical areas' challenges.
- Staff felt there was senior executive engagement with the hubs, IPsG and local teams.
- That there has been considerable improvement and progress made in line with the Improvement Plan actions.
- The Estates team was applauded for the sites generally looking clean and tidy although this needs to be 'business as usual' and highlighted a perception of the Trust being reactive and not consistently proactive.
- There were concerns raised regarding the limited nature of the inspection and in particular, the small rooms available for Focus groups and the risk was that many areas of the workforce were not reached. This was a result of the focussed nature of the re-inspection.

The most recent Improvement Plan Delivery Board (IPDB) was held on 16th September 2016, with a focus upon exceptional reporting of outstanding actions and the agreement of a process to deliver an interim revised improvement plan prior to the CQC inspection results delivered in December 2016; this would be produced for the end of October IPDB.

Update upon programme activities:

- Fortnightly detailed performance reviews with divisions regarding progress and pace of improvements to current plan and the development of the interim plan following divisions' engagement with each Hub;
- Divisional reporting dashboards delivered and updated;
- Monthly IPDB to hold all action owners to account for the delivery of their plans;
- The development of organisational IPDB KPIs which have been amalgamated into revised Integrated Performance Report/Balanced Scorecard. These are presented at each Board;
- Monthly improvement visits & feedback via the QI Facilitators to clinical areas to support staff in preparation for re inspection are regularly taking place. Approximately 100 areas have been visited across all sites since February 2016;
- Bi-monthly Improvement Plan CQC Steering Group meetings to engage staff and work alongside the Quality Improvement and Innovation Hubs (QIIHs) continue;
- A 'Fortnightly Focus' communications strategy with a supporting programme of speakers through the QII Hubs has been published;

Based on the September 2016 NHS Choices report (August 16 reporting period) the 6 outstanding red actions are detailed below:

- Temporary staff induction (MD 22) – Systems in place but inadequate method of capturing compliance. Forecast recovery 50% October 2016, 85% December 2016.
- Pain scores (MD24) – audit compliance waited although revision required given diverse nature of clinical areas. This action will feature in interim plan.
- Mental Health (MD05) – red rated due to slippage against scheme and continued risks which are being addressed in liaison with external partners, COO with KMPT. This action will feature in interim plan.
- Governance & Leadership (MD16) – red rated due to outstanding actions highlighted in Grant Thornton report regarding divisional governance arrangements. Improvements noted in the report at Board level. Forecast completion – October 16.
- Policy compliance (MD18) – red rated due to failure to achieve by June 2016 and additional infrastructure required. Manual process in place and Policy Compliance Group to mitigate risk. This action will feature in interim plan.
- Adult Safeguarding (MD20) – red rated due to training data showing 50% compliance at L1 and L2. L1 training to be met via a staff booklet for all staff with July payslips. L1 now at 100%. Divisions to provide trajectories for releasing staff for L2 training. Revised Forecast completion – November 2016.

These were reviewed at the NHSI Performance Review Meeting on 15th September 2016 and discussed in detail.

1.2 FINANCIAL RECOVERY

The Trust's monthly I&E deficit in August was £3.5m. This was as a result of removing expected Sustainability and Transformation Fund (STF) income of £1.34m per month for the months of July and August based on the Trust not delivering to trajectory against the published NHSI Control Total of a £0.6m surplus.

The year to date I&E deficit stands at £9.37m to month 5. STF income of £4m relating to Q1 has been received.

If STF income was included, the August deficit would have been £0.8m, a marginal deterioration on the £0.6m deficit reported in June and July as a result of lower clinical activity in August.

As a result of the STF adjustment, income in month reduced to £45.9m, £2.5m below plan.

Pay costs in month were £28m as against an average of £28.1m per month up to month 4. Agency and locum costs continued at current trends being £2.15m as against an average of £2.1m per month and now stand at £10.6m for the year to date. Although the current trend is above that required to hit the £23m ceiling, agency and locum spend for the same period in 2015/16 was £13.4m, representing a real spend reduction of £2.8m (21%). Measures continue to be strengthened to reduce the agency bill, but are challenged from the high number of vacant medical staff posts, particularly in medicine.

The Trust's CIPS target remains £20m. Including income, for the year to date, £5.1m has been delivered against a target of £5.2m. The risk adjusted forecast is £15.9m and further action is being taken to close the gap. This includes discussion at Finance and Performance Committee and at the Trust Board. This work is being progressed as a priority.

Demand for services continues to run at unprecedented levels, testing the Trust's capacity to deliver the required levels of activity and its target trajectories. Against the

same period in 2015/16 the Trust has carried out 1,048 more non elective inpatient procedures, offset by a smaller reduction in elective cases, and seen 3,562 more A&E attenders.

CCG commissioner 'challenges' against activity reporting and contracting matters are at an historical high with £6m of challenges tabled by month 3. The Trust is confident that it can appropriately defend its position and will also continue discussions on this with NHSI.

The Trust is continuing to discuss its cash requirements with NHSI and to the end of M5 had accessed £12.8 of its approved interim credit facility of £14.6m. The latest forecast submitted to NHSI indicates a requirement for £32.5m.

The Trust's year end forecast is £24m comprising the £12m deficit plan and £12m of lost STF income. The forecast will continue to be impacted by:

- continuing operational and workforce pressures including rising levels of staff turnover,
- vacancies and sickness
- further discussion with NHSI and the eligibility or otherwise of the Trust to secure STF
- crystallisation of income, CQUIN, activity and CIPS delivery risks and opportunities
- temporary staff costs, driven by operational pressures and critical staff shortages

The Finance Director and I have recently met with NHSI colleagues and have discussed the importance of reducing this forecast deficit. This is crucial due to the impact on this year's position but importantly the following two years. Control totals for this period will be published shortly and therefore we will continue the work on maximising CIPs this year and also maintain a close working relationship with NHSI. Further discussions will occur following the month 6 results are known and we will further update the board with progress at that time.

1.3 OPERATIONAL AND CONTRACTING PLANNING GUIDANCE & SINGLE OVERSIGHT FRAMEWORK

NHS Trusts and Clinical Commissioning Groups have now received this year's operational and contracting planning guidance from NHS England and NHS Improvement which came into force on 1 October 2016. This sets out the priorities from the Government and is our 'must do' list for the next two years.

One of the big headlines is that it has put more structure in place to help the different NHS organisations in each area work more closely together rather than competitively. We'll be jointly responsible for Kent and Medway NHS finances, for example, not just our own. More and more, the different organisations in the NHS are coming together to work in partnership, and by embracing this we can achieve great things for patients, as it will help us iron out 'gaps in the system' and enable great healthcare for each person regardless of how many organisational boundaries they cross during their care. This is one of our big aspirations at EKHUFT, which is why 'partnership' is one of our strategic priorities.

By Christmas, all NHS organisations in Kent and Medway will need to submit their agreed plans for implementing the guidance here in Kent.

NHS Improvement has also published its Single Oversight Framework. The Framework focuses on five themes with the aim of supporting providers to attain and/or maintain a CQC 'good' or 'outstanding' rating. These themes are:

- Quality of care (safe, effective, caring, responsive);
- Finance and use of resources;
- Operational Performance;
- Strategic change;
- Leadership and improvement capability (well-led).

The Framework describes the approach NHSI will take in terms of monitoring and the information collected to identify potential support needs.

https://improvement.nhs.uk/resources/single-oversight-framework/

2 CLINICAL STRATEGY UPDATE

The Trust continues to look at innovative models of care and how clinical pathways can be delivered differently in the future. The aim is ensure as many people as possible get the care they require without being admitted to hospital, leaving hospital beds for those who really need them. Examples of this may mean using technology to link clinicians in secondary with patients and doctors in primary care or assessing and diagnosing patients before sending them home the same day with the right treatment and support. Workforce in some areas continues to be a challenge, so it is important to consider how these patient pathways will be delivered and what training may be required to facilitate new sustainable roles.

The Trust is working with the East Kent Strategy Board (EKSB) to ensure the above pathways are delivered across the health economy and the right infrastructure to support them is available in primary and community care. EKSB has engaged some external support to:

- Develop options and evaluation criteria for how services may be delivered in the future; and
- Fully explore the out of hospital model, understand the activity shifts and the workforce profile required to deliver the model

The EKSB is working with the South East Coast Clinical Senate to ensure the future options identified have been assessed against robust clinical criteria. The strategy board is required to submit evidence to support the issues raised in the case for change and how this would improve with future delivery options.

The initial patient focus groups have now finished and they will be presenting their outputs to the next EKSB in October. Further listening events are planned October and there will also be engagement to ensure input into option development and evaluation.

EKSB is linking in and contributing to the Kent and Medway STP. Carnall Farrar have been appointed to run the Programme office for the Kent and Medway STP. An initial financial submission requesting £100 million for capital money for EKHUFT has been submitted on 16th September to NHS England. There will be a resubmission of the narrative describing the Kent and Medway STP on 21st October and further updates will be provided to the board following this.

3 WILLIAM HARVEY HOSPITAL TRAUMA REVIEW

The NHS England Peer Review of The William Harvey Hospital Trauma Unit took place on the 6th of September. The Review Panel assessed compliance with the NHS England TQuINS. Overall the panel was extremely complimentary and praised EKHUFT for it's standards in Trauma Care. There were some concerns to highlight areas for development including some of the documentation we use, the rehabilitation side of care and the need to complete the patient pathway all the way to

discharge. We have already progressed some of these and work will continue as we develop our trauma service.

4 LETTER OF DECLARATION' AND SELF-ASSESSMENT AGAINST NHS CORE STANDARD FOR EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR)

As an acute provider there is a requirement that the Trust is able to plan for and respond to a wide range of emergencies and business continuity incidents. These requirements are set out by the Civil Contingencies Act, 2004 NHS England's Emergency Preparedness, Resilience and Response (EPRR) Framework 2013.

NHS England requires that all providers benchmark their processes against the NHS Core Standard for Emergency Preparedness, Resilience and Response (EPRR). This standard demonstrates whether acute providers have an effective emergency planning and business continuity framework and programme in place.

The Trust is required to self-assess its compliance and then subject it to challenge with the CCG Commissioning Support Unit. The criteria for assessment differ to last year's criteria. Although additional "deep dive" questions on this year's assurance framework, an analysis shows a significant improvement in the Trust's position compared to last year's assessment.

The Trust is required to benchmark against the following compliance levels:

- Fully Compliant
- Substantially Compliant
- Partially Compliant
- Non-Compliant

The table below provides an overview of the Trust's position against the Core Standard which is described through a series of 54 criteria outlined at Appendix A.

Compliance Level	Total Number of criteria
Fully Compliant	51
Partially Compliant	3
Non-Compliant	0

On the basis of the Self-Assessment the 'Letter of Declaration' states that the Trust is Substantially Compliant.
There are four areas that are Partially Compliant and the following actions will be in the annual workplan:

- Estates Utilities & IT Failure Plans need review
- Divisional Business Continuity Plans need updating & review
- Assurance from Purchasing that they check Supplier and contractors BC Plans
- Increase the number of CBRN/HAZMAT staff trained

The Emergency Planning Programme has been completely reviewed in the past year and with assistance from Maidstone & Tunbridge Wells NHS Trust as part of an innovative collaboration between Kent Hospitals.

A detailed work programme to assist divisions increasing their resilience and introducing a culture of resilience is underway. Significant progress with Command Training and CBRN/HAZMAT training is evident along with a complete review of the suite of Emergency Planning & Response documents.

That the Board is asked to note the 'Letter of Declaration' (Appendix 2) supported by the Self-Assessment which states that the Trust's overall level of compliance against

the EPRR Core Standard is Substantially Compliant as agreed at Trust Management Board.

5 DEMAND AND CAPACITY PLANNING

The Board of Directors will receive a report at the December Board outlining the Demand and Capacity Plans for the whole health economy and to support delivery of national plans for referral to treatment (RTT), A&E, cancer and diagnostics. A communications exercise took place on the 30 September 2016, led by East Kent Resilience, the outcome of which will inform the development of these plans.

6 GOOD NEWS STORIES

Ministerial Visit

Minister of State for Health, Philip Dunne, visited William Harvey Hospital on 15 September.
The policy areas the Minister leads on include NHS operations and performance, healthcare quality regulation, patient safety and maternity care, so his tour included Maternity, Neo-Natal Intensive Care, ITU, the Cardiac Catheter Lab and the Innovation and Improvement Hub.

The Minister met privately with a group of staff and separately with the Chief Executive.

His visit gave him the opportunity to see for himself the progress that the Trust has made and he was quoted in the post-visit press release as saying:

"I saw first-hand the great strides in improving the quality of care that the Trust is making and the positive effect these changes are having on staff and patients.

"I enjoyed meeting and talking with a wide range of members of staff from across the hospital. It was very clear that everyone is passionate and united in their desire to continue to improve services."

William Harvey Hospital Chemotherapy Unit

Work on the new Chemotherapy Unit at William Harvey Hospital is scheduled to begin in October, and is likely to take four to six weeks to complete.

The Unit will allow the Trust to bring back all chemotherapy services previously available on the site before the enforced closure of the Celia Blakey Unit last year.

It will provide a bright, spacious environment for patients undergoing chemotherapy. It will be larger than the previous unit allowing more privacy within a modern, attractive environment.

Once the unit is fully operational, the mobile chemotherapy unit currently on the hospital site will be relocated to other areas in the south of east Kent to offer chemotherapy in rural areas.

PLACE audit

The Trust has seen a great improvement in its annual PLACE audit results. Patient-Led Assessment in Care Environments (PLACE) audits were introduced nationally in 2013, and have been designed to assess the quality of the patient environment. All hospitals, hospices and day treatment centres that give NHS-funded care are subject to a PLACE inspection.

The 2016 PLACE audits were carried out in May across the Queen Elizabeth The Queen Mother, Kent and Canterbury and William Harvey hospitals.
The results show a significant improvement upon the 2015 results, with the Trust now being above the national average in nearly all measures. Most significant areas of improvement include hospital cleaning, ward food and the condition and maintenance of buildings.

6 CHIEF EXECUTIVE ACTIVITY – SEPTEMBER 2016

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

- Various meetings with NHSI, including a PRM
- Hosted a visit from the Minister of State for Health
- Board of Directors meeting
- Various meetings with the CQC including the Trust presentation during the Inspection
- Number of Long Service badge presentations to staff across the Trust
- A variety of 1:1s with a range of staff
- Executive Mid-Year Review meetings
- East Kent Strategy Board
- Meetings with East Kent MPs Five Year Forward View
- Interview Panel for Kent and Medway Vascular Network Clinical Lead Roles
- Improvement Plan Delivery Board
- Staff Committee meeting
- Therapies Excellence in Clinical Practice
- Risk Register Sessions
- Trust inductions
- A number of STP meetings
- Children and Young People's Therapy meeting
- A&E Delivery Board
- Meetings with Kent County Council
- Kent Providers' Meeting
- Cancer Boards
- Visit to Faversham Health Centre for the X-Ray Launch event

I have also attended the following Board Committees:

- Quality Committee
- Finance and Performance 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

Kent and Canterbury Hospital,
Ethelbert Road,
Kent,
CT1 3NG

26th September 2014

To: Head of EPRR NHS England South

Cc: East Kent Hospitals University NHS Foundation Trust Accountable Emergency Officer

Dear Colleague,

Letter of Declaration against the NHS Core Standard for Emergency, Preparedness, Resilience and Response (EPRR).

This 'Letter of Declaration' is to confirm that the East Kent Hospitals University NHS Foundation Trust's Board of Directors approves the Trust's Self-Assessment which identifies the overall level of compliance against the NHS Core Standard for Emergency, Preparedness, Resilience and Response (EPRR) as **Substantially Compliant.**

The Board Paper and Self-Assessment are enclosed in support of this Declaration.

Yours faithfully,

Chairman on behalf of Board of Directors

Encs:

Paper to Board of Directors Friday 26th September 2014
Trust's Self-Assessment against NHS Core Standard
Statement of Compliance

NHS

South East
Commissioning Support Unit

EAST KENT HOSPITALS UNIVERSITY FOUNDATION TRUST

EPRR Assurance Assessment Report

September 2016

SOUTH EAST / CSU

Date	Version	Author	Notes
15.9.16	V1	Samantha Proctor	

Assurance Visit

South East CSU Business Resilience team visited East Kent Hospitals University Foundation Trust [EKHUFT] to conduct an assessment of their Emergency Planning Response and Recovery [EPRR] preparedness against the NHS England EPRR Core Standards.

The purpose of the visit was to enable EKHUFT to provide assurance to their commissioners as to their level of preparedness.

Assessment Details	
Date of assessment	15th September 2016
Locations of assessment	Kent and Canterbury Hospital, Canterbury
Assessors	Samantha Proctor [SECSU] and John Morrissey [SECSU] on behalf of Ashford CCG, Canterbury and Coastal CCG, South Kent Coast CCG and Thanet CCG
Provider Representatives	John Weeks, Head of EPRR, EKHUFT and MTW Nick May, EPRR, EKHUFT

Areas Investigated

The assessment looked for evidence against the core standards identified by NHS England as being required to be in place by an acute healthcare provider. The investigated areas were:

- EPRR Core Standards
- Deep Dive – Business Continuity
- HazMat/ CBRN Core Standards

Audit Results

EKHUFT were able to demonstrate and to provide evidence to demonstrate the following rates of compliance

	Green [full compliance]	Amber [plans to address gaps on annual work programme]	Red [significant gaps with no plan to address]
EPRR Core Standards	**33/34**	**1/34**	**0/34**
Deep Dive – Business Continuity	**5/6**	**1/6**	**0/6**
HazMat/CBRN Standards	**13/14**	**1/14**	**0/14**

Full assessment results are appended to this report.

Based on the NHS England levels of assurance below we conclude that EKHUFT meets the requirements for **Substantial Compliance**

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

Audit Narrative

EKHUFT have continued to work hard to improve their performance against the NHS England EPRR Assurance Framework Standards.

In September 2015 they were assessed as being non-compliant and a significant amount of work has been undertaken to move to their current positon of substantial compliance.

The commissioners of this provider can be assured that the trust has in place the required measures to respond to both internal disruptions and external major incidents.

However it is to be noted that there remains ongoing work to ensure that all the arrangements put in place during the last 12 months are further embedded into the culture and organisational structures of EKHUFT.

There were 3 standards found to be at amber status, as follows:

- EPRR Core Standard 8 – utilities, IT and telecommunications failure – it is noted that whilst there are some plans in place to manage such an incident, these plans would not necessarily stand up to detailed scrutiny and that further work is required to ensure that the arrangements are robust and can ensure continuation of service delivery. Work is already underway within the trust to address this.

- Deep Dive – Business Continuity – standard DD5 – AEO assurance for all providers/sub-contractors – the trust could evidence a degree of compliance with this standard with documentary evidence of assurances being sought from their contracted providers. However further evidence and assurance is required to provide wide enough evidence across the full range of contracted providers to score the trust anything other than amber. A process is in place to ensure full compliance during the next year.

- HazMat/CBRN core standard 41 – adequate and appropriate decontamination capability available 24/7 - at September 2015 there were no staff suitably trained and qualified within the trust. A plan was put in place to immediately rectify this situation and at time of assessment on 15.9.16 the trust now have 78 fully trained /qualified staff across the trust. By the end of November 2016 a further 20 staff will be trained/qualified bringing the trust close to its target number of over 100. Once this target is achieved the trust will move to a ‘maintenance programme ‘ of training to ensure that they have suitably trained/qualified staff available 24/7

Examples of good practice

During the assessment a number of examples of good practice were identified that it was felt were worthy of highlight largely as a result of the new team approach in collaboration with MTW where good practice is being rolled out with joint training and planning activities.

- EPRR Core standard 5 – risk assessment – a robust system of risk assessment is in place and is being used consistently across the trust.
- EPRR Core standard 8 – Pan Flu plan - a bespoke SITREP template has been developed as part of the Pan Flu plan which will allow for clear reporting from across the trust to be provided to those who are managing any pan flu response. This is in place across the Kent hospitals.
- EPRR Core standard 16 – on call training meeting set competency requirements – The trust have in place a Command Accreditation Scheme. This scheme is in place across EKHUFT/MTW and DVH trusts and all 'gold' and 'silver' level trust incident commanders are subject to this scheme. This is portfolio based and is linked to the trusts pdp processes as well.
- HazMat/CBRN trained staff – once staff are trained they are required to maintain a CBRN/Hazmat Assessment Record, which evidences that they are maintaining their skills and competencies. Upon completion of their training all staff are given a badge which identifies them as competent staff and all of them carry a 'permit to work'. This permit would be required to be shown to allow them to be part of any Hazmat/CBRN response, thus ensuring at a glance that those responding have the appropriate skills. This is in place across the Kent Hospitals

Principal Risks Report (Strategic & Corporate Risk Registers)

East Kent Hospitals University NHS
NHS Foundation Trust

Report Date	27 Sep 2016
Comparison Date	In the past 30 Day(s)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 32	Inability to share information about children and young people **Risk Owner:** Sally Smith **Delegated Risk Owner:** Trish Hubbard **Last Updated:** 16 Aug 2016 **Latest Review Date:** 12 Sep 2016 **Latest Review By:** Sally Smith **Latest Review Comments:** Further updates are being sought from the Division who are working on a plan.	12 Aug 2016	**Cause** * Notice of cessation of the Children and Young Persons Liaison Service by the CCG from September 2016 **Effect** * Potential lack of recognition of frequent offenders and safeguarding concerns going unrecognised * Reputational damage * Legal challenge	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 4 L = 4 High (16)	Interim arrangements in place after the closure of the service **Control Owner:** Carol Tilling	I = 4 L = 4 High (16)	Design and commission jointly with the CCGs a paediatric liaison service within the Trust. **Person Responsible:** Trish Hubbard **To be implemented by:** 31 Dec 2016	**16 Aug 2016** Discussions have commenced. The deep dive is being shared with the Trust and an action plan will be written. Funding is yet to be agreed and the model of care.	I = 4 L = 2 Moderate (8)
CRR 8	Lack of timely mental health interventions for Patients with mental health problems **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 13 Jul 2016 **Latest Review Date:** 06 Sep 2016 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk actions have been updated.	22 Feb 2016	**Cause** KMPT have reduced the Ilaison Psychiatry cover to the Trust to 08.00 to 16.00 hours as they are not able to recruit into their current vacancies and they have relied on agency cover to maintain their rotas. There is a national shortage of in-patient mental health beds. **Effect** Patients with recognised mental health disorders may not be treated in a timely way. There are an increasing number of calls to security and to SafeAssist Acute to manage challenging and violent behaviour. Other patients and staff are put at risk of harm from violent episodes. Patients who require in-patient mental health care are managed in acute facilities which are not fit for this purpose.	AO1: Patients. Help patients take control of their own health	I = 4 L = 5 Extreme (20)	Regular escalation and meetings between the Trust COO and the COO of KMPT and the CCGs is in place. **Control Owner:** Jane Ely Increase in cover arrangements for a 12 hour period across all 3 sites in place **Control Owner:** Jane Ely Single point of access for referrals for emergency and urgent patients from 01 April 2016 with a separate crisis team covering this area. Arrangements for other patients, including self-referrals and existing patients set up through GPs and NHS111. **Control Owner:** Jane Ely Employment of dual qualified RN and RMNs in Emergency Departments. **Control Owner:** Jane Ely Nominated consultant psychiatric cover for each site with Band 7 RMN and 5xBand 6 support to cover 08.00 to 16.00 hours. **Control Owner:** Jane Ely Agreed SOP in place to order additional nursing staff when a mental health patient has attended or is admitted. RMN, then RN, the HCA if the others are not available. **Control Owner:** Sally Smith	I = 4 L = 4 High (16)	On-going work with local Commissioners and the mental Health Trust is underway, following a wider health economy improvement plan away day in December 2015. A cogent and coherent action plan is required to ensure cover is provided in line with national timescale. **Person Responsible:** Jane Ely **To be implemented by:** 31 Mar 2017 Plans being formulated to ensure 24 hour cover across the Trust by 2020. Mental Health Commissioner locally is leading the commissioning intentions up to this date. **Person Responsible:** Jane Ely **To be implemented by:** 31 Mar 2020	**06 Sep 2016** KMPT is now providing a daily report of patients waiting for a mental health bed or assessment. Escalation in this way has allowed for daily communication between the two organisations to maximise responsiveness. **26 Jun 2016** Further discussions took place at the Quality Committee on Thursday 23rd June 16 with the CCGs.	I = 4 L = 2 Moderate (8)
CRR 22	Failure to record/carry out timely Venous Thromboprophylaxis (VTE) risk assessments **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Gillian Evans **Last Updated:** 13 Jul 2016 **Latest Review Date:** 15 Sep 2016 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Reviewed by Paul Stevens. No change to risk scores. Actions updated and completed actions added to controls. New action added.	26 May 2016	**Cause** The move from a paper to an electronic reporting system has resulted in issues with data accuracy and with data capture. VTE assessments either not completed on the Vital Pac system or not captured due to technical difficulties **Effect** Non-compliance with NICE CG92 Non-compliance with NICE Quality Standard (QS3) VTE in adults Harm to patients Reputational damage - Increased Complaints - Legal Claims - Financial Loss	AO3: Provision: Provide the services needed and do it well	I = 5 L = 4 Extreme (20)	VTE assessment recording data extracted from the VitalPAc system **Control Owner:** Paul Stevens No Patient is allowed to leave Clinical Decisions Units/A&E without VTE assessment **Control Owner:** Jonathon Hawkins Consultants iPads able to access the VitalPAC system **Control Owner:** Paul Stevens No patient is allowed to leave the Theatre recovery area without VTE assessment being recorded **Control Owner:** Nic Goodger	I = 5 L = 3 High (15)	Provide access to VitalPAC for recording of VTE assessments in the Emergency Department **Person Responsible:** Paul Stevens **To be implemented by:** 16 Dec 2016 Implement action plan devised in collaboration with the CCG quality leads to ensure the current reported rate of risk assessment improves and is sustained at the national level. **Person Responsible:** Gillian Evans **To be implemented by:** 30 Sep 2016	**26 Jun 2016** Regular feedback and progress is feedback to the CCGs against the action plan.	I = 3 L = 2 Low (6)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 28	Potential delays in treatment of Patients requiring Emergency Care **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 18 Jul 2016 **Latest Review Date:** 15 Sep 2016 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Paul Stevens. No changes to risk scores. Progress notes added to risk actions.	06 Jul 2016	**Cause** * Overcrowding in the Emergency Departments due to lack of flow through the Emergency Care Pathway **Effect** * Poor Patient experience * Harm to Patients * Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 5 L = 4 Extreme (20)	Urgent Care Recovery Plan in place **Control Owner:** Jane Ely Support from the Emergency Care Improvement Programme **Control Owner:** Jane Ely	I = 5 L = 3 High (15)	Develop an effective Acute Medical Model **Person Responsible:** Jonathon Hawkins **To be implemented by:** 30 Sep 2016	**15 Sep 2016** This is likely to be delayed pending recruitment of Acute positions	I = 5 L = 2 Moderate (10)
								Implementation of the Safer Bundle in WHH **Person Responsible:** Jonathan Purday **To be implemented by:** 31 Aug 2016	**15 Sep 2016** Partially implemented. Not all components of the Safer Bundle have been implemented. This is still ongoing. New implementation date to be advised.	
								Implementation of the Safer Bundle in QEQM **Person Responsible:** Paul Stevens **To be implemented by:** 31 Aug 2016	**15 Sep 2016** Partially implemented. Not all components of the Safer Bundle have been implemented. This is still ongoing. New implementation date to be advised.	
SRR 8	Inability to attract, recruit and retain high calibre staff to the Trust **Risk Owner:** Sandra Le Blanc **Delegated Risk Owner:** Jacqui Siggers **Last Updated:** 21 Jul 2016 **Latest Review Date:** 14 Sep 2016 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Reviewed by Sandra Le Blanc. No change to risk scores. Assurance levels reviewed and two assurance levels moved to adequate.	23 Feb 2016	**Cause** * It is widely known that there is a national shortage of healthcare staff in specific occupational groups / specialities. * It is a highly competitive recruitment market for these hard to fill roles, * Potential negative impact of Brexit * The Trust being in special measures, cultural issues identified in the CQC inspection * Proximity to London has impacted on the ability to attract and retain high calibre staff. **Effect** * Potential negatively impact on patient outcomes and experience * Financial loss * Reputational damage * Negative impact on staff health and wellbeing.	AO2: People: Identify, recruit and develop talented staff	I = 5 L = 4 Extreme (20)	The Trust has a plan in place that supports the retention of the majority of newly qualified nursing staff locally. **Control Owner:** Sally Smith Training plans in place in each division / corporate area that supports staff development. Talent management and succession planning process being piloted for full implementation later in the year. Staff able to access training and development to enable them to undertake their current role and meet their aspirations **Control Owner:** Jacqui Siggers Continued implementation of the Cultural Change Programme as part of the Trust's Improvement Journey - focusing on Leadership and Management Development, Staff Health and Wellbeing, 'Respecting Each Other' programme **Control Owner:** Sandra Le Blanc There is an agreed programme to recruit 90 nurses from EU / India for 2016/17. **Control Owner:** Jacqui Siggers Divisional Great Place to Work Action Plans in place **Control Owner:** Jane Waters New Appraisal Process in place **Control Owner:** Jane Waters implementation of retention plan as agreed with the Strategic Workforce Committee **Control Owner:** Jacqui Siggers	I = 5 L = 3 High (15)	Implementing a long term workforce plan that enables us to attract and retain high calibre staff **Person Responsible:** Jacqui Siggers **To be implemented by:** 29 Jun 2018	**12 Jul 2016** Long term workforce plan in discussion at fortnightly task and finish group meeting - initially focusing on Nursing	I = 5 L = 2 Moderate (10)
								In advance of finalising the Trust's communication strategy working with recruitment team to improve the 'branding' of the organisation to improve the attraction of the Trust **Person Responsible:** Natalie Yost **To be implemented by:** 30 Sep 2016	**14 Sep 2016** The Communications and Engagement strategy is going to the October board for approval. The following actions have been completed: *Recruitment stand designed and delivered to use in recruitment activity *Your Hospitals magazine launched to promote Trust as a great place to work *Great place to work film uploaded to job site *NHS jobs profile updated *Social media strategy in development *Refresh of jobs section of website in development **19 Aug 2016** Draft Communications Strategy in place. Anticipate approval at the 9th September BOD meeting.	
								Finalise plan for recruitment to hard to fill roles **Person Responsible:** Jaz Mallan **To be implemented by:** 29 Jul 2016	**19 Aug 2016** The target date for implementation is end March 2017. July 2016 was the start date. **02 Aug 2016** Met with JS to clarify feedback from SWC regarding further action required to provide assurance.	
								Implement Divisional Great Place to Work Action Plans **Person Responsible:** Jane Waters **To be implemented by:** 31 Mar 2017	**14 Sep 2016** Divisional Great Place to Work action plans facilitated and developed with support from HR Business Partners. Each division has presented their plan to the Strategic Workforce Committee and are currently implementing the actions. These plans are available for all to access on Staff Zone and will be updated with progress.	

East Kent Hospitals University NHS
NHS Foundation Trust

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 26	Regulatory non-compliance in Obstetrics and Maternity **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Helen Bland **Last Updated:** 18 Jul 2016 **Latest Review Date:** 15 Sep 2016 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Paul Stevens. No change to risk scores.	23 Jun 2016	**Cause** Reports from both the Royal College of Obstetrics and Gynaecology (RCOG) and the Local Supervisory Authority (LSA) identified gaps in regulatory compliance and also other areas for improvement in maternity services. The LSA report specifically highlighted gaps in the statutory supervision of midwives in the Trust. **Effect** Potential harm to patients (both pregnant women in our care and neonates). Reputational loss Regulatory concerns	AO3: Provision: Provide the services needed and do it well	I = 5 L = 4 Extreme (20)	The RCOG and LSA Combined Action Plan in place **Control Owner:** Helen Bland	I = 5 L = 3 High (15)	Deliver all the actions in the RCOG and LSA Combined Action Plan **Person Responsible:** El-Hussein Rfidah **To be implemented by:** 31 Oct 2016		I = 5 L = 2 Moderate (10)
SRR 1	Unable to deliver a clinical strategy that can be resourced **Risk Owner:** Liz Shutler **Delegated Risk Owner:** Rachel Jones **Last Updated:** 13 Jul 2016 **Latest Review Date:** 13 Sep 2016 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Reviewed by Liz Shutler. Actions updated and new actions added. No change to risk scores.	15 Jan 2016	**Cause** - Four CCGs having differing agendas; - Lack of stakeholder agreement; - Lack of clear commissioning intentions; - Parliamentary timings may not be conducive to timely implementation **Effect** - Patient care - Emergency transfer of services will become necessary - Reputational damage - Enforcement actions - Trust's provider licence (finance)	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 5 L = 4 Extreme (20)	Financial Recovery Plan **Control Owner:** Nick Gerrard Regular meetings with external partners / MPs / HOSC and within the Trust **Control Owner:** Liz Shutler 1st phase of NHS England assurance process passed **Control Owner:** Liz Shutler Internal clinical strategy board **Control Owner:** Matthew Kershaw East Kent Strategy Board **Control Owner:** Liz Shutler	I = 5 L = 3 High (15)	Submit next Kent & Medway STP **Person Responsible:** Liz Shutler **To be implemented by:** 21 Oct 2016 Agreement of final consultation document by all partners **Person Responsible:** Liz Shutler **To be implemented by:** 30 Nov 2016 To develop programme required to support an emergency transfer of services if required **Person Responsible:** Liz Shutler **To be implemented by:** 30 Sep 2016 NHS England assurance process **Person Responsible:** Liz Shutler **To be implemented by:** 30 Nov 2016	**13 Sep 2016** Programme unlikely to meet delivery date. Table top exercise planned for middle of October. Risk assessed options and trigger points agreed. **13 Sep 2016** Clinical senate date agreed 8th November and NHSE investment committee date being sought.	I = 4 L = 2 Moderate (8)

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 OCTOBER 2016**
SUBJECT:	**HIGHEST MITIGATED RISKS** • **Corporate Risk Register** • **Strategic Risk Register**
BOARD SPONSOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**DEPUTY DIRECTOR OF RISK, GOVERNANCE AND PATIENT SAFETY**
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY

This report provides the Board of Directors with an update on the Corporate and Strategic Risk Registers at 28 September 2016 and new emerging risks proposed for inclusion to the Corporate Risk Register. The new risks discussed and agreed at the August Management Board meetings were added to the risk system (4Risk). Further risks were discussed at the September meeting for inclusion as agreed; these are detailed in the paper. The risks rated as "red" post mitigation (residual) were reviewed by the Board of Directors on 9 September 2016; the full register was reviewed by the Board at the January 2016 meeting. The top 10 risks were last reviewed by the Integrated Audit and Governance Committee on 19 April 2016 and the full register was reviewed on 19 July 2016. At the time of writing the Quality risks were reviewed and discussed at the Quality Committee on 03 August 2016.

Monthly meetings are being held with the responsible Executive lead to review the scoring, actions and the specific wording for each strategic and corporate risk.

Following ratification of the revised Risk Management Policy by the Trust Board on 09 September 2016, the 4Risk System has been updated with the new risk matrix which is reflected in the appended Corporate Risk Register report. The risk scores were previously classified as Low, Moderate, High and Extreme but now include Very Low.

This paper appends the Principal Risks Report ('Extreme' and 'High' risks on the Corporate and Strategic Risk Registers reported by residual risk score).

Heat Map (by Residual risk score)

Corporate Risks

Strategic Risks

Principal Risks (Highest Mitigated)
The following risks are reported with a residual risk score of 15 or above and categorised as 'extreme' or 'high' on the Corporate Risk Register:

Risk Ref	Risk Title	Residual Risk Score	Direction of Travel
CRR 32	Inability to share information about children and young people	16	
CRR 8	Lack of timely mental health interventions for Patients with mental health problems	16	
CRR 22	Failure to record/carry out timely VTE risk assessments	15	
CRR 28	Potential delays in treatment of patients requiring Emergency Care	15	
CRR 26	Regulatory non-compliance in Obstetrics & Maternity	15	

The highest mitigated risks with a residual risk score of 15 or above and categorised as 'extreme' or 'high' on the Strategic Risk Register:

Risk Ref	Risk Title	Residual Risk Score	Direction of Travel
SRR 8	Inability to attract, recruit and retain high calibre staff to the Trust	15	
SRR 1	Unable to deliver a clinical strategy that can be resourced	15	

Emerging (New) Risks
The following emerging Corporate risks were discussed at Management Board on 28 September 2016:

1 **Potential negative impact of PAS system implementation on 18 weeks Referral to Treatment (RTT) – Executive Lead (Jane Ely)**

This risk has been referred for inclusion in the Corporate Risk Register by the Surgical Governance Board.
Due to the implementation of the new PAS system, there is a risk that the Trust requirement for a reduction of clinics for elective Patients (including outpatients) could lead to delayed surgical intervention and further difficulty in meeting the 18 week RTT waiting times across most specialties.
Actions required include:

- Implementing lessons learned from PAS implementation by other Trusts;
- Review of the proposed reduction of clinics and operating theatre activities in order to minimise the impact.

The risk is one associated with Patient safety and potential reputational damage.

2 **Failure of PACS and Radiology Information System (RIS) – Executive Lead (Liz Shutler)**

Concerns have been raised across the Kent & Medway Consortium about problems following the last update to PACS and RIS resulting in further delays in reporting MRI and CT imaging and obstetric ultrasound and its negative effects on cancer pathways and other diagnostics.
Actions required include:

- Meeting regularly with supplier to come up with sustainable solutions;
- Reporting the impact of these delays on the Strategic Executive Information

System (STEIS) across the Consortium;
- Carry out a full system review and Root Cause Analysis (RCA) around IT and potential patient safety issues.

The risk is one associated with Patient safety and potential reputational damage.

3 **Inadequate Adult Safeguarding training arrangements Trust-wide – Executive Lead (Sally Smith)**

This risk is associated with the delivery of the Adult Safeguarding training element of the Improvement Plan for the Trust. The Trust has set a target to meet a training compliance of 85% for Adult Safeguarding at level 2. This is currently 64%; there is 100% compliance at level 1.

There is a risk that the training arrangements for Adult Safeguarding are inadequate as a result of reduced staffing levels in the Adult Safeguarding team.

Actions required include:
- Approval of the level 2 online Adult Safeguarding Training to supplement face-to-face training;
- Working with HR Systems to capture all areas of non-compliance with Level 2 training.

The risk is one associated with patient safety, role-specific essential training non-compliance and potential reputational damage due to not meeting the Schedule 4 contractual requirements.

4 **Delays in Radiological reporting – Executive Lead (Paul Stevens)**

Concerns were raised about these delays at the Clinical Support Divisions Executive Performance Review on 21 September 2016. There is a risk that delays in reporting images may lead to delays in diagnosis and start of essential treatment. This is as a result of increased demand, lack of capacity and is further compounded by problems with PACS and RIS.

The risk is one associated with patient safety and potential reputational damage.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The attached Corporate and Strategic Risk Registers reflect the corporate and strategic risks facing the Trust and the mitigating actions in place.
LINKS TO STRATEGIC OBJECTIVES:	The Corporate and Strategic risks align to all of the four Strategic Priorities: **Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	This paper provides an update on the highest mitigated risks and risk themes for the Trust.
RESOURCE IMPLICATIONS:	None specifically identified other than identified in the Risk Registers.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	The Risk Group and Management Board will review any new risks and the scoring of the existing risks.

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors are invited to review the Corporate and Strategic risk registers that are appended; and to note and discuss the emerging risks.

The Board is invited to consider the sufficiency of the corrective actions identified in relation to the risks and provide positive challenge where necessary.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 OCTOBER 2016**
SUBJECT:	**STRATEGIC WORKFORCE COMMITTEE**
BOARD SPONSOR:	**CHAIR OF THE STRATEGIC WORKFORCE COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE STRATEGIC WORKFORCE COMMITTEE**
PURPOSE:	**Approval**

BACKGROUND AND EXECUTIVE SUMMARY

The Committee is responsible for providing the Board with assurance on all aspects relating to the workforce, including strategy, delivery, governance, risk management.

This report presented reflects Committee activity for the September 2016 meeting.

The report seeks to answer the following questions in relation to workforce:

- What went well over the period reported?
- What concerns were highlighted?
- What corrective action was sought?

Discussion relating to HR metrics:

- Concern was raised at the previous meeting about the data being presented in the Integrated Performance Report. This issue had been rectified and the data was now correctly represented.
- The Turnover rate has increased in the past two months, which has also increased the vacancy rate from 9.7% in June to 10.3% in July. However, the average Turnover rate for the past 12 months remains significantly lower than the previous 12 months at 11.2%.
- Sickness absence increased to 4% in June, against the Trust target of 3.3%. Divisions have submitted a monthly trajectory for sickness absence, which are examined at EPRs and monthly Agency Pay Control meetings. Although Divisions are running behind their trajectories, the 12 month average remains lower than the previous 12 month average.
- The percentage of employees claiming overtime remains relatively static at 8.2%, after peaking at 10.1% earlier in the year.
- Statutory training was at 86% for July which remains above the target of 85%, and the 12 month average remains significantly above the previous 12 months.
- The Trust staff appraisal rate has continued to recover in July to 75.4%, but remains below the 90% target. Due to summer annual leave it is unlikely that there be any significant improvement until September.
- The most recent staff FFT, run during August, had a response rate of 30%. This compares favourably with the national average of 16%. The percentage of staff that would recommend the Trust as a place to work has risen to 58%, the highest score to date, and those that would recommend it as a place to be treated has remained at 78%. This demonstrates an overall upward trend over the last 18 months.

The following concerns were highlighted:

- Local Induction Compliance remained at 15%, although it remains significantly higher than in previous months. The current method of recording that a local induction has taken place

is unhelpful as both the individual and their line-manager must indicate that the induction has occurred. Action: HR is seeking to identify alternative methods of confirming that a local induction has taken place; in addition the Director of Nursing and Director of Quality will be discussing local induction at the Head of Nursing meeting.

- The members' discussed concerns in relation to the Trust being an outlier for medical agency spend. It was confirmed that all actions necessary were being taken to reduce the locum spend as had been confirmed in the deep dive in the previous month. The Executive continued to provide challenge to the Divisional Management at the Executive performance Reviews.
- Job planning was taking longer than expected and the Committee have requested an update at its next meeting on progress as well as confirmation that there were resource in place to support the work.
- An update was received on the business case submitted to NHS Improvement to support the Leadership and Management development programme. Following the submission, NHSI had requested further information as to the deliverables and a more detailed breakdown of the costs. NHSI indicated that there were less costly leadership and development programmes that should be considered by the Trust. The Committee was concerned that NHSI had not understood the breadth of the programme as it was a more holistic approach to embedding improvement in to the Trust's culture. Gill Gibb agreed to review the possibility of the Charitable Funds Committee supporting the leadership and development programme.
- The Committee received the first report from the Joint Chairs of Staff Committee, this identified concerns in how the recent TUPE transfer of speech and language therapy staff to the Community Trust had been handled. Lessons had been learned by the Trust and these would be taken into account if the Trust was to give notice on a service in the future.

The Committee received the following reports and assurances:

- The Committee received a presentation from the Specialist Services Division providing an overview of their workforce plans (achievements, risks and mitigations). Highest risks for Specialist were noted as: maternity turnover and recruitment; maternity culture, although that was improving; medical recruitment in dermatology and fill rate of deanery posts. The Committee was assured by the innovative work being undertaken in the Division in relation to women's health leadership, the innovative recruitment of specialist nurses in chemotherapy, midwifery and paediatrics, where recruitment days were held that enabled the Trust to interview and offer on the same day (where appropriate). The Division provided assurance in relation to their job planning processes which would result in a quality job plan linked to activity for each medic. The Division was an early adopter of flat rate PA's and would push to adopt annualised 11PA contracts if this was supported Trust-wide. The Head of Human Resources and Medical Director will be reviewing the Job Planning Policy. Job Planning and Programmes Activities will be included in the discussions at Finance and Performance Committee and Board on cost efficiency plans in October.
- The Committee reviewed the deep dive into workforce benchmarking. It was agreed that further analysis and validation of the benchmarking data through discussions with Divisional Directors will ensure that the actual risks and opportunities are identified. The Turnaround Director and Head of Human Resources will be meeting with the Divisions to discuss and understand the opportunities and risks.
- The Committee received the outcome of the Medical Engagement Survey which ran during July and August 2016. In total 234 doctors across all grades completed the survey, giving a response rate of 40%. The results show that there has been significant improvement since April 2015. The Committee has requested an action plan for its next meeting.
- The People Strategy was well received and is recommended for approval to the Board of Directors. The Director of Human Resource is developing an implementation plan which will be available for the Committee's November meeting.
- Following the initial report in July and a verbal update in August the Heads of Nursing for Urgent Care and Long Term Conditions outlined their plans and timeline to put in place an Emergency Nurse Practitioner (ENP) service. This required investment and therefore a business case would be presented internally for consideration. In the meantime the Division has identified a number of initiatives to ensure that patient safety and quality are not

compromised:

- Introduction of Emergency Severity Index assessment system at WHH to ensure that all ambulant patients are met on arrival by a senior nurse, streamed to the correct area and that further assessment by a clinician (doctor or ENP) is undertaken promptly;
- Introduction of the Rapid Assessment and Treatment area within majors at WHH. This is due to commence in October 2016 when two additional ED consultants commence in the Trust;
- Introduction of "team" working at QEQMH where a doctor, trained nurse and technician are allocated to a group of patients and work together, thus providing continuity and consistency of care;
- Use of the 'UPDATED' pneumonic to ensure patients are receiving safe care. This addresses pain, comfort, treatments, and special needs;
- Introduction of a revised escalation tool and response to increased demand within the department;
- A checklist for patients who may need to be cared for outside of a designated cubicle, at times of high demand which may lead to crowding;
- A checklist for undertaking a board round, between the nurse in charge and doctor in charge at 2 hourly intervals to ensure that all patients have a plan for their care.

ACTION:

To note and discuss the report from the Strategic Workforce Committee**.**
To APPROVE the People Strategy appended to this report.

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BoD 83/16

People Strategy
Together We Care

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People Strategy – what is it?

East Kent Hospitals University NHS
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- This outlines our approach to 'Great People' and becoming the NHS employer of choice – through attracting, retaining and developing our people through a career path here at East Kent Hospitals.
- Our vision is to deliver ' Great Healthcare' by having high performing staff, with the right skills, in the right place, at the right time.
- To become an employer of choice, we need to progress to being in the top 20% of Trusts in all the annual NHS staff survey key findings and our cultural change programme 'Great Place to Work' programme that is well underway is fundamental to achieving this aim.

- The inspiration for the 'People Strategy' is based on our 'Great Place to Work' programme and our Quality Strategy, as we strive to improve the services we deliver to our patients and their families by providing safe, effective and person-centred care.
- The 'People Strategy' was developed after engagement and consultation with the Board of Directors, Divisional Leadership Teams, managers, staff and staff representatives.
- The People Strategy will have a detailed implementation plan with strong measures that will be monitored at Management Board, Strategic Workforce Committee, and other staff committees.

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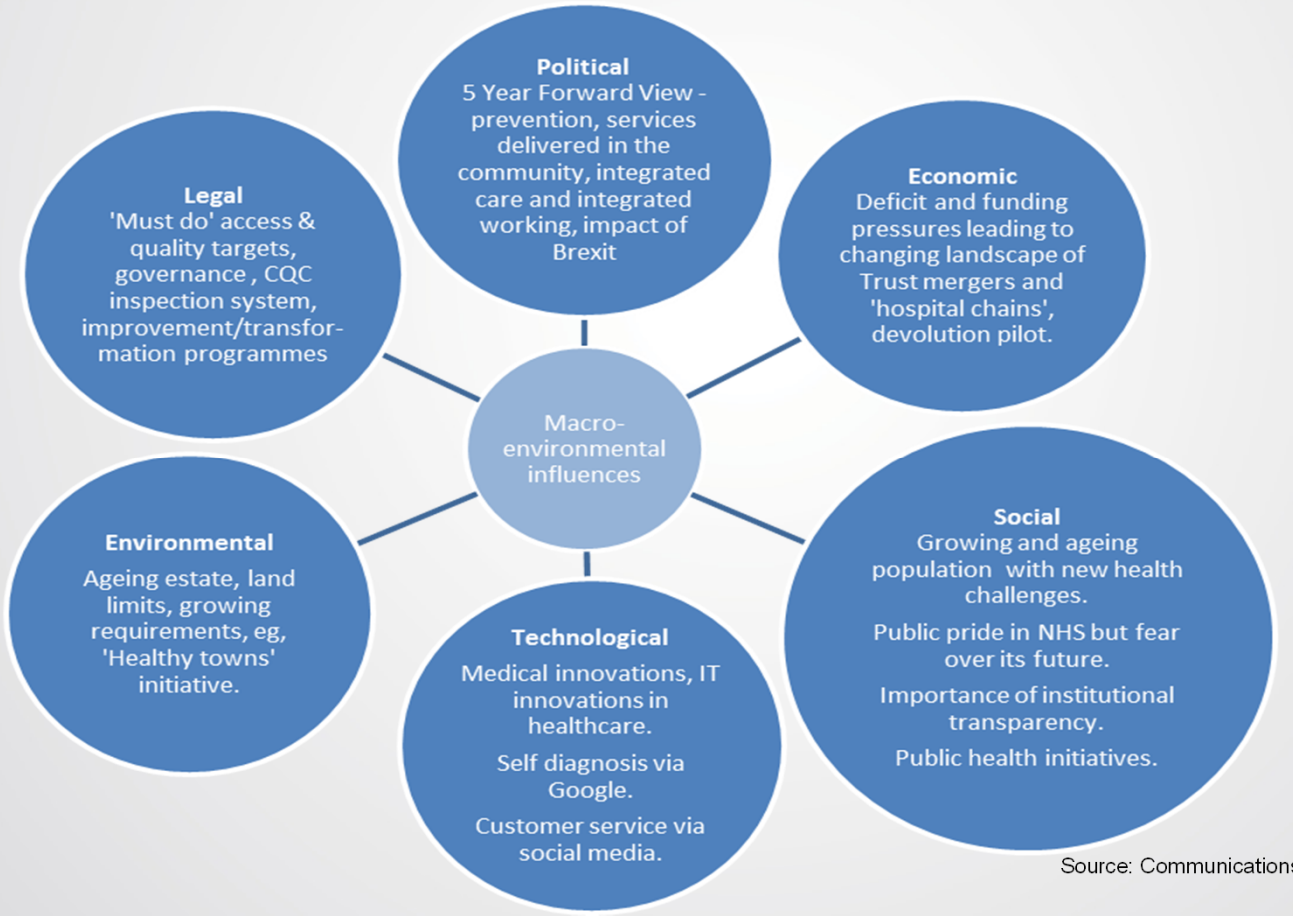
Strategy in Context - External Environment

The Trust is operating in a changing and pressured environment and needs to build a strong reputation as a provider of great healthcare, as a key partner in integrated care and as an employer of choice. We need to have a flexible and adaptable workforce to meet the rising demands for healthcare and increased expectations of our patients.



Source: Communications Strategy 2016

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Strategy in Context - Staff Views

- **Staff Friends and Family Test:** Introduced in April 2014 to give staff the opportunity to feedback their views and support the cultural shift in NHS Organisations. The Trust actively encourages staff to 'speak up' and ensures that their views are heard and acted upon. We have achieved the best results since the introduction in 2014 with 58% of staff saying they would recommend the Trust as a place to work, and 78% as a place for treatment.

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Strategy in context - Workforce performance indicators

Workforce performance indicators (those regularly reported at board level) are given below showing the improvement or deterioration since 2014 when we were placed in special measures.

	2014	2015	2016
Funded establishment (in whole time equivalent numbers)	6990.46	7278.57	7684.38
Average vacancy level for previous 12 months	5.9%	7.3%	8.9%
Turnover for previous 12 months	11%	12.6%	11.2%
Average sickness level for the year	3.7%	3.9%	3.7%
Appraised in the last 12 months	78%	78%	79.5%

Source 2016 – July 2016 IPR

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Strategy in Context

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Our Vision, Mission, Values and Strategic Priorities. People - *We want to 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.*

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Strategic Aims of our People Strategy

Our People Strategy has four strategic aims – to **Attract, Develop, Engage and Retain** staff to deliver our vision of 'good healthcare' and embed our values and behaviours - caring, respect, confident and making a difference.

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Strategic Aims

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Details the key themes under the four strategic aims supported by clear diversity and inclusion strategy.

Attract	Develop	Engage	Retain
Recruitment	Leadership Development	'Great Place to Work' Programme	Staff Health and Wellbeing
Induction	Education	Role that makes a difference	'Right size' and 'Right Skill staffing profile
Reward and Recognition	Talent Management and Development	Leading organisational change	Career Development and Succession Planning

Diversity and Inclusion

Attract

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Aim

Attract, retain and reward high calibre staff who demonstrate our values and behaviours.

Key Objectives

We will:

•Produce and implement a comprehensive resourcing plan that reflects the required workforce profile and plans (size and skills) for now and the future.

• Fully embed our values and behaviours into the recruitment process, together with an assessment for potential for leadership roles to ensure we recruit the right calibre of staff with future potential.

•Develop an 'employer brand' with coordinated recruitment activities across all media outlets, from traditional press advertising through to social media contacts such as Facebook, LinkedIn, Twitter etc.

•Develop and deliver best practice, consistent, robust and seamless induction (both corporate and local) process for all new staff.

•Have a tailored process for attracting, recruiting and induction of our people from overseas in line with our values and behaviours

•Attract, retain and motivate high calibre staff, pay and reward staff fairly according to their competence, qualifications and experience, that is locally competitive.

•Recognise staff for their contribution in delivering safe, effective, person-centred care, and exhibiting our values and behaviours with staff/patients/carers and other service users.

Embed apprenticeships into routine recruitment activity; actively identifying new posts

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Develop

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Aim

Support our staff to fulfil their potential and ensure that the Trust has the right skills to meet current and future needs through effective learning, development and education.

Key Objectives

We will:

•Have an EKHUFT leadership framework so that our managers and leaders know what is expected of them, and they are supported in achieving those expectations through a range of leadership and management interventions, locally through the EKHUFT Leadership Academy and national leadership programmes.

•Ensure that staff have meaningful personal development plans, with access to appropriate learning, development and educational opportunities for their current role and support their transition to more senior positions.

•Produce in partnership, with staff and their representatives, clear career paths for common roles across the organisation.

•Develop our most talented leaders, creating a pool of people with strong leadership for EKHUFT and the wider healthcare system and making sure we have succession plans in place for key critical posts

•Have an integrated approach across the Trust for all Learning, Development & Education activities and resources aligned to the Trust's strategic direction

•Have a transparent method of allocating funding to departments and wards for learning, development and education that ensures maximum Return on Investment (ROI) for delivering high quality person-centred care

•Monitor and report training, development and education support to individuals to ensure that all staff are fairly supported in meeting their personal development plans.

•Have a range of mixed learning opportunities including visual & social media and simulation are available to support employee development and progression

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Engage

Aim

Create a culture where staff feel empowered and are recognised for their contribution to delivering high quality, safe, person-centred care.

Key Objectives

We will

•Continue to revise and implement our 'Great Place to Work' cultural development programme improving working life for our staff.

•Engage with staff and staff representatives on changes that affect them, so that they can be part of the decision making process and there be 'no surprises'.

•Proactively engage our medical staff, by increasing their involvement in strategic planning and and development, to deliver improved service changes.

•Have the right organisation structure in place to support staff in delivering safe effective person-centred care and that decisions are taking place at the right level of the organisation.

•Create an environment where staff can take individual action and initiative whether small or large to do something positive for patients, service users of other staff to make a difference every day.

•Equip staff with the knowledge and tools to carry out improvements locally and more widely that deliver better person-centred care and experience.

•Proactively support staff to have and maintain a healthy work/life balance.

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Retain

Aim
Have a proactive approach to staff health and wellbeing to increase the quality of service provided to our patients

Improve patient services and deliver cost effective services through our workforce

Key Objectives

We will

•Provide staff with appropriate physical and psychological working environment, including access to rest areas, stress management, mental health and mindfulness programmes and will be kept updated on a Trust wide level and more locally within their divisions, department and team.

•Ensure that every staff member is aware of the Trust staff health and wellbeing initiatives and that they are able to engage through various channels including social media (Facebook, LinkedIn, Twitter etc.).

•Provide training and resources to line managers so that they can support the health and wellbeing of their staff, particularly their mental health.

•Work with leaders to understand the key skills and numbers of staff required to deliver 'great healthcare' aligned to the Trust's clinical strategy to ensure that workforce is planned - resources in right place right time, doing the right things.

•Work in partnership with our trade union colleagues to develop measures of workforce productivity and use this to the benefit of our patients, enhancing patient and staff experience.

•Benchmark ourselves to understand whether we are providing value for money and work with staff and leaders to understand variance and address it.

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Diversity and Inclusion

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Aim

We will create a work environment free from discrimination where everyone is valued, supported and treated with dignity and respect

Key Objectives

We will

•Have an unambiguous diversity and inclusion Trust statement in respect of discrimination, creating an inclusive environment for our staff, patients and service users. This will form the basis of our diversity and inclusion objectives to be monitored by the Equality, Diversity and Inclusion Group.

•Provide leaders and managers with training and resources to support their staff to achieve a working environment that is free from discrimination

•Have a strategy to develop existing staff network groups (purpose, value and greater participation), and provide the support to develop more network groups to represent our diverse workforce.

•Increase the monitoring of our human resources policies and practices to ensure all our staff are treated fairly in relation to training, development, career progression, reward and recognition.

•Enhance the timeliness and quality of Equality Impact Assessments to ensure that any issues are discussed before decisions are made.

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Excellence in HR Service Delivery

- Ultimately, line managers are responsible for the competence, performance, development and health and wellbeing of their staff. Nevertheless, the HR function is pivotal in delivering HR solutions, therefore the capacity, capability and skills of the HR function is key to the Trust delivering this strategy.

- **Service delivery** –The aim is to be best in class in terms of quality of service and cost efficiency, using comparative benchmarking data. We will also seek to work with our system partners to deliver services through shared services.

- **Capacity and Capability Analysis** – an analysis of the function will be undertaken to ensure they have the right skills and capacity for current and future needs, and that the Trust continues to invest in the team's professional development and address any identified critical gaps in knowledge or experience.

- **HR Systems** – The Trust will continue to realise the benefits from electronic rostering for the effective deployment of all staff, and progress to an employee service model with an increased reliance on the Trust's intranet for initial support and guidance. We will also seek to invest an in electronic performance management and appraisal system

- **HR KPIs** –The team will continue to benchmark its performance against other NHS and non NHS organisations in order to identify opportunities for improved performance and productivity.

- **HR 'Brand'** - An annual customer feedback survey will be introduced so that we have formal feedback from customers (employees, leaders, managers, applicants, and corporate team)s to identify and address areas for improvement, and understand where we deliver to customer needs, thereby enabling the delivery of excellent patient care and experience.

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How will we know if the strategy has made a difference?

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- We will have the ‘right size’ organisation with high performing staff that have the ‘right skills’ to deliver national performance standards.
- Improved staff engagement, a sense of belonging to ‘EKHUFT’ giving improved NHS Staff Survey results (top 20% of acute trusts), patient satisfaction (patient surveys) and health outcomes
- Key staff retained and the ability to attract high calibre talent to the organisation,
- Reduced reliance on temporary staff (agency, locum and bank) with improved use of substantive staff enabling us to deliver a more clinically and financial sustainable service for our patients
- Achieved the metrics as set out in the strategic objectives in terms of employer of choice
    - NHS staff survey and Staff Friends and Family results over 75% by 2019
    - Staff turnover rates and reducing the high levels of staff leaving within first year of employment
    - Improved the talent pool
    - Improve the quality and quantity of applicants to clinical and non-clinical posts
    - Increasing clinical productivity and reducing clinical variation

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Monitoring and Measurement

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Metrics for measuring the implementation of the strategy will be set and monitoring will be through Management Board and Strategic Workforce Committee.

Attract	Develop
- Length of time to recruit - Actual vs. planned turnover - Recruitment costs i.e. cost per hire - Number of failed probations - Withheld incremental increases	- Internal promotions vs. external appointments - Talent plans in place - Quality of staff appraisals - Number of serious incidents - Related staff complaints
Engage	**Retain**
- Staff Friends and Family Test - Annual NHS staff survey results - Identified questions in national NHS patient surveys - Reduction in sickness absence - Actual vs. planned turnover	- Workforce Plans delivered - Succession plans in place - Roster efficiency metrics - Exit interview feedback - Staff Health and Wellbeing CQUIN / NICE targets and measures
Diversity and Inclusion - Selection by key performance indicators - Retention by key performance indicators - Workforce profile (WRES, WDES) - Delivery of Diversity and Inclusion Strategy	

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REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 SEPTEMBER 2016**
SUBJECT:	**INTEGRATED PERFORMANCE REPORT**
BOARD SPONSOR:	**DIRECTOR OF FINANCE AND PERFORMANCE** **CHIEF OPERATING OFFICER** **DIRECTOR OF HUMAN RESOURCES** **CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**HEAD OF INFORMATION**
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY

The Integrated Performance Report provides a summary of performance across all key metrics. The attached report reflects performance as at August 2016. Key highlights include:

- Results from the friends and family test continue to demonstrate positive perception of care provided to patients.
- Performance around response times to complaints reported further progress, but further improvement work is in place which is expected to come to fruition later this year.
- 4 hour and 18 week RTT continue to report non-compliance. Work continues both internally and externally.
- The Trust continues to report positive figures on mortality rates, new harms and serious incident reports which reflects the work done by staff on providing safe and effective care.
- There are ongoing risks with infection control and pressure ulcers and demonstrates the need to maintain an absolute focus on all aspects of care. The heat map is used to demonstrate progress on these and other metrics.
- Informal feedback from the CQC re-inspection was positive around our caring staff, great place to work initiative, and the perception of care provided to patients. However, there is more work to be done to ensure this is embedded across the Trust.
- Financial performance remains a challenge. The in-month position has been affected by the provisions made around the Sustainability and Transformation funding not being secured. Discussions continue with NHSI. In the meantime, cost improvement plans, a focus on agency costs and vacancies remains a central part of the work we are doing.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	As referred to in the Executive Summary.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	Links are made to the Strategic and Corporate Risk Register.
RESOURCE IMPLICATIONS:	As referred to in the Executive Summary.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Finance and Performance Committee Quality Committee Strategic Workforce Committee

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

RECOMMENDATIONS AND ACTION REQUIRED: The Board of Directors is asked to discuss the report.

East Kent Hospitals University NHS
NHS Foundation Trust

AUGUST 2016

INTEGRATED PERFORMANCE REPORT

East Kent Hospitals University NHS
NHS Foundation Trust

Chief Executive's Summary

The results from the friends and family test continue to demonstrate positive perception of the care provided to patients and this has been reinforced by the initial informal feedback from the recent CQC re-inspection. More formal feedback and a decision on special measures will be made in December and the unannounced inspections and further information provision are now occurring as part of the normal CQC process. We have been very clear that the improvement journey will continue irrespective of the outcome of the re-inspection as we are completely committed to the work to further improve the care we provide to patients and the support we give to our staff.

The work on responding to complaints has shown further progress this month but there is much more to be done as evidenced by the performance improvement required in terms of replying to complaints within 30 days which is not at the level to which we aspire. A number of changes to the process are being implemented to support this and improvement is expected from this work later in the year.

Overall performance against the national standards remains a real challenge. The work on diagnostics and 2 week wait cancer referrals continues to deliver to the expected standards but 4 hour waits in the emergency department and 18 week waits need more substantial improvement. Safety and the experience for patients is the key first step to this work but performance is similarly crucial and a renewed focus on both through the A&E delivery board and Trust and CCG discussions on RTT will help to drive more executive level support to the detailed work by clinical and managerial staff operationally. This means continue to focus internally and externally on those initiatives we know will help from our own work and best practice locally, regionally and nationally.

The report shows continued positive figures on mortality rates, new harms and serious incident reports which reflects the work done by staff on providing safe and effective care. However, the ongoing risks with infection control and pressure ulcers demonstrates how we have to and will maintain an absolute focus on all aspects of care - including these core standards. The heat map used to demonstrate progress on these and other key metrics right across the Trust is an important tool helping with our absolute commitment to improving safety for patients and staff.

The recent informal feedback from the CQC re-inspection talked positively about our caring staff, the great place to work initiative and openness and enthusiasm of the staff themselves. This is all part of the commitment to improving the Trust as a place to work and the figures on appraisal rates and mandatory training reinforce this. However, there is significant more work to be done to ensure this is consistent across the Trust and is truly embedded in how we work on a day to day basis.

Finally, finances remain extremely difficult and the in month position has been affected by the provisions made around Sustainability and Transformation funding not being secured. Further discussions are being held at senior level with NHS Improvement to address this but in the meantime, cost improvement plans, a focus on agency costs and vacancies remains a central part of the work we are doing. As I set out in my recent blog, delivering on our financial responsibilities needs to be seen along with safe and effective care and performance as three essential elements of successful delivery. Addressing all three aspects will demonstrate that we are making positive progress on our overall improvement journey for our patients and staff.

East Kent Hospitals University NHS
NHS Foundation Trust

Understanding the IPR

1 **Headlines**: Each domain has an aggregated score which is made up of a weighted score derived from their respective sub-domain. There is an overall executive Trust summary followed by more specific commentaries for each of the five domains which are based on the recent Carter review and the way that the CQC organises its inspection into specific areas.

2 **Domain Metrics**: Each domain will have two pages; one showing overall aggregated scores split by sub-domain and another showing a selection of key metrics which help form the sub-domain aggregated metric scores. The first page indicates the sub-domain weighting % which is used to calculate the overall domain score. The second page illustrates key (but not all) metrics measured within that sub-domain.
This is important as it explains why the sum of each metric doesn't total 100%. A list of all metrics used in the calculation is summarised in the Glossary pages.

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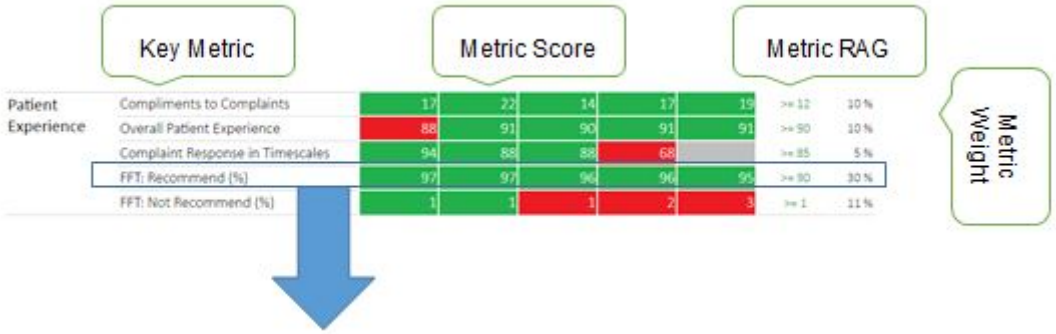
Understanding the IPR

3 **Key Metrics:** This section provides the actual data that builds up into the domain, the actual performance in percentage or volume terms for any given metric. These metrics are explored in more detail in the next section, Strategic Themes.



4 **Strategic Themes**: The Strategic Theme pages house key metrics with additional analysis, showing trend over the last 12 months. They show the latest month RAG together with the last 12 months position status (ie improved or worsened % from the previous 12 months plus average metric score). The 12 month positions will either be an average (if a % or index) or total sum (if a number). In addition to this it includes a metric description and data assurance stars which reflects how assured the data is. Description for how the data assurance stars are formulated is explained in the Glossary.

All RAGs are banded as Green, Amber and Red. The threshold for the green RAG point is indicated in the Glossary pages together with how much weight each metric holds towards the sub-domain.

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Strategic Priorities

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Headlines

	Positives	Challenges	
Caring	-97% of our patients would recommend the Trust to their friends and family -More than 90% of our inpatients were satisfied with their care whilst an inpatient with us -We exceeded our standard of 85% with 95% of our complaints responded to within agreed timescales - PLACE scores this year have shown an improvement across all of the metrics	-We are still reporting mixed sex breaches for non-clinical reasons -We did not meet the 30 working day stretch standard for complaint responses	A M J J Aug Sally Smith
Effective	-Cancelled operations for non-clinical reasons remain low -There has been a slight reduction in the number of delayed transfers of care from our hospitals	-There has been no change in the hospital bed occupancy -There has been a slight decline in theatre on time starts and the audit results for the WHO theatre checklist	A M J J Aug Jane Ely
Responsive	-Performance for the diagnostic waiting times remains strong at well over 99% completed within 6 weeks -We have achieved the two week wait cancer standard for referral to being seen by a consultant -The 62 day cancer standard performance has improved slightly to the level in June	-The performance against the Emergency four hour standard has not improved despite all the hard work that our staff deliver everyday -Our performance against the 18 weeks referrals to treatment standard has not improved.	A M J J Aug Jane Ely
Safe	-Fewer serious incidents were reported in August compared to July -Lower than the national average mortality rates -New harms in the safety thermometer are better than the national average -No cases of MRSA in month	-Two deep pressure ulcers were reported -C-difficile rates remain a risk	A M J J Aug Paul Stevens
Well Led	- Mandatory training at 88% - Appraisal rates have increased for the 4th month (79.5%) - Cash balances at £17.5m - Health and Safety concerns continue to be low - Cultural change programme enhanced through recent CQC re-inspection	- Excluding the impact of the STF, the Trust's financial position was marginally worse (£0.2m) in August. - Securing CIPS in a challenging workforce and operational environment - Staff turnover remains at 12% with vacancy levels having risen to 11% - Shifts filled (day) reduced in July to 91% - Sickness levels now at 4% - Agency spend increased marginally in August	A M J J Aug Matthew Kershaw

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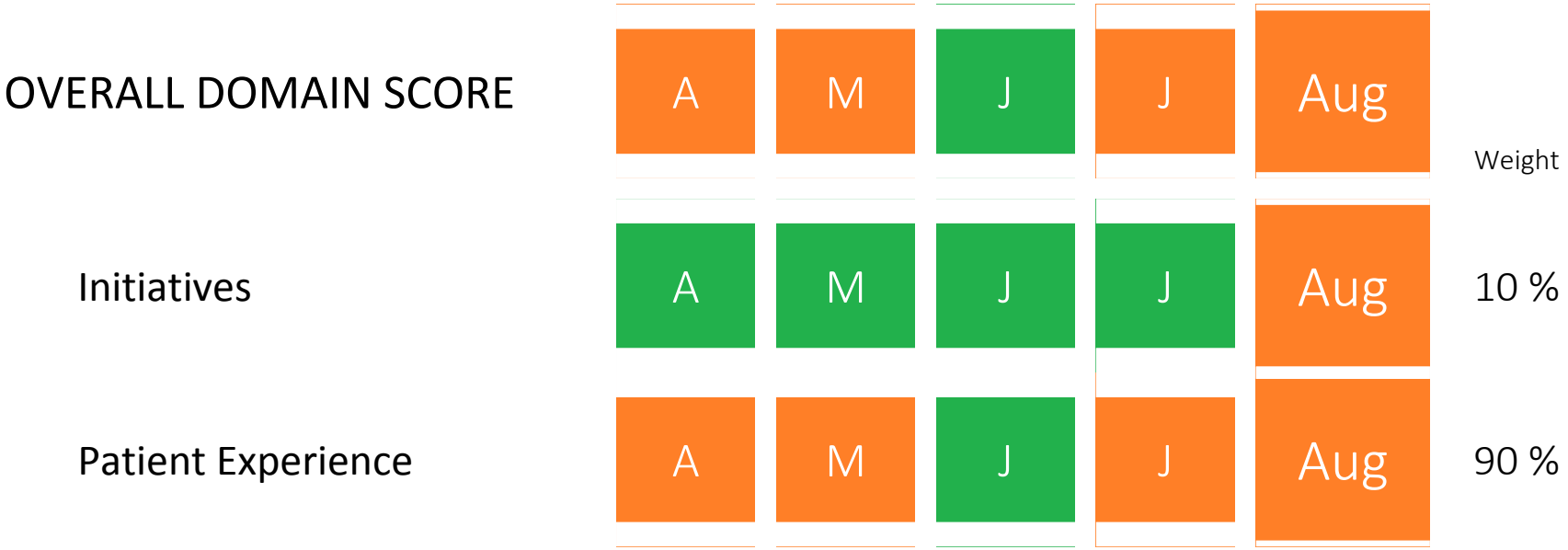
Caring



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Caring

		Apr	May	Jun	Jul	Aug	Green	Weight
Initiatives	Staff Health & Wellbeing CQUIN	100	100	100	100	100	>= 100	20 %
	Sepsis CQUIN Delivered %	90	90	90	90	90	>= 100	20 %
	Antimicrobial Resistance &	100	100	100	100	100	>= 100	20 %
	End of Life Pathway CQUIN Delivered	100	100	100	100	90	>= 100	20 %
	Patient Flow CQUIN Delivered %	100	100	100	100	100	>= 100	20 %
Patient Experience	Compliments to Complaints (#/1)	16	13	12	12	15	>= 12	10 %
	Mixed Sex Breaches	26	0	11	29	45	1	10 %
	Overall Patient Experience %	91	91	91	92	92	>= 90	10 %
	Complaint Response in Timescales %	54	84	94	96	97	>= 85	5 %
	FFT: Recommend (%)	96	97	98	97	97	>= 90	30 %
	FFT: Not Recommend (%)	1.6	1.5	1.0	1.7	1.1	>= 1	10 %

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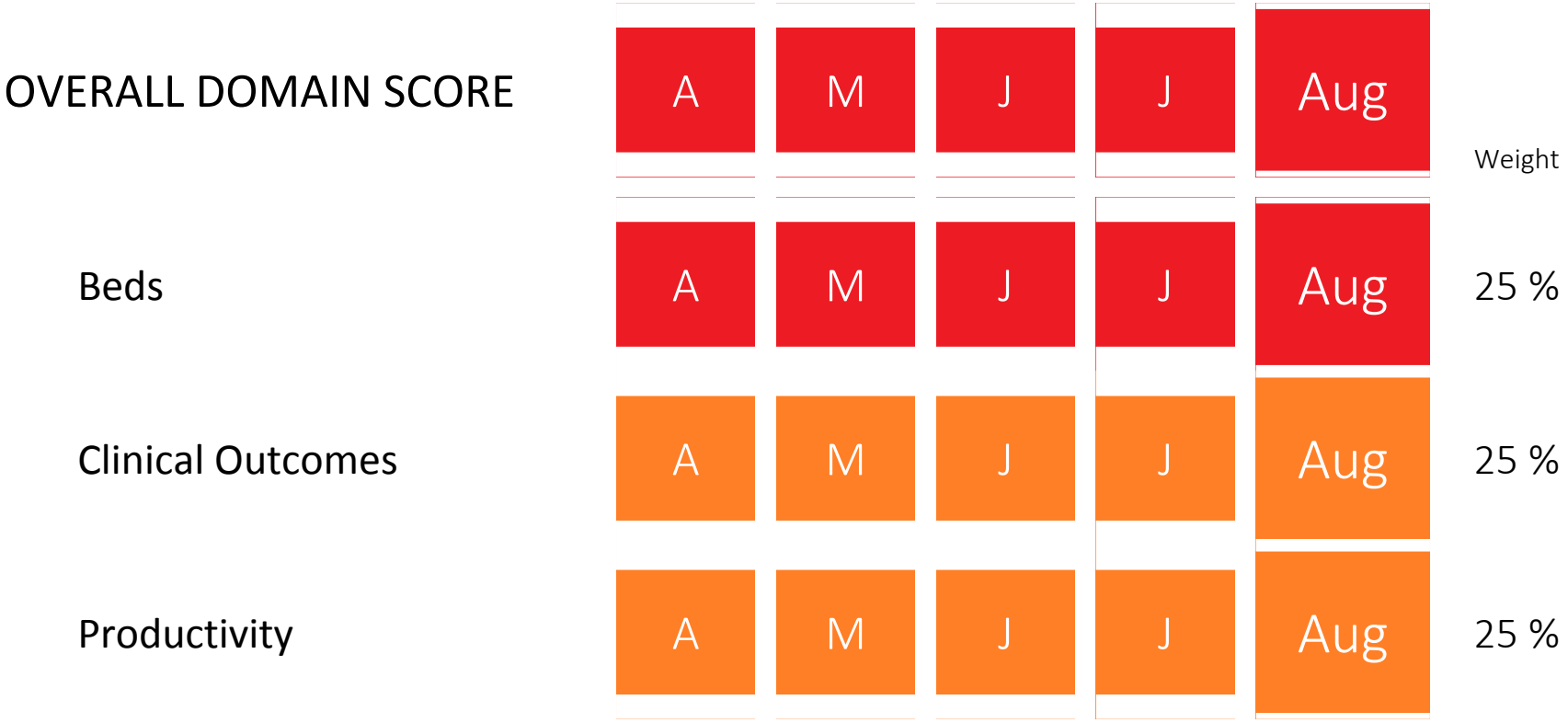
Effective



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Effective

		Apr	May	Jun	Jul	Aug	Green	Weight
Beds	Bed Occupancy (%)	103	101	98	99	99	<= 90	60 %
	IP - Discharges Before Midday (%)	15	15	15	16	16	>= 35	10 %
	DToCs (Average per Day)	78	62	62	62	58	< 28	30 %
Clinical Outcomes	Readmissions: EL dis. 30d (12M%)	3	3	3	3	3	< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	17	17	17	16	16	< 15	15 %
	Clinical Audit Prog. Audit	3	3	3	3	3	>= 3	5 %
	Audit of WHO Checklist %	100	99	99	98	96	>= 99	10 %
Demand vs Capacity	DNA Rate: New %	7.7	8.1	8.1	7.9	7.9	< 7	0 %
	DNA Rate: Fup %	8.1	9.0	8.0	7.3	7.2	< 7	0 %
	New:FUp Ratio (1:#)	0.7	0.7	0.7	0.7	0.7		0 %
Productivity	LoS: Elective (Days)	3.3	3.2	2.8	2.9	3.1		0 %
	LoS: Non-Elective (Days)	6.1	5.7	6.3	5.8	6.0		0 %
	Theatres: Session Utilisation (%)	82	83	85	82	82	>= 85	25 %
	Theatres: On Time Start (% 30min)	83	79	81	81	78	>= 90	10 %
	Non-Clinical Cancellations (%)	0.1	0.0	0.0	0.0	0.3	< 0.8	20 %
	EME PPE Compliance %	85	85	85	83	83	>= 90	20 %

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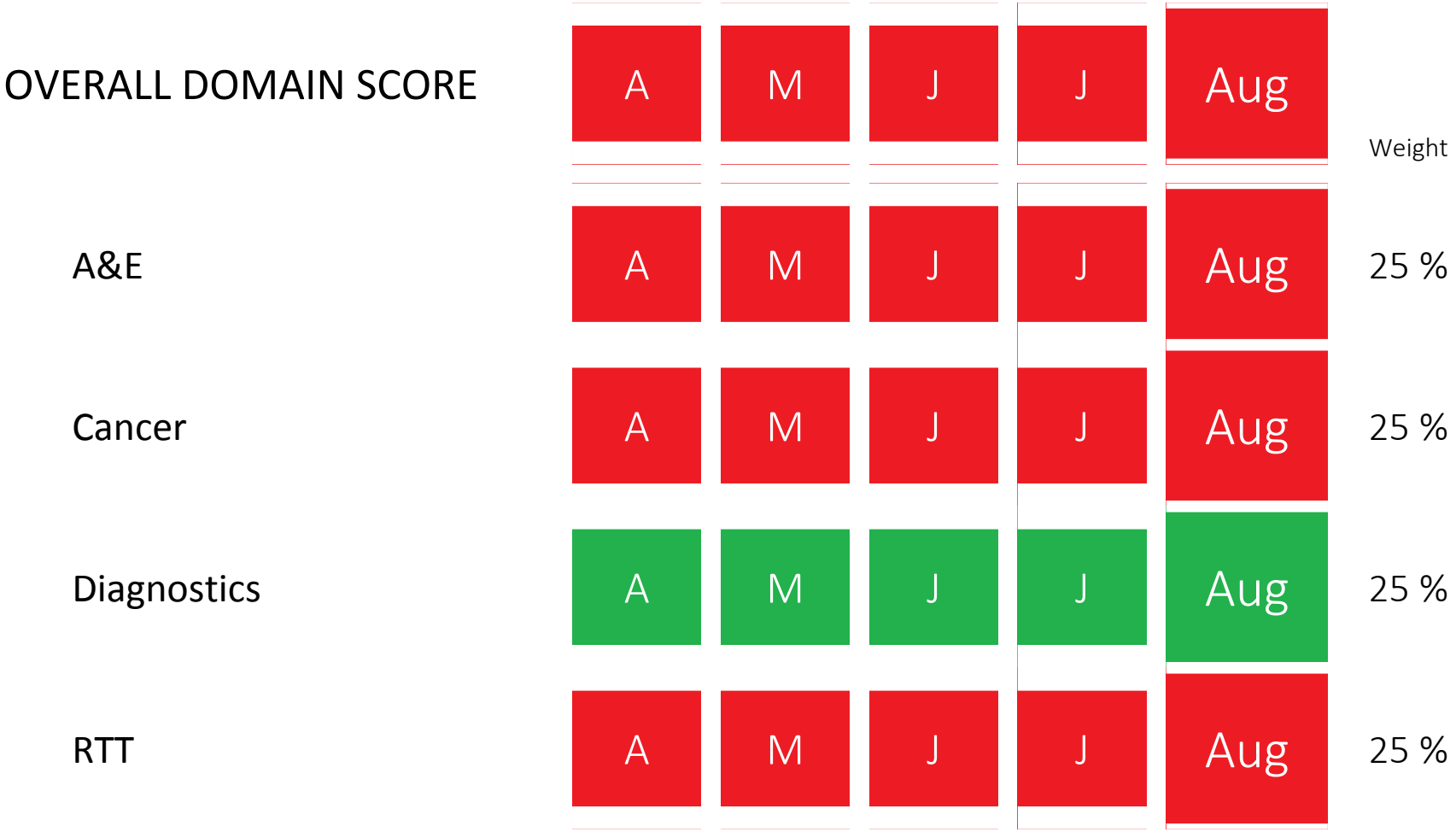
Responsive



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Responsive

		Apr	May	Jun	Jul	Aug	Green	Weight
A&E	ED - 4hr Compliance (%)	84.06	82.69	85.40	82.88	82.25	>= 95	100 %
Cancer	Cancer: 2ww (All) %	89.25	88.48	94.61	96.43	94.73	>= 93	10 %
	Cancer: 2ww (Breast) %	85.00	83.73	93.71	93.10	92.44	>= 93	5 %
	Cancer: 31d (Diag - Treat) %	96.11	96.31	94.55	94.35	93.53	>= 96	15 %
	Cancer: 31d (2nd Treat - Surg) %	91.49	88.24	86.96	96.61	92.00	>= 94	5 %
	Cancer: 31d (Drug) %	98.25	98.95	100.00	97.37	98.89	>= 98	5 %
	Cancer: 62d (GP Ref) %	71.04	79.20	75.42	70.62	75.91	>= 85	50 %
	Cancer: 62d (Screening Ref) %	92.86	93.10	100.00	83.33	86.67	>= 90	5 %
	Cancer: 62d (Con Upgrade) %	100.00	57.14	100.00	82.35	85.71	>= 85	5 %
Diagnostics	DM01: Diagnostic Waits %	99.78	99.87	99.86	99.77	99.56	>= 99	100 %
	Audio: Complete Path. 18wks (%)	99.65	100.00	100.00	100.00	100.00	>= 99	0 %
	Audio: Incomplete Path. 18wks (%)	100.00	100.00	100.00	100.00	100.00	>= 99	0 %
RTT	RTT: Incompletes (%)	88.56	87.89	86.81	86.65	85.52	>= 92	100 %
	RTT: 52 Week Waits (Number)	6	9	17	27	20	< 1	0 %

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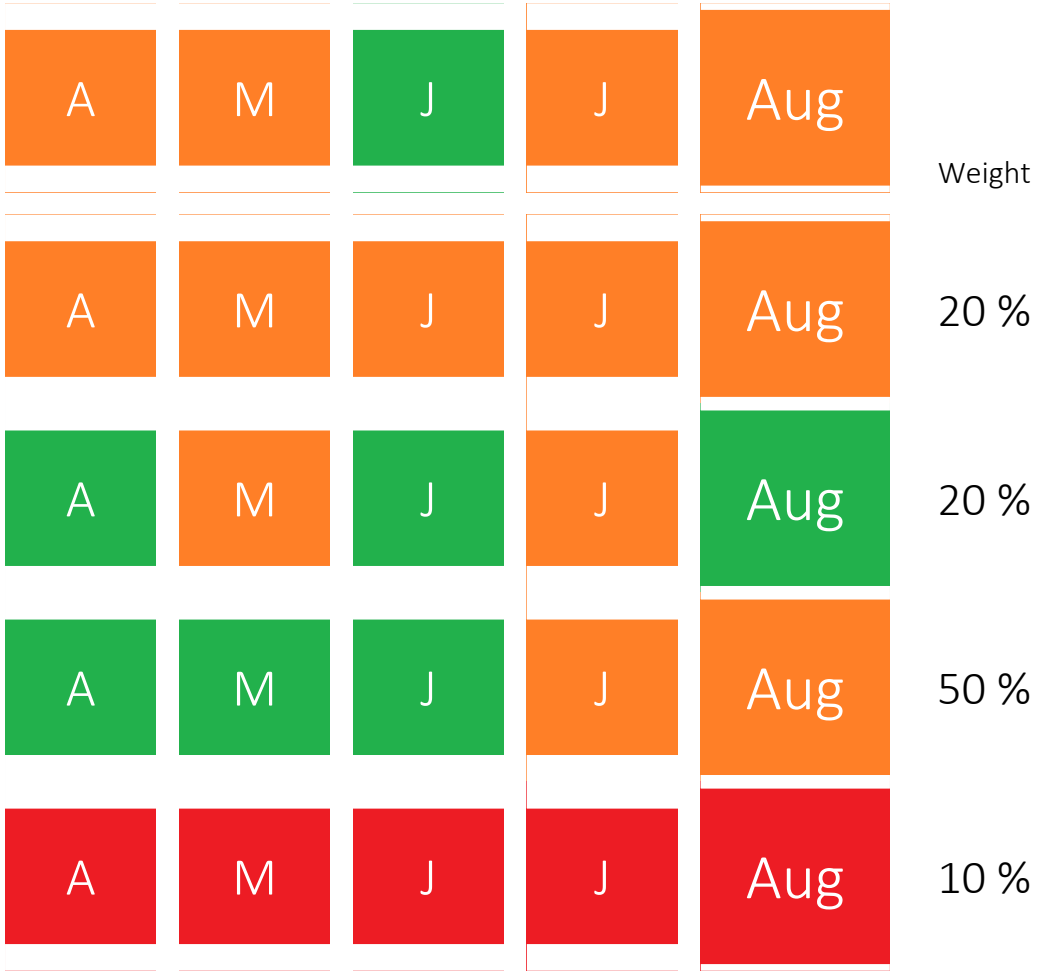
Safe



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Safe

		Apr	May	Jun	Jul	Aug	Green	Weight
Incidents	Serious Incidents (STEIS)	4	7	12	9	5		0 %
	Harm Free Care: New Harms (%)	97.8	97.7	98.5	98.0	97.9	>= 98	20 %
	Falls (per 1,000 bed days)	5.34	4.93	5.84	5.46	5.51	< = 5	20 %
	Pressure Ulcers Cat 2 (per 1,000)	0.32	0.37	0.26	0.18	0.25	<= 0.15	10 %
	Clinical Incidents: Total (#)	1230	1313	1357	1248	1243		0 %
Infection	Cases of MRSA (per month)	0	1	0	0	0	< 1	40 %
	Cases of C. Diff (Cumulative)	4	8	11	16	19	<= Traj	40 %
Mortality	HSMR (Index)	84	83	83			< 90	35 %
	Crude Mortality EL (per 1,000)	0.8	0.7	0.5	0.4	0.4	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	29	26	26	30	30	< 27.1	10 %
	RAMI (Index)	84	84				< 87.45	30 %
Observations	VTE: Risk Assessment %	83	87	88	87	87	>= 95	20 %

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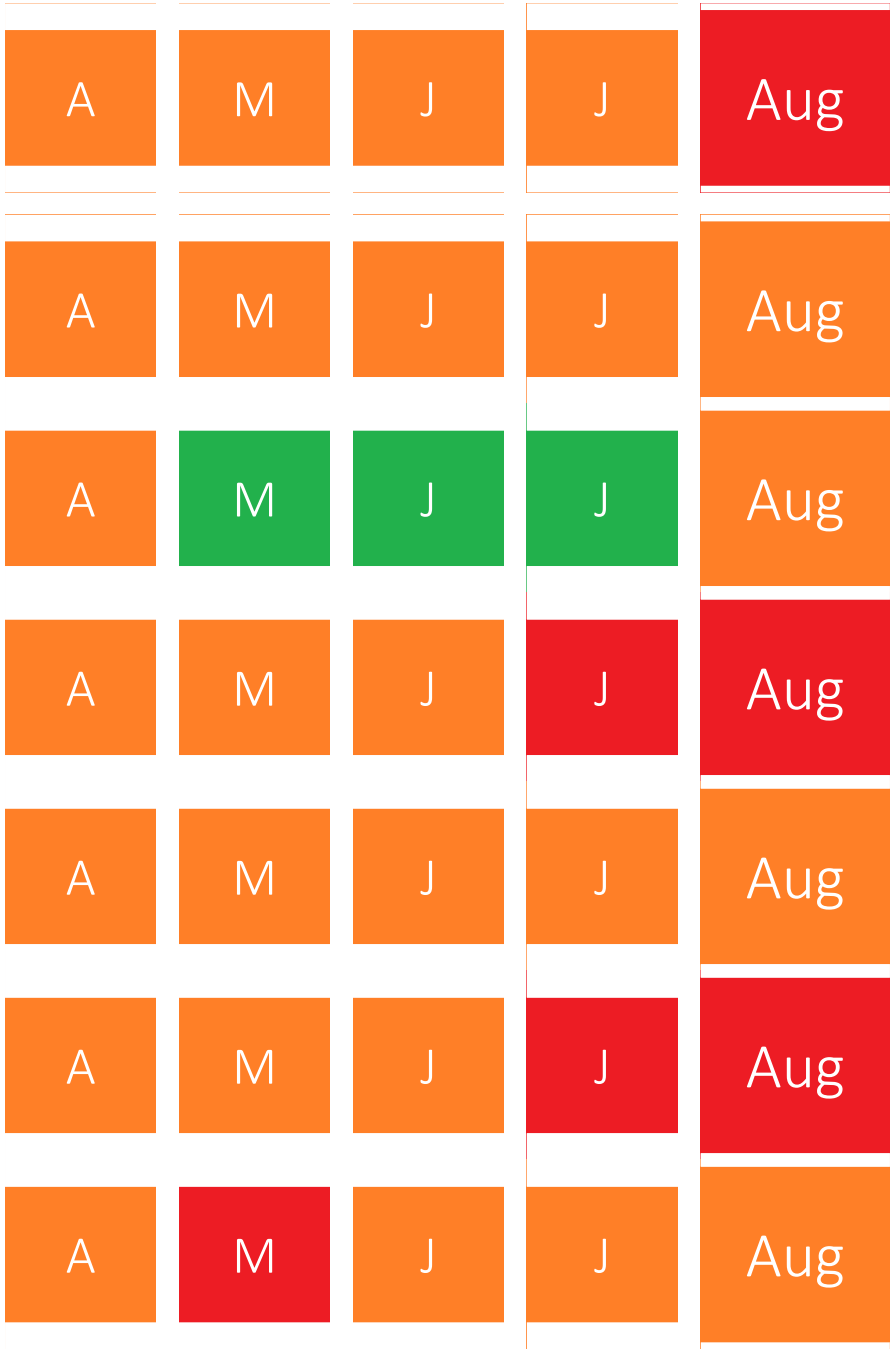
Well Led



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Well Led

		Apr	May	Jun	Jul	Aug	Green	Weight
Culture	Staff FFT - Work (%)	58	58	58	58	58	>= 60	50 %
	Staff FFT - Treatment (%)	78	78	78	79	79	>= 81.4	40 %
Data Quality & Assurance	Not Cached Up Clinics %	2	2	1	1	2	< 4	25 %
	Valid NHS Number %	99	99	99	99	99	>= 99.5	40 %
	Uncoded Spells %	0	0	0	0	1	< 0.25	25 %
Finance	I&E £m	-2.8	-1.9	-0.6	-0.6	-3.5	>= Plan	30 %
	Cash Balance £m	7.9	8.5	8.5	14.2	17.5	>= Plan	20 %
	Total Cost £m	-47.9	-48.0	-47.4	-47.4	-49.4	>= Plan	20 %
	Forecast I&E £m	0.0	-11.0	-11.0	-11.0	-24.5	>= Plan	20 %
	Normalised Forecast £m	-16.6	-27.6	-27.6	-27.6	-27.6	>= Plan	10 %
Health & Safety	RIDDOR Reports (Number)	0	0	0	1	1	<= 3	20 %
	Formal Notices	0	1	0	0	0	1	15 %
Staffing	Sickness (%)	3.9	3.8	3.8	3.8	4.0	< 3.6	10 %
	Staff Turnover (%)	11.2	11.3	11.8	12.1	12.0	<= 10	15 %
	Vacancy (%)	8.8	9.2	9.7	10.4	11.0	<= 7	15 %
	Shifts Filled - Day (%)	97	101	98	91	91	>= 97	15 %
	Shifts Filled - Night (%)	102	105	103	103	102	>= 97	15 %
	Agency %	16.3	18.3	18.1	20.3	21.7	<= 10	0 %
	NHSP Use % of Agency	100.0	100.0	100.0	100.0	100.0	> 90	0 %
Training	Appraisal Rate (%)	79.2	70.0	73.1	75.4	79.5	>= 90	50 %
	Mandatory Training (%)	87	79	87	87	88	>= 85	50 %

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Strategic Theme: Patient Safety

Mortality

Aug	HSMR (Index)	86 (-7.4%)	90, 89, 87, 86, 85, 85, 84, 84, 83, 83	Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data together with variance against previous
Aug	RAMI (Index)	91 (-2.9%)	99, 99, 95, 93, 90, 88, 86, 84, 84	Risk Adjusted Mortality (via CHKS) computes the risk of death for hospital patients and compares to others with similar characteristics. Data including age, sex, length of stay, clinical grouping, diagnoses, procedures and discharge method is used. Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Aug	SHMI	101 (-1.7%)	102, 100, 100, 100	Summary Hospital Mortality Indicator (SHMI) as reported via HSCIC includes in hospital and out of hospital deaths within 30 days of discharge. Latest quarter identifies last reported 12 month period. Please note this metric has recently been changed to reflect HSCIC, not CHKS. Arrow indicates average of last 12 months data (as shown in
Aug	Crude Mortality EL (per 1,000)	0.4 (-0.2%)	0.4, 0.1, 0.0, 0.7, 0.1, 0.2, 0.5, 0.8, 0.7, 0.5, 0.4, 0.4	The number of deaths per 1,000 elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Crude Mortality NEL (per 1,000)	30 (-3.2%)	28, 27, 25, 31, 32, 36, 33, 29, 26, 26, 30, 30	The number of deaths per 1,000 non-elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments: The mortality figures for the month of August continue to show that we have a lower mortality than the national average.
The mortality review group now meets and this allows a more in-depth view of hospital mortality. This will allow us to understand areas for improvement and any actions we need to take in order to reduce preventable causes of death.

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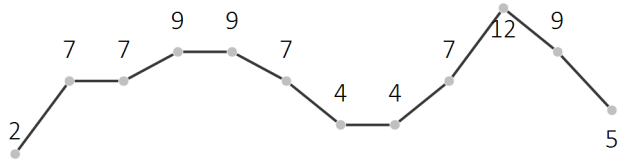
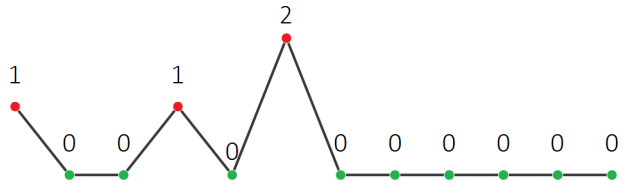
Strategic Theme: Patient Safety

Serious Incidents

Aug	Serious Incidents (STEIS)	82 (-4.7%)		Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.
Aug	Never Events (STEIS)	4 (0.0%)		Monthly number of Never Events. Uses validated data from STEIS. Arrow indicatessum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.

Comments:

Total open SIs on StEIS Aug 2016: 75 (including 5 new)
SIs under investigation: 40
Breaches: 12
Non-breaches: 28

SIs awaiting closure: 35
Waiting CCG response: 22
Waiting EKHUFT non-closure response: 13

Supporting Narrative:
The number of breached cases have risen from 11 to 12. This has been in part due to focused work for the CQC visit and delays due to the summer break. Work continues on clearing the longest breached cases and there has been progress on this and further progress is predicted.
Additional advice has been given to divisions to further enhance the quality of investigations to assist in internal RCA completion within the 60 day deadline. Divisions have continued to investigate mainly by use of health records and not by other forms of evidence. This leads to delays as the Clinical Risk Team (CRT) requires further delving. CRT are reviewing the process for when the draft report comes to the team.

There were five new SIs relating to:
- two treatment delays (lung cancer and ophthalmology)
- one VTE (fatal pulmonary embolism identified at post mortem following trauma injury)
- one maternal and foetal death
- one medication incident (methotrexate overdose)

The Trust has received for comment the new Never Event guidance. We are formulating our views, co-ordinated by the Corporate Team.

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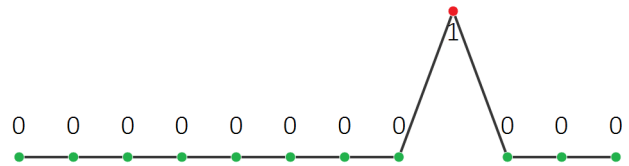
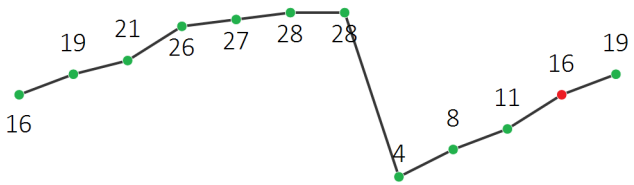
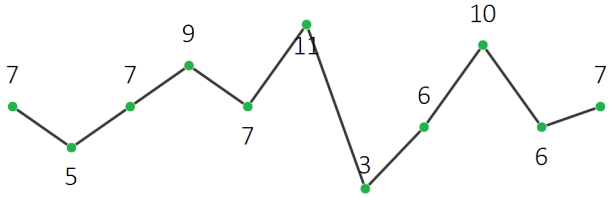
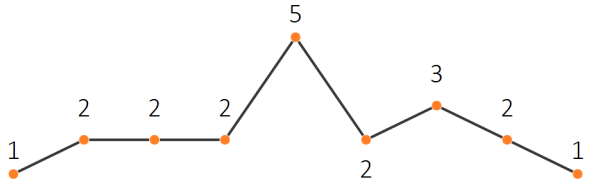
Strategic Theme: Patient Safety

Infection Control

Aug	Cases of MRSA (per month)	1 (-50.0%)		Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.
Aug	Cases of C. Diff (Cumulative)	19 (18.8%)		Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01). Position in arrow shows YTD cumulative position and variance against previous month. Graph shows last 12 months, noting that C. Diff is reported as a cumulative YTD position, which explains the drop from 28 (as at March-
Aug	E. Coli	78 (34.5%)		The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	MSSA	20 (0.0%)		The total number of MSSA bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

There has been one case of MRSA bacteremia in the last 12 month period. This case has been referred to the Third Party for assignment.

Please note that the C.diff 'graph' is cumulative from the beginning of the financial year ie year to date we have had a total of 19 cases, whereas the MRSA, MSSA and E.coli graphs indicate numbers each month.

In August, we had 3 new cases of C.difficile compared to 5 cases in July. The total number of C.difficile case is 19 which is line with trajectory for this year.

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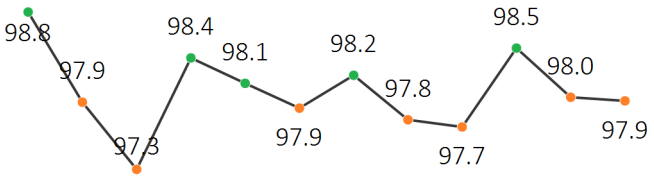
Strategic Theme: Patient Safety

Harm Free Care

Aug	Harm Free Care: New Harms (%)	98.0 (-0.3%)		Percent of Inpatients deemed free from new, hospital acquired harm (ie, free from new: pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12

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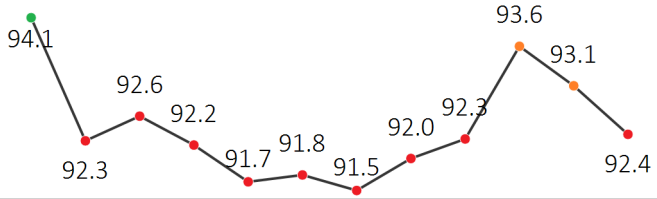
Strategic Theme: Patient Safety

Aug

Harm Free Care: All Harms (%)

92.5
(-0.6%)



Percent of Inpatients deemed free from harm (ie, free from old & new harm- pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12 months.

Comments:

Harm free care

Overall Harm Free Care (HFC) relates to the Harms patients are admitted with as well as those they acquire in our care. HFC in August was 92.36% compared to 93.07% in July and remains below both the overall national average of 94.19% and the acute hospitals only national average of 94.21%. A wide variation, as expected, is seen across the divisions with specialist achieving 98.79%, surgical 91.83% and UCLTC 90.47%.

However, Harm Free Care experienced in our care (New Harms only) at 97.94% in August is higher than national average which means that our patients are receiving care that causes less harm than is reported nationally. New Harms only were 2.06% compared to 2.07% national average for acute hospitals, this means that our patients acquire lower levels of new harms than the national average for acute hospitals. All harms were 7.64% compared to national average of 5.79%, this means our patients are admitted with a higher level of harm than the national average.

QEH New Harms Only HFC fell slightly to 98.33% in August compared to 98.66% in July.
WHH New Harms Only HFC fell to 97.52% in August compared to 98.63% in July.
K&C New Harms Only HFC improved to 98.17% in August from 95.59% in July.

HFC (new harms only) for individual harms are lower than the national average for acute hospitals for 3 out of the 4 harms measured. The Safety Thermometer for August demonstrates lower levels of New Pressure Ulcers 0.59% compared to acute hospitals 0.72%, catheters & New UTI's 0.10% compared to acute hospitals 0.39% and New VTEs 0.49% compared to acute hospitals 0.55%. However, our Falls with harm at 0.88% is higher than the average 0.45% for acute hospitals and focused work is being carried out to reduce the number of falls to ensure patient safety.

HFC (all harms) shows a higher than national level of patients being admitted who have already started treatment for UTI or a UTI was already present on admission - 1.08% compared to the national average of 1.01% for acute hospitals. Identification of the reasons for the higher rate of patients admitted with UTIs with catheters will be undertaken through collaborative work with community partners.

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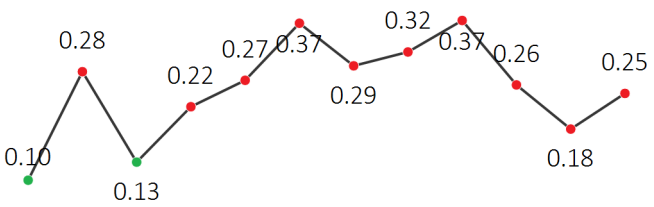
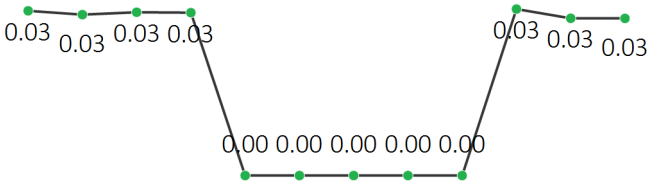
Strategic Theme: Patient Safety

Pressure Damage

Aug	Pressure Ulcers Cat 2 (per 1,000)	0.25 (-44.5%)		Number of avoidable Category 2 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Pressure Ulcers Cat 3/4 (per 1,000)	0.02 (-74.8%)		Number of avoidable Category 3/4 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

In August 16 a total of 26 category two pressure ulcers were reported and 8 were confirmed as avoidable. This is an increase of 4 avoidable ulcers from last month. Three affected the sacrum/buttocks occurring on Cambridge K, Cheerful Sparrows Male, Mount/McMaster and Invicta. Two affected the heels on RSW and CL. These reflect recurrent themes of repositioning and heel off loading evidence and a number of interventions have been taken to address them including the 'Bottoms Up' and 'Think Heels' campaign. The annual pressure ulcer prevalence audit results demonstrated good improvements in these interventions. However local factors can create variability in achievements, such as staffing levels. The other two avoidable were related to medical devices affecting the nose on A & E (BiPAP) and ear on CM1 (nasal cannula) with evidence of sufficient skin protection lacking. The SKINS bundle now contains a prompt for these issues and will be uploaded onto PAS once requested amendments are approved.

In August 16 there was one avoidable confirmed category three pressure ulcer on KC1 and one avoidable potential deep pressure ulcer on Clarke. Common to both incidents were delays in risk assessment, equipment and repositioning evidence which will be the focus of further investigations and specific actions.

Trust wide actions undertaken in August included Tissue Viability Support workers working with EME to improve access to equipment; the updated Pressure Ulcer Policy was ratified and training has been undertaken to ward based teams, EU Nurses and as part of the Health Care Certificate. It is planned to enhance the tissue viability link network by regular hub events on each site which will commence in September.

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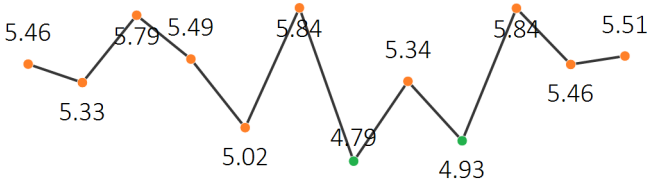
Strategic Theme: Patient Safety

Falls

Aug	Falls (per 1,000 bed days)	5.39 (-58.1%)		Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments: In August, 2016 there were 182 in patient falls. 81 were at WHH, 57 at QEQMH and 44 at K&CH. Wards with the most reported falls were CDU at WHH (9), Cambridge L (16) and Kings B (9). There were no fractures. One incident on Cambridge K resulted in the death of a patient. This is being investigated but first impressions indicate that the patient collapsed as a result of a medical condition and sustained a head injury as a result of the collapse. The incident itself was unavoidable. The Fallstop project will be commencing soon at WHH with multi professional support from therapies and pharmacy. It is hoped that the programme will benefit from the TIPS programme (Teams Improving Patient Safety) in 2017 and support from the Trust lead has been obtained.

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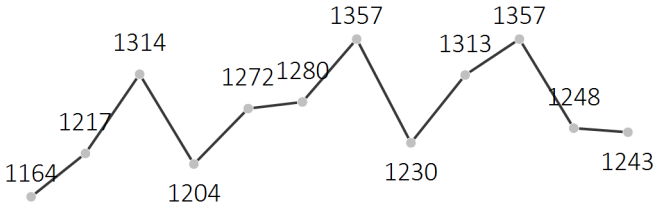
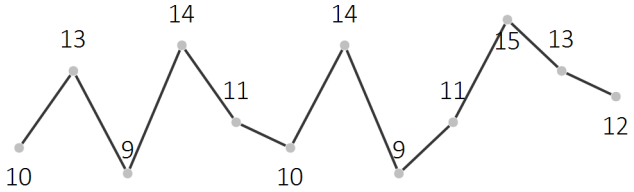
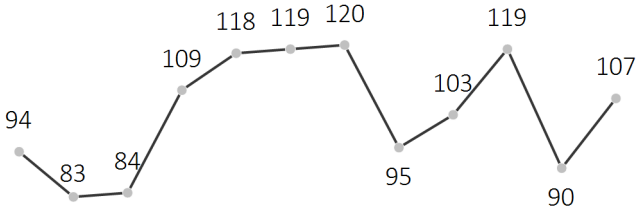
Strategic Theme: Patient Safety

Incidents

Aug	Clinical Incidents: Total (#)	15199 (9.0%)		Number of Total Clinical Incidents reported, recorded on Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.
Aug	Blood Transfusion Errors	141 (-15.1%)		The number of blood transfusion errors sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.
Aug	Medicines Mgmt. Incidents	1241 (1.6%)		The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.

Strategic Theme: Patient Safety

Comments:

A total of 1238 clinical incidents have been logged as occurring in Aug-16 compared with 1243 recorded for Jul-16 and 1249 in Aug-15. In Aug-16, nine incidents have been graded as death and seven as severe harm. In addition, 22 incidents have been escalated as a serious near miss, of which 18 are still under investigation. The number of moderate harm incidents reported during Aug-16 is higher than in previous months [Aug-16: 52 compared with Jul-16: 36 and Aug-15: 30].
Five serious incidents were required to be reported on STEIS in August. Four cases have been closed; there remains 75 serious incidents open at the end of August.
Over the last 12 months incident reporting has increased at WHH and QEH, and remains constant at K&CH.

Blood transfusion

In August, there were 11 blood transfusion errors reported (12 in Jul-16 and 18 in Aug-15). There were three themes in August: three delays in provision of blood component/product, three suspected allergic reactions to transfusions and two prescription/documentation errors. Eight incidents were graded no harm and three low harm.
Reporting by site: four at K&CH, four at QEH and three at WHH.

Medicines management

There were 107 medication incidents reported as occurring in August (89 in Jul-16 and 119 in Aug-15). On average, over the last 12 months, the numbers of medication incidents reported at WHH and K&CH have risen and at QEH have declined.
Of the 107 reported, 84 were graded as no harm (including five serious near misses) and 20 as low harm. There were three incidents graded moderate harm: Multiple medication omissions for patient suffering from seizures; patient with penicillin allergy was given Co-amoxiclav; patient given 5x250mg (belonging to a different patient) Tapentadol instead of 5x50mg from ward stock. These three incidents are currently under investigation. Top reporting areas were: Cheerful Sparrows male ward (QEH) and Folkestone ward (WHH) with six incidents each; Cathedral day unit (K&CH), CDU (QEH) and ITU (WHH) with five incidents each; ECC (K&CH) with four; Harbledown ward (K&CH), Pharmacy (K&CH), A&E (QEH), Birchington ward (QEH), Kingsgate ward (QEH), A&E (WHH) and Kings B ward (WHH) with three incidents each; other areas reported 2 incidents or fewer. Thirty incidents occurred at K&CH, 34 at QEH and 42 at WHH.
*Missing Drugs are broken down as follows: nine incidents relating to stock control/documentation errors, one incident where drugs went missing when patient transferred wards and one incident relating to disposal of expired inhalers.

Total
Drug error - prescribing 19
Drug error - dispensing 10
Drug error - administering 59
Drug shortage (not available or in stock) 1
Drug missing* (stock discrepancy or lost between wards/pharmacy) 11
Adverse drug reaction 2
Infusion injury - extravasation 3
Infusion problems - medication related 2
Totals: 107

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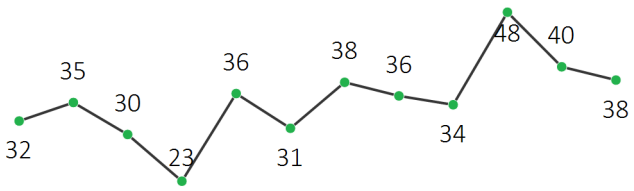
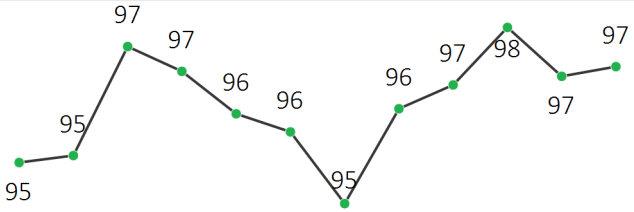
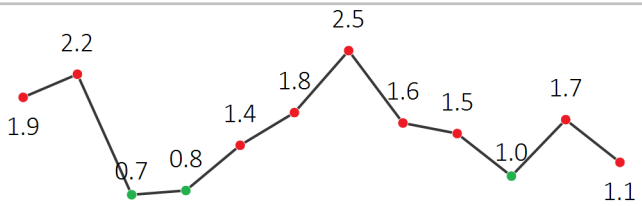
Strategic Theme: Patient Safety

Friends & Family Test

Aug	FFT: Response Rate (%)	35 (-7.4%)		The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	FFT: Recommend (%)	96 (1.3%)		Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	FFT: Not Recommend (%)	1.5 (-34.0%)		Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

FFT

During August we received 11,434 responses in total. Overall 49% eligible patients responded and 90% would recommend us to their friends and family and 6% would not. The total number of inpatients, including paediatrics who would recommend our services was 97% (95% July -16). For A&E it was 78% (79% July -16), maternity 98% (Same as July -16), outpatients 92% (Same as July -16) and day cases 95% (Same as July -16). The Trust star rating in August is 4.51 (4.52 in July-16).

Work to improve response rates has resulted in significant improvement. The response rate for inpatients was 38% (40% in July -16), A&E 20% (19% in July -16), maternity 28% (31% in July -16). (Please note as per DH guidelines only the Birth experience is given a response rate, FFT questions at other stages in the patient's pathway are not calculated or required nationally). The response rate for day cases was 33% (27% in July -16) but for outpatients was not available due to a national reporting error. 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 Divisional Governance teams.

FFT patient comments demonstrate similar positive and negative themes across many departments/wards. All comments received from patients are recorded and entered into the ward service reports; these are displayed and available on the wards for patients and staff to view.

ED
1,129 positive comments; Positive Themes – Good care, kind, friendly, professional, quick care
284 negative comments; Negative Themes – Waiting times

Strategic Theme: Patient Safety

Inpatients
1,200 positive comments; Positive Themes – understanding, helpful, caring , kind
31 negative comments; Negative Themes - Long discharge, poor communication, Drs not listening, noisy environment

Out patients
2,474 positive comment; Positives Themes - Great care, considerate, polite, kind, professional
175 negative comments; Negative Themes – Drs attitude, communication, waiting time

Maternity
Birth – 130 positive comments; Positive Themes - Great care/staff, kind, caring, friendly, helpful
There were no negative comments

Postnatal ward – 126 positive comments; Positive Themes – Helpful, professional, great teamwork, patient, helpful.
6 negative comments; Negative Themes- Noisy, hot ward, staff - no time

Postnatal community – 27 positive comments; Positive Themes – Excellent care, friendly, caring, kind, professional.
There were no negative comments

Day Case
117 positive comments; Positive Themes – Compassion, great care, kind, good communication
6 negative comments; Negative Themes – Waiting time, No food/drink, pain

The trust needs to improve on the waiting times for patients within the ED, Outpatients and Day Case care. Inpatient and Outpatient feedback indicates that we should look to improve our communication and Drs attitude. We also need to work on improving discharge time. Maternity will find it difficult to improve on the temperature on the ward but can improve on staff time. It should be highlighted that there are considerably more positive comments regarding Staff attitude and the excellent care that is given by all departments, which staff must be congratulated on.

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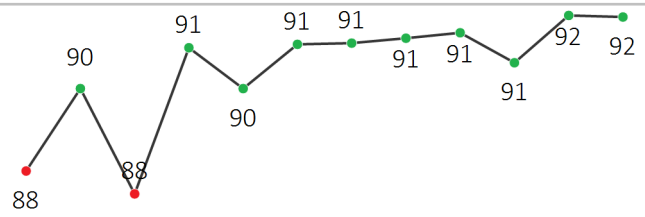
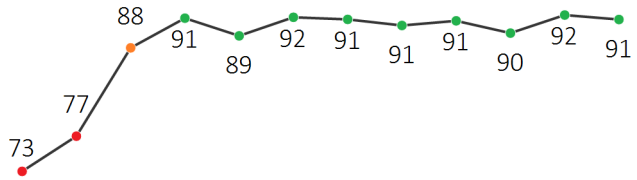
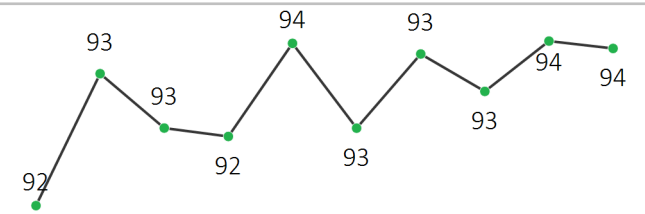
Strategic Theme: Patient Safety

Patient Experience 1

Aug	Overall Patient Experience %	91 (2.9%)		Based on questions asked within the Trust's Inpatient Survey, this provides an overall inpatient experience % by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1). Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Aug	Care Explained? %	90 (19.8%)		Based on a question asked within the Trust's Inpatient Survey, was your care or treatment explained to you in a way you could understand by the medical/nursing/support staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Aug	Care that matters to you? %	93		Based on a question asked within the Trust's Inpatient Survey, did you get the care that matters to you? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data (as shown in graph).

Comments: This month patient experience as recorded in real-time by the patients is similar to last month with only cleanliness being rated as amber by the patients. This is being monitored on a daily basis by SERCO with daily audits undertaken in conjunction with the Matron or Ward Manager. Corrective action is taken immediately when any deficits occur. There are a number of wards that have not submitted during August. We are still refining the App that is used which may mean the data have not been captured, but each of these wards will be followed up by the Divisional Head of Nursing. Improvement work also needs to focus on the 'Care that matters to you' metric within our medical wards.

East Kent Hospitals University NHS
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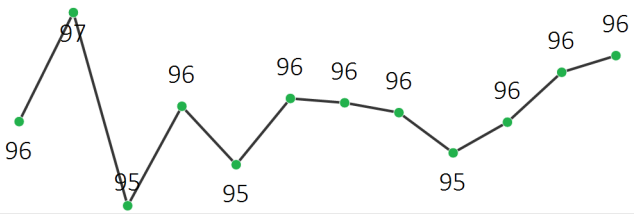
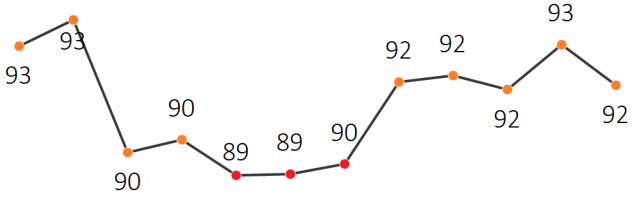
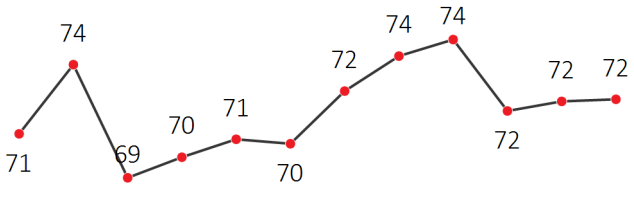
Strategic Theme: Patient Safety

Patient Experience 2

Aug	Respect & Dignity? %	96 (-0.2%)		Based on a question asked within the Trust's Inpatient Survey, overall, did you feel you were treated with respect and dignity while you were in hospital by the nasing staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Aug	Cleanliness? %	91 (-1.4%)		Based on a question asked within the Trust's Inpatient Survey, in your opinion, how clean was the hospital room or ward that you were in? % of inpatients who answered 'very clean' or 'fairly clean'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Hospital Food? %	72 (1.6%)		Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? % of inpatients who answered 'very good' or 'good'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

Cleanliness remains in the low 90% this month. This has remained consistent for the last quarter. The Trust continues to manage cleaning on a daily basis through its weekly auditing process. The Audits continue to show a positive stable picture of cleanliness.

Hospital Food remains in the low 70% range this month. We continue to monitor performance of the catering contract and any new initiatives through the Food Steering group.

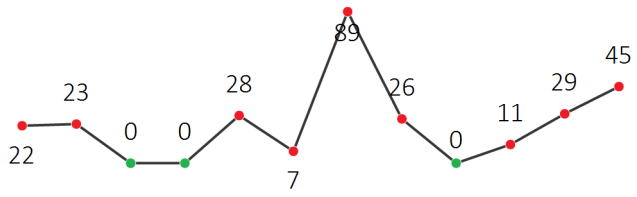
Strategic Theme: Patient Safety

Mixed Sex

Aug

Mixed Sex Breaches

280
(-5.7%)



Number of patients experiencing mixed sex accommodation due to non-clinical reasons.
Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

During August-16, 7 non-justifiable incidents of mixed sex accommodation breaches occurred 6 at WHH CDU and 1 at QEQM AE Obs Bay due to capacity issues. This information has been reported to NHS England via the Unify2 system.

There were 15 mixed sex accommodation occurrences in total, affecting 71 patients. This number has decreased slightly since last month when there were a total of 16 occurrences affecting 74 patients. The remaining incidents occurred at QEQM on the Fordwich stroke unit (4), QEQM CCU (2), K&C Kingston stroke unit (2), which are justifiable mixes based on clinical need.

During August-16 daily reporting of mixed sex occurrences has improved at the three acute sites. WHH CDU has an increased number of mixed sex breaches during August and to minimise the risk of mix sex occurrences the nursing team are:

- Nursing staff move patients continuously to stop mixed sex breaches
- Discharge patients home as soon as possible
- Use the discharge lounge, whilst patients await transport etc.
- Observation bay is used for patients when possible to stop any mixed sex breaches
- Each side of CDU is separated one side for males and the other for females
- Side rooms are used (if mixing has to occur on the male/female side)
- Failsafe put into place for ward clerk to document mixed sex breaches onto excel spreadsheet, to assist in validation

NB: the mixed sex breaches were during the time of the extremely hot days and extreme operational pressure over the past several weeks during August, which had a major impact and increased admissions into WHH CDU.

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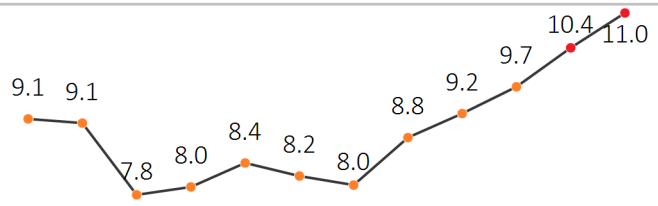
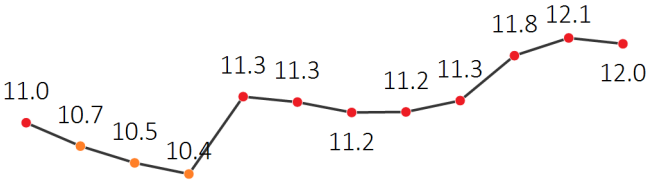
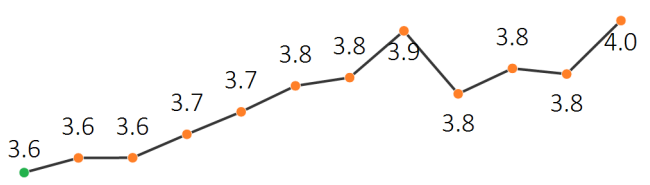
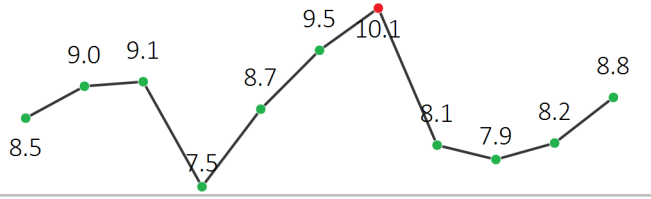
Strategic Theme: Human Resources

Gaps & Overtime

Aug	Vacancy (%)	9.0 (2.8%)		% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Staff Turnover (%)	11.2 (-19.1%)		% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Sickness (%)	3.7 (-0.5%)		% of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the
Aug	Overtime %	8.7		% of Employee's that claim overtime. Number indicates average of last 12 months data (as shown in graph).

Comments:

In September, the Turnover rate remained at 12% and the vacancy rate increased marginally from 10.37% to 10.97%. However, the average Turnover rate for the past 12 months remains significantly lower than the previous 12 months at 11.2%. The vacancy and turnover rates by Division are examined in detail at Executive Performance Reviews (EPR), and Divisions have actions in place to address their recruitment and retention challenges.

Sickness absence decreased slightly to 3.96 in August, against the Trust target of 3.3%. Divisions have submitted a monthly trajectory for sickness absence, which are examined at EPRs and monthly Agency Pay Control meetings. Although Divisions are running behind their trajectories, the 12 month average remains lower than the previous 12 month average.

The percentage of employees claiming overtime increased to 8.8%, against an annual average of 8.7%.

East Kent Hospitals University NHS
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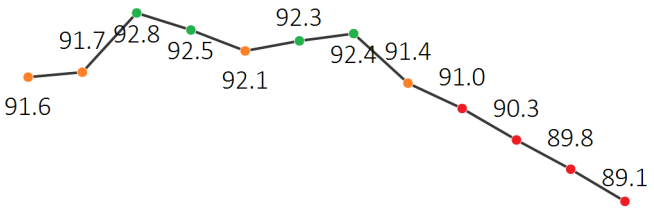
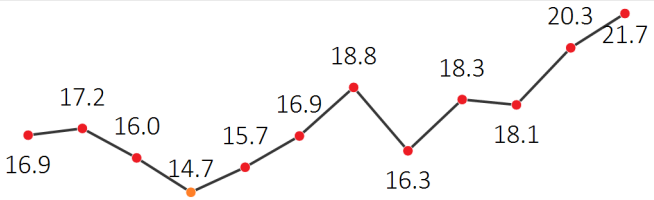
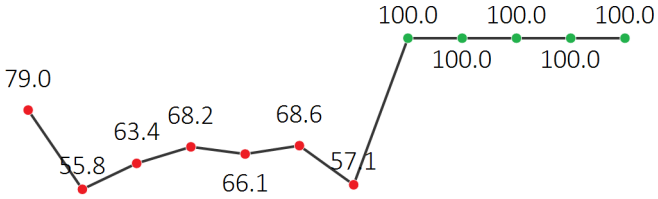
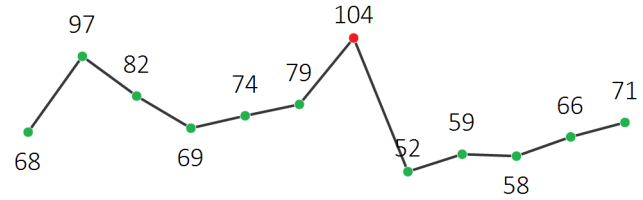
Strategic Theme: Human Resources

Temporary Staff

Aug	Employed vs Temporary Staff (%)	91.4 (-0.5%)		Ratio showing mix of permanent vs temporary staff in post. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Agency %	17.6		% of Staff working employed through an agency. Number indicates average of last 12 months data (as shown in graph).
Aug	NHSP Use % of Agency	76.8		% of Employee's deployed through an agency that are NHSP. Number indicates average of last 12 months data (as shown in graph).
Aug	Agency Orders Placed	73		Total count of agency orders placed. Number indicates average of last 12 months data (as shown in graph).

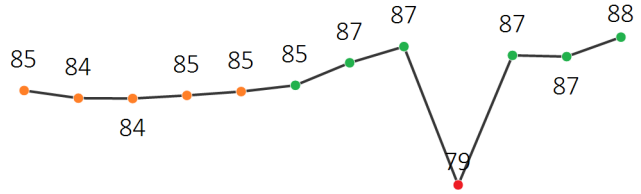
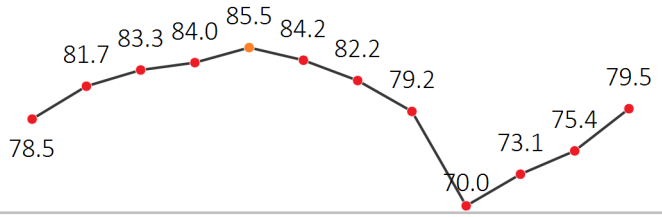
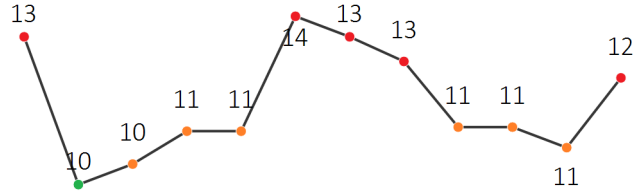
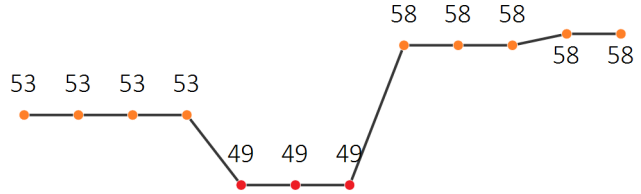
Comments: Reduction in agency spend is a key component of our cost improvement programme (£4.1m). There is an Agency Pay Control programme, led by the Head of Human Resources and supported by the Improvement Delivery Team. The Trust monitors and reports on a weekly basis, all agency shifts that breach the agency framework and NHSI pay caps by occupational group and division. The percentage of employees deployed through an agency that are NHSP remains at 100%.

Divisions are held to account for their Agency CIPs at EPR meetings, and against Divisional Agency Spend Trajectories, that are updated monthly by Divisional Finance Leads and HR Business Partners.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Human Resources

Workforce & Culture

Aug	Mandatory Training (%)	85 (5.3%)		The percentage of staff that have completed mandatory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Appraisal Rate (%)	79.7 (4.2%)		Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Time to Recruit	12 (6.9%)		Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Staff FFT - Work (%)	54 (12.0%)		Percentage of staff who would recommend the organisation as a place to work - data is quarterly and from the national submission. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

East Kent Hospitals University NHS
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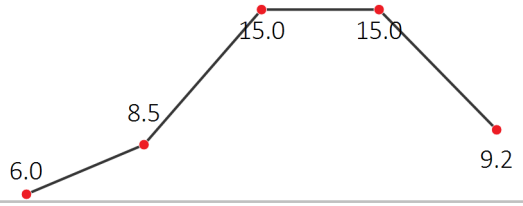
Strategic Theme: Human Resources

Aug

Local Induction Compliance %

10.8



Local Induction Compliance rates (%) for temporary employee's to the Trust.
Number indicates average of last 12 months data (as shown in graph).

Comments:

Statutory training was at 86% for September which remains above the target of 85%, although a slight reduction from the previous month most likely due to delays in staff renewing their training due to annual leave. There remains a significant risk in regard to statutory training compliance, particularly with staff who have been identified as not completing one or more of the statutory training courses required; 642 staff fall in this category in September which is a reduction from 700 in the previous month. The Divisions are monitored at EPR on how they are addressing those staff who have never completed one or more of the statutory training requirements.

The Trust staff appraisal rate has continued to increase in September to 80%, but remains below the 90% target. Divisions have been focussed on improving appraisal compliance, and most have not implemented a more consistent and robust way of reporting Appraisal dates to the HR Systems team. Work continues to implement less manual ways of reporting the information.

Time taken to recruit increased to 12.2 weeks which is a seasonal trend due to annual leave and the increased recruitment activity for the Doctors in Training. Weekly Recruitment Updates are sent out by the Resourcing Team to Divisions to provide information on workload within the team, and plans to reduce time the time taken to recruit.

The results of the staff Friends and Family showed a further increase in staff recommending the organisation as a place to work to 58%. The Divisions supported by HR will be undertaking further analysis of the results to ensure that existing cultural change and Great Place to Work plans continue to provide appropriate responses and interventions. The full staff survey launches on 3rd October.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Activity

Activity vs. Internal Business Plan

Key Performance Indicators

Aug

	Aug-16				YTD				YTD vs Last Yr				
	Activity	Plan	Var #	Var %	Activity	Plan	Var #	Var %	Activity	Last Yr	Var #	Var %	Green
Referral Primary Care	14,203	14,018	185	1%	74,938	72,473	2,465	3%	74,938	74,003	935	1%	<=0%
Referral Non-Primary Care	13,588	13,129	459	3%	69,394	74,156	(-4,762)	-6%	69,394	74,573	(-5,179)	-7%	<=0%
OP New	19,789	19,312	477	2%	102,161	101,308	853	1%	102,161	102,141	20	0%	>=0%
OP Follow Up	39,807	38,690	1,117	3%	204,673	206,559	(-1,886)	-1%	204,673	209,578	(-4,905)	-2%	>=0%
Elective Daycase	6,187	7,235	(-1,048)	-14%	33,682	37,321	(-3,639)	-10%	33,682	34,290	(-608)	-2%	>=0%
Elective Inpatient	1,285	1,286	(-1)	0%	6,453	6,800	(-347)	-5%	6,453	6,528	(-75)	-1%	>=0%
A&E	17,865	16,939	926	5%	89,475	85,226	4,249	5%	89,475	85,913	3,562	4%	>=0 & <5%
Urgent Care Assessment	909	1,126	(-217)	-19%	5,557	5,705	(-148)	-3%	5,557	5,816	(-259)	-4%	>=0 & <5%
Non-Elective Inpatient	5,771	5,661	110	2%	29,565	29,004	561	2%	29,565	28,517	1,048	4%	>=0 & <5%
Chemotherapy	1,354	926	428	46%	6,483	5,225	1,258	24%	6,483	5,526	957	17%	>=0%
Critical Care	1,827	1,884	(-57)	-3%	8,896	8,923	(-27)	0%	8,896	9,009	(-113)	-1%	>=0%
Dialysis	6,972	7,245	(-273)	-4%	34,733	35,790	(-1,057)	-3%	34,733	35,790	(-1,057)	-3%	>=0%
Maternity Pathway	1,098	1,186	(-88)	-7%	5,686	5,957	(-271)	-5%	5,686	5,898	(-212)	-4%	>=0%
Pre-Op Assessments	2,917	2,877	40	1%	14,235	14,367	(-132)	-1%	14,235	14,449	(-214)	-1%	>=0%
Diagnostic	424,753	474,079	(-49,326)	-10%	2,212,286	2,285,143	(-72,857)	-3%	2,212,286	2,154,650	57,636	3%	<=0%
Other	4,572	3,748	824	22%	23,172	19,328	3,844	20%	23,172	18,196	4,976	27%	>=0%

The 2016/17 Internal Business Plan has been developed at specialty level by our Operational Teams; Demand uses the 2015/16 Outturn as a baseline, growth was applied to all points of delivery for key areas where evidence supports exponential activity growth from referrals, activity required to achieve sustainable elective services is included and further adjustments for patient safety/best practice issues such as reductions or increases in new to follow up rates have been applied. Finally EKHUFT have taken a view on the viability of CCG QIPP schemes achieving a reduction in demand in 2016/17. It should be noted that this does not reflect demand levels agreed within the 2016/17 contract. All trajectories to support attainment of the Sustainability and Transformation Funding have been based on this activity plan.

The capacity levels within the plans should be considered achievable although in many instances will stretch our services beyond their internal substantive capacity, efficiency programmes, workforce recruitments plans and it is anticipated therefore that substantial elements of the plan will continue to be delivered though additional waiting list payments. Within Orthopaedics and Dermatology projected demand exceeded our ability to deliver the operative demand and as such agreements have been made with our local CCGs for services to be directly commissioned with alternative providers.

August 2016

The Primary Care demand received by the Trust was at planned levels this month which has reduced the Trust level over performance to just 1%, this equates to almost 1,000 additional referrals YTD. Encouragingly the Trust has not observed the historic exponential growth that has occurred in both Gastroenterology and Breast Referrals, although referrals into key specialties Orthopaedics, Maxillo Facial and Paediatrics continue to significantly exceed plan levels. The Trusts Internal Business Plan stretches most services to maximum capacity and as such we have not been able to flex our capacity further to deal with this unplanned demand. The Trust does not have the operative capacity to deal with the current demand, a key element of our business plan requires Orthopaedic referrals to be directed to the independent sector at point of referral, unfortunately there is no evidence to support this redirection and referrals continue to arrive at a rate which far exceeds our ability to treat patients within 18 weeks.

Rapid Access referrals into the Dermatology service over performed the plan by 21% (+236) in August 2016, this was in part bought about by a change in referral profile, with the annual spike of rapid access referrals arriving August as opposed to July. The service in conjunction with insourcing company DMC and delivered 341 new outpatient appointments above plan, this ensured they and were able to achieve the two week wait cancer target despite this unprecedented level of demand.

Gastroenterology activity continues to drive the biggest underperformance in activity across the Trust. The service has been supported by locum consultants, which has not provided consistent and sustainable levels of activity to enable the business plan to be delivered. The service cannot commit to delivering the shortfall from quarter one and two in quarter three due to the reliance on the temporary workforce, with current capacity being used to focus on patients on Cancer and Referral to Treatment pathways. As planned an Acute Physician commenced in post on 5 September and clinical activity in endoscopy and gastroenterology commenced week beginning 12 September. A further increase in activity is planned from 3 October with the appointment of a Consultant Gastroenterologist. The service is proactively looking to recruit further to reduce the reliance on locum workforce, recruitment will be focused on Consultant and Nurse Specialist posts.

An unusual profile of annual leave was observed in July 2016, as described last month the underperformance did not continue into August, with the Trust exceeding the outpatient plan by almost 1,600 attendances. This Trend was particularly prevalent within Orthopaedics, Ophthalmology, Cardiology and Oncology. With the exception of Cardiology the services significantly over performed their plans in August, with Cardiology returning to normal activity levels.

The HCOOP service has had a significant reduction in outpatient capacity following a consultant retirement; this is further to additional pressures in the year to date position from unplanned leave. The service is expecting further retirement in August, and whilst some clinics are able to be covered it is expected they will have a capacity shortfall of ~40 attendances per month. The Trust intends to fill this capacity with locum cover in the short term, with long term recruitment plans expected to proceed to shortlisting at the end of August 2016.

The Neurology Service, significantly over subscribed outpatient activity throughout the first 4 months of the year, this over performance delivered locum doctors enable the service to significantly reduce waiting times from referral to treatment. The service is now performing well against the national standard and has now reduced the additional capacity accordingly.

Gynaecology elective activity has underperformed in the year to date due to gaps in the middle grade rota, unexpected staff leave, being unable to utilise a list at WHH due to clinician job plan clashes, and being unable to replace a consultant who left late in 2015. The service have been actively bringing breached patients forward to be seen in Outpatients sooner, which has resulted in a large number being listed for Surgery and thus further deteriorating both the Non Admitted and Elective backlog. Attempts to recruit the known locum failed due to their preference for a post elsewhere, the service has secured an additional locum consultant who joined the team in September. Furthermore we are exploring whether there is any possibility of securing a second consultant via NHSP or agency. The net result of any additional consultants will be focused predominantly on Electives whilst supporting clinics to improve the outpatient throughput.

The Orthopaedic team have been unable to provide the Independent Sector Capacity stated in the contract so far this year, this is in part due to delays with the tender exercises and also due to the inability to obtain enough capacity within the Spencer Wing. To mitigate against this risk the service is working with commissioners to agree alternative providers for patients waiting for elective and daycase procedures, the Trust has secured additional capacity on behalf of the CCG and has commenced the transfer to the independent sectors for Orthopaedics, 279 patients have been transferred to date with a further 150 being validated. The commissioning support unit and our primary care colleagues are continuing to source additional outpatient capacity to divert referrals this is reviewed at the primary care Contract Performance Notice meetings (CPN)

The Ophthalmology service implemented a contractually mandated cost neutral change in activity recording within the AMD Injection service. The service is now recording and reporting approximately 600-800 injections per month as outpatient procedures as opposed to Elective admitted daycase activity. The change is reflective of the PbR tariff the trust receives for this activity. As a result of the change we are now expecting Daycase activity to underperform the plan for the remainder of the year.

Looking ahead into quarter three the Trust is likely to see a reduction in the levels of activity delivered as our workforce responds to the proposed industrial action. A series of 5 day strikes are scheduled for October through to December during which time elective activity will be reduced to enable us to cope with Emergency demand. Further to this the Trust is implementing a new Patient Administration System in December 2016, during the first few weeks of implementation elective activity will be reduced, where appropriate, to enable users to negotiate the new system and minimise delays experienced by our patients in clinic. This will only affect outpatient activity and will not impact upon delivery of urgent or Cancer pathways.

YTD Exception Reporting: Top 10 Outliers

Referral Primary Care

Specialty	Activity	Plan	Var (%)	Significance
301 - Gastroenterology	3,538	4,052	-13%	-514
103 - Breast Surgery	2,928	3,165	-7%	-237
107 - Vascular Surgery	1,152	990	16%	162
410 - Rheumatology	1,473	1,305	13%	168
130 - Ophthalmology	7,912	7,693	3%	219
140 - Maxillo Facial	3,404	3,060	11%	344
330 - Dermatology	6,306	5,932	6%	374
420 - Paediatrics	2,157	1,734	24%	423
502 - Gynaecology	4,435	3,777	17%	658
110 - Trauma & Orthopaedics	4,683	4,017	17%	666
Total	**63,825**	**60,991**	**5%**	**2,834**

Referral Non-Primary Care

Specialty	Activity	Plan	Var (%)	Significance
800 - Clinical Oncology	4,441	4,958	-10%	-517
560 - Midwifery	1	453	-100%	-452
110 - Trauma & Orthopaedics	8,902	9,252	-4%	-350
502 - Gynaecology	3,031	3,303	-8%	-272
140 - Maxillo Facial	746	997	-25%	-251
100 - General Surgery	1,442	1,268	14%	174
400 - Neurology	1,096	918	19%	178
BLANK	189	5	4072%	184
101 - Urology	2,938	2,658	11%	280
130 - Ophthalmology	4,422	3,996	11%	426
Total	**44,705**	**45,350**	**-1%**	**-645**

OP New

Specialty	Activity	Plan	Var (%)	Significance
301 - Gastroenterology	2,677	3,513	-24%	-836
100 - General Surgery	2,217	2,843	-22%	-626
430 - HCOOP	2,057	2,343	-12%	-286
340 - Respiratory Medicine	2,768	2,556	8%	212
420 - Paediatrics	3,411	3,076	11%	335
502 - Gynaecology	6,455	6,060	7%	395
300 - General Medicine	934	501	86%	433
130 - Ophthalmology	9,749	9,246	5%	503
110 - Trauma & Orthopaedics	9,644	8,766	10%	878
330 - Dermatology	6,235	5,206	20%	1029
Total	**78,988**	**77,773**	**2%**	**1,215**

OP Follow Up

Specialty	Activity	Plan	Var (%)	Significance
301 - Gastroenterology	4,607	7,410	-38%	-2803
100 - General Surgery	1,227	2,135	-43%	-908
324 - Anticoagulation Service	6,545	7,366	-11%	-821
302 - Endocrinology	3,220	4,018	-20%	-798
430 - HCOOP	1,619	2,309	-30%	-690
502 - Gynaecology	6,072	6,662	-9%	-590
361 - Renal	7,837	7,272	8%	565
103 - Breast Surgery	2,745	2,163	27%	582
110 - Trauma & Orthopaedics	16,126	14,224	13%	1902
130 - Ophthalmology	26,177	23,763	10%	2414
Total	**158,530**	**159,722**	**-1%**	**-1,192**

*PbR Contract Activity Only

Elective Daycase

Specialty	Activity	Plan	Var (%)	Significance
300 - General Medicine	5,814	7,722	-25%	-1908
330 - Dermatology	1,513	1,786	-15%	-273
110 - Trauma & Orthopaedics	2,069	2,269	-9%	-200
100 - General Surgery	672	841	-20%	-169
502 - Gynaecology	645	760	-15%	-115
410 - Rheumatology	535	640	-16%	-105
130 - Ophthalmology	4,907	5,009	-2%	-102
101 - Urology	2,651	2,527	5%	124
140 - Maxillo Facial	810	676	20%	134
303 - Clinical Haematology	1,184	1,001	18%	183
Total	**27,428**	**30,086**	**-9%**	**-2,658**

Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
502 - Gynaecology	489	654	-25%	-165
110 - Trauma & Orthopaedics	1,309	1,460	-10%	-151
100 - General Surgery	414	520	-20%	-106
320 - Cardiology	233	312	-25%	-79
300 - General Medicine	289	340	-15%	-51
430 - HCOOP	21	50	-58%	-29
103 - Breast Surgery	163	137	19%	26
503 - Gynaecology Oncology	42	10	319%	32
400 - Neurology	128	90	42%	38
101 - Urology	984	896	10%	88
Total	**5,151**	**5,514**	**-7%**	**-363**

Non-Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
502 - Gynaecology	555	863	-36%	-308
100 - General Surgery	2,002	2,262	-11%	-260
420 - Paediatrics	1,995	2,203	-9%	-208
501 - Obstetrics	1,563	1,728	-10%	-165
110 - Trauma & Orthopaedics	1,322	1,487	-11%	-165
320 - Cardiology	652	768	-15%	-116
120 - Ear, Nose & Throat	343	261	31%	82
430 - HCOOP	3,498	3,320	5%	178
180 - Accident & Emergency	2,323	1,859	25%	464
300 - General Medicine	6,940	5,862	18%	1078
Total	**23,730**	**23,343**	**2%**	**387**

*PbR Contract Activity Only

East Kent Hospitals University NHS
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Strategic Theme: KPIs

4 Hour Emergency Access Standard

Key Performance Indicators

82.21 %

	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
4 Hour Compliance	87.54%	87.01%	89.37%	87.78%	84.91%	80.01%	79.25%	84.06%	82.69%	85.40%	82.88%	82.21%
12 Hour Trolley Waits	0	0	0	0	1	0	1	1	0	0	0	0
Left without being seen	2.79%	2.87%	3.06%	3.19%	2.87%	3.78%	4.20%	3.46%	4.09%	3.84%	4.58%	4.13%
Unplanned Reattenders	8.98%	8.80%	8.93%	8.71%	8.88%	8.97%	9.31%	9.10%	9.40%	9.22%	8.62%	8.47%
Time to initial assessment (15 mins)	94.9%	91.1%	89.5%	91.7%	93.3%	92.6%	91.1%	86.0%	86.0%	89.0%	82.5%	73.5%
% Time to Treatment (60 Mins)	49.4%	51.0%	49.9%	50.3%	49.5%	43.5%	40.8%	46.3%	43.5%	48.3%	46.1%	48.8%

Sustainability & Transformational Funding Trajectory (Submission 18th April 2016)

-8.59 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
STF Trajectory	85.22%	90.02%	90.17%	89.68%	90.80%	90.80%	91.20%	91.50%	89.90%	89.83%	90.48%	91.40%
Performance	84.06%	82.69%	85.40%	82.88%	82.21%							

Summary Performance

The NHS Constitution sets out that a minimum of 95 per cent of patients attending an A&E department in England must be seen, treated, and then admitted or discharged in under 4 hours. This target was last revised by the Department of Health in 2010. When a decision to admit a patient from the emergency department is made, there is zero tolerance for waits of over 12 hours for admission to a ward.

The Emergency Access Standard is subject to a Contract Performance Notice due to the Trust being unable to achieve compliance against the 4 Hour Standard. An Emergency Care Recovery Plan (ECRP) has been developed, which reviews all aspect of the emergency patient pathways from attendance in the Emergency Department to discharge

from an inpatient ward. The aim of the plan is to improve performance and ensure that the ECRP delivers sustainability across emergency care pathways. It has been mandated through the Sustainability & Transformational Plans that the Trust will achieve performance levels which demonstrate consistent improvement over the course of 2016-17, with overall compliance in excess of 90%.

August performance against the 4 hour target was 82.21%, against a trajectory of 90.80% and a compliance target of 95%. August's performance shows a slight decline compared to the July position, with a lower proportion of patients seen within 4 hours. Analysis of the breach reasons shows a split in breach reasons similar to that seen in previous months, with the largest proportion of breaches assigned as due to delays to be seen by a first clinician (44% of all breaches, compared to 47% in July). The next biggest breach reason was around delays to Treatment Decision (18% of all breaches). Breaches due to Bed Management reasons remain at reduced levels (compared to previous months where bed pressures had this breach reason for upwards of 30% of breaches), with 13% of breaches for these reasons.

While the delay in Treatment Decision breach reason continues to relate to a large proportion of the breaches, performance against the 60 minute time to treatment improved in August compared to July (48.8% from 46.1%). The WHH site performance against this metric improved drastically from 33.7% to 38.8%, with performance at the QEQM decreasing slightly from 38.4% to 38.0%.

Volume of attendances remained high. This continues the trend of year to date attendance volumes being in excess of the planned activity levels (5.0% above plan YTD, +5.5% in Month). Volumes of attendances to Trust A&E departments continue to be higher than the previous year (+4.1% YTD), with raised volumes in particular noted at the Dover Buckland Hospital Minor Injuries Unit.

Improvements in Emergency Department performance are being pursued through the ECRP. The programme now has a dedicated programme manager who has supported a full review of the governance arrangements and a detailed review of the ERCP, including updating the evidence portfolio for all closed actions. The programme uses a BRAG rating to monitor progress against the plan and any new actions relating to improving emergency care pathways are discussed / agreed at the Urgent Care Board to ensure that there is an audit and governance trail. During August the ERCP has been fully reviewed to ensure that the plan reflects all local initiatives which the clinical teams in the ED's, Acute Medical Unit, Operational Control Centres and SAFER programme have identified.

Good progress is being made across all the work streams with the following notable highlights in August:

Improving ED Clinical Leadership:

- WHH launched the ESI (Early Senior Intervention) model on the 22 August with immediate improvement in the 60 minute first clinician metric. The model ensures that there is an assessment nurse in the waiting room who will allocate the patient a card which is presented to the receptionist. Patients who are very unwell will be streamed direct to majors, patients who have a minor injury will be streamed to the minors area and those patients who do not fit into either category will be allocated to the 'purple zone'. The purple zone is a consulting room which is managed by an ED senior doctor and nurse; patient will receive an early senior review and be stream to the appropriate clinical area and may also be 'seen and treated' by the ED senior doctor.

  The impact of ESI has been very positive with excellent feedback from patients and staff alike. The WHH has managed to maintain the ESI service across the full 24/7 period due to the high commitment of staff in the Department to the service. It is planned that the model will be shared with QEQMH following early evaluation.

- At QEQMH ED the Majors Assessment Pilot (MAP) being tested as and when staffing resources are available to support it. This pilot involves an ED Consultant or senior doctor, Consultant Acute Physician, Emergency Surgeon and senior ED nurse to either see and treat or directly stream patients to a speciality. The pilot has also been successfully managed by and ED Consultant and Acute Physician, if a surgical colleague has not been available. The MAP pilot requires the whole of the minor's area to be available to stream patients; however the clinical team are actively reviewing the pilot to assess whether it can be provided within current space constraints or alternative options can be accommodated.

  Consideration will be given as to how the MAP pilot may compliment ESI. Initial feedback from clinicians is that the process reduces delays and handoffs in the emergency pathway and on the days that the MAP has been piloted there has been improved performance against the 4 hour access standard.

- The new paediatric area at WHH has successfully opened and is being fully utilised by staff. The area provides a dedicated waiting area with assessment and treatment cubicles. This area is an excellent addition to the department and initial feedback from parents and children has been very positive.

- A full nursing review is almost completed to establish the staffing requirements to provide a dedicated Emergency Nurse Practitioner service across a minimum of 12 hours per day. This would reduce the requirement for medical staff to support the minor injuries service and develop a sustainable service for the future.

Acute Medical Model

- The Acute Medical Model project group at WHH is now established with actions being progressed at pace. Shared learning is underway via the Acute Medicine clinical lead to ensure that best practice from the QEQMH model is being implemented at WHH. The Acute Medicine Consultant job description and advertisement is under review with the Trust being represented at the BMA jobs fair in the autumn. Active networking and recruitment is underway in the meantime with shared posts across Divisions being actively considered to ensure that all opportunities to engage substantive consultants are being progressed.

- At QEQMH the Acute Medical Model continues to become embedded with a second Nurse Consultant now started in post. This post will enable further nurse led services to be developed and expanding the opportunity for MDT working and challenge on ward and board rounds.

Implementation of SAFER & Patient Flow Programme

Phase 1 of the Improving Patient Flow (enhancing SAFER) Programme has been completed and the Closure Report was presented on 19th August; this signified the end of the intensive support from Four Eyes Insight. The four wards participating in phase 1 were Cambridge L, Cambridge J1 and J2 and Cambridge M2. Success has been monitored through weekly production of the SAFER Dashboard (see Picture 1) in line with five KPI's:

- Reduced Medical outliers on surgical wards

- 33% of ward discharges before 12.00
- Weekly review and reduction of patients with a LOS >7 days
- 90% of EDD's set and recorded on PAS within 24hrs of admission to the ward
- 10% reduction in LOS within the target wards.

Clinical engagement within the Programme has been essential to success and this was the main area of involvement for Four Eyes insight, although the entire multidisciplinary team have been actively engaged across all four wards. This has been supported by the Improvement Delivery Business Partners , who have worked in partnership with ward and MDT teams to develop Standard Operating Procedures for Board Rounds and Setting of EDD's, as well as agreeing Roles and Responsibilities for key staff groups involved with patient flow. A Training and Communication cascade process has been specifically tailored for each ward, to reflect issues identified during the preparatory 'deep dive' analysis. An overarching Patient Flow Toolkit is in its final stages of development and will form part of the 'central repository', soon to be available within a dedicated webpage on the Trust's Internet Staff Zone.

Provision of Senior Review and an EDD (the 'SA' of SAFER) has been well embedded within the target wards, but it is acknowledged that additional input is required to fully implement better flow of patients, earlier discharge and weekly review of patients with a >7 day LOS (the 'FER' o SAFER). This will be the IDBP's priority until 31st August, before commencing the phase 2 rollout.

Priorities for August have been:

- Sustain achievement of progress to date and embed the remaining elements of **SAFER** on the initial target wards, until 31st August.
- Commence phase 2 rollout and undertake baseline assessments, deep dives, training, engagement and communication.
- Celebrate the success of phase 1 wards and agree a quarterly baseline review process with Matrons, to ensure sustainability.
- Develop and provide discharge competency training across the WHH site, in association with Matrons and the Integrated Discharge Team; especially in relation to CHOICE.
- Finalise the Patient Flow Toolkit and break it down into 'learning units' for ease.
- Finalise and establish the Improving Patient Flow webpage (Staff Zone)
- Patients EDD to be written on white boards above the bed to and all staff are to be encouraged to discuss EDD with patients &/or family.
- Finalise and implement the Inpatient PTL tool to enable visibility of the patients pathway and any associated delays.

Operational Control Centres:

- The staff consultation to review the current site management teams and support the implementation of a 24/7 clinical site management team is in the process of being implemented through an active recruitment plan.
- The Operational Control Centres (OCC's) standardised approach to recording site SITREP information with a RAG rates report being sent out following the site SITREP meetings at 08:00, 13:00 and 16:00 continues to become embedded.
- Escalation action cards are being actively used in the OCC environment and are being shared with ward staff and consultants to normalise their use.

- The escalation plan is being rewritten to include a more proactive and pre-emptive approach by all specialities to managing the risk of overcrowding in ED.

Notable risks

- The Emergency Departments (ED's) continue to have a high level of specialty doctor vacancies. This is an on-going national issue and is a key workforce risk within the ECRP. UK and international recruitment continues along with a nursing review to enable an Emergency Nurse Practitioner Service which will reduce the departments dependency on medical staff.

  During August there has continued to be gaps in the specialty doctor rota, particularly on evening and night shifts. Mitigating actions have continued to ensure that a safe service is provided, however, despite these actions there continues to be a serious risk in identifying sustainable cover for the rota and this does result in increased breaches in the evenings and overnight.

- There has been an increase in the number of patients presenting to QEQMH and WHH with mental health conditions. This has been a significant risk at QEQMH with an occasion in which there was 8 patients with a mental health condition in the ED overnight. To mitigate the risk a 24/7 agency mental health nurse is booked to support the nursing staff and mitigate the risk to patients and staff. Once assessed there have been significant delays for those patients requiring a mental health bed. There has been a significant risk of a high risk patient absconding and on-going monitoring of such patients creates additional pressure on the ED nursing staff. Although there is a mental health team allocated to each site between 08.00 and 20.00, in reality any patient attending after 6pm is likely to have to wait for the Crisis Team to assess overnight and this may be delayed if there are high risk patients in the community. Once assessed there may be a delay of several days before a mental health bed is identified.

Trajectory Confidence

August performance against the 4 hour target was 82.21%, against a trajectory of 90.80%. The increased activity levels seen so far this year remain above plan 5.5% in August, compared to +4.8% above plan in July. The numbers attending the departments, particularly in the evenings and overnight continue to have an adverse effect on the Trusts ability to meet the 4 hour standard for patients, with difficulties caused by spikes in activity and also the gaps in the specialty doctor rota. It is not unusual for 35 – 40 patients to attend over two hours and such high numbers of attendances are creating additional pressure in already busy departments.

The increased levels of activity experienced in through the summer have continued. The QEQMH and WHH have continued to see high numbers of patients attending in the evenings and overnight. The increase in children attending in the evenings has not abated.

There has been a movement in activity with QEQMH in particular seeing higher numbers of ambulances from the Canterbury catchment area since the new Urgent Care Centre criteria has been implemented. ED clinicians continue to work closely with SECAMB colleagues to reduce handover delays. Patients are being clinically assessed on arrival and safely streamed to areas such as the waiting room or minors. The conversion to admission is an indication that the patients have had a higher medical acuity with patients also being streamed to ambulatory care where possible.

The on-going risk to delivery of the trajectory is:

- A high % of breaches of the 4 hour emergency access standard relate to patient flow and bed availability.
- High numbers of patients attending ED in the evenings and weekends who could be managed by primary care, in particular paediatric attendances.
- Impact on the efficiency of the ED when trying to safely manage patients with a mental health condition who are awaiting assessment overnight by the Crisis Team.
- Mental health patients who require a mental health bed often having to wait several days for a bed, both in ED assessment beds and also in the wider ward bed base.
- Medical staffing vacancies, which medical staffing agencies are unable to fill. QEQMH is a particular risk due to the geographic location of the hospital.
- The number of DTOC's (delayed transfers of care) and access to short term external capacity in the community continues to be a high risk. There have been issues with a lack of external capacity across all geographic areas.

Actions taken:

- From the last week in August through to the 15th September, there were daily whole health economy calls to discuss the DTOCs and those that only needed domiciliary care packages to go home. The capacity and availability for nursing and care staff meant that success was limited. This exercise did however, provide valuable information as a baseline to the new "home First" programme that is about to start.
- Central guidance issued at the end of August has priorities for rapid improvement against the ED standard. These themes are A&E Streaming at the Front Door; increasing the % of calls transferred to a clinical advisor; Improved Ambulance Services; Patient Flow; and Discharge. We are in the process of aligning our actions plans to these themes.

East Kent Hospitals University NHS
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Strategic Theme: KPIs

Cancer Compliance

Key Performance Indicators

75.91 %

	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Green
62 day Treatments	69.76%	70.45%	70.89%	79.11%	71.68%	79.86%	73.57%	71.04%	79.20%	75.42%	70.62%	75.91%	>=85%
100 day breaches	86	130	87	75	57	64	65	61	42	56	57	45	<0
Demand: 2ww Refs	3,055	3,015	3,034	2,782	2,986	3,132	3,162	3,292	3,212	3,279	3,140	2,969	2858 - 3159
2ww Compliance	95.05%	95.62%	94.52%	93.87%	93.28%	94.10%	93.58%	89.25%	88.48%	94.61%	96.43%	94.73%	>=93%
Symptomatic Breast	93.46%	94.12%	93.55%	92.22%	94.06%	88.03%	92.98%	85.00%	83.73%	93.71%	93.10%	92.44%	>=93%
31 Day First Treatment	93.17%	96.43%	97.48%	98.00%	94.82%	97.07%	98.10%	96.11%	96.31%	94.55%	94.35%	93.53%	>=96%
31 Day Subsequent Surgery	92.11%	94.44%	96.97%	94.44%	94.59%	97.50%	96.72%	91.49%	88.24%	86.96%	96.61%	92.00%	>=94%
31 Day Subsequent Drug	100.00%	100.00%	98.53%	98.44%	86.17%	100.00%	100.00%	98.25%	98.95%	100.00%	97.37%	98.89%	>=98%
62 Day Screening	86.27%	84.21%	86.36%	85.00%	93.75%	95.65%	92.31%	92.86%	93.10%	100.00%	83.33%	86.67%	>=90%
62 Day Upgrades	91.67%	66.67%	77.78%	70.00%	50.00%	86.67%	70.37%	100.00%	57.14%	100.00%	82.35%	85.71%	>=85%

Sustainability & Transformational Funding Trajectory

-6.79 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	74.10%	76.40%	77.60%	77.40%	82.70%	85.40%	85.00%	85.50%	85.20%	85.10%	85.40%	85.20%	Sept
Performance	71.04%	79.20%	75.42%	70.62%	75.91%								Sept

Summary Performance

The Trust's main priority within cancer services is to ensure our patients receive treatment within the appropriate timeframe. The national target which has been consistently difficult for the Trust to maintain is the 62-day referral to treatment, which is made up of three key components: following an urgent referral from their GP, patients should be seen by a clinician within 14 days. If the diagnosis is cancer, a decision to treat should be made as soon as possible, and treatment should begin within 31 days of agreeing

this treatment. Over the patient's total pathway, treatment should be initiated within 62 days of the GP making the original urgent referral. There is a zero tolerance of patient waiting greater than 100 days for treatment, and Lead Clinicians now review each of these cases to identify causes and risk of harm to the patient. Where potential harm is identified, a full root cause analysis will be conducted and shared with our Clinical Commissioning Groups and internal governance boards.

Due to non-compliance of this 62-day standard over the past year, it is this target for which the Trust has developed an improvement trajectory as part of the Sustainability and Transformation Fund. The Trust has developed an internal plan to return to compliance, including revising capacity in outpatient clinics, re-launching multi-disciplinary team meetings and agreeing timed pathways and operation procedures.

August performance is 75.91% against the improvement trajectory of 82.79% (as at 19/09/16). Gynaecology, Head and Neck and Upper GI have met their recovery trajectories in August. Urology failed, but has a recovery plan agreed, which should see the performance improve in line with their trajectory in October. Colorectal performance remains the significant concern for the Trust.

Recovery action plans agreed at the extraordinary Cancer Board meeting in June will be discussed in detail at the September Cancer Board.

The Trust maintains its focus on patients waiting greater than 100 days and Clinical Nurse Specialists are working closely with the Cancer Compliance Team to review all patients that have been waiting greater than 100 days to understand what action are required to diagnose the patient with cancer or to remove the patient from the cancer pathway as appropriate. Actions are followed up at the PTL (Patient Target List) meetings and at MDM.

In August 64 patients were waiting over 100 days, representing 2.15% of patients on the PTL. 20 of these patients had a diagnosis, with 15 having a decision to treat.

The Key actions from the Recovery plan in August include:

PTL

- Introduction of WEBEX for all PTL meetings to improve the facilities to run the meetings and participation. Meetings are recorded and actions shared.
- PTL's have been themed to identify bottlenecks or on-going problems.
- Escalation continues and Divisional Directors are informed if actions are not taken
- PTL attendance had been audited and the report issues to Divisional Directors. Clinical Nurse Specialist attendance at PTL has been increased as a result of the audit.
- Key events agreed via Operational staff training day to be incorporated into the PTL to manage patients against key events. Failure to meet a key event will be treated as a breach and therefore, require investigation.

Communication

- Operational Management Training Day took place on 11th August. A further session is planned in October.
- Clinical Lead for Cancer has written to all MDM Leads via email to reinforce the Cancer Waiting Times and Access policy.
- Consultants and Clinical Nurse Specialist annual leave planning has been discussed at KPI.

Capacity

- Endoscopy capacity remains a concern for the Trust. Plans for additional resource are scheduled to come on line in October.
- MRI failure at Canterbury has impacted on the Prostate pathway in Urology. Patients are required to travel to William Harvey Hospital or Queen Elizabeth Queen Mother Hospital.
- An application to the National Diagnostic Capacity Fund Bid has been submitted. This includes a training Endoscopy post to ensure nurse and relevant doctors become JAG accredited and a radiology reporting post.
- Rapid Access Clinics for 2 week wait referrals are required for all tumour sites and will be a focus of business planning in the autumn.
- Histopathology wait times have improved to within the standard for reporting (7 days)
- Radiology reporting times remain a concern for the cancer pathway

Governance

- A full review of Serious Incidents has been undertaken. Identifying 16 SI's between January 2014 and Augusts2016 (31 months).
- A deep dive into the colorectal pathway is scheduled for September

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

18 Week Referral to Treatment Standard

Key Performance Indicators

85.52 %

	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Green
Performance	90.13%	92.06%	91.51%	88.82%	90.10%	89.17%	89.27%	88.56%	87.89%	86.81%	86.65%	85.52%	>=92%
52w+	15	12	3	5	2	4	4	6	9	17	27	20	0
Waiting list Size	42,577	40,125	39,842	41,178	42,239	42,791	43,000	44,620	45,663	44,213	45,488	45,352	<38,938
Backlog Size	4,201	3,186	3,384	4,604	4,181	4,634	4,614	5,105	5,531	5,831	6,073	6,568	<2,178
Demand: PC Referrals	15,954	16,444	15,712	14,305	15,039	15,891	16,405	16,709	15,909	16,030	15,922	15,117	<15,484
Demand: Additions to IP WL	3,199	3,442	3,526	3,035	3,220	3,375	3,385	3,236	3,366	3,776	3,545	3,560	<3,076
Pathway 1st OPA													>=92%
Pathway Decision to Treat													>=92%

Sustainability & Transformational Funding Trajectory

-6.15 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	89.03%	89.86%	90.45%	90.96%	91.67%	92.10%	92.66%	92.94%	92.57%	92.93%	93.42%	94.41%	Sept
Performance	88.56%	87.89%	86.81%	86.65%	85.52%								Sept

Summary Performance

The NHS Constitution gives all patients the legal right to start their non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral; unless they choose to wait longer or it is clinically appropriate that they wait longer. To measure compliance against this constitutional right EKHUFT is monitored against the Percentage of Patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral, the Threshold for national compliance has been set at 92%. There is a zero tolerance for any patient waiting over 52 weeks for treatment to commence. All breaches undergo a full root cause analysis, the results are shared with our Clinical Commissioning Groups and themes and lessons learnt are cascaded through our divisional governance structure.

Throughout the last year the Trust has been unable to deliver performance against the national standard as the number of patients waiting for treatment significantly exceeded our capability to see and treat within 18 weeks of referral. The Trust has developed internal activity plans which address the imbalance, and delivery of these activity levels alongside primary care commitments to reduce demand will enable the Trust to successfully deliver the Trajectory over the course of the financial year, this has formed the basis of our Sustainability and Transformation Fund Improvement Trajectory. The Trust intends to deliver compliance against the national standard by September 2016.

In August performance against the standard was 85.52%. There were twenty patients who were waiting for treatment for more than 52 weeks as at the end of the month. There are number of issues that are driving the reduction in performance against the trajectory; higher than planned primary care referrals and an inability to deliver the additional capacity identified within business plans in key specialities such as Orthopaedics, General Surgery, Gastroenterology, and Gynaecology across all points in the patients pathway (first appointment, follow up and patients listed for surgery intervention). In other specialities such as ENT there are administrative delays leading to an unreliable reported waiting list position.

The Trust continues to receive primary care demand over the predicted planned referral rate, in the year to date the trust has received over 1,600 more referrals than planned. They key areas are Orthopaedics, Maxillo Facial, Gynaecology and Paediatrics. The current rate of referrals means that the trajectory for referral to treatment for patients is unachievable unless the trust and the CCG agree a process to either; invest to create more internal capacity across the patient pathway which will involve additional pay and non-pay resource, outsourcing to the independent sector; or contract with alternative providers to utilise our facilities with an alternative workforce to the trusts. The decision making process to this will be taken jointly with the CCG and the trust within the existing meeting structures

There has been a significant decrease in the number of 52 week waiters is predominantly within the ENT specialty. The Trust has a capacity deficit within the Otology sub specialty due to vacancies, and is currently working in partnership with the Royal National Throat, Nose and Ear Hospital in London and primary care to ensure patients receive treatment.

The Trust has developed four key priorities which address all of the issues detailed above and we will continue to work with our local commissioners to achieve the sustainability and transformational trajectories and comply with our NHS constitutional duty.

Priority 1 - Improve Pathway Management

Development of New Interactive Patient Tracking List – We have developed a new Interactive Patient Tracking System which will enable our Operational Teams to access to live data, ensuring all patients waiting for Treatment are being actively monitored and managed, it is anticipated that this will significantly reduce the risk of patients waiting in excess of 52 weeks for Treatment.

- The system will be fully operational from 22nd August
- Over 6000 patient records were validated in August
- The Trust has developed innovative methods to identify data quality metrics which enables us to direct training to the most challenged areas.

Documented Timed Referral to Treatment Patient Pathways – Each specialty to have 18 week compliant pathways to enable us to unblock delays, monitor and hold ourselves to account to achievement of the RTT standard.

- All clinical pathways have now been mapped and agreed with the clinical staff, implementation of these pathways is now required to commence. This will begin in September.

Priority 2 - Achieve the Outpatient Milestones

Demand Management – The health system acknowledges the Trust does not have the operational capacity to deal with the current demand, as such our local Clinical Commissioning Groups (CCGs) committed to reducing referrals to East Kent in 2016/17.

- The CCGs are continuing to identify alternative providers to deliver Orthopaedic pathways in 2016/17.
- The CCG's are implementing choice navigators into referral management centres for Orthopaedics and are exploring other avenues to aid other specialities, such as gastroenterology and Gynaecology.
- The CCG are in the process of awarding the contracts for outpatient procedure management of wet macular oedema (Ophthalmology). This will mean patients will receive treatment closer to home in a primary care setting and will no longer have to attend hospital. As of the end of August the tender is yet to be awarded.
- The trust is working with the CCG to explore the development of in-house sleep studies in ENT to enable a one stop service to avoid transfer to the community for diagnostic testing.

The Trust is addressing current shortfalls in capacity with increased demand by;

- Additional outpatient internal capacity is being established for Orthopaedics, ENT, General Surgery, Maxillo Facial and gynaecology
- A tender process is underway to secure additional capacity in Ophthalmology using a company who will utilise our facilities in order to treat our patients.
- Two new consultants commencing in gastroenterology in September to stabilise the service
- Two new consultants commencing in Otology in November
- One new consultant commencing in October in Maxillo Facial
- Seven new consultant posts in recruitment process for Ophthalmology, interviews in November
- Validation process in ENT being reviewed with individual consultants with training being provided on the RTT pathway
- The Trust has identified an alternative provider who will accept tertiary referrals for complex adult ear procedures. The trust is liaising with London for outcomes of these treatments
- Improve Slot Utilisation – The Trust has developed operational datasets to locate and identify and fill unused slots, a baseline has been produced and the effectiveness in reducing waste has commenced.

- Bring forward the Decision to Treat Date – Identifying patients who have passed the optimal point in patient pathway and securing decision or treatment capacity

Priority 3 - Deliver the Efficiency Programme

Deliver Theatre Booking Magic Numbers – In collaboration with Medical Productivity & Clinical Service Redesign Specialists, Four Eyes Insight, and the Trust has identified an efficiency opportunity of 5,000 operative procedures per annum.

- The Trust has developed key monitoring documentation and enhanced the booking procedures required to achieve the required Theatre efficiency target.
- Increase in number of sessions run.
- General Surgery, Gynaecology and Ophthalmology continue to be the areas for focus during August and September

6-4-2 Programme – The Trust has established a programme of work to reduce the number of Theatre sessions that are cancelled and not re-established.

- The Trust has developed future focused reports and established meetings to review underutilised and empty theatre sessions.
- Profile of unused theatre lists are addressed at weekly theatre site meetings and weekly Trust theatre efficiency meetings.

Priority 4 – Deliver recurrent demand substantively

Live view of current demand – Monitoring referrals on a weekly basis to identify outpatient and admitted capacity required to respond

Real time response – Developing a process to empower staff to address changes in demand, this will reduce delays in responding to unplanned or unexpected changes to patient flow.

- Agreed waiting list initiative authorisation process, to include weekly demand monitoring and risk management within in the established PTL meetings.

Substantive planning – identifying demand within core capacity to deliver within financial constraints

- Job planning of clinical teams to deliver flexible sessions to achieve cross covering of clinical commitment during leave in outpatient and theatres is now operational
- Identified Ophthalmology sessions to transfer to extended days to release theatre capacity and provide cross cover – commenced
- Capacity to be commissioned from alternative provider for Ophthalmology during August and September until recruitment of consultants and technical staff has been successful. 3,000 appointments to be commenced during August and September – commenced
- The trust has secured additional capacity on behalf of the CCG and has commenced the transfer to the independent sectors for Orthopaedics, 279 patients have been transferred to date with a further 150 being validated. The commissioning support unit and our primary care colleagues are

continuing to source additional outpatient capacity to divert referrals this is reviewed at the primary care Contract and Performance Notice meetings (CPN)

- The trust has also secured additional capacity (130) on behalf of the CCG with the independent sector for General Surgery and has commenced transfer of patients for treatment.

Closing the loop on business planning and accountability – Developing operational procedures and monitoring tools to ensure delivery of the Business Plan

- Develop, train and embed consultant session tracker models to ensure we achieve our substantive internal activity.
- Deliver business planning action plans at speciality level to be monitored weekly at the RTT meeting.
- Clear objective setting, monitoring and accountability at monthly 1-2-1 meetings.

On the basis of all these actions, we are now recalculating our predicted performance against the trajectory. Unless demand is reduced through referral management mechanisms, we are unlikely to reach compliance until the last quarter.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

6 Week Referral to Diagnostic Standard

Key Performance Indicators

99.56 %

	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Performance	99.73%	99.84%	99.86%	99.90%	99.81%	99.65%	99.65%	99.78%	99.87%	99.86%	99.77%	99.56%
Waiting list Size	14,137	13,962	12,799	13,593	12,496	12,993	13,358	13,449	14,812	13,533	13,321	10,269
Waiting > 6 Week Breaches	38	23	18	13	24	45	47	29	19	19	31	45
Average Wait												

Sustainability & Transformational Funding Trajectory

0.43 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
STF Trajectory	99.08%	99.09%	99.15%	99.15%	99.13%	99.14%	99.13%	99.05%	99.10%	99.02%	99.03%	99.13%
Performance	99.78%	99.87%	99.86%	99.77%	99.56%							

Summary Performance

The DM01 is a national monthly report of performance against the 6 week standard for 15 key diagnostic tests. These include Radiology (MRI, CT and Ultrasound), Audiology, Echocardiography, Neurophysiology and Cystoscopy. Around 13/14 thousand tests per month are measured against the 6 week standard. The Division support the pathways for all patients on an 18 week and Cancer pathway. As well as monitoring the % of patients waiting 6 weeks or less for a diagnostic, the waiting list size and number of breaches over 6 weeks are also monitored, as these are key indicators that result in achievement of the DM01 standard.

45 patients waited over the 6 weeks standards in August 16 – breakdown below

Non-obstetric ultrasound – 29
Colonoscopy – 5
Gastroscopy – 5
MRI – 4
Cystoscopy - 1
Neurophysiology - 1

Risks and Issues to sustainable performance

- Aging equipment and downtime, rebooking enabling patient choice is a risk mitigated by daily conference call across the Trust with full overview and management of slot availability and use of alternative sites. Working on case for MRI interim arrangement as mobile at KCH is limited in what clinical activity is safe to use for.
- GE RIS failure has impacted the reporting turnaround times and created a large burden of additional administrative and clinical backlog of work. Access to the systems has impacted on the effective allocation of capacity.
- Increasing demand in modalities of CT MRI and Ultrasound- continue to vet requests.
- Recruitment to key Consultant, Radiographer, Ultra sonographer and Nursing posts, with locums vacancies of Consultants in Radiology, Endoscopy and Neurophysiology
- Reduction to current workforce and outsourcing availability would dramatically reduce the ability to deliver and sustain the DMO1 position –it would further compromise the RTT and cancer standards
- National public drives in screening can drive capacity and demand issues particularly in Endoscopy. The volume of cancer related to endoscopy referrals this month is at unprecedented levels for the Trust and we are reporting serious incident in relation to the demand and impact this could have on waiting times.
- Management HR issues and MHPS issues may impact on performance

What actions are we taking to mitigate and improve performance?

- Management and servicing of equipment managed closely. Serviced regularly to maximise use and work flow.
- Additional administrative support to manage the backlog from the GE RIS downtime.
- Daily overview and mapping of demand to capacity – bi-weekly overview by senior team to ensure on track and mitigate any issues in month
- Additional lists being undertaken to include both extended days during the week and Saturday lists.
- Consultant workforce recruiting to 4 vacancies and reviewing the speciality Interest of posts including Breast. Interview May 16 and July 16 - NHS Locums in place to mitigate in interim.
- Developing Business case to convert locums to substantive whilst ensuring full productivity and maximise DPA time of all consultants
- Neurophysiology- Consultant vacancy - The Consultant is employed by EKHUFT on a sessional basis to carry out the diagnostic reporting until the post is recruited to. This allows us to continue to achieve compliance. The vacancy is being actively recruited to.

- Additional outsourcing of reporting and using I.S. for MRI and Ultrasound (as required) to support delivery.
- Full Review of demand by speciality and by Division and Direct Access flows – this is actively being shared with Divisions and CCGs
- Working with Cardiology to review their pathways and booking processes and enable Nurse led booking of requests and reduce bulk ordering of tests.

Endoscopy – we will continue to manage with daily overview of all available

East Kent Hospitals University NHS
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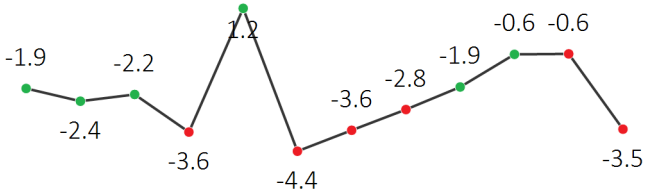
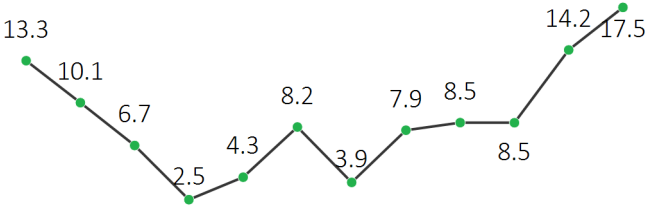
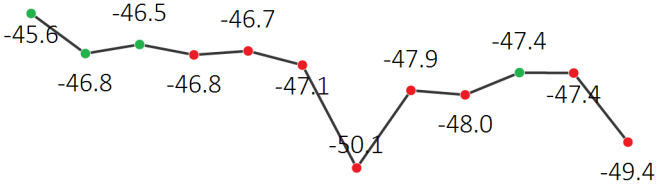
Strategic Theme: Finance

Finance

Aug	I&E £m	-9.4 (506.6%)		The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position. The year to date plan = £5.2m deficit adjusted for "extra" CIPS
Aug	Cash Balance £m	17.5 (23.4%)		Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.
Aug	Total Cost £m	-49.4 (4.3%)		Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.
Aug	Forecast I&E £m	-24.5 (123.8%)		This shows the latest forecast year end Income & Expenditure position as at 31st March 2017. The latest plan is yet to be agreed. The arrow shows latest monthly figure together with % variance against the last month reported.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Finance

Aug

Normalised Forecast £m

-27.6
(0.0%)

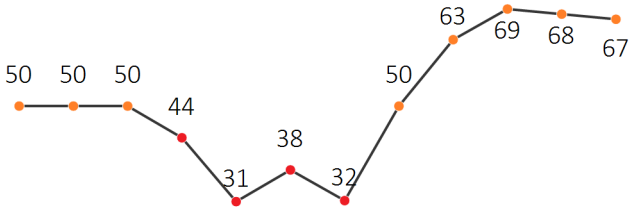
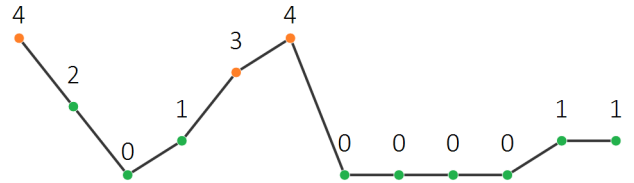
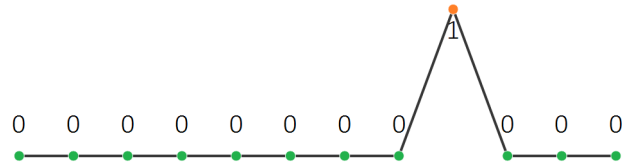
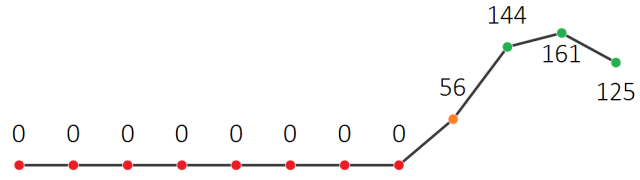
This shows the Normalised Income & Expenditure Forecast as at 31st March 2017. The arrow shows latest monthly figure together with % variance against the last month reported.

Comments: The Trust's monthly I&E deficit in August was £3.5m. This was as a result of removing expected Sustainabilty and Transformation Fund (STF) income of £1.34m per month for the months of July and August based on the Trust not delivering to trajectory against the published NHSI Control Total of a £0.6m surplus. The year to date I&E deficit stands at £9.37m to month 5. STF income of £4m relating to Q1 has been received. If STF income was included, the August deficit would have been £0.8m, a marginal deterioration on the £0.6m deficit reported in June and July as a result of lower clinical ativity in August.Pay costs in month were £28m as against an average of £28.1m per month up to month 4. Agency and locum costs continued at current trends being £2.15m as against an average of £2.1m per month and now stand at £10.6m for the year to date. The Trust is continuing to discuss its cash requirements with NHSI and to the end of M5 had accessed £12.8 of its approved interim credit facility of £14.6m. The Trust's year end forecast is £24m comprising the £12m deficit plan and £12m of lost STF income.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 1

Aug	Representation at H&S	611 (27.1%)		% of Clinical Divisions representation/attendance at each site's Health & Safety Committee. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	RIDDOR Reports (Number)	16 (-20.0%)		RIDDOR reports sent to HSE each month. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Formal Notices	1		Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).
Aug	Health & Safety Training	486		H&S Training includes all H&S and risk avoidance training including manual handling

Comments:

H&S representation dropped 1% to 67% in August, this remains a positive picture given the number of people of leave in month. Overall the trajectory of attendance remains on plan with divisional and site team meetings being better attended. The Strategic H&S Committee has asked for a report on attendees so as to make sure delegates can be organised and the meetings can be prioritised.

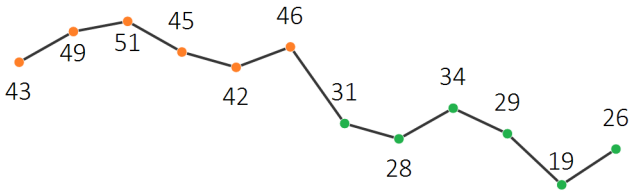
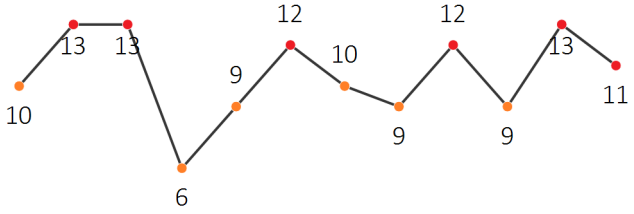
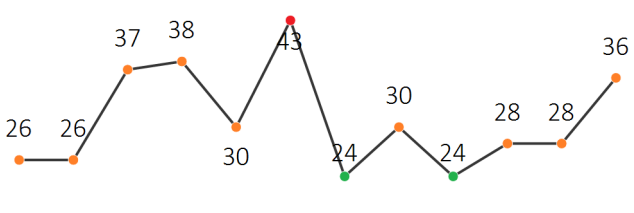
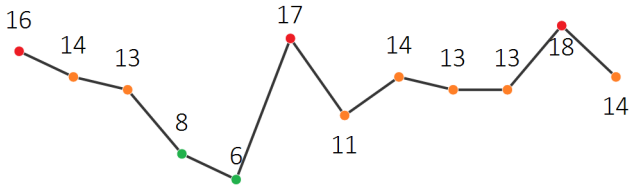
One RIDDOR occurred in Aug - a member of staff was sustained an injury following an assault by a patient with dementia.

The number of staff receiving training in Aug was lower than July largely due to the August leave period.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 2

Aug	Accidents	443 (-19.6%)		Accidents excluding sharps (needles etc) but including manual handling. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Fire Incidents	127 (-5.2%)		Fire alarm activations (including false alarms). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Violence & Aggression	370 (-16.1%)		Violence, aggression and verbal abuse. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Sharps	157 (207.8%)		Incidents with sharps (e.g. needle stick). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

The number of accidents increased slightly in August but remains in green.

Violence and aggression increased in month to 36. This is the highest number in the last 6 months but remains below the peak of 43 earlier this year.

The number of sharps incidents dropped slightly in August but cumulatively remains high. The issue was discussed at the Strategic H&S committee with representatives asked to cascade within their divisions whether there was further support or training required in specific areas. Occupational health will also link with Procurement to ensure that the intended trial of new sharps bins doesn't increase overall risk and appropriate safety measures are in place.

East Kent Hospitals University NHS
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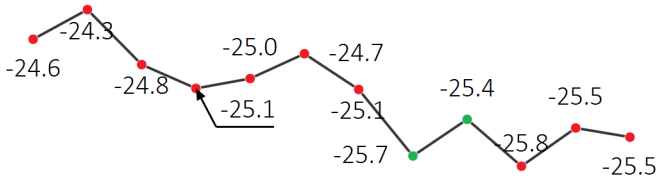
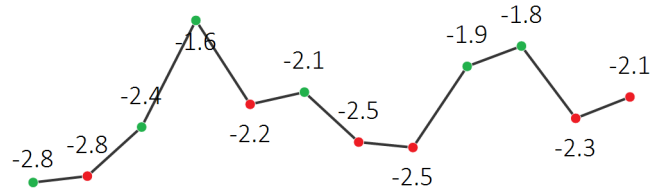
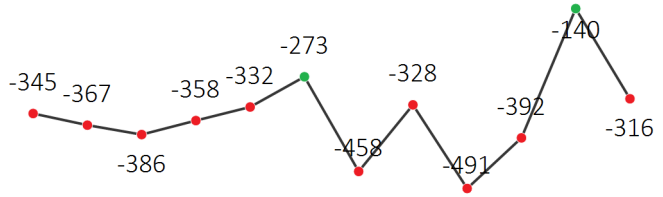
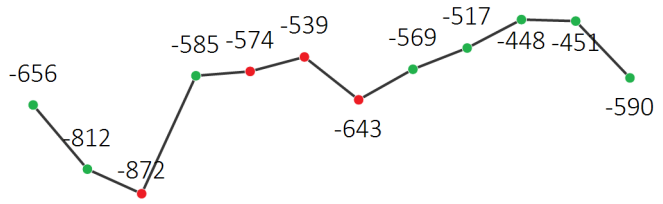
Strategic Theme: Use of Resources

Pay Independent

Aug	Payroll Pay £m	-25.5 (0.4%)		Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.
Aug	Agency Spend £m	-2.1 (-7.2%)		Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.
Aug	Additional sessions £k	-316 (125.4%)		Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.
Aug	Independent Sector £k	-590 (30.7%)		Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.

Comments: Pay costs in month were £28m as against an average of £28.1m per month up to month 4. Agency and locum costs continued at current trends being £2.15m as against an average of £2.1m per month and now stand at £10.6m for the year to date. Although the current trend is above that required to hit the £23m ceiling, agency and locum spend for the same period in 2015/16 was £13.4m, representing a real spend reduction of £2.8m (21%). Measures continue to be strengthened to reduce the agency bill but are challenged from the high number of vacant medical staff posts, particularly in medicine.

East Kent Hospitals University NHS
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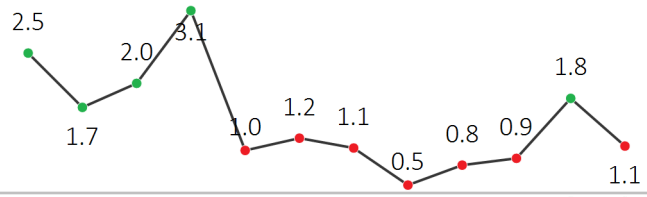
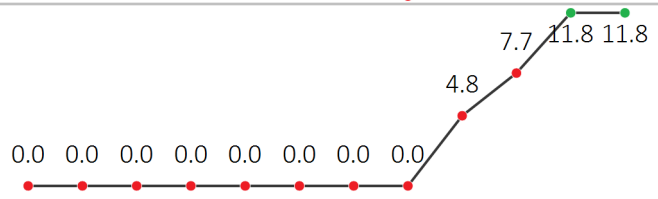
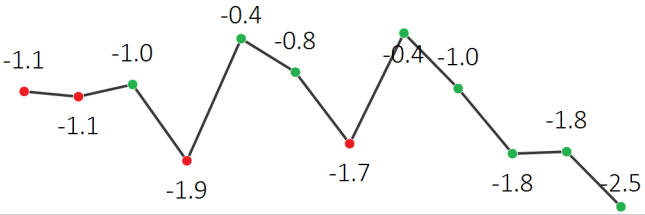
Strategic Theme: Use of Resources

Balance Sheet

Aug	CIPS £m	5.1 (-39.1%)		Cost Improvement Programmes (CIPs): Graph shows monthly delivery of savings. The arrow shows the cumulative year to date position with the % change against the previous month.
Aug	Cash borrowings £m			Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.
Aug	Capital position £m	-7.5 (37.3%)		Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow. The Annual Plan is £14.27m.

Comments:

CIPS of £3.9m (75% of YTD plan) have been reported YTD which is £1.3m below plan mainly due to the delay in recording theatres efficiency savings for months 3-5, and some slippage on Outpatients and Workforce. Additionally, income CIPs contribution of £1.2m YTD has been delivered. The CIPS target for the year is £20m. As at the end of August, schemes valued at £17.7m had been identified. This reduces to £15.9m when risk adjusted. The forecast for Income Completeness schemes is £1.9m. Urgent mitigation action has been taken with new CIPs Ideas sufficient to close the gap discussed at Turnaround Board by the Executive Team. These are now being developed further with divisions for implementation.

The Trust has borrowed £11.8M compared to an agreed borrowing level of £14.6M. Negotiations to extend this value are in progress with £32.5m the forecast requirement.

Capital spend is a little behind plan due to delays in ordering medical equipment but is expected to catch up later in the year.

East Kent Hospitals University NHS
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Strategic Theme: Use of Resources

Productivity

Aug	Clinical Productivity: Theatres	0.0	0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0	Clinical Productivity graph: theatre sessions v plan.
Aug	Clinical Productivity: Outpatient	0.0	0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0	Clinical Productivity graph: outpatient sessions v plan

Comments:

Theatres: The planned savings in year for Theatre efficiencies are £3.2M to be driven by increasing the number of cases per list and reducing dropped sessions. The work has been supported by Four Eyes who have provided the Trust with evidence of improvements which is currently being reviewed.

Out Patients: Identified savings are £1M based on cost reductions. Divisions continue to struggle to cope with high levels of activity and, as a result, have highlighted a significant risk to achieving the cost savings. The Trust continues to review the potential in this area but is not currently recognising any savings.

The Finance and Performance Committee will be considering productivity at its meeting in October.

East Kent Hospitals University NHS
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Strategic Theme: Improvement Journey

		Apr	May	Jun	Jul	Aug
MD02 - Emergency Pathway	ED - 4hr Compliance (%)	84.06	82.69	85.40	82.89	82.25
MD03 - Maternity Capacity	Midwife:Birth Ratio (%)	29	28	25	30	
MD06 - Pathway Flow	IP - Discharges Before Midday (%)	16	15	16	17	16
	DToCs (Average per Day)	78	62	62	62	58
MD07 - Medicines Management	Pharm: Fridges Locked (%)	92	94	94	90	92
	Pharm: Fridge Temps (%)	88	85	83	83	81
	Pharm: Drug Trolleys Locked (%)	98	100	100	97	99
	Pharm: Resus. Trolley Check (%)	85	88	88	92	90
	Pharm: Drug Cupboards Locked (%)	87	89	91	91	92
MD08 - Staffing Levels	Vacancy (%)	8.8	9.2	9.7	10.4	11.0
	Shifts Filled - Day (%)	97	101	98	91	91
	Shifts Filled - Night (%)	102	105	103	103	102
MD09 - Workforce Culture	Sickness (%)	3.9	3.8	3.8	3.8	4.0
	Appraisal Rate (%)	79.2	70.0	73.1	75.4	79.5
	Staff Turnover (%)	11.2	11.3	11.8	12.1	12.0
	Corporate Induction (%)	100	100	100	100	100
	Staff FFT - Work (%)	58	58	58	58	58
	Staff FFT - Treatment (%)	78	78	78	79	79
MD11 - Clinical Audit	Clinical Audit Prog. Audit	3	3	3	3	3
	Clinical Audit Review	3	3	3	3	3

MD12 - Environment	Cleanliness Audits (%)	98	98	98	98	98
MD17 - Incident Reporting	Clinical Incidents: Total (#)	1230	1313	1357	1245	1241
MD19 - Major Incident Planning	Major Incident Training (%)	25	27	30	33	34
MD22 - Agency Staffing	Unplanned Agency Expense	95	68	68	98	100
	Clinical Time Worked (%)	74	73	73	74	71
	Temp Staff (WTE)	196	205	202	205	226
	Employed vs Temporary Staff (%)	91.4	91.0	90.3	89.8	89.1
	Local Induction Compliance %	6.0	8.5	15.0	15.0	9.2
MD26 - Complaints Process	Complaint Response in Timescales %	54	84	94	96	97
MD30 - Medicines Management	Medicines Mgmt. Incidents	95	103	119	90	107

East Kent Hospitals University NHS
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Glossary

Domain	Metric Name	Metric Description	Green	Weight
				0 %
A&E	ED - 4hr Compliance (%)	% of A&E attendances who were in department less than 4 hours - from arrival at A&E to admission/transfer/discharge.	>= 95	100 %
Beds	Bed Occupancy (%)	This metric looks at the number of beds the Trust has utilised over the month. This is calculated as funded beds / (number of patients per day X average length of episode stay). The metric now excludes all Maternity, Intensive Treatment Unit (ITU) and Paediatric beds and activity.	<= 90	60 %
	DToCs (Average per Day)	The average number of delayed transfers of care	< 28	30 %
	Extra Beds	Number of extra 'unfunded' beds available		0 %
	IP - Discharges Before Midday (%)	% of Inpatients discharged before midday	>= 35	10 %
	Outliers	Number of Bed Outliers in the Trust, where the intended use of the bed is used for another service		0 %
Cancer	Cancer: 2ww (All) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent GP referral for suspected cancer (CB_B6)	>= 93	10 %
	Cancer: 2ww (Breast) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected (CB_B7).	>= 93	5 %
	Cancer: 31d (2nd Treat - Surg) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is a Surgery (CB_B9).	>= 94	5 %
	Cancer: 31d (Diag - Treat) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat') (CB_B8)	>= 96	15 %
	Cancer: 31d (Drug) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is an Anti-Cancer Drug Regimen (CB_B10).	>= 98	5 %
	Cancer: 62d (Con Upgrade) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	>= 85	5 %
	Cancer: 62d (GP Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer.	>= 85	50 %
	Cancer: 62d (Screening Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service.	>= 90	5 %
Clinical Outcomes	Audit of WHO Checklist %	An observational audit takes place to audit the World Health Organisation (WHO) checklist	>= 99	10 %
	Cleanliness Audits (%)	Cleaning Schedule Audits	>= 98	5 %
	Clinical Audit Prog. Audit	Agreed Clinical Audit programme meets national programme requirements	>= 3	5 %

Clinical Outcomes	Clinical Audit Review	Review of the Clinical Audit Programme	>= 3	5 %
	FNoF (36h) (%)	% Fragility hip fractures operated on within 36 hours (Time to Surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an Inpatient, to the start of anaesthesia). Data taken from the National Hip Fracture Database. Reporting one month in arrears to ensure upload completeness to the National Hip Fracture Database.	>= 85	5 %
	Pharm: Drug Cupboards Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug cupboards locked	>= 90	5 %
	Pharm: Drug Trolleys Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug trolley's locked	>= 90	5 %
	Pharm: Fridge Temps (%)	Data taken from Medicines Storage & Waste Audit - percentage of wards recording temperature of fridges each day	>= 100	5 %
	Pharm: Fridges Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of fridges locked	>=95	5 %
	Pharm: Resus. Trolley Check (%)	Data taken from Medicines Storage & Waste Audit - percentage of resus trolley's checked	>= 90	5 %
	pPCI (Balloon w/in 150m) (%)	% Achievement of Call to Balloon Time within 150 mins of pPCI.	>= 75	5 %
	PROMs EQ-5D Index: Groin Hernia	PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.		0 %
	PROMs EQ-5D Index: Hip Replacement	PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.		0 %
	PROMs EQ-5D Index: Knee Replacement	PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.		0 %
	Readmissions: EL dis. 30d (12M%)	Percentage of patients that have been discharged from an elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	Percentage of patients that have been discharged from a non-elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	< 15	15 %
	Stroke Brain Scans (24h) (%)	% stroke patients receiving a brain CT scan within 24 hours.	>= 100	5 %
Culture	Policies in Date (%)	All documents that are marked as policies are in date on the SharePoint system	>= 95	10 %
	Staff FFT - Treatment (%)	Percentage of staff who would recommend the organisation for treatment - data is quarterly and from the national submission.	>= 81.4	40 %
	Staff FFT - Work (%)	Percentage of staff who would recommend the organisation as a place to work - data is quarterly and from the national submission. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 60	50 %

Data Quality & Assurance	Not Cached Up Clinics %	Outpatients bookings that either have no outcome coded (i.e. attended, DNA or cancelled) or there is a conflict (e.g. patient discharged but no discharge date) as a % of all outpatient bookings.	< 4	25 %
	Uncoded Spells %	Inpatient spells that either have no HRG code or a U-coded HRG as a % of total spells (included uncoded spells).	< 0.25	25 %
	Valid Ethnic Category Code %	Patient contacts where Ethnicity is not blank as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	5 %
	Valid GP Code %	Patient contacts where GP code is not blank or G9999998 or G9999991 (or is blank/G9999998/G9999991 and NHS number status is 7) as a % of all patient contacts. Includes all OP, IP and A&E contacts	>= 99.5	5 %
	Valid NHS Number %	Patient contacts where NHS number is not blank (or NHS number is blank and NHS Number Status is equal to 7) as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	40 %
Demand vs Capacity	DNA Rate: Fup %	Follow up appointments where the patient did not attend (appointment type=2, appointment status=3) as a % of all follow up appointments.	< 7	0 %
	DNA Rate: New %	New appointments where the patient did not attend (appointment type=1, appointment status=3) as a % of all new appointments.	< 7	0 %
	New:FUp Ratio (1:#)	Ratio of attended follow up appointments compared to attended new appointments		0 %
Diagnostics	Audio: Complete Path. 18wks (%)	AD01 = % of Patients waiting under 18wks on a completed Audiology pathway	>= 99	0 %
	Audio: Incomplete Path. 18wks (%)	AD02 = % of Patients waiting under 18wks on an incomplete Audiology pathway	>= 99	0 %
	DM01: Diagnostic Waits %	The percentage of patients waiting less than 6 weeks for diagnostic testing. The Diagnostics Waiting Times and Activity Data Set provides definitions to support the national data collections on diagnostic tests, a key element towards monitoring waits from referral to treatment. Organisations responsible for the diagnostic test activity, report the diagnostic test waiting times and the number of tests completed.The diagnostic investigations are grouped into categories of Imaging, Physiological Measurement and Endoscopy and covers 15 key diagnostic tests.	>= 99	100 %
Finance	Cash Balance £m	Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
	Forecast I&E £m	This shows the latest forecast year end Income & Expenditure position as at 31st March 2017. The latest plan is yet to be agreed. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
	I&E £m	The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position. The year to date plan = £5.2m deficit adjusted for “extra” CIPS	>= Plan	30 %
	Normalised Forecast £m	This shows the Normalised Income & Expenditure Forecast as at 31st March 2017. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	10 %
	Total Cost £m	Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
Health & Safety	Accidents	Accidents excluding sharps (needles etc) but including manual handling. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 40	15 %

Health & Safety	Fire Incidents	Fire alarm activations (including false alarms). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 5	10 %
	Formal Notices	Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).	1	15 %
	Health & Safety Training	H&S Training includes all H&S and risk avoidance training including manual handling	>= 80	5 %
	Representation at H&S	% of Clinical Divisions representation/attendance at each site's Health & Safety Committee. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 76	20 %
	RIDDOR Reports (Number)	RIDDOR reports sent to HSE each month. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 3	20 %
	Sharps	Incidents with sharps (e.g. needle stick). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	5 %
	Violence & Aggression	Violence, aggression and verbal abuse. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 25	10 %
Incidents	All Pressure Damage: Cat 2	Number of all (old and new) Category 2 pressure ulcers. Data source - Datix.		0 %
	Blood Transfusion Errors	The number of blood transfusion errors sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		0 %
	Clinical Incidents: Total (#)	Number of Total Clinical Incidents reported, recorded on Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		0 %
	Falls (per 1,000 bed days)	Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< = 5	20 %
	Falls: Total	Total number of recorded falls. Assisted falls and rolls are excluded. Data source - Datix.	< 3	0 %
	Harm Free Care: All Harms (%)	Percent of Inpatients deemed free from harm (ie, free from old & new harm- pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 94	10 %

Incidents	Harm Free Care: New Harms (%)	Percent of Inpatients deemed free from new, hospital acquired harm (ie, free from new: pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 98	20 %
	Medicines Mgmt. Incidents	The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		0 %
	Never Events (STEIS)	Monthly number of Never Events. Uses validated data from STEIS. Arrow indicatessum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.	< 1	30 %
	Number of Cardiac Arrests	Number of actual cardiac arrests, not calls	>= 1	0 %
	Pressure Ulcers Cat 2 (per 1,000)	Number of avoidable Category 2 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 0.15	10 %
	Pressure Ulcers Cat 3/4 (per 1,000)	Number of avoidable Category 3/4 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 1	10 %
	Serious Incidents (STEIS)	Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		0 %
Infection	Bare Below Elbows Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	0 %
	Blood Culture Training	Blood Culture Training compliance	>= 85	0 %
	C Diff (per 100,000 bed days)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01), recorded at greater than 72h post admission per 100,000 bed days	< 1	0 %
	C. Diff Infections (Post 72h)	The number of Clostridium difficile cases recorded at greater than 72h post admission. Data source - VitalPAC (James Nash).	< 1	0 %
	Cases of C. Diff (Cumulative)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01). Position in arrow shows YTD cumulative position and variance against previous month. Graph shows last 12 months, noting that C. Diff is reported as a cumulative YTD position, which explains the drop from 28 (as at March-16) down to 4 (new financial year at April-16).	<= Traj	40 %
	Cases of MRSA (per month)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.	< 1	40 %
	Commode Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	0 %

Infection	E Coli (per 100,000 population)	The total number of E-Coli bacteraemia per 100,000 population.	< 44	0 %
	E. Coli	The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 44	10 %
	Infection Control Training	Percentage of staff compliant with the Infection Prevention Control Mandatory Training - staff within six weeks of joining and are non-compliant are excluded	>= 85	0 %
	MRSA (per 100,000 bed days)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT, cases per 100,000 bed days	< 1	0 %
	MSSA	The total number of MSSA bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 1	10 %
	MSSA (per 100,000 population)	The total number of MSSA bacteraemia per 100,000 population.	< 12	0 %
	MSSA - 48hr (per 100,000 bed days)	The total number of Trust assigned (post 48h) MSSA bacteraemia per 100,000 bed days.	< 1	0 %
Initiatives	75+ Frailty Pathway CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway	>= 100	0 %
	Antimicrobial Resistance & Stewardship CQUIN Delivered %	CQUIN made up of two parts – reducing antibiotic consumption in named antibiotics and review of patients on antibiotics after 48/72 hours	>= 100	20 %
	COPD CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway and improve referral rates to the Stop Smoking Service and to the Community Respiratory Team	>= 100	0 %
	Dementia Diagnosed CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to monitor the diagnosis for Dementia. Green = on target for case finding, assessment and referral to reach 90% for each indicator for 3 consecutive months, AND staff training on target for improvement, AND on target to provide support to carers	>= 100	0 %
	Diabetes CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway	>= 100	0 %
	End of Life Pathway CQUIN Delivered %	CQUIN linked to current improvement work and multi-agency policy	>= 100	20 %
	Heart Failure CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway and sustain EQ HF measures	>= 100	0 %
	Patient Flow CQUIN Delivered %	CQUIN linked to SAFER project	>= 100	20 %
	Sepsis CQUIN Delivered %	CQUIN including acute wards and with antibiotic review at 72 hours	>= 100	20 %

Initiatives	Staff Health & Wellbeing CQUIN Delivered %	CQUIN made up of three parts – staff access to healthy activities, health food options on site and flu vaccine uptake	>= 100	20 %
Mortality	Crude Mortality EL (per 1,000)	The number of deaths per 1,000 elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	The number of deaths per 1,000 non-elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 27.1	10 %
	HSMR (Index)	Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data together with variance against previous 12 months.	< 90	35 %
	RAMI (Index)	Risk Adjusted Mortality (via CHKS) computes the risk of death for hospital patients and compares to others with similar characteristics. Data including age, sex, length of stay, clinical grouping, diagnoses, procedures and discharge method is used. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	< 87.45	30 %
	SHMI	Summary Hospital Mortality Indicator (SHMI) as reported via HSCIC includes in hospital and out of hospital deaths within 30 days of discharge. Latest quarter identifies last reported 12 month period. Please note this metric has recently been changed to reflect HSCIC, not CHKS. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 0.95	15 %
Observations	Cannula: Daily Check (%)	The % of cannulas checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Catheter: Daily Check (%)	The % of catheters which were checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Central Line: Daily Check (%)	The % of central lines checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Obs. On Time - 8am-9pm (%)	Number of patient observations taken on time	>= 90	25 %
	Obs. On Time - 9pm-8am (%)	Number of patient observations taken on time	>= 90	25 %
	VTE: Risk Assessment %	Adults who have had a Venous Thromboembolism (VTE) Risk Assessment at any point during their Admission. Low-Risk Cohort counted as compliant.	>= 95	20 %
Patient Experience	Care Explained? %	Based on a question asked within the Trust's Inpatient Survey, was your care or treatment explained to you in a way you could understand by the medical/nursing/support staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 89	4 %

Patient Experience	Care that matters to you? %	Based on a question asked within the Trust's Inpatient Survey, did you get the care that matters to you? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data (as shown in graph).	>= 89	4 %
	Cleanliness? %	Based on a question asked within the Trust's Inpatient Survey, in your opinion, how clean was the hospital room or ward that you were in? % of inpatients who answered 'very clean' or 'fairly clean'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 95	5 %
	Complaint Response in Timescales %	Audit due to commence in January - Percentage of controlled drugs signed off by two nurses	>= 85	5 %
	Compliments to Complaints (#/1)	Number of compliments per complaint	>= 12	10 %
	FFT: Not Recommend (%)	Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 1	10 %
	FFT: Recommend (%)	Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 90	30 %
	FFT: Response Rate (%)	The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 15	1 %
	Hospital Food? %	Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? % of inpatients who answered 'very good' or 'good'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	5 %
	Mixed Sex Breaches	Number of patients experiencing mixed sex accommodation due to non-clinical reasons. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	1	10 %
	Number of Complaints	The number of complaints recorded per ward. Data source - Datix.		0 %
	Number of Compliments	The number of compliments recorded per ward. Data source - Patient Experience Team (Kayleigh McIntyre).	>= 1	0 %
	Overall Patient Experience %	Based on questions asked within the Trust's Inpatient Survey, this provides an overall inpatient experience % by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1). Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 90	10 %
	Respect & Dignity? %	Based on a question asked within the Trust's Inpatient Survey, overall, did you feel you were treated with respect and dignity while you were in hospital by the nursing staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 89	2 %
	Returning Complaints	Number of complaints returned		4 %

Productivity	BADS	British Association of Day Surgery (BADS) Efficiency Score calculated on actual v predicted overnight bed use – allowing comparison between procedure, specialty and case mix.	>= 100	10 %
	eDN Communication	% of patients discharged with an Electronic Discharge Notification (eDN).	>= 99	5 %
	EME PPE Compliance %	EME PPE % Compliance	>= 90	20 %
	LoS: Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for admitted elective patients. M.Sakel (NuroRehab) excluded for EL.		0 %
	LoS: Non-Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for non-admitted elective patients.		0 %
	Non-Clinical Cancellations (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations as a % of the total non-clinical cancellations.	< 0.8	20 %
	Non-Clinical Canx Breaches (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations that were not rebooked within 28days as a % of total admitted patients.	< 5	10 %
	Pharmacy TTAs Dispensed (%)	The percentage of Discharge Prescriptions (known as TTAs, TTOs or EDNS) dispensed by Pharmacy before the time required on the ward	>= 80	0 %
	Theatres: On Time Start (% 30min)	The % of cases that start within 30 minutes of their planned start time.	>= 90	10 %
	Theatres: Session Utilisation (%)	% of allocated time in theatre used, including turn around time between cases, excluding early starts and over runs.	>= 85	25 %
RTT	RTT: 52 Week Waits (Number)	Zero tolerance of any referral to treatment waits of more than 52 weeks, with intervention, as stated in NHS Operating Framework	< 1	0 %
	RTT: Incompletes (%)	% of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways, completed non-admitted pathways and incomplete pathways, as stated by NHS Operating Framework. CB_B3 - the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	>= 92	100 %
Staffing	Agency %	% of Staff working employed through an agency. Number indicates average of last 12 months data (as shown in graph).	<= 10	0 %
	Agency & Locum Spend	Total agency spend including NHSP spend		0 %
	Agency Orders Placed	Total count of agency orders placed. Number indicates average of last 12 months data (as shown in graph).	<= 100	0 %
	Clinical Time Worked (%)	% of clinical time worked as a % of total rostered hours.	>= 74	2 %
	Employed vs Temporary Staff (%)	Ratio showing mix of permanent vs temporary staff in post. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 92.1	1 %
	Local Induction Compliance %	Local Induction Compliance rates (%) for temporary employee's to the Trust. Number indicates average of last 12 months data (as shown in graph).	>= 85	0 %

Staffing	Midwife:Birth Ratio (%)	The number of births compared to the number of whole time equivilant midwives per month (total midwive staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwives budget codes.	< 28	2 %
	NHSP Use % of Agency	% of Employee's deployed through an agency that are NHSP. Number indicates average of last 12 months data (as shown in graph).	> 90	0 %
	Overtime %	% of Employee's that claim overtime. Number indicates average of last 12 months data (as shown in graph).	<= 10	0 %
	Overtime (WTE)	Count of employee's claiming overtime	<= 60	1 %
	Roster Effectiveness (%)	The time ward staff attribute to clinical duties as a % of the ward duty roster. Data source - eRoster.		15 %
	Shifts Filled - Day (%)	Percentage of RCN and HCA shifts filled on wards during the day (split by RCN & HCA)	>= 97	15 %
	Shifts Filled - Night (%)	Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA)	>= 97	15 %
	Sickness (%)	% of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 3.6	10 %
	Stability Index (excl JDs) %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate – WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage. exclude Junior medical staff, any staff with grade codes beginning MN or MT		0 %
	Stability Index (incl JDs) %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate – WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage		0 %
	Staff Turnover (%)	% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	15 %
	Staffing Level Difficulties	Any incident related to Staffing Levels Difficulties		1 %
	Temp Staff (WTE)	Count of Temporary Staff in post	< 182	1 %
	Time to Recruit	Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	0 %
	Total Staff In Post (FundEst)	Count of total funded establishment staff		1 %
	Total Staff In Post (SiP)	Count of total staff in post		1 %
	Unplanned Agency Expense	Total expediture on agency staff as a % of total monthly budget.	< 100	5 %

Staffing	Vacancy (%)	% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	15 %
Training	Appraisal Rate (%)	Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 90	50 %
	Corporate Induction (%)	% of people who have undertaken a Corporate Induction	>= 95	0 %
	EME Planned Maintenance (%)	Planned maintenance of EME managed medical equipment	>= 95	0 %
	Major Incident Training (%)	% of people who have undertaken Major Incident Training	>= 95	0 %
	Mandatory Training (%)	The percentage of staff that have completed mandatory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	50 %
Use of Resources	Additional sessions £k	Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	0	0 %
	Agency Spend £m	Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.	0	0 %
	Capital position £m	Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow. The Annual Plan is £14.27m.	0	0 %
	Cash borrowings £m	Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.	0	0 %
	CIPS £m	Cost Improvement Programmes (CIPs): Graph shows monthly delivery of savings. The arrow shows the cumulative year to date position with the % change against the previous month.	0	0 %
	Clinical Productivity: Outpatient	Clinical Productivity graph: outpatient sessions v plan		0 %
	Clinical Productivity: Theatres	Clinical Productivity graph: theatre sessions v plan.		0 %
	Independent Sector £k	Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	0	0 %
	Payroll Pay £m	Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	0	0 %

Data Assurance Stars

Not captured on an electronic system, no assurance process, data is not robust

Data is either not captured on an electronic system or via a manual feeder sheet, does not follow an assured process, or not validated/reconciled

Data captured on electronic system with direct feed, data has an assured process, data is validated/reconciled

East Kent Hospitals University NHS
NHS Foundation Trust

Patient Safety Heatmap

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	Number of Complaints	Number of Compliments	Care that matters to you? %	Care Explained? %	Respect & Dignity? %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)
KCH - Kent & Canterbury																
Specialist																
DOLP - DOLPHIN WARD		0	0	0	0	1	0									
KBRA - BRABOURNE (KCH)	100.0	0	0	0	0	0	47				85	100	0.0		81	107
MARL - MARLOWE WARD	100.0	6	7	0	0	5	150				29	97	0.0	88.6	81	88
Surgical																
CLKE - CLARKE WARD	100.0	4	3	0	0	1	1				23	99	0.0	90.6	84	105
DSSC - DAY SURGERY		0	1	0	0	0	0									
KENT - KENT WARD	100.0	4	6	0	0	0	0	100	98	100	71	100	0.0	94.0	108	98
KITU - KCH ITU	100.0	2	1	0	0	0	0							89.5	89	98
Urgent Care																
HARB - HARBLEDOWN WARD	91.3	3	7	2	0	0	13	71	92	96	29	90	4.8	78.7	89	92
HARV - HARVEY WARD		0	0	0	1	0	0								87	100
INV - INVICTA WARD	100.0	1	0	0	0	0	29	97	87	94	35	100	0.0	87.9	92	108
KCDU - EMERGENCY CARE CENTRE	94.7	0	1	1	0	0	0	95	92	99	0			94.0		
KING - KINGSTON WARD	95.0	0	3	0	0	0	1	78	72	84	22	100	0.0	104.1	92	101
KNRU - EAST KENT NEURO REHAB UNIT	100.0	0	2	0	0	0	0				50	100	0.0	91.1		
MTMC - MOUNT/MCMASTER WARD	100.0	1	1	0	0	1	9	92	92	94	0			81.0	85	132
TAY - TAYLOR WARD	100.0	1	2	1	0	0	1	100	100	100	155	100	0.0	88.7	63	100
TREB - TREBLE WARD	100.0	0	5	0	0	2	30	93	93	98	42	100	0.0	91.7	69	124
QEH - Queen Elizabeth Queen Mother																
Specialist																
BIR - BIRCHINGTON WARD	94.7	0	5	0	0	3	124				21	97	2.9	98.7	100	101
KIN - KINGSGATE WARD	100.0	0	0	0	0	1	0							97.2	72	87
QSCB - QEH SPECIAL CARE BABY UNIT	100.0	0	0	0	0	0	14							98.1	99	100
RAI - RAINBOW WARD	100.0	0	0	0	0	1	2				14	96	0.0	92.2	85	104
Surgical																
BIS - BISHOPSTONE WARD	100.0	0	2	0	0	2	1				50	100	0.0	88.0	93	84

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	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	Number of Complaints	Number of Compliments	Care that matters to you? %	Care Explained? %	Respect & Dignity? %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)
CSF - CHEERFUL SPARROWS FEMALE	96.2	3	4	0	0	1	15	64	79	90	37	97	0.0	76.3	93	125
CSM - CHEERFUL SPARROWS MALE	100.0	1	3	0	0	3	0	97	95	97	51	95	0.0	81.4	100	117
QITU - QEH ITU	100.0	1	1	0	0	0	37							97.2	82	95
QX - QUEX WARD	95.0	0	2	0	0	1	1	98	89	94	84	97	0.0	85.8	82	95
SB - SEA BATHING WARD	95.7	0	0	0	0	0	0	100	100	100	50	96	0.0	93.9		
Urgent Care																
DEAL - DEAL WARD	96.4	0	8	1	0	0	0	96	93	95	27	87	6.7	95.7	114	116
FRD - FORDWICH WARD STROKE UNIT	100.0	0	1	0	0	0	0	96	96	96	35	100	0.0	78.1	93	104
MW - MINSTER WARD	100.0	9	4	0	0	2	194				90	98	1.9	84.0	96	96
QCCU - QEH CCU	100.0	0	1	0	0	0	1	100	100	100	58	100	0.0	94.1	81	104
QCDU - QEH CDU	100.0	12	5	0	1	2	2				27	94	3.7	87.0		
SAN - SANDWICH BAY WARD	100.0	2	3	0	0	0	116				21	100	0.0	84.5	119	138
SAU - ST AUGUSTINES, THE REHAB. WARD	97.5	1	6	0	0	1	113	67	94	91	43	87	0.0	75.3		
STM - ST MARGARETS WARD		0	1	0	0	1	25				58	100	0.0	98.1	91	106
WHH - William Harvey																
Specialist																
FF - FOLKESTONE	100.0	0	0	0	0	1	0								84	82
KEN - KENNINGTON WARD	100.0	0	0	0	0	1	0				39	96	2.2	90.2	89	98
PAD - PADUA	100.0	0	0	0	0	1	21				16	98	2.2		88	88
SCBU - THOMAS HOBBES NEONATAL UNIT	100.0	0	0	0	0	1	44								86	95
SING - SINGLETON MLU		0	0	0	0	0	0								94	95
Surgical																
DSC - DAY SURGERY CENTRE		0	0	0	0	3	0									
ITU - WHH ITU	100.0	3	1	0	0	0	12							92.5	110	102
KA2 - KINGS A2	90.0	1	4	0	0	0	0	98	93	98	67	96	0.0	94.8	100	106
KB - KINGS B	96.3	2	9	0	0	1	94	92	90	99	32	97	0.0	95.6	93	148
KC - KINGS C1	96.3	1	5	0	1	0	0	100	94	96	43	100	0.0	86.0	92	106
KC2 - KINGS C2	100.0	0	0	0	0	0	1				38	98	0.0	85.2	88	99
KDF - KINGS D FEMALE	100.0	2	4	0	0	0	170	94	89	94	70	95	5.1	93.3		
KDM - KINGS D MALE	96.0	0	4	0	0	0	1	85	92	94	29	96	0.0		102	103
RW - ROTARY WARD	100.0	0	2	0	0	2	68	93	95	98	47	99	1.2	94.6	98	103
SEAU - SURGICAL EMERGENCY ASSESS WHH		0	0	0	0	0	0				132	93	2.9			

Urgent Care	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	Number of Complaints	Number of Compliments	Care that matters to you? %	Care Explained? %	Respect & Dignity? %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)
CCU - CCU	100.0	0	3	3	0	0	47				70	100	0.0	82.5	92	100
CJ2 - CAMBRIDGE J2	91.3	0	6	0	0	4	0	100	92	94	16	100	0.0	78.8	88	127
CK - CAMBRIDGE K	100.0	1	1	0	0	0	41	92	78	94	96	100	0.0	91.0	100	97
CL - CAMBRIDGE L REHABILITATION	92.3	3	16	0	0	1	23				40	93	6.7	81.2	84	122
CM1 - CAMBRIDGE M1 SHORT STAY		1	5	0	0	1	0				0					
CM2 - CAMBRIDGE M2	94.7	1	1	1	0	1	65	97	93	97	48	95	0.0	97.6	100	103
OXF - OXFORD	100.0	0	1	0	0	0	15				37	93	0.0	91.5	100	118
RST1 - RICHARD STEVENS 1 STROKE UNIT	95.7	3	7	0	0	1	0				36	100	0.0	91.8	86	92
WAEO - A&E OBSERVATION BAY WHH		0	0	0	0	0	0	100	100	88						
WCDM - WHH CDU MIXED	100.0	10	9	3	0	1	0	94	90	97	21	82	10.3			

East Kent Hospitals University NHS
NHS Foundation Trust

Human Resources Heatmap

	Clinical	Finance & Perform	HR & Corporate	Qual Safety & Ops	Specialist	Strat Dev & Cap Plan	Surgical	Urgent & Long Term
Agency %	5.7	0.0	4.5	9.5	13.8	2.5	23.9	48.1
Appraisal Rate (%)	83.7	89.4	75.6	79.3	77.7	71.1	86.1	71.6
Employed vs Temporary Staff (%)	88.9	63.4	87.3	88.3	92.8	89.4	91.9	86.8
Mandatory Training (%)	91	88	90	84	83	89	88	89
NHSP Use % of Agency	100.0		100.0	100.0	100.0	100.0	100.0	100.0
Sickness (%)	4.0	1.7	2.4	2.7	4.5	3.5	4.0	3.9
Staff Turnover (%)	13.1	11.6	16.7	17.1	10.4	11.9	9.9	13.5
Vacancy (%)	11.1	36.6	14.4	13.0	7.3	10.6	8.2	13.2

Apdx.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 OCTOBER 16**
SUBJECT:	**CQC IMPROVEMENT PLAN & UPDATE**
BOARD SPONSOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PURPOSE:	**Discussion**
IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Identified risks include: A successful outcome to the CQC re-inspection on the 5th, 6th & 7th September that enables the Trust to come out of Special Measures. **Management Actions are:** 1. The CQC Improvement Steering Group continues to meet weekly to engage staff and work alongside the Quality Improvement and Innovation Hubs; 2. The Improvement Plan Delivery Board will continue to meet monthly to ensure delivery of the regulatory requirements cited by the CQC and to ensure all of the recommendations in the reports, and the new report are delivered; 3. A Divisional reporting process is in place in relation to the local divisional improvement plans and mechanisms have been agreed for implementation and communication with front line staff;
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR 2 - Failure to action and deliver our regulatory requirements
RESOURCE IMPLICATIONS:	Nothing additional
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Management Board

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

BACKGROUND AND EXECUTIVE SUMMARY

The CQC re-inspection has taken place including an announced visit to the Urgent Care Centre and two wards at K&CH, and a visit to the Emergency Department at QEQM on Wednesday 21st September 16. Early feedback has been received and we await the draft report in December. In the meantime a new interim plan is being developed and the old plan will continue to be implemented.

This report updates the Board of Directors of progress against the CQC Improvement Plan and the monthly NHS Choices Return submitted in September 16.

SUMMARY:

The re-inspection visit has taken place and early feedback has been shared by Alan Thorne, Head of Hospital Inspections. The preliminary findings were:

- The CQC asked the Executive to thank the staff of the trust for the openness with which they discussed issues with the CQC team;
- They highlighted the caring and compassionate nature of all observed interactions between staff, patients and carers;
- They commended the alcohol support team in the emergency department, the learning sessions in the emergency department, the stroke units approach to falls and ulcer prevention and the integrated discharge team;
- They also advised that the maternity MDT working, maternity bereavement support, CNS support from SPCT towards wards and the EOLC facilitator were viewed as impressive.

In addition they outlined some areas of concern which included:

- Paediatric nursing cover in the emergency department at QEQM;
- The working hours of middle grade doctors in the emergency departments;
- The review of notes for safeguarding purposes in the emergency department;
- The matching of nursing skill mix to patient acuity on medical wards;
- The levels of midwifery staffing and impact on birth ratio and 1:1 care in labour;
- The variable levels of implementation of new EOLC and MCA documentation and process across the trust;
- The lack of fast track discharge processes for EOLC patients.

These areas plus the remaining outstanding items of the current improvement plan will be incorporated into a new interim plan ahead of the draft reports arriving in December. The current governance arrangements around the Improvement Journey will continue with:

- Divisional performance reviews regarding progress and pace of improvements to plan;
- Monthly IPDB to hold all action owners to account;
- Continuation of the Improvement Plan CQC Steering Group meetings to engage staff and work alongside the Quality Improvement and Innovation Hubs (QIIHs);
- Divisional reporting dashboards to be delivered and updated.

The most recent IPDB was held on Friday 16th September 2016. The August IPDB held on Friday 19th August comprised of a workshop with two CQC Inspectors based in South West England who guided staff through the process of a focused inspection. Minutes of the performance aspect of the meeting are attached.

Based on the September 2016 NHS Choices report (August 16 reporting period) the red

schemes are as below:

- MD20 – MCA assessments – training compliance – recovery forecast November 16.
- MD22 – Temporary staff induction – compliance evidence – recovery forecast to 50% October 16; 85% December 16.
- MD24 – Pain Scores – audits awaited – recovery forecast December 16. This action requires refreshing as practice has moved forward.
- MD16 – Governance – requires delivery of the GT report – forecast as per GT plan. This action requires refreshing given the developments and audit report.
- MD18 – Policies – manual procedures in place, requires resourcing to fully complete. This action will feature on the new plan.
- MD05 – Mental health patients in ED – On-going issues remain despite focused work by our COO with KMPT. This action will carry over to the new plan.

These were reviewed at our regular performance meetings with NHS Improvement.

RECOMMENDATIONS:

The Board of Directors are invited to discuss the progress to date and seek any further assurances that may be required.

Special Measures Improvement Plan Update

East Kent Hospitals University NHS Foundation Trust

Date of Report: 13th September 2016

Date of Reporting Period: August 2016

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

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

Background & Summary

- The Trust was put into special measures on the 29th August 2014 following a CQC inspection with reports that identified two of the three main sites as "inadequate" and the Trust rated overall as "inadequate". The sites rated as inadequate were the Kent and Canterbury Hospital and the William Harvey Hospital. The Trust was also rated "inadequate" in the safety and well-led domains.
- On the 16th November 2015, the CQC presented the findings of their subsequent inspection in the Trust which took place in July 2015. The reports identified improvement since the last inspection. The overall Trust rating went from "inadequate" to "requires improvement". The trust was rated "requires improvement" for the domains of safe, responsive and well-led. The domain of caring was rated as "good". The Trust was rated as "inadequate" for effective services. The three acute sites (William Harvey Hospital, Kent & Canterbury Hospital and Queen Elizabeth Queen Mother Hospital) were all rated as "requires improvement" with the Buckland Hospital and Royal Victoria Hospital, Folkestone, rated as "good".
- The Trust has been given a variety of recommendations that can be themed below:
  - Trust leadership and governance arrangements– sustaining of changes made since the last report;
  - Staff engagement and organisational culture to address the gap between frontline staff and senior managers;
  - Safe staffing to delivery timely patient care;
  - Staff training and development, specifically around mandatory training;
  - Demand and capacity pressures on patient experience, specifically within the emergency pathway and onward flow through the hospital and maternity services;
  - Following national best practice and policy consistently, specifically in relation to end of life care – ensuring there is a suitable pathway, documentation and education in place;
  - Support services are in place to ensure 7 day services can be delivered in priority areas – including pharmacy and radiology;
  - Mental health provision and timely specialist response for our patients;
  - Caring for children and young people outside dedicated paediatric areas;
  - Estate and equipment maintenance and replacement programme concerns;
  - Key national and local audits are undertaken and action plans implemented to improve care;
  - Incident reporting processes are robustly followed and learning from incidents and complaints is shared with all teams to improve services
  - Clinical Strategy - in place and communicated with all members of staff.

- The published CQC report can be found on the CQC website: : *http://www.cqc.org.uk/provider/RVV*
- The Trust agreed an implementation plan to deal with 30 must do actions within the High Level Improvement Plan. These can be grouped into 12 thematic work streams. Each clinical division also has a local plan containing actions surrounding all of the detailed key findings, with timeframes and corresponding key performance indicators. We recognised all of the recommendations and are addressing them to improve the quality of services.
- This document provides a summary of Trust progress against our published High Level Improvement Plan - which provides further detail. A decision was made that despite evidence of improvement, the Trust should remain in 'special measures' to ensure that required changes made are sustained. The new Improvement Plan builds on the previous plan to continue the Trust Improvement Journey and get to "good".
- Oversight and improvement arrangements have been put in place to support changes required. The Improvement Plan is overseen by a monthly Improvement Plan Delivery Board, chaired by Dr David Hargroves, Clinical Lead. The Delivery Board is accountable to the Board of Directors. Operationally progress is reviewed via a fortnightly Improvement Plan Steering Committee with accountable named leads for each site and division. A Quality Innovation and Improvement Hub is in place on each hospital site and is used as a vehicle to drive change and communicate progress. A Programme Office has ben established with Programme Management support and a Quality Improvement Facilitator working with front line divisional teams.
- This report outlines on a monthly basis the progress that is being made in implementing the organisational improvement plans – our Trust Improvement Journey.

Who is responsible?

- Our actions to address the recommendations have been agreed by the Trust Board and shared with our staff.
- Our Chief Executive, Matthew Kershaw, is ultimately responsible for implementing actions in this document. Other key staff are the Chief Nurse, Director of Quality and the Medical Director, who provide the executive leadership for quality, patient safety and patient experience.
- The Improvement Director assigned to East Kent Hospitals University NHS Foundation Trust is Susan Lewis, who will be acting on behalf of Monitor and in concert with the relevant Regional Team of Monitor to oversee the implementation of the action plan overleaf and ensure delivery of the improvements. Should you require any further information on this role please contact specialmeasures@monitor.gov.uk
- If you have any questions about how we're doing, contact our Trust Secretary, Alison Fox on 01227 766877 (ext 722 2518) or by email at alison.fox4@nhs.net

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

How we will communicate our progress to you

- We will update this progress report every month while we are in special measures. Our High Level Improvement Plan will also be available through the Trust internet site (link to be added when live).

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

Chair Name: Nikki Cole	Signature:		Date: 13 September 16
Chief Executive Name: Matthew Kershaw	Signature:		Date: 13 September 16

East Kent Hospitals University NHS Foundation Trust – Summary of progress against improvement plan

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
Safe *MD07 - There are robust systems to monitor the safe management of medicines and IV fluids according to national guidelines.*	December 2015 – March 2016	The monthly audit tool has been strengthened. Average monthly performance continues to be 89-90% . An environmental audit of current IV storage facilities has been undertaken. Audit shows most areas only require minor works – aside from critical care, theatres and renal OPD. Action plan agreed at May Heads of Nursing meeting and implemented. IV storage to be added to weekly audit from June 16 and will continue as business as usual. External assurance will be required by the CCGs	Blue: Actions complete. Monitoring as part of business as usual and IPDB. **Status of previous reporting month (July 16) – Blue.**
MD30 – The Medicine Management Policy is adhered with – and there are systems in place to ensure that prescribing practices across site for critical drugs are uniform.	December 2015-February 2016	Noradrenaline standardised prescribing policy agreed and has been rolled out to all areas. Compliance monitoring in place. Audit on track for completion in June 16 according to plan.	Blue: Actions complete. **Status of previous reporting month (July 16) - Blue.**
MD08 - There are sufficient numbers of suitably qualified, skilled and experienced staff available to deliver patient care in a timely manner.	December 2015 – On-going (with monthly review)	In May 16, Trust is carrying a 8.5% overall vacancy factor. Workforce and recruitment and retention plans are in place. Safe staffing reports for nursing are reported every month to the Board. Targeted campaign planned for BMJ about working at EKHUFT as a Consultant. Recent overseas nursing recruitment in India in June has very successfully led to 100 offers with additional EU recruitment in July. Strategy for hard to recruit areas on track with success in pharmacy, renal and NICU. Some slippage regarding 'on boarding' and exit interview strategy. Exit interview process re launched in October 15. Targeted Nurse Recruitment Days at QEQM held and further day planned for September. Revised vacancy trajectories approved at May 16 Strategic Workforce Committee and presented at Improvement Plan Delivery Board. External assurance will be required by the CCGs	Green: Plans on track. Concerns remain around the ability to recruit sufficient Consultant staff in the Emergency Departments and Therapy staff due to national supply. Recruitment and Retention Plan overseen by the Strategic Workforce Committee. Ability to recruit overseas nurses a risk due to changes in ELTS (English Language qualification). **Status of previous reporting month (July 16) - Green**
MD19 - The major incident policy is up to date and staff are aware of their roles and responsibilities. Staff are confident in its application having received sufficient training and 'drills' in appropriate areas.	December 2015 - September 2016	Shared service formalised with Maidstone and Tunbridge Wells NHS Trust. Head of Service appointed and 2x Band 7 managers. A full major incident exercise took place on 30th June 16. Emergency Planning Annual Report presented to the Trust Board. External assessment undertaken by CSU on behalf of NHSE– compliant in most areas. Further work to do on training trajectories and Policy to be revised by module. Some deficit in CBRN training numbers but plan being worked up. EPRR self assessment undertaken in Aug 16. External assurance provided South East CSU on behalf of NHSE	Green: On Track **Status of previous reporting month (July 16) - Green**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
MD20 - Staff training is focused on the principles of the MCA (2005) and how to assess capacity. Trust policies relating to adult safeguarding are updated regularly and are easily accessible. There is evidence that staff consider mental capacity in the planning and delivering care. Capacity assessments are considered carefully and are proportionate to patients' needs. *Best interests decisions are timely and issue specific.*	December 2015 –June 2016	The Policy was approved in December 2015. The content of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) training has been reviewed and TNA refreshed. Agreement that refresher should be every 3 years (not 2 years) in line with UK Core Skills Training Framework. Need for trajectory to be refreshed to take account of this. The Safeguarding intranet and internet has been refreshed with much clearer signposting for staff on accessing the correct information. Training has been delivered in the QII Hubs on MCA and DoLS and will continue across all sites on a rolling programme. An "Ask 5 questions" audit is being rolled out to assess staff understanding of both areas. Collaboration with Learning and Development has identified the cohort of staff requiring extended training and will be used to report training compliance. 100% of staff have now received L1 training (via a leaflet in July payslip). A new Intercollegiate document has recommended further enhanced training for L2 which takes 4 hours and is face to face and as such has meant overall compliance has reduced. Current rates of L2 training have improved and are 61% against a target of 85%. An action plan has been developed with a trajectory for improvement to 85% by the end of November 2016. The CCG Contract Quality Metrics require reporting of training numbers by level. To be in place by June 2016.	Red: Actions complete although improvement required in % compliance at L2. Trajectory for improvement by November 2016. **Status of previous reporting month (July 2016) – Red** **RECOVERY FORECAST: NOVEMBER 16 .**
MD21 - There is a Trust specific Children's Safeguarding Policy (which is consistent with the Kent & Medway Multiagency policy).	December 2015 - March 2016	The Trust specific Policy was approved at the Policy Compliance Group in March and is being disseminated to staff. Board Seminar on Safeguarding to be held. The Kent & Medway Children's Safeguarding Board require assurance and receive this via the Board's work.	Blue: Compete **Status of previous reporting month (July 2016) - Blue**
MD22 - All temporary/agency staff (all disciplines) should have the appropriate competencies for the clinical environment they are placed within and receive appropriate induction.	December 2015 – August 2016	Induction checklist compliance data now widely available via IPR and targets agreed. Current rates are still low so communications campaign planned for August 16 to improve awareness. The bank contract is currently out to retender and the requirement for agency checklists to be stored and available for reporting is included (from June 16). Use of revised locum handbook to be audited by HR Business Partners. External assurance is being requested by the CCGs	Red: Slippage in programme. Trajectory for improvement – 50% compliance by October 16 and 85% by December 16. **Status of previous reporting month (July 2016) – Amber.** **RECOVERY FORECAST: OCTOBER 16 .**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
MD23 - The pharmacy department is appropriately staffed and skilled to support the timely and safe discharge of patients.	December 2015 - March 2016	Recruitment and retention plans are in place, although at present the pharmacy department is still carrying a 27% vacancy factor for qualified staff and a 14% vacancy factor for unqualified (March 16). 22 new pharmacists however are due to start in post over the next four months which will improve the overall vacancy factor. There are 4 posts currently out for advert. The Department have taken part in the 'Safer Start' initiative during January and have tested out prioritising those being discharged to reduce delays. The workforce development plan has been completed and submitted to CSSD Board in March, along with the pharmacy business plan which describes in detail the strategic plan for development of pharmacy in line with the recommendations of the Carter Report. Plans now agreed. An initial assessment using the TDA Trust development tool for Medicines Optimisation has been completed. A proposal has been made about level of service by ward (with associated KPIs) and agreed at Improvement Plan Delivery Board.	Blue: all actions completed. On going work with local teams to ensure support is provided prior to new recruits coming on line. Delivery of the strategy and workforce plans to sustain improvements. **Status of previous reporting month (July 2016) – Blue**
MD28 - Fine bore naso-gastric tubes are inserted and checked in accordance with NHS England's patient safety alerts; the Trust NG Policy is in line with this guidance.	December 2015	Trust NG policy implemented. Governance procedures in place to ensure compliance against standards. There is an article in Risk Wise (Trust wide Risk publication) this month to reinforce the learning. An external review of the safety of the system for NG tube insertion was independently reviewed by a Patient Safety Consultant; there were no issues identified. NHS England undertook an external review of Trust use of the Central Alert System (CAS) on Friday 19th February 16. This does not impact on completion of this action but will provide assurance regarding Trust use of the CAS.	Blue – Completed **Status of previous reporting month (July 2016) - Blue**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
Effective *MD11 - There is participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services, benchmarking, peer review and service accreditation. Accurate and up-to-date information about effectiveness is shared internally and externally and is understood by staff. It is used to improve care and treatment and people's outcomes. Clear action plans developed and managed through the Trust governance framework.*	December 2015 - December 2016	Internal audit undertaken and report received. The clinical audit forward programme for 2016 / 17 was approved by the Clinical Audit and Effectiveness Committee in March and was reviewed by the Integrated Audit Governance Committee in April. The forward programme is divided into "Must do", Carried over & New audit topics with priority given to the "Must do" topics. Quarterly status reports are being provided by the clinical audit team and review meetings set up to ensure that any slippage is identified early and mitigations can be put in place. The clinical audit website was re launched in April. The Clinical Audit Strategy is being revised by October 2016 ahead of date to reflect developments within the improvement journey. A review of job planned PAs for audit is in progress - as part of annual job planning. Internal audit assurance is at the planning stage with an anticipated start in March 2016	Green: plans on track. End date reviewed with Improvement Director and amended to December 16 to ensure that governance embedded. **Status of previous reporting month (July 2016) – Green**
MD12 - The environment and facilities in which patients are cared for must be safe, well maintained, fit for purpose and meet current best practice standards.	December 2015- On-going but with key milestones achieved and evidenced by June 2016	Sessions held in QII hubs promoting process and timetable for environment bids. Space mapping completed to review storage, patient and staff facilities to improve patient experience and staff facilities, a program of refurbishments is being rolled out from May 2016. Particular improvements will be undertaken at WHH Cambridge wards. Estates service now operates 7am to 10pm and are undertaking PPM and minor jobs in these hours more effectively. Productivity data is being discussed locally to ensure quick resolution of estates jobs. Web based Self reporting as been piloted with feedback being incorporated into the further deployment. Now being used in wards with great end user feedback. The first Estates store to support estates staff to be able to resolve work order quickly is 80% stocked at K&C. Work in the WHH A&E is nearing completion with only the Paediatric area needing to be completed. Work to St Augustine's at QEQM is progressing well. Finally the Trust has run two fire evacuation exercises with Kent Fire and Rescue to test the robustness of procedures and safety and a third exercise in the K&C Renal unit. HSE are working with the Trust at present to ensure compliance to essential standards.	Blue: actions complete. On-going estates improvement plan monitored as part of business as usual through PEIC. **Status of previous reporting month (July 2016) – Blue**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
MD13 - There is sufficient equipment in place to enable the safe delivery of care and treatment, equipment is regularly maintained and fit for purpose to reduce the risk to patients and staff.	December 2015 Start February 2016 End	A programme of equipment maintenance is in place and will continue going forward. The equipment library is working effectively. The Medical Devices Group manages the equipment requirements across the Trust ensuring there is sufficient equipment in place for safe delivery of care and to manage the risk. Approval of business case at June Strategic Investment Committee for additional resources for EME team to ensure PPM levels can be sustained. Current performance is 83% for EME equipment and 94% for high risk equipment. New electronic system is in place where departments can review equipment and date of last service. To be communicated to all leads. Approach to training compliance agreed at June Improvement Plan Delivery Board and to be taken forward via Heads of Nursing. Reports to Improvement Plan Delivery Board to ensure sustained compliance.	Blue: Actions complete. Roll out of business case and training plan as business as usual and IPDB. **Status of previous reporting month (July 2016) – Blue.**
		No external assurance is being sought at present.	
MD27 - Operating Theatres on all sites comply with HTM 05-01, particularly in relation to risk assessment, the environment and staff training.	December 2015 - March 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Compliant. All operating theatres are compliant with HTM 05-01 and undergo an annual verification. The General manager for surgery works closely with estates to co-ordinate a cycle of closures and repairs annually	Blue: Actions complete **Status of previous reporting month (July 2016) – Blue.**
		External assurance is provided via the Trusts external Authorised Engineer.	

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
MD29 - All escalation wards/clinical areas are appropriately staffed and equipped to safely care for the cohort of patients intended.	December 2015 -March 2016	Recruitment is in progress and each of the escalation areas has been risk assessed. Where possible the escalation beds are closed when not required according to the demand in the Trust. The Trust has approved funding for substantive staff in areas that are consistently opened. These posts are being recruited into currently. A paper presenting the care model options for St Augustine's has been drafted - model to be signed at within division during August. Capital works have commenced on St Augustine's ward. Confirmation has been made to recruit to unfunded beds on Cheerful Sparrows Ward.	Blue: Actions identified complete. Model of Care changes and substantive recruitment to areas to form part of on-going improvement plan. **Status of previous reporting month (July 2016) - Blue**
Caring *MD24 - Patients' pain scores should be regularly and clearly documented and there should be interventions - pharmaceutical and alternative therapies. There are clear tools for use with patients with dementia and learning disability.*	December 2015- August 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Pain scores are collected via Vital Pac and there is an audit process in place. A review of pain interventions available and access to specialist advice is underway. A tool has been developed for patients with dementia and also learning disability. Consultation and communication has been undertaken with patients and staff and the tool has been made available on PAS as a clinical form. In addition to the above, an audit of pain management scores across the Trust and patient's experience of pain and an associated action plan will be in place by August 2016. Pain assessment documentation will also be made universal (August 2016). No external assurance or support being sought.	Red: Some actions incomplete. Pain scores not universal due to IT systems in place. Actions to be agreed. **Status of previous reporting month (July 2016) - Amber**
MD26 - Patients' complaints are responded to as per national standards. Ensure there is a clear process for learning across the Trust.	December 2015 - On-going but with key milestones achieved and evidenced by April 2016.	There has been considerable work undertaken with the complaints response team and response times are improving. A trajectory for improvement has been established with a focus on 30 day response rates. Q4 compliance of complaints responded to within 30 days is 26%. Surgical Services have a very effective 'Outcomes with Learning' newsletter for staff related to complaints. This format is being shared with the other divisions. The Terms of Reference for the Steering Group have been revised now incorporating other forms of patient feedback. Complaints training is being considered as part of the 1617 action plan for the Group. An Away Day was held with the Patient Experience Team w/c 29th March and additional investment made in the RSO role. The Deputy Chief Nurse has undertaken a review of the complaints process with recommendations for improvement. No external assurance or support being sought.	Blue: actions identified completed. Remaining improvements to be outlined in improvement plan. **Status of previous reporting month (July 2016) – Blue.** **.**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
Responsive *MD06 - Effective processes are in place on each site (and between sites) to manage flow - senior on site leadership supported by accountable leads. Information supports escalation and decision making. Patients are cared for in the most appropriate place and care is coordinated.*	December 2015 On-going (key milestones set out in column K and detailed in interrelated Emergency Care Recovery Plan).	Clinical Site Operational Leads in place on each site and substantive model agreed for implementation. Baseline bed model agreed in May 16. Access target trajectories agreed with CCGs as part of 1617 contract. The Emergency Pathway Improvement Plan is being implemented. ECIP are working with the Trust to make the necessary improvements in patient flow, safety and quality across the Trust. The Site Management Standard Operating Procedure draft to be circulated for the end of February. The Safer Care Bundle has been launched across all sites. Information has been improved to support predicted admission and discharges from each site and a revised dashboard is now in place. Substantive recruitment is progressing for Clinical Site Managers. Consultation has closed for discharge teams. Slippage identified in relation to mapping of social care beds (external partner led) and review of bed base across Trust. ECIP Support is in place and multi partner support via the SRG	Amber: Slippage against some milestones in ED Recovery Plan. (Programme risks include insufficient pathway 3 bed capacity out of hospital. This is being taken forward via the SRG. Safer Care Bundle to be further embedded - job planning will support maintenance). **Status of previous reporting month (July 2016) - Amber**
MD25 - Inpatient areas are supported by 7 day services (radiology, therapies and pharmacy) to enable effective use of capacity and enable flow.	December 2015 Start On-going but with key milestones achieved and evidenced by June 2016.	Clinical Divisions have assessed which services are currently 7 days and which services may benefit from 7 day working. This forms part of workforce plans. Also ensuring that teams are aware of how to access out of hours services and is clearly documented. Discussion within contract negotiations with commissioners around short, medium and long term plan. Diagnostic audit has been undertaken and a position paper written for Executive discussion in March 2016. A 7 Day Services Working Group to be established at Trust level to carry forward work and planning for 2020. No external support or assurance requested.	Blue: Actions complete. **Status of previous reporting month (July 2016) - Blue**
Well led *MD09 - There is a positive workforce culture demonstrated by content staff who are supported and empowered to lead improvement, are aware of the Trust vision and their role within it and provide excellent patient care. Leaders at all levels have the skills to support and embed cultural change.*	December 2015 Start On-going (key milestones set out in column K and detailed in Cultural Programme Plan).	Very positive recent staff FFT results. Score for recommending EKHUFT for treatment has gone up 4% since March to 78% and up 8% to 57% as a place to work - the highest scores to date. Further workshops happening re 'Respect' campaign. Health and Wellbeing Group has been established. New appraisal process launched on 1st April with conversation around Trust Values and Behaviours. Contract awarded for leadership development. NHSI Business case underway. Divisional 'Great Place to Work' action plans agreed. There is slippage against timescales for the 'People Strategy' which will go to Board in September 2016. Recent Medical Engagement Scores (received Sept 16) show improvement in many areas). External consultancy support has been utilised for OD Strategy. Monitor are requesting further assurance around the next steps and embedding of the cultural values.	Amber: Minor slippage against milestones. **Status of previous reporting month (July 2016) – Amber** **Recovery trajectory: September 2016**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
MD10 - The clinical strategy plan is delivered to timescale and communicated and implemented successfully led by clinical champions.	December 2015 - December 2016 (interim milestones within HLIP). Next milestone – development of models of care (April 16). STP complete end of June 16.	We continue to work closely, via the East Kent Strategy Board and aligned clinical meetings, to design of sustainable model of health and social care for east Kent. The national request for health economies to produce a 5 year Sustainability and Transformation Plan by June 2016 has also been aligned with the work on strategy. The Trust held a significant clinical engagement event on 1st to 3rd March to consider how acute care will be developed in the future and a range of meetings have taken place with staff who responded to a call for ideas for future ways of working. The output of these sessions was reviewed by the Trust Board in April and further work is being progressed for presentation back in June 16. Clinical engagement event to be held in July regarding next steps prior to consultation. The public facing case for change has been published and the stage 1 NHS Assurance process is underway. External collaboration is central to this item and is in place.	Green: On Track **Status of previous reporting month (July 2016) - Green**
MD16 –The Trust governance arrangements are clear and transparent	December 2015 - March 2016 (with interim measurable milestones)	GT Review received. Improvements noted since Deloitte review. Further corporate and divisional actions to embed. Additional communications complete regarding staff awareness. External support commissioned by Trust from Grant Thornton regarding board governance. Report received.	Red: Some slippage. GT Report outlined improvements in Board governance but further improvements required to ensure standardised divisional arrangements. **Status of previous reporting month (July 2016) – Red .**
MD17 - The Trust incident reporting process is robustly followed by all departments - with focus on ED departments at WHH, QEQM and Maternity services. Ensure that incidents are acted on in a timely manner and that staff receive feedback	December 2015 Start September 2016	Incident reporting is high across the Trust when benchmarked against peers. Forums are in place where incidents are reviewed and action plans monitored. The next national report from the NRLS is awaited in order to confirm national benchmarking for reporting. Datix V14 testing was completed in April and fully rolled out across the Trust with a few minor issues which were resolved without issue. External support is not required.	Green: On Track **Status of previous reporting month (July 2016) - Green**
MD18 - Trust wide policies are procedures are up to date and in line with best practice. Policies and procedures are clearly written and easily accessible by staff.	December 2015 Start June 16 (but trajectory for improvement set based on programme plan)	Policy group has been set up and meets regularly to ensure policies are up to date and are in line with best practice. There is a manual process for identification if any policy documentation which will be out of date within 2 months. A system has been purchased to provide assurance that staff have accessed and read policies relevant to role. In order for this to work effectively, the system must be configured and a member of staff must be nominated to work on this project. External support is not required.	Red: Slippage against milestones. Risk mitigated by manual systems and governance via Policy and Compliance Group. **Status of previous reporting month (July 2016) – Red** **Recovery forecast (for blue) – September 16**

East Kent Hospitals University NHS Foundation Trust – Summary of progress against improvement plan

Specific service (i.e. cutting across CQC Key Questions)	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
End of Life *MD01 - A suitable End of Life Pathway will be in place and staff will be competent in its consistent application. Contribution to local and national audits to evidence compliance.*	December 2015 Start June 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	The End of Life Board meets bi monthly chaired by the Divisional Head of Nursing, Specialist Services with Executive level leadership. Revised documentation which is trust specific and nationally compliant is now complete and available. Multidisciplinary staff awareness of the inclusive responsibility of end of life knowledge and expertise is progressing through specific training on end of life conversations local clinical area based Link Nurses. The Link Nurse contract has been agreed and nurses identified for all areas. Link Nurses Away Day planned in July 16. The EKHUFT section of the Interagency Policy was completed for the end of March. A report following the EoL Carers Experience Questionnaire was presented to the EoL Board in April 16. The EoL Facilitator has started in June 2016. Macmillan have in addition confirmed two band 7 posts for a two year period to support the Trust's implementation programme. Draft recommendations for training were discussed on the 14th April at the EoL Board. Training has gone live for Link Nurses. Further proposal for mandatory training for August EoL Board. Final Multi-Agency Policy sign off delay - CCG led. Tier 4 (EKHUFT) section complete. Now ratified in August 2016.	Blue: All actions to date complete apart from those outside Trust control. End of Life Board to develop next stage improvement plan by the end of September 2016. **Status of previous reporting month (July 2016) – Blue.** .
Urgent & Emergency Care *MD02 - The Trust has an effective and safe emergency and urgent care pathway. Care is delivered in the most appropriate environment, working alongside local partners, with multi-agency leadership.*	On-going (key milestones set out in column K and detailed in Emergency Care Recovery Plan).	The Emergency Pathway Improvement Plan is being implemented. ECIP are working with the Trust to make the necessary improvements in patient flow, safety and quality across the Trust. The ED Recovery Plan has been updated to reflected the HLIP and vice versa (February 2016). New UCC model to be in operation from July 16. A workforce model for mid grade doctors is being written. The building work in ED Minors has been completed meaning there is more space and an appropriate paediatric waiting area. Funding has been agreed for continuation of IDT and H&S Care Village beds until July 16. The ED Escalation Policy/SOP has been approved and being rolled out. There is some slippage against programme schemes and risks. Continued risks regarding the ability to recruit to medical vacancies although 9 senior grade/consultant offers have recently been made. Revised trajectory agreed by SRG around 4 hour performance. 82.84% average achieved for July. Further work on-going to ensure privacy and dignity maintained when there is overcrowding in the department. ECIP Support is in place	Amber: Some slippage against the ED Recovery Plan. **Status of previous reporting month (July 2016)- Amber**

Specific service (i.e. cutting across CQC Key Questions)	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
Children & Young People *MD15 - Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.*	December 2015 - March 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Recruitment and retention plans are in place . Work Programme overseen by Children's Board led by Executive Director.	Blue: Actions complete **Status of previous reporting month (July 2016 – blue)**
MD14 - There are sufficient numbers of paediatric trained staff within Emergency and Urgent Care Pathway.	December 2015 - March 2016 (with interim measurable milestones to demonstrate trajectory of improvement	Recruitment of paediatric nurses in the ED is complete to enable 24/7 cover. 24/7 cover now in place on WHH and QEQM sites.	Blue: Actions complete **Status of previous reporting month (July 2016 – blue).**
Maternity Services *MD04 - The Trust offers safe, effective, caring, responsive and well-led maternity services*	December 2015- September 2016	The MBRRACE-UK report has been published and shows the Trust to have a 10% lower average mortality rate for its comparator group. The RCOG final report has been received and an action plan signed off in May 2016. Maternity dashboard now updated monthly and in use. Work underway on bereavement suite at QEQM to be complete in August 16. Environmental constraints mean problematic to improve facilities for partners but written information to be reviewed. CTG machines received and replacement programme in place. Maternity Vision Strategy approved and 'Great Place to Work' workshops set up for staff involvement.	Green: Plans on track. **Status of previous reporting month (July 2016 – green).**
MD03 – The Trust has sufficient capacity for women in labour on a day to day basis	April 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	The final version of Birth Rate Plus has been received. The Trust assesses staff requirements on a shift basis and addresses any shortfalls that occur with temporary staffing. A live database is in place for recruitment. A database has also been put in place to record the number of diverts and closures to the unit and a revised policy circulated for comment for sign off in July 16. An initial review of demand and capacity has been undertaken but there continues to be data quality issues. An action plan has been agreed to ensure that additional data is collected on PAS to enable more accurate modelling to occur. This will be overseen by the Information Task and Finish Group linking into the Information Assurance Board.	Blue: actions complete but additional actions identified to feed into next iteration of the improvement plan (including action plan around data quality in maternity and work to ensure maternity scorecard is embedded at all levels). **Status of previous reporting month (July 2016) -Red**

Specific service (i.e. cutting across CQC Key Questions)	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
Mental Health *MD05 - Patients receive timely mental health assessment and have appropriate facilities whilst waiting.*	December 2015-May 2016	In December 2015, a HLIP partnership engagement session took place where the accountable officers for the local CCGs agreed to support an action plan regarding the level of psychiatric liaison support required as part of the emergency pathway. An interim solution was agreed until the end of March 2016. SRG have approved an options appraisal for model of care. From end of May 16, KMPT is providing 8-8pm cover on all three sites 7 days per week. A third consultant will also be employed. Changes to the physical environment in the WHH ED are complete. Internal Escalation Policy signed off and communicated with all staff – outlining practice for safe, high quality care whilst patients are awaiting assessment. Consideration to be given of additional training required by staff. Further external escalation occurring . KMPT (MH provider) and all CCG Accountable Officers . Risks around delays to specialist assessment and availability of specialist inpatient beds have been escalated.	Red: Slippage against deadline **Status of previous reporting month (July 2016) – Red**

Other (e.g. concerns arising after CQC re-inspection; awaiting CQC report from re-inspection etc.)

No other concerns noted.

Other comments for reporting period (August 2016):

A regular programme of Improvement Visits has been established and the template embedded in operational process. The fifth Improvement Visit in June 2016 ensured 85 clinical areas have been covered since February. A formal mock inspection, with participation from our external partners, happened on Friday 15th July 16.

A Communications Plan has been launched – a themed fortnightly message is cascaded to staff and supported by training and a programme of speakers in the Quality Improvement and Innovation Hubs on each site acute site. Launches are planned for QII Hubs on the Royal Victoria Hospital Folkestone and Buckland Hospital Dover site in August 2016.

Plans are in place ahead of the re-inspection which has been confirmed as Monday 5th-Wednesday 7th September 2016 and led via the weekly Improvement Steering Group chaired by the Chief Nurse. Site based teams have been re mobilised with continued work through the Quality Improvement and Innovation Hubs. A pre-inspection provider presentation was made to the CQC inspection team and invited external partners on Friday 12th August 2016.

The pace of progress has continued since the plan was signed off and continues to progress - as part of our organisational Improvement Journey.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 OCTOBER 2016**
SUBJECT:	**EMERGENCY CARE RECOVERY PLAN**
BOARD SPONSOR:	**CHIEF OPERATING OFFICER**
PAPER AUTHOR:	**DIVISIONAL DIRECTOR UCLTC**
PURPOSE:	Discussion

BACKGROUND AND EXECUTIVE SUMMARY
The purpose of this report is to provide an update on:

- Emergency Recovery Plan
- Performance against the 4 hour Emergency Access Standard for August 2016 and performance against the STP improvement trajectory.

The NHS Constitution sets out that a minimum of 95 per cent of patients attending an A&E department in England must be seen, treated, and then admitted or discharged in under 4 hours.
The Emergency Access Standard is subject to a Contract Performance Notice due to the Trust being unable to achieve compliance against the 4 Hour Standard. It has been mandated through the Sustainability & Transformational Plans that the Trust will achieve performance levels which demonstrate consistent improvement over the course of 2016-17, with overall compliance in excess of 90%.

August performance against the 4 hour target was 82.21%, against a trajectory of 90.80% and a compliance target of 95%. August's performance shows a slight decline compared to the July position. The next biggest breach reason was around delays to Treatment Decision (18% of all breaches).

While the delay in Treatment Decision breach reason continues to relate to a large proportion of the breaches, performance against the 60 minute time to treatment improved in August compared to July (48.8% from 46.1%). The WHH site performance against this metric improved drastically from 33.7% to 38.8%, with performance at the QEQM decreasing slightly from 38.4% to 38.0%.

Volume of attendances remained high. This continues the trend of year to date attendance volumes being in excess of the planned activity levels (5.0% above plan YTD, +5.5% in Month).

During August the ERCP has been fully reviewed to ensure that the plan reflects all local initiatives which the clinical teams in the ED's, Acute Medical Unit, Operational Control Centres and SAFER programme have identified.

Good progress is being made across all the workstreams with the following notable highlights in August:
Improving ED Clinical Leadership:

- WHH launched the ESI (Early Senior Intervention) model on the 22 August with immediate improvement in the 60 minute first clinician metric. The impact of ESI has been very positive with excellent feedback from patients and staff alike. The WHH has managed to maintain the ESI service across the full 24/7 period due to the high commitment of staff in the Department to the service. It is planned that the model will be shared with QEQMH following early evaluation.

- At QEQMH ED the Majors Assessment Pilot (MAP) being tested as and when staffing resources are available to support it. This pilot involves an ED Consultant or senior doctor, Consultant Acute Physician, Emergency Surgeon and senior ED nurse to either see and treat or directly stream patients to a speciality.

- The new paediatric area at WHH has successfully opened and is being fully utilised by staff. The area provides a dedicated waiting area with assessment and treatment cubicles.

- A full nursing review is almost completed to establish the staffing requirements to provide a dedicated Emergency Nurse Practitioner service across a minimum of 12 hours per day. This would reduce the requirement for medical staff to support the minor injuries service and develop a sustainable service for the future.

Acute Medical Model

- The Acute Medical Model project group at WHH is now established with actions being progressed at pace. The Acute Medicine Consultant job description and advertisement is under review with the Trust being represented at the BMA jobs fair in the Autumn.

- At QEQMH the Acute Medical Model continues to become embedded with a second Nurse Consultant now started in post.

Implementation of SAFER & Patient Flow Programme

Phase 1 of the Improving Patient Flow (enhancing SAFER) Programme has been completed and the Closure Report was presented on 19th August; this signified the end of the intensive support from Four Eyes Insight.

Success has been monitored through weekly production of the SAFER Dashboard (see Picture 1) in line with five KPI's:

- Reduced Medical outliers on surgical wards
- 33% of ward discharges before 12.00
- Weekly review and reduction of patients with a LOS >7 days
- 90% of EDD's set and recorded on PAS within 24hrs of admission to the ward
- 10% reduction in LOS within the target wards.

Provision of Senior Review and an EDD (the 'SA' of SAFER) has been well embedded within the target wards, but it is acknowledged that additional input is required to fully implement better flow of patients, earlier discharge and weekly review of patients with a >7 day LOS (the 'FER' o SAFER). This will be a priority until 31st August, before commencing the phase 2 rollout.

Priorities for August have been:

- Sustain achievement of progress to date and embed the remaining elements of SA**FER** on the initial target wards, until 31st August.
- Commence phase 2 rollout and undertake baseline assessments, deep dives, training, engagement and communication.
- Celebrate the success of phase 1 wards and agree a quarterly baseline review process with Matrons, to ensure sustainability.
- Develop and provide discharge competency training across the WHH site, in association with Matrons and the Integrated Discharge Team; especially in relation to CHOICE.
- Finalise the Patient Flow Toolkit and break it down into 'learning units' for ease.
- Finalise and establish the Improving Patient Flow webpage (Staff Zone)
- Patients EDD to be written on white boards above the bed to and all staff are to be encouraged to discuss EDD with patients &/or family.
- Finalise and implement the Inpatient PTL tool to enable visibility of the patients

pathway and any associated delays.

Operational Control Centres:

- The staff consultation to review the current site management teams and support the implementation of a 24/7 clinical site management team is being implemented.
- The Operational Control Centres (OCC's) have a standardised approach to recording site SITREP information.
- Escalation action cards are being actively used in the OCC environment and are being shared with ward staff and consultants to normalise their use.
- The escalation plan is being rewritten to include a more proactive and pre-emptive approach by all specialities to managing the risk of overcrowding in ED.

Notable risks

- The Emergency Departments (ED's) continue to have a high level of specialty doctor vacancies.

- There has been an increase in the number of patients presenting to QEQMH and WHH with mental health conditions. This has been a significant risk at QEQMH with an occasion in which there was 8 patients with a mental health condition in the ED overnight.

Trajectory Confidence

August performance against the 4 hour target was 82.21%, against a trajectory of 90.80%. The increased activity levels seen so far this year remain above plan 5.5% in August, compared to +4.8% above plan in July. The numbers attending the departments, particularly in the evenings and overnight have continued.

There has been a movement in activity with QEQMH in particular seeing higher numbers of ambulances from the Canterbury catchment area since the new Urgent Care Centre criteria has been implemented.

The on-going risk to delivery of the trajectory is:

- A high % of breaches of the 4 hour emergency access standard relate to patient flow and bed availability.
- High numbers of patients attending ED in the evenings and weekends who could be managed by primary care, in particular paediatric attendances.
- Impact on the efficiency of the ED when trying to safely manage patients with a mental health condition who are awaiting assessment by the Crisis Team or a mental health bed.
- Medical staffing vacancies, which medical staffing agencies are unable to fill. QEQMH is a particular risk due to the geographic location of the hospital.
- The number of DTOC's (delayed transfers of care) and access to short term external capacity in the community continues to be a high risk. There have been issues with a lack of external capacity across all geographic areas.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	**Continued increase in ED demand and conversion to emergency medical admissions.** *Mitigation – Escalate via the EKCOO's and Contracting meetings of over performance against the contracted plan. To stream, as appropriate, patients to ambulatory care. Provide additional resource where able to source from our own staff or locums* **Increasing risk of patients with a mental health condition being delayed in ED for assessment and if**

	required, a mental health bed due to lack of mental health in patient bed capacity locally and also nationally. The increased risk has been particularly noticeable at QEQMH. *Mitigation – Daily escalation via the Chief Operating Officer (COO) or Divisional Director to senior management at KMPT. Issues are escalated by COO at the weekly EKCOO's meeting.* *QEQMH have developed a local protocol to cohort patients presenting with mental in to the observation bay to reduce the risk of patients leaving the department unnoticed. The staff have been given permission to book a 24/7 mental health nurse to support staff managing the risk as QEQMH regularly has more than 4 patients in the department at the 8am Site SITREP meeting.*
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	Risk to the achievement of the 4 hour Emergency Access Standard.
RESOURCE IMPLICATIONS:	Middle grade medical staff
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Urgent Care Board Management Board Finance and Performance Committee

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

RECOMMENDATIONS AND ACTION REQUIRED:

- To note and discuss.
- For EKCOO's to continue to monitor and escalate issues relating to delays for patients attending with mental health problems and mental health bed delays.
- Executive and UCLTC Divisional Director to continue to escalate the impact of increased activity to ED and impact of GP referrals arriving to the ED in the early evenings.

EMERGENCY CARE RECOVERY PLAN
PROGRESS REPORT
SEPTEMBER 2016

Key Performance Indicators

82.21 %

	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
4 Hour Compliance	87.54%	87.01%	89.37%	87.78%	84.91%	80.01%	79.25%	84.06%	82.69%	85.40%	82.88%	82.21%
12 Hour Trolley Waits	0	0	0	0	1	0	1	1	0	0	0	0
Left without being seen	2.79%	2.87%	3.06%	3.19%	2.87%	3.78%	4.20%	3.46%	4.09%	3.84%	4.58%	4.13%
Unplanned Reattenders	8.98%	8.80%	8.93%	8.71%	8.88%	8.97%	9.31%	9.10%	9.40%	9.22%	8.62%	8.47%
Time to initial assessment (15 mins)	94.9%	91.1%	89.5%	91.7%	93.3%	92.6%	91.1%	86.0%	86.0%	89.0%	82.5%	73.5%
% Time to Treatment (60 Mins)	49.4%	51.0%	49.9%	50.3%	49.5%	43.5%	40.8%	46.3%	43.5%	48.3%	46.1%	48.8%

Sustainability & Transformational Funding Trajectory (Submission 18th April 2016)

-8.59 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
STF Trajectory	85.22%	90.02%	90.17%	89.68%	90.80%	90.80%	91.20%	91.50%	89.90%	89.83%	90.48%	91.40%
Performance	84.06%	82.69%	85.40%	82.88%	82.21%							

Summary Performance

The NHS Constitution sets out that a minimum of 95 per cent of patients attending an A&E department in England must be seen, treated, and then admitted or discharged in under 4 hours. This target was last revised by the Department of Health in 2010. When a decision to admit a patient from the emergency department is made, there is zero tolerance for waits of over 12 hours for admission to a ward.

The Emergency Access Standard is subject to a Contract Performance Notice due to the Trust being unable to achieve compliance against the 4 Hour Standard. An Emergency Care Recovery Plan (ECRP) has been developed, which reviews all aspect of the emergency patient pathways from attendance in the Emergency Department to discharge from an inpatient ward. The aim of the plan is to improve performance and ensure that the ECRP delivers sustainability across emergency care pathways. It has been mandated through the Sustainability & Transformational Plans that the Trust will achieve performance levels which demonstrate consistent improvement over the course of 2016-17, with overall compliance in excess of 90%.

August performance against the 4 hour target was 82.21%, against a trajectory of 90.80% and a compliance target of 95%. August's performance shows a slight decline compared to the July position, with a lower proportion of patients seen within 4 hours. Analysis of the breach reasons shows a split in breach reasons similar to that seen in previous months, with the largest proportion of breaches assigned as due to delays to be seen by a first clinician (44% of all breaches, compared to 47% in July). The next biggest breach reason was around delays to Treatment Decision (18% of all breaches). Breaches due to Bed Management reasons remain at reduced levels (compared to previous months where bed pressures had this breach reason for upwards of 30% of breaches), with 13% of breaches for these reasons.

While the delay in Treatment Decision breach reason continues to relate to a large proportion of the breaches, performance against the 60 minute time to treatment improved in August compared to July (48.8% from 46.1%). The WHH site performance against this metric improved drastically from 33.7% to 38.8%, with performance at the QEQM decreasing slightly from 38.4% to 38.0%.

Volume of attendances remained high. This continues the trend of year to date attendance volumes being in excess of the planned activity levels (5.0% above plan YTD, +5.5% in Month). Volumes of attendances to Trust A&E departments continue to be higher than the previous year (+4.1% YTD), with raised volumes in particular noted at the Dover Buckland Hospital Minor Injuries Unit.

Improvements in Emergency Department performance are being pursued through the ECRP. The programme now has a dedicated programme manager who has supported a full review of the governance arrangements and a detailed review of the ERCP, including updating the evidence portfolio for all closed actions. The programme uses a BRAG rating to monitor progress against the plan and any new actions relating to improving emergency care pathways are discussed / agreed at the Urgent Care Board to ensure that there is an audit and governance trail. During August the ERCP has been fully reviewed to ensure that the plan reflects all local initiatives which the clinical teams in the ED's, Acute Medical Unit, Operational Control Centres and SAFER programme have identified.

Good progress is being made across all the workstreams with the following notable highlights in August:

Improving ED Clinical Leadership:

- WHH launched the ESI (Early Senior Intervention) model on the 22 August with immediate improvement in the 60 minute first clinician metric. The model ensures that there is an assessment nurse in the waiting room who will allocate the patient a card which is presented to the receptionist. Patients who are very unwell will be streamed direct to majors, patients who have a minor injury will be streamed to the minors area and those patients who do not fit into either category will be allocated to the 'purple zone'. The purple zone is a consulting room which is managed by an ED senior doctor and nurse; patient will receive an early senior review and be stream to the appropriate clinical area and may also be 'seen and treated' by the ED senior doctor.

  The impact of ESI has been very positive with excellent feedback from patients and staff alike. The WHH has managed to maintain the ESI service across the full 24/7 period due to the high commitment of staff in the Department to the service. It is planned that the model will be shared with QEQMH following early evaluation.

- At QEQMH ED the Majors Assessment Pilot (MAP) being tested as and when staffing resources are available to support it. This pilot involves an ED Consultant or senior doctor, Consultant Acute Physician, Emergency Surgeon and senior ED nurse to either see and treat or directly stream patients to a speciality. The pilot has also been successfully managed by and ED Consultant and Acute Physician, if a surgical colleague has not been available. The MAP pilot requires the whole of the minor's area to be available to stream patients; however the clinical team are actively reviewing the pilot to assess whether it can be provided within current space constraints or alternative options can be accommodated.

  Consideration will be given as to how the MAP pilot may compliment ESI. Initial feedback from clinicians is that the process reduces delays and handoffs in the emergency pathway and on the days that the MAP has been piloted there has been improved performance against the 4 hour access standard.

- The new paediatric area at WHH has successfully opened and is being fully utilised by staff. The area provides a dedicated waiting area with assessment and treatment cubicles. This area is an excellent addition to the department and initial feedback from parents and children has been very positive.

- A full nursing review is almost completed to establish the staffing requirements to provide a dedicated Emergency Nurse Practitioner service across a minimum of 12 hours per day. This would reduce the requirement for medical staff to support the minor injuries service and develop a sustainable service for the future.

Acute Medical Model

- The Acute Medical Model project group at WHH is now established with actions being progressed at pace. Shared learning is underway via the Acute Medicine clinical lead to ensure that best practice from the QEQMH model is being implemented at WHH. The Acute Medicine Consultant job description and advertisement is under review with the Trust being represented at the BMA jobs fair in the Autumn. Active networking and recruitment is underway in the meantime with shared posts across Divisions being actively considered to ensure that all opportunities to engage substantive consultants are being progressed.

- At QEQMH the Acute Medical Model continues to become embedded with a second Nurse Consultant now started in post. This post will enable further nurse led services to be developed and expanding the opportunity for MDT working and challenge on ward and board rounds.

Implementation of SAFER & Patient Flow Programme

Phase 1 of the Improving Patient Flow (enhancing SAFER) Programme has been completed and the Closure Report was presented on 19th August; this signified the end of the intensive support from Four Eyes Insight. The four wards participating in phase 1 were Cambridge L, Cambridge J1 and J2 and Cambridge M2. Success has been monitored through weekly production of the SAFER Dashboard (see Picture 1) in line with five KPI's:

- Reduced Medical outliers on surgical wards
- 33% of ward discharges before 12.00
- Weekly review and reduction of patients with a LOS >7 days
- 90% of EDD's set and recorded on PAS within 24hrs of admission to the ward
- 10% reduction in LOS within the target wards.

Clinical engagement within the Programme has been essential to success and this was the main area of involvement for Four Eyes insight, although the entire multidisciplinary team have been actively engaged across all four wards. This has been supported by the Improvement Delivery Business Partners , who have worked in partnership with ward and MDT teams to develop Standard Operating Procedures for Board Rounds and Setting of EDD's, as well as agreeing Roles and Responsibilities for key staff groups involved with patient flow. A Training and Communication cascade process has been specifically tailored for each ward, to reflect issues identified during the preparatory 'deep dive' analysis. An overarching Patient Flow Toolkit is in its final stages of development and will form part of the 'central repository', soon to be available within a dedicated webpage on the Trust's Internet Staff Zone.

Provision of Senior Review and an EDD (the 'SA' of SAFER) has been well embedded within the target wards, but it is acknowledged that additional input is required to fully implement better flow of patients, earlier discharge and weekly review of patients with a >7 day LOS (the 'FER' o SAFER). This will be the IDBP's priority until 31st August, before commencing the phase 2 rollout.

Priorities for August have been:

- Sustain achievement of progress to date and embed the remaining elements of SA**FER** on the initial target wards, until 31st August.
- Commence phase 2 rollout and undertake baseline assessments, deep dives, training, engagement and communication.
- Celebrate the success of phase 1 wards and agree a quarterly baseline review process with Matrons, to ensure sustainability.
- Develop and provide discharge competency training across the WHH site, in association with Matrons and the Integrated Discharge Team; especially in relation to CHOICE.
- Finalise the Patient Flow Toolkit and break it down into 'learning units' for ease.
- Finalise and establish the Improving Patient Flow webpage (Staff Zone)
- Patients EDD to be written on white boards above the bed to and all staff are to be encouraged to discuss EDD with patients &/or family.
- Finalise and implement the Inpatient PTL tool to enable visibility of the patients pathway and any associated delays.

Operational Control Centres:

- The staff consultation to review the current site management teams and support the implementation of a 24/7 clinical site management team is in the process of being implemented through an active recruitment plan.
- The Operational Control Centres (OCC's) standardised approach to recording site SITREP information with a RAG rates report being sent out following the site SITREP meetings at 08:00, 13:00 and 16:00 continues to become embedded.
- Escalation action cards are being actively used in the OCC environment and are being shared with ward staff and consultants to normalise their use.
- The escalation plan is being rewritten to include a more proactive and pre-emptive approach by all specialities to managing the risk of overcrowding in ED.

Notable risks

- The Emergency Departments (ED's) continue to have a high level of specialty doctor vacancies. This is an on-going national issue and is a key workforce risk within the ECRP. UK and international recruitment continues along with a nursing review to enable an Emergency Nurse Practitioner Service which will reduce the departments' dependency on medical staff.

  During August there has continued to be gaps in the specialty doctor rota, particularly on evening and night shifts. Mitigating actions have continued to ensure that a safe service is provided, however, despite these actions there continues to be a serious risk in identifying sustainable cover for the rota and this does result in increased breaches in the evenings and overnight.

- There has been an increase in the number of patients presenting to QEQMH and WHH with mental health conditions. This has been a significant risk at QEQMH with an occasion in

which there was 8 patients with a mental health condition in the ED overnight. To mitigate the risk a 24/7 agency mental health nurse is booked to support the nursing staff and mitigate the risk to patients and staff. Once assessed there have been significant delays for those patients requiring a mental health bed. There has been a significant risk of an high risk patient absconding and ongoing monitoring of such patients creates additional pressure on the ED nursing staff. Although there is a mental health team allocated to each site between 08.00 and 20.00, in reality any patient attending after 6pm is likely to have to wait for the Crisis Team to assess overnight and this may be delayed if there are high risk patients in the community. Once assessed there may be a delay of several days before a mental health bed is identified.

Trajectory Confidence

August performance against the 4 hour target was 82.21%, against a trajectory of 90.80%. The increased activity levels seen so far this year remain above plan 5.5% in August, compared to +4.8% above plan in July. The numbers attending the departments, particularly in the evenings and overnight continue to have an adverse effect on the Trusts ability to meet the 4 hour standard for patients, with difficulties caused by spikes in activity and also the gaps in the specialty doctor rota. It is not unusual for 35 – 40 patients to attend over two hours and such high numbers of attendances are creating additional pressure in already busy departments.

The increased levels of activity experienced in through the summer have continued. The QEQMH and WHH have continued to see high numbers of patients attending in the evenings and overnight. The increase in children attending in the evenings has not abated.

There has been a movement in activity with QEQMH in particular seeing higher numbers of ambulances from the Canterbury catchment area since the new Urgent Care Centre criteria has been implemented. ED clinicians continue to work closely with SECAMB colleagues to reduce handover delays. Patients are being clinically assessed on arrival and safely streamed to areas such as the waiting room or minors. The conversion to admission is an indication that the patients have had a higher medical acuity with patients also being streamed to ambulatory care where possible.

The on-going risk to delivery of the trajectory is:

- A high % of breaches of the 4 hour emergency access standard relate to patient flow and bed availability.
- High numbers of patients attending ED in the evenings and weekends who could be managed by primary care, in particular paediatric attendances.
- Impact on the efficiency of the ED when trying to safely manage patients with a mental health condition who are awaiting assessment overnight by the Crisis Team.
- Mental health patients who require a mental health bed often having to wait several days for a bed, both in ED assessment beds and also in the wider ward bed base.
- Medical staffing vacancies, which medical staffing agencies are unable to fill. QEQMH is a particular risk due to the geographic location of the hospital.
- The number of DTOC's (delayed transfers of care) and access to short term external capacity in the community continues to be a high risk. There have been issues with a lack of external capacity across all geographic areas.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 OCTOBER 2016**
SUBJECT:	**COMMUNICATIONS AND ENGAGEMENT STRATEGY**
BOARD SPONSOR:	**DIRECTOR OF COMMUNICATIONS AND ENGAGEMENT**
PAPER AUTHOR:	**DIRECTOR OF COMMUNICATIONS AND ENGAGEMENT**
PURPOSE:	**Approval**

BACKGROUND AND EXECUTIVE SUMMARY

This is the Communication and Engagement Strategy for East Kent Hospitals University NHS Foundation Trust. It sets out how the Trust will communicate and engage with its audiences over the next four years (2016-2020) and supports the delivery of the Trust's mission, vision, values and objectives.

It supports other Trust strategies, including the Council of Governor's Membership Engagement Strategy, the Quality Improvement Strategy, the People Strategy and the Research and Innovation Strategy.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Included in SWOT in strategy
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	Listed in Board Governance Review Action Plan
RESOURCE IMPLICATIONS:	Resourced from existing communications pay and non pay budget
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	EMT, COG Membership Engagement Committee, Management Board, Staff Committee

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

RECOMMENDATIONS AND ACTION REQUIRED:

That the Board approves the Communication and Engagement Strategy

East Kent Hospitals University NHS
NHS Foundation Trust

Communication and Engagement Strategy 2016-2020

East Kent Hospitals University NHS
NHS Foundation Trust

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1. Executive Summary

The Communication and Engagement Strategy for East Kent Hospitals University NHS Foundation Trust, sets out how the Trust will communicate and engage with its audiences over the next four years (2016-2020), and supports the delivery of its vision, mission, values and objectives.

The need to communicate and engage well with our staff, the public, patients and users of our services and their carers; partners and other key stakeholders is essential for the delivery of safe and effective patient care and central to the success of the organisation. It needs to be what we do, every day, and involves everyone within the Trust.

We are committed to improving how we communicate and engage and understand the importance of clear, open, timely and relevant communication and meaningful engagement.

As with all NHS Trusts we are addressing the challenge of driving up quality of care and improving patient experience, while making sure services can meet growing demand and are sustainable. This puts an increased importance on communicating and engaging effectively.

This strategy aims to build our reputation, with staff feeling proud to work for the Trust. Making the Trust an attractive place to work will help us to keep and attract new staff to come and work for us.

It recognises the need to listen to and involve patients, the public, our partners and external stakeholders; and give greater emphasis to improving communication and engagement with our staff to create a well-informed and engaged workforce that is proud to work here and represent the Trust.

It describes the communication and engagement tools the Trust uses, and will develop, based on research and feedback; and how we will measure and review their effectiveness.

This strategy supports other Trust strategies, including the Council of Governor's Membership Engagement Strategy, the Quality Improvement Strategy, the People Strategy and the Research and Innovation Strategy, as well as supporting the Trust's charity.

The Trust is developing its newly formed communications and engagement team which brings together people with a range of skills, including specialist knowledge of the media and internal and external communication skills.

The team's role is to add value and support good communication and engagement. It complements the commitment required of every member of staff at all levels of the organisation to communicate and engage well.

2. Communications and engagement priorities

The key priorities for the next four years are to:

- Embed the Trust's mission, vision, values and strategic aims with our staff and communicate this effectively with our patients and external stakeholders
- Engage and involve people in improving the quality of our services so we are better at meeting their needs
- Work collaboratively with our partners to communicate the changes needed to health and social care in east Kent and the importance of people being cared for in the right place, at the right time, as described in the clinical strategy for East Kent
- Engage and support senior managers to communicate and engage effectively and to involve their staff in decision-making.
- Be proactive in our communications and use of different channels
- Make the most of our Trust membership, supported by working with our governors

3. Roles and responsibilities

Every member of **staff** has a role to play in supporting the delivery of this strategy to ensure good and effective communication takes place internally, the delivery of key messages externally, engaging with partners and the public or by helping to gather good news.

The Council of Governors and other stakeholders need to be kept up to date and have the right information so they can support our strategy.

Communication is everyone's business and cannot be left to the communication and engagement team alone, within this caveat, there are some individuals and groups with specific roles:

Council of Governors

Governors provide a vital link between the communities they represent, and we serve, and the Board. Governors need to stay well informed and be aware of what is happening in the Trust and engage with their constituents so they can feed that information into the Trust so that it influences Trust strategy.

Trust Board

The Trust Board's role is one of leadership and support. Board members have a role to play as individuals representing the organisation and, as a full Board, how it communicates with the public. The public attending the monthly Trust Board meetings are representatives of their communities and as such, are important communicators with local people.

Executive Directors and Management Team

Executive Directors have an on-going day-to-day responsibility for delivering the organisation's strategic objectives which includes this strategy.

Communications and Engagement Team

The Communications and Engagement Team is a small team of dedicated communications professionals providing leadership, technical expertise, advice and guidance. It has a lead role in protecting the Trust's brand and reputation, developing communication channels, co-ordinating media relations and providing information for staff, patients, the public and stakeholders. The Communications and Engagement Team should add value to others to enable them to do their work.

Divisional Directors, Heads of Nursing and Trust Management Board

The Senior Management Team has a responsibility to directly support the delivery of this strategy and to encourage their teams to do so, and has a responsibility in ensuring this strategy is delivered and information is cascaded throughout the organisation.

4. Communication and engagement principles

- Every communication contributes to our reputation, and should at all times be consistent with our values and what we want to be known for
- We are open and transparent about how the Trust is performing[1] and observe our duty of candour
- We adhere to the NHS Constitution, ensuring people can exercise their statutory right to have their say on current and future NHS services
- We work to meet the communication needs of diverse and hard-to-reach groups, and ensure their voice is heard.

All our communication and engagement activity should be:

- Clear, timely and accurate
- Targeted and relevant to the audience's needs
- Based on research, insight and emerging issues
- Accountable
- Planned, consistent and professional
- Purposeful and measured.
- Build a consistent and clear story of the organisation (vision, values, what it stands for)
- Use all available channels and techniques that are appropriate to the audience
- Provide a feedback mechanism at all times
- Use NHS resources efficiently

[1] The Francis Report, Robert Francis QC, 2013

5. Reputation management principles

The Trust's reputation is essential to recruiting, retaining and engaging with staff; maintaining the confidence of our patients and commissioners and ensuring support from external stakeholders such as MPs and the media.

Reputation is a stakeholder's overall impression of an organisation, established over time - the sum of what the organisation does, what it says about itself and what others say about it. Therefore, the Trust's communications and engagement activity is fundamental to how it influences and contributes to its reputation:

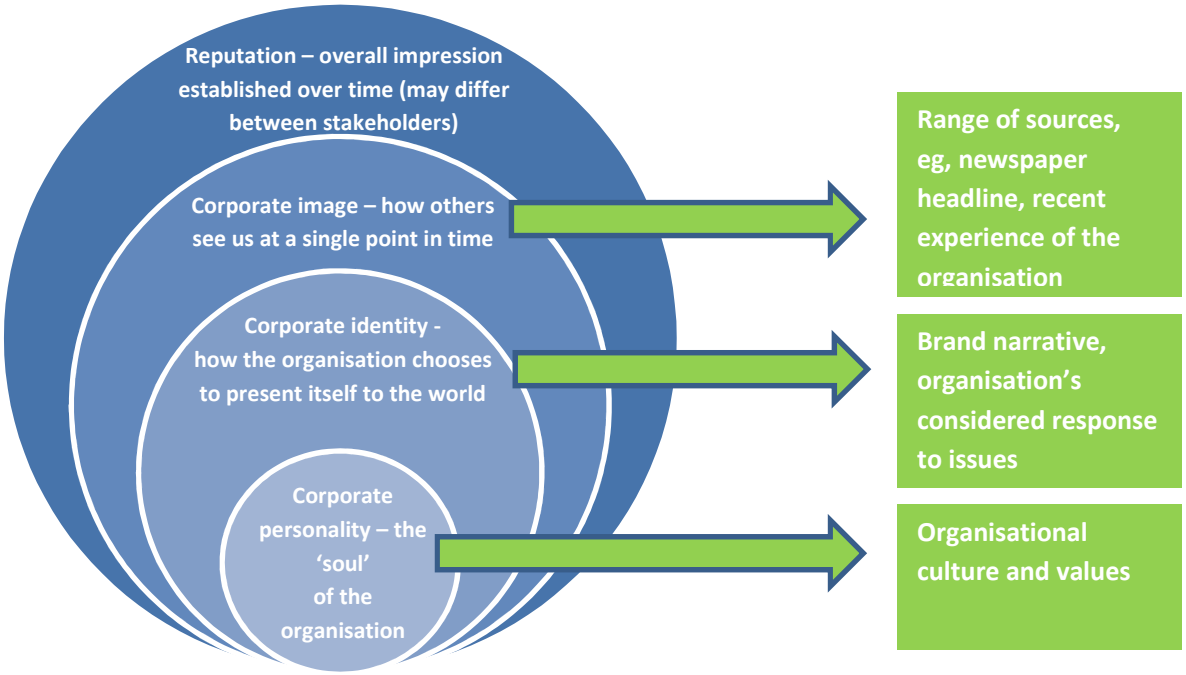


Figure 1.0: Elements that contribute to reputation.

As part of managing EKHUFT's reputation, the Communications and Engagement Team will:

- Take a proactive approach to issues management, horizon scanning and ensuring the Trust's response to emerging issues is clear and well-publicised
- Ensure all communications and engagement activity is in line with the Trust's vision and values
- Build collaboration and trust with EKHUFT's external stakeholders through supporting engagement on key issues
- Develop a compelling story describing what EKHUFT wants to be known for that our stakeholders recognise
- Monitor the Trust's reputation with stakeholders regularly, and take action to address any 'gaps' between the Trust's vision and the views stakeholders hold.

6. Situation analysis

The importance of the NHS to the public it serves, and the growing demand for transparency, requires clear and effective communication.

The Trust is operating in a changing and pressured environment which our communication and engagement strategy needs to address over the next four years. The Trust needs to build a strong reputation as a provider of great healthcare, as an employer of choice and as a key partner in integrated care.

This is in the context of rising demand for healthcare and increased expectations of patients; pressures on our workforce and the need to reconfigure our services as part of our clinical strategy to improve quality and sustainability.

We will need to engage and involve all our internal and external stakeholders in the future of our organisation, and the services it runs, to deliver the real transformation the NHS and its patients need.

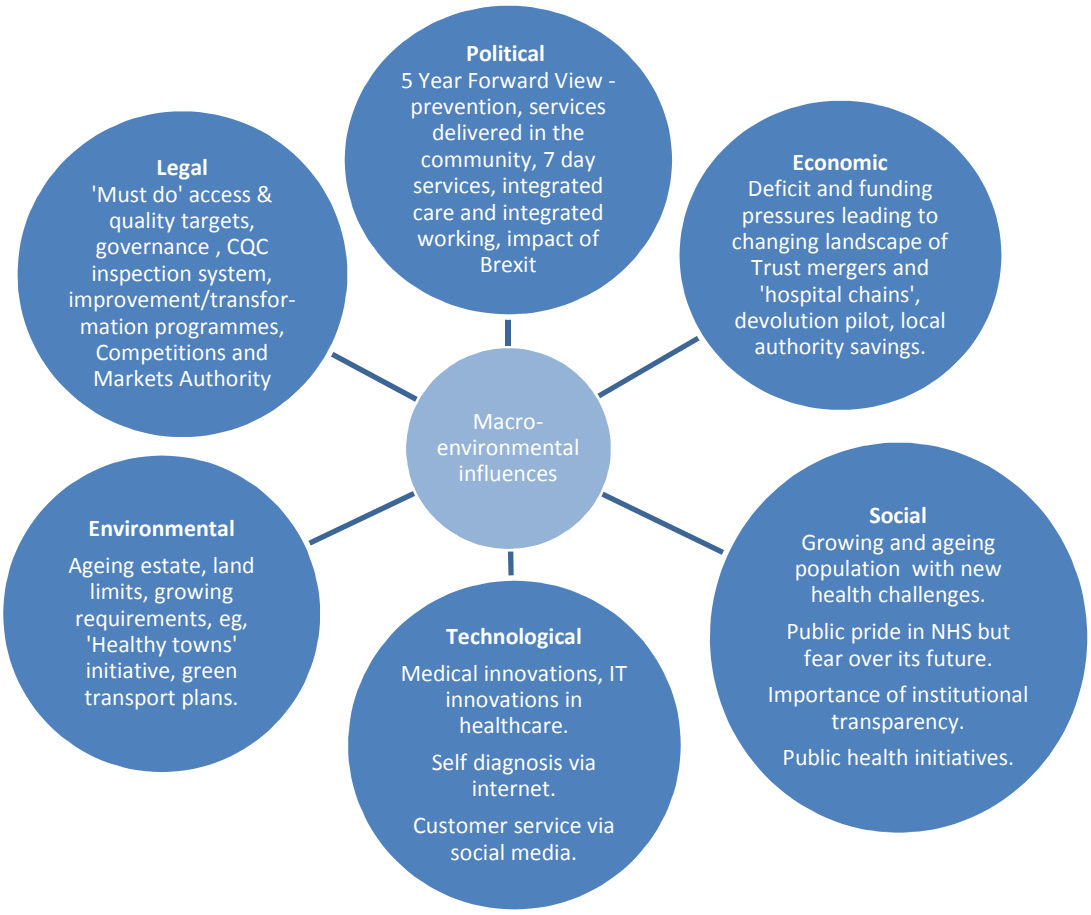


Figure 2.0: PESTEL (Political, Economic, Social, Technological, Environmental, Legal) analysis of issues in EKHUFT's current external environment.

7. Audience analysis

The public and our patients

East Kent has diverse and well defined communities. People identify strongly with their local area and local hospital and tend to engage when they feel services local to them are under threat.

How the public access information

71% of all adults in the UK now own a Smartphone (Ofcom), making online services more important

44% of internet users use the internet to find health information – it is one of the top three uses, along with shopping and news (Ofcom)

Internet access is increasing most in 55-64 year-olds, over 75s are the lowest internet users (Ofcom)

42% of people aged 65 and over use internet daily for email or to find information on services - but not for social media (Age UK). Over 55s prefer TV, radio and newspapers for news.

Kent Online is the fastest growing regional news network – with 2 million unique browsers a month (Audited Bureau of Circulation, 2015). Kent Messenger newspaper circulation is 44,492.

We should provide people with a good understanding of what the Trust does and the services it provides. We need people to seek help early, to look after their own health and to use NHS services appropriately, for example when choosing to attend A&E.

We need to give people opportunities to be involved when services need to change and explain why change is needed in clear, open and timely ways.

We need to provide information in a variety of formats, not just digitally. Information needs to be clear and easy to understand and available in alternative formats.

We need to give patients timely information about how long they may have to wait in A&E and what suitable alternatives there are.

We will be open with the public and our patients and apologise and explain when things go wrong.

East Kent has a high number of well-established local newspapers and broadcast media. Local people follow the local media more closely than the population as whole. The media plays a strong role in communicating news about the Trust.

The Trust receives 27 written compliments, and many more thank yous, for each complaint (July, 2016) and yet this is not reflected in press coverage. This is not because there is a shortage of positive news to tell.

We need to be more proactive in providing stories, interviews and pictures to the local media.

Staff

Most of our staff are also residents of East Kent and are important communicators of the Trust's messages both at work and at home. What they say to their friends, family and our partners is key to the public's perception of the Trust.

Employee "influence footprint"

One employee influences 12 close contacts, who each influence 12 more. This means one employee has a potential reach of 144 people.

As an organisation with 8,000 employees, East Kent Hospitals influences 1,152,000 people.

The Trust will be going through a period of significant change with the reconfiguration of services as part of the east Kent-wide clinical strategy, informed by a public consultation in late 2016. We need to engage staff in the development of new models of care to improve quality, meet standards and make services sustainable and communicate changes clearly and effectively.

We will also need excellent change communication to guide staff through the period of change and embedding, both within the Trust and working differently with other health and social care organisations in east Kent.

How our staff receive information (internal communications survey, 2016)

- 79% of staff read Trust News weekly and 70% of staff read the CEO blog weekly
- 75% of staff can access Trust communications on a PC/Smartphone/tablet easily
- Staff's preferred way of receiving information is email (59%), followed by face-to-face team briefing at 46%
- 33% of staff report that they rarely or never have a team meeting

We need to make communication with staff clear, open, relevant and timely. We need to communicate in ways which work for staff whether they work in offices, on sites, in wards or in the community and ensure staff access to team meetings.

We need to recognise and have pride in the achievements of our staff, and promote the Trust and east Kent as a “great place to work” for them and for potential employees thinking of working for us.

We need staff to be aware of all the options for engaging with the Board, for example whistle blowing, raising a quality issue or giving a presentation about their service. Staff should be able to ask the Executive questions and give feedback and we need to explain what we have done with that feedback.

Governors

Public Governors not only represent the views of members in their constituency, they also represent the views of residents who are not Trust members. Staff Governors represent our staff and Partnership Governors represent the public sector.

Our governors enable the Trust to be a truly patient-focussed organisation, providing a vital link between the communities they represent, and we serve, and the Board.

All governors need to be well informed and aware of what is happening in the Trust and have opportunities to engage with their constituents so the Trust has valuable feedback about its services.

Members

Anyone can contact the local governor for their area and be involved in the Trust. However, it is our members who elect the governor who will represent their area on the Council of Governors, which in turn holds the Board to account through the Trust’s Non-executive Directors.

Members can also be as involved as much or as little as they wish. There are a number of ways that members can be involved in the Trust, for example by being on interview panels, focus groups, attending events or helping us to ensure patient information is accessible.

We need to make sure that members know how to contact their local governor and have access to information about the Trust which is clear, open, timely and relevant. Members should have the opportunity to meet their local governor in their locality.

Information needs to be made available in a variety of ways, not just digitally. Information should be clear and easy to understand and available in alternative formats such as large print, braille and different languages.

Partner organisations

Our partners have a vital role in the Trust achieving its objectives. The only way we can provide good quality, sustainable health and social care to the people of east Kent is by working in partnership. There are strong networks and structures in place to support this.

We need to listen to, communicate with and engage our partners in ways which are clear, open, timely and relevant and foster these good working relationships.

External stakeholders

The Trust has worked hard to develop good relationships with its external stakeholders (a full stakeholder list is available in Appendix 1). We want to build on these relationships, as the support of our stakeholders is essential in meeting our aims. As with partners, we need to listen to, communicate with and engage with our stakeholders in ways which are clear, open, timely and relevant.

Stakeholders and audiences

The Trust needs to maintain positive relationships with all its internal and external stakeholders.

A full list of all our stakeholders is available in Appendix 1, but we recognise there are key audiences the Communications and Engagement Team need to work with regularly, who have differing information needs:

Timely communication and reassurance on our performance and plans Regulatory bodies – NHS Improvement, KCC, HOSC, NHS England, HEKSS CCGs MPs and councillors	**Regular communication and on-going engagement** Staff Media Governors
Timely information as required Suppliers Local universities Local businesses Schools	**Targeted information and engagement on relevant issues** Patients and public FT membership Health partners – NHS, social care and voluntary sector, GPs Healthwatch Trade unions Contracted staff, eg, Serco

8. Channels and tools

Internal channels:

Staff zone is the staff intranet and the place for staff to go to find a wide range of news, information and policies to help them in their roles.

Trust News is our weekly newsletter for staff, it is online and also available as a PDF so it can be printed out for staff who are not desk based. It keeps staff informed of the Trust's news and includes staff notices and information about training opportunities.

The CEO's weekly message is sent to all staff by email once a week. It includes the key messages from the Board that every member of staff needs to be aware of.

Staff engagement sessions are held regularly and are open to all staff, they are an information exchange and always include a question and answer session, usually with members of the Executive team.

The Leader is an email bulletin sent to people managers whenever there is information they need to be aware of and act on.

Team Talk is a single subject presentation for managers to use to engage their staff in team meetings/huddles so they are communicating consistent information to their teams. It should be delivered alongside local news and updates from the manager.

Leadership events are held in April and September and are an opportunity for senior managers to hear about and discuss Trust strategy, our vision and what is expected of our people managers.

External channels:

The Trust's website has useful information for patients and the public about the Trust, its services and its performance. It promotes the Trust as a great place to work and describes the benefits and opportunities of working here. It explains how people can get in touch with us and be involved in a variety of ways.

Your Hospitals magazine is produced 3 or 4 times a year and 25,000 copies are distributed for the public to pick up free of charge via 300 drop off points across our sites and in the community. It contains inspirational stories about the difference our staff make to patients and gives important information to the public.

We email an electronic version of our magazine to our members who are on email and post printed copies where this has been specifically requested, as well as making printed copies widely available.

We use **social media** to reach people through digital channels to engage and communicate with the public.

We work with the **local media** to provide information and news to the public.

Our **stakeholder e-bulletin** provides external stakeholders with information about how the Trust is performing, our latest news and innovations and how we are working with our partners.

In addition to using these channels, **individual communications and engagement plans** are developed to support the Trust's strategic objectives.

We are developing a **public engagement network** so that people who want to be more involved with the Trust can choose a variety of ways to do this.

Patients are represented on a number of groups and committees.

We hold an **Annual Members' Meeting** and attend other public events so that people can find out what the Trust does.

The Trust's key channels and tools for communicating and engaging with our internal and external stakeholders will be:

Channel	One-way (awareness)	Two-way (engagement)
Public and patients		
Website	■	■
Your Hospitals magazine	■	
Information screens/posters in waiting areas	■	
Social media		■
Traditional media (press, radio, TV)	■	
Patient committees and focus groups		■
Patient information leaflets	■	
Calendar of engagement events and annual members meeting		■
Patient Engagement Network		■
Staff		
Face-to-face staff forums		■
The Leader briefing for managers		■
Staff Zone (intranet)	■	■
Team Talk for people managers/team meetings		■
CEO and Executive blogs	■	■
Live digital "chat" with CEO	■	■
CEO and Exec visibility programme	■	■
Weekly Trust newsletter	■	■
PC 'desktop wallpaper'	■	
Email 'Newsflash'	■	
Staff information boards	■	
Professional journals	■	
Governors		
Face-to-face briefing sessions and Q&As		■
Email briefings, eg, emerging issues and media coverage	■	
Monthly report on communications and engagement activity	■	
Members		
Trust magazine	■	
Dedicated area of public website	■	■
Calendar of engagement events and annual members meeting		■
Locality based sessions with Governors		■
Patient Engagement Network		■
Partner organisations		
Health economy meetings	■	■
Monthly stakeholder e-bulletin and CEO message	■	■
Programme of engagement sessions	■	■
Stakeholders		
Monthly stakeholder e-bulletin and CEO message	■	■
Programme of engagement sessions	■	■

9. Implementation

Objective	Actions	When
Public and patients		
People understand what the Trust does and the services it provides, people seek help early, look after their own health, and use NHS services appropriately.	Provide a vibrant website which clearly explains the Trust's role and services and signposts to alternative sources of support.	January 2017
	Alternatives to A&E and public health information is provided in real time in A&E and through the Trust's communication channels, including digital and printed.	October 2016
	Information screens in waiting areas display public health information and information about our services	October 2016
People have opportunities to be involved in shaping service change and we are clear and open about why change is needed.	Publicise the case for change for Trust services and health and care in east Kent	August 2016
	Work with our commissioners to support public consultation on changes to services, providing a wide range of ways people can be involved	Tbc
	Public Engagement Network established	November 2016
	Increase the number of patient representatives on our committees, focus groups and inspections and invited to events	March 2017
	Calendar of engagement events and annual members meeting in place	October 2016
	Broaden the engagement opportunities for volunteers, people involved in research and East Kent Hospitals Charity.	March 2017
Information is provided in a variety of formats. Information is clear and easy to understand and available in alternative formats.	Trust magazine is revamped and printed copies are provided in 300 pick-up points in the community.	3-4 times a year
	Posters and signage in waiting areas and clinics is kept under review and up dated regularly	ongoing
	Anyone can request any information in an alternative language or format and how to do this is clearly communicated.	ongoing
Patients have timely information about how long they may have to wait in A&E and what suitable alternatives there are.	Information screens in A&E are updated to include real time information about the people waiting, waiting time to be seen and approximate time to be discharged.	October 2016
	The public website reflects the information being provided to patients in real time in our hospitals with information about alternatives	October 2016
	Trust magazine includes alternatives to A&E	August 2016
We are more proactive about providing positive stories, interviews and pictures to the local media, in particular the areas that we want to be	There is a 100% increase in the number of positive stories issued monthly compared to 2015, in particular for the areas for which we want to be known.	July 2016
	Social media channels are revised	Aug 2016
	There is a 400% increase in followers of the Trust's social media compared to May 2016	May 2017
	The number of positive stories on our website increases by 100% compared to a year ago	June 2017

known for.	Net positive balance of media coverage	Jan 2017
Objective	**Actions**	**When**
Staff		
Staff are engaged in the Trust's plans to deliver the Five Year Forward View, for example new models of care.	Annual programme of face to face engagement sessions with relevant information targeted at groups of staff, as well as all staff sessions	August 2016
	Staff can give feedback on proposals directly through portal on Staffzone	October 2017
	Business planning is bottom up with opportunities for all staff to shape their service's future	March 2017
Communication with staff is clear, open, relevant and timely and we use ways which work for all our staff.	CEO weekly blog sent to all staff, provides top level messages, supplemented by messages from Board members and weekly Trust news	August 2016
	Timely briefing for managers sent by email as information needs to be cascaded	
	Managers are supported to communicate and engage with teams with training and toolkits	March 2017
	Staff intranet updated daily with specific reference section for all recent communications	December 2016
	Trust magazine informs and celebrates staff achievements in patient care	Aug 2016 ongoing
	Live digital "chat" with CEO launched to increase access, added to face to face/walking the wards	December 2016
	Executive director walkabouts include back offices/support staff	October 2016
Staff have the opportunity to engage with the Board, ask questions and give feedback and we explain what we have done with that feedback.	Annual programme of face to face engagement sessions with relevant information targeted at groups of staff, as well as all staff sessions	August 2016
	Staff encouraged to attend Board meetings and there are increased opportunities for staff to present to the Board	January 2017
	Visibility and access to Staff governors increased	December 2016
	Dedicated area of Staff Zone and posters etc describing "you said, we did" and "why we didn't"	January 2017
The achievements of staff are recognised and the Trust is promoted as a "great place to work" for them and potential employees thinking of working for us.	Annual staff awards recognises nominees with certificate of recognition and category winners invited to awards event	December 2016 and annually
	Trust magazine informs and celebrates staff achievements in patient care	August 2016 and ongoing
	Vibrant "work here" section of public website	October 2016
	Increased placing of positive stories in national and specialist press	January 2017
Objective	**Actions**	**When**
Governors		
Governors are listened to and can hold the Board to account	CEO locality information based briefings for groups of governors	August 2016
	All governor "state of the nation" briefing sessions with Q and A session	September 2016

	Refreshed COG committee structure and improved information to support assurance role	June 2016
Governors are well informed and aware of what is being said about the Trust.	Heads up briefings on emerging issues and media coverage	June 2016
	Monthly report on all communications and engagement activity	June 2016
Objective	**Actions**	**When**
Members		
Members know how to contact their local governor and have access to information about the Trust which is clear, open, timely and relevant.	Trust magazine includes governor feature, contact details and forthcoming events	August 2016 and ongoing
	Refreshed area of public website with information about how members can communicate and engage	December 2016
	Calendar of engagement events for governors to meet members in the Trust and locally	October 2016
	Meet your Governor locality sessions	tbc
Members are aware of the different ways that they can get involved	All new members written to with choices about how they can get involved	October 2016
	Trust magazine and other channels have feature about how engagement has improved services	August 2016 and ongoing
	Members invited to annual meeting and other events	August 2016
Information is clear and easy to understand and available in alternative formats.	Every opportunity is used to promote fact that all communications can be provided, on request, in different formats and languages	Ongoing
Objective	**Actions**	**When**
Partner organisations		
Partners are listened to, communicated with and engaged in ways which are clear and open.	Trust commitment to East Kent Strategy Board, Sustainability & Transformation steering group, KCC's Health Overview and Scrutiny Committee and similar forums	Ongoing
	Monthly stakeholder e-bulletin with message from CEO launched with ways to feedback	August 2016
	Programme of engagement sessions with partner trusts, MPs, healthwatch, vol orgs	December 2016
Objective	**Actions**	**When**
Stakeholders		
Stakeholders are listened to, communicated with and engaged in ways which are clear, open, timely and relevant.	Monthly stakeholder e-bulletin with message from CEO launched with ways to feedback	August 2016
	Programme of engagement sessions with partner trusts, MPs, Healthwatch, voluntary organisations	December 2016

10. Monitoring and evaluation

We will monitor the effectiveness of our communication and engagement activities through:

Media

- A comprehensive media analysis will be used to understand the impact of our communications activity, month on month, by October 2017

Staff engagement

- The quarterly NHS Staff Friends and Family Test and annual NHS Staff Survey measure of staff engagement metrics and the NHS Staff Survey measure of specific communication metrics.
- An annual internal communications survey to measure staff use and satisfaction with internal communication channels and information.
- Team brief metrics to monitor take-up of corporate messages by division and individual team.
- Pulse Surveys and medical engagement scale

Patient and public engagement

- Feedback from patients received via Trust Governors
- Annual patient survey
- Quarterly content analysis of social media mentions/patient opinion posts/letters to the press

External stakeholder engagement

- Take-up of monthly stakeholder bulletin (open/click rates)
- Annual perception survey/qualitative interviews

11. Conclusion

Our strategy sets out how we will improve how we communicate and engage; and do so in clear, open, timely, relevant and meaningful ways.

We will be recognised as:

- *a Trust that involves the public in decisions about their care and the services we provide*
- *a Trust which places high importance on research and innovation, to deliver the best care possible*
- *a great place to work where people feel valued and motivated, and have opportunities to develop*
- *a Trust that listens to its patients, staff and stakeholders and works collaboratively with its partners*

We will uphold the NHS brand and what it stands for (The NHS constitution).

12. APPENDIX 1: Our stakeholders

Local council leaders and chief officers
HOSC
Local councillors and officers
Local authority planners

Local MPs and MEPs
Local/national political organisations/pressure groups
National health committees

The public
Public organisations, eg, residents associations
Voluntary organisations and community groups
Charities

Local businesses
Business organisations, eg, Rotary

Patients/services users
Healthwatch
Patient groups and networks
Carers and relatives

EKHUFT staff
Wider NHS staff
Trade unions
Potential staff
Local authority staff
Contractor staff, eg, SERCO
GPs, pharmacists

Media (including local newspapers, radio, TV, digital, professional and trade press, national media)

Board members
Council of Governors
Health commissioners (CCGs)
Health partners, eg, Public Health England,
Regulators, eg, NHS Improvement, CQC
Board members of NHS partner/neighbouring organisations

Ministers
Department of Health
NHS England

APPENDIX 2: Communications and engagement SWOT analysis

Strengths	**Weaknesses**
New structure for EKHUFT's communications function, with the addition of a Communications Director to ensure a strong link between the Board and the communications and engagement function Strong vision and direction for the Trust to drive communications	East Kent geography means the potential for new audiences is limited The Trust has no defining narrative (unique selling point) Low 'social legitimacy' of NHS Trusts in media and public opinion
Opportunities	**Threats**
New team of communications professionals with a wide and complementary mix of skills, knowledge and experience Imminent major change programme provides the opportunity to develop people managers' communication skills and embed strong internal communications practice Imminent major change programme provides the opportunity to develop genuine, transformational engagement with all our stakeholders National social marketing drive that supports Trust's public health messaging Growing empowerment of staff leading to 'brand ambassadors'	National pressures and change framework as reported in media could lead to mixed messages for patients and staff Entrenched culture/public opinion on how NHS services should be provided National politics, eg, early general election, driving NHS rhetoric NHS organisations struggling to deliver on public/staff expectation

APPENDIX 3 (a): Internal communications survey results March 2016

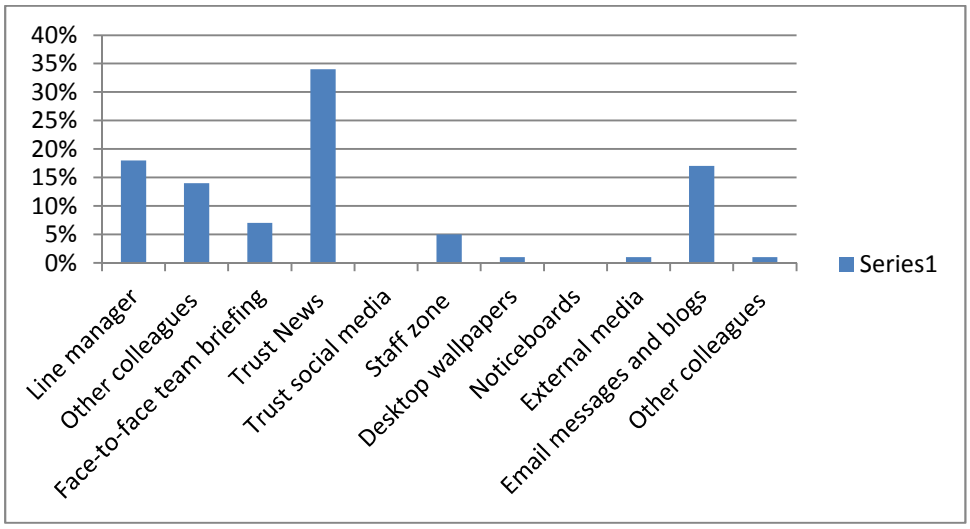
An annual internal communication survey is carried out every March as part of the Staff Friends and Family Test.

The headline survey results for the March 2016 survey are:

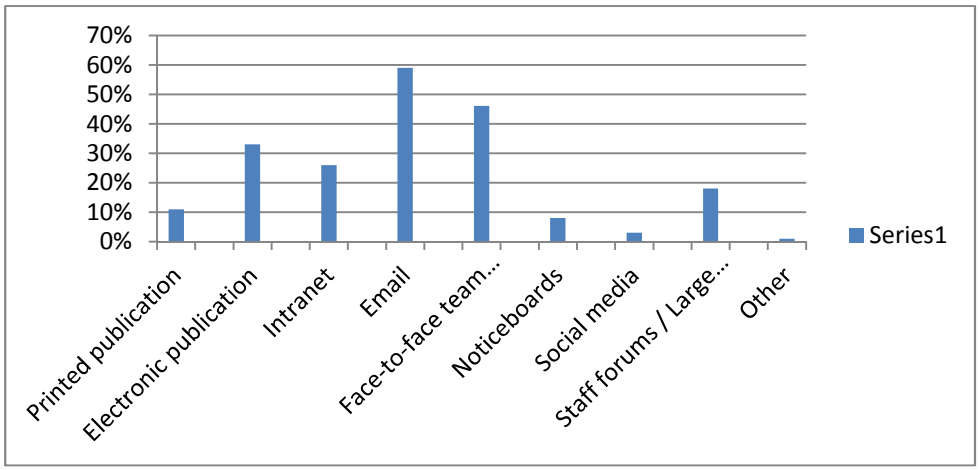
- 63% of staff said they feel well informed about what is going on in the Trust
- 52% said they have a way to put forward their views and ideas about the Trust
- 67% said they have a way to put forward their views and ideas about their area of work
- 68% (of people managers) said they have sufficient information to communicate messages to their team with confidence.

1.1 Most-used information channels

Respondents were asked to identify which channel they get most of their information from. Most-used information channels were Trust News (34%), line manager (18%) and email messages/blogs (17%).



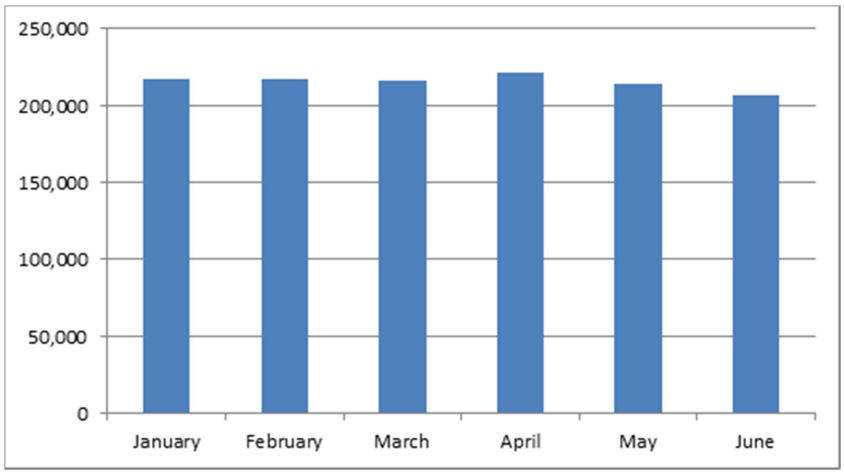
1.2 Preferred channels
(Respondents could select up to three channels)



Appendix 4: Public and patient use of our digital channels

www.ekhuft.nhs.uk/patients-and-visitors

All figures reported are from January – June 2016



Total number of page views on Patients and Visitors website: **1,294,606**

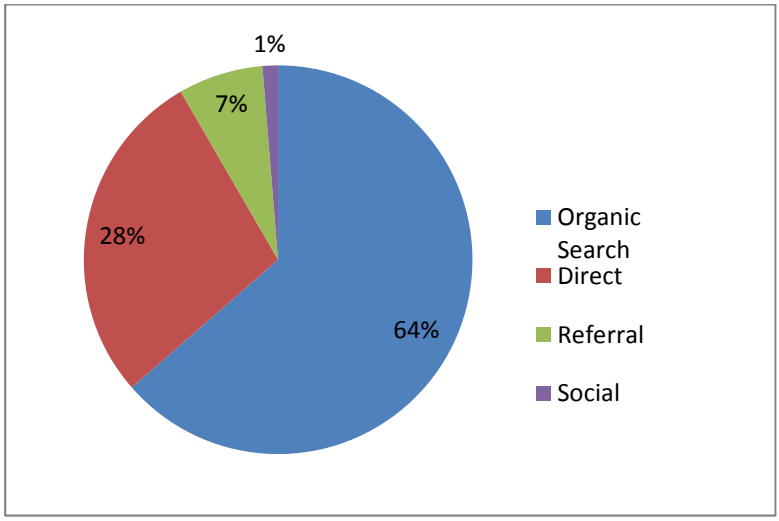
Unique page views: **958,433**

Average time on page: **00:01:04**

Average pages per session: **3.04**

Accessing information

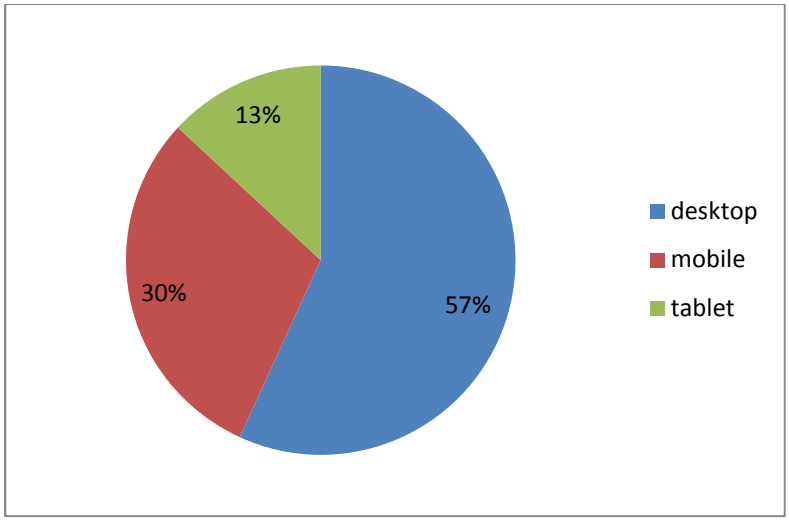
How users arrive at our website:



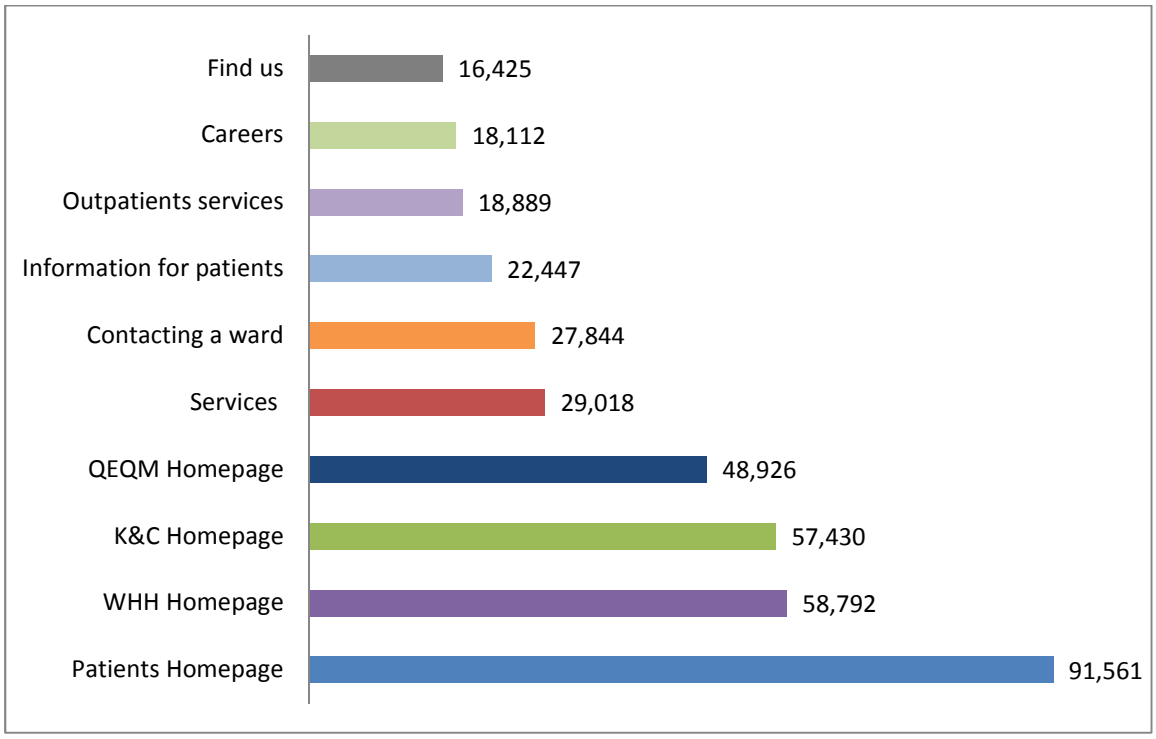
Organic - Visitors referred by a search engine eg. Google
Direct – Visitors typed in the URL directly or links from emails / documents
Referral – Visitors clicked links on other websites

Social – Visitors clicked through links on social media

Desktop vs Mobile vs Tablet

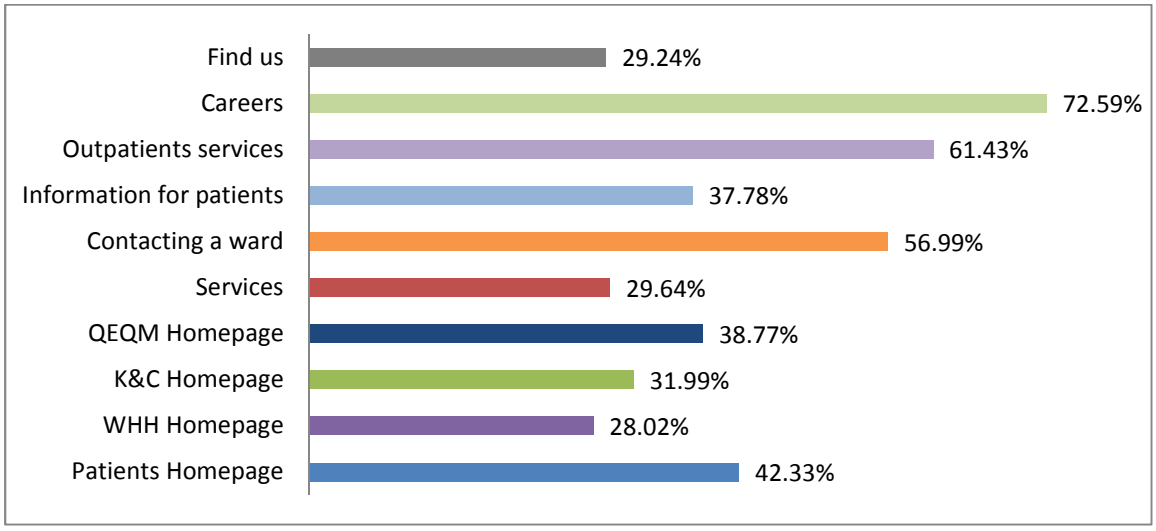


Top 10 pages

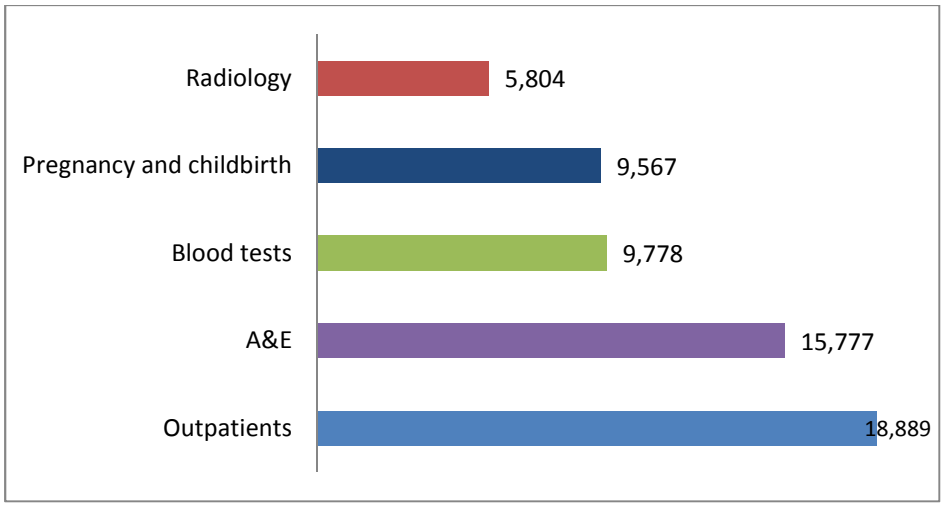


Bounce rate:

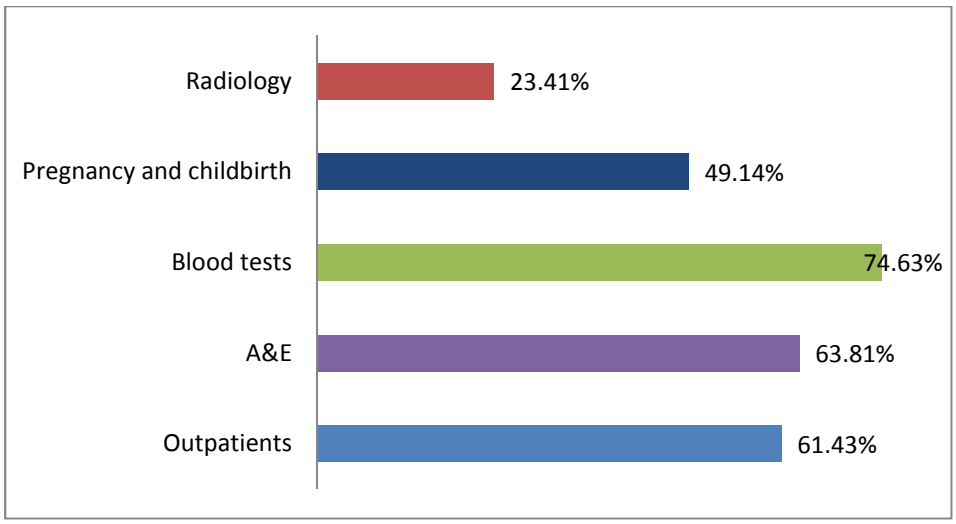
Bounce rate - The percentage of single page visits – where users exit the website from the same page they entered without looking browsing further.



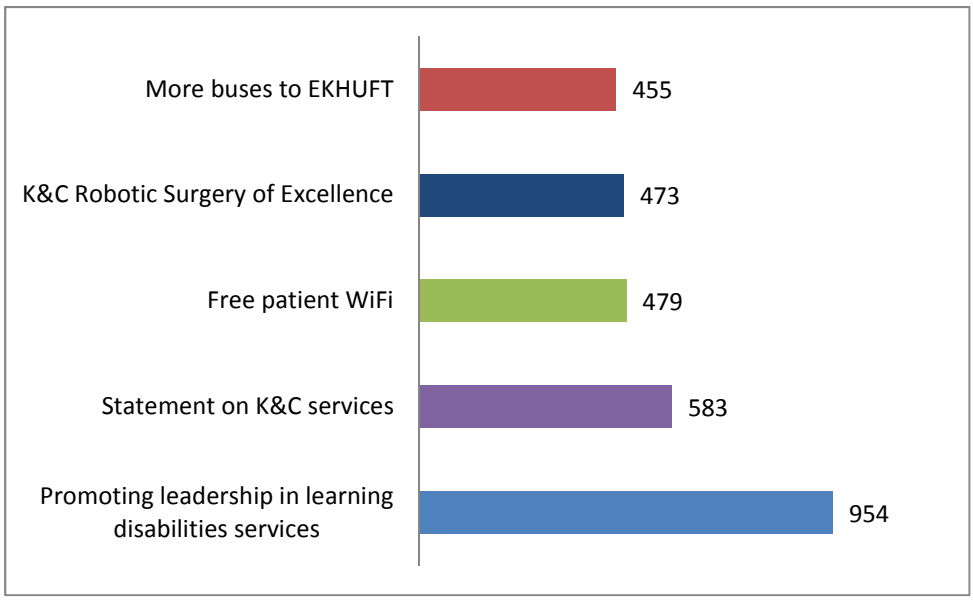
Top 5 services pages



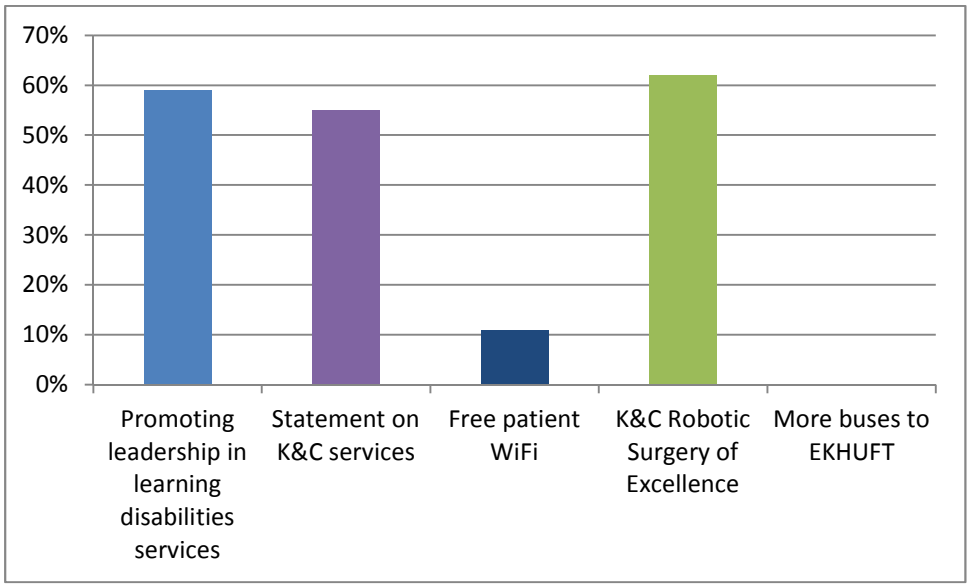
Bounce rate



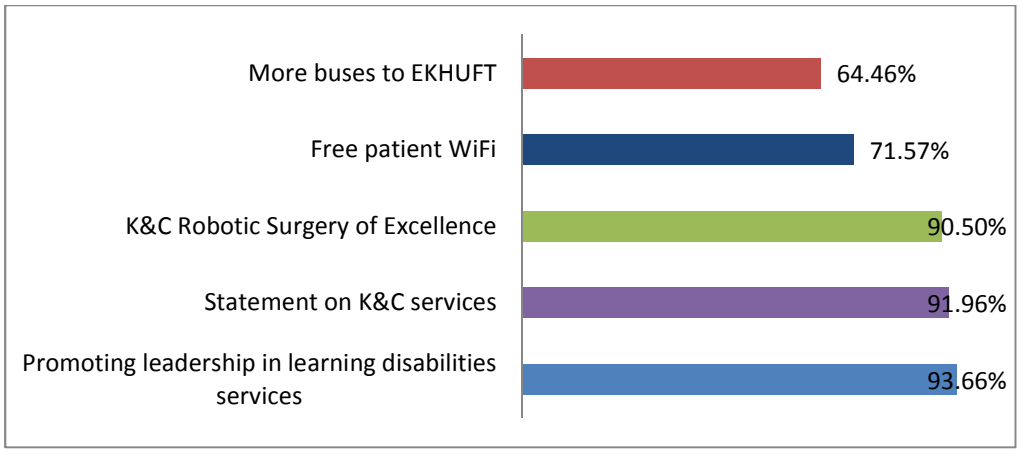
Top 5 news stories



Referrals from social media (Facebook)



Bounce rate



Summary

Most patients and visitors access our website using a search engine.

43% of users access our website using a tablet or mobile device. We have a mobile responsive website, but we must ensure that content is fit for purpose across all platforms.

Most people access our site to find information about our services (eg outpatients), how to contact wards and departments, how to get to our hospitals and working with us.

Using social media to promote news stories is successful – with over 50% of views for our top 5 stories coming via Facebook promotion.

Equality Analysis
COMMUNICATIONS AND ENGAGEMENT STRATEGY **BOD 87/16**

23 September 2016.

This Equality Analysis should be attached to any policy, strategy or business case for decision.	
Name of the policy, strategy or business case:	Communications and Engagement Policy 2015-2020
Details of person completing the Analysis	
Name	Natalie Yost
Job Title	Director of Communications and Engagement
Division/Directorate	Chief Executive's Office
Telephone Number	01227 864154
What are the main aims, purpose and outcomes of the policy, strategy or business case?	To direct and improve the way the Trust communicates and engages with its staff, patients, the public and stakeholders.
Does it relate to our role as a service provider and/or an employer?	It relates to both us as a service provider and an employer
Is the policy, strategy or business case relevant to the aims of the equality duty? Guidance on the aims can be found in the EHRC's PSED Policy Guidance.	
Aim	**Yes/No**
Eliminate discrimination, harassment and victimisation	**Yes**
Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it	**Yes**
Foster good relations between persons who share a relevant protected characteristic and persons who do not share it	**Yes**

Assess the relevance of the policy to people with different protected characteristics and assess the impact of the policy on people with different protected characteristics. When assessing relevance and impact, make it clear who the assessment applies to within the protected characteristic category. For example, a decision may have high relevance for young people but low relevance for older people; it may have a positive impact on women but a neutral impact on men.		
Protected characteristic	**Relevance to decision** High/Medium/Low/None	**Impact of decision** Positive/Neutral/Negative
Age	**Medium**	Positive
Disability	**Medium**	Positive
Gender reassignment	**Low**	Neutral
Marriage and civil partnership	**None**	Neutral
Pregnancy and maternity	**Medium**	Positive
Race	**Medium**	Positive
Religion or belief	**Low**	Neutral
Sex	**Low**	Neutral
Sexual orientation	**Low**	Neutral
Mitigating negative impact: Where any negative impact has been identified, outline the measures taken to mitigate against it.	No negative impact has been identified.	

Information and research: • Outline the information and research that has informed the policy. • Include sources and key findings. Include information on how the policy will affect people with different protected characteristics.	The policy includes positive action to make information accessible. For example in different formats and languages on request (Age, Disability, Race). There are actions to provide more information to people in printed formats (Age). It follows national guidance under the accessible information standard https://www.england.nhs.uk/ourwork/accessibleinfo/ and digital communications follows national standards https://www.w3.org/WAI/intro/accessibility.php (Disability). The strategy includes promoting access to services (Age, Disability, Race, Maternity) and communications will promote images which positively promote inclusion and diversity (all characteristics)
Consultation: • Has there been specific consultation on this policy? • What were the results of the consultation? • Did the consultation analysis reveal any difference in views across the protected characteristics? Can any conclusions be drawn from the analysis on how the policy will affect people with different protected characteristics?	Consultation has included governors as representatives of the public and patients, the Board, Staff Side, Management Board, Head of Diversity and Inclusion, Head of Learning Disabilities, Director of Research and Innovation. Consultation feedback was positive about the impact on people with protected characteristics and this was strengthened in the report. Consultation analysis did not reveal any difference in views across the protected characteristics but it did highlight that the strategy will positively affect people with different protected characteristics.
Conclusion: • Consider how due regard has been had to the equality duty, from start to finish. • There should be no unlawful discrimination arising from the decision (see PSED Guidance). Advise on the overall equality implications that should be taken into account in the final policy, considering relevance and impact.	The strategy includes actions which have a positive impact on most protected characteristics. This needs to now be put into practice as the strategy is implemented.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 OCTOBER 2016**
SUBJECT:	**1) R&D REPORT FOR 2015-16 FY** 2) **R, I & I STRATEGY FOR 2016-2020**
BOARD SPONSOR:	**MEDICAL DIRECTOR**
PAPER AUTHOR:	**1) TRUST RESEARCH AND DEVELOPMENT MANAGER AND DIRECTOR OF RESEARCH AND DEVELOPMENT** **2) DIRECTOR OF RESEARCH AND DEVELOPMENT AND ASSOCIATE DIRECTOR TRANSFORMATIONAL RESEARCH AND PRACTICE DEVELOPMENT**
PURPOSE:	**Approve**

BACKGROUND AND EXECUTIVE SUMMARY

1) R&D Report – annual overview of Trust's R&D activity

Successes:

- Large NIHR grant awards (c. £250k to Dr David Stephensen)
- Appointment of Prof Chris Farmer as Clinical Professor of Medicine at UoK
- National recognition for our researchers & positive stories promulgated by local media about research
- Recruitment to 118 different NIHR Portfolio studies across 18 different disease areas
- Significant progress with staff & public/patient engagement relating to R&D (N.B. this a major priority nationally for NIHR/Trust R&D departments)

Challenges:

- Reduced overall recruitment to NIHR Portfolio studies (by 44% to 1315)
- Slight reduction in industry income (by 11.5% to £729k): although overall funding increased in 2015-16, this reduction – if sustained – is of concern in the context of a 7% reduction in Clinical Research Network (CRN): KSS funding in 2016-17

2) Research, Inquiry & Innovation (R,I&I) strategy for 2016-20

Stakeholder event held in January 2016. Output from this event distilled through a rigorous process outlined in the document to provide a set of strategic objectives and a workplan for R,I&I over the coming four years that:

- Aligns with and fully supports the Trust's strategic objectives
- Will facilitate delivery of our vision - "Making a difference to the experience and outcomes of health care to the people of Kent, the NHS and internationally through Research, Inquiry and Innovation"

Building on our existing strategy, the present document describes several key themes:

- To position R,I&I as core Trust business, with particular emphasis on positive communication and engagement
- To grow our capacity and capability to undertake research that, in particular, aligns to the needs of our local population

- To work collaboratively – at both strategic and operational levels – with existing and emerging external partners (NHS, university, industry) to deliver high quality research & innovation

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	1) Annual report - for information only 2) R,I&I Strategy - risks of not approving: delayed/lack of strategic direction in context of significant external pressures (e.g. CRN:KSS funding reductions, rapidly evolving research landscape, recruitment & retention difficulties)
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	None
RESOURCE IMPLICATIONS:	R,I&I remains almost entirely self-funding through CRN:KSS funding, grant awards & industry income
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Management Board

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

RECOMMENDATIONS AND ACTION REQUIRED:

1) Annual report: to be noted & approved
2) R, I & I strategy for 2016-2020: to be approved

East Kent Hospitals University NHS
NHS Foundation Trust

Research, Inquiry and Innovation Strategy

2016 to 2020

"Making a difference to the experience and outcomes of health care to the people of Kent, the NHS and internationally through Research, Inquiry and Innovation."

Draft

Version Control

Version	Date	Author	Status	Comment
1.0	5/5/2016	Dr Tim Doulton (Director of R&I) Prof Kim Manley (Associate Director Transformational Research & Practice Development)	Draft	Circulated to working group for comment & comments incorporated
1.1	15/6/2016	As above	Draft	Circulated to all Jan 2016 workshop attendees
1.2	18/8/2016	As above	Draft	Comments from workshop attendees incorporated
1.3	21/9/2016	As above	Draft	Comments from Director of Communications (Natalie Yost) incorporated

Acknowledgements

I am hugely indebted to Prof. Kim Manley and the other members of the steering group (see 2.2.1) – especially those external to the Trust – who volunteered a significant amount of their time and energy in helping to deliver the Strategy Workshop in January 2016, and who subsequently contributed to and assisted with drafting this document. I am also grateful to Joanne Isaacs for administrative and practical support before, during and after the workshop.

Dr Tim Doulton, Director of R&I, 21st September 2016

Draft

1. Introduction

1.1 East Kent Hospitals University NHS Foundation Trust's (EKHUFT's) vision is **'great healthcare from great people'**. Three elements underpin great healthcare: high quality clinical care[1]; excellence in teaching and learning; and cutting-edge research, scholarly inquiry[2] and innovation.

1.2 The Trust has four major strategic priorities: Patients, People, Provision and Partnership. Through our strategy for **Research, Inquiry and Innovation (R, I & I)** covering 2016 to 2020 R, I & I will underpin the Trust's vision and mission, and ensure that these activities become embedded within the Trust's broader strategic objectives. Below we provide some examples of how this will happen.

1.2.1 **Patients: 'Help all patients take control of their own health'.** Wanting to better understand or 'take control' of their own condition is frequently cited by research participants as a reason for becoming involved in a research study[3]. By broadening the scope and increase the research opportunities we offer to patients, we will help support this strategic priority. To ensure we take account of what matters for the people of East Kent, we will engage with our local population and groups that represent them to better understand what their priorities are for research and inquiry.

1.2.2 **People: 'Identify, recruit, educate and develop talented staff'.** When properly resourced, R, I & I has an important role in making the Trust an attractive employer for high quality and committed staff. Moreover, quality care and improvement go hand-in-hand with research and scholarly inquiry, evidenced by the most research-active organisations having better patient outcomes[4]. We will work to ensure R, I & I is embedded in Trust human resources policies and procedures to support achievement of this strategic objective.

Draft

[1] Within EKHUFT high quality clinical care is defined as the achievement of person-centred, safe and effective care and an effective workplace culture that sustains these outcomes.

[2] We define scholarly inquiry (or 'inquiry') as utilizing co-operative and participative approaches that encourage our staff in partnership with patients & service users to build their curiosity about their own and collective practice and to identify the gaps in our knowledge & understanding (http://wagner.nyu.edu/files/leadership/avina_heron_reason2.pdf). Our definition also includes Boyer's model wherein research is integrated with learning and practice. (Boyer, E. (1990). Scholarship reconsidered: Priorities for the professoriate. Princeton, NJ: The Carnegie Foundation for the Advancement of Teaching).

[3] CRN:KSS Research Participant Survey 2015

[4] Ozdemir BA, Karthikesalingam A, Sinha S, Poloniecki JD, Hinchliffe RJ, et al. (2015) Research Activity and the Association with Mortality. PLoS ONE 10(2): e0118253. doi:10.1371/journal.pone.0118253

1.2.3 **Provision: 'Provide the services people need and do it well'.** By identifying ourselves as being a research-active and innovative organisation, we will enhance our reputation with our local population and commissioners by underlining how effective service provision is achieved by blending research evidence with patients' expertise, professional expertise and the local context[5].

1.2.4 **Partnership: 'Work with other people and other organisations to give patients the best care'**. Collaboration, inclusion and participation are fundamental to successful delivery and implementation of research, and we have an established track record of working with local universities and other partner agencies to achieve our research ambitions. Building upon what has come before we will continue this collaborative approach with universities (for example, by being a leading member of the Kent & Medway Health Partners initiative) whilst building new strategic alliances with other NHS providers (for example, Kent Community Health FT (KCHFT) with whom we are developing plans for joint research delivery staff).

1.3 **"We do research because that's how you get better treatment"**. This quote from a patient succinctly describes why research is vital in our business: developing and contributing to knowledge through research and adopting and applying new knowledge and innovation through rigorous processes of testing and learning are fundamental to excellent healthcare.

1.4 **The role of the National Institute for Health Research (NIHR):** NIHR is the body that oversees, commissions, funds and, through the clinical research networks (CRNs), supports delivery of clinical research within the NHS. For a number of years EKHUFT has been the one of the main contributors in the Kent, Surrey and Sussex region for participant recruitment into NIHR 'Portfolio' studies – those studies that have been adopted onto the 'Portfolio' following open, peer-reviewed funding awards or those supported by industry. We need to maintain this momentum and continue to offer our patients and public the opportunity to participate in as wider choice of clinical trials as we have the capacity to deliver.

1.5 **The need for more home-grown research:** In tandem with delivering NIHR Portfolio studies, we need to invest in and grow a richer and more diverse research base around all research methodologies – including patient experience, knowledge mobilisation, health service delivery, leadership and quality improvement – to develop, fund and deliver more research that is relevant to patients and public in Kent, Surrey and Sussex.

[5] Rycroft-Malone J, Seers K, Titchen A, Harvey G, et al. (2004) What counts as evidence in evidence-based practice? J Adv Nursing **47(1)**: 81-90

Draft

1.6 The **purpose of this strategy document** is to clearly state our vision for research, inquiry and innovation in EKHUFT over the period from October 2016 to October 2020, to set clear objectives that will enable fulfilment of the vision and to lay down milestones that define whether we have been successful in realising our vision.

2. Taking forward research, inquiry & innovation in EKHUFT

2.1 Many of the drivers for EKHUFT to be a highly research active organisation are previously outlined in the Trust's R&I strategy for 2013-16: www.ekhuft.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=282265. Some of these now assume a relatively greater weight, for example: patient and public expectations around being involved in research; Department of Health requirements and key benchmarks (e.g. Performance in Initiation & Delivery of research and others); new knowledge and how being a research active organisation is in itself is associated with better clinical outcomes to name but a few. The current document builds on and extends our previous strategy, and will enable us to respond rapidly and effectively to the evolving research environment.

2.2 **Development and implementation of this strategy document**: Fifty-seven stakeholder representatives attended a workshop held at University of Kent (Canterbury Campus) on 15th January 2016 (Appendix A). Those that have contributed to the development of this strategy have done so because they passionately believe that R, I & I in all its forms has a central role in improving healthcare experience and outcomes for all the people of East Kent, the NHS and beyond.

2.2.1 The workshop was organised and facilitated by a working group, comprising: Tim Doulton (EKHUFT, Chair), Kim Manley (EKHUFT), Annette King (NIHR RDS SE & CHSS, UoK), Ruth Hulbert (EKHUFT), Julie Hedayiolgu (KentHealth, UoK), Barbara Mercier (NIHR CRN:KSS), Julia Simister (NIHR CRN:KSS), Art Ationu (EKHUFT; deputy Richard Collins)

2.2.2 **Strategy Development:** Over several meetings following the workshop, between January and May 2016, the working group took the output from workshop group sessions through several stages to distil key themes around strategic and sub-objectives, along with the milestones that are intended to enable delivery of those objectives. The audit trail for this process is given in Appendix B.

2.2.3 **Publication:** Early drafts of this document were reviewed and revised by the working group members, and the final draft will be circulated to all those who

attended the workshop for final comments and approval, prior to presentation to the Trust Board of Directors and formal publication.

2.2.4 **Implementation:** The workplan for delivery of the objectives is presented in Section 5. Progress against milestones will be RAG rated, and subject to regular review by the R&I Committee.

3. Our vision for research, inquiry and innovation in East Kent

Our **vision** is "Making a difference to the experience and outcomes of health care to the people of Kent, the NHS and internationally through Research, Inquiry and Innovation." It is underpinned by six strategic objectives, as described below.

4. Our strategic objectives (SO), activities and milestones

4.1 SO 1: Geography of East Kent and demographics of the local population

4.1.1 Our **objective** is to **help improve the experience & outcomes of healthcare in Kent**.

4.1.2 Our **activities** will be:

- To actively position R, I & I as central to the Trust's quality agenda and communication and engagement strategy.
- To explore the establishment of a database whereby patients opt in to and consent to be contacted by Trust staff about research opportunities.
- To explore, with other NHS providers in Kent and Medway, the opportunities for an integrated approach in aspects of operational management of R&I across the county.
- To develop a system to identify and prioritize *local* research and inquiry direction, whilst remaining cognisant of national priorities for research (e.g. through the work of the James Lind Alliance) and research funding (e.g. through themed funding calls from NIHR).

4.1.3 Our **milestones** are to have:

1. Contributed to drafting and implementing EKHUFTs communications and engagement strategy.
2. Developed and implemented a searchable register of patients who consent to be contacted about research opportunities, and linked this register to EKHUFTs patient administration system (PAS) to permit flagging of patients when admitted or seen in the Trust.

3. Developed a process - using different mechanisms e.g. focus groups, surveys etc. - by which patients, local public, EKHUFT staff and other local stakeholders can contribute to identifying priorities for R, I & I in East Kent.

4.2 SO 2: Communication, Perception & Promotion

4.2.1 Our **objective** is to **raise the profile of R, I & I with patients & public, staff and the Trust Board**

4.2.2 Our **activities** will be:

- To develop a communications plan that raises patient and public awareness of research opportunities, activity and impacts in Kent.
- To develop a systematic approach to showcasing the impact of the Trust's R, I & I activity across Kent, the NHS and internationally.
- To provide staff, students and other stakeholders with high quality information and signposting to enable them to develop their research ideas.
- To engage with the Trust Board, especially non-executive directors (NEDs), to promote the benefits to patients and the organisation of EKHUFT being research active, and to explore how to similarly promote this message to Trust Governors and Members and other senior leaders within the organisation.
- To work with Primary Care and KCHFT colleagues to enhance awareness of opportunities for patients to participate in research in EKHUFT, whilst supporting and facilitating research activities in those areas, creating a 'win-win' environment. Specifically we will ask colleagues in these organisations and sectors to:
    - Raise the possibility of patients participating in research e.g. when referred into secondary care
    - Advertise research participation opportunities in their surgeries and facilities
    - Actively signpost to EKHUFT patients who express interest in participating in studies that we host
- To work with local charities to take forward research ideas and capitalize on *local* funding opportunities.

4.2.3 Our **milestones** are to have:

1. Developed a process in partnership with the Trust communications team that profiles the following internally and externally (including general practices and KCHFT). For example:
    - Maintained clear research branding: "Research: Good for you, Good for the NHS"
    - Increased presence of positive patient and staff stories about research in external and internal media e.g. local newspapers/TV news and Trust News

- Visual presence throughout trust e.g. Talking Head posters
- "What's going on now" themed communications about research
- More use of social media e.g. "A day in the life of a research patient", YouTube films, blogs and so on.
- Thank you letters for research participants

2. Implemented a programme for the Trust Board/NEDs to promote benefits of EKHUFT being a research active organisation and to explore the applicability of this programme to Trust Governors and Members and other senior leaders within the organisation.
3. Developed a standardized branded dissemination template for all new and completed research.
4. Developed impact narratives, to incorporate feedback to research participants (both patients and staff).
5. Improved our R, I & I webpages, and to make more patient friendly with more links to other relevant websites (e.g. Join Dementia Research) and other online research-related resources, and to ensure that we keep these pages maintained & up-to-date.
6. Utilized and improved existing resources (QII Hub rooms and website, R&I webpages, presence on NHS R&D Forum, R&I office) to signpost staff & external stakeholders who wish to undertake research in the Trust.

4.3 SO 3: Collaboration & Involvement

4.3.1 Our **objective** is to **further develop our collaborative partnerships and broaden our involvement of other stakeholders in initiation, funding & delivery of research**.

4.3.2 Our **activities** will be:

- To continue active participation, playing a leading role, in the Kent and Medway Health Partners (KMHP) initiative as a vehicle that will facilitate development of new and existing NHS/University/3rd sector partnerships in research.
- To promote opportunities for research collaborations across the whole local health community (for example, action research studies addressing local needs that have incorporated GPs, community staff, residential and nursing homes, community pharmacists).
- To build relationships with the Trust's own Charity, League of Friends and other local (Kent) health-related charities to influence funding and focus of research.
- To build formal relationships with other NHS organisations and local industry partners to identify opportunities for delivering integrated ways of working in research.

4.3.3 Our **milestones** are to have:

1. Continued to be an active partner in KMHP through attendance at KMHP meetings and active promotion of its vision to act as a hub to co-ordinate and deliver health and social care research across Kent and Medway.
2. Worked with KSS AHSN to scope out and develop a network for influencing funding and the focus of R&I with local industry.
3. Established dialogue between EKHUFT (e.g. League of Friends, EKHUFT Charitable Funds) and other local charities so as to agree joint priorities for funding and focus of research.
4. To have fully implemented all changes implicit in HRA Approval of research and to be using continuous improvement to maximize efficiencies within the research management and governance processes.

4.4 SO 4: Capacity & Capability

4.4.1 Our **objective** is to **grow our capacity and capabilities across all professional staff groups & specialities to participate in R, I & I activities**.

4.4.2 Our **activities** will be:

- To develop clear expectations and opportunities for all professional staff groups in relation to R, I & I, including exploring incorporation of an R&I section in the Trust's induction programme
- To provide access to funding and support for all Trust staff to undertake small research & inquiry projects that are free of some of the restrictions of NIHR and other similar funding streams.
- In partnership with local Universities, to continue to develop our capacity and capability in R, I & I.
- To use existing research strengths as a means to attract new talent to the Trust.
- To support researchers from all professional backgrounds to lead or participate in locally-led NIHR Portfolio and non-Portfolio research projects as Chief, Principal or Co-Investigators.
- To retain our focus on Industry research, thereby ensuring patients have access to cutting edge treatments.

4.4.3 Our **milestones** are to have:

1. Embedded expectations about R, I & I for all professional staff groups within job descriptions and the Shared Purpose Framework.

2. Achieved integration of R, I & I into the Trust's recruitment and retention strategy through engagement with the HR department. To include specific actions including, but not limited to: standardized paragraph in job descriptions and job advertisements.
3. Encouraged the profile of departmental research activity is included within job advertisements and job descriptions.
4. Established small project grants scheme (c. £20k pot per annum).
5. Trialled "Dragon's Den" approach to critique research ideas and explore linking to small project grants scheme.
6. Reviewed the impacts of the Trust's RSS and PPS schemes on research capacity and capability in the Trust by the 2017-18 financial year.
7. Used the QIIH, grey area projects process (incorporating service evaluation & service improvement), AHP Forum, KMHP, KSS AHSN, ECPD, RDS-SE, CHSS, CRN:KSS, HEE:KSS & EKHUFT staff who have completed postgraduate studies (Masters & PhD) to identify and grow expertise and/or mentorship in relation to a full range of specific research approaches (to include: action research, appreciative inquiry, phenomenology, ethnography, qualitative, quantitative and mixed methods methodologies).
8. Engaged EKHUFT libraries to support R, I & I activity.
9. Continued to support schemes to attract undergraduates to research (e.g. KentHealth Student Vacation Scheme) and to look for other similar opportunities with other universities.
10. Increased joint appointments, in partnership with local universities, across a range of clinical academic models.
12. Gained intelligence from CRN:KSS on returned Industry study expressions of interest (EoIs) as a means to improve and quality assure this process.

4.5 SO 5: Infrastructure

4.5.1 Our **objective** is to **strengthen physical resources to successfully deliver our ambitions for R, I & SE over the next 10 years**.

4.5.2 Our **activities** will be:

- Realise the opportunities arising from clinical information systems development in EKHUFT and the local health economy as a resource to support delivery (e.g. identifying study participants) of research and data mining.
- Explore opportunities for collaborative working, sharing of resources and potential for future joint appointments in areas of R, I & I that have been historically or currently challenging to recruit to.

- Continue to work with the Trust Strategic Development Department (incorporating estates and facilities) to ensure that staff and patients engaged in research benefit from estate that are fit for purpose and supports achievement of our strategic objectives for R, I & I.

4.5.3 Our **milestones** are to have:

1. Developed visible site-specific spaces for R, I & I activity linked to existing facilities (e.g. research team bases, QIIH Rooms, R&I Department, Libraries).
2. Undertaken a benchmarking exercise around use of R&I accommodation and file storage.
3. Engaged with other NHS organisations in Kent and Medway to scope out opportunities for joint working in operational management of R&I activities and pooling of resources and infrastructure.
4. Re-developed existing space to provide high quality accommodation for research delivery staff, clinic +/- day case space, laboratory facilities etc., aligned to Trust strategy for delivery of clinical services.

4.6 SO 6: Funding & Incentives

4.6.1 Our **objective** is to **ensure growing and self-sustaining funding for R, I & I in the Trust**.

4.6.2 Our **activities** will be:

- To ensure that we effectively disseminate – by both push and pull – all relevant funding opportunities to Trust staff.
- To enable greater opportunities for collaborative bids to external funding bodies, including exploring the role of research facilitators within the Trust to: support busy clinicians to develop their research ideas; link with support offered by NIHR RDS-SE and other organisations (e.g. KentHealth); manage systems that alert colleagues to funding opportunities etc.
- To tap into potential of internal & external recognition of research achievements (e.g. support for honorary academic posts, external awards, Trust awards).
- To continue encouraging Industry study research, through facilitation of Industry study EoI returns and provision of adequate PI time via Trust's RSS scheme to enable effective study delivery.

4.6.3 Our **milestones** are to have:

1. Used the QIIH, Trust R&I webpages & social media to have a regular feed of research funding opportunities to Trust employees

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2. Developed an alerting system through QIIH, EKHUFT Twitter to forewarn experts/champions of funding opportunities that are relevant to their areas of interest
3. Developed NHR Portfolio Industry study activity in at least one new disease area per annum.

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5 Our work plan

Strategic Objective		Description of milestone	Person responsible for delivery	Target Completion Date
1. To help improve the experience and outcomes of healthcare in Kent	1	Drafted and facilitated implementation of R&I sections of Trust's communication and engagement strategy	Lead Research Nurse	Apr-17
	2	Developed and implemented a searchable register of patients who consent to be contacted about research opportunities	Director of R&I	Apr-18
	3	Linkage of register to PAS to permit flagging of patients admitted or seen	Director of R&I	Oct-18
	4	Developed a process by which patients, local public, Trust staff and other stakeholders can contribute to identifying priorities for R, I & I in East Kent	Lead Research Nurse	Oct-18
2. To raise the profile of R, I & I with patients & the public, staff and the Trust Board	1	Developed a process in partnership with Trust communications team that conveys positive messages about research internally and externally to the Trust	Lead Research Nurse	Apr-17
	2	Implemented a programme for the Trust Board and NEDs to promote benefits of the Trust as a research active organization	Director of R&I	Oct-17
	3	Improved R, I & I webpages. Specifically: improved 'patient friendliness', better links to other websites and on-line research related resources	Director of R&I	Apr-17

Draft

	4	Improved existing resources (relevant sections of R&I webpages, QIIH, R&I office) to signpost staff and external stakeholders	R&I Manager	Apr-17
	5	Developed a standardized and branded dissemination template for new and completed research	Associate Director: Clinical Quality & Patient Safety	Apr-17
	6	Developed impact narratives that incorporate feedback to research participants	Lead Research Nurse	Oct-17
3. To further develop our collaborative partnerships and broaden our involvement of other stakeholders in initiation, funding & delivery of research	1	Become active partner in KMHP though regular attendance at KMHP meetings and actively articulating and promoting KMHP's vision as it applies to EKHUFT	Director of R&I	Oct-16
	2	Implemented all changes arising from HRA Approvals process	R&I Manager	Apr-17
	3	Established relationships with Trust and other local charities to agree mutual priorities for funding and focus of research	Director of R&I	Oct-17
	4	Worked with KSS AHSN to scope out and develop a network for influencing funding for and focus of R&I with local industry	Director of R&I	Oct-18
4. Grow our capacity and capabilities across all professional staff groups & specialities to participate in R, I & I activities	1	Worked with HR to: (a) embed statements regarding obligations towards R&I into Trust JDs for all professional groups (b) ensure R, I & I is embedded in Trusts recruitment and retention strategy, through presenting EKHUFT as an attractive place to work (c) encourage EKHUFT departments to profile their R, I & I activites in adverts and JDs for all professional staff groups	R&I Manager	Oct-17

Draft

	2	Established a small projects grant scheme and trial 'Dragon's Den' approach as one means to distribute this funding	Director of R&I	Apr-17
	3	Worked with CRN:KSS Industry Lead to get regular feedback on Industry study EoIs to improve and/or quality assure our processes in this area	R&I Manager	Oct-17
	4	Engaged EKHUFT libraries to realise full potential of their role(s) and ensured this is fully embedded within the research process	R&I Manager	Oct-17
	5	Used a variety of organisations [listed above] and resources to identify and grow mentorship and expertise is relation to the full range of research approaches	Associate Director: Clinical Quality & Patient Safety	Oct-17
	6	Explored with local universities opportunities to attract undergraduates to NHS research (e.g. develop schemes along lines of UoK Student Vaccation Scheme)	Director of R&I	Oct-17
	7	Reviewed impacts of RSS and PPS schemes on capability and capacity	Director of R&I	Apr-18
	8	Established at least one additional joint appointment between EKHUFT and local universities	Director of R&I	Oct-18
5. Strengthen physical resources to successfully deliver our ambitions for R, I & I over the next 10 years	1	Developed visible site-specific spaces for R, I & I activity linked to existing facilities (e.g. research team bases, QIIH Rooms, R&I Department, Libraries)	Lead Research Nurse	Oct-17
	2	Undertaken a benchmarking exercise to define space requirements: clinical, back-office, filing	R&I Manager	Apr-18

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	3	Engaged with other NHS organisations in Kent & Medway to scope out opportunities for joint working in operational management of R&I activities and pooling of resources and infrastructure	Director of R&I	Oct-18
	4	Re-developed existing space to provide high quality accommodation for research delivery staff, clinic +/- day case space, laboratory facilities etc., aligned to Trust strategy for delivery of clinical services	Director of R&I	Apr-19
6. Ensure growing & self-sustaining funding for R, I & I in the Trust	1	Used a variety of outlets to provide a regular feed & alerting system of research funding opportunities and themed funding calls to Trust employees	R&I Manager	Oct-17
	2	Developed NIHR Portfolio Industry study activity in at least one new disease area per annum over first 2 years.	Director of R&I	Oct-18

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6.1 Appendix C: Workshop Attendees

Name	Organisation Represented
Ibrahim Balogun	EKHUFT
Jayanti Rai	EKHUFT
Sandra Tapsell	EKHUFT
Janine Musselwhite	EKHUFT
Sarah Lines	EKHUFT
Karen Barnes	Patient Representative
Kate Springett	CCCU
Hazel Everest	MTW NHS Trust
James Porecca	NIHR CRN KSS
Annette King*	UoK/NIHR RDS-SE
Chris Pocock	EKHUFT
Gillian Eaglestone	EKHUFT
Richard Collins	EKHUFT
Farzin Deravi	UoK
Bridget Fuller	Dartford NHS Trust
Pat Wolstenholme	Patient Representative
Sarah Dickens	KMPT
Ruth Hulbert*	EKHUFT
Nicky Wood	EKHUFT
Anthea Potter	EKHUFT
Andrew Gillian	EKHUFT
Sarah Knight	EKHUFT
Ian Danks	Patient Representative
Dawn Nortman	KCHT
Barbara Mercier*	NIHR CRN KSS
Sue Drakeley	EKHUFT
Esther Tanton	EKHUFT
Dick Jones	UoK
Lee Tomlinson	KCHT
Paul Stevens	EKHUFT
Des Holden	KSS AHSN
David Walsh	Patient Representative, formerly of Pfizer
Julia Simister*	NIHR CRN KSS
Mo Sakel	EKHUFT
Yvonne Morrissey	EKHUFT
Anna Verrion	EKHUFT
Vanessa Short	UoK/EKHUFT
Gordon Ferns	NIHR CRN KSS
Margaret Hall	NIHR CRN KSS
Peter Nicholls	UoK
Jenny Witherden	CCCU
Kim Manley*	EKHUFT/CCCU
Chris Farmer	EKHUFT/UoK
Syanne Aston	EKHUFT
Sarah Stirrup	EKHUFT
Stuart Gill-Banham	EKHUFT
Brent Murray	Patient Representative

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David Wilkinson	Director, NIHR RDS-SE/UoK
Heather Gillham	COO, NIHR CRN KSS
Robert Hughes	MMH NHS Trust
Sally Smith	Chief Nurse, EKHUFT
Julie Hedayioglu*	UoK
Fritz Muhlschlegl	EKHUFT
Edmund Lamb	EKHUFT
Matthew Kershaw	CEO, EKHUFT
Paul Stevens	Medical Director, EKHUFT
Tim Doulton	Director of R&I, EKHUFT

*Denotes **facilitators** for group work

Draft

6.2 Appendix B: Strategy Workshop Audit Trail

Vision

Making a Difference to the experience and outcomes of health care to the people of Kent, the NHS and internationally through Research, Scholarly Inquiry and Innovation

1. Geography of East Kent & demographics of the local population

<table>
<tr><td colspan="2">Draft Strategic Objective 1</td></tr>
<tr><td colspan="2">To help improve the experience & outcomes of healthcare in Kent.</td></tr>
<tr><td>Data from Thematic Analysis from SWOT Analysis:

• Drawing on characteristics of our local population – particularly taking into account demographic changes e.g. aging, demands for clinical services, move towards stratified medicine – to identify priorities for research, innovation & scholarly enquiry (R,I & SE)
• Drawing on our local population as a resource to inform priorities for research ideas & as participants in research
• Work with potential competitors (for staff, funding, studies, infrastructure) as collaborators instead</td><td>Sub-Objectives:

Actively positioning R&I as central to the Trust's quality agenda and public engagement strategies.

Patient choice system: Establish Trust system whereby patients opt in or opt out of research opportunities & patients consent to be contacted by Trust staff about research opportunities.

Working towards an integrated approach to operational management of R&I across Kent & Medway.

Developing a system to identify & prioritize research & inquiry direction.</td></tr>
<tr><td>Draft Milestones from SWOT Analysis:

1. To contribute to drafting & implementation of EKHUFTs public engagement strategy. [Year 1]
2. To engage with other NHS organisations in Kent & Medway, and to scope out opportunities for joint working in operational management of R&I activities. [Year 2]
3. To develop & implement a searchable register of patients who consent to be contacted about research opportunities. [year 1]
4. To link EKHUFT research register to PAS, to permit flagging of patients when admitted or seen in the Trust [tba – to discuss w Andy Barker]
5. To develop a process - using different mechanisms e.g. focus groups, surveys etc. - by which patients, public, EKHUFT staff and other stakeholders (e.g. HEI researchers, charities, national registries) can contribute to identifying priorities for research & inquiry</td><td>Action Points from Stakeholder Day

• A process to engage all partners once a research Q has been identified (Group 5)
• A process for prioritising research Qs of importance to the trust (Group 5)
• Ask our patients what to focus on and what matters to them
• focus on Industry Drug studies that can provide immediate benefit to patients
• some Registry Studies will also provide evidence for NICE approval of drugs
• To determine clinically relevant areas

Align with partners

1. To determine clinically relevant areas
2. Following on from (a) to then map out key, overlapping research areas
a. By reputation (grant awards, publications)
b. By number of individuals interested / by how multidisciplinary area is (e.g. cuts across nursing, physio, and SALT)
c. By service provision (by size?)</td></tr>
</table>

2. Communication, Perception & Promotion

Draft Strategic Objective 2

To raise profile of R, I & SE to patients & public, staff and the Trust Board**.**

Data from Thematic Analysis from SWOT Analysis:

- Address negative perceptions about relevance, accessibility & impacts of research amongst both patients, public & staff; address perceptions that R&I office seen as administrative rather than facilitative.
- To develop a positive media strategy – both traditional & social – to convey patient stories, research successes, opportunities to contribute to research – participant, lay reviewer, co-researcher etc.
- To raise profile of support services around research: EKHUFT R&I Office; NIHR RDS-SE; Mentors
- To raise the overall profile of R. D & I in EKHUFT
- To raise our electronic profile e.g. Trust research webpages, social media
- To use films (e.g. YouTube) to communicate our message about importance of research, patient stories etc.

Sub-Objectives:

To develop an communications strategy that raises public and patient awareness of research opportunities, activity and impacts in Kent

To develop a systematic approach to showcasing the impacts of the Trust's R, I & I activity across Kent, the NHS & internationally

To provide staff & other stakeholders with high quality information & signposting to enable them to develop their research ideas

To engage with Board, especially non-executive directors, to promote the benefits to patients & the organisation of EKHUFT being research active

Working with Primary Care

- As first point of contact - publicity
- GPs introducing prospect of research e.g. when referred

Sign posting to

Draft Milestones from SWOT Analysis:

1. To develop a process with Trust communications team that profiles the following internally & externally (including GPs):
   - Clear research branding e.g. "do something wonderful"
   - Patient & staff stories about research in external & internal media e.g. local newspapers/TV news & Trust News
   - Visual presence throughout trust e.g. Talking head posters
   - "What's going on now" themed communications about research
   - More use of social media e.g. "A day in the life of a research patient", YouTube films, blogs
   - Thank-you letters for research participants

2. To implement a programme for Board/NEDs to promote benefits of EKHUFT being a research active organisation – examples to include:
   - patient access to novel drugs
   - drugs/ equipment often provided free of charge and can represent considerable cost savings
   - free staff training on delivery of novel drugs/equipment/surgical/radiological etc. procedures, which assists learning and

Action Points from Stakeholder Day

- Signposting where to go with ideas & 'next steps'
- Use technology to enhance information provision

Raise profile by:

- Linking with Trust Comms dept.
- More stories in local press – things that make an impact & interest the public
- Newsletter for patients/public – including patient contributions and distribution and/or articles in other established newsletters e.g. Local Authority Newsletter, other Trust newsletters.
- Establish steering group for PPIE
- More use of social media, e.g. "A day in the life of a research patient"
- Improve website, make more patient friendly more links to other relevant websites, e.g. Join Dementia Research, other online research (NB. must be maintained /kept up to date),
- Research 'branding' - focus to make more personal, e.g. "Do something wonderful"
- Engage in a variety of ways: focus groups, surveys, websites

develops skills at Departmental level and ensures staff have experience of novel treatments when they are taken into standard treatment pathways 3. To develop a standardized branded research dissemination template 4. To develop impact narratives, to incorporate feedback to research participants (both patients & staff) 5. To map & improve our resources to R&I webpages from patient & staff perspective 6. To improve website, make more patient friendly, more links to other relevant websites, e.g. Join Dementia Research, other online research (NB. must be maintained /kept up to date) 7. To utilize & improve existing resources (QIIH, R&I webpages, presence on NHS R&I Forum, R&I office) to signpost staff & external stakeholders	"Opt out" of research – wording added to outpatient letters **Raise the benefits of research at senior (Board) level in the Trust:** • patient access to novel drugs • drugs/ equipment often provided free of charge and can represent considerable cost savings • free staff training on delivery of novel drugs/equipment/surgical/radiological etc. procedures, which assists learning and develops skills at Departmental level and ensures staff have experience of novel treatments when they are taken into standard treatment pathways **Align with partners** a. Use technology to enhance information provision b. To find a way to regularly (6 monthly?) communicate research activity across organisations using systems already established or develop an additional, simple pathway c. If developing a research strategy, to include consistency in how research is described / promoted within the Trust - - there is potential to link to other organisations - - I am in the process of developing flyers within KCHFT explaining own research, portfolio research, and industry research.

3. Collaboration & Involvement

Draft Strategic Objective 3	
To develop our collaborative partnerships and broaden our involvement of other stakeholders in initiation, funding & delivery of research.	
Data from Thematic Analysis from SWOT Analysis: • Drawing on resource of patients & public to inform & participate in R, I & SE in Kent, to include local charities & patient engagement groups • Widening participation of all of our staff in R, I & SE to not only support delivery of research, but to also contribute other benefits to EKHUFT e.g. recruitment & retention of staff. • Build upon & develop joint partnerships with HEIs & local health economy, including CRN KSS & AHSN, HEKSS, Community Trusts, MH Trusts & Primary Care, to include jointly funded	**Sub-Objectives:** To continue active contribution to K&M Health Partners initiative as a vehicle that can facilitate development of new & existing NHS/HEI/3rd sector partnerships in research To promote opportunities for research collaborations across the whole local health community (for example, action research studies addressing local needs that have incorporated GPs, residential & nursing homes, community pharmacists) To build relationships with Trust's own Charity,

Draft

posts. • Work with Industry partners relevant to the local population of Kent & NHS more widely	League of Friends & other local (Kent) health-related charities to influence funding & focus of research To build formal relationships with other NHS organisations & local industry partners to identify opportunities for & deliver truly integrated ways of working in research
Draft Milestones from SWOT Analysis: 1. EKHUFT becomes an active partner in K&M Health Partners through attendance at K&MHP meetings & active promotion of its vision, thereby enabling this it to act as a hub to co-ordinate & deliver health & social care research across K&M 2. To work with KSS AHSN to scope out and develop a network for influencing funding & focus of research & innovation with local industry 3. To establish dialogue with EKHUFT & local charities and to agree joint priorities for funding & focus of research 4. To implement fully all changes implicit in HRA Approval of research and to remove unnecessary barriers arising from research governance	**Action Points from Stakeholder Day** • Include enthusiastic advocates include research and inquiry in undergraduate programmes (Group 5) • Develop formal Networks and partnerships for taking forward research Qs (Group 5) • Awareness of who is interested and in which specialty/therapeutic/ areas of research – collaborate • Bring together academic research leaders and clinicians – development via clinically led priorities • Governance without more barriers • Facilitation (for HRA) – new roles for R+D? • Proportionate risk evaluation • Access to mentoring/supervision/peer support • Support before ideas go to RDS [help closing the gap] • Liaising with GPs – Primary Care is where majority of patients interface with the NHS • Patients who have taken part - keeping them involved • Thank you letter for research participants – as if they want to feed back and/or want to get more involved • Provide feedback to patients- study specific & more generally • seek out Industry Partners for future opportunities • identify potential P.Is in priority areas • increase number of expressions of interest for Industry studies (currently 12% of those circulated) • increase patient involvement, especially through the Patient Ambassador role, which can promote participation in research through sharing experiences • To work with world class partners to maintain specific interests and keep high class individuals in the Trust • To join forces to achieve research priorities such as EKHUFT – KMPT dementia national database • To identify key academics and key clinicians and encourage more alignment / collaborative initiatives • To bring in other KSS colleagues who have complimentary skills

4. Capacity & Capability

Draft Strategic Objective 4

To grow our capacity and capabilities across all professional staff groups & specialities to participate in R, I & SE activities.

Data from Thematic Analysis from SWOT Analysis:

- Embedding R, I & SE in job descriptions, advertisements, recruitment & selection processes, employment contracts etc.
- Build relationships with HEIs involved in educating healthcare staff (e.g. CCCU, Greenwich, HEKSS, BSMS) to enhance profile of R, I & SE
- To link existing areas of acknowledged clinical expertise with research as a 'marketing tool' to attract staff
- Work in partnership with EKHUFT Library Services to promote the opportunities therein to support R, I & SE
- Pioneering innovative ideas to engage talents of our staff to advance their interest in R, I & SE
- Keep a focus on Industry research, to ensure patients have access to cutting edge treatments (that are potentially unavailable via other routes)
- (Succession planning ….)

Sub-Objectives:

To develop clear expectations for all professional staff groups in relation to R, I & I

To provide access to funding & support for all Trust staff to undertake small research & enquiry projects, outwith some of the restrictions of NIHR & other similar funding streams

In partnership to HEIs, continue to develop our capacity & capability in R,I&I

To use existing research strengths as a means to attract new talent to the Trust

Support researchers from all professional backgrounds to lead or participate in locally-led NIHR Portfolio and non-Portfolio research projects as Chief, Principal or Co-Investigators

Retain our focus on Industry research, to ensure patients have access to cutting edge treatments

- Provide seed funding – to investigators to support time/investment in new research projects
- Focus: Involve patients and public in decisions around EHUHT priorities for research
- Build on strengths – renal, ophthalmology, gyane oncology, haematology, neuro rehabilitation, laboratory medicine

Ensure return of accurate feasibility for Industry trials by:

- establishing a list of key named multidisciplinary staff who have been appropriately trained to complete feasibility forms
- sharing intelligence across KSS using CRN staff as facilitators

Draft Milestones from SWOT Analysis:

1. Embed expectations about R,I&I for all professional staff groups within job descriptions & the Shared Purpose Framework
2. Achieve integration of R,I&I into the Trust's recruitment & retention strategy through engagement with the HR department. To include specific actions including, but not limited to: standardized paragraph in JDs, job advertisements etc.

Action Points from Stakeholder Day

- Incentives for clinicians to identify key research Qs linked to enabling research, scholarly inquiry to be part of everyone's role (Group 5)
- A way of identifying who is available to help take research question forward(Group 5)
- Dragons Den for critiquing ideas and research questions (Group 5)
- Growing critical companions, leaders, mentors to support practitioners in the trust (Group 5)

Draft

3. Ensure the profile of departmental research activity is profiled within job advertisements & JDs 4. Establish small project grants scheme (c. £20k pot per annum) 5. Trial Dragon's Den approach to critique research ideas & explore linking to small project grants scheme 6. Review the impacts of the Trust's RSS & PPS schemes in 2017-18 FY on research capacity & capability in the Trust 7. Use the QIH, AHP Forum, K&MHP, KSS AHSN, ECPD, RDS-SE, CHSS, CRN KSS, HEKSS, EKHUFT staff who have completed postgraduate studies (Masters & PhD) to identify & grow expertise and/or mentorship in relation to a full range of specific research approaches (to include: action research, appreciative enquiry, phenomenology, ethnography, qualitative & quantitative methodologies) 8. Engage Libraries and Learning & Development to support R,I&I activity 9. Continue to support schemes to attract undergraduates to research (e.g. KentHealth Student Vacation Scheme) and to look for other similar opportunities in other HEIs 10. Increased joint appointments, in partnership with local HEIs, across a range of clinical academic models 11. Develop concept of 'Industry Study Champions' within each NIHR Specialty Group to act as primary point of contact 12. Gain intelligence from CRN KSS on returned EoIs as a means to quality assure the process	• Supporting the workforce to generate own inquiry questions to take forward (Group 5) • Marrying people across departments to work together (Group 5) • Establish Research as part of normal NHS service/practice • Enable more AHPs to develop and deliver research • Start in one area (e.g. Renal) and build up partnerships and then use as a base to explore other areas • To determine how to protect clinician research time • Utilise PhD / Masters students more strategically and effectively for the student, clinician, Trust, and HEI. * To provide more coordinated and consistent support for staff at all levels to avoid them feeling 'overwhelmed' by the notion of research **Align with partners** a. Start in one area (e.g. Renal) and build up partnerships and then use as a base to explore other areas b. To determine how to protect clinician research time c. Utilise PhD / Masters students more strategically and effectively for the student, clinician, Trust, and HEI. * d. To provide more coordinated and consistent support for staff at all levels to avoid them feeling 'overwhelmed' by the notion of research 1. * A PhD student could be a good resource to support staff who are new to research 2. To think about research facilitator / health researcher role to advise staff on the design of projects, to facilitate the project management of studies, and to coordinate the promotion of research across the Trust.

5. Infrastructure

Draft Strategic Objective 5	
To strengthen physical resources to successfully deliver our ambitions for R, I & SE over the next 10 years	
Data from Thematic Analysis from SWOT Analysis: • Capitalize on opportunities arising from developments in EKHUFT clinical information systems e.g. e-prescribing • Acknowledge & mitigate potential risks associated	**Sub-Objectives:** Realise the opportunities arising from clinical information systems development in EKHUFT & the local health economy as a resource to support delivery (e.g. identifying study participants) of

with current funding of pharmacy trials staff & infrastructure • Acknowledge how current working environment ('back office' & clinic space, for example) impacts on morale • Build links to national registries (e.g. dementia research registry) • To explore, with other NHS organisations in K&M, how we might pool expertise, staff, resources & infrastructure	research & data mining Explore opportunities for collaborative working, sharing of resources and potential for future joint appointments in areas of R,I&I that have been historically or currently challenging to recruit to e.g. clinical trials pharmacists Accommodation
Draft Milestones from SWOT Analysis: 1. To develop visible site-specific spaces for R, D & I activity linked to existing facilities (e.g. research team bases, QIIH Rooms, R&I Department, Libraries) 2. To re-develop existing space to provide high quality accommodation for research delivery staff, clinic +/- day case space, laboratory facilities etc., aligned to Trust strategy for delivery of clinical services 3. Benchmarking exercise around use of R&I accommodation & file storage 4. Open dialogue with other key NHS organisations in K&M regarding pooling of research delivery resources & infrastructure (i.e. core R&I teams, trials pharmacy teams)	**Action Points from Stakeholder Day** • To open dialogues / create pathways around key areas of infrastructure (e.g. statistics support) • To learn from Surrey Health Partners / other partnerships in terms of strategic approaches to research and its infrastructure in the Kent & Medway region • To utilise other agencies such as HEKSS to promote research as core part of medical training • Work with CCCU to embed research within nursing degrees • To create research leads – academic and clinical fellows who can lead, develop and support research projects and take research agendas forward **Align with our partners** a. To open dialogues / create pathways around key areas of infrastructure (e.g. statistics support) b. To learn from Surrey Health Partners / other partnerships in terms of strategic approaches to research and its infrastructure in the Kent & Medway region c. To utilise other agencies such as HEKSS to promote research as core part of medical training d. Work with CCCU to embed research within nursing degrees e. To create research leads – academic and clinical fellows who can lead, develop and support research projects and take research agendas forward

6. Funding & Incentives

Draft Strategic Objective 6	
To ensure growing & self-sustaining funding for R, I & SE in the Trust.	
Data from Thematic Analysis from SWOT Analysis:	**Sub-Objectives:** Have a strategy for determining priorities for funding

• Incentives for staff to be research-active e.g. through R&I department financially supporting relevant training opportunities • Addressing gaps left by narrow focus of external grant bodies and/or charitable funding • Raising awareness about funding bodies/charities/patient interest groups by working with relevant departments at CCCU/UoK • Grow further Industry study activity to deliver self-sustaining capability • Mechanisms to sustain funding for programmes of work: role for doctoral students	continuing professional development of staff involved in R,I&I activities Ensure that we effectively disseminate (both push & pull) all relevant funding opportunities to Trust staff Enable greater opportunities for collaborative bids to external funding bodie
Draft Milestones from SWOT Analysis: 1. Develop relationships with key local charitable funders (e.g. LoFs, EKHUFT Charitable Funds) to gain insight into mutual priorities and funding opportunities 2. Explore opportunities to link to local industries through KSS AHSN 3. In collaboration with Learning & Development, develop criteria & application process for staff wishing to apply for CPD funding supported by the R&I department 4. Use the QIH & social media (e.g. Twitter) to have a live feed of research funding opportunities 5. Develop an alert system through QIH, EKHUFT Twitter to forewarn experts/champions of funding opportunities that are relevant to their areas of interest 6. Tap potential of internal & external recognition of research achievements (e.g. support for honorary academic posts, external awards, Trust awards)	**Action Points from Stakeholder Day** • Capturing Innovation (working) with Industry >linking< with NHS • To determine a funding strategy (e.g. encourage individuals towards NIHR? Or charitable funds?) • To provide financial or status incentives around involvement in research (e.g. some type of recognition that the individual is valued for their research work) **Correct policies/standard operating procedures at Trust Level fit for purpose to facilitate Industry studies that:** • flex across departments where income/expenditure may not match at Departmental budget level i.e. cost savings in one Department but cost pressures on a different department • demonstrate visibility regarding distribution of payment • allow exceptions to standard HR staff recruitment processes to support rapid recruitment of staff, essential to maintain correct staff capacity to deliver complex trials with small eligible numbers of patients per trial (high and demanding workload) **Align with partners** a. To determine a funding strategy (e.g. encourage individuals towards NIHR? Or charitable funds?) b. To provide financial or status incentives around involvement in research (e.g. some type of recognition that the individual is valued for their research work) c. Perhaps the best way forward is to have an awareness of the funding bodies (again ideally mapped on to the key research areas), possibly with the deadlines and requirements. Then encourage individuals to do some work around this looking into the funding body themselves

	and becoming familiar with the process. This could act as a very good step to judging commitment and ability to progressing research ideas.

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6.3 Appendix C: Abbreviations

AHP	Allied Health Professional
AHSN	Academic Health Sciences Network
CCCU	Canterbury Christ Church University
CHSS	Centre for Health Services Studies, University of Kent
CI	Chief Investigator[6]
CRN	Clinical Research Network
CRN:KSS	CRN Kent, Surrey & Sussex
CTIMP	Clinical Trial of Investigational Medicinal Product
ECPD	England Centre for Practice Development
EKHUFT	East Kent Hospitals University NHS Foundation Trust
EoIs	Expressions of Interest
GCP	Good Clinical Practice
HEI	Higher Education Institute
HEE KSS	Health Education England: Kent, Surrey & Sussex
HR	Human Resources
HRA	Health Research Authority
IPR	Intellectual Property Rights
KCHFT	Kent Community Health Foundation Trust
KMHP	Kent & Medway Health Partners
NEDs	Non-executive directors
NIHR	National Institute for Health Research
PI	Principal Investigator[7]
PPI	Patient & Public Involvement
PPS	[EKHUFT] Pump Priming Scheme (Replacement for IPGS)
QIIH	Quality, Improvement & Innovation Hub
RAG	'Red, Amber, Green'
RDS-SE	Research Design Service-South East
REC	Research Ethics Committee
RSS	[EKHUFT] Research Session Scheme
UoK	University of Kent

[6] Chief Investigator and Principal Investigator are specifically defined within the context of CTIMPs. For the purposes of this strategy, we use the term 'CI' to denote an investigator who is leading a study, either with EKHUFT as a single-site (i.e. a "home-grown" study) or over multiple sites. We use the term 'PI' to denote an investigator who is responsible for delivery of study activities on an EKHUFT site, within the setting of a multi-centre study.

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