EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**8 APRIL 2016**
SUBJECT:	**CQC IMPROVEMENT PLAN**
REPORT FROM:	**CLINICAL CHAIR IPDB** / **CHIEF NURSE & DIRECTOR OF QUALITY**
PURPOSE:	**Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

- The Trust was put into special measures in August 2014 following a CQC inspection in March 2014 which rated the Trust overall as 'inadequate'.
- In response the Trust developed a detailed action plan based on the 21 Key Findings and 26 Must Do areas that were identified in the CQC report.
- The Trust underwent a re-inspection w/c July 13th 2015.
- On the 16th November 2016, the Trust received the findings of the re-inspection. With an overall improvement rating from 'inadequate' to 'requires improvement'.
- The Trust received a number of recommendations for improvement which form part of the new Trust High Level Improvement Plan (HLIP). This consists of 30 Must Do actions which each are aligned to a Committee with Executive level representation. This was formally submitted to the CQC on 14th December 2015.
- Divisional action plans with additional key findings are complete and were submitted to monitor January 2016.
- The Trust is assuming an inspection will take place 6 months after the Quality Summit – week beginning 16th May 2016 or thereafter. At the point of writing we have not received a date for our re-inspection.

SUMMARY:

Performance Review Meetings by a visiting Monitor team critiqued the improvement plan, NHS choices submission and progress of actions at both the February 2016 and 22nd March 2016 meetings. Emphasis was placed upon the need for the Board of Director's detailed appraisal of those 'Must Do' actions that may be delayed, with particular attention to those where financial constraints may undermine completion. The March NHS Choices submission demonstrated 9 work streams that are now additionally at risk of delay, rated from green to Amber (now 13 Green, 16 Amber, 1 blue - none Red):

- Recruitment and retention (MD08)
- Temporary and agency staff (MD22)
- Pharmacy staffing and strategy (MD23)
- Audit and Effectiveness (MD11)
- Urgent & Emergency Care (MD02) and Access and Operations (MD06)
- Environnent & Facilites (MD12) – Financial contraints;
- Complaints (MD26) – 30 day compliance target achievement;
- Workforce Culture (MD09)
- 7 Day services (MD25)
- Maternity (MD04)

- Mental Health (MD05) – potential delays in agreeing mid-long term commissioning model;
- Escalation Wards/Clinical Areas (MD29) –risk in recruitment and capital investment

Mitigation plans are in place for areas that are 'amber' although recruitment continues to be highly challenging despite a detailed set of actions in place, and Estates and Facilities' improvements are potentially undermined by financial constraints.

The Improvement Plan Delivery Board (IPDB) has undertaken the following activities since the last Board report in February 2016:

- Continued acknowledgement, commitment and communication of the Trusts primary objective to come out of special measures, following a satisfactory re inspection – 3 months' notice expected;
- CEO commitment to the IPDB and from February 2016 shares the chairing of the IPDB with the clinical chair;
- Responded to a request from the Monitor appointed Improvement Director for a clarified governance arrangement for the new plan, particularly in relation to the implementation of divisional improvement plans. The paper was updated and signed off at the 18th March IPDB;
- Fortnightly detailed divisional performance reviews with the implementation of a divisionally owned, self reported, electronic graphics 'donuts' to demonstrate progress upon divisional plans;
- Development of organisational CQC Key Performance Indicators; to be amalgamated into the revised Integrated Performance Report/Balanced Scorecard. The 'go live' date is April 2016;
- An interim Communications Plan has been developed – based around a theme of the fortnight ('Fortnightly Focus') with a supporting programme of speakers through the QII Hubs. Interview to 0.6 WTE communications support for the programme is due 30.3.16;
- Monthly Improvement visits to clinical areas continues. This has a publicised schedule and a proforma based on the CQC 'Key Lines of Enquiry' standards;
- Work is on-going to revive the site based teams and rebuild the Hub Teams – in particular on the Kent & Canterbury site – where many of original leads have moved onto other posts. A new team has been formed with multidisciplinary representation and the Hub is set to re-launch in April. Hub models are also being agreed for RVF and BHD.

RECOMMENDATIONS:

The Board is invited to discuss the progress to date and seek any further assurances that may be required;
To identify and risk assess the challenging elements of the plan (amber), acknowledging those areas where compliance is unlikely.

The Board of Directors is also asked to formally receive the March 2016 NHS Choices submission.

NEXT STEPS:

Monitoring of the actions will take place through the Improvement Programme Governance Structure (monthly Improvement Plan Delivery Board and weekly Improvement Plan Steering Group Meetings). At a divisional level monitoring will

take place via the Monthly CQC Improvement Plan Review Meetings and Executive Performance Reviews. The divisions have local structures in place for managing plans and disseminating to staff.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

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

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

SO3: Place the Trust at the leading edge of healthcare in the UK, shaping its future and reputation by promoting a culture of innovation, undertaking novel improvement projects and rapidly implementing best practice from across the world.

LINKS TO BOARD ASSURANCE FRAMEWORK:

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

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

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

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

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

Identified risks include:

1. Failure to deliver improvements in the Urgent & Emergency Care (MD02) and Access and Operations (MD06) work streams;
2. Failure to recruit and retain adequate numbers of clinical staff, particularly upon the emergency floor, necessitating continued high agency use;
3. Low staff moral, exacerbated by strategic uncertainty, financial constraint and variable clinical level leadership.

Management Actions are:

1. Support site based delivery of Emergency Care Recovery Plan, through local ownership and robust leadership which may require additional seconded internal staff backfill;
2. Publicise and action the recruitment and retention strategy; risk assessing hard to recruit to areas and communicating mitigation strategies;
3. Urgently deliver an evolving communications IPDB strategy; to engage staff and demonstrate improvements to date, and to prepare for the next CQC inspection.

FINANCIAL AND RESOURCE IMPLICATIONS:

Improvement initiatives that are successfully delivered and embedded into daily operations support the more effective and efficient use of resources.

Administration support has also been agreed and is to go through the Vacancy Panel on the 24/03/16. Interviews are being arranged in relation to interim communications support w/c 28th March.

Some 'must do' actions require expenditure such as those relating to the Estate and Facilities in the Trust.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

The Trust is currently in breach of its Licence with Monitor by virtue of being placed in Special Measures.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

None.

ACTION REQUIRED:

(a) To discuss and note

CONSEQUENCES OF NOT TAKING ACTION:

The Trust may remain in Special Measures and in breach of its Licence.

Special Measures Improvement Plan Update

East Kent Hospitals University NHS Foundation Trust

Date of Report: 10th March 2016

Date of Reporting Period: February 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.

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: 10 March 16
Chief Executive Name: Matthew Kershaw	Signature:		Date: 10 March 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.* *MD30 – The Medicines 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 - March 2016	A System to monitor the safe management of medicines and IV fluids according to national guidelines is designed. Monthly audit tool has been strengthened. This is a multi-professional piece. 87% average audit performance as of 15th February 16. Continued weekly monitoring with pharmacy and nursing lead oversight. Risk assessments undertaken for areas of concern (Feb 16). An environmental audit has taken place to inform where investment is needed for storage. Noradrenaline standardised prescribing policy agreed and to be rolled out to all areas for 1st March 16. Compliance will be monitored. External assurance will be required by the CCGs	Green: On Track **Status of previous reporting month (January 16) - Green**
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)	Over 138 Registered Nurses have been recruited since July 2015. The Trust as of the end of January is carrying a 13% vacancy factor in nursing. The ward staffing establishment review was presented to the Strategic Workforce Committee in January 2016 and the Board of Directors in February. Workforce plans and recruitment and retention plans are in place. Safe Staffing reports for nursing are reported every month to the Board. Dedicated recruitment campaigns continue for Consultant staff, AHPs and Pharmacy staff where higher vacancy rate. Work has been initiated to look at 'retention' initiatives for hard to recruit staff (part of Recruitment Strategy 15-18). Overseas Nurse Survey being undertaken to help inform next recruitment. Some slippage regarding induction and exit interview strategy (March 16). External assurance will be required by the CCGs	Amber: Possible delays given recruitment challenges. Concerns remain around the ability to recruit sufficient Consultant staff in the Emergency Departments, Pharmacy and Therapy staff due to national supply. Ability to recruit overseas nurses a risk due to changes in ELTS (English Language qualification). **Status of previous reporting month (January 16) - Amber**
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	The Trust has enlisted the help of Maidstone & Tunbridge Wells NHS Trust Emergency Planning Team. In December 2015 a major incident test took place. The outputs of this are being analysed at present. The Policy is being updated. On 22nd March a full table top exercise will be conducted led by external partners. Training DVD has been re launched. 2139 staff trained since April 15. Emergency Planning Annual Report presented to the Trust Board. External assurance is being required from NHSE	Green: On Track **Status of previous reporting month (January 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 has been 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 (from 2), inline with UK Core Skills Training Framework. Trajectory will be refreshed for end of March in light of this and will improve compliance. The Safeguarding website is being reviewed to ensure staff can access clear and concise information as needed. Training has been scheduled in the QII Hubs on MCA and DoLS; 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. 1200 clinical staff have received training this year (L1 and L2). The CCG Contract Quality Metrics require reporting of training numbers.	Green: On Track **Status of previous reporting month (January 2016) - Green**
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 has been developed to be presented to the Policy Compliance Group and Children's Safeguarding Board in February 2016. There has been some slippage from the original deadline of January 2016. Revisions to the Policy are required . To go back to March Policy Compliance Group. The Kent & Medway Children's Safeguarding Board require assurance and receive this via the Board's work.	Amber: Slippage in the Policy being signed off from January to February 16. **Status of previous reporting month (January 2016) - Green**
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 -On going	Appropriately competent specialist staff are appointed to the areas requested. Local induction is in place for agency staff who work on the wards and environments. NHSP staff undertake the Trust induction programme. Work to ensure compliance against this standard has yet to be undertaken although a plan has been agreed. Deadline is March 2016. RAG status amended to reflect slippage to programme. External assurance is being requested by the CCGs	Amber: Slippage in programme but plan in place. **Status of previous reporting month (January 2016) - Green**

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, but at present at the end of January the pharmacy department is carrying a 28% vacancy factor for qualified staff and 12% for non qualified. The Department have taken part in the 'Safer Start' initiative during January and have tested out prioritising those being discharged to reduce delays. A review of Pharmacy Workforce requirements is being undertaken, the outputs of which will also inform the delivery of the Trust Clinical Strategy. The TDA Medicines Optimisation Framework (2014) is being adopted by the end of March 16 to measure improvement in key metrics.	Amber: Possible delays difficulties in recruiting and retaining Pharmacy staff is the major risk to this action. National/regional shortages of Pharmacists. **Status of previous reporting month (January 2016) - Amber**
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 (January 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 - January 2016	The Quality Committee (Board Committee) have requested an action for the Trust to review the processes and systems around the audit programme and also a review of the effectiveness of the monitoring and delivery of action plans relating to audits. An Internal Audit of divisional engagement and governance started 20 February 2016 The 16/17 Clinical Audit Plans are in draft for each division for presentation at the Clinical Audit and Effectiveness Committee at the end of March. Work is on going to ensure that all staff see the benefit of audit on patient care and as part of their role. Clinical leadership will be pivotal in ensuring that Audit Plans are monitored and that action plans are implemented. There is executive leadership from the Medical Director. Internal audit assurance is at the planning stage with an anticipated start in March 2016	Amber: Possible delays to audit programmes being agreed. They will then require regular monitoring to ensure compliance. *Expected delivery March 2016* **Status of previous reporting month (January 2016) - Amber**
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 April 2016.	Sessions held in QII hubs to agree approach for environment sessions, process developed with joint matron/estates and sessions being held in Feb for 16/17 finance bids. Mapping being undertaken to review storage, patient and staff facilities so that work required can form part of the work plan. Consultation has closed regarding availability of estates team. Team to be available for extended hours 7 days per week. This will also increase capacity for planned maintenance. Work on-going to develop Estates Web Portal for reporting jobs and monitoring progress. HSE are working with the Trust at present to ensure compliance to essential standards.	Amber: Possible delays *given the financial position of the Trust this may place an element of risk on the plan. Divisional Plans presented at February 16 Trust Board. Investment to be prioritised based on risk.* **Status of previous reporting month (January 2016) - Amber**

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. A business plan is being written to ensure the EME department is appropriately staffed to meet the compliance targets outlined. The deadline for this has slipped from February but will be completed by the end of March 16. No external assurance is being sought at present.	Amber: Possible delays *Financial risk around capital (although prioritisation of programme based on risk/clinical need) and revenue (sufficient staffing levels in EME to meet the target trajectory for maintenance).* **Status of previous reporting month (January 2016) – Amber.**
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 External assurance is provided via the Trusts external Authorised Engineer.	Green: on track (evidence to be uploaded and then status can become blue). **Status of previous reporting month (January 2016) - Green**

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 are being risk assessed by the end of January 2016 to gain an accurate picture of all aspects of safe care required. The model of care for St Augustine's Ward is being reviewed. To be agreed by the end of March 16. The environment has been reviewed and £100K capital agreed for required improvements. Funding agreed for Cheerful Sparrows Beds. Divisional Head of Nursing for Surgery leading on recruitment.	Amber: Delay to approval to recruit staff in some areas. **Status of previous reporting month (January 2016) - Amber** .
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- March 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 (target completed date – April 16). The dementia team and learning disability Practice Development Nurse are reviewing tools for the use of patients with dementia and learning disability (target completion date – June 16). 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.	Green: On Track **Status of previous reporting month (January 2016) - Green**
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 is still significant work to do to improve the response time within 30 days. A trajectory for improvement will be discussed and agreed by the Complaints and Patient/Carer Feedback Group. Q3 compliance of complaints responded to within 30 days is 33%. 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. No external assurance or support being sought.	Amber: Some slippage to programme (risk relating to resource within Patient Experience Team). **Status of previous reporting month (January 2016) - Green**

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. 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 has been circulated. The Safer Care Bundle will be launched on the 22nd February with main focus on the WHH site. Information has been improved to support predicted admission and discharges from each site and a revised dashboard is now in place. The Clinical site Operational Leads have tested processes and the learning will be used to replicate better practice ECIP Support is in place and multi partner support via the SRG	Amber: Slippage against some milestones in ED Recovery Plan **Status of previous reporting month (January 2016) - Green**
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 April 2016.	Clinical Divisions are assessing 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. No external support or assurance requested.	Amber: Possible delays given financial and recruitment implications of full 7/7 therapy and pharmacy services. **Status of previous reporting month (January 2016) - Amber**
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).	The Cultural Steering Group is embarking on the next steps of the programme through initiatives to ensure the appraisal system and recruitment processes embed the Trust values. Staff recognition initiatives are being piloted. This work will form part of the Trust's Trust wide leadership development plans currently being scoped. Annual Staff Survey results have been received. Improvements noted in many areas although considerable work still to do in relation staff experience in relation to bullying and harassment. There is slippage against timescales for the OD Strategy and Communications Plan (although work is being undertaken around local messaging using the Hubs). 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: Some slippage against milestones **Status of previous reporting month (January 2016) - Green**

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 due end of June 16.	The Clinical Forum meetings have continued and have focussed on developing out of hospital models. This has been supported by provider organisations who are both providing and triangulating in hospital data to better understand the type of activity that will be managed out of hospital future models of care. 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 Sustainability and Transformation Plan (STP) is due at the end of June 2016. The Trust has a significant clinical engagement event planned for 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. External collaboration is central to this item and is in place.	Green: On Track **Status of previous reporting month (January 2016) - Green**
MD16 –The Trust governance arrangements are clear and transparent	December 2015 - March 2016 (with interim measurable milestones)	The outputs of the external governance reviews have been implemented. An evaluation of the new governance arrangements is outstanding as is a review of staff understanding of the arrangements. External support not required.	Amber: Some slippage against milestones **Status of previous reporting month (January 2016) - Green**
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 and Lessons are learned and communicated widely to support improvement in other areas as well as services that are directly affected.	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. Change registers are in place in the Divisions. Learning is shared in a variety of ways across the Trust and new ways of sharing learning are being explored. The Trust is migrating to Internet Explorer 11 and there may be compatibility issues with the current version of Datix V12.3. Dates are being confirmed to implement Datix V14 and funding for the upgrade identified. External support is not required and external assurances are not being sought.	Green: On Track **Status of previous reporting month (January 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)	A system has been purchased to provide assurance that staff have accessed and read policies relevant to their role. In order for this to work effectively, the system must be configured and linked with SharePoint and a member of staff must be nominated to work on this project. External support is not required.	Green: On Track (although risks to June 16 completion without dedicated support due to revisions required in process). **Status of previous reporting month (January 2016) - Green**

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 March 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	The End of Life Board meets bi monthly chaired by the medical director. 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. Link Nurses have been nominated. A draft wrap around End of Life Multiagency Strategy is also being developed with a completion date of March 2016. A draft has been received as of 22nd January 16. A carers survey has been initiated in January. Very positive results received so far. EoL Facilitator post has been advertised although lack of interest at present. External support is not required and external assurances are not being sought.	Green: On Track **Status of previous reporting month (January 2016) - Green** .
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 current focus in month has been on safe and effective discharge, senior decision making and leadership in ED and improved site management. The ED Recovery Plan has been updated to reflected the HLIP and vice versa (February 2016). Work has commenced on defining the ECC model with a due date of June 2016. 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. There is some slippage against programme schemes and risks. A nursing review is outstanding and there are continued risks regarding the ability to recruit to medical vacancies although 9 senior grade/consultant offers have recently been made. ECIP Support is in place	Amber: Some slippage against the ED Recovery Plan. **Status of previous reporting month (January 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.* *MD14 - There are sufficient numbers of paediatric trained staff within Emergency and Urgent Care Pathway to ensure that children and young people receive effective care and treatment to meet their needs.*	December 2015 - March 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Recruitment and retention plans are in place to ensure appropriately trained staff are in place. Recruitment of paediatric nurses in the ED is almost complete to enable 24/7 cover. At present cover is provided 0730-2000 7 days per week. At the QEQM there is a vacancy of 0.2 WTE to fill to ensure 24/7 cover. All vacant posts have been offered at the WHH (in addition to the 2 RNs on 0730-2000) to enable 24/7 cover. All recruits should be in place for the end of April 16. A nursing review to be undertaken to ensure establishment is correct.	Green: On Track **Status of previous reporting month (January 2016)- Green**
Maternity Services *MD04 - The Trust offers safe, effective, caring, responsive and well-led maternity services*	April 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	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 report was received on the 18th February. Actions will need to be incorporated into the improvement plan. The deadline for embedding the new maternity dashboard has slipped and will be in place for the end of March 16.	Amber: Some slippage against milestones **Status of previous reporting month (January 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).	Birth-Rate Plus is currently in progress with reporting on the 1st March 2016. Recruitment of midwives has been undertaken. The Trust assesses staff requirements on a shift basis and addresses any shortfalls that occur with temporary staffing. The number of closures of the maternity unit has reduced. A database has been put in place to record the number of diverts and closures to the unit and a revised policy circulated for comment. The review of demand and capacity for the unit is outstanding with a revised date of end of March 16.	Green: On Track **Status of previous reporting month (January 2016) - Green**
Mental Health *MD05 - Patients receive timely mental health assessment and have appropriate facilities whilst waiting.*	December 2015- April 2016 (agreed with partnership stakeholders on 04/12/15).	An interim solution is in place (additional liaison support as a pilot) funded via winter pressures funding until March 16. Metrics are being collected and a partnership working group has convened to review the service model needed following the pilot . This has been completed and a plan is in place for mental health liaison for 1617. Work is being taken forward via the Surge Resilience Group. An internal SOP will be written by the end of March (escalation of specialist referral and safe care of patient whilst waiting for input). KMPT (MH provider) and all CCG Accountable Officers	Amber: Possible delays to commissioning of adequate mental health services. **Status of previous reporting month (January 2016) - Amber**

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 (January 2016):

Following submission of the High Level Action Plan (HLP) to the CQC on the 14th December 2015, a programme of work has been in place to support the development and sign off of Divisional (and speciality/site based) Plans. A series of workshops have been held with the Divisional Leads. The Divisional Plans were signed off at the Improvement Plan Delivery Board (IPDB) on Friday 22nd January 2016. The reporting cycle has been refreshed and will be overseen by the Programme Office.

A Quality Improvement Facilitator has been appointed into the Programme Team. A regular programme of Improvement Visits has been established and the template embedded in operational process.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS**

DATE: **8 APRIL 2016**

SUBJECT: **TURNAROUND DIRECTOR**

REPORT FROM: **DIRECTOR OF FINANCE AND PERFORMANCE**

PURPOSE: **Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

Turnaround Programme progress update

EXECUTIVE SUMMARY:

At a glance

- The M11 financial position is a deficit of £31.6m. The year-end forecast is £36.4m
- The cash flow forecast shows a positive position at the year-end of c.£3m
- Month 11 YTD CIPs are ahead of plan by £1.3m delivering £15.2m (Rec 11.1m, 73%) against plan of £13.9m
- FY15-16 CIPs are also forecast above plan to deliver a risk adjusted £16.3m (Rec £11.3m) against a plan of £16.2m
- Under-delivery of £3.3m in the Clinical efficiency and Workforce workstreams has been more than compensated by additional non-recurrent and recurrent CIPs
- Specialist support from external specialists working closely with Trust teams to provide the capacity and capability to deliver efficiency savings of c.£5m identified in the key workstreams of Theatres and Outpatients.
- Diagnostic work done in two further key areas has identified savings opportunities of c.£1.5m-£2m in Patient Flow and c.£1.5m in Workforce
- Proposal for implementation support agreed by the Executive Team to be progressed for business case approval by Monitor.
- Overall pay trend shows a reduction to £27.1m compared to previous month and the average of £27.5m since Oct-15
- Agency spend has continued to reduce for the fourth successive month to £2.4m
- Significant operational pressures increasing agency costs from additional escalation beds
- Both agency and substantive pay in February is lower than previous months
- VCP controls resulting in a significant reduction in employment offers
- If this trend continues the combined reduction in substantive and agency pay costs will result in an overall pay cost reduction month-on-month
- The average monthly trend for non-pay costs of £17.1m is unchanged
- Factors causing upward cost pressure on run-rate:
  - Escalation beds from high emergency demand driving additional agency spend
  - Pre Dec-15 recruitment 'wave' impact increasing substantive pay costs
  - Need to improve A&E and RTT performance
  - Under-delivery of £3.3m in Clinical efficiencies and Workforce recurrent CIPs
  - Increased spending on additional session payments and independent sector work

- Continued focus on reducing the monthly run-rate of expenditure by combating the adverse cost impact of the above drivers.

- Actions taken to reduce monthly run-rate expenditure include:
  - Agency and management costs reduction of £0.66m remain on target
  - Additional run-rate reductions of £1.0m in Q4 this year remain on target
  - Support from clinical efficiencies specialists continues to progress at pace with focus on opportunities in Q1 to help reduce the run-rate
  - Agency Control Group to reduce agency spend and set a downward trajectory
  - Vacancy Control Panel (VCP) to apply strict controls and help reverse the impact of the pre Dec recruitment 'wave' and reduce substantive pay costs from Q1 next year.

- FY16-17 CIP target £20m
- As at 21 Mar-16 plans in development £25.3m (gross), risk adjusted to £15m
- A further £4.2m of income schemes have also been developed
- Focus on 8 key transformation schemes that provide a high level of recurrent savings (Theatres, Patient flow, Outpatients, Medical productivity, Agency and Workforce, Procurement, Medicines Management)
- Divisions presented their detailed plans on 21 March and further work is required in some key workstreams to finalise fully developed and signed-off plans that are ready for implementation
- PMO re-organised from 1 April saving £350k p.a.
- Resources to be focused on providing delivery support to the Divisions
- Decision required urgently on the make-up of the delivery team to provide support to Divisions from 1 April.

Overview

The CIPs savings this year are expected to deliver slightly ahead of plan (£16.3m vs £16.2m). However, this has been achieved by compensating for the shortfall in recurrent savings by non-recurrent measures of c.£5m.

For FY16-17, the approach is to focus on 8 key transformation schemes with significant recurrent savings opportunities to deliver the £20m CIPs target. With the specialist external support now in place the Trust is in a strong position to deliver these savings.

As at 21 Mar-16 FY16-17 CIPs plans in development were £25.3m (gross) which were risk adjusted to £15m. A further £4.2m of income schemes have also been developed which are being reported separately to reflect the prudent view being taken until the outcome of contract negotiations with the CCGs is known. A significant number of additional plans continue to be worked on.

The overall pay trend at M11 shows a reduction to £27.1m compared to previous month and the average of £27.5m since Oct. Both agency and substantive pay in February is lower than previous months.

Agency spend has continued to reduce for the fourth successive month despite significant operational pressures in Feb which has necessitated additional agency spend. For substantive pay costs there is a significant reduction in employment offers.

If this trend continues, a reduction in substantive pay costs combined with the downward trend in agency will manifest itself in an overall pay cost reduction in the coming months. Therefore, it is expected that the run-rate will begin to come down from Q1 next year.

Delivery capability and Sustainability

The Trust has put in place the specialist delivery support from Four Eyes in the clinical efficiency schemes with implementation starting from this month. Diagnostic work done in two further key areas has identified savings opportunities of c.£1.5m-£2m in Patient Flow and c.£1.5m in Workforce (Clinical Admin). A proposal for implementation support for these two workstreams has been agreed by the Executive Team to be progressed for business case approval by Monitor which is expected to take a further 6 weeks before the Trust can proceed to implementation in mid-May at the earliest.

The PMO is being re-organised from 1 April to a smaller team of two and focus more resources in providing delivery support to the Divisions. A decision by the Executive Team is urgently required on the make-up of the delivery resources so that the Divisions have the delivery support they need to from 1 April.

A key priority for the Trust is to develop its Sustainability Plan that describes how it will develop its own delivery capability and ensure the transfer of skills for continued delivery of benefits from the substantial investment it has made in engaging external support.

Clinical and Staff Engagement

At the second meeting of the Clinical Engagement Steering Group (CESG) on 8 Mar-16 Dr. Andrew Smith was elected as the new Chair and Dr. Matt Jones as Deputy. Now that the group has been established it is expected that momentum will build and key ideas that influence positive clinical change are to start emerging from this group.

Key Issues and Risks:

- Continued and increasing reduction in monthly pay and non-pay run-rate expenditure
- Capability and on-going sustainability to deliver transformation savings

RECOMMENDATIONS:

The Board is asked to discuss the report.

NEXT STEPS:

The Turnaround and Transformation programme will take time to deliver. High emergency demand is exerting significant upward cost pressures slowing down the momentum of run-rate costs reductions. However, the Trust is taking the right actions going forward to deliver recurrent CIPs by focusing on a few key transformation schemes, engaging delivery support and continuing to take proactive actions to reduce the run-rate of expenditure in a sustainable manner to ensure the balance of priorities between quality, operational performance and finance is maintained.

The key priorities are:

- Managing cash
- Increase the reduction in the monthly run-rate of expenditure
- Complete FY16-17 CIPs plans to achieve £20m target
- Deliver Clinical efficiency schemes
- Commission delivery support for Workforce schemes
- Enable Clinical Engagement Steering Group (CESG) to provide clinical leadership for

the programme
- Sustainability - develop internal capability through coaching and development

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Financial sustainability underpins all of the Trust's Strategic Objectives.

LINKS TO BOARD ASSURANCE FRAMEWORK:

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

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

The Trust's Financial Recover Group is tasked with ongoing scrutiny of the turnaround programme. Detailed scrutiny is also undertaken by the Finance and Investment Committee.

FINANCIAL AND RESOURCE IMPLICATIONS:
The Trust will not be able to deliver financially, clinically and operationally sustainable services.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

N/A

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

N/A

ACTION REQUIRED:
(a) Discuss and note

CONSEQUENCES OF NOT TAKING ACTION:
The Trust will not be able to deliver financially, clinically and operationally sustainable services.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**8 APRIL 2016**
SUBJECT:	**EMERGENCY RECOVERY PLAN REPORT**
REPORT FROM:	**CHIEF OPERATING OFFICER**
PURPOSE:	**Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

This paper provides an update to the Board on the progress being made against Emergency Recovery Plan and should be read in conjunction with the Key National Performance Targets report.

SUMMARY:

This paper outlines performance trends against the 4 hour standard over the last 12 weeks and identifies the progress made against the Trust Emergency Recovery Plan.

- The Trust and the system is currently not achieving the agreed trajectories in respect of performance against the 4 hour standard and the complex discharge improvement trajectories and recent weeks continue to decline in performance in these areas.

- The number of programme RED RAG actions remains high although this continues to reduce.– Continued Executive lead focus is required to maintain momentum.

- The ERP programme is being reviewed and refreshed following agreement by the UCPB, supported by Sue Lewis from Monitor. The plan will be updated to include all CQC relevant improvement actions and will include clear cross referencing. This review will be completed by mid-February.

- The Trust's CEO has identified 3 key areas of high impact focus to ensure consistent achievement of 90% by March 2016 as follows:

  (a) Establishing a permanent site/divisional management appointments.
  (b) Rapid roll out of the SAFER Patient flow bundle
  (c) Rapid improvement of systems and processes within the ED Departments

RECOMMENDATIONS:

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

NEXT STEPS:

The revised emergency recovery plan will be presented to the Trust's Urgent Care Programme Board and Management Board in February.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

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

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

LINKS TO BOARD ASSURANCE FRAMEWORK:

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

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

All these standards are being closely monitored and mitigating actions are being taken where appropriate (in collaboration with the whole health economy)

FINANCIAL AND RESOURCE IMPLICATIONS:

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

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

None

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

N/A

ACTION REQUIRED:

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

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

Update on the Priorities for Emergency Care

21st March 2016

Introduction:

"The NHS Constitution sets out that a minimum of 95% of patients attending an A&E department in England must be seen, treated and then admitted or discharged in under four hours" - East Kent Hospitals University Foundation Trust (EKHUFT) has not achieved the required standard since August 2014.

Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
94.7%	94.5%	93.8%	92.4%	95.1%	92.9%	92.8%	90.7%	88.4%	88.8%	88.2%	87.6%	89.3%	88.3%	88.0%	86.5%	88.5%	87.5%	87.0%	89.4%	87.8%	84.9%	79.9%

As a result of this failure of a constitutional standard, the Trust is in breach of its licence and Monitor has required the Trust to comply with a number of undertakings. EKHUFT is also subject to a contract performance notice from our commissioners.

EKHUFT has over the past year(s) developed a very comprehensive recovery plan, which over time has been "managed" as a single plan, site based plan and a system plan. However, directly linking the actions to a measured improvement has been difficult until a bespoke "dashboard" could be developed. This "dashboard" (Appendix 1) has indicated that specific actions are required to ensure that there is improvement with regard to:

1. Processes within the emergency department – measured by time to be seen by first clinician (within 1 hour)
2. (Recruitment of nursing staff within the emergency department)
3. Improved patient flow – measured by total admissions with a length of stay over seven days(LOS), time of discharge and numbers discharged that required support (IDT metrics)

EKHUFT, along with all health and social care partners within east Kent, is currently part of a national Emergency Care Improvement Programme support by the Emergency Care Intensive Support Team. As part of this programme a number of key priorities have been agreed for the system:

1. Pre Emergency Department actions
2. Improving leadership in the emergency department
3. Implementing the SAFER flow bundle
4. Developing an effective Medical model
5. Effective site management

The content of this paper provides an update on each priority and describes the support offered from the ECIP programme. In addition, there is reference to the bed capacity modelling that took place in 2015/16 and links this to the current work on improving patient flow.

Priority 1: Pre Emergency Department

This priority was recognised for our external colleagues to agree to a number of actions that could reduce the need for the public to attend the emergency department.

Key issues identified:

1. Rapid Response / intermediate care team capacity
2. Limited mitigation for increasing 999 and 111 demand
3. Handover delays resulting in impact on response times

Actions that have worked so far?

- Surge resilience (winter) funding allocated to increase Rapid Response capacity
- Reductions in conveyance through managing 999 responses differently and, in some parts of the area, paramedic home visiting.

Actions that have not worked and why?

- Recruitment to Rapid Response team has been problematic due to the fixed term nature of the posts
- (Varied uptake of IBIS by CCGs – key enabler for further conveyance reduction (is this the issue or is this about single clinical record?))
- Reduction in conveyance is suggested that those attending would lead to an increased acuity/case mix in the emergency department.

Additional actions being taken, by when?

- Review of Rapid Response Team capacity and patient pathways across East Kent to redesign current service model – CCGs and KCHFT by May 2016

What impact with this have, by when?

- Consistent access to Rapid Response Team across east Kent.
- Provision of access to urgent community support across all 3 EKHUFT sites

Priority 2: Improving Leadership in the Emergency Department

Key issues

1. Need to develop consistent assessment models
2. Lack of required medical and nursing workforce

Actions that have worked so far?

- Piloting of See & Treat, RAT Assessment Model and Early Severity Index (ESI) has been supported by ECIP
- Overseas recruitment campaign for nursing and medical staff and recruitment incentives for medical staff

Actions that have not worked and why?

- Consistent roll out of See &Treat and RAT affected by regular Emergency Department overcrowding, (restrictions at WHH by the building work) and staffing issues
- Availability of quality locum and agency middle grade medical staff and nursing staff agency (especially at QEQM)

Additional actions being taken, by when?

- Enhanced nursing leadership – current and April onwards
    - ECIP support to both WHH and QEQM teams
    - Secondment of a senior A&E nurse (2 days per week) to QEQM
    - Agreed roles and responsibilities confirmed at WHH (in relation to escalation in the dept.)
    - Confirmed head of nursing site focus at WHH and QEQM.
- Roll out and implementation of ESI, RAT and See &Treat across WHH and QEQM – current
- Implementation of new middle grade doctor rota aligned to demand profile - from April 16
- Consideration of alternative roles in the emergency departments – Physicians assistants and possibly nurse consultants that could reduce the reliance on doctors. Implementation plan to be reviewed in May 16.

What Impact will this have an by when?

- Improved performance against the 1 hour to first assessment standard

Further issue raised:

- There is still a need to use nursing agency in the emergency departments and the CDUs on both sites. It has been highlighted that particularly at QEQM one agency provider has a limited fill rate and there have been a number of shifts cancelled at short notice.

Priority 3: Implementing SAFER Flow Bundle

Additional actions being taken, by when?

- Review of the IDT by Four Eyes Insight (in collaboration with CCGs) – draft report received
- SAFER patient level review initiative commenced 22nd Feb and is on-going
    - Daily inpatient board rounds/ ward reviews on all sites
    - WHH – Cambridge L ward
    - QEQM – Minster ward, St Augustines ward..
- Re-launch of SAFER project supported by ECIP and included 10 by 10 initiative
- Implementation of Full Hospital Protocol/Boarding Policy – 7th March
    - This has been implemented on wards that have been risk assessed
- Implementation of Direction of Choice Policy - 7th March
    - Training of all staff is now required across the Trust
- Community Geriatrician support to ensure MDTs have access to senior medical review. In place by May 2016.
- Review of IDT working - KCHFT workshops supported by KCC transformation partner Newton Europe, daily integrated wash-ups, regular site IDT management meetings to share good practice, memorandum of understanding

What impact with this have, by when?

- The initial impact is a reduction in the number of medical outliers in surgical beds (allowing trauma admissions at WHH).
- The plan is to improve the daily discharge profile across all three sites – increase % discharge before 10 to 20% and before 3pm to 66%
- Community Geriatrician will provide senior medical review of all patients in the 92 Community Hospital beds. Will improve patient flow and ensure discharges are expedited more quickly than they are now. Will reduce LOS. By June 2016.

Priority 4: Developing an effective Medical model

Key issues

- Lack of sufficient number of acute physicians to provide 8am to 8pm – 7 days a week on all three sites
- The Emergency Care Centre model at Kent and Canterbury is currently being reviewed, with a need to resolve the model in order to support the medical trainees
- WHH – no identified location for "hot" ambulatory care

Actions that have worked so far?

- Strong clinical leadership and model at QEQM – Mon to Friday.
- Redefined areas and roles and responsibilities at QEQM and implementation of nurse led discharge at QEQM.

Actions that have not worked and why?

- Protection of Ambulatory care capacity when bed capacity under pressure
- Difficulty in recruiting Acute Physicians

Additional actions being taken, by when/whom?

- Agreed models are being developed on each of the three sites
    - Weekly project meetings taking place
- Combining acute physicians with specialist teams to implement an interim model – April 16

What impact with this have, by when?

- Increase in medical % of patients discharged within 24 hours and more treated and discharged within 3 days

Priority 5: Effective Site Management

Appendix 2 contains a summary presentation for the plans for site management.

Key issues

- Interim and seconded appointments
- Escalation needs to be embedded

Actions that have worked so far?

- Established Operational Control Centres and appointed seconded site based Heads of Clinical Operations
- Site management being a corporate operational team instead of being part of UC&LTC

Actions that have not worked and why?

- Need to review roles and responsibilities of all senior roles out of hours.

Additional actions being taken, by when/whom?

- Advertise for substantive site team appointments – March 16
- Confirm all roles and responsibilities of the current people in post – March 16
- Implement ECIP RESPONSE site management model linked to SAFER – March 16

What impact with this have, by when?

- Improved site management and consistent implementation of escalation policy

Bed Modelling and aim to reduce the number of additional acute inpatient beds in use.

This year EKHUFT developed a comprehensive bed model (Appendix 3) that indicated that there was a short fall in acute capacity even when contingencies had been applied.

It has been agreed by the Surge Resilience Group (SRG) that this work will be repeated for 2016/17 and more work will be done to evaluate capacity outside of the acute hospitals, which would include teams that can support people in their own homes.

The SRG listed a number of actions that would potential close the gap in acute beds and we will be working through these in order to identify impacts they may have had in order to develop a robust plan for 16/17. .

EKHUFT:

- Rapid Frailty Model Implementation – update needed.
- Establish Surgical Assessment Unit at QEQM – update needed .
- Focus on embedding SAFER Flow Bundle (Priority QEQM)
- Fund discharge lounge at K&C linked to St Lawrence Ward – actioned but St Lawrence could not be staffed?
- Impact of new Site Management Arrangements – HoCOps – implemented
- IDT Improvement including impact of line management changes.- implemented
- Implement consistent consultant triage of GP phone calls. – update
- Inter-hospital transfers to utilise K&C capacity. – not implemented .

- Strengthening clinical leadership in Urgent Care with aligned project support. – update required.

SYSTEM:

- System focused drive to reduce number of medically fit patients in acute hospitals. – update required.
- Commission additional community bed capacity (PW3?).
- Commission additional social care package capacity.- not actioned only PW1 capacity that was built up gradually from 9 per day to 17 per day
- Agree increased flexible of existing community and social care bed capacity. – update required
- Possible targeted actions focused on expected increase in respiratory patients. – update required
- Intelligent and further reductions in conveyance by Ambulance service
- Urgent actions to improve MH capacity and response – update required
- ECIP support aligned to priority areas – actioned
- Further prevention actions/role of LRU – update required.
- Increase provision of support to Elderly in homes – update required.
- Influence profile of GP expected attendances – not actioned

EKHUFT will now be working through a plan to improve patient flow and aim to reduce the current number of extra beds in the hospitals.

APPENDIX 1- Dashboard

Emergency Care Recovery Plan KPI Dashboard

Economy-Wide Metrics

	Week End:	27 Dec	03 Jan	10 Jan	17 Jan	24 Jan	31 Jan	07 Feb	14 Feb	21 Feb	28 Feb	06 Mar	13 Mar
Overall Compliance													
ED - 4hr Compliance (%)	Actuals:	91.31	85.16	83.58	87.27	84.87	84.35	80.75	79.13	78.13	81.37	84.67	76.59
	Trajectory:	89.30	89.30	89.30	90.90	90.90	90.90	90.90	91.40	91.40	91.40	91.40	93.30
Improve Leadership in ED													
ED - Total Attendances	Actuals:	3,438	3,891	3,887	3,756	3,786	4,082	4,127	4,005	3,902	4,107	4,130	4,613
ED - Major Attendances	Actuals:	1,395	1,598	1,623	1,538	1,614	1,638	1,731	1,599	1,575	1,653	1,692	1,963
ED - Minor Attendances	Actuals:	2,043	2,293	2,264	2,218	2,172	2,444	2,396	2,406	2,327	2,454	2,438	2,650
ED - Total Breaches	Actuals:	294	578	638	472	570	629	792	832	848	765	629	1,003
ED - Major Breaches	Actuals:	268	507	585	431	525	554	713	767	783	697	562	905
ED - Minor Breaches	Actuals:	26	71	53	41	45	75	79	65	65	68	67	98
ED - 4hr Major Compliance (%)	Actuals:	86.65	78.03	74.38	80.27	75.83	76.99	70.30	67.99	66.28	71.76	76.83	63.35
ED - 4hr Minor Compliance (%)	Actuals:	98.11	95.53	96.69	97.31	97.18	95.35	95.39	95.91	95.82	95.85	96.00	94.60
ED - Ambulance Triage < 15 mins (%)	Actuals:	93.76	96.72	96.12	95.16	94.26	95.29	95.89	95.05	92.92	94.30	93.51	90.86
ED - Clinician Seen - 1st Assess. < 1hr (%)	Actuals:	49.86	42.09	46.50	49.83	44.96	41.48	39.07	44.60	43.48	41.79	43.63	40.28
	Trajectory:	48.00	48.00	48.00	50.00	50.00	50.00	50.00	52.00	52.00	52.00	52.00	54.00
ED - Decision to Admit < 2 hrs (%)	Actuals:	23.27	17.19	17.91	28.26	18.38	19.02	21.50	16.55	11.66	9.68	17.09	7.19
ED - Seen by Specialist Ref. < 30 mins (%)	Actuals:	32.67	31.25	33.83	33.88	30.17	33.80	33.58	34.55	32.83	32.95	33.43	28.84
ED - Clinically Complete 210-240 mins	Actuals:	715	829	725	705	683	833	844	720	719	821	788	793
HR - ED Senior Medical Vacancies (WTE)	Actuals:	19.8	19.8	19.8	19.8	19.8	19.8	19.8	19.8	19.8	19.8	19.8	19.8
	Trajectory:	22.2	22.2	22.2	22.2	22.2	22.2	22.2	22.2	22.2	22.2	22.2	20.2
HR - UC Band 5 Nursing Vacancies (WTE)	Actuals:	70.9	70.5	91.4	90.3	90.3	92.4	90.5	94.4	93.2	92.8	92.8	93.2
	Trajectory:	92.0	92.0	92.0	94.7	94.7	94.7	94.7	49.0	49.0	49.0	49.0	44.3
HR - ED Nurse Band 5 Vacancies (WTE)	Actuals:	9.2	9.2	11.2	10.6	11.6	13.4	9.4	11.8	12.6	12.6	13.6	14.2
	Trajectory:	13.9	6.8	6.8	6.8	6.8	6.8	6.8	8.8	8.8	8.8	8.8	10.8
SAFER Flow Bundle													
IP - Stranded Patient Metric (> 7 Days LoS)	Actuals:	380.9	413.1	442.0	434.7	436.3	450.1	467.3	452.0	457.9	450.0	434.9	442.7
IP - LoS - Medical - exc. 0 day (Avg)	Actuals:	7.9	7.6	8.0	9.2	9.8	9.1	8.1	9.7	8.5	9.4	7.8	8.4
IP - LoS - Surgical - exc. 0 day (Avg)	Actuals:	8.0	5.9	5.4	6.4	4.7	5.1	5.6	5.7	5.8	5.2	6.3	6.2
IP - Discharges before 10am (%)	Actuals:	8.28	9.02	7.68	8.90	7.86	7.51	8.54	8.86	9.23	7.43	7.26	9.08
IP - Discharges before Midday (%)	Actuals:	18.05	17.03	17.02	18.08	17.11	17.14	16.67	18.89	17.82	17.99	16.53	18.17
IP - Discharges before 3pm (%)	Actuals:	43.18	43.09	41.59	40.99	40.08	38.46	42.15	40.13	40.90	43.65	38.36	41.26
IDT - Pathway 1 Discharges (Avg)	Actuals:	8.0	7.0	8.7	8.7	9.3	7.4	9.9	7.7	8.3	8.1	7.7	7.3
	Trajectory:	13.0	13.0	13.0	17.0	17.0	17.0	17.0	16.0	16.0	16.0	16.0	16.0
IDT - Patients Awaiting PW2 Disch. (Snp)	Actuals:	14	6	13	12	18	17	21	21	20	16	26	38
	Trajectory:	8	8	8	5	5	5	5	4	4	4	4	4
IDT - Patients Awaiting PW3 Disch. (Snp)	Actuals:	17	18	14	28	27	25	16	15	14	12	12	15
	Trajectory:	18	18	18	15	15	15	15	14	14	14	14	14
IDT - DToC - Occupied Bed Days (Total)	Actuals:	311	391	426	458	457	512	558	401	364	373	458	553
	Trajectory:	155	135	155	135	135	135	135	115	115	115	115	94
IDT - DToC - Total Patients (Avg)	Actuals:	51.8	55.9	60.9	65.4	65.3	73.1	79.7	66.8	52.0	53.3	65.4	79.0
	Trajectory:	42.0	42.0	42.0	39.0	39.0	39.0	39.0	35.0	35.0	35.0	35.0	33.0
IDT - DToC - Health Patients (Avg)	Actuals:	42.8	45.7	46.0	54.3	56.3	59.9	66.9	59.3	44.4	45.6	58.6	69.6
IDT- Medically Optimised (Snp)	Actuals:	95.0	80.0	76.0	92.0	103.0	93.0	145.0	118.0	139.0	103.0	114.0	111.0
	Trajectory:	76.0	76.0	76.0	70.0	70.0	70.0	70.0	65.0	65.0	65.0	65.0	55.0
ALL - Medically Optimised (Avg)	Actuals:	130.0	137.0	158.3	169.9	164.4	159.3	139.7	117.2	112.0	97.0	104.4	101.4
Effective Medical Model													
IP - NEL Medical Discharges < 24h (%)	Actuals:	42.89	45.15	42.74	42.25	40.75	39.84	37.51	36.92	36.85	40.11	42.24	45.05
IP - NEL Medical Discharges < 72h (%)	Actuals:	63.27	67.72	62.03	63.54	59.48	63.54	59.91	58.58	58.96	59.55	61.30	65.64
IP - Admissions via Ambulatory Care (%)	Actuals:	7.63	7.57	10.74	8.74	9.55	10.00	10.40	8.16	10.33	10.74	10.89	9.91
Effective Site Management													
IP - Occupancy @ Midnight (%)	Actuals:	83.69	96.09	107.45	107.54	111.95	109.81	111.28	113.51	114.24	110.99	108.24	108.10
IP - Escalcation Beds @ Midnight (Avg)	Actuals:	53.0	79.1	109.0	104.4	131.4	121.1	130.0	141.2	147.7	132.4	109.7	106.3
IP - Medical Outliers (Avg)	Actuals:	58.1	80.1	76.3	79.4	85.3	87.0	87.3	90.4	93.4	76.4	71.3	85.7

APPENDIX 2 – Site Management

East Kent Hospitals University NHS
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Securing Safe, Effective, Responsive Hospitals 24/7

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The Case for Change

- Highlighted by regulators as a major risk – lack of clarity as to who is responsible for each site.
- Lack of consistent whole hospital/site engagement in the management of site related risks.
- Lack of clinical and ward ownership of hospital flow and discharge
- Significant sustained periods of site based operational and clinical risk currently being experienced.
- Lack of **effective** and **proactive** escalation systems and processes internally and externally.
- Fragmented information flows and reliance on manual systems that mean inconsistent assessments of risk.
- Operational management on-call intensity not sustainable.
- Continued poor performance against the emergency care standard.

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The Vision for Site Management

Key Principles/Responsibilities

- To be clinically led 24/7
- To be responsible for optimising site patient flow from admission to discharge
- To be responsible for ensuring patient safety and service quality across the site 24/7
- To be responsible for ensuring that capacity and flow risks are managed in accordance with Trust and System wide escalation policies and procedures
- To identify, implement and support service and patient flow improvements that will underpin sustainable delivery of urgent and planned care quality and access standards
- To ensure that use of site related capacity and resources are optimally utilised.
- To ensure that safe staffing levels are monitored and maintained across all clinical areas 24/7
- To ensure that the site is fully prepared and ready for a major incident response.

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The Building Blocks

SAFE, EFFECTIVE, RESPONSIVE 24/7

Processes & Procedures	Operational Control Centre	Site Management Team	Management Information Systems	Whole Hospital Engagement
• Escalation • Full Hospital • Site Management • SAFER • Choice • IPS • Policies	• Location • Infratructure • Bed Mtgs • Trust VCs • Function	• Model • Recruitment • Training • Support • Funding • Rota's	• SHREWD • Bed Man. • ED System • SMARTIES • Amb. Inbound • Workforce • Site Reps • Media • DTOCs • +14 + 7 days	• Escalation • Training • Comms Plan • Breach Rev. • Service Resp.

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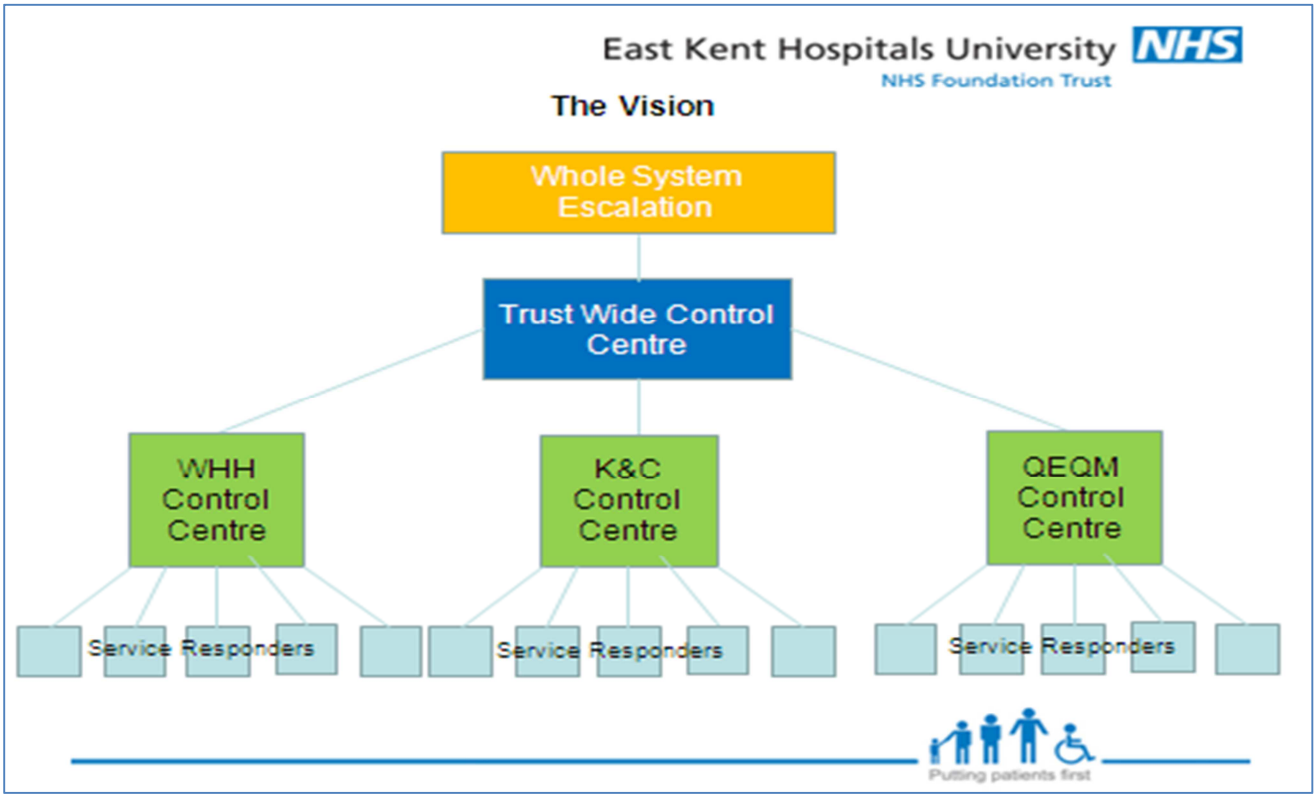
East Kent Hospitals University NHS
NHS Foundation Trust
The Vision
Whole System Escalation
Trust Wide Control Centre
WHH Control Centre
K&C Control Centre
QEQM Control Centre
Service Responders
Service Responders
Service Responders
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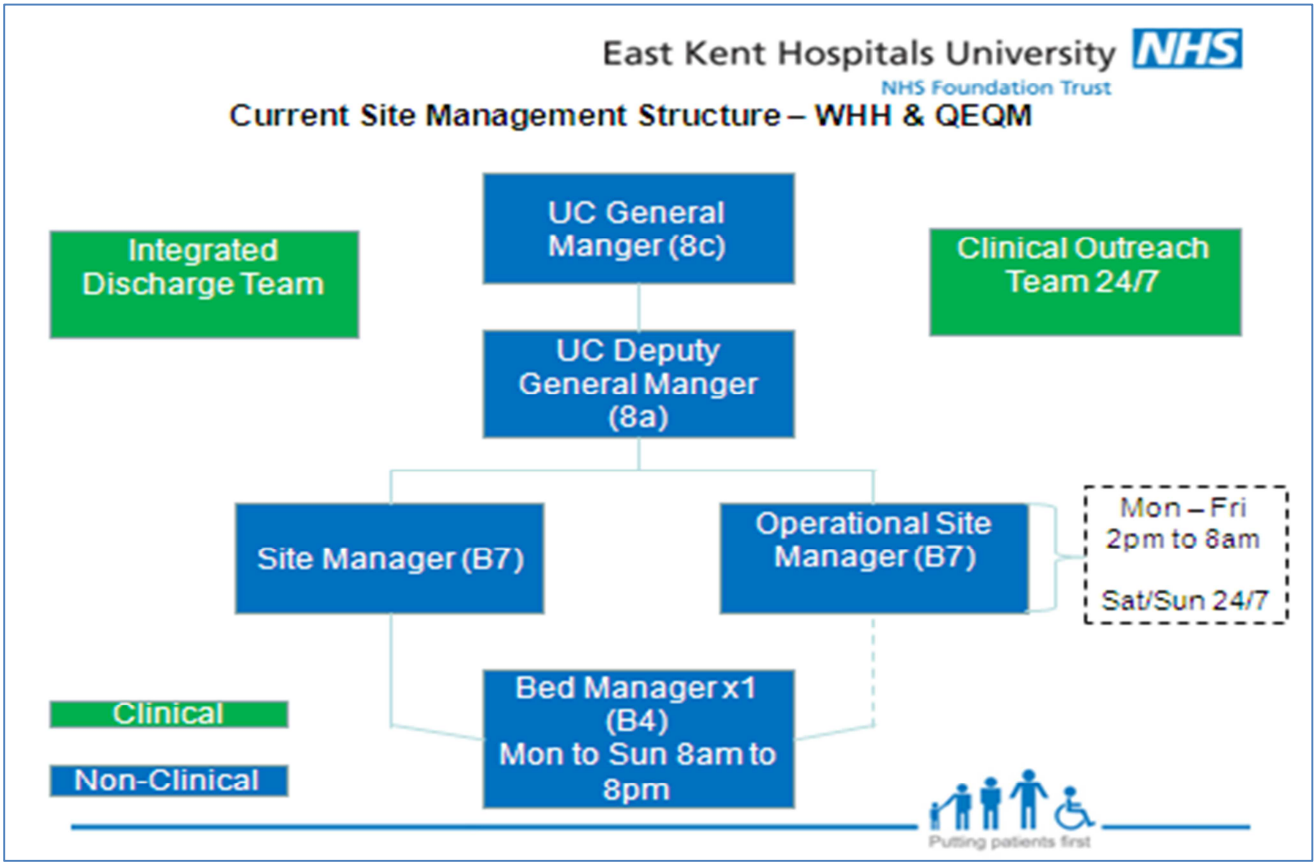
East Kent Hospitals University NHS
NHS Foundation Trust
Current Site Management Structure – WHH & QEQM
UC General Manger (8c)
Integrated Discharge Team
Clinical Outreach Team 24/7
UC Deputy General Manger (8a)
Site Manager (B7)
Operational Site Manager (B7)
Mon – Fri 2pm to 8am
Sat/Sun 24/7
Bed Manager x1 (B4) Mon to Sun 8am to 8pm
Clinical
Non-Clinical
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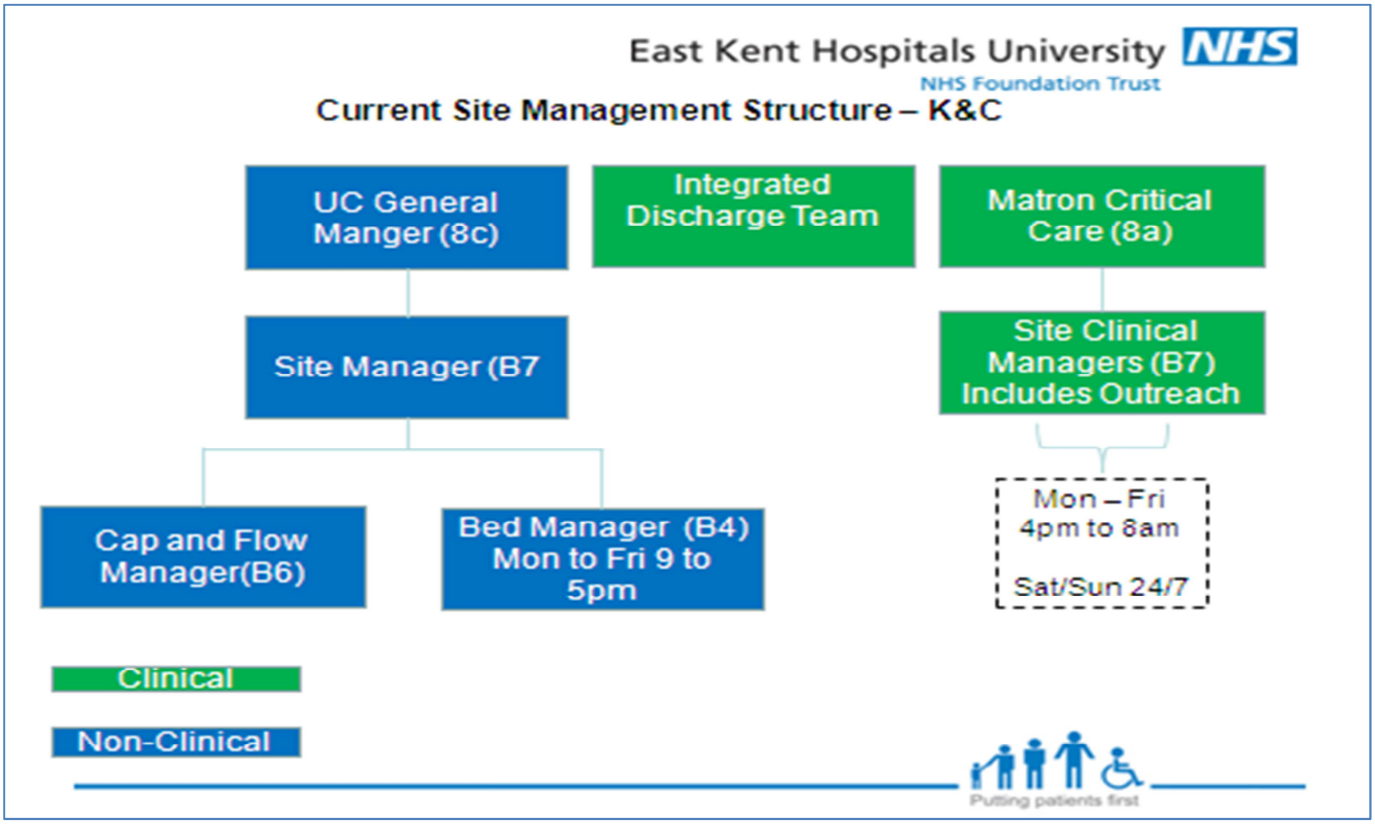
East Kent Hospitals University NHS
NHS Foundation Trust
Current Site Management Structure – K&C
UC General Manger (8c)
Integrated Discharge Team
Matron Critical Care (8a)
Site Manager (B7
Site Clinical Managers (B7) Includes Outreach
Mon – Fri 4pm to 8am
Sat/Sun 24/7
Cap and Flow Manager(B6)
Bed Manager (B4) Mon to Fri 9 to 5pm
Clinical
Non-Clinical
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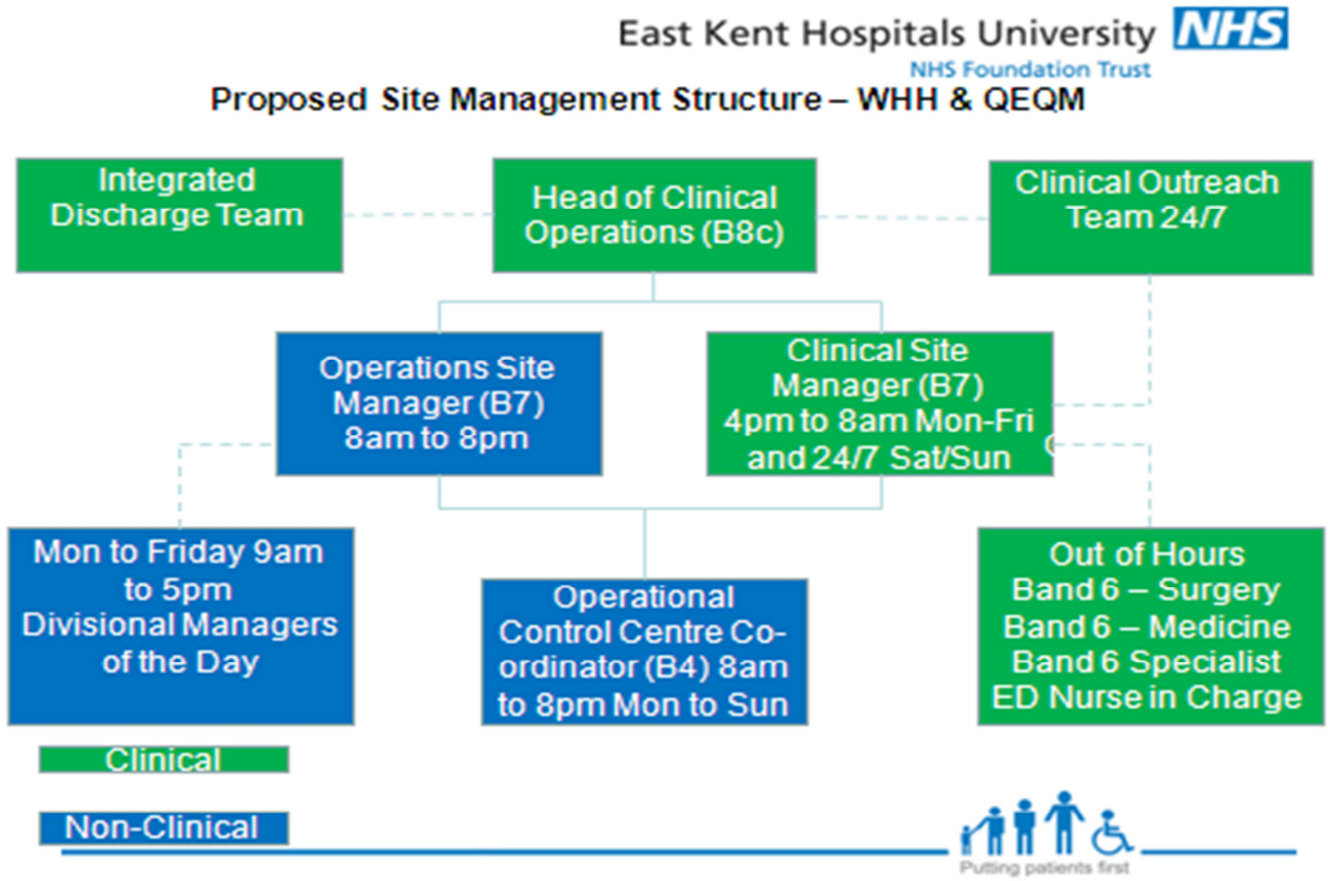
East Kent Hospitals University NHS
NHS Foundation Trust
Proposed Site Management Structure – WHH & QEQM
Integrated Discharge Team
Head of Clinical Operations (B8c)
Clinical Outreach Team 24/7
Operations Site Manager (B7) 8am to 8pm
Clinical Site Manager (B7) 4pm to 8am Mon-Fri and 24/7 Sat/Sun
Mon to Friday 9am to 5pm Divisional Managers of the Day
Operational Control Centre Co-ordinator (B4) 8am to 8pm Mon to Sun
Out of Hours Band 6 – Surgery Band 6 – Medicine Band 6 Specialist ED Nurse in Charge
Clinical
Non-Clinical
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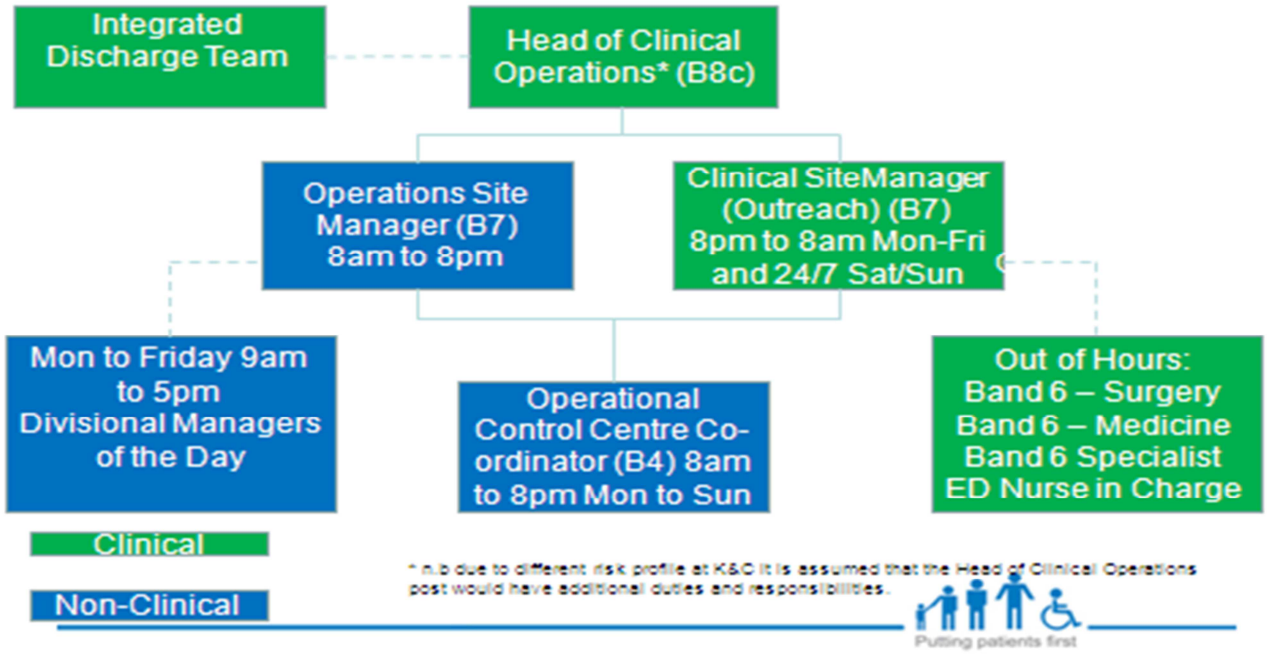
Proposed Site Management Structure – K&C



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Underpinning Supporting Assumptions

- Need to give ownership of the discharge management process back to the wards.
- Standardised implementation of SAFER principles across all wards and teams
- ED department to be responsible for flow management within ED
- EDDs and PAS to be updated in real time
- Implementation of interim electronic bed management system across all wards/sites.
- Full and consistent implementation of capacity and demand escalation policy
- Consistent input from divisional managers of the day
- Out of hours divisional support from supernummery band 6 posts
- Establish appropriate operational control centre locations on each site

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Posts Directly Affected

- Current Operational Service Managers at WHH and QEQM
- Bed Managers – all three sites
- Cap and Flow Manager – K&C
- Site Manager Roles at QEQM, WHH and K&C

Posts In-Directly Affected

- Senior Matron roles K&C, WHH and QEQM
- Deputy General Managers – UC&LTC

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Next steps

- Agreement to proposed site management model
- Finalisation of role and job descriptions
- Identify and confirm financial costs and risks e.g. protection, re-deployment.
- Confirm funding sources
- Finalise consultation document and agree organisational change timescales.
- Advertise for permanent appointments.
- Implementation

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APPENDIX 3 – Bed Model

Revised Winter Capacity Plan

Bed Capacity		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Substantive Bed Base	Medical	507	507	507	507	507	507	507	507	536	552	552	533
	Surgical	317.9	317.9	317.9	317.9	317.9	317.9	317.9	317.9	317.9	317.9	317.9	317.9
	Specialist	61.356	61.356	61.356	61.356	61.356	61.356	61.356	61.356	61.356	61.356	61.356	61.356
Total Substantive Bed Base		**886**	**886**	**886**	**886**	**886**	**886**	**886**	**886**	**915**	**931**	**931**	**912**

Bedday Demand		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Elective Admissions	Medical	179	184	224	297	181	219	180	176	133	165	150	183
	Surgical	780	824	876	920	786	843	901	954	873	882	917	918
	Specialist	151	159	202	176	168	154	173.8	167.39	135.6	154.4	150.26	161.55
Total Elective Admissions		**1,110**	**1,167**	**1,302**	**1,393**	**1,135**	**1,216**	**1,255**	**1,297**	**1,142**	**1,201**	**1,217**	**1,263**
Beddays Required	Medical	513.33	467.78	633.33	718.89	566.67	770	629.6	597.14	482.09	539.8	587.14	604.88
	Surgical	2224.4	2498.9	2377.8	2423.3	2274.4	2736.7	2410.9	2468.8	2238.2	2288	2350.4	2354.7
	Specialist	405.56	296.67	390	408.89	442.22	356.67	412.03	387.58	313.94	359.61	355.13	383.22
Total Elective Bed Days		**3,143**	**3,263**	**3,401**	**3,551**	**3,283**	**3,863**	**3,453**	**3,454**	**3,034**	**3,187**	**3,293**	**3,343**
Non Elective Admissions	Medical	3801	3870	3813	4083	3848	3975	4142	3969	4074	4214	3834	4154
	Surgical	1304	1385	1413	1474	1406	1322	1354	1354	1354	1467	1467	1467
	Specialist	194	221	201	182	255	254	230.66	202.96	206.03	233.94	221.27	234.81
Total Non-Elective Admissions		**5,299**	**5,476**	**5,427**	**5,739**	**5,509**	**5,551**	**5,727**	**5,526**	**5,634**	**5,915**	**5,522**	**5,856**
Beddays Required	Medical	18957	17251	17236	16969	17860	18422	17002	15397	18892	19956	19009	18622
	Surgical	6716.7	6875.6	7224.4	7441.1	6767.8	6800	6551.8	6409.4	6409.4	6904	6904	6904
	Specialist	715.56	914.44	1051.1	787.78	995.56	613.33	904.32	773.97	867.3	849.62	881.81	915.45
Total Non-Elective Bed Days		**26,389**	**25,041**	**25,511**	**25,198**	**25,623**	**25,836**	**24,458**	**22,580**	**26,169**	**27,709**	**26,795**	**26,441**

Occupancy Options		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Elective Bed Model	Medical	17.111	15.09	21.111	23.19	18.28	25.667	20.31	19.905	15.551	17.413	20.246	19.512
	Surgical	74.148	80.609	79.259	78.172	73.369	91.222	77.771	82.294	72.201	73.805	81.049	75.958
	Specialist	13.519	9.5699	13	13.19	14.265	11.889	13.291	12.919	10.127	11.6	12.246	12.362
Non Elective Bed Model	Medical	631.89	556.49	574.52	547.38	576.13	614.07	548.45	513.22	609.43	643.73	655.49	600.71
	Surgical	223.89	221.79	240.81	240.04	218.32	226.67	211.35	213.65	206.76	222.71	238.07	222.71
	Specialist	23.852	29.498	35.037	25.412	32.115	20.444	29.172	25.799	27.978	27.407	30.407	29.531
Total Bed Requirement		**984**	**913**	**964**	**927**	**932**	**990**	**900**	**868**	**942**	**997**	**1038**	**961**
Predicted Bed State		**-98**	**-27**	**-77**	**-41**	**-46**	**-104**	**-14**	**18**	**-27**	**-65**	**-106**	**-49**

Revised Trust Capacity v Demand

East Kent Hospitals University NHS
NHS Foundation Trust

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Surgical	298	302	320	318	292	318	289	296	279	297	319	299
Medical	649	572	596	571	594	640	569	533	625	661	676	620
Specialist	37	39	48	39	46	32	42	39	38	39	43	42
Total Contingency Beds	58	58	58	58	54	54	54	54	45	45	45	44
Total Substantive Bed Base	886	886	886	886	886	886	886	886	915	931	931	912

Site Wide (All Beds Considered)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Total Bed Requirement	984	913	964	927	932	990	900	868	942	997	1038	961
Total Substantive Bed Base	886	886	886	886	886	886	886	886	915	931	931	912
GAP (From Funded beds)	-98	-27	-77	-41	46	-104	-14	Within Funded	-27	65	-106	-49
Total Contingency Beds	58	58	58	58	54	54	54	54	45	45	45	44
GAP (From Contingency)	-40	Within Contingency	-19	Within Contingency	Within Contingency	-50	Within Contingency	Within Funded	Within Contingency	-21	-61	-4

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Revised K&C Capacity v Demand

East Kent Hospitals University NHS
NHS Foundation Trust

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Surgical	50	40	56	52	46	44	42	43	41	45	49	46
Medical	178	154	151	157	177	180	161	151	177	157	183	179
Specialist	22	23	29	23	29	16	25	23	25	23	27	26
Total Contingency Beds	18	18	18	18	18	18	18	18	21	21	21	21
Total Substantive Bed Base	245	245	245	245	245	245	245	245	245	261	261	261

Site Wide (All Beds Considered)	Apr-15	May-15	Jun-15	Jul-15	Aug15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Total Bed Requirement	250	217	236	232	252	241	228	217	243	224	259	251
Total Substantive Bed Base	245	245	245	245	245	245	245	245	245	261	261	261
GAP (From Funded beds)	-5	Within Funded	Within Funded	Within Funded	-1	Within Funded	Within Funded	Within Funded	Within Funded	Within Funded	Within Funded	Within Funded
Total Contingency Beds	18	18	18	18	18	18	18	18	21	21	21	21
GAP (From Contingency)	Within Contingency	Within Funded	Within Funded	Within Funded	Within Contingency	Within Funded	Within Funded	Within Funded	Within Funded	Within Funded	Within Funded	Within Funded

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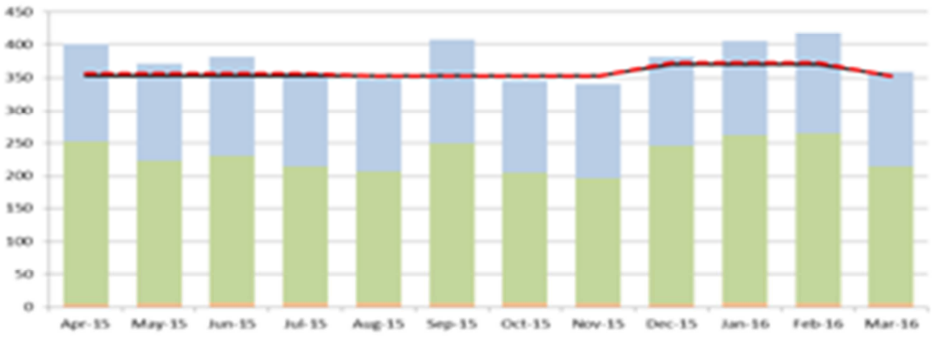
Revised WHH Capacity v Demand

East Kent Hospitals University NHS

Site Wide: Beds Required Vs All Available Beds



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Surgical	148	149	151	144	140	157	141	144	136	143	154	144
Medical	247	217	224	208	200	243	198	190	241	256	259	209
Specialist	6	6	7	7	7	6	7	6	5	7	6	6
Total Contingency Beds	4	4	4	4	0	0	0	0	3	3	3	0
Total Substantive Bed Base	353	353	353	353	353	353	353	353	370	370	370	353

Specialist Medical Surgical Total Substantive Bed Base Total Contingency Beds

Site Wide (All Beds Considered)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Total Bed Requirement	401	372	382	358	347	407	346	341	381	406	429	359
Total Substantive Bed Base	353	353	353	353	353	353	353	353	370	370	370	353
GAP (From Funded beds)	-48	-19	-29	-5	Within Funded	-54	Within Funded	Within Funded	-11	-36	-59	-6
Total Contingency Beds	4	4	4	4	0	0	0	0	3	3	3	0
GAP (From Contingency)	-48	-15	-31	-1	Within Funded	-54	Within Funded	Within Funded	-8	-33	-56	-6

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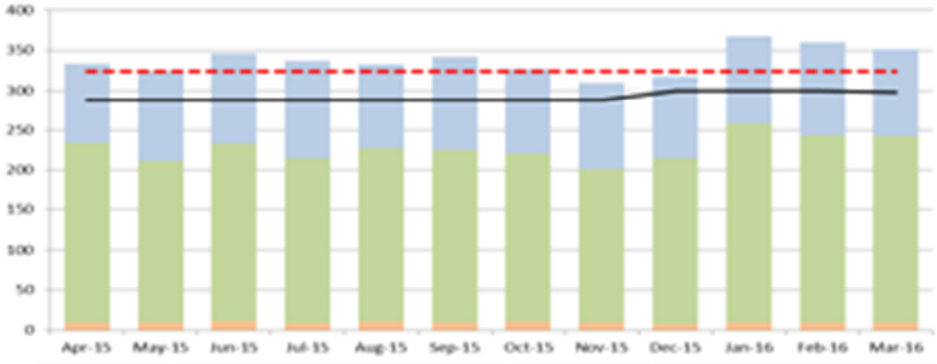
Revised QEQM Capacity v Demand

East Kent Hospitals University NHS

Site Wide: Beds Required Vs All Available Beds



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Surgical	99	114	113	122	106	116	107	109	103	108	116	109
Medical	224	201	221	206	217	216	210	191	207	249	233	233
Specialist	10	10	11	9	10	10	10	10	8	10	9	10
Total Contingency Beds	36	36	36	36	36	36	36	36	24	24	24	26
Total Substantive Bed Base	288	288	288	288	288	288	288	288	300	300	300	298

Specialist Medical Surgical Total Substantive Bed Base Total Contingency Beds

Site Wide (All Beds Considered)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Total Bed Requirement	333	325	346	337	333	342	327	310	318	367	359	351
Total Substantive Bed Base	288	288	288	288	288	288	288	288	300	300	300	298
GAP (From Funded beds)	-45	-37	-58	-49	-45	-54	-39	-22	-18	-67	-59	-54
Total Contingency Beds	36	36	36	36	36	36	36	36	24	24	24	26
GAP (From Contingency)	-9	-1	-22	-13	-9	-18	-3	Within Contingency	Within Contingency	-43	-35	-28

Putting patients first

Potential Mitigating Actions:

East Kent Hospitals University NHS
NHS Foundation Trust

EKHUFT:

- Rapid Frailty Model Implementation
- Establish Surgical Assessment Unit at QEQM
- Focus on embedding SAFER Flow Bundle (Priority QEQM)
- Fund discharge lounge at K&C linked to St Lawrence Ward
- Impact of new Site Management Arrangements – HoCOps
- IDT Improvement including impact of line management changes.
- Implement consistent consultant triage of GP phone calls.
- Inter-hospital transfers to utilise K&C capacity.
- Strengthening clinical leadership in Urgent Care with aligned project support.

SYSTEM:

- System focused drive to reduce number of medically fit patients in acute hospitals.
- Commission additional community bed capacity (PW3?).
- Commission additional social care package capacity.
- Agree increased flexible of existing community and social care bed capacity.
- Possible targeted actions focused on expected increase in respiratory patients.
- Intelligent and further reductions in conveyancing by Ambulance service
- Urgent actions to improve MH capacity and response
- ECIP support aligned to priority areas
- Further prevention actions/role of LRU
- Increase provision of support to Elderly in homes
- Influence profile of GP expected attendances

Putting patients first

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS**

DATE: **8 APRIL 2016**

SUBJECT: **STAFF SURVEY RESULTS**

REPORT FROM: **DIRECTOR OF HUMAN RESOURCES**

PURPOSE: **Decision**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

The annual NHS staff survey results were published on 23rd February with our organisation's benchmarked position. The Strategic Workforce Committee (SWC) agreed in January, based on a review of the Picker Survey results, that areas for action would be:

- A continuing focus on the 'Respecting Each Other' campaign including working with Health & Safety on the broader aspects of violence and aggression
- Re-launch of the health and well-being group for the organisation with a focus on providing useful interventions to support staff in feeling well, using recent NICE guidance as a road map for action
- Post implementation evaluation and promotion of Trust's new appraisal process
- A focus on capacity and capability of managers / leaders in the organisation

These priorities have been reinforced by analysis of the national results and follow-up data presented by Picker at the SWC in March.

SUMMARY:

The NHS Staff Survey was conducted online for all staff in September / October 2015, the brief summary of results showing the organisation's benchmarked position against all acute trusts and performance in 2014 is attached. Response rate continued to be at around 40% which is consistent with 2014 but still lower than previous years, in 2013 a response of 50% was achieved.

The report shows two types of key finding:

- Percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions
- Scale summary scores, calculated by converting staff response to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5.

The questionnaire, key findings and benchmarking groups have all undergone substantial revision since the previous staff survey. This means that for some key findings there are not comparisons available to previous year's results.

The report confirms that the organisation has generally improved its results from the 2014 survey however in most key areas the Trust continues to sit in the lowest (worst) 20% of acute trusts when benchmarked.

To understand the context of the improvement seen since 2014 the results for 2015 have, for some key indicators, been compared to results in 2013 and 2012 where available. This gives a sense of whether the improvement is a genuine sustaining

one or perhaps a return to the organisation's position prior to the CQC report publication in Summer 2014. The report from page 15 onwards also provides detailed analysis of individual key findings providing information on both the average results of acute trusts as well as the best score in 2015 for all acute trusts.

Friends and Family test percentage results are shown on page 4 of the summary report and analysis of the comparative position (including acute trust average) over time is shown below:-

Key questions	2015	2015 avge	2014	2014 avge	2013	2013 avge	2012	2012 avge
Care of patients / service users is my organisation's top priority	67	75	57	71	60	69	57	64
My organisation acts on concerns raised by patients / service users	63	73	53	72	64	71	61	68
I would recommend my organisation as a place to work	48	61	40	60	53	61	50	56
If a friend of relative needed my treatment, I would be happy with the standard of care provided by this organisation	60	70	53	67	57	67	55	65

The organisation's overall staff engagement scores in 2015 have shown improvement across all indicators although the organisation continues to be in the worst 20% of all acute trusts (these results are again shown over the last 4 years):-

Key findings (KF)	2015	2015 avge	2014	2014 avge	2013	2013 avge	2012	2012 avge
Overall staff engagement	3.66	3.79	3.51	3.75	3.63	3.75	3.59	3.7
KF1. Staff recommendation of the Trust as a place to work or receive treatment	3.50	3.76	3.32	3.71	3.53	3.71	3.47	3.62
KF4. Staff motivation at work	3.86	3.94	3.71	3.85	3.83	3.86	3.78	3.83
KF7. Percentage of staff able to contribute towards improvements at work	65	69	60	69	61	68	62	68

The Trust's top ranking scores, shown on page 6 of the report, typically sit around the average when benchmarked. The organisation is not high performing in any area, the predominance of indicators shown on page 13 and 14 show performance at the lowest 20% of all acute trusts.

RAG rated reports have been produced for each of the divisions and corporate groups to help identify any 'hot spots' for targeted interventions, which will be actioned in addition to the Trust priorities below:

'Respecting Each Other' programme

The Trust's bottom ranking scores continue to include staff experience of harassment, bullying or abuse from staff and there has been no change in the Trust's results. This is an area that requires ongoing focus and attention by the Board. Staff experience has shown deterioration in only one area in 2015 which relates to the percentage of staff / colleagues reporting most recent experience of violence which has reduced by over 10% since 2014. It is important therefore that the programme of work in regard to 'Respecting Each Other' includes support to staff in understanding the importance of reporting experience of violence particular in areas who report high levels of violence.

Health and well being
A first meeting of the group has taken place to agree terms of reference and membership as well as areas for action in 2016/17. A lot of good work is already underway in this area and a focus on internal communications and engagement of staff in this agenda will be the key to the success of this work stream in 16/17.

Appraisal
The Trusts revised appraisal process launched on 1 April 2016. It brings together the whole process – preparation, objective setting, personal development and review – in one document. It also incorporates EKHUFT's values and behaviours, placing an emphasis on the 'how' as well as the 'what'. Initial feedback from the refresher training sessions has been very positive.

Leadership capacity and capability
The survey results suggest a continuing need to establish a consistent leadership style / framework approach across EKHUFT and an understanding for those who work in these roles, and those who manage them, of where their key strengths and development areas lie. This need has been reinforced by Monitor's recent feedback, suggesting EKHUFT needs to undertake robust assessment and development of its leaders. A proposal on assessing competence and capability of the top 200 leaders in the organisation has been recently been agreed by the Executive team.

Engagement
An internal communications plan is being implemented to support the development of ideas for action and sharing of results with staff.

RECOMMENDATIONS:
The Board is asked to discuss and agree the priorities for action.

NEXT STEPS:
'Respecting Each Other' will have 'anniversary' road shows in April/May which will include the launch of the 'refreshed' anti-bullying video and workshops for managers and staff on what bullying is and is not.

HR Business Partners are currently engaging with their divisions and corporate areas to create '*Great Place to Work*' action plans, based on the survey results, to address Trust-wide and group priorities.

The Appraisal Project group will continue to meet on a bi-monthly basis and are planning a post-implementation survey, quality checks on paperwork and staff experience and a review of the appraiser hierarchy.

A tender is currently being prepared to recruit an external partner to support the work on leadership assessment and development. A review of education and training across the Trust will be presented to the SWC in May. It is expected the review will address issues in regard to how the Trust organises leadership and management development in future to more clearly align to the organisation's strategic objectives. It will be important that there is a consistent approach in leadership development for the organisation moving forward.

Progress against the Trust-wide priorities and divisional plans will be presented on a regular basis to SWC. The Board will receive an update at their June meeting.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

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

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

SO3: Place the Trust at the leading edge of healthcare in the UK, shaping its future and reputation by promoting a culture of innovation, undertaking novel improvement projects and rapidly implementing best practice from across the world

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

LINKS TO BOARD ASSURANCE FRAMEWORK:

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

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

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

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

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:
The turnaround time for staff survey data means that there is limited time to act now to influence 2016 results. It is important for staff and for our regulators that we evidence that we act quickly in response to staff survey feedback.

FINANCIAL AND RESOURCE IMPLICATIONS:
Resource requirements will need to be identified when particular focus is agreed.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:
None

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES
None

ACTION REQUIRED:
Continue to explore the key findings in the staff survey results that provide insight into staff perceptions and use this insight to support the Board of Directors in decision making in regard to actions relating to the survey as well as the broader strategic agenda.

CONSEQUENCES OF NOT TAKING ACTION:
Failure to evidence that we responding positively, at pace, to staff feedback

2015 National NHS staff survey

Brief summary of results from East Kent Hospitals University NHS Foundation Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2015 national NHS staff survey conducted in East Kent Hospitals University NHS Foundation Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

These sections of the report have been structured around four of the seven pledges to staff in the NHS Constitution which was published in March 2013 (http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution) plus three additional themes:

- Staff Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.
- Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.
- Staff Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
- Additional theme: Equality and diversity
- Additional theme: Errors and incidents
- Additional theme: Patient experience measures

Please note, the questionnaire, key findings and benchmarking groups have all undergone substantial revision since the previous staff survey. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2015 survey results for East Kent Hospitals University NHS Foundation Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

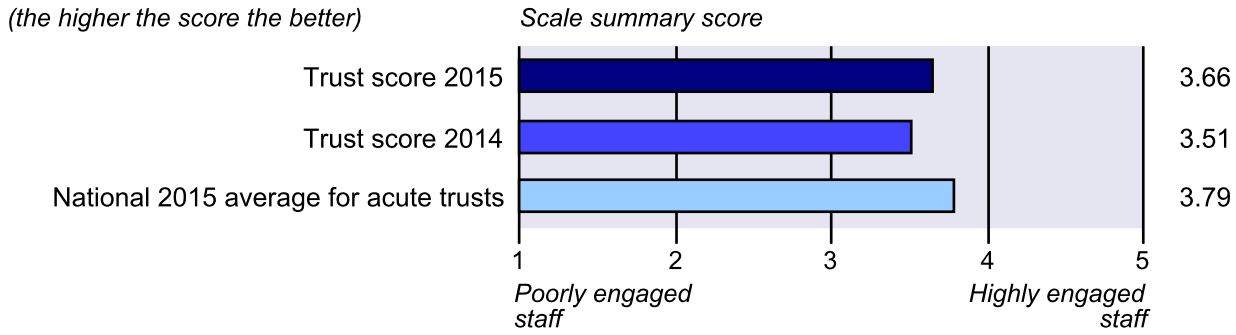
Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

		Your Trust in 2015	Average (median) for acute trusts	Your Trust in 2014
Q21a	"Care of patients / service users is my organisation's top priority"	67%	75%	57%
Q21b	"My organisation acts on concerns raised by patients / service users"	63%	73%	53%
Q21c	"I would recommend my organisation as a place to work"	48%	61%	40%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	60%	70%	53%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.50	3.76	3.32

2. Overall indicator of staff engagement for East Kent Hospitals University NHS Foundation Trust

The figure below shows how East Kent Hospitals University NHS Foundation Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.66 was in the lowest (worst) 20% when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how East Kent Hospitals University NHS Foundation Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a change since the 2014 survey.

	Change since 2014 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	✓ Increase (better than 14)	! Lowest (worst) 20%
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	✓ Increase (better than 14)	! Lowest (worst) 20%
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	✓ Increase (better than 14)	! Lowest (worst) 20%
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	✓ Increase (better than 14)	! Lowest (worst) 20%

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

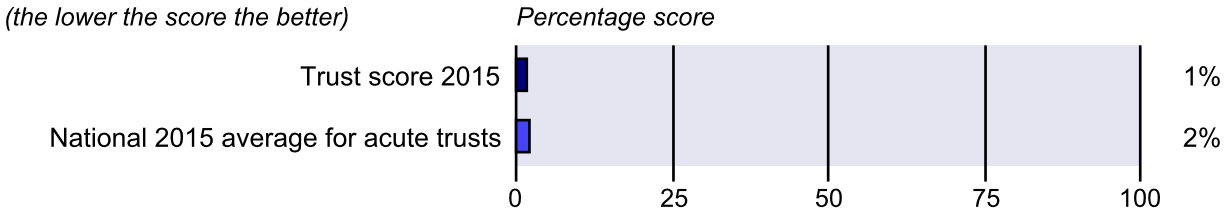
3. Summary of 2015 Key Findings for East Kent Hospitals University NHS Foundation Trust

3.1 Top and Bottom Ranking Scores

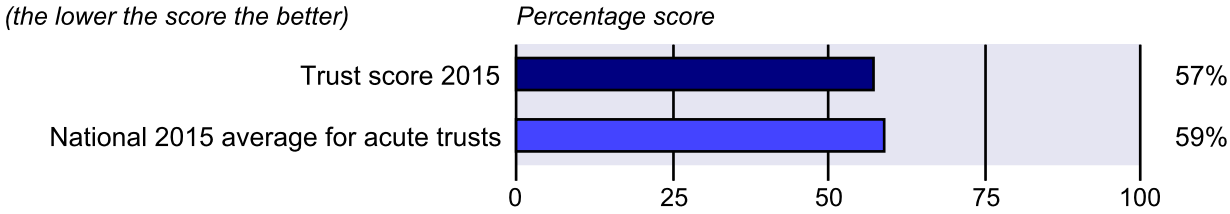
This page highlights the four Key Findings for which East Kent Hospitals University NHS Foundation Trust compares most favourably with other acute trusts in England.

TOP FOUR RANKING SCORES

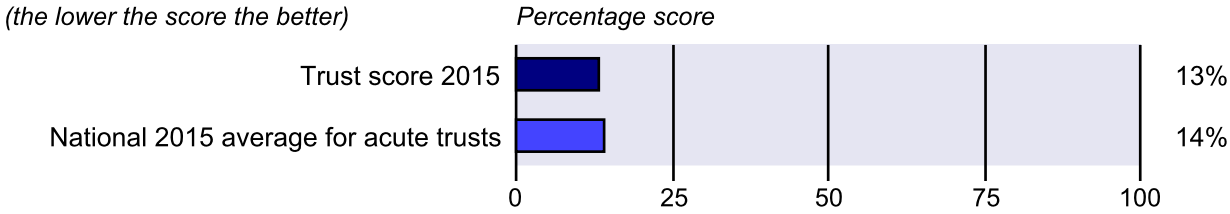
✓KF23. Percentage of staff experiencing physical violence from staff in last 12 months



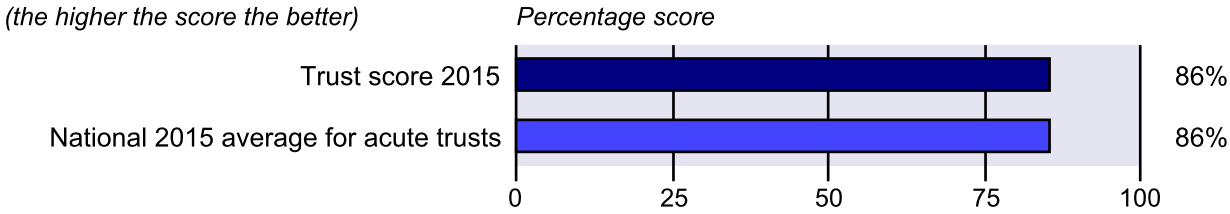
✓KF18. Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell



✓KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months



✓KF11. Percentage of staff appraised in last 12 months



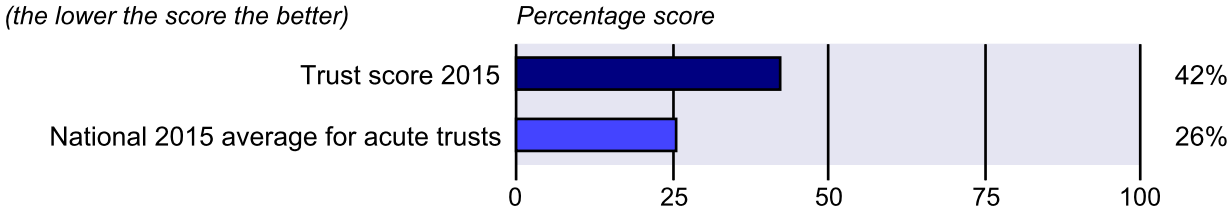
For each of the 32 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 99 (the bottom ranking score). East Kent Hospitals University NHS Foundation Trust's four highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which East Kent Hospitals University NHS Foundation Trust compares least favourably with other acute trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

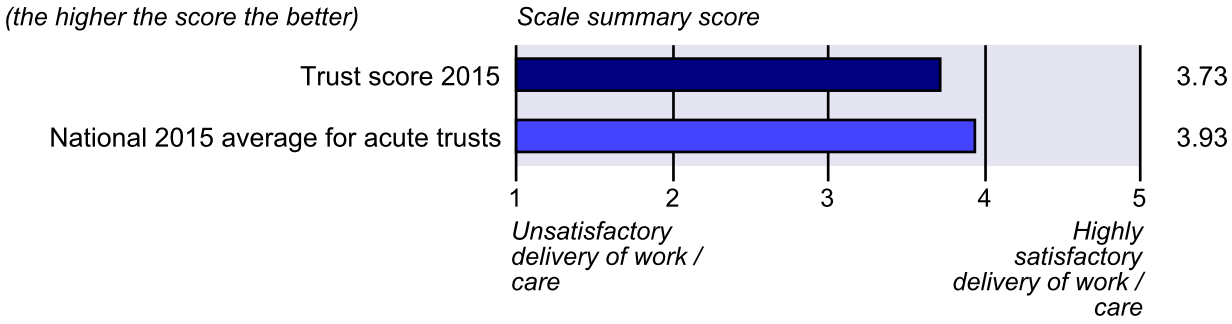
! KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



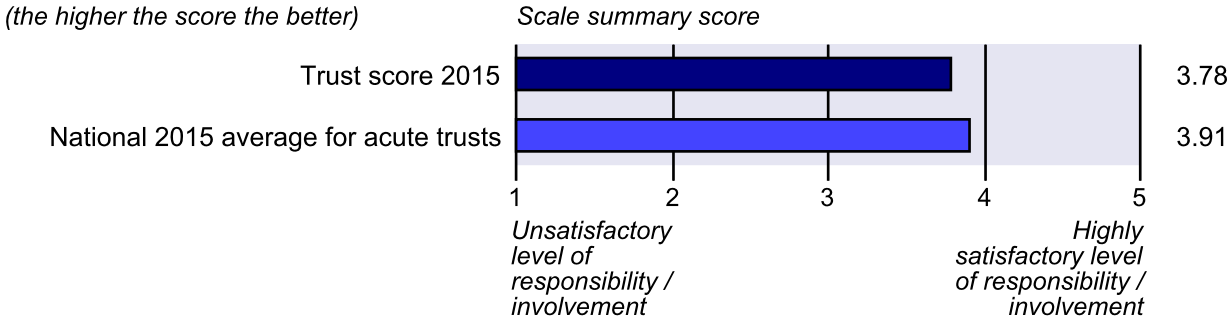
! KF2. Staff satisfaction with the quality of work and patient care they are able to deliver

(the higher the score the better)



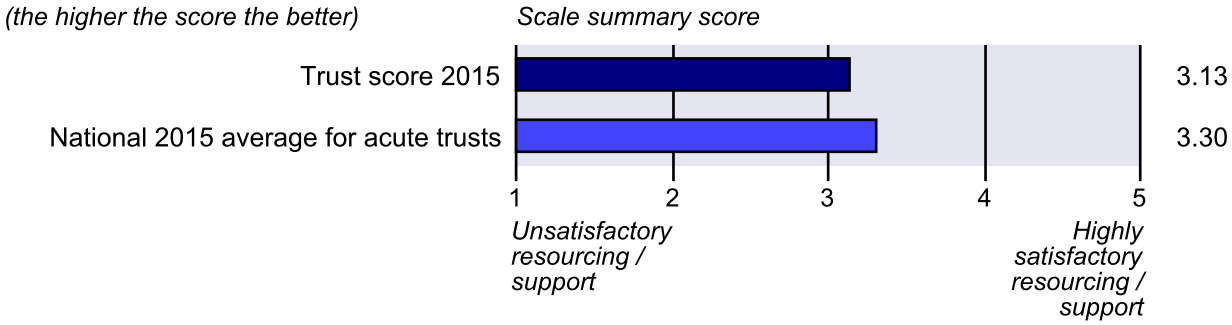
! KF8. Staff satisfaction with level of responsibility and involvement

(the higher the score the better)



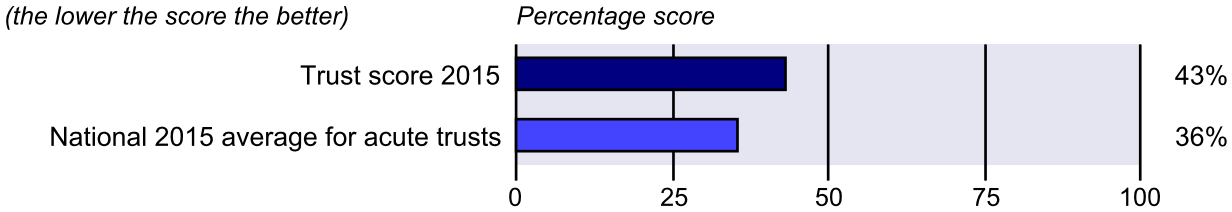
! KF14. Staff satisfaction with resourcing and support

(the higher the score the better)



! KF17. Percentage of staff suffering work related stress in last 12 months

(the lower the score the better)



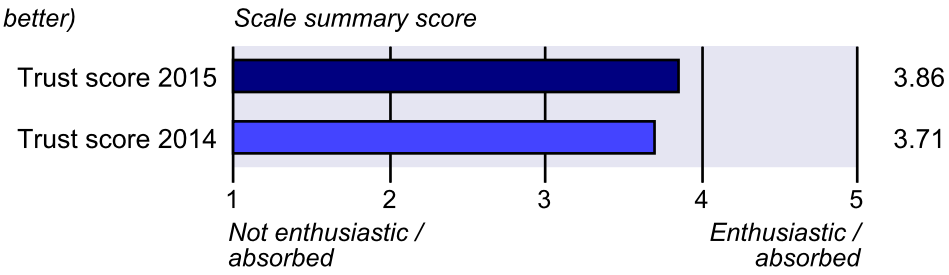
3.2 Largest Local Changes since the 2014 Survey

This page highlights the five Key Findings where staff experiences have improved at East Kent Hospitals University NHS Foundation Trust since the 2014 survey. (This is a positive local result. However, please note that, as shown in section 3.3, when compared with other acute trusts in England, the scores for Key findings KF4, KF7, KF28, and KF32 are worse than average).

WHERE STAFF EXPERIENCE HAS IMPROVED

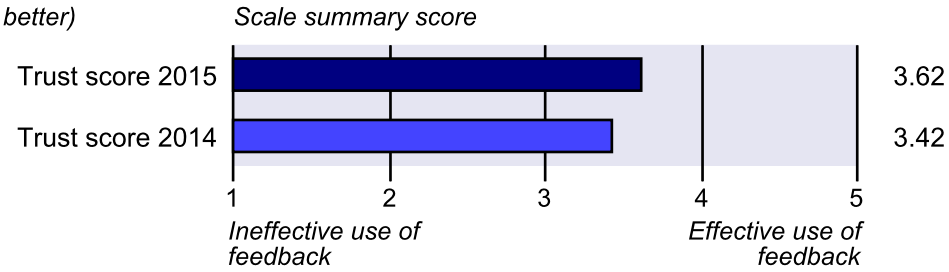
✓KF4. Staff motivation at work

(the higher the score the better)



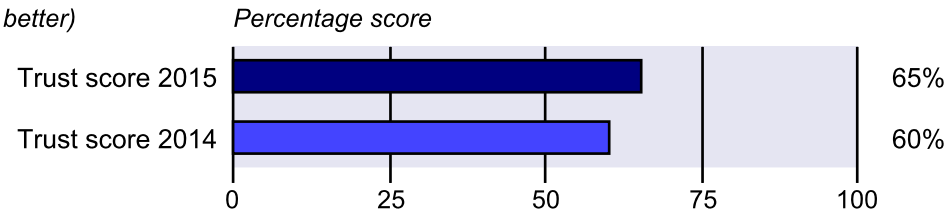
✓KF32. Effective use of patient / service user feedback

(the higher the score the better)



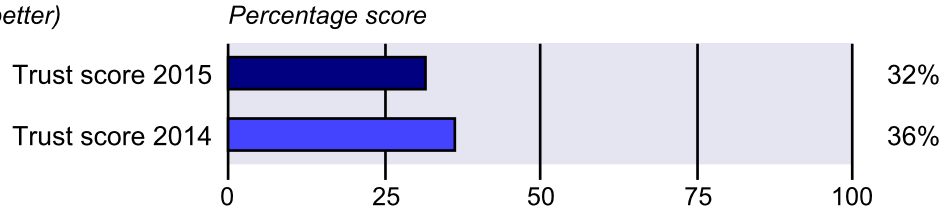
✓KF7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)



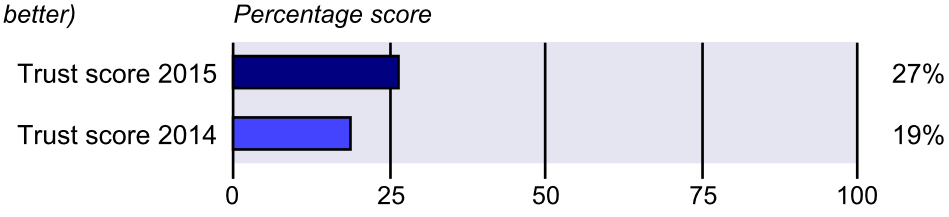
✓KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



✓KF6. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)

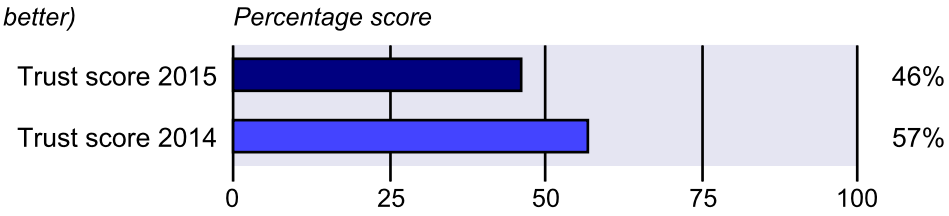


This page highlights the Key Finding that has deteriorated at East Kent Hospitals University NHS Foundation Trust since the 2014 survey. It is suggested that this might be seen as a starting point for local action to improve as an employer.

WHERE STAFF EXPERIENCE HAS DETERIORATED

! KF24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



3.3. Summary of all Key Findings for East Kent Hospitals University NHS Foundation Trust

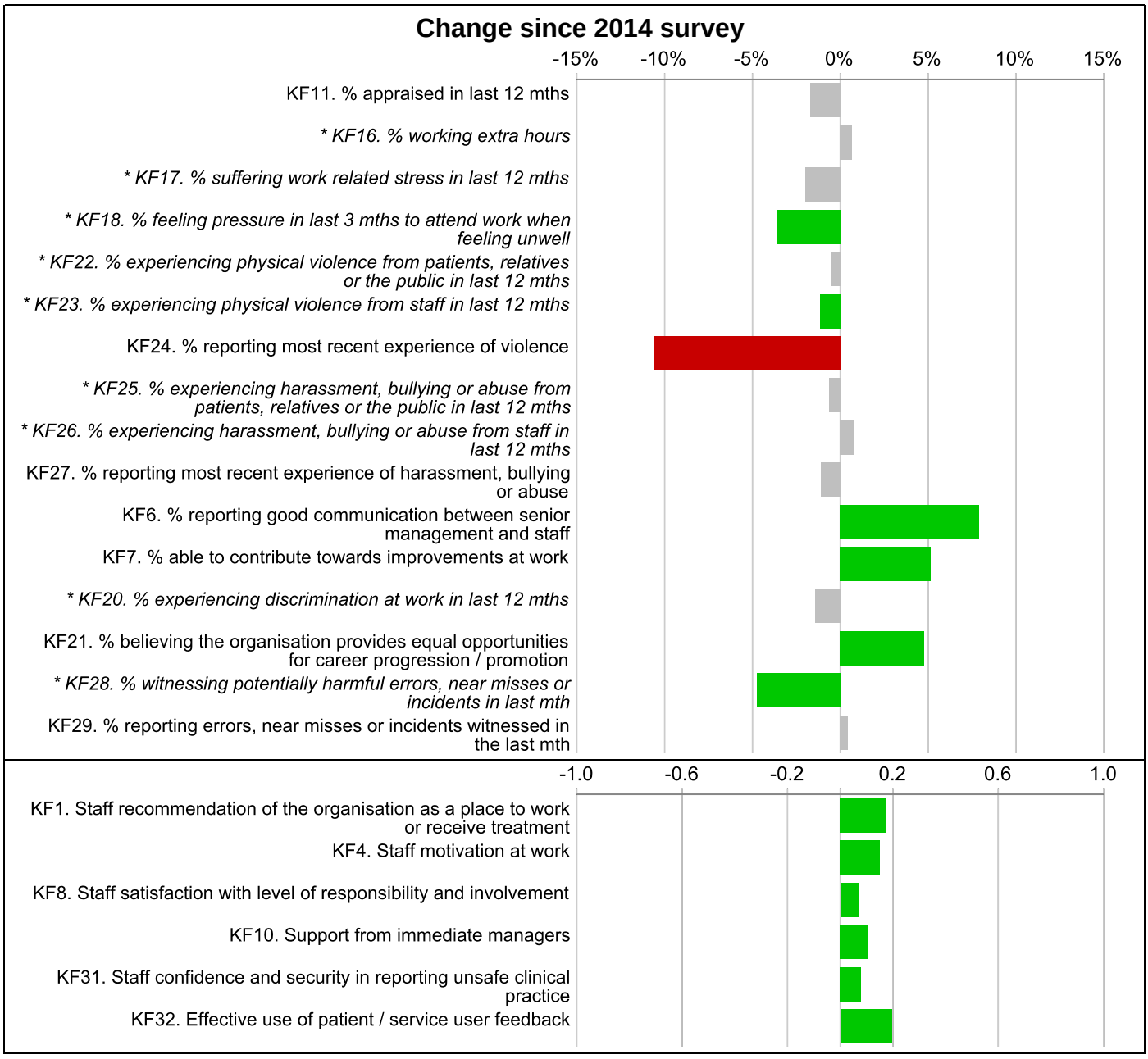
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2014 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2014 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2014 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for East Kent Hospitals University NHS Foundation Trust

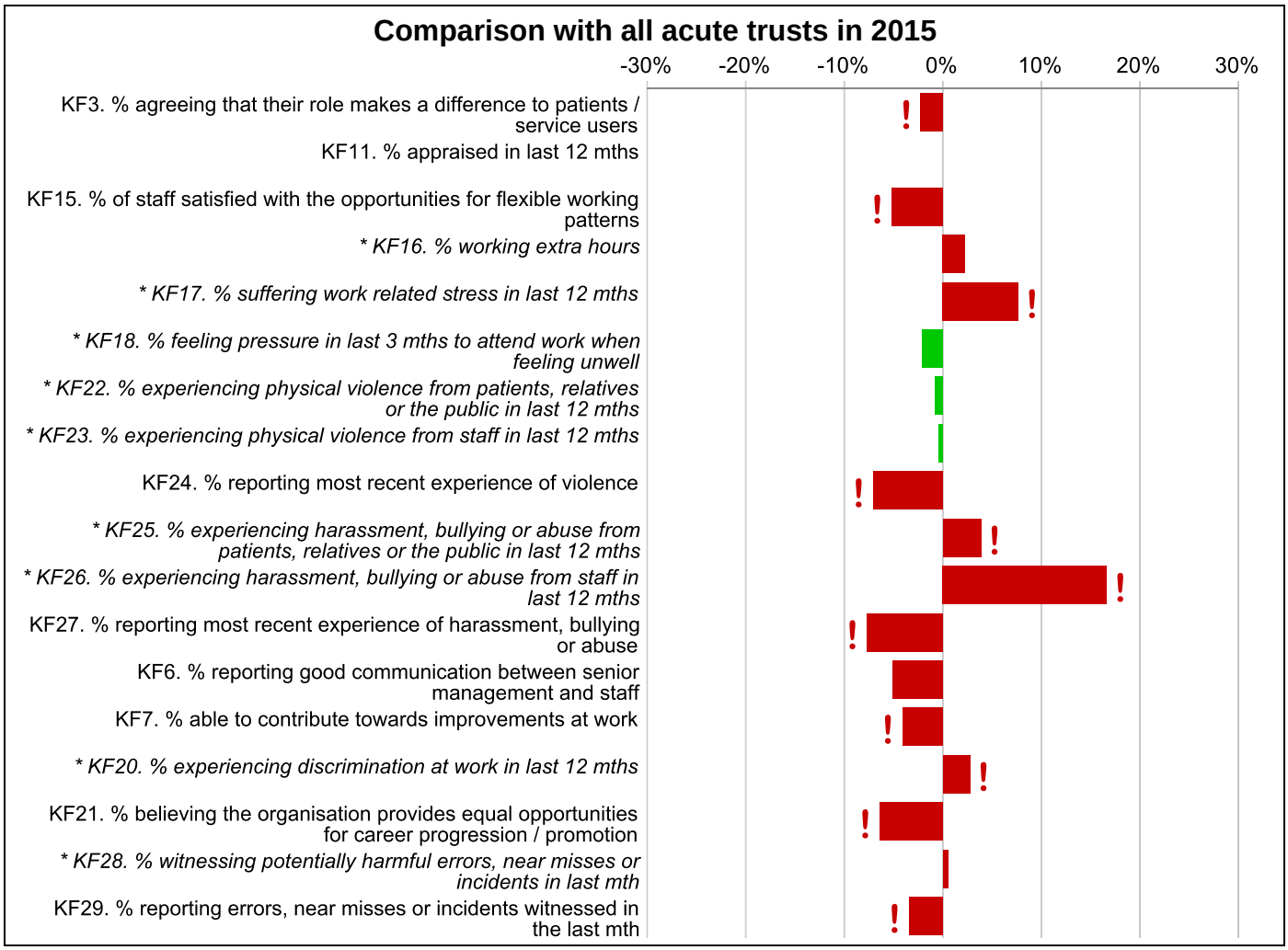
KEY

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, e.g. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for East Kent Hospitals University NHS Foundation Trust

KEY

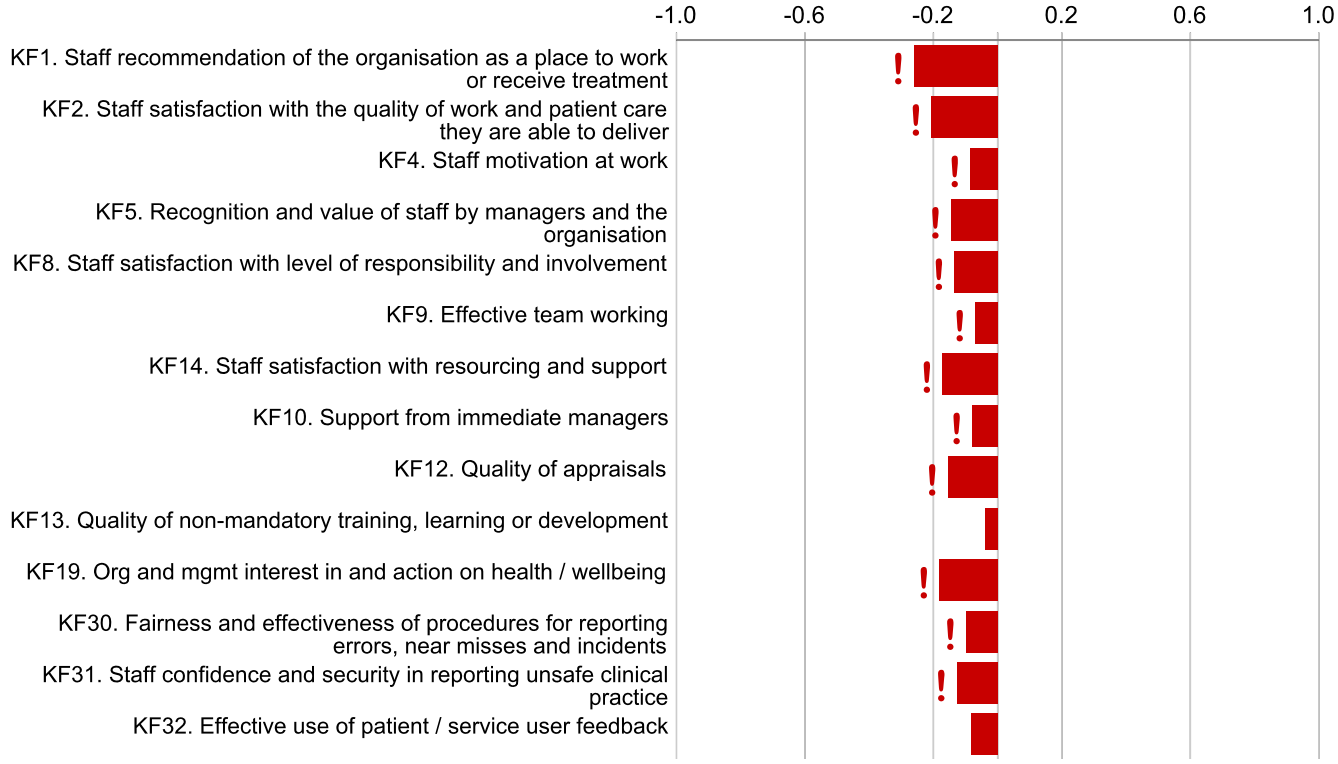
Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, e.g. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Comparison with all acute trusts in 2015 (cont)



3.4. Summary of all Key Findings for East Kent Hospitals University NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. in the best 20% of acute trusts, better than average, better than 2014.

! Red = Negative finding, e.g. in the worst 20% of acute trusts, worse than average, worse than 2014.

'Change since 2014 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2014 survey.

-- Because of changes to the format of the survey questions this year, comparisons with the 2014 score are not possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2014 survey	Ranking, compared with all acute trusts in 2015
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	✓ Increase (better than 14)	! Lowest (worst) 20%
KF2. Staff satisfaction with the quality of work and patient care they are able to deliver	--	! Lowest (worst) 20%
KF3. % agreeing that their role makes a difference to patients / service users	--	! Lowest (worst) 20%
KF4. Staff motivation at work	✓ Increase (better than 14)	! Lowest (worst) 20%
KF5. Recognition and value of staff by managers and the organisation	--	! Lowest (worst) 20%
KF8. Staff satisfaction with level of responsibility and involvement	✓ Increase (better than 14)	! Lowest (worst) 20%
KF9. Effective team working	--	! Lowest (worst) 20%
KF14. Staff satisfaction with resourcing and support	--	! Lowest (worst) 20%
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.		
KF10. Support from immediate managers	✓ Increase (better than 14)	! Lowest (worst) 20%
KF11. % appraised in last 12 mths	• No change	• Average
KF12. Quality of appraisals	--	! Lowest (worst) 20%
KF13. Quality of non-mandatory training, learning or development	--	! Below (worse than) average
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.		
Health and well-being		
KF15. % of staff satisfied with the opportunities for flexible working patterns	--	! Lowest (worst) 20%
* *KF16. % working extra hours*	• No change	! Above (worse than) average
* *KF17. % suffering work related stress in last 12 mths*	• No change	! Highest (worst) 20%
* *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell*	✓ Decrease (better than 14)	✓ Below (better than) average
KF19. Org and mgmt interest in and action on health / wellbeing	--	! Lowest (worst) 20%

3.4. Summary of all Key Findings for East Kent Hospitals University NHS Foundation Trust (cont)

	Change since 2014 survey	Ranking, compared with all acute trusts in 2015
Violence and harassment		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	✓ Below (better than) average
* *KF23. % experiencing physical violence from staff in last 12 mths*	✓ Decrease (better than 14)	✓ Below (better than) average
KF24. % reporting most recent experience of violence	! Decrease (worse than 14)	! Lowest (worst) 20%
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	! Highest (worst) 20%
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	! Highest (worst) 20%
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	! Lowest (worst) 20%
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.		
KF6. % reporting good communication between senior management and staff	✓ Increase (better than 14)	! Below (worse than) average
KF7. % able to contribute towards improvements at work	✓ Increase (better than 14)	! Lowest (worst) 20%
ADDITIONAL THEME: Equality and diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	! Highest (worst) 20%
KF21. % believing the organisation provides equal opportunities for career progression / promotion	✓ Increase (better than 14)	! Lowest (worst) 20%
ADDITIONAL THEME: Errors and incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	✓ Decrease (better than 14)	! Above (worse than) average
KF29. % reporting errors, near misses or incidents witnessed in the last mth	• No change	! Lowest (worst) 20%
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	--	! Lowest (worst) 20%
KF31. Staff confidence and security in reporting unsafe clinical practice	✓ Increase (better than 14)	! Lowest (worst) 20%
ADDITIONAL THEME: Patient experience measures		
KF32. Effective use of patient / service user feedback	✓ Increase (better than 14)	! Below (worse than) average

4. Key Findings for East Kent Hospitals University NHS Foundation Trust

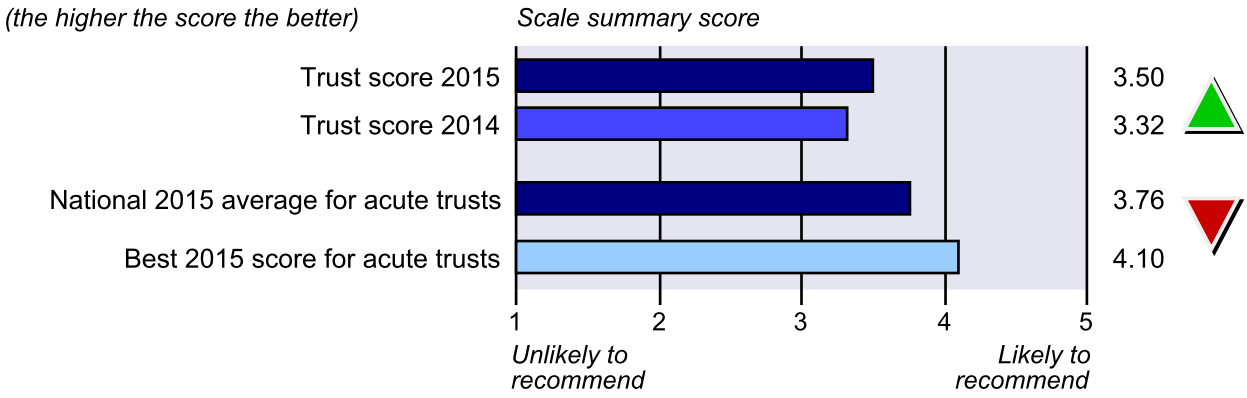
3044 staff at East Kent Hospitals University NHS Foundation Trust took part in this survey. This is a response rate of 40%[1] which is average for acute trusts in England, and compares with a response rate of 41% in this trust in the 2014 survey.

This section presents each of the 32 Key Findings, using data from the trust's 2015 survey, and compares these to other acute trusts in England and to the trust's performance in the 2014 survey. The findings are arranged under seven headings – the four staff pledges from the NHS Constitution, and the three additional themes of equality and diversity, errors and incidents, and patient experience measures.

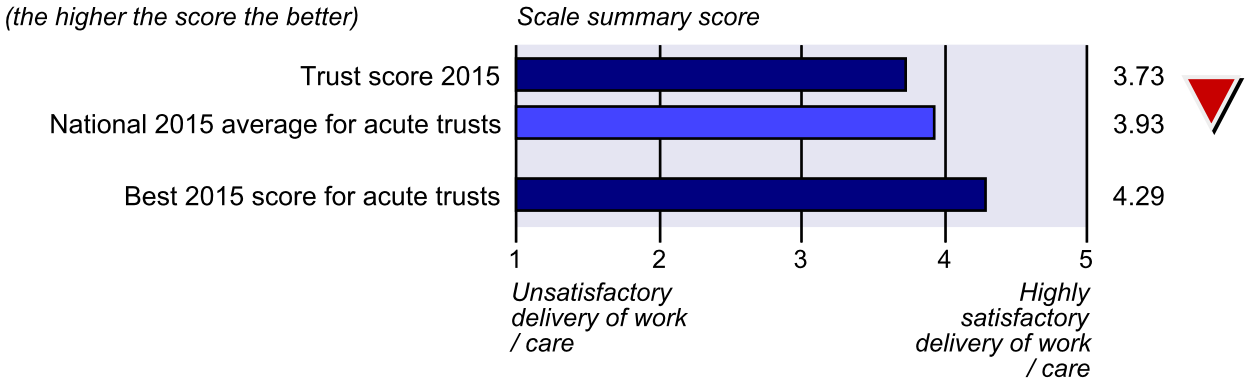
Positive findings are indicated with a green arrow (e.g. where the trust is in the best 20% of trusts, or where the score has improved since 2014). Negative findings are highlighted with a red arrow (e.g. where the trust's score is in the worst 20% of trusts, or where the score is not as good as 2014). An equals sign indicates that there has been no change.

STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.

KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment



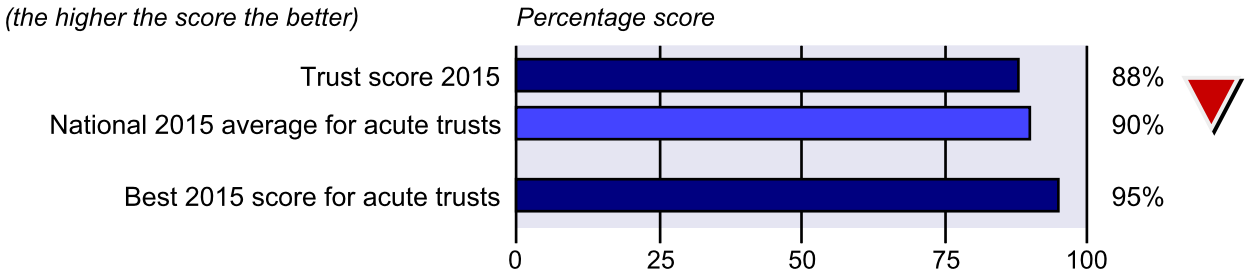
KEY FINDING 2. Staff satisfaction with the quality of work and patient care they are able to deliver



[1]Questionnaires were sent to all 7520 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

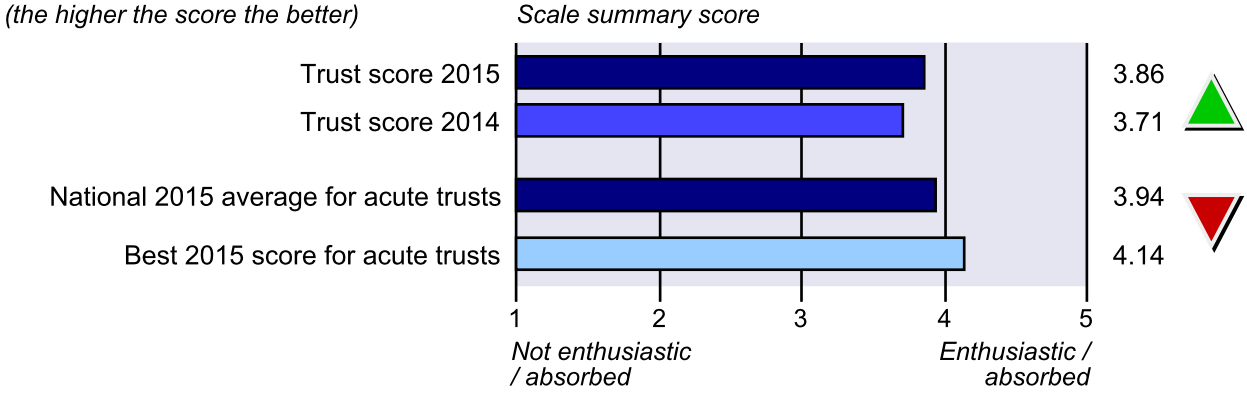
KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



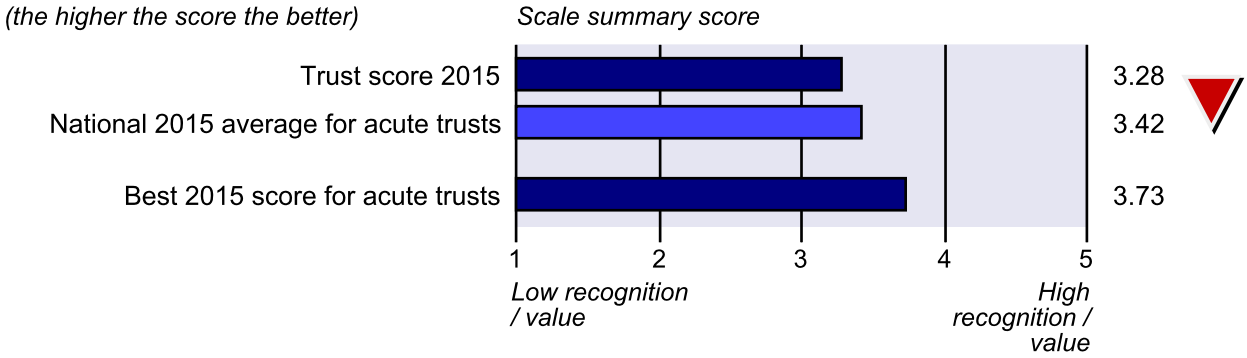
KEY FINDING 4. Staff motivation at work

(the higher the score the better)



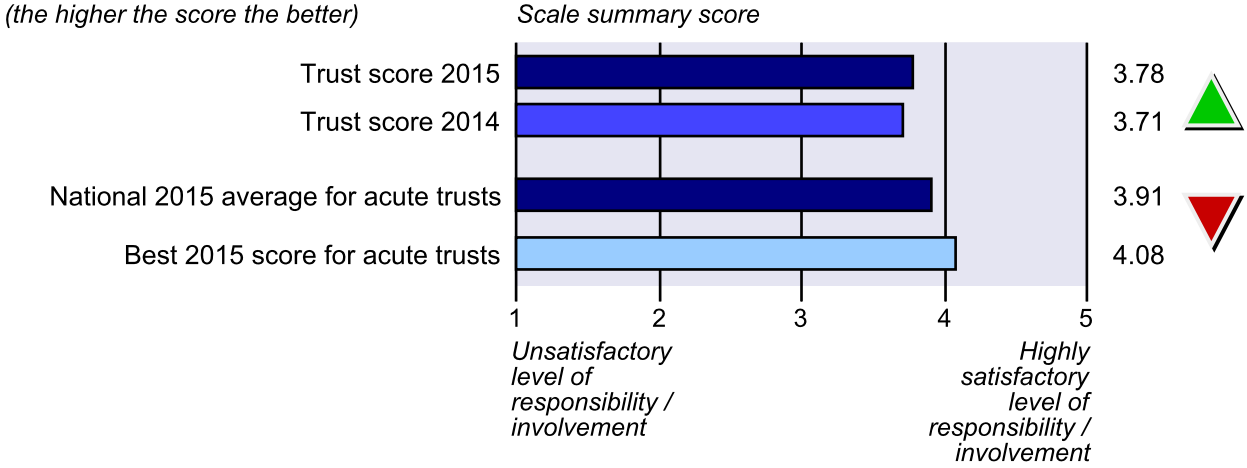
KEY FINDING 5. Recognition and value of staff by managers and the organisation

(the higher the score the better)

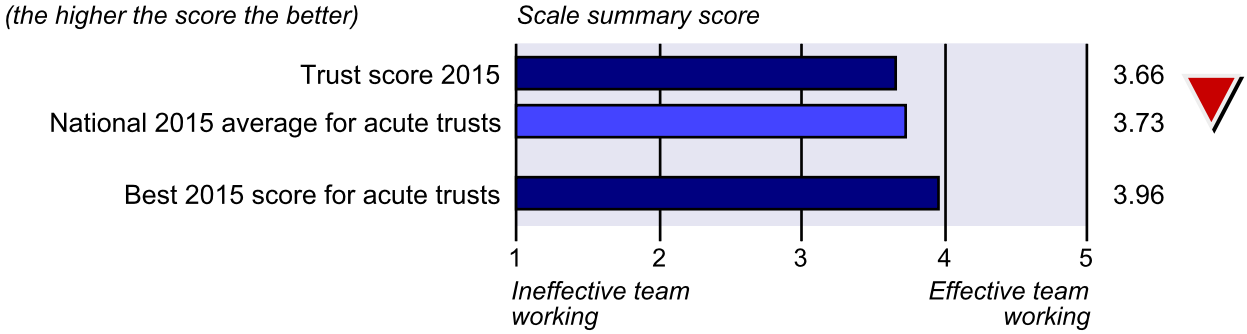


KEY FINDING 8. Staff satisfaction with level of responsibility and involvement

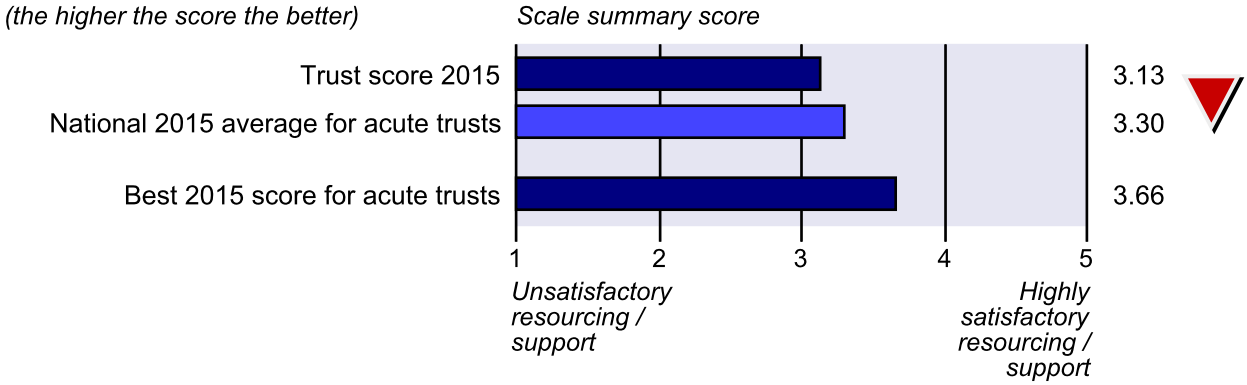
(the higher the score the better)



KEY FINDING 9. Effective team working

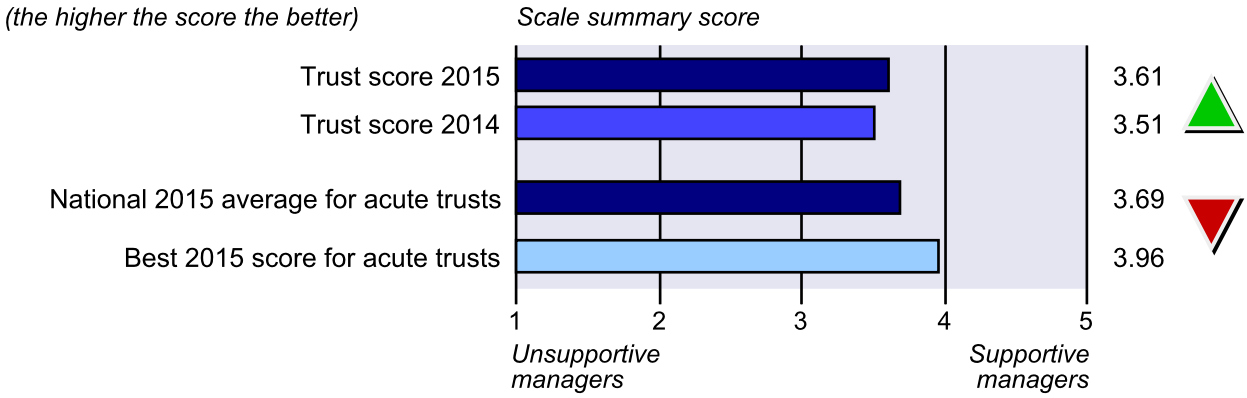


KEY FINDING 14. Staff satisfaction with resourcing and support

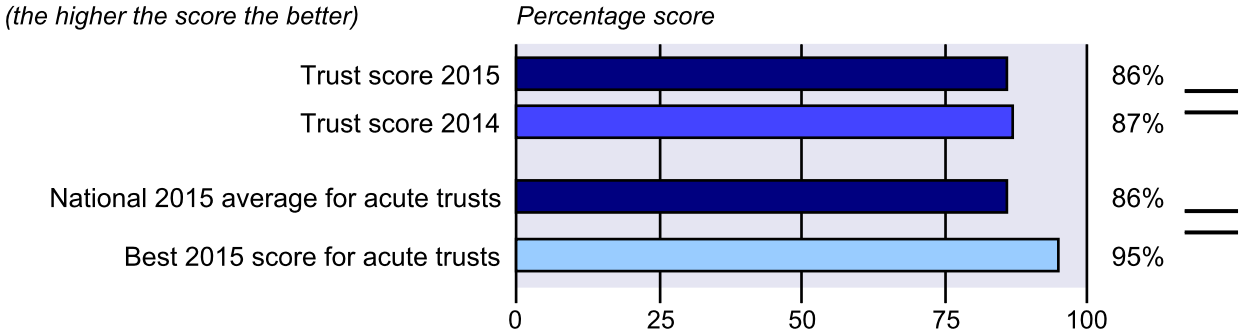


STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

KEY FINDING 10. Support from immediate managers

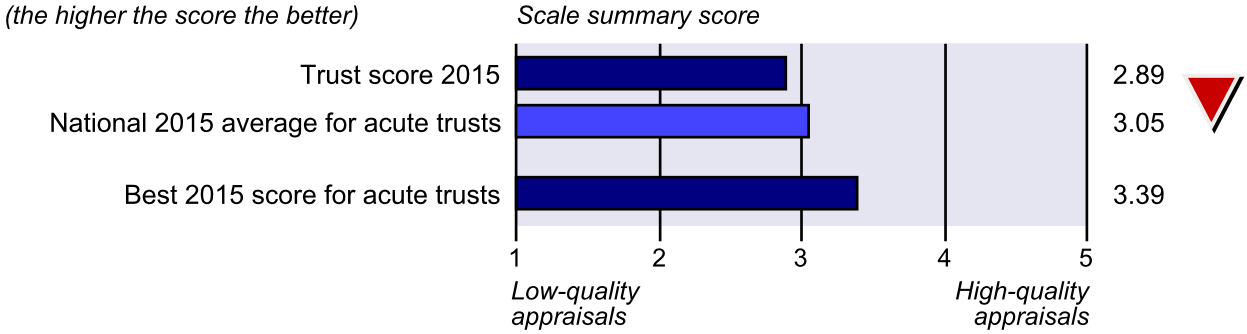


KEY FINDING 11. Percentage of staff appraised in last 12 months



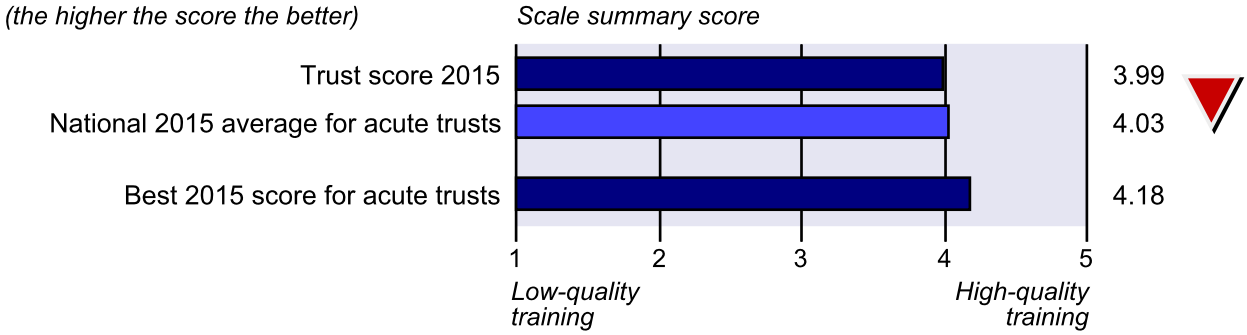
KEY FINDING 12. Quality of appraisals

(the higher the score the better)



KEY FINDING 13. Quality of non-mandatory training, learning or development

(the higher the score the better)

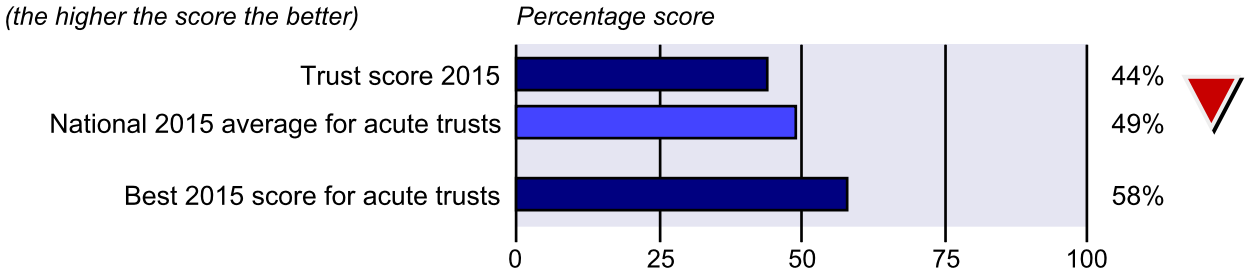


STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

Health and well-being

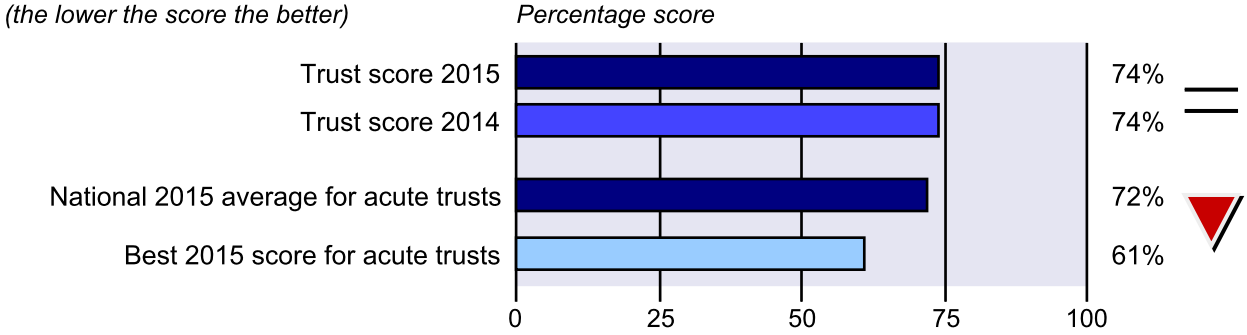
KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns

(the higher the score the better)



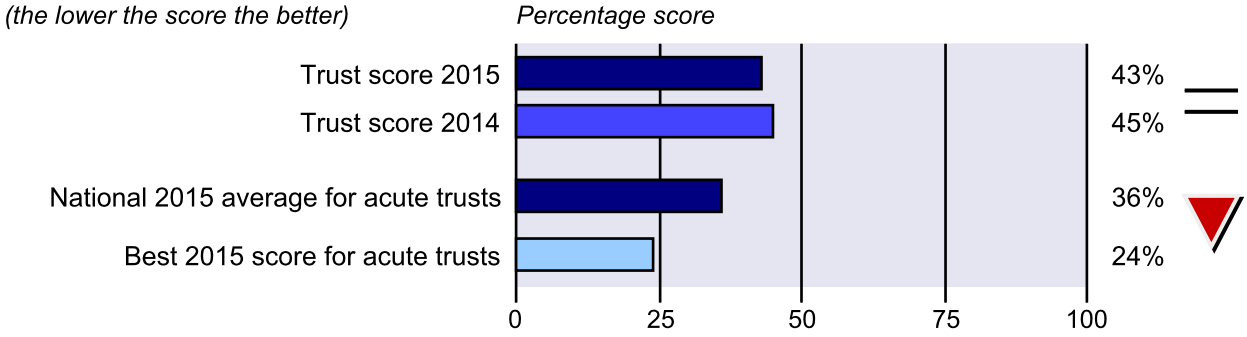
KEY FINDING 16. Percentage of staff working extra hours

(the lower the score the better)



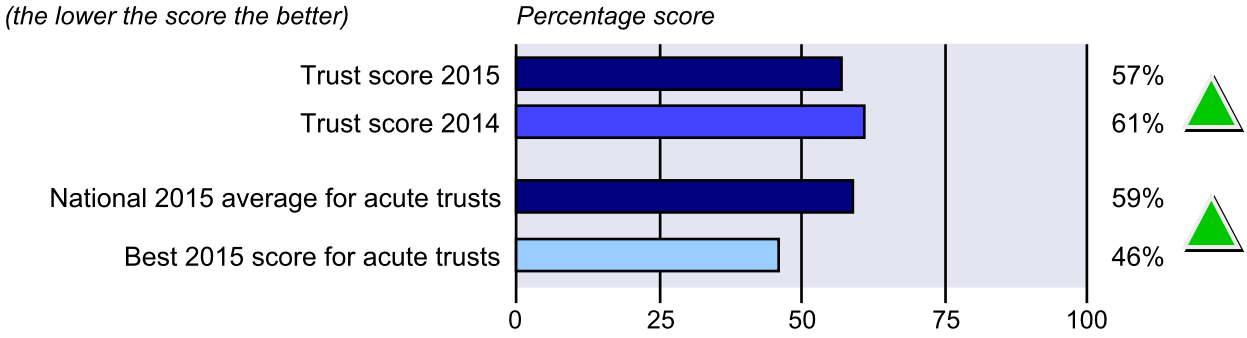
KEY FINDING 17. Percentage of staff suffering work related stress in last 12 months

(the lower the score the better)



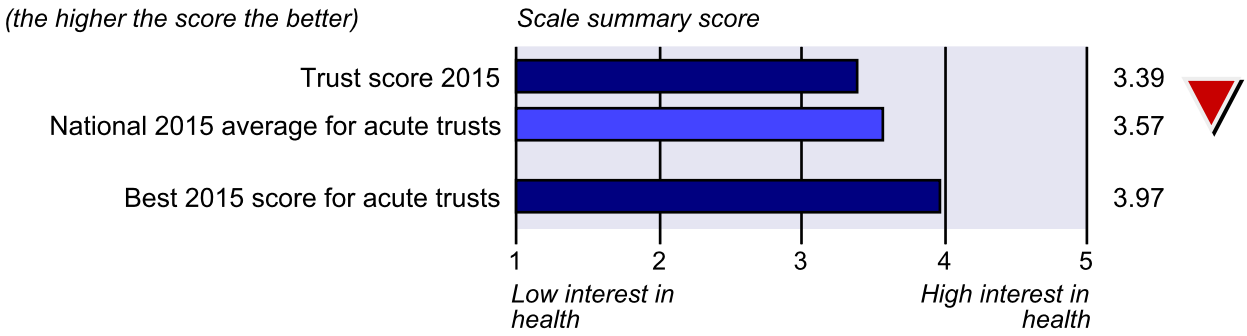
KEY FINDING 18. Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell

(the lower the score the better)



KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

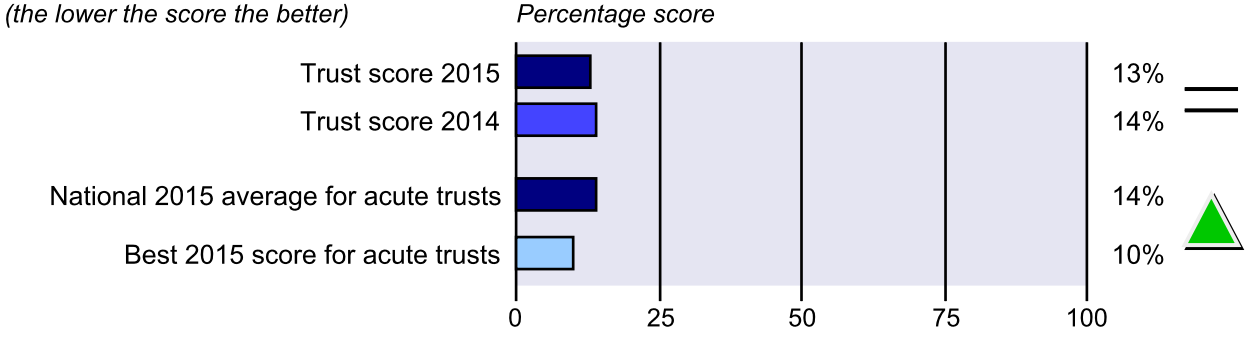
(the higher the score the better)



Violence and harassment

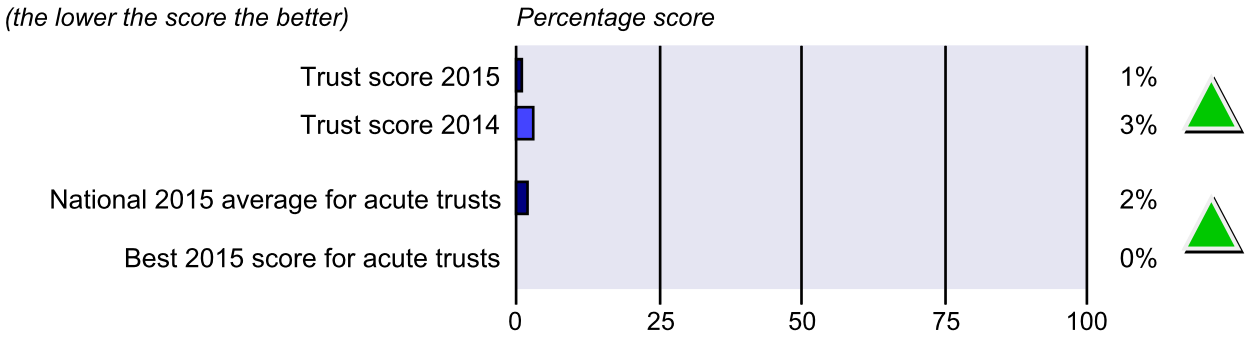
KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



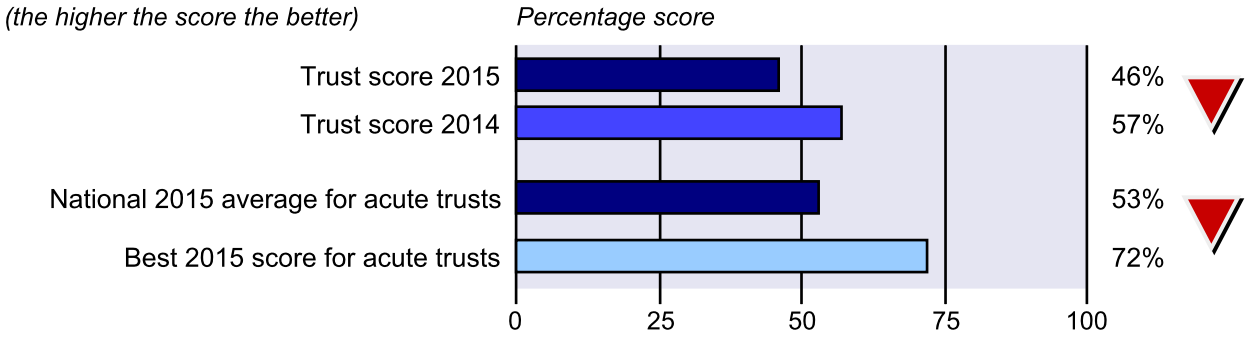
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



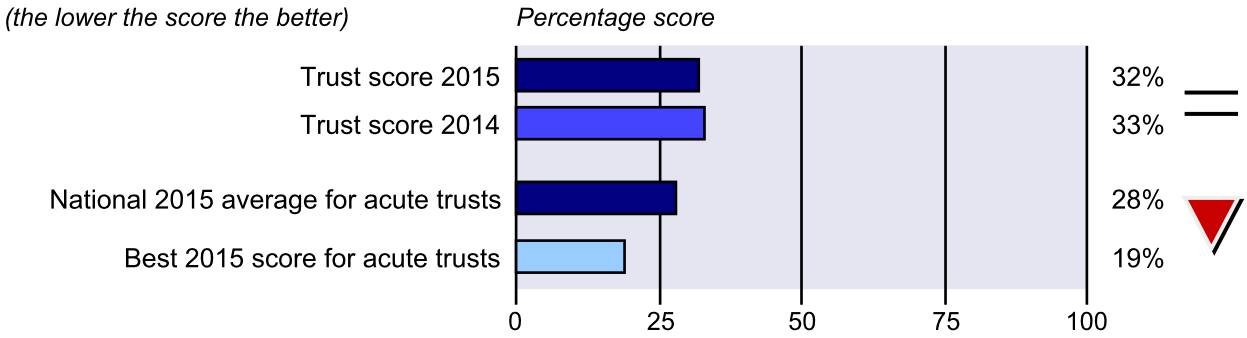
KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



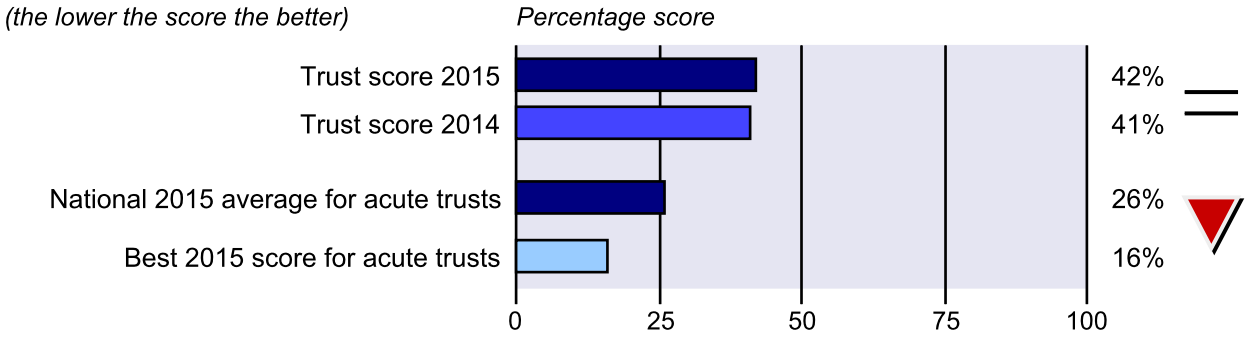
KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



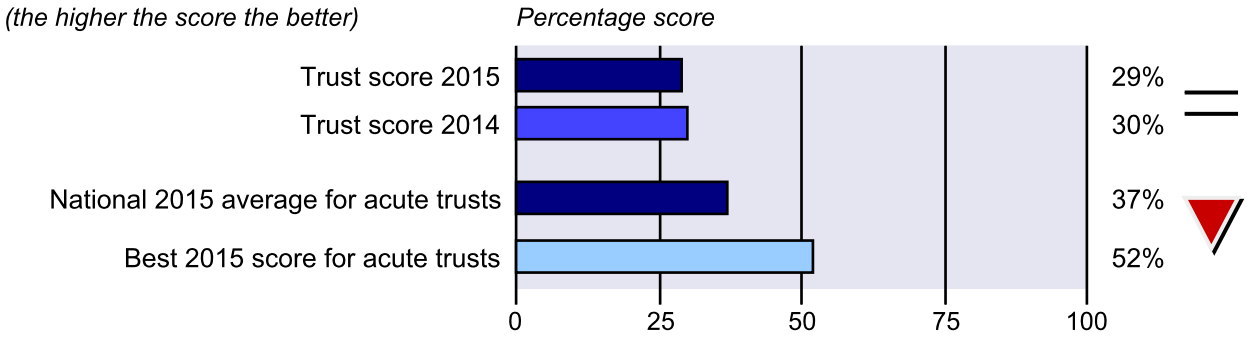
KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

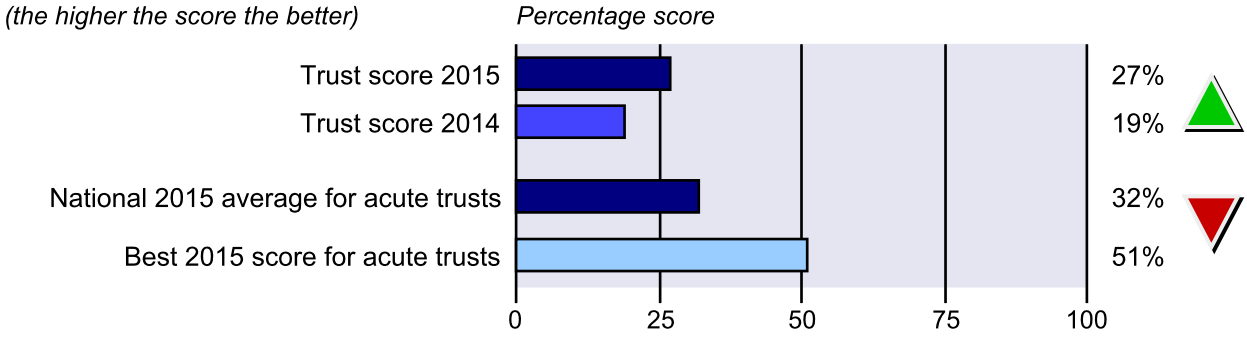
(the higher the score the better)



STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

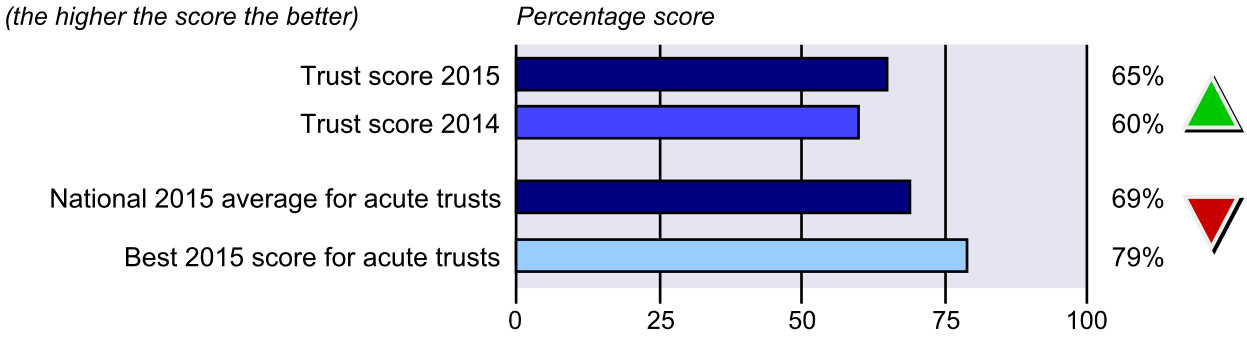
KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)



KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

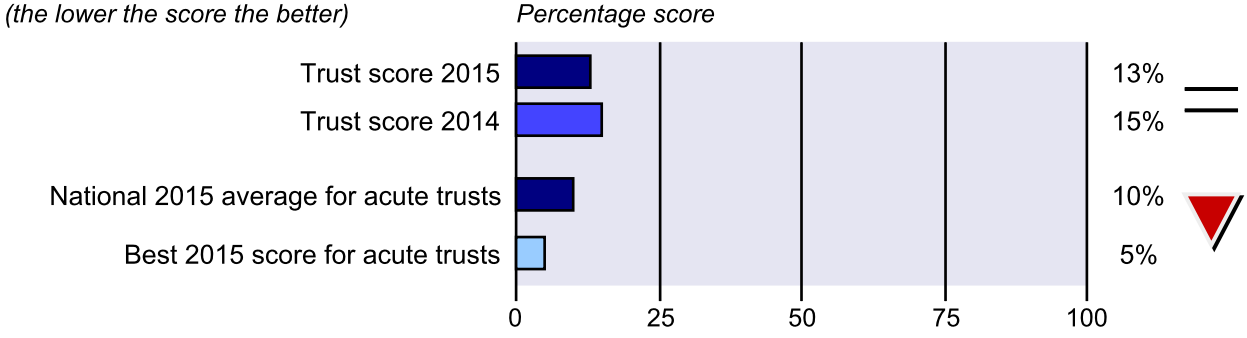
(the higher the score the better)



ADDITIONAL THEME: Equality and diversity

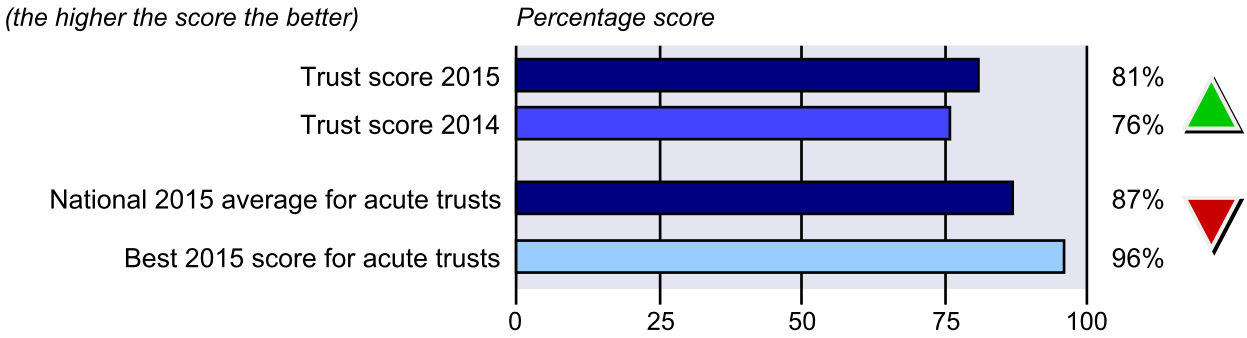
KEY FINDING 20. Percentage of staff experiencing discrimination at work in last 12 months

(the lower the score the better)



KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

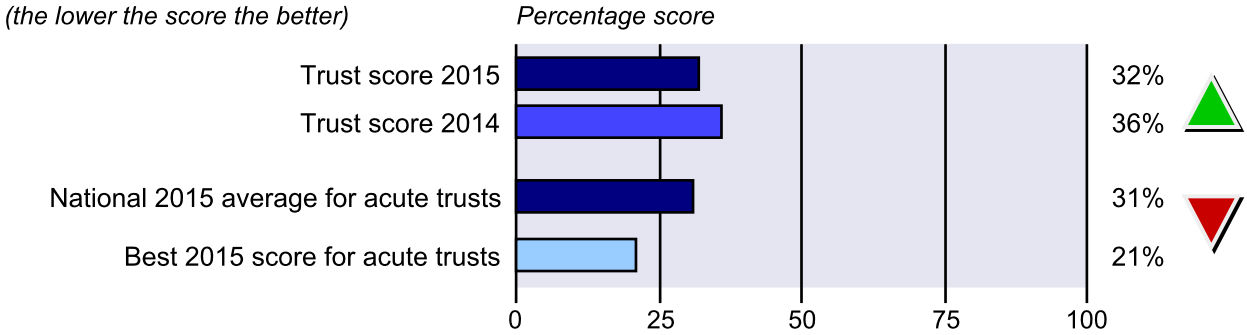
(the higher the score the better)



ADDITIONAL THEME: Errors and incidents

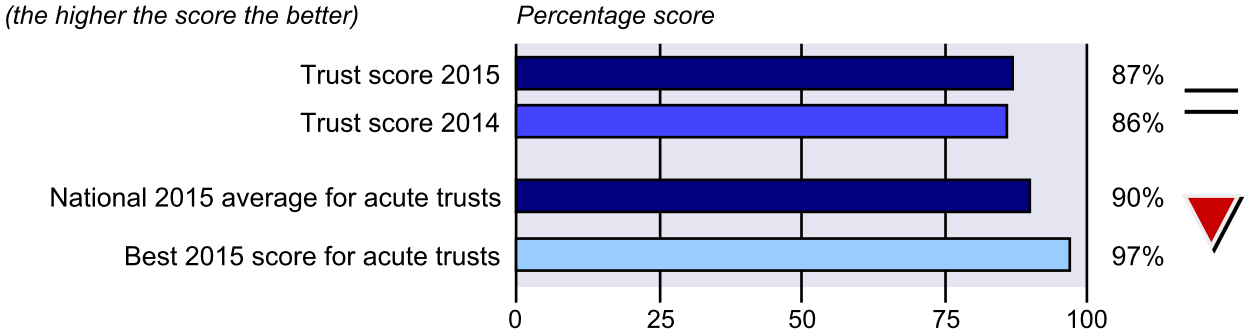
KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



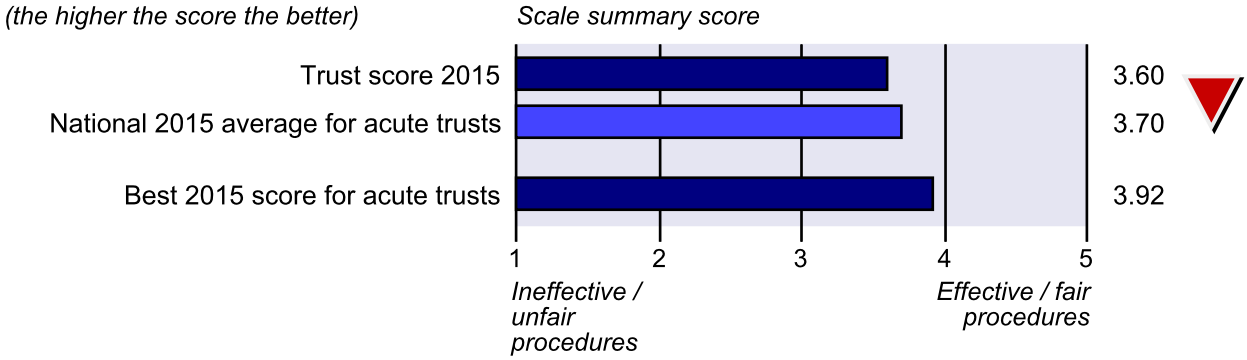
KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



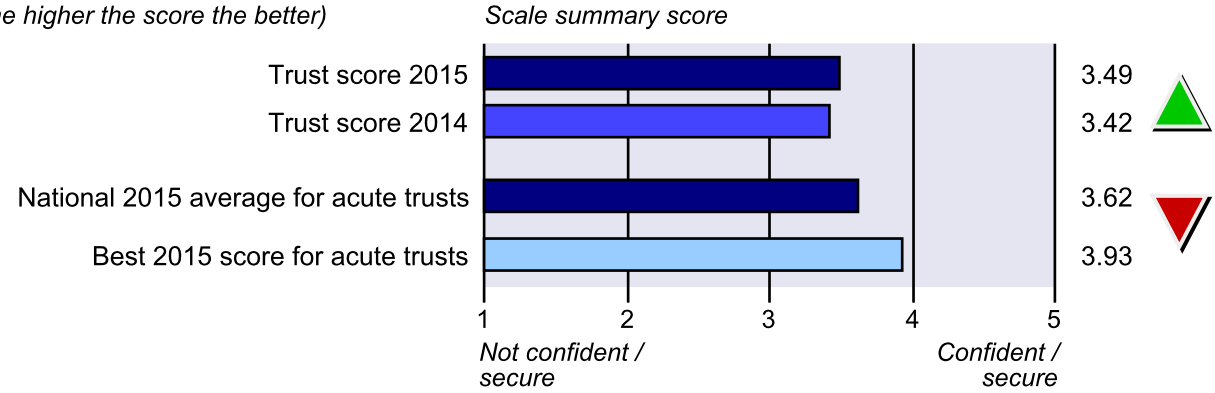
KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)



KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice

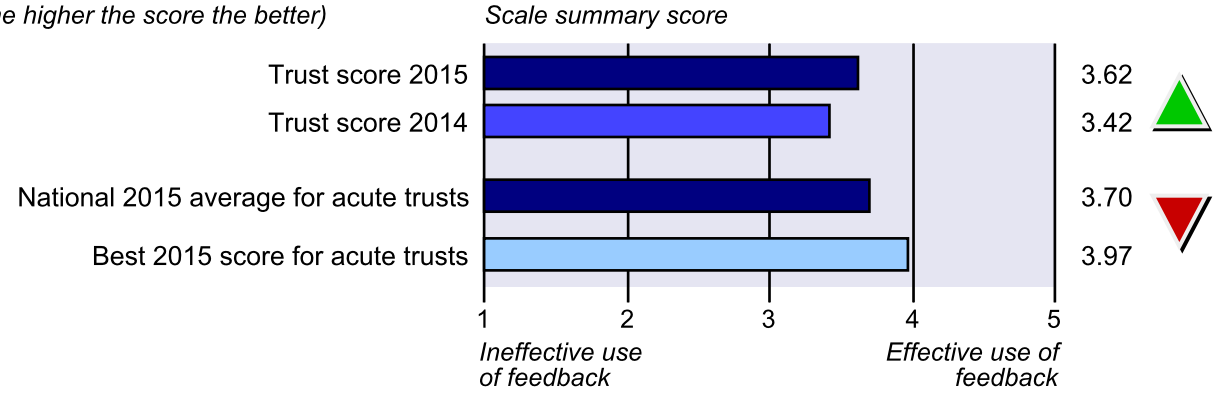
(the higher the score the better)



ADDITIONAL THEME: Patient experience measures

KEY FINDING 32. Effective use of patient / service user feedback

(the higher the score the better)



EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS**

DATE: **8 APRIL 2016**

SUBJECT: **HEALTH & SAFETY KPI UPDATE**

REPORT FROM: **DIRECTOR OF ESTATES AND FACILITIES**

PURPOSE: **Decision**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

In addition to the six monthly Board Health & Safety report the Board have asked for additional Key Performance Indicators (KPIs) to be considered.

1. SUMMARY:

The Health and Safety team currently capture a number of KPIs form the Trusts Datix system and from management reports. Table 1 outlines the current metrics.

Table 1

Incidents by Sub category and Incident date grouped by Category
Extract of non clinical incidents (KPIs)
Accident / Fall (staff or visitors only)
Exposure to blood and bodily fluids
Chemical Spill
Contact with cold liquid / substance / surface
Contact with hot liquid / substance / surface
Electric shock
Exposure to / contact with harmful substance
Knocked or hit stationary object
Knocked or hit by moving object
Motor vehicle accident
Other
Sharps - near miss contact with a sharp / needle
Sharps - contact with used sharp / needle
Slip trip or fall - from a height (not patient falls, please choose clinical incident)
Slip trip or fall - from the same level (not patient falls, please choose clinical incident)
Traps (hand in door or window)
Fire including false alarm
Fire - actual fire
Fire - false fire alarm
Security (V&A only)
Patient behaviour - aggressive behaviour to another patient
Patient behaviour - aggressive behaviour to a member of staff
Patient behaviour - aggressive behaviour other
Patient behaviour - physical assault to a member of staff
Patient behaviour - physical assault other
Patient behaviour - sexual assault or abuse towards another
Patient behaviour - verbal abuse to a member of staff
Staff behaviour - verbal abuse to another member of staff
Security - attempted suicide or self harm
Security - knife / weapon related
Visitor or Other person/s behaviour - aggressive behaviour other
Visitor or Other person/s behaviour - aggressive behaviour to a member of staff
Visitor or Other person/s behaviour - verbal abuse to member of staff
Visitor or Other person/s behaviour - verbal abuse other

These metrics are reported, RAG rated and monitored by the Strategic Health & Safety Committee. Table 2 outlines the rating.

Table 2

Heath & Safety, Fire and Security Trust KPIs - revised March 2016

	KPI Description	Jan-16	Feb-16	Mar-16
Proposed KPIs				
KPI 1	Divisional representation at H&S meetings	56%	64%	56%
KPI 2	RIDDOR reports	3	4	0
KPI 3	Formal Notices	0	0	0
KPI 4	Accidents	47	64	34
KPI 5	Fire Incidents	10	11	6
KPI 6	Violence and Aggression	32	38	22

KEY to Proposed KPI's				
	Red	**Amber**	**Green**	
Proposed KPIs				
KPI 1	48<	49-75	76>	% of Clinical Divisions represention at the site H&S committees
KPI 2	6>	4-6	0-3	Monthly RIDDOR reports
KPI 3	3>	2	0	Notices from HSE
KPI 4	60>	41-60	40<	Accidents including sharps excluding manual handling
KPI 5	11>	6-10	5<	Fire alarm activations (including false alarms)
KPI 6	40>	26-40	25<	Violence, aggression and verbal abuse

2. The Trust Board asked for further KPIs to be considered. The Health and Safety Advisor has meet with departmental leads and can report as follows:

2.1 Lost Time Accidents

Currently all accidents are recorded on Datix but there is no record of **lost time** recorded unless RIDDOR reportable. Additionally Staff sickness records lost time but these are not always categorised as to cause and could be resulting from personal or other issues.

Should the Trust decide to use LTA as a metric it would be possible to compare the Trust results with HSE annual statistics for the Health and Social Care Sector. However comparison with non-NHS bodies and companies would be problematic due to the nature of our differing risk profiles.

Currently many LTAs only have standard Datix investigations conducted with the standard of investigation variable. If we decide to use LTAs as a measure, it would be sensible to require all LTAs to have an Adverse Incident Report (AIR) or an RCA depending on severity and complexity conducted as part of the review.

2.2 Never Events

Currently all 'Never Events' are reported to Board separately following reviews by the Division concerned and by the Trust Governance committees and, therefore, could be included quite easily.

2.3 Risk Assessments

Currently there is no central system for holding all Trust related risk assessments.

The Health & Safety Toolkit Audit System (HASTAS) requires a review of a percentage of risk assessments for the purposes of quality assurance, but does not record the number of current risk assessments in each area and or whether they are in date.

Risk registers should record all current significant health and safety risks. If the accuracy of risk registers is improved, the number of health and safety risks on Divisional and Corporate risk registers would be a sensible metric and could be incorporated.

2.4 Health and Safety Training

The Trust has a good record of overall H&S training, as reviewed by the HSE. There are several levels of Health & Safety Training that the Trust provides as flows:

- Basic H&S e-learning undertaken by all staff members and monitored through "staff training records";
- 2 day training for Health & Safety Link Workers (staff with departmental H&S responsibilities). Annual records kept and a full list of people trained each year is maintained;
- 4 day IOSH Managing Safely course for senior managers with H&S responsibilities. A more structured approach to allocating and centrally recording posts with H&S responsibilities at senior level is required before this can become a useful metric.

It is therefore possible to include this metric within the Health & Safety dashboard.

2.5 Safeguarding Vulnerable Adults and Children plus Mental Incapacity

Having discussed with the Safeguarding lead, reports of neglect allegations and whether they were up held in part or full as a possible KPI, it was identified as possible to include this in the H&S dashboard.

RECOMMENDATIONS:

To note the current KPIs and agree whether to include additional metrics

NEXT STEPS:

To include the revised H&S KPIs into the revised Trust dashboard.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

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

LINKS TO BOARD ASSURANCE FRAMEWORK:

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

AO2:Embedding the improvements in the High Level Improvement Plan to ensure the Trust provides care to its patients that exceeds the fundamental standards expected
IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS: N/A
FINANCIAL AND RESOURCE IMPLICATIONS: N/A
LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY: N/A
PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES N/A
ACTION REQUIRED: To note the current KPIs and agree whether additional KPIs are required.
CONSEQUENCES OF NOT TAKING ACTION: N/A

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**8 APRIL 2016**
SUBJECT:	**CORPORATE RISK REGISTER**
REPORT FROM:	**CHIEF NURSE & DIRECTOR OF QUALITY**
PURPOSE:	**Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

This document provides the Board of Directors (BoD) with the top ten corporate risks and the new risks proposed for the Corporate Risk Register. The new risks added to the register were reviewed at the Management Board on 30 March 2016; however, due to the timings of the meetings it has not been possible to make the changes to the register before submission of this paper. The top 10 risks were received by the Board of Directors at the October 2015 meeting; the full register was reviewed by the Board at the January 2016 meeting and the strategic risks by the Board in December 2015. The top 10 risks were last reviewed by the Integrated Audit and Governance Committee on 19 October 2015 and the full register was reviewed on 20 July 2015. Quality risks were reviewed and discussed at the Quality Committee on 06 April 2016.

SUMMARY

The corporate and strategic risks have been reformatted and re-scored following discussions with the Executive leads for each risk. These have included the risks identified from the newly drafted strategic risks that will be discussed at Board of Director Meeting agenda item 8: Strategic Direction and Annual Objectives.

A new database “Insight” is being populated and a training programme for Divisions and the key corporate areas is being planned with the company. Recruitment into new Risk Manager post will be completed during April.

The top ten corporate risks remain:

1. Failure to achieve financial stability and deliver financial plans; the unmitigated score 25; the residual risk score is 20;
2. The Trust fails to plan for changing levels of demand appropriately; the unmitigated score is 20; the residual risk score is 12;
3. Patient's eyesight may be adversely affected by inadequate follow up arrangements; the unmitigated score is 20; the residual risk is12;
4. New European Data Protection Rules; the unmitigated score is 20; the residual risk score is 10;
5. Patients with mental health problems may be harmed because they do not receive timely mental health interventions; the unmitigated score is 16; the residual risk is 12;
6. Potential delayed treatment of patients requiring emergency acute general surgery intervention at the Kent and Canterbury Hospital site; the unmitigated score is 15; the residual risk is 15;
7. Ability to attract, recruit and retain high calibre staff to the Trust; the unmitigated score is 15; the residual risk score is 12;
8. K&CH Ward or ECC patients may suffer adverse harm; the unmitigated score is 15; the residual risk score is 12

9. Patients with sepsis are not recognised or treated in a timely way which may affect their outcome; unmitigated score is 15; the residual risk score is 10
10. Blood and blood product transfusion errors; unmitigated score is 15; the residual risk score is 5.

New Risks

A number of new risks were discussed at the Management Board on the 30 March 2016. The following risks will be added to the Corporate Risk Register:

1 **Complaints management process and delays in first response times**

Following the last meeting of the Improvement Plan Delivery Board on 18 March 2016, the committee requested that the management of complaints within the Trust is re-added to the risk register. The action around MD26 - Patients' complaints are responded to as per national standards. Ensure there is a clear process for learning across the Trust.

There is still significant work to do to improve the response time within 30 days. A trajectory for improvement will be discussed and agreed by the Complaints and Patient/Carer Feedback Group. Q3 compliance of complaints responded to within 30 days is 33%. Surgical Services have a very effective 'Outcomes with Learning' (OWL) 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 2016/17 action plan for the Group.

A review of current staffing levels within the Patient Experience Team corporately and locally within the division is starting and the resources aggregated to meet the actions required. There is currently slippage with the timeframe for action completion.

A move to a web-based complaints system is currently being reviewed in order to provide greater transparency to the divisions. This system in line with the incident reporting process and comes from the same supplier as our existing systems. The set up costs are £7,000 plus VAT, with an annual licence of around £6,000 plus VAT.

The Management Board agreed to add this risk.

2 **Storage and ownership of oncology healthcare records**

An issue has arisen about the storage and ownership of oncology/radiotherapy records, which are currently stored and managed outside the main patient healthcare record. This does not follow recognised best practice regarding a single unified health record for each patient in order to ensure transparency of management across differing specialties. During initial investigation, the same practice is in operation for patients on the haemophilia pathway. The requirement for a single healthcare record is enshrined in NHS practice within the document Records Management: NHS Code of Practice 2006 and is defined as:

> "A single record with a unique identifier containing information relating to the physical or mental health of a given patient who can be identified from that information and which has been recorded by, or on behalf of, a health professional, in connection with the care of that patient. This may comprise text, sound, image and/or paper and must contain sufficient information to support the diagnosis, justify the treatment and facilitate the on-going care of the patient to whom it refers."

Furthermore the records are held on the Kent and Canterbury Hospital site and are being managed by staff working for Maidstone and Tunbridge Wells NHS Trust who have technically no ownership of these additional records. It is unclear as to what policies and procedures these records are being managed.

There is a risk that relevant cancer treatment is not forming part of the current healthcare records for these patients and elective and emergency admissions outside the cancer pathway may not have relevant information included as part of their assessment.

Sections of these oncology records are removed from the full oncology records folder for any patient treatment on Brabourne Ward and the Cathedral Day Unit. This further compounds the risk of missing information as these records are held in both areas where the facilities are sub-optimal for this purpose and the tracking and traceability functions are not in line with SOPs within the Trust Healthcare records department.

The Management Board agreed to add this risk.

3 **Retrospective case note review process**

Following the Mazar's Report into deaths at Southern Health NHS Foundation Trust published in December 2015, NHS England introduced the concept of a retrospective case note review on all patient deaths, expected or not, for all trusts in England. This process is due to commence on 01 April 2016. The national pro forma was due to be shared by 31 January 2016; however this has still not been consulted upon or disseminated. There is a structure of mortality and morbidity meetings in all divisions and across most clinical specialties; however the rigour of questioning and the evidence of shared learning is inconsistent, sometimes across sites within specialties. Each healthcare record must be assessed in order to record whether the death was avoidable, or not.

The number of deaths reported annually is over 2,500, with the majority occurring in UC&LTC and has huge resource implications in order to complete this new process in addition to running a mortality and morbidity programme. Both the surgical and specialist divisions can probably use their current resources to manage the changes; UC&LTC cannot manage to review the 200-220 death occurring monthly.

The Trust is also required to set up a Mortality Surveillance Group (MSG) with direct reporting to the Board of Directors' and which is fully multidisciplinary. Initial discussions are on-going and a proposal, based on the letter and guidance from NHS England, is further outlined below:

1. Chaired by a Board level clinician and have representation from CCGs
2. Responsible for reviewing data on patient deaths, including results and learning generated by local mortality reviews, and to consider strategies to improve care and reduce avoidable mortality.
3. Receive regular reports of overall crude mortality and numbers of deaths by diagnostic groups.
4. Review deaths by site, ward, at weekends & Bank Holidays, on a regular basis.
5. Review the outputs of National audits that provide information on mortality at Trust level e.g. ICNARC, National Bowel Cancer Audit, NELA
6. Review minutes and action logs from Mortality and Morbidity meetings.
7. Amend regular reporting to the BoD to include:
    a. Number of deaths in last month
    b. Three biggest causes of death and current mortality rates for these areas
    c. Overall crude mortality rate, HSMR and SHMI
    d. Specialties or Sub-specialties that are national outliers
    e. Evidence that Trust is working towards / achieving daily senior review and seven day working.

The Management Board agreed to add this risk to the Corporate Risk Register.

4 **Process for reporting and analysing harm from delays in cancer pathways of more than 100 days**

A letter was issued by NHS England, Monitor and the TDA in October 2015. This outlined a process for all trusts for any patient waiting for more than 104 days on any cancer pathway. The commissioners sought assurance at the February 2016 Performance meeting that the Trust had a process in place to assess each patient and evaluate the potential harm caused by the delay, to undertake a full RCA for each patient and report externally onto StEIS where harm was serious. The cancer compliance team have a system of recording the progress of each patient on cancer pathways. This pro forma has been revised to record an assessment of points of failure in the pathway, reasons for delays occurring and whether this has resulted in harm to the patient. This is currently a manual system with no method of capturing this information centrally or visibly.

Each lead consultant has been asked to assess every patient waiting for more than 100 days; this listing is sent weekly because of the frequent changes to the patient tracking lists; there are currently two patients where a delay has possibly resulted in harm to the patient and a full RCA has been requested. The normal process of managing incidents requiring an RCA is on the Datix system; these delayed treatment cases are not being reported as incidents and the governance around their management cannot be assured. There are some consultants who have not engaged fully with the initial risk assessment process and there may be patients who have been harmed. The Datix system has been revised to add in a sub-category to the delayed treatment category in order to account for these patients in a robust and fully auditable system.

The commissioners have requested a regular report and the work plan for the Patient Safety Board updated to receive a quarterly report on all patients waiting for more than 100 days on any cancer pathway. The Management Board agreed to add this risk to the Corporate Risk Register.

5 **Delays in turnaround times for clinic letter typing**

The Clinical Support Services Division brought clinical letter typing turnaround times to the Management Board for action and discussion. It was agreed that the risk posed should be added to the Corporate Risk Register. The issue is described below.

The Trust is now reporting performance against the standard for turnaround times of clinic letters against the agreed stretched standards. The Trust previously did not measure compliance against letters and has agreed with commissioners a stretch standard for this year – benchmarking across the Country advises there are no nationally agreed metrics with exception of 2WW and Rapid access – however best practice suggests locally agreed metrics with tolerance levels approved by commissioners and Providers; improves the quality of the letters and patient care.

Our agreed standards and tolerances are of all correspondence to GPs - 90% of all routine letters to be received by GP within 10 working days and 90% 2 week wait and rapid access letters within 72 hrs. Our current year to date performance is 65.7% compliance. The Divisions are developing recovery plans and will be held to account via the Divisional Executive Performance Reviews.

6 **Junior Doctors' strike**

The impact of the junior Doctors' forthcoming strikes on patient safety and the smooth running of the hospitals was considered by the Management Board. It was agreed to add this risk to the Corporate Risk Register. Robust emergency planning is underway in the organisation led by the Chief Operating Officer and Medical Director.

RECOMMENDATIONS:

The Board is asked to review the new risks outlined and corporate risks currently on the database.

NEXT STEPS:

The Risk Group will review any new risks and the scoring of the existing risks.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

The Strategic objectives and BAF will ultimately drive the Annual Governance Statement, which represents the Trusts' ability to identify and manage risks effectively. Failure to demonstrate a consistent approach to the mitigation and control of risks can impact considerably on the effective delivery of the Trust's strategic and annual objectives.

LINKS TO BOARD ASSURANCE FRAMEWORK:

There is an integral link to the Board Assurance Framework that runs through all the risks on the risk register; there is a specific link to A01.

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

The attached risk register reflects the risks affecting the Trust and the mitigating actions in place.

FINANCIAL IMPLICATIONS:

Actions to mitigate certain risks have considerable impact on Trust expenditure; financial risks are now quantified in terms of single or cumulative costs. Failure to mitigate some risks will also result in financial loss or an inability to sustain projected income levels.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

The Trust could face litigation if risks are not addressed effectively. The aim of the Public Sector Equality Duty is relevant to the report in terms of the provision of safe services across the nine protected characteristics.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

Not applicable

BOARD ACTION REQUIRED:

(a) to discuss and determine actions as appropriate

CONSEQUENCES OF NOT TAKING ACTION:

The Trust will continue to face unmitigated risks which may result in a worsening of the current position.

Corporate Risk Register

East Kent Hospitals University NHS
NHS Foundation Trust

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

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority
CRR 8	Patients with mental health problems may be harmed because they do not receive timely mental health interventions **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 22 Feb 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**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.	I = 4 L = 4 Extreme (16)	Planned increase in cover arrangements for a 12 hour period across all 3 sites planned from May 2016. **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 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. **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	I = 4 L = 3 Extreme (12)	On-going work with local Commissioners and the mental Health Trust is underway, following a wider health economy improvement plan away day in December. 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		I = 4 L = 2 High (8)

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority
CRR 15	Ability to attract, recruit and retain high calibre staff to the Trust **Risk Owner:** Sandra Le Blanc **Delegated Risk Owner:** **Last Updated:** 23 Feb 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** There is a national shortage of staff in some specialties. The results of the annual staff surveys and the staff FFT have placed the Trust in the lowest performing quartile for several years. The location of the Trust in relatively close proximity to London, makes the retention of staff more challenging. Publication of NICE guidelines on ward-based staffing has raised the profile of the adequacy of staffing. **Effect** This is affecting some allied health professions more than other staff groups, including Pharmacy, SaLT etc. There has been an increase in the number of agency staff usage to meet the staffing shortfalls; this has come as in creased cost pressure for the Trust.	I = 3 L = 5 Extreme (15)	Universities well engaged and the Trust recruits the majority of newly qualifies staff locally. Specific education and training programmes developed for Band 4 practitioner posts to cover EDs and operating theatre vacancies. **Control Owner:** Sally Smith Recruitment process revised and Job descriptions updated to incorporate Trust values and behaviours. **Control Owner:** Sandra Le Blanc Development of the Cultural Change Programme and recruitment based on the core Trust values. **Control Owner:** Sandra Le Blanc Publication of scheduled versus actual staffing levels on each ward, updated each shift to ensure visibility. **Control Owner:** Sally Smith Programme of overseas nurse recruitment established with 109 nurses recruited from Spain, Portugal, Greece, Italy, Malta, Romania and Croatia. **Control Owner:** Sally Smith	I = 3 L = 4 High (12)	**Person Responsible:** **To be implemented by:**		

East Kent Hospitals University NHS
NHS Foundation Trust

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority
CRR 10	New European Data Protection Rules **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 22 Feb 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** European Privacy Law will become part of UK statute in 2018 placing specific responsibilities on all organisations for the use of personal data; this will affect patients in the main, but staff records will be included within the regulations. **Effect** The Trust may not have the necessary infrastructure in place to deliver against the following key areas: 1. Obtaining individual consent for disclosure 2. Privacy Impact Assessments to enable the organisation to understand the risks to personal data and privacy. 3. The Trust will need to establish systems to ensure that protections of personal data are included in all areas of business. 4. The Trust will need to be transparent in reporting externally all breaches of security and confidentiality to regulators and the persons affected. 5. A process is required to give individuals the right to be forgotten. 6. There is a financial penalties, up to 4% of turnover is possible, equivalent to £20million,	I = 5 L = 3 Extreme (15)	The IG Manager is actively engaging nationally with peer and national leaders in order to assess accurately the impact of the proposed changes to legislation within the Trust. **Control Owner:** Paul Stevens The Trust is registered with the Office of the Information Commissioner and reports IG breaches locally and nationally **Control Owner:** Paul Stevens The Trust has an Information Governance function within the corporate team to support the changes required **Control Owner:** Paul Stevens	I = 5 L = 2 Extreme (10)	Comprehensive review of the IG function and succession planning arrangements to identify core gaps internally. **Person Responsible:** Paul Stevens **To be implemented by:** 31 Mar 2017		I = 4 L = 2 High (8)

Annual Objective 1 - Patient Safety - Delivering the improvements identified in the Quality Strategy in relation to patient safety, patient experience and clinical effectiveness. Safe Care - by improving safety and reducing harm

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority
CRR 1	K&CH Ward or ECC patients may suffer adverse harm **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 05 Feb 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** - Lack of sperate medical rota to cover ECC - No formal consultant rota to support trainees over a 24 hr period - Reliant for several years on a medical rota covered only by trainees **Effect** - Poor training experience for our trainees - Possibility of losing trainees at K&CH - Dilute consultant cover from wards to cover ECC rota - Patient experience / harm - Media interests	I = 3 L = 5 Extreme (15)	Monitoring of harm through incidents and complaints and reported claims arising from ECC **Control Owner:** Helen Goodwin New and sperate physician rota to provide 12 hrs a day where they are roterd only in EEC **Control Owner:** Paul Stevens There is an Emergency Care Improvement Programme (ECIP) in place that reviews all actions identified by external review (Oct 15) **Control Owner:** Jane Ely	I = 3 L = 4 High (12)	Consult on Clinical Strategy around emergency care provision **Person Responsible:** Liz Shutler **To be implemented by:** 30 Sep 2016		I = 1 L = 1 Low (1)

Annual Objective 1 - Patient Safety - Delivering the improvements identified in the Quality Strategy in relation to patient safety, patient experience and clinical effectiveness. Safe Care - by improving safety and reducing harm

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority
CRR 4	Patients with sepsis are not recognised or treated in a timely way which may affect their outcome **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 09 Feb 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** The opportunities and systems in place to recognise and manage patients presenting with or developing sepsis are not taken and/or the deteriorating patient is not recognised. Patients with cancer undergoing chemotherapy are susceptible to neutropenic sepsis. Previously fit and healthy adults may compensate clinically until they are critically ill. **Effect** Treatment is not administered in a timely way due to delayed recognition and and patients may suffer adverse outcomes.	I = 5 L = 3 Extreme (15)	Documentation in all EDs revised to record consistently patients vital signs and blood test results **Control Owner:** Paul Stevens All Point of Care testing equipment for blood gas analysis updated to include lactate measurements in EDs. **Control Owner:** Paul Stevens Clinical staff issued with aide-memoire on sepsis managment and compliance tested using CEM audit and local audit **Control Owner:** Paul Stevens Staff training in place on the recognition of patients with sepsis in line with national best practice, including primary care and Ambulance service **Control Owner:** Paul Stevens	I = 5 L = 2 Extreme (10)	Trust requires a solution to electronic recording of vital signs across the whole Trust to ensure the deteriorating patient can be readily identified from the point of access. **Person Responsible:** Paul Stevens **To be implemented by:** 03 Apr 2017		I = 4 L = 2 High (8)
CRR 5	Blood and blood product transfusion errors **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 09 Feb 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** A patient, or patients, may receive incompatible blood or blood products in error **Effect** The patient may suffer a blood transfusion reaction resulting in harm or death	I = 5 L = 3 Extreme (15)	Alert triggers in place for ABO and rhesus incompatibility **Control Owner:** Sally Smith Specific training and competency assessment for clinical and non-clinical staff on PPID, blood group compatibility and fating in line with NPSA SPN 14 **Control Owner:** Sally Smith	I = 5 L = 1 High (5)	Ensure A+ patient trigger alert is activated for O+ plasm on APEX system **Person Responsible:** Sally Smith **To be implemented by:** 03 Feb 2016		I = 5 L = 1 High (5)
CRR 7	Potential delayed treatment of patients requiring emergency acute general surgery intervention at the Kent and Canterbury Hospital site **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 22 Feb 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** There is provision for specialist vascular and urology surgery on the Kent and Canterbury site only and the provision for the emergency pathway is restricted to an ECC model and not a full ED. This situation was widely shared with GP and SECAmb partners over 10 years ago. In the past general surgical intervention, when needed, was covered by vascular surgeons. With the introduction of Specialist Medical Training (Calman Report) the ability of surgeons to be deemed competent to perform procedures outside their registered speciality has decreased. **Effect** Patients requiring general surgical intervention are occasionally transferred to the K&CH site and require subsequent transfer to either the WHH or QEQMH after stabilisation. Some vascular surgeons do maintain core clinical competencies for general surgery but there is not a formal rota at the K&CH site and this can result in delays to treatment. Where the patient is considered	I = 5 L = 3 Extreme (15)	Clarity of the function of the K&CH site as not having the capability to manage general surgical emergencies communicated to external partners including SECAmb and GPs. Rapid assessment of patients and transfer out to the WHH and QEQMH or competent vascular surgical intervention at the K&CH, Fundamentally, the clinical strategy will mitigate the risk. **Control Owner:** Paul Stevens	I = 5 L = 3 Extreme (15)	Implementation of clinical strategy with a stable rota of general surgical cover across the Trust. **Person Responsible:** Liz Shutler **To be implemented by:** 31 Mar 2017		I = 5 L = 1 High (5)

Annual Objective 1 - Patient Safety - Delivering the improvements identified in the Quality Strategy in relation to patient safety, patient experience and clinical effectiveness. Safe Care - by improving safety and reducing harm

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority
CRR 12	Patient's eyesight may be adversely affected by inadequate follow up arrangements **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 02 Mar 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** Due to historic PAS systems, the true patient follow up capacity gap has never been visible. Partial booking has given transparency to the issues facing patients requiring regular follow up. Ophthalmology specialties provide services in predicted high growth areas and these are expected to further increase with an aging demographic. **Effect** There are approximately 7,000 patients waiting for a follow up appointment outside of their required timeframe to be seen. Nearly 1,500 patients are being validated as they are not indicated at speciality level. Therefore nearly 5,500 patients have been escalated as requiring an appointment that is overdue and require urgent follow-up within the specialty. There is a lack of out-patient capacity to manage the backlog and maintain the current patient cohort.	I = 4 L = 5 Extreme (20)	Proposals for Virtual clinics have been described in the business case for follow up diabetic medical retina patients, with a conservative estimate of 3,000 patients who would benefit from this approach. **Control Owner:** Paul Stevens A pathway has been developed for the commissioners to enable the safe transfer of stable follow up glaucoma patients into the community **Control Owner:** Paul Stevens The service has been successful in bidding for government monies for an electronic patient record which can be shared from acute to community. This will facilitate patient flow with speed and reduce clinical risk. **Control Owner:** Paul Stevens	I = 4 L = 3 Extreme (12)	Implement the ophthalmology transformation strategy, which involves an increase in staff numbers and new equipment to support these staff. **Person Responsible:** Paul Stevens **To be implemented by:** 31 Mar 2017 Introduce an electronic patient record system in the form of Openeyes software, which will drive both efficiency increases and cost savings. The system can also be rolled out to, and integrated with, community services to support the flow of patients in and out of acute services. **Person Responsible:** Paul Stevens **To be implemented by:** 31 Mar 2016		I = 4 L = 2 High (8)

Annual Objective 3 - Operational Performance (NHS Constitution) Delivering Improvements in patient access performance to meet the standards expected by patients as outlined in the NHS Constitution and our Provider Licence with Monitor

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority
CRR 3	The Trust fails to plan for changing levels of demand appropriately **Risk Owner:** Jane Ely **Delegated Risk Owner:** **Last Updated:** 05 Feb 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** There is a increased and un-planned local demand for emergency and elective services that the Trust is unable to meet with the resources and infrastructure available. Surge resilience plans do not meet unprecedented demand **Effect** Plans in place for activity and demand are not synchronised with actual activity performed and there is a resultant loss of income and the Trust carrying the risk in isolation. Engagement with commissioners and specialist commissioners is compromised making agreement about contracted activity difficult to manage. The Trust experiences increased costs associated with out-sourcing activity further compromising financial stability, patient safety and experience. The Trust is in breach of its licence to operate and is subject to close scrutiny by Monitor	I = 4 L = 5 Extreme (20)	The Trust is participating in the Emergency Care Improvement Programme (ECIP) **Control Owner:** Jane Ely Demand and capacity monitored in all areas outlined in the Operating Framework **Control Owner:** Jane Ely The CEO and COO are both active members of the SRG and have raised this lack of whole health economy capacity plans. **Control Owner:** Jane Ely	I = 4 L = 3 Extreme (12)	Review of clinical leadership in ED and effectiveness of current controls to be assessed by ECIP **Person Responsible:** Paul Stevens **To be implemented by:** 02 May 2016		I = 3 L = 3 High (9)

East Kent Hospitals University NHS
NHS Foundation Trust

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority
CRR 2	Failure to achieve financial stability and deliver financial plans **Risk Owner:** Nick Gerrard **Delegated Risk Owner:** **Last Updated:** 05 Feb 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** Due to : - poor planning - poor recurrent CIP delivery - poor cash management, and - gaps in financial governance **Effect** Resulting in: - potential breaches to the Trust's Monitor licence - adverse impact on the Trust's ability to deliver all of its services and, in the longer term, the clinical strategy, which further impacts on - the reputation of the organisation, and - the Trust being sustainable as a going concern in future as creditors lose confidence and there are reduced resources for investment.	I = 5 L = 5 Extreme (25)	Financial governance systems in place **Control Owner:** Nick Gerrard Financial recovery plan in place **Control Owner:** Nick Gerrard Divisional specific Cost Improvement Plan targets in place with PMO and workstream support **Control Owner:** Nick Gerrard Turnaround Director in post from October 2015 **Control Owner:** Nick Gerrard Clinical workstreams in place to ensure the standards of care delivered are not adversely affected **Control Owner:** Sally Smith	I = 5 L = 4 Extreme (20)	Implementation of financial governance action plan **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2016		I = 5 L = 3 Extreme (15)

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS**

DATE: **8 APRIL 2016**

SUBJECT: **MEDICAL DIRECTOR'S REPORT**

REPORT FROM: **MEDICAL DIRECTOR**

PURPOSE: **Decision**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

The report covers the following:
1. Junior doctors contract
2. Emergency Care Centre Update
3. Update on nasogastric tube assurance visit actions
4. Mortality and Mortality Governance Review

SUMMARY:

Junior Doctors Contract. NHS Employers released the final version of the new junior doctors contract at 14.00 on the 31st March 2016. Key aspects of the new contract are detailed in the report. The timetable for implementation runs from August 2016 to August 2017. Following the release of the finalised version of the new junior doctors contract the BMA launched a legal challenge relating to equality and diversity on the 1st April 2016. NHS Employers acknowledge that the decision to implement this contract without the agreement of the BMA Junior Doctors Committee remains a source of concern for Boards and as a Foundation Trust EKHUFT is not obliged to implement the contract. Whether or not the BoD recommends implementation certain preparatory work needs to be undertaken with effect from now, such as appointment of a Guardian.

Emergency Care Centre (ECC). Actions taken to safeguard patient safety and medical trainees experience in the ECC at Canterbury are detailed. HEKSS re-visited medical training at Canterbury on the 14th March 2016 and have not raised any further concerns following that visit.

Nasogastric (NG) tube assurance. The final action from the NG tube assurance visit to be completed is the review of the Trust's response to central alerts. This report is still awaited. A decision by the Crown Prosecution Service on whether or not to pursue a charge of corporate manslaughter against the Trust is still awaited although we were told we could expect this at the end of March 2016.

Mortality. An overview of mortality is presented which encompasses definitions, current reporting of mortality, potential outlying areas, potential opportunities for improved learning and the proposals for future mortality governance.

RECOMMENDATIONS:

1. To discuss and note the report.
2. To make a decision concerning implementation of the new Junior Doctors

contract, options include
   a. Agree to implement and begin preparatory work now
   b. Defer agreement to implement pending further developments but begin preparatory work now
   c. Negotiate a local agreement
   d. Do nothing
3. To support the establishment of a Mortality Steering Group and a review of mortality governance

NEXT STEPS:

BoD recommendations will be taken forward by the Trust. Additional actions will be taken forward by the Trust as outlined in the report.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

SO1: Deliver excellence in the quality of care and experience of every person, every time they access our services
SO2: Ensure comprehensive communication and engagement with our workforce, patients, carers, members GPs and the public in the planning and delivery of healthcare

LINKS TO BOARD ASSURANCE FRAMEWORK:

AO1: Delivering the improvements identified in the Quality Strategy in relation to patient safety, patient experience and clinical effectiveness
AO2:Embedding the improvements in the High Level Improvement Plan to ensure the Trust provides care to its patients that exceeds the fundamental standards expected
AO6: Delivering the cultural change programme to increase staff engagement and satisfaction

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

Reputational risk and public confidence.
Risk of disengagement of junior doctor workforce and compromising future training placements.
Risks are articulated on the Trust's risk register.

FINANCIAL AND RESOURCE IMPLICATIONS:

The new junior doctors contract is not cost neutral and has an impact of Trust pension contributions.
Establishment of a mortality steering group and review of mortality governance throughout the Trust will have time implications for clinicians involved.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

Possible legal implication related to NG tube assurance.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

None

ACTION REQUIRED:

(a) Discussion
(b) Decision concerning junior doctors contract
(c) Decision relating to mortality steering group and mortality governance review

CONSEQUENCES OF NOT TAKING ACTION:

Risk to placements of junior doctors in training for the future.
Potential consequences for future patients from not undertaking a mortality governance review and improving the opportunities for improved learning and quality improvement in healthcare.
Reputational risk.

MEDICAL DIRECTORS REPORT

1. Junior Doctors Contract

1.1 Introduction

Following the failure to reach a national agreement on a new contract of employment for doctors in training Jeremy Hunt announced to Parliament on 11 February that the contract would be imposed. Subsequently the BMA have made clear their resistance to this imposition and took further industrial action, a series of strikes have been undertaken and these are continuing with complete withdrawal of labour planned for between 0800-17.00 on both the 26 and 27 April.

NHS employers published the terms and conditions of service (TCS) and a pay circular for the new 2016 doctors in training contract on the 31st March 2016. The TCS set out the details of the contractual terms that NHS Employers believe will ensure safe working hours for doctors in training, alongside the system of pay and reward. The TCS have been reviewed by the Secretary of State for Health in line with his Public Sector Equality Duty leading to some slight changes to the February proposals ensuring no less favourable treatment for part time workers, those with families, those on maternity leave and doctors in training who have a disability.

A phased implementation is proposed which starts from August 2016 and completes by August 2017. The timescale for implementation for doctors commencing on 1st August 2016 requires rotas to be redesigned by the end of April.

1.2 Preparatory Work Required For Implementation

This includes the appointment of the guardian of safe working (see below), rota design, engagement with doctors in the organisation and issuing of job offers in accordance with the national timetable.

1.3 Assurances NHS Employers Are Giving Trust Boards

Danny Mortimer, CEO of NHS Employers has indicated that he would want to assure Trust Boards that the terms are:-

- Safe and fair, designed to safeguard hours of work and ensure doctors are paid for all the work they do
- honouring agreements reached with the BMA during discussions with them from November 2015 to February 2016 including the offer made by Sir David Dalton and himself to the BMA on 9 February 2016, regarding payment for frequent Saturday working and availability for non-resident on call.

1.4 Key Aspects of the new contract

- Appointment of Guardian of Safe Working to oversee robust work schedule review processes and address concerns relating to hours worked and access to training opportunities
- An end to time-served incremental pay progression with a direct link between basic pay and the grade at which a doctor is working
- An extension of plain time into the evenings and Saturdays

1.5 Issues and risks

The main area of contention surrounds weekend working. The current position is that plain time is defined as 7am until 7pm, Monday to Friday, with banding supplements used to recognise both work in addition to the standard 40 hour week and more intense working patterns. Under the new system between 9pm to 7am every day of the week there would be a 50 per cent pay enhancement and on Saturday 5pm to 9pm and Sunday 7am to 9pm a 30 per cent pay enhancement.

Trainees who work shifts beginning on Saturdays 1:4 weeks or more frequently will additionally receive a 30 per cent pay enhancement for any work done on Saturday 7am-5pm

As a Foundation Trust the organisation is not obliged to implement the new junior doctor contract. The BMA have written to the Chief Executive asking that the organisation support the junior doctors in making the decision not to implement. On the other side the CEO of Health Education England has suggested withdrawal of their funding for trainee posts if the contract is not implemented.

Whether or not the Board of Directors decide to recommend implementation now it will be necessary to commence preparatory work immediately to ensure we meet the deadline should a decision be made to implement subsequently.

There is no national funding to support the pay protection provided under the transitional arrangements and consequently a decision to implement will lead to additional costs although these have yet to be identified.

If we chose not to proceed with the new contract the organisation would need to determine the terms that we would wish to offer and negotiate this locally, this is unlikely to be achievable within the timescale described. The alternative would be to continue on the old terms, however it has been pointed out to organisations that both the BMA and the NHS have agreed nationally that these terms lead to unsafe working rotas.

The organisation employs a number of Trust grade doctors whose terms mirror those of doctors in training. These staff are not covered by the changes to national terms and the Trust will need to locally determine the terms under which we will employ Trust grade doctors in future.

1.6 Next steps

- A meeting between trainees and the CEO and MD should be planned for late April to discuss the new contract and appointment of the Guardian of Safe working.

- Board approval to appoint to the Guardian of Safe working and commencement of the recruitment process.

- Divisions to work with Human Resources to ensure that all current doctors in training rotas are correctly described on the DRS system to

allow review to take place and costing of the financial impact to be undertaken.

1.7 Proposed Implementation Timeline

Milestone	**Milestone completion date**	**Supporting product/activity**	**Product published date**
Post commencing in August 2016			
Consultation with existing doctors regarding new rotas	April	Factsheets on Pay, Safety, and Training	Available
August rotas reworked	April 2016	Guide to safe working hours	Available
August work schedules completed	May 2016	Work schedule template, Implementation guidance	Available
Pay assessed for all work schedules	31 May 2016	Generic work schedule template, Software providers new contract systems	Available Available for rotas/pay April
Deadline employers to offer jobs to doctors for August and provide generic work schedules incorporating rota, pay and on call; model contract; template offer letter	8 June 2016	As above, plus template covering letter	4 April
Guardian to be appointed	July 2016	Job description, Person specification, Section guide guardian, National Guardian of Safe Working Hours conference*	Available (*26 July, bookings from 2 May)
Exception reporting mechanism in place	July 2016	TCS	Available
Work schedule reviews system in place	July 2016	TCS	Available
Personalised work schedules created in consultation and updated	August 2016 onwards	TCS	Available

2. Emergency Care Centre Update

2.1 SECAMB

The revised criteria for conveyance of patients to the ECC at K&CH have been agreed and commissioning aspects have also been agreed between SECAMB and Canterbury & Coastal CCG.

2.2 ECC Redesign

There a 2 main areas of work still requiring completion; the withdrawal of medical teams from the front door to a medical admissions unit with the

establishment of a primary care led urgent care centre and agreement of arrangements at the front door for urology and vascular surgery. The steering group is drawing up a compendium of pathways of care which will also inform the communications strategy.

2.3 HEKSS

HEKSS re-visited medical trainees at K&CH on the 14th March and were accompanied on that visit by the GMC. They appeared satisfied that all the required changes are underway and will be completed by August 2016. It was acknowledged by both HEKSS and EKHUFT that arrangements for patients with acute general surgical problems, both self-presenting at the ECC and developing in hospital, need further strengthening. To date formal written feedback has not been received.

3. Update on nasogastric tube assurance visit actions

The final action has been completed but a report from Sandi Carman, Head of Patient and Healthcare Governance at Sheffield Teaching Hospitals NHS Foundation Trust, has yet to be received (this is in part because of a request for further documentation in order for her to complete her report).

4. Mortality

4.1 Mortality Definitions

Crude Mortality. Crude mortality is a simple measure of the number of deaths that occur in a hospital in any given year which can be compared against the amount of people admitted for care in that hospital for the same time period. This is usually expressed as the number of deaths for every 1000 patients admitted.

Hospital standardised mortality ratio (HSMR). HSMR is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect. HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups. The expected deaths are calculated from logistical regression models taking into account and adjusting for a case-mix of: age band, gender, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

Summary hospital level mortality indicator (SHMI). The SHMI is also a ratio of the observed number of deaths to the expected number of deaths for a Trust. However for SHMI the observed number of deaths is the total number of finished provider spells for the trust which resulted in a death either in-hospital or within 30 days (inclusive) of discharge from the trust. Importantly if the patient is treated by another trust within 30 days of discharge, their death is attributed to the last non-specialist acute trust to treat them. The expected number of deaths is calculated from a risk-adjusted model with a patient case-mix of age, gender, admission

method, year index, Charlson Comorbidity Index and diagnosis grouping. SHMI also uses a larger number of CCS diagnostic groupings (around 140 groups). A three year dataset is used to create the risk-adjusted models. A one year dataset is used to score the SHMI and to calculate the contextual indicators. SHMI is reported 6 months in arrears.

Risk adjusted mortality index (RAMI). RAMI is similar to SHMI except that RAMI does not include deaths within 30 days of hospital discharge or deaths with a zero length of stay and RAMI also has an exclusion for palliative care, excluding any death coded Z51.5 (palliative care code).

4.2 Current reporting of mortality and potential outliers

Within the current board reports both HSMR and SHMI are routinely reported alongside the crude mortality rates for both elective and non-elective (emergency) admissions. These can be seen as usual in this month's Clinical Quality and Patient Safety Report.

Such methods of mortality reporting are commonly used as indicators of a hospital's quality but this has not been validated. This is highly relevant, even more so for us because we have 3 acute hospital sites. As a Trust our mortality indices do not cause concern, but there are differences between our sites (for example SHMI for June 2014 to July 2015 was 102.6 overall but was 94.4 at K&CH, 106.5 at WHH and 106.8 at QEQMH). We know that not all deaths are avoidable but equally we know that some deaths are avoidable. The proportion of hospital deaths judged to be avoidable based on retrospective case record review has been reported to be about 4-5% but the association between the indices of mortality we currently use and the proportion of avoidable deaths is uncertain.

To illustrate the problems cardiac mortality is used as an example. Crude unadjusted hospital mortality for all percutaneous coronary artery procedures nationally for 2014 (the latest available audit data) is 1.9%, the WHH unit has a crude mortality of 4.2% for the same time period. We also know that during the latest period of reporting for SHMI (October 2014 to September 2015) within the 140 clinical groups contributing to the indicator those that would map to percutaneous coronary intervention (PCI) suggest increased mortality. Overall in that period for those groups there were 275 observed deaths versus 201.3 expected. Is that a problem?

Part of the problem with looking at individual diagnosis groups is the very definition of SHMI. The PCI unit takes referrals from several different hospitals and as outlined above in the SHMI definition if a patient is treated by another trust within 30 days of discharge, their death is attributed to the last non-specialist acute trust to treat them. Similarly, even when comparing PCI units in the national audit data behind the crude mortality data for PCI are a number of other important considerations. Nationally the proportion of PCI performed as an emergency in 2014 was 65%, at the WHH unit this was 80% and the WHH had one of the 5 highest proportions of patients required respiratory support prior to PCI (essentially these are the poorest prognosis group). Finally, the difference between hospital crude mortality and 30 day post-discharge mortality following PCI at the WHH is 0.5%, nationally this is much higher (2.8%).

The lack of association between currently reported mortality indices and the proportion of avoidable deaths was highlighted in a publication in the British Medical Journal last year (Hogan et al. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. BMJ 2015;351:h3239) which has prompted a suggested review of mortality governance.

4.3 Proposals for future mortality governance and potential opportunities for improved learning

Alongside other Trusts in the country we have self-assessed our avoidable mortality using a simple tool supplied by NHS England. What this tells us is that of the 2585 deaths/year occurring in our hospitals, using methodology from the study cited above, 79 ± 17 (95% confidence intervals) deaths have a 50:50 chance that death may have been attributable to problems in healthcare. Even if we believe that we provide 25% better care than the average that still leaves 59 ± 12 (95% CI) deaths with a 50:50 chance that death may have been attributable to problems in healthcare. If we then look at our current systems and processes that have identified and reported deaths as attributable to problems in healthcare we're left with around at least 30 additional opportunities for investigation and learning/year. This is borne out by previous audit work undertaken by Dr Michelle Webb when she demonstrated that despite our overall low HSMR case note review reveals deficiencies in care for younger vulnerable adults which have resulted in potentially avoidable deaths.

The Mortality Governance Guide (Appendix 1 to this report) describes in detail the proposals for future mortality governance. Briefly these include:

- Establishment of a mortality surveillance group which should receive statistical information about all deaths in the Trust and track those in the highest risk groups
- Mortality reporting to the trust Board (this already happens as part of the CQ&PS report)
- A high level assessment of all deaths should be undertaken

Appendix 1 Mortality Governance Guide

Mortality Governance Guide

This document seeks to provide some basic guidance around mortality governance and how a focus on clinical care should be the Board's highest priority. This will also help prepare trusts for a programme of work underway in NHS England's Patient Safety Domain, around standardising retrospective case record review (RCRR) for in-hospital deaths. Whilst this guidance is largely applicable to acute trusts, there is clearly a need for similar processes in Community and Mental Health services and Ambulance Trusts in order to allow the Board to gain assurance on the quality of patient care. This is especially the case as the system moves towards greater integration of care delivery.

General Principles

While most hospitals undertake some form of mortality review, there is wide variation in terms of methodology, scope, data analysis, and contribution to learning. By establishing a consistent process of reviewing care through a structured analysis of patient records, we aim to improve the quality of care by helping hospitals to learn from problems that contribute to avoidable patient death and harm. NHS England has

commissioned HQIP to manage procurement of development of a standardised methodology and training roll out to all NHS trusts in England. A supplier will be in place by January 2016, with a pilot expected to start in Q1 2016/17.

Whilst those that die will account for 3% or less of those admitted to an acute hospital, concentrating attention on the factors that cause those deaths will also impact positively on all patients, reducing complications, length of stay and readmission rates. This is through the mechanism of improving pathways of care, reducing variability of care delivery through the use of care bundles, and early recognition and escalation of care of the deteriorating patient. Retrospective case record review will identify examples where these processes can be improved and this information needs to be constantly fed back to clinicians. Furthermore, it will be possible to gain an understanding of the care delivered to those whose death is expected and inevitable. In many organisations this group of patients does not receive optimal care, often because the diagnosis (i.e. this person is dying) is not made or the necessary expertise is in short supply.

In time it will be possible to raise awareness amongst clinicians and managers of the need to promote best practice and behaviours, reduce variability, and make the focus on mortality everyone's business. It should become the subject of formal and informal conversations, from the Board room to the coffee room. Therefore, attention to the issues discussed in this document is relevant for all NHS providers, not just those for whom there are judged to be concerns around mortality.

Governance Processes

Mortality governance should be a top priority for trust Boards. Executive and Non-Executive Directors should have the capability and capacity to understand the issues affecting mortality and to provide appropriate challenge. It is recommended that Trusts have in place the following or similar processes in support of mortality governance, which will also help prepare for roll out of the national RCRR programme.

1) All trusts should have a mortality surveillance group (MSG), with multidisciplinary and multi-professional membership

The primary role of the MSG is to provide assurance to the Trust Board on patient mortality. Mortality indicator statistics do not in themselves constitute evidence regarding the standard of care delivered. Therefore, assurance must be based on review of care received by those who die as well as understanding the statistics. This group should review data on patient deaths, including results and learning generated by local mortality review, and consider strategies to improve care and reduce avoidable mortality. This should be chaired by a Board level clinician (i.e. the Medical Director or Director of Nursing). Serious consideration should be given to external membership from the local clinical commissioning group or NHS England area team and also a local service user/member of the public (e.g. a member of the local Healthwatch group). Attached at Appendix 1 is an example of Terms of Reference for an acute trust mortality surveillance group. Terms of reference for other types of provider would be broadly similar although the use of benchmark data would be different.

In addition to contextual information about quality of care the MSG should also receive statistical information about all deaths in the Trust and should track those in the highest risk groups. In most Acute Hospitals the largest numbers of deaths are in those patients admitted as acute medical emergencies with the diagnoses of sepsis, pneumonia, stroke, myocardial infarction, and heart failure. Other important diagnoses are Acute Kidney Injury and fractured neck of femur. The hospital

information department or a commercial provider should be able to provide regular reports of overall crude mortality and numbers of deaths by diagnostic groups. Further detailed information on for example, deaths by ward, at weekends, Bank Holidays can be reviewed on a regular basis.

National audits providing information on mortality at Trust level, such as ICNARC, TARN, the National Bowel Cancer audit, and other aspects of care including stroke (SSNAP) and myocardial infarction (MINAP) should also be used to identify areas where care may need to be improved.

It may be useful to understand the source of referral for patients who die within 24-36 hours of admission. A significant proportion of these are people who are inevitably at the end of their lives and admission to an acute or community provider may not be in their best interest. Many will be referred from nursing homes or their own homes despite the presence of an appropriate care plan. This is easily achieved by tracking admissions by postcode. Undertaking this type of audit may provide rich information for engaging with commissioners and other LHE partners. It will also provide valuable insights into how these patients are managed in the acute trust, whether decisions, interventions and care are appropriate for this group of patients bearing in mind the recommendations of the review "One Chance to get it Right".

If there are concerns about a cluster of cases or a distinct diagnostic group (for example fractured neck of femur) as identified by an elevated mortality rate, adverse audit report, complaints, Deanery feedback or information arising from a Morbidity and Mortality meeting then a process as described in the section "Response to a mortality alert" (below) should be followed.

2) Mortality reporting to the trust Board

Mortality reporting must be provided regularly in order that Executives remain aware and Non Executives can provide appropriate challenge. This should be at the public section of the meeting with the data suitably anonymised. We would expect the Non Executives to satisfy themselves that appropriate governance processes are in place, that the Trust is providing safe care and that systems exist to detect and reduce the level of avoidable deaths. The type of questions we expect to be asked of the Executives are:

- *What process exists for review of all deaths?*
- *How many people died in the Trust last month?*
- *What are the 3 biggest causes of death in the Trust and the current mortality rates for these?*
- *What is the Trust's current overall crude mortality rate, HSMR and SHMI?*
- *How does the Mortality Surveillance Group (MSG) function, what information does it consider, who are its members and chair?*
- *How will the MSG maintain oversight of avoidable mortality and identify outliers?*
- *Are there any specialities, sub-specialties, diagnostic codes or times of the week for which the data suggest elevated mortality levels? What further analysis and actions are you taking?*
- *How will the MSG keep the Board informed about the work it does?*
- *What steps is the Trust taking to implement the advice from the Academy of Medical Royal Colleges regarding daily senior review and 7 day working in the Hospital?*
- *Is support from Critical Care outreach available 24/7?*

3) In order to understand the standard of care being delivered to those who die there needs to be a high level assessment of all deaths

This is quite achievable if the responsibility is distributed amongst all consultants in those specialties with large numbers of deaths (e.g. acute medicine). It is the responsibility of all registered medical practitioners to understand the outcomes of their clinical practice so this should form a core element of SPA time. In specialties with fewer deaths (e.g. orthopaedics), case note review can be undertaken by a nominated individual. For those patients on a supportive care pathway where death should be judged unavoidable, assessment is still necessary in order to provide assurance of appropriateness and standard of care delivered.

The national RCRR methodology will include a standard review proforma and two-staged review process. Until rolled out, local mortality review templates (ideally electronic) may be used for this initial assessment of all deaths and include: demographic details, mode of admission, initial clinical assessment, ongoing management including investigations and interventions, issues around infection and venous thromboembolism (VTE), nutrition and hydration, recognition of deterioration, use of critical care services, end of life care and appropriateness of cardiorespiratory resuscitation (DNAR) assessment. This is not an exhaustive or exclusive list. In order to improve clinician engagement it is worth considering, in collaboration with the clinical teams, developing bespoke templates for different groups of patients e.g. acute medicine, acute abdomen, stroke, fractured neck of femur, end of life care as these patients will have different needs and their care should be informed by the relevant guidance from NICE, royal college or specialist association.

Standards from these guidance documents should be embedded into these review templates along with generic Trust standards for care. Please note: the national methodology will also include scope for local, specialist adaption to the review form. If there is a desire to understand the level of avoidable mortality then deaths can be categorised using a stratification tool such as the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categorisation (see "Process for responding to a mortality alert" below). This is largely a subjective judgement which will also be supported by the national methodology, based on the PRISM studies.

If there are found to be concerns about the standard of care then the case must be reviewed in-depth by a multidisciplinary team. This should be at a regular departmental morbidity and mortality meeting with representation from senior and junior doctors and nurses, and other AHPs as appropriate for that specialty. These meetings should have equivalent priority, administrative support and governance as other MDT meetings that exist to decide care in for example all cancer disciplines. The outputs from these meetings need to be recorded, especially conclusions about outstanding care and suboptimal care, both of which should be captured and sent on to provide data for the **MSG.**

Furthermore it might also be prudent to undertake a case note review as described in a selection of high risk diagnostic groups (typically for most acute trusts pneumonia, heart failure, sepsis, stroke, AKI, #neck of femur) at least annually in order to provide ongoing assurance. Redesign of the pathway of care for the group of patients concerned should be considered making use of care bundles and including advice from NICE, Royal Colleges and other professional groups on current best practice. Given the known association between staffing levels (doctors and nurses) and clinical outcomes including mortality rates the MSG should pay particular attention to these issues at all times when reviewing a service or circumstance where concerns have been raised.

4) Process for responding to a mortality alert

It is not the purpose of this document to provide detailed advice on this as there other publications which cover this ("Dying to Know" published by Association of Public Health Observatories October 2010).

In summary if there are concerns about mortality in any particular patient group then it is necessary to undertake an in depth case note review. It is important to identify the correct cohort of patients. This may be obvious depending upon the source of the concern (e.g. CQC alert or elevated SMR for a particular diagnostic group) or may require further investigation (e.g. global high weekend mortality). Once this has been established then a review of the case notes for a reasonable consecutive sample of the patients who died (say 30 – 40) by a relevant multidisciplinary group should be undertaken in order to establish whether the clinical care those patients received was appropriate or not. The review group should decide the criteria to be used for judging the standard of care much in the same way as the high level template described above although in this situation more detail may be required. This group will need adequate time and administrative support. There should be a lead person identified who will be responsible for the review and writing up the result.

The care should be categorised. The standardised RCRR methodology will include direction on categorisation, but in the interim, a useful approach is to employ the Confidential Enquiry into Stillbirths in Infancy (CESDI) mortality classification bandings. Deaths are classified according to CESDI as follows:
• Grade 0- Unavoidable Death, No Suboptimal Care,
• Grade 1- Unavoidable Death, Suboptimal care, but different management would not have made a difference to the outcome.
• Grade 2- Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)
• Grade 3- Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death).

Alternatively, the NCEPOD grading of care can be used:
• 1 = Good practice: A standard that you would accept from yourself, your trainees and your institution.
• 2 = Room for improvement: Aspects of clinical care that could have been better.
• 3 = Room for improvement: Aspects of organisational care that could have been better.
• 4 = Room for improvement: Aspects of both clinical and organisational care that could have been better.
• 5 = Less than satisfactory: Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution.

In this way it is straightforward to determine if there is a problem. Assessment of coding should be part of the case note review but the primary focus should be to provide assurance on the quality of care. It is entirely possible that good care was provided to all patients and that all the deaths in the "alert" were unavoidable but experience in several Trusts shows 10-15% of cases will have elements of sub-optimal care. In any event following this approach will provide assurance to the Board that there is a formal process in place underpinned by sound documentary evidence.

5) Coding

Accurate clinical coding is essential in order that the correct information is collected in terms of activity and outcomes. This is necessary for a host of reasons not least that this constitutes the raw data upon which decisions are made about the Trust's

income. Clinicians need to be educated about how coders extract information from the hospital notes and how the way they record clinical findings and opinions support or hinder that process. Meetings and educational events between clinicians and coders can help build mutual understanding between these groups.

6) Feedback to the frontline

Clinicians need to be kept informed of the outcomes of their work if they are to learn and improve. It is essential that there is a mechanism for the outputs of the mortality governance process to be fed back to clinical staff as well as plans for improvement, lessons learnt and pathway redesign.
Dashboards depicting outcomes at individual / team / ward / department level can be used for these processes and are best devised in conjunction with the individuals concerned. Other vehicles such as safety lesson of the week email alerts, cascading through governance groups using this data as part of appraisals should be considered.

Example Terms of Reference for an Acute Hospital Mortality Surveillance Group

MEMBERSHIP

Chairman – Medical Director
Information Department Representation
Director of Nursing or Deputy
Senior Nurse
Doctor-Anaesthetist
Doctor-Acute Physician
Doctor – Care of the Elderly
Doctor – Respiratory /Cardiology
Doctor – Accident & Emergency
Doctor – General Surgery
Governance Representation
Junior Doctor Representation

QUORUM

Four members plus the Chairman (one nurse, two doctors and a governance representative).

FREQUENCY OF MEETINGS

The Committee will meet monthly.

Operational functions:

To work towards the elimination of all avoidable in-hospital mortality.

1. To review on a monthly basis, the benchmarked mortality rates of the Trust.
2. To consider the mortality data in conjunction with other qualitative clinical data and identify areas for future investigation. To facilitate the increased use of Clinical databases, run by various bodies including professional societies in the fuller assessment of in-hospital mortality.
3. To investigate any alerts received from the Care Quality Commission (CQC) or identified by the Mortality monitoring information systems e.g. Dr Foster, HED, etc.
4. To develop data collection systems to ensure the Trust's mortality data is timely robust and in line with national and international best practice.

5. To ensure mortality information linked to consultant appraisals is accurate, contextual and engenders a culture of clinical excellence.
6. To develop an annual mortality clinical coding improvement plan and receive regular reports on its implementation.
7. To assign clinical leads to address raised mortality in particular clinical areas by the deployment of strong evidence based interventions such as care bundles. The MC will receive regular reports on implementation and the measurable impact of these interventions on hospital mortality.
8. To work with established groups to ensure each junior doctor intake receives the latest guidelines on care protocol implementation and clinical coding best practice.
9. To review and monitor compliance with other Hospital policies including DNAR and Death Certification Policy.
10. To monitor and consider the information from the electronic review of all in hospital deaths.

Strategic functions:

1. To act as the strategic hospital mortality overview group with senior leadership and support to ensure the alignment of the hospital departments for the purpose of reducing all avoidable deaths.
2. Strategic oversight of extant mortality review committee(s).
3. To produce a Mortality Reduction Strategy that aligns hospital systems such as audit, information services, training and clinical directorates. This strategy will be reviewed on an annual basis by the Medical Director
4. Sign off of action plans and methodologies that are designed to reduce morbidity and mortality across the trust.
5. Sign off of all regulatory mortality responses.
6. To report on Mortality performance to the Board.

ACCOUNTABILITY

The MSG would be formally accountable the Trust Board

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS MEETING**

DATE: **8 APRIL 2016**

REPORT FROM: **FINANCE & INVESTMENT COMMITTEE: MEETINGS HELD ON 5 APRIL 2016**

PURPOSE: **Decision**

PURPOSE OF THE COMMITTEE

The purpose of the Committee is to maintain a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. This will include:-

- Overseeing the development and maintenance of the Trust's Financial Recovery Plan, delivery of any financial undertakings to Monitor in place, and medium and long term financial strategy".
- reviewing and monitoring financial plans and their link to operational performance
- overseeing financial risk evaluation, measurement and management
- scrutiny and approval of business cases and oversight of the capital programme
- maintaining oversight of the finance function, key financial policies and other financial issues that may arise

Matters for Trust Board to Note

1. FIC to receive statement on 2015/16 cost and ROI of PMO/Turnaround (by 19 April)
2. FIC to receive PMO/delivery plan for 2016/17 CIPS (June)
3. Confirmed FIC to receive paper on Finance structure in July
4. FIC reports to include A&E 'reasons for breach' (from May)
5. FIC to receive report on how planned procurement savings map to addressable spend (by 22 April)
6. FIC to receive Turnaround Reports that have a more focused narrative and that more clearly demonstrate pace of change and the cause and effect of actions (from May)
7. FIC to receive update on Carter Report recommendations (May)
8. FIC to receive any future business cases for external (CIPS) support (visibility rather than approval)
9. FIC to receive monthly progress reports on against Four Eyes programme
10. FIC to receive report on the operational and financial risks of the implementation phase including managing through limiting capacity (July)
11. Strategy paper on integrated care to be circulated to FIC (immediate)
12. FIC thanked the Finance and Information Teams for their work during 2015/16

Reports Against Agenda Items

DoF/COO/HRD Report

- Continuing performance pressures in A&E and against RTT and access standards, with high demand, high numbers of extra beds and DTOCs.
- High re-admission levels indicated
- High levels of vacancies in UCLTC but some success with overseas doctor recruitment
- Agency 'ceiling' for 2016/17 set at £20.1m. Request to increase to £23m.
- Performance impacting financial position with high agency usage.
- Month 11 I&E £31.6m deficit
- Year end forecast c£36.4m deficit

Cash Flow

- Cash at year end £3.8m
- 2016/17 range of funding required £25m to £40m

Turnaround Report

- 2015/16 CIPS reported on plan
- Four Eyes commenced theatres efficiency project. Just about to start outpatients. Combined £5m saving.
- Four Eyes developing two further workstreams: patient flow (£1.5m to £2m) and clinical admin support (£1.5m). Business case required.
- Vacancy Control Panel operating. Need further evidence of impact in Q1.
- Completing detailed planning of 2016/17 CIPs. £20m over 8 major schemes, £15m risk adjusted.
- PMO restructure underway to establish small central team and delivery managers
- CIPS 2016/17 to be reported under current definitions but also as 'real' year on ear and quarter on quarter changes

Financial Risk Register: felt to adequately reflect current issues

Capital Programme and Major Projects Update: no issues raised. Limited capital availability noted.

2016/17 Plan Update:

- Draft Plan: £16.1m STF, breakeven control total, £32m CIPS, no penalties
- Significant contact 'gap' with commissioners (£30m to £50m)
- £12m of unidentified QIPP
- Moving towards PbR based contract
- Had been made clear that RTT 92% was required trajectory
- Endoscopy and T&O key issues
- CCG and Trust teams meeting 5/4 to try and firm up activity volumes
- Need for clarity on which organisation commissions IS work
- Monitor guidance not to submit 'unrealistic' plans
- No guidance yet on applicability of readmissions fines
- Final plan submission date 11 April

PAS Implementation

- Joint programme with MTW
- Considerable scrutiny from HSCIC on technical and financial progress

- Centrally funded
- Learning lessons from other sites
- Potential reduced activity over period of 'go ive'
- Use of model office/simulation facilities
- The Committee asked for clarification of the role of the role of "Operational Super User/SRO for Operations" so as to ensure accountability and responsiveness of divisions in putting plans in place to mitigate against any risk associated with the switch over. The Committee requested a further update on the implementation at its July meeting.

Compliance with Provider Licence:

The Committee reviewed the Licence provisions in relation to finance and strategy and requested clarification of how the Trust meeting the Integrated Care provision. The Strategic Development Team had produced a brief based on the NHS Improvement guidance and this was circulated after the meeting.

BOARD OF DIRECTORS ACTION REQUIRED:

1. To approve change of name from the 'Finance & Investment Committee' to the 'Finance & Performance Committee'
2. To request from Executive colleagues an update on A&E performance including what further and different actions can be taken to improve performance from the current level consistent with trajectories towards 95%
3. To discuss the terms and conditions for accessing DH cash support in 2016/17 (agenda item)
4. Board to receive update on 2016/17 Plan/contracting (agenda item)
5. NG to review current status of Monitor undertakings (by 11 April)

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS MEETING**

DATE: **8 APRIL 2016**

REPORT FROM: **QUALITY COMMITTEE**
MEETINGS HELD ON: 6 APRIL 2016

PURPOSE: **Discussion**

PURPOSE OF THE COMMITTEE:

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

SUMMARY OF KEY AGENDA ITEMS AND BUSINESS:

MEETING HELD ON 6 APRIL 2016

Update on Patient Safety

The following updates were received:

- No MRSA bacteraemia or *C.difficile* for a two month period. Two new MRSAs had been identified in April 2016 but were likely to be community acquired.
- Immediate action from Never events reported to February Board of Directors (O Positive Plasma to A Positive Patient; and Retained Tampon) have been taken forward. Further work was required, in general, to promulgate lessons learned from incidents across the Trust.
- Significant work undertaken with commissioners to establish an action plan around VTE assessments.
- Performance in acute laparotomy has been recognised as one of the best performing in the country. The Committee commended the work of the team.
- Initial information from the recent Royal College of Obstetrics and Gynaecology Maternity Review report is clear - the Trust does not have an unsafe maternity service but there is improvement work to do around how the service is run in some areas.
- Concern was raised regarding clinical engagement at Patient Safety Board. The Committee noted the work of the Executive Team to review & restructure its governance structure.
- The Committee requested a report at its next meeting outlining all clinical systems, system owners (and their role). The Committee wanted to understand further risks around near patient IT systems, particularly for implementation of new systems or upgrades.

Clinical Quality and Patient Safety

The Committee's attention was drawn to the following areas which reported a worsening position compared to the previous year:

- Mortality rates: outcome of the internal review is awaited and scheduled to be received by the Board. Work is ongoing to improve clinical coding, linked to recording and structuring of medical records.
- Mortality rates after acute laparotomy have significantly improved & the Trust's outcomes fall within the top 15% in the South
- The Trust is reporting slightly higher avoidable pressure ulcers compared to the previous year. However, the Trust is meeting its trajectory for deep ulcers. A root cause analysis team and

steering group are reviewing this.
- The number of falls had slightly increased in February 2016, but reported below the national average. Work was ongoing to recruit to a depleted falls team. Interviews at the end of March.
- The number of extra beds reported at 80 (as at 6 April 2016).
- CQUINS standards had been met for 2015/16 with the exception of Acute Kidney Injury and sepsis, although the sepsis standard reported significant improvement compared to the previous year. Focussed collaborative work was ongoing to look at the sepsis pathway.
- Complaints management would be added to the Corporate Risk Register due to resourcing issues within the Patient Experience Team. Improvement work was ongoing with the team to smooth the complaints pathway.
- The latest heat map was reviewed and the following areas were flagged to the Committee: Deal Ward; Harvey Ward; Richard Stevens; Kingston Ward; Cambridge K. Work would be undertaken to identify key drivers, majority were resource issues.
- Work was ongoing to correlate reasons for discharge to reasons for readmissions.
- Accurate recording of diagnoses in clinical notes & note filing are essential to aid accurate coding.
- Inaccurate coding will impact on a PBR contract.

In general, the Committee noted the performance reported reflected the operational pressures faced by the Trust, in particular challenges within the emergency department and patient flow. The Trust was focussing its attention on: streaming the front door; management of ED itself; internal patient flow; and patient discharge and links to the community.

Outpatient Improvement Board Update

The Committee received an excellent presentation and recognised the Trust was now delivering against the six site model in line with the Outpatient Clinical Strategy releasing a cost saving of £417K. The Head of Out-Patient Services was congratulated on progress.

The Committee requested a further presentation in September 2016 covering:
- Utilisation of all six outpatient sites.
- Useage of Procedure Rooms.
- The move to 'one stop' services.

The Committee noted the outpatient team had mitigating plans in place to manage the forthcoming PAS implementation.

CQC Update

The Committee received the same report which is being received by the April Board. The Committee noted the most significant challenge was around recruitment.

Statutory Declaration to Monitor: Compliance with the Provider Licence

The Committee received the compliance and evidence against the Provider licence conditions relevant to the Quality Committee. The Committee was satisfied with all evidence was robust.

Integrated Incident, Patient Experience and Claims Report – Quarter 3

The Committee received the latest quarterly report. Main discussion points were noted:
- Themes were noted: staffing; equipment; delays; clinical risk; and VTE. Tracking of action plans at Divisional level will be undertaken by the Patient Safety Board.
- A material problem with availability of clinical staff to attend inquests. Coroners have been asked to plan inquests in a more timely fashion.
- The trust's reporting rate was above the median level for acute trusts
- Focussed work was required regarding completion of Duty of Candour in Datix.

- Focussed work was required to strengthen clinical handovers.

The Committee agreed the line of sight from divisional level to the role of this Committee and Board needed to be strengthened. Themes would be included in the new integrated performance report on a quarterly basis.

Root Cause Analysis Reports – Learning from Claims, Incidents and Complaints

Discussions focussed on high cost claims, particularly in Obstetrics.

- An action plan was in place to strengthen the management of third and fourth degree perineal tears in maternity.
- Awareness of risks around occipito-posterior (face) presentation were being communicated (associated with delayed transition of birth).

Corporate Risk Register

The Board of Directors would be receiving an updated report at its April meeting which incorporated risks agreed by Management Board. The Committee received the strategic risk register.

A discussion will take place at the Board regarding the inclusion of the risks around emergency department.

The Committee noted the new risk register format was still in development and further refinements were needed. However, the Committee welcomed the new style report.

Quality Impact Assessments

The Committee noted the latest quality impact assessments which had been signed off.

Reports from Governance Boards

Clinical Support Services Division:

The minutes were noted, issues discussed:

- Review of consultant job plans was underway.
- The Division was actively monitoring mandatory training and appraisal rates.
- The backlog of MRI was discussed. The main risk was the inability to control direct access MRI. The Committee agreed that Direct Access to MRI investigation needed particular focus,and possible limitation, as part of contract negotiations.

Specialist Services Division:

The minutes were noted; issues discussed:

- Challenges within chemotherapy services were recognised. These were being managed on a day to day basis with an action plan in place.

Urgent Care and Long Term Conditions Division:

No representative present at the meeting, although reports received and noted.

Surgical Services Division

No representative present at the meeting, although reports received and noted.

Any Other Business

The Committee discussed Non Executive Director involvement in regular programmed visits to areas within the Trust. In particular, visits linked to the cultural change programme, CQC improvement visits and ward peer reviews.

Chief Nurse and Director of Quality will email visits to the Non Executive Directors regularly to encourage participation.

The Committee discussed the format of reports received and agreed the narrative needed to be more precise and focused to the role of the Committee. Analysis of trends with actions being taken to address them and the methods in place to monitor the resultant change.

SUMMARY OF ACTION REQUIRED BY THE BOARD:

To discuss and note the report**.**

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS MEETING**

DATE: **8 APRIL 2016**

REPORT FROM: **STRATEGIC WORKFORCE COMMITTEE**
MEETINGS HELD ON: 19/2/16 AND 24/4/16

PURPOSE: **Discussion**

PURPOSE OF THE COMMITTEE:

The purpose of the committee is to provide advice, and make recommendations to the Board of Directors on all aspects of workforce and organisational development, and raise concern (if appropriate) on any workforce risks that are significant for escalating.

SUMMARY OF KEY AGENDA ITEMS AND BUSINESS:

MEETING HELD ON 19 FEBRUARY 2016

Redevelopment of Appraisal Process

The Committee received a copy of revised appraisal paperwork for AfC staff which would be launched on 1 April 2016. The team had tried to make the documentation easier to use, with the Trust's values and behaviours embedded within the paperwork.

Training would be carried out in-house and several sessions had been advertised on each site. There would also be drop-in sessions in the hubs, a help-line and email addresses for appraisers. Training for new appraisers would also be continued.

Finalisation of the strategic objectives would be required before rolling out the revised paperwork.

It was agreed that the proposed new appraisal process was fit for purpose, tested and well received. The Committee recognised that further work was required on talent management and this would be revisited in six months' time.

Strategic Workforce Report

The Committee received the latest workforce report for scrutiny.

High levels of annual leave were experienced during December and the temporary pay spend was greater.

The Trust was not an outlier for sickness absence although there were high levels in Estates and ancillary staff which required attention.

The Committee felt that discussions at Executive Performance Reviews (EPRs) needed to be reflected in the narrative presented to the Committee. The debate in EPRs tended to be operational and needed to focus more strategically on 'people' metrics, e.g. skills and competencies.

The Committee raised a concern around the high numbers of staff who had never undertaken statutory and mandatory training and requested this be subject to investigation by divisional staff.

Staff Survey 2015

The Committee received the results of the 2015 survey. A number of indicators around staff engagement had improved and Picker had been asked to provide some trend data to review the impact of the CQC report.

It was disappointing that the bullying and harassment scores were unchanged from last year, but this could be due to staff feeling more able to raise issues. The Committee agreed that focus was needed on leadership capacity and capability. The Committee noted there had been positive feedback from the Clinical Leadership Programme. A formal evaluation would be undertaken.

The different approaches of the Picker data and NHS benchmarking survey were noted.

The Committee received a number of proposed actions and agreed they were appropriate were appropriate.

The Board would be receiving a report at its April meeting.

Overseas Recruitment Evaluation

Lessons from previous recruitment campaigns had been learnt and would inform how future overseas recruitment activity.

Recruitment of nurses from outside the EU was being progressed. The importance of the pastoral role for these staff and newly qualified nurses was noted.

Cultural Change Programme Update

The Committee received an update on work undertaken to date.

The Trust wished to ensure that what was done was fully integrated and had line of sight between the direction of the Board and the activities being initiated with frontline staff in order to improve cultural improvement.

Review of Education and Training across the Trust

This item was deferred to the April 2016 meeting.

MEETING HELD ON 24 MARCH 2016

Monitor, NHS Improvement Undertakings

The Committee received a report from the Director of HR on two Undertakings relating to workforce. The Trust had been asked to provide to Monitor by 30 September 2015 an assessment or the Trust's leadership capacity and capability to deliver the financial strategy, i.e. a short term and long term plan. This had been submitted by Chris Bown, however the requirement was for a more detailed, focused approach to address areas where there was insufficient capacity and capability to deliver the organisation's key objectives and financial strategy. A proposal had been provided to NHSI and was due to be discussed at the most recent PRM however this had not taken place. Instead it is hoped a telephone update will happen shortly.

The Committee reviewed the proposal shared with NHS and it was agreed that an external partner would need to be engaged who had the appropriate skills and experience in view of EKHUFT's particular size and multi-site challenges. It was thought that involvement of a Non-Executive Director on the tender evaluation panel would be beneficial.

The Trust had also received feedback on the workforce plan, approved by the SWC and submitted in October 2015, which had been seen by NHSI as a plan to write a plan. Since then significant work had been undertaken as part of the business planning cycle on developing the workforce alongside the financial and activity plans in Divisions. An initial return was provided to NHSI in early February and a progress update paper had been written for NHSI when they visited the Trust to review our processes on 9th March 2016. The progress paper was shared. The next return, of the APR template, to NHSI is due in early April and work is well underway to understand the links between activity, workforce and finance to support this return. The Committee was assured of the progress with meeting the Undertakings and felt that the sharing of this update had been worthwhile for the Non-Executives.

ED Workforce

The Committee received an update on the progress. Further work was required but was proceeding positively.

Specialty Doctor recruitment was also proving effective. The development of the Margate area was noted, with attractive and affordable housing and a commutable distance from London which was helping to attract a new workforce. It was agreed that the best advocates for the Trust were those who had taken up the opportunity to work for the Trust. It will be important that the new Director of Communications develops strong communications around advertising the Margate area when they join the organisation.

Concerns were raised about the impact of the new NMC rules on EU registration of nurses and required completion of IELTS. This could well impact emergency department nurse recruitment.

Thought would be given to the optimum time to present the risks, pros and cons of a different training model within the Trust.

Job Planning

A report on progress was given. There was considerable concern expressed by the Committee about a lack of progress, in a number of areas, in the approval of consultant job plans. The Medical Director said there were two specialties within the UC&LTC Division where currently there were no clinical leads and this was an area of concern. Operational pressures were making it difficult for clinical leads to find the time to complete this work. The SWC asked if there was any support that could be provided to get this important work done within the timescale originally planned. It was noted that the appointment of a Deputy Medical Director would enable greater support to be provided.

The Committee thanked the interim Medical HR Lead, responsible for this project, for her work.

Strategic Workforce Report

The Committee received the workforce data for January 2016. This report included the agency trajectories for 15/16 as requested at the meeting in February. The committee agreed that trajectories for planned agency usage in Divisions in 16/17 should be in a consistent format. The Committee agreed that identification and presentation of themes were preferable to detailed data. It was agreed that the Chair of SWC would work with the Head of HR to identify the themes to be interrogated.

There was concern about the risks surrounding the number of staff who have never completed any mandatory training. This information had been shared with the Divisions to ensure it is followed up with the individuals concerned. A further report will be presented on this to the next meeting.

Update on Revalidation for Nurses and Midwives

An update was provided on the process for renewing registration with the Nursing and Midwifery Council and the criteria for revalidation was outlined. The NMC had clarified that staff could undertake the process up to six months before the due revalidation date and they would therefore be encouraged not to delay for too long.

Statutory Declaration to Monitor: Compliance with Provider Licence

The Committee was advised that the Trust did not comply with Condition G4 re Fit and Proper Persons this was being addressed and a process to resolve had been agreed with the Chair. It was agreed to discuss this at the next Nominations Committee.

National NHS Staff Survey Results 2015

A presentation was given by representatives of Picker. This focused on comparison with other Trusts and trends within EKHUFT. The Committee now appreciated that improvement in any Trust would take several years and the members questioned whether becoming one of the top 20% trusts by 2019 was realistic However, progress was evident and needed to be maintained. It was felt that addressing *specific* issues raised by staff would gain real traction.

Cultural Change Programme Update

The Cultural Change Manager updated the Committee on progress and highlighted
(i) the appraisal process would go live on 1 April 2016
(ii) the process for leadership capability evaluation
(iii) the importance of embedding the cultural development work.

Any Other Business – Junior Doctor Contract

Two strikes were planned and the second (26/27 April) would have serious implications for services within the Trust. The proposed new national junior doctors contract had not been provided by NHS Employers but when to hand it would be useful for the Board to understand the consequences regarding Doctors in Training and the impact on senior clinicians.

SUMMARY OF ACTION REQUIRED BY THE BOARD:

To discuss and note the report**.**

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS MEETING**

DATE: **8 APRIL 2016**

REPORT FROM: **REMUNERATION COMMITTEE: MEETING HELD ON 22 MARCH 2016**

PURPOSE: **Approval**

PURPOSE OF THE COMMITTEE:

The Remuneration Committee is a Committee of the Board and fulfils the role of the Remuneration Committee (for executive directors) described in the Trust's constitution and the NHS Foundation Trust Code of Governance.

The purpose of the committee will be to decide on the appropriate remuneration, allowances and terms of and conditions of service for the chief executive and other executive directors including:

(i) all aspects of salary (including performance related elements/ bonuses)
(ii) provisions for other benefits, including pensions and cars
(iii) arrangements for termination of employment and other contractual terms

To recommend the level of remuneration for Executive Directors and monitor the level and structure of remuneration for very senior management.

To agree and oversee, on behalf of the Board of Directors, performance management of the executive directors, including the chief executive.

SUMMARY OF KEY AGENDA ITEMS AND BUSINESS:

MEETING HELD ON 22 MARCH 2016

CEO Remuneration and Performance Objectives

The Committee discussed the CEO Remuneration and its approach to implementing performance objectives which were specific and measurable. The Committee would be revisiting this again at its next meeting in May 2016.

Pay Terms and Conditions – options

The Committee was presented with a paper that provided details on the freedoms of Foundation Trusts to develop local terms and conditions of service. The Committee agreed that now was not an appropriate time to consider introducing local pay terms and conditions given the current operational environment. However, it did agree work should be undertaken in parallel to the turnaround programme to explore this further for a future decision.

Executive Director and Non Executive Director Remuneration Survey Results

The Committee received the latest published data from NHS Providers and would be considering this at its next meeting when conducting the annual review of Executive Director Pay.

Results would be shared with the Council of Governors Nominations and Remuneration Committee in relation to its responsibilities for reviewing Non Executive Director remuneration.

Review of Policy for Determining the Remuneration and Performance of Executive Directors

The Committee approved a revised policy which had been amended to clarify performance required to be considered for a consolidated pay increase.

The Committee agreed the policy should be subject to a complete review over the next six to 12 months with principles to be agreed including market forces and strategic aims of the organisation to move towards improved performance.

Annual Review of Pay Policy for Very Senior Managers

The Committee approved a revised policy which had been amended to clarify the criterion applied to staff eligible for a non-consolidated non-pensionable payment..

The Committee agreed the policy should be subject to a complete review over the next six to 12 months.

Review of Committee Effectiveness

The Committee noted the report presented concluded the Committee had operated in line with its terms of reference.

Succession planning appeared on both the Remuneration Committee and Nominations Committee terms of reference. It was agreed that one Committee should be responsible and this should be the Nominations Committee.

The Board of Directors is asked to endorse amended Terms of Reference noting this change.

SUMMARY OF ACTION REQUIRED BY THE BOARD:

To note the report.
To approve the amended Terms of Reference.

East Kent Hospitals University NHS
NHS Foundation Trust

REMUNERATION COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION

1.1 The Board of Directors has established a committee of the Board known as the Remuneration Committee. It is a Non-Executive committee and has no executive powers, other than those specifically delegated in these Terms of Reference. These Terms of Reference can only be amended with the approval of the Board of Directors.

2. PURPOSE

2.1 The Remuneration Committee is a Committee of the Board and fulfils the role of the Remuneration Committee (for executive directors) described in the Trust's constitution and the NHS Foundation Trust Code of Governance.

2.2 The purpose of the committee will be to decide on the appropriate remuneration, allowances and terms of and conditions of service for the chief executive and other executive directors including:

(i) all aspects of salary (including performance related elements/ bonuses)
(ii) provisions for other benefits, including pensions and cars
(iii) arrangements for termination of employment and other contractual terms

2.3 To recommend the level of remuneration for Executive Directors and monitor the level and structure of remuneration for very senior management.

2.4 To agree and oversee, on behalf of the Board of Directors, performance management of the executive directors, including the chief executive.

2.5 Any proposed changes to the terms of reference will be approved by the Board.

3. OBJECTIVES

3.1 To set the remuneration and terms of service for the chief executive and executive directors with the support of independent advice as appropriate.

3.2 To ensure that individual executive directors have performance objectives and personal development plans, that are reviewed twice yearly. The review will also consider the capability of the executives as a team as well as at the level of individuals identifying any team development needs

3.3 To include in its decisions all aspects of salary (including any performance related elements) and provisions for other benefits (including pensions and cars).

3.4 To decide on the appropriate contractual arrangements for executive directors, including a proper calculation and scrutiny of termination payments, taking account of legislation and such national guidance as is appropriate.

3.5 To ensure the Trust achieves proper control of the total remuneration paid to the executive directors by developing appropriate pay and reward policies for these posts. The Committee will ensure it has a clear statement of the responsibilities of the individual posts and their accountabilities for meeting the objectives of the organisation, a person specification for each post, a means of assessing the comparative job "weight", with comparative salary information from the NHS and other areas and criteria and mechanisms for assessing performance.

3.6 To ensure the publication, in annual reports, of the total remuneration from NHS sources of the chief executive and executive directors.

3.7 To recommend and monitor the level and structure of remuneration for senior management. The definition of senior management for this purpose will be determined by the Board and described in the Pay Policy for very Senior Managers.

3.8 To receive an annual report on the application of the Pay Policy for very Senior Managers from the chief executive

3.9 Approve any non-contractual termination payments to staff in-line with the Trust's Special Severance Pay Policy.

~~3.10 To review the Trust's succession plans for Executive Director post ensuring any gaps are effectively mitigated.~~

4. MEMBERSHIP AND ATTENDANCE

Members

4.1 The core membership will comprise the Trust Chairman and all non-executive directors in accordance with the constitution.

Chair

4.2 The chairman of the committee will be the Trust chairman or non-executive director as determined by the Nominations Committee of the Board.

Attendees

4.3 The Director of Human Resources (or representative) will attend in an advisory capacity.

4.4 The Chief Executive will attend (except when their own post is under discussion) and should attend when Executive Directors remuneration is discussed.

Quorum

4.5 Business will only be conducted if the meeting is quorate. The Committee will be quorate with four Non-Executive Directors present. If the Chair is in attendance, this will count towards the quorum.

4.6 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Board of Directors meeting as an urgent item.

Attendance

4.7 The Chair, or their nominated deputy, of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 80% of all meetings.

Attendance by Officers

4.8 The Committee will be open to the Trust Secretary to attend.

4.9 Other staff, or external advisors, may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

Voting

4.10 When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the person presiding shall have a second or casting vote.

5 FREQUENCY OF MEETINGS

5.1 Meetings of the Committee shall be generally held up to four times a year, as determined by the work of the Committee. The likely timetable of meetings is as shown below:

Date	Purpose
End May	Sign off Executive Director performance appraisal for preceding financial year and performance objectives for current financial year. Identify personal and team development needs for the executives as individuals as team members.
July	Review salaries of Executive Directors as appropriate
Oct / Nov	Review mid-year performance of Executive Directors. Make a final decision on any appeals from Executive Directors on access to annual pay uplift Review progress against personal development plans where appropriate.
Feb	Review policies for remuneration of Executive Directors and senior managers not covered by National terms and conditions

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

6.2 Reference should be made as appropriate, to the Standing Orders and Standing Financial Instructions of the Trust.

6.3 The committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the

committee. However, Board Committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Trust Board (Standing Order 5.5 refers).

6.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7 SERVICING ARRANGEMENTS

7.1 A member of the Board Secretariat shall attend meetings and take minutes.

7.2 Agendas and papers shall be distributed in accordance with deadlines agreed with the Committee Chair.

7.3 Members will be encouraged to comment via correspondence between meetings as appropriate.

7.4 The Committee will maintain a rolling annual work plan that will inform its agendas and seek to ensure that all duties are covered over the annual cycle. The planning of the meetings is the responsibility of the Chair.

8. ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

8.2 Chair reports will be provided to the Board of Directors to include: committee activity by exception; decisions made under its own delegated authority; any recommendations for decision; and any issues of significant concern.

8.3 Approved minutes will be circulated to the Board of Directors. Requests for copies of the minutes by a member of public or member of staff outside of the Committee membership will be considered in line with the Freedom of Information Act 2000.

9. RELATIONSHIPS WITH OTHER COMMITTEES

9.1 Council of Governors' Nominations and Remuneration Committee

10. MONITORING EFFECTIVENESS AND REVIEW

10.1 The Committee will provide an annual report outlining the activities it has undertaken throughout the year.

10.2 A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

10.3 The terms of reference will be reviewed and approved by the Board of Directors on an annual basis.

Approved by Board: December 2015

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS MEETING**

DATE: **8 APRIL 2016**

REPORT FROM: **NOMINATIONS COMMITTEE: MEETING HELD ON 22 MARCH 2016**

PURPOSE: **Discussion**

PURPOSE OF THE COMMITTEE:

The Nominations Committee is a Committee of the Board and fulfils the role of the Nominations Committee for executive directors described in the Trust's constitution and the NHS Foundation Trust Code of Governance.

The Trust chairman and other non-executive directors and chief executive (except in the case of the appointment of a chief executive) are responsible for deciding the appointment of executive directors.

SUMMARY OF KEY AGENDA ITEMS AND BUSINESS:

MEETING HELD ON 22 MARCH 2016

Action Plan from Internal Board Assessment

The Committee received the action plan from the internal board assessment and Board Development Plan following the self-assessment undertaken by an independent HR consultant which concluded December 2015. Timelines were reviewed and a further updated action plan would be brought to the next meeting for ongoing monitoring.

The Board of Directors agreed at its February 2016 meeting three priority areas for Board development:

- Strategic Marketing;
- Estates & Assets Management;
- Diversity, equity and strategy to support workforce planning

The Committee received the latest Board Development Programme which had been updated to reflect the areas of focus.

The Board considered Strategic Marketing at a Board Development Day held in March and an action plan was being developed. Estates and Assets Management; and Diversity, equity and strategy to support workforce planning have been programmed into the Development Programme.

External Board Governance Review

The Trust was currently out to tender to identify an organisation to work with the Trust to conduct a review against Monitor's Well-Led Framework. A copy of the scope was received by the Committee for information. The process was anticipated to conclude in June 2016.

Succession Planning

The Committee had a positive discussion around succession planning. The Committee learned the Executive Team have agreed to undertake further work before presenting a report to the next

Nominations Committee. The work being undertaken includes:

- A collective review of staff that have been identified as talent for the future executive director and very senior manager posts;
- Discussions to take place with staff that have been identified as talent for senior positions to ensure that they wish to be included in the talent management pool for targeted development; and
- An agreement on the broader development opportunities outside their normal portfolio such as coaching, mentoring, sponsoring of educational/training opportunities as required.

Committee Effectiveness

The Committee received a report which concluded it had operated within its terms of reference during 2015/16. It was noted succession planning was included in terms of reference for both the Remuneration Committee and Nominations Committee. The Committee concluded that the responsibility lies with the Nominations Committee. A proposal will be put to Board (via the Remuneration Committee Chair Report) to agree this amendment to the terms of reference.

SUMMARY OF ACTION REQUIRED BY THE BOARD:

To discuss and note the report**.**

2016 LOCAL ELECTION AND EU REFERENDUM
PURDAH CONSIDERATIONS FOR NHS PROVIDERS

This briefing sets out considerations for NHS foundation trusts and trusts in the periods of time - known as 'purdah' - leading up to the 2016 English local government elections and the referendum on the UK's membership of the European Union (EU). Local government elections will only take place in certain areas of the country; details of local authorities holding elections this year can be accessed here.

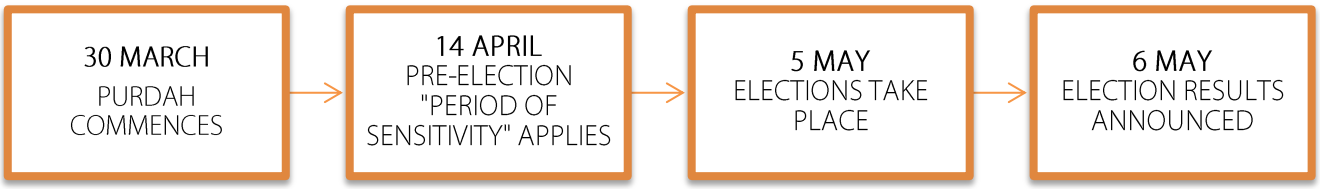
The briefing highlights the practical implications around provider activities and communication during the two periods of purdah; a detailed breakdown is provided in section 6 of this document. It also covers the requirements on central and local government, the civil service and arms length bodies during purdah to maintain political impartiality in carrying out public duties and ensure that public resources are not used for the purposes of political parties or campaign groups.

Full guidance on purdah in the lead up to the EU referendum has not yet been published; we will update this briefing in line with it when this becomes available in the coming weeks. Should you have questions around specific communications or activities which your organisation is planning, please do not hesitate to get in touch with NHS Providers via amy.mcgregor@nhsproviders.org.

1) LOCAL ELECTION AND EU REFERENDUM TIMETABLES

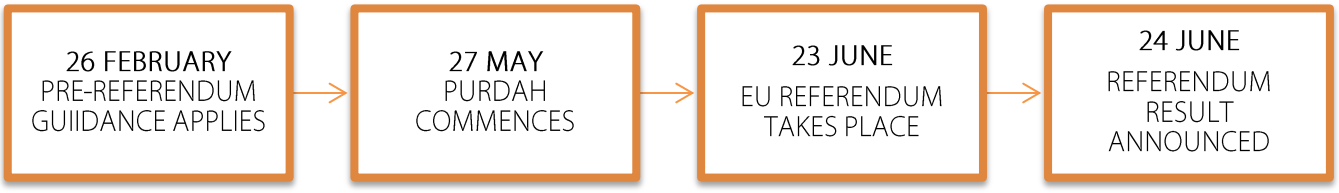
The timetables associated with the English local government elections and EU referendum are set out below. All technical terms referenced are explained in the body of this briefing.

Local government elections



NB: Elections in the devolved nations (Scotland, Wales and Northern Ireland) and mayoral elections in England will also take place on 6 May 2016.

EU referendum



2) WHAT IS PURDAH?

The term "purdah" is used across central and local governments to describe the period of time immediately before elections or referendums when specific restrictions on the activity of civil servants and local government officials, where appropriate, are in place. The term pre-election or pre-referendum period is also used synonymously with purdah. Purdah prevents announcements from and activities by public bodies which could influence or be seen to influence the election.

Contact: Amy McGregor, senior public affairs officer, amy.mcgregor@nhsproviders.org

3) WHEN DOES PURDAH COMMENCE?

For 2016 local government elections in England, purdah commences upon the local publication of the notice of election; this must take place by **30 March 2016** at the latest.
For the EU referendum, purdah commences on **27 May 2016**, although rules applying to in the lead up to the purdah period are already in place; further details are provided in section 5 of this briefing.

4) RULES AND REGULATIONS DURING LOCAL GOVERNMENT ELECTION PURDAH

The behaviour of central government, elected officials, civil servants and arms length bodies during purdah is governed by the:

- Local Government Act 1986[1]
- 2011 Code Recommended Practice on Local Authority Publicity[2]
- Cabinet Office guidance on conduct for the May 2016 elections for civil servants[3]

Details of how these are applied are set out below.

Local authorities

Although the ordinary functions of councils should continue during purdah, some restrictions do apply, by law, to all councillors and officers. The restrictions on local government during purdah are governed by Section 2 of the Local Government Act 1986.[1] Under these restrictions, councils should "not publish any material which, in whole or in part, appears to be designed to affect public support for a political party."

The 2011 Code of Recommended Practice on Local Authority Publicity[2] provides guidance for local government on communications during purdah. It recommends that all communication is: lawful; cost effective; objective; even-handed, appropriate; has regard to equality and diversity; and, issued with care during periods of heightened sensitivity.

Central government, civil servants and arm's length bodies

As the UK government will remain in office following the 2016 local elections, government ministers will continue to carry out their functions as usual during the first fortnight of purdah and civil servants will continue to support ministers in their work.

However, a "period of sensitivity" applies from three weeks prior to the local government elections; this will commence on 14 April 2016. To support civil servants in UK government departments and the staff and members of non-departmental public bodies and arm's length bodies during purdah and the period of sensitivity in particular, the Cabinet Office has issued specific guidance[3]. This sets out the principles of maintaining the political impartiality of the civil service and ensuring that public resources are not used for party political purposes.

How does the NHS fit in to local government elections?

Whilst discussion of the NHS is rarely central to local government election campaigns, the delivery of public services, of which social care is a key tenet, is at the heart local government elections. As such, it is important that NHS providers follow the custom and practice of purdah to adopt to avoid any impression of influencing the election or its outcomes.

Practical considerations for NHS trusts and foundation trusts in respect of purdah ahead of local government elections are provided in section 6 of this briefing.

5) RULES AND REGULATIONS COVERING PURDAH AHEAD OF THE EU REFERENDUM

The behaviour of central government, civil servants and arms length bodies in the period before purdah commences for the EU referendum is governed by:

- EU Referendum – Guidance for the Civil Service and Special Advisers[4]

Central government, civil servants and arm's length bodies

In February 2016 the Cabinet Secretary, Sir Jeremy Heywood, issued guidance[4] to apply up until statutory period of purdah ahead of the EU referendum commences on 27 May 2016[5].

The Cabinet Secretary's current guidance sets out that Government Departments should continue to support ministers in the normal manner "in supporting the Government's position on the EU". Heywood has clarified this further:

> *"The spirit is clear: all normal Government business, including EU business, continues, except in relation to the in-out question, on which we don't provide briefing material or speech material for Ministers to attack the Government position."*[6]

Official purdah guidance for government departments and all staff within non-department public bodies and arm's length bodies is yet to be published. **This guidance is expected in the coming weeks and we will issue an updated version of this briefing thereafter.**

How does the NHS fit in to the EU referendum?

The NHS has not been a core element within the early stages of the national referendum debate. Focus on the NHS may increase given that the "Leave" campaign argues that public services are being put under pressures due to immigration while health secretary Jeremy Hunt has voiced his opinion that a vote to leave the EU would lead to a loss of investment, "inevitably mean less money" for the NHS and may lead to some foreign EU citizens within the NHS workforce leaving the country.[7]

Practical considerations for NHS trusts and foundation trusts in respect of purdah ahead of the EU referendum is provided in section 6, below.

6) PRACTICAL CONSIDERATIONS FOR NHS FOUNDATION TRUSTS AND TRUSTS DURING PERIODS OF PURDAH AHEAD OF LOCAL GOVERNMENT ELECTIONS AND THE EU REFERENDUM

a) Key principles

- **No activity should be undertaken which could be considered politically controversial or influential**, which could compete for public attention or which could be identified with a party / candidate/ designated campaign group.
- **Would you do the same for everyone?** NHS providers have discretion in their approach, but must be able to demonstrate the same approach for every political party, official candidate and designated campaign groups in order to:
    - avoid allegations of bias or pre-judging the electorate
    - ensure you will be able to form a constructive relationship with whoever wins the seat
- **The NHS may be under the media spotlight, locally and nationally.** It is advisable to have a plan in place for:
    - how the organisation will manage the purdah periods (with both its risks and its opportunities)
    - the potential for the organisation or its partners to be singled out in the media

b) Board meetings and normal regulation

Normal business and regulation needs to continue during the purdah period. NHS Improvement, for example, is not expected to alter the dates on which it expects information from foundation trusts. Where a board discussion or sign off is required, there is no problem with holding a board meeting.

Where board meetings need to take place, the agenda should be confined to those matters that need a board decision or require board oversight. Matters of future strategy or the future deployment of resources may be construed as favouring one party over another and should be avoided.

Use of the confidential part or part 2 of the agenda to discuss matters that may be politically controversial is not recommended. Such matters should be deferred until after the purdah periods.

c) Publishing information and making announcements

Care should be taken not to comment on the policies of political parties or campaign groups and websites should not be updated with any information that may be considered political. The rule of thumb should be that communications activities necessary for patient safety, quality and operational delivery purposes should continue as normal, but any other activity beyond that and not required in the pre-election period should wait until after the election.

Wherever possible, information to be published about the organisation should be factual and released in advance of purdah commencing. After purdah begins, requests for new information are best handled by applying FOI rules.

Organisations should not start long-term initiatives or undertake major publicity campaigns unless time critical (such as a public health emergency), and should instead wait until after the election. Unless strictly necessary, high-level public sector appointments should not be made.

Public consultations should not be launched during purdah. Those already in progress should continue, but it is advisable to extend the period to take account of purdah and avoid public meetings and publicity. Responses received should not be commented on and no announcements should be made until after local government elections.

We would only expect civil servants to release data (such as the regulator publishing trusts' financial returns) when a precise publication date has been pre-announced.

d) Political visits and engagement

The Cabinet Office guidance on purdah during local government elections offers specific advice relevant to NHS trusts and foundation trusts in respect of visits:

"Particular care" should be taken with respect to proposed visits to areas holding elections. Official support must not be given to visits and events with a party political or campaigning purpose.

Use of NHS Property for *"electioneering purposes"* is a decision for the relevant NHS body to make, *"but should visits be permitted to, for example, hospitals, it should be on the basis that there is no disruption to services and that the same facilities are available to all candidates. Care should also be taken to avoid any intrusion into the lives of individuals using the services."*[3]

Current Cabinet Office guidance on the EU referendum does not make explicit reference to the NHS however the Cabinet Secretary has stated[6] that it follows the precedent set by the Scottish referendum guidance which outlines:

"In the case of NHS property, decisions are for the relevant NHS Board. If hospital visits are permitted, they should not disrupt services and the same facilities should be offered to all campaigns. Campaign meetings must not be permitted on NHS premises."[8]

As such, an NHS provider has the discretion to decide whether or not to allow visits by politicians during a local election campaign or representatives from campaign groups during the referendum campaign. When considering whether to host a visit, safety and operational considerations must come first and guidance states that campaign visits should not disrupt services or care[3].

In addition, the same approach must be applied to all requests from all official candidates and political parties, irrespective of their size. All requests from candidates to visit may be declined, but if they are allowed, then all requests should be accepted. If you do not plan to permit any campaign visits, it is worth considering formally advising all candidates and campaign groups in advance at the same time to ensure clear and consistent understanding.

Organisations may wish to engage with the prospective councillors in relevant wards whilst care should be taken to ensure that current councillors are not treated any differently. Again, we would recommend that all candidates and campaign groups are treated in the same way and any invitations or opportunities for engagement are extended to all parties. For example, if one party or campaign group makes an announcement on site, it would be advisable to ensure that all parties do so.

e) Foundation trust governor elections

In law, there is nothing to prevent foundation trust governor elections from taking place during the purdah period, although some trusts may have previously chosen not to do so as a precautionary measure. Given the consecutive periods of purdah ahead of this year's local government elections and the EU referendum, however, delaying elections during the three months over which the two periods of purdah run could prove impractical. We would advise that, where necessary, governor elections should proceed but with particular caution exercised, as set out below.

Foundation trusts have no control over what governors may say in their election statements, at hustings or elsewhere they cannot guarantee a politically neutral outcome. While governor elections have for the most part not been party political events, there is nothing in law to prevent them from becoming so. Governor candidates should be clearly advised to not to include or express anything within their personal election statements or during hustings which could be deemed as party political or in support of a particular referendum campaign group. What might be deemed to be party political or in support of a referendum campaign group can be quite broad.

For further information relating to governor elections please contact John Coutts, governance advisor: john.coutts@nhsproviders.org, 0207 304 6875.

f) Activism onsite or by individual staff

NHS employees are free to undertake political activism and public debate in a personal capacity. They should, however, avoid involving their organisation or creating any impression of their organisation's involvement. They are not permitted to use any official premises, equipment (including uniforms) or information they would only have access to through their work and which is not publically available. Naturally, patient confidentiality must be preserved at all times and normal professional conduct and contractual rules apply as usual in this respect.

Especially given the prevalence of social media and the balancing act people perform in presenting their personal and professional lives and views, it becomes easier to blur or mistake the capacity within which individuals are contributing online. At all times every effort should be made to preserve public professional neutrality while not inhibiting personal activity.

g) Voter registration, postal votes and proxy votes

It might be helpful to advise staff on the trust's provisions for postal and proxy voting to support those – both staff, patients, service users and their families – who may not be able to go to their polling station on the day. National advice is available here: https://www.gov.uk/register-to-vote.

We would advise that NHS staff and trusts should not undertake any voter registration or proxy or postal voting activity for those in their care to avoid any possible concern being raised about inappropriate influence.

h) Trade union activities and engagement

Trade unions may be active during the election campaigning on issues concerning their members. All organisations will have existing relationships, channels and protocols for working effectively with trade unions and these should be used as normal. Nevertheless, given the importance of NHS organisations preserving their neutrality, it is worth considering itemising the local elections and referendum for discussion at an imminent meeting.

7) SHARING THIS BRIEFING WITHIN YOUR ORGANISATION

We suggest NHS providers share this briefing and/or its specific pre-election planning with all staff and stakeholders who may find it useful to be aware of the steps you are taking.

References

[1] *Local Government Act 1986.* Available at: http://www.legislation.gov.uk/ukpga/1986/10/section/2
[2] *Recommended code of practice for local authority publicity* (2011). Available at: https://www.gov.uk/government/publications/recommended-code-of-practice-for-local-authority-publicity
[3] *Cabinet Office: Election guidance for civil servants* (2016). Available at: https://www.gov.uk/government/publications/election-guidance-for-civil-servants
[4] *Cabinet Office: EU Referendum - Guidance for the Civil Service and Special Advisers* (2016). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/502580/Jeremy_Heywood_to_Permanent_Secretaries_-_EU_Referendum_Guidance.pdf
[5] As regulated by section 125 of the Political Parties, Elections and Referendums Act 2000. Available at: http://www.legislation.gov.uk/ukpga/2000/41/section/125
[6] Evidence given by Sir Jeremy Heywood KCB, Cabinet Secretary and Head of the Civil Service to the Public Administration and Constitutional Affairs Committee (March 2016). Available at: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-administration-and-constitutional-affairs-committee/eu-referendum/oral/29911.html
[7] *The Guardian: A strong NHS needs a strong economy – we should not put that at risk with Brexit – Jeremy Hunt,* (March 2016). Available at: http://www.theguardian.com/commentisfree/2016/mar/26/jeremy-hunt-brexit-nhs
[8] *Scottish Government: restrictions on government activity in the 28 days before the independence referendum* (2014). Available at: http://www.gov.scot/Resource/0045/00457748.pdf