Board of Directors - Open Meeting (Thursday 1 February 2024)

Thu 01 February 2024, 01:15 PM - 04:50 PM
WebEx

Agenda

East Kent Hospitals University NHS Foundation Trust

OPENING/STANDING ITEMS

01:15 PM - 01:25 PM
10 min

23/140
Welcome and Apologies for Absence

To Note *Acting Chairman*

Verbal

01:25 PM - 01:25 PM
0 min

23/141
Confirmation of Quoracy

To Note *Acting Chairman*

Verbal

01:25 PM - 01:25 PM
0 min

23/142
Declaration of Interests

To Note *Acting Chairman*

23-142 - Board of Directors register of interests - January 2024.pdf (3 pages)

01:25 PM - 01:25 PM
0 min

23/143
Minutes of Previous Meeting held on 7 December 2023

Approval *Acting Chairman*

23-143 - Unconfirmed BoD 07.12.23 Open Minutes.pdf (16 pages)

01:25 PM - 01:25 PM
0 min

23/144
Matters Arising from the Minutes on 7 December 2023

Approval *Acting Chairman*

23-144 - Front Sheet Open BoD Action Log.pdf (6 pages)

Patients - Quality and Safety

01:25 PM - 01:55 PM
30 min

23/145
Patient Story

Discussion *Chief Nursing and Midwifery Officer (CNMO)*

- 23-145.1 - Front sheet Patient Story Board Feb 2024 FINAL.pdf (2 pages)
- 23-145.2 - Appendix 1 Carer Experience Story Board 1 Feb 2024 FINAL.pdf (4 pages)
- 23-145.3 - Appendix 2 Visitor charter - Final.pdf (1 pages)

REGULATORY AND GOVERNANCE

01:55 PM - 02:00 PM
5 min

23/146
Acting Chairman's Report

Information *Acting Chairman*

- 23-146 - Acting Chairman BoD Report FINAL 01.02.24.pdf (5 pages)

02:00 PM - 02:10 PM
10 min

23/147
Chief Executive's (CE's) Report

Discussion *Chief Executive*

- 23-147 - CEO Report to Board - February 2024 V.1.pdf (6 pages)

02:10 PM - 02:40 PM
30 min

23/148
Integrated Performance Report (IPR)

Discussion *Chief Executive / Executive Directors*

- 23-148.1 - Front Sheet Jan 24 IPR.pdf (3 pages)
- 23-148.2 - Appendix 1 IPR_v5.0_Dec23_FINAL.pdf (64 pages)

23/148.1
Month 9 Finance Report

Information *Interim Chief Finance Officer (CFO)*

- 23-148.1.1 - M9 Finance Report front sheet FINAL.pdf (4 pages)
- 23-148.1.2 - Appendix 1 Dec 23 Finance Report Short.pdf (8 pages)

02:40 PM - 02:50 PM
10 min

23/149
Report on Journey to Exit NHS Oversight Framework (NOF4) and Integrated Improvement Plan (IIP)

Discussion *Chief Strategy & Partnerships Officer (CSPO)*

- 23-149.1 - Board IIP Progress Report 24.01.24.pdf (2 pages)
- 23-149.2 - Appendix 1 Board IIP Report 23.01.24.pdf (15 pages)
- 23-149.3 - Appendix 2 IIP Programme Risk Register 22.01.24.pdf (4 pages)

02:50 PM - 03:00 PM
10 min

TEA/COFFEE BREAK 2.50 PM - 3.00 PM (10 MINS)

03:00 PM - 03:40 PM
40 min

23/150
Board Committee - Chair Assurance Reports:

Assurance *Board Committee Chairs*

People

23/150.1
Nominations and Remuneration Committee (NRC) - Chair Assurance Report (3.00 pm to 3.05 pm)

Assurance *Chair NRC - Stewart Baird*

23-150.1 - NRC Board Chair Assurance Report 12.12.23.pdf (2 pages)

Patients - Quality and Safety

23/150.2
Quality and Safety Committee (Q&SC) - Chair Assurance Report (3.05 pm to 3.15 pm)

Assurance *Chair Q&SC - Andrew Catto*

23-150.2 - QSC Chair's Report 230124 final.pdf (5 pages)

Partnerships - Sustainability

23/150.3
Finance and Performance Committee (FPC) - Chair Assurance Report (3.15 pm to 3.25 pm)

Approval *Chair FPC - Richard Oirschot*

23-150.3.1 - FPC Board Chair Assurance Report 23.01.24 FINAL v1.pdf (5 pages)
23-150.3.2 - FPC Committee Assurance Report 09012024 Final (002).pdf (6 pages)

23/150.4
Integrated Audit and Governance Committee (IAGC) - Chair Assurance Report (3.25 pm to 3.35 pm)

Assurance *Chair IAGC - Dr Olu Olasode*

- **NHS England Annual Emergency Preparedness Resilience and Response (EPRR) Assurance Process 2023 – Kent and Medway Local Health Resilience Partnership (LHRP): Confirmation of Compliance Levels**

Verbal

23/150.5
Charitable Funds Committee (CFC) - Chair Assurance Report (3.35 pm to 3.45)

Assurance *Chair CFC - Claudia Sykes*

23-150.5 - CFC Board report 14.12.23.pdf (2 pages)

Patients - Quality and Safety - People

03:40 PM - 04:10 PM
30 min

23/151
Chief Nursing and Midwifery Officer Reports:

CNMO

23/151.1

Serious Incidents (SI) Report

Assurance *CNMO*

- 23-151.1.1 - Front Sheet Serious Incident Report November 2023.pdf (2 pages)
- 23-151.1.2 - Appendix 1 EKHUFT SI Report Nov 2023.pdf (13 pages)

23/151.2
Patient Safety Incident Response Framework (PSIRF)

Information *CNMO*

- 23-151.2 - PSIRF Monthly Report BOARD 19.01.24 final.pdf (8 pages)

23/151.3
Safeguarding All Age Annual Report 2022/23

Information *CNMO*

- 23-151.3.1 - Final Joint Safeguarding Annual Report (2022-23) Board.pdf (22 pages)
- 23-151.3.2 - Appendix 1 Outpatient Data.pdf (3 pages)
- 23-151.3.3 - Appendix 2 Safeguarding Adult report to KMSAB.pdf (9 pages)

23/151.4
Quarterly Care Quality Commission (CQC) Report

Discussion *CNMO*

- 23-151.4 - Front Sheet CQC quarterly update Feb 24 Board.pdf (8 pages)

04:10 PM - 04:20 PM
10 min

23/152
Chief Medical Officer's (CMO's) Reports:

Chief Medical Officer (CMO)

23/152.1
Medical Appraisal and Revalidation

Assurance *CMO*

- 23-152.1 - Medical Revalidation BoD paper 1 Feb 24.pdf (4 pages)

23/152.2
Equality Delivery System (EDS) Report 2023

Approval *CMO*

- 23-152.2.1 - Front Sheet EDS Annual Report Feb 2024 FINAL.pdf (4 pages)
- 23-152.2.2 - Appendix 1 EDS report 2023 Board FINAL v2.pdf (18 pages)

Partnerships - Sustainability

04:20 PM - 04:30 PM
10 min

23/153
Winter Plan

Information *Interim Chief Operating Officer (COO)*

- 23-153.1 - Front sheet_Winter Plan_Board Update Feb 2024.pdf (3 pages)
- 23-153.2 - Appendix 1 EKHUFT Winter Plan_Board Update Feb 2024.pdf (8 pages)
- 23-153.3 - Appendix 2 UEC Improvement Plan.pdf (11 pages)

CLOSING MATTERS

04:30 PM - 04:35 PM
5 min

23/154
Any Other Business

Discussion *All*

Verbal

04:35 PM - 04:50 PM
15 min

23/155
Questions from the Public

Discussion *All*

Verbal

Date of Next Meeting: Thursday 7 March 2024

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM JANUARY 2024

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ANAKWE, RAYMOND	Non-Executive Director	Medical Director and Consultant Trauma and Orthopaedic Surgeon at Imperial College Healthcare NHS Trust **(1)**	1 June 2021 (First term)
ASHMAN, ANDREA	Chief People Officer	None	Appointed 1 September 2019
BAIRD, STEWART	Acting Chairman	Stone Venture Partners Ltd (started 23 September 2010) **(1)** Stone VP (No 1) Ltd (started 15 August 2017) **(1)** Stone VP (No 2) Ltd (started 1 December 2015) **(1)** Hidden Travel Holdings Ltd (started 16 May 2014) **(1)** Hidden Travel Group Ltd (started 15 October 2015) **(1)** Trustee of Kent Search and Rescue (Lowland) (started 2013) **(4)** Non-Executive Director of Spencer Private Hospitals (started 1 November 2021) **(1)** Director of SJB Securities Limited (started 30 October 2013) **(1)** Non-Executive Director of Continuity of Care Services Ltd (started 1 October 2022) **(1)**	1 June 2021 (First term)
CATTO, ANDREW	Non-Executive Director	Chief Executive Officer, Integrated Care 24 (IC24) **(1)** Member of east Kent Health and Care Partnership (HCP) **(1)**	1 November 2022 (First term)
CORBEN, SIMON	Non-Executive Director	Director and Head of Profession, NHS Estates and Facilities, NHS England **(1)**	1 October 2022 (First term)
FLETCHER, TRACEY	Chief Executive	None	Appointed 4 April 2022
FULCI, LUISA	Non-Executive Director	Director of Digital, Customer and Commercial Services, Dudley Council (started 6 April 2021) **(1)** Director of Dudley & Kent Commercial Services Ltd. (started 11 May 2022) **(1)**	1 April 2021 (First term)

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM JANUARY 2024

GLENN, TIM	Interim Chief Finance Officer	Chief Finance Officer and Deputy Chief Executive, Royal Papworth Hospital NHS Foundation Trust (substantive role – on secondment to East Kent Hospitals) **(1)**	6 November 2023
HAYES, SARAH	Chief Nursing and Midwifery Officer	Charity Trustee, The 1930 Fund for Nurses (Charity) **(4)**	18 September 2023
HODGKISS, ROB	Interim Chief Operating Officer	To be confirmed	2 January 2024
HOLDEN, DES	Chief Medical Officer	To be confirmed	2 January 2024
HOLLAND, CHRISTOPHER	Associate Non-Executive Director	Director of South London Critical Care Ltd **(1)** Shareholder in South London Critical Care Ltd **(2)** Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University and the University of Kent **(4)** South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services **(5)**	Appointed 13 December 2019 (Second term)
O'CALLAGHAN, JAMIE	Interim Director of Corporate Governance	To be confirmed	2 January 2024
OIRSCHOT, RICHARD	Non-Executive Director	Non-Executive Director, Puma Alpha VCT plc (July 2019) **(1)** Director, R Oirschot Limited (August 2010) **(3)** Trustee, Camber Memorial Hall (June 2016) **(4)**	1 March 2023 (First term)
OLASODE, OLU	Senior Independent Director (SID)/Non-Executive Director	Chief Executive Officer, TL First Consulting Group (started 9 May 2000) **(1)** Chairman, ICE Innovation Hub UK (started 11 September 2018) **(1)** Independent Chair, Audit and Governance Committee, London Borough of Croydon (started 1 October 2021) **(1)** Independent Non-Executive Director (Adult Care), Priory Group (Adult Social Care and Mental Health Division) (started 1 June 2022) **(1)**	1 April 2021 (First term)

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM JANUARY 2024

STEVENS, BEN	Chief Strategy and Partnerships Officer	None	1 June 2023 (substantive) (20 March 2023 interim)
SYKES, CLAUDIA	Non-Executive Director	Director, Cloudier Skies Ltd **(1)** (started 21 December 2022) Chair, East Kent Health and Care Partnership (HCP) (**1**) (1 January 2024)	1 March 2023 (First term)
YOST, NATALIE	Executive Director of Communications and Engagement	None	31 May 2016

Footnote: All members of the Board of Directors are Trustees of East Kent Hospitals Charity

The Trust has a number of subsidiaries and has nominated individuals as their 'Directors' in line with the subsidiary and associated companies articles of association and shareholder agreements

2gether Support Solutions Limited:
Simon Corben – Non-Executive Director in common

Spencer Private Hospitals:
Stewart Baird – Non-Executive Director in common

Categories:

1 Directorships
2 Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS
3 Majority or controlling shareholding
4 Position(s) of authority in a charity or voluntary body
5 Any connection with a voluntary or other body contracting for NHS services
6 Membership of a political party

UNCONFIRMED MINUTES OF THE ONE HUNDRED AND THIRTY FIFTH MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 7 DECEMBER 2023 AT 1.20 PM HELD AS A WEBEX TELECONFERENCE

PRESENT:

Mr N Dickson	Trust Chairman (Meeting Chair)	ND
Mr S Baird	Non-Executive Director (NED)/People and Quality Committee (P&CC) Chair/Nominations and Remuneration Committee (NRC) Chair/Vice Chairman	SB
Mr R Anakwe	NED (joined by WebEx)	RA
Ms A Ashman	Chief People Officer (CPO)	AA
Dr A Catto	NED/Quality and Safety Committee (Q&SC) Chair	AC
Mr S Corben	NED/2gether Support Solutions (2gether) NED In-Common	SC
Ms J Dickson	Interim Chief Operating Officer (COO) (Urgent and Emergency Care (UEC)) (left meeting at 3.55 pm)	JD
Ms T Fletcher	Chief Executive (CE)	TF
Ms L Fulci	NED (joined by WebEx)	
Mr T Glenn	Interim Chief Finance Officer (CFO) (joined by WebEx)	TG
Mr N Goodger	Interim Chief Medical Officer (CMO)	NG
Ms S Hayes	Chief Nursing and Midwifery Officer (CNMO)	SH
Mr R Oirschot	NED/Finance and Performance Committee (FPC) Chair	RO
Dr O Olasode	NED/ Senior Independent Director (SID)/Integrated Audit and Governance Committee (IAGC) Chair (joined by WebEx)	OO
Mr B Stevens	Chief Strategy and Partnerships Officer (CSPO)/Interim COO (Planned Care)	BS
Ms C Sykes	NED/Charitable Funds Committee (CFC) Chair/*Reading the Signals* Oversight Group Chair	CS

ATTENDEES:

Ms M Durbridge	Improvement Director, NHS England (NHSE)	MD
Ms J Evans	Director of Research & Innovation (R&I) and Clinical Trials Unit (CTU) (minute number 23/136.1)	JE
Professor C Holland	Associate NED/Dean, Kent & Medway Medical School (KMMS)	CH
Ms A Smith	Deputy DoM (minute number 23/134.1)	AS
Mr M Wood	Interim Group Company Secretary (GCS) (joined by WebEx)	MW
Mrs N Yost	Executive Director of Communications and Engagement (EDC&E)	NY

IN ATTENDANCE:

Mr T Cook	Special Adviser to the Chairman and Deputy GCS	TC
Miss S Robson	Board Support Secretary (Minutes)	SR
Ms J Smith	Good Governance Institute (GGI)	JS

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mr K Bradshaw	Journalist – ITV
Ms C Garrett	Member of Staff
Ms C Gregory	Member of the Public
Ms C Heggie	Member of the Public
Ms L Judd	Governor
Mrs B Mayall	Governor
Ms S Mahmood	Governor
Ms A Moore	Journalist – HSJ
Mr D Richford	Member of the Public
Mr P Schofield	Governor
Mr C Shorter	Governor
Ms L Silvana Adragna	Member of Staff
Mrs M Smith	Member of the Public
Mr M Taylor	Member of the Public
Ms J Thomas	Governor
Mrs M Warburton	Member of the Public

MINUTE NO.		ACTION
23/122	**CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE** The Chairman opened the meeting, welcomed everyone present, noted there were no apologies received, members of the public joining the meeting virtually, and the opportunity at the end of the meeting to type and ask questions in the Question and Answer function. The Chairman welcomed Mr Tim Glenn, Interim CFO who was joining virtually. It was noted this was the last Board of Directors meeting for Ms Jane Dickson (leaving the COO role at end of December 2023) and Mr Nic Goodger (stepping down from the Interim CMO role at end of December 2023), and thanked them both for their support and considerable contribution to the Board. The Chairman reported a Closed Board meeting had been held that morning, discussions included the Trust's financial position, Winter Plan, Endoscopy recovery, Renal service, Capital requirements, Elective Patient Tracking list, Risk Register review, Board Assurance Framework refresh, Board and Board Committee meeting dates, CMO's Report, and CNMO's Report.	
23/123	**CONFIRMATION OF QUORACY** The Chairman **NOTED** and confirmed the meeting was quorate.	
23/124	**DECLARATION OF INTERESTS** There were no new interests declared.	
23/125	**MINUTES OF THE PREVIOUS MEETING HELD ON 2 NOVEMBER 2023** **DECISION:** The Board of Directors **APPROVED** the minutes of the previous meeting held on 2 November 2023 as an accurate record.	
23/126	**MATTERS ARISING FROM THE MINUTES ON 2 NOVEMBER 2023** The Board of Directors **NOTED** the action log, **NOTED** the updates on the actions, and **NOTED** the actions for future Board meetings.	
23/127	**STAFF EXPERIENCE STORY** The Chairman reported the Staff Experience Story had had to be deferred. The CPO explained the story was in respect of the Freedom to Speak Up (FTSU) service and further information was needed to be collated for presentation to the Board. Due to the alternating Staff and Patient Experience Story, this Story would be presented to the March 2024 meeting.	
23/128	**CHAIRMAN'S REPORT** The Chairman highlighted the following key elements: • Thanks to Mr Stewart Baird, Vice-Chairman, for supporting the Trust and Board during his leave of absence; • Thanks to all the Trust's front line staff for their continued support, hard work and commitment, in managing the significant unprecedented operational	

demand, activity and pressures. Trust continued to work with partners around solutions to improve patient flow and managing patients during this busy winter period;
- Impact of the limited capital funding available and concern around the difficulties maintaining equipment, devices and the estate.

The Board of Directors **NOTED** the Chairman's report.

23/129 **CHIEF EXECUTIVE'S (CE's) REPORT**

The CE reported the following key points:

- Awaiting receipt of the Fire Safety Audit report from Kent Fire & Rescue Service. There had been provision of additional capital funding to address the requirements for fire doors, compartmentation and assessments;
- Thanks to Ms Jane Dickson and Mr Nic Goodger for their support to the Trust and to her whilst covering the Interim roles. The substantive CMO, Des Holden, would be commencing on 2 January 2024;
- In the process of recruiting an Interim COO until this role was substantively appointed to, which was currently out for advertisement;
- Further junior doctor industrial action would be taken prior to the Christmas period and in the New Year, planning work had already commenced on how activity would be managed during this period;
- Some Facilities and Estates team staff from 2gether Support Solutions (2gether) to be taking industrial action, Trust was working closely with 2gether's management team to understand and address any potential impact.

The NEDs raised the NHS National Staff Survey (NSS), how and what the Trust could do to increase the response rate, looking at what other trusts were doing to learn what was working well. The CE noted this would need to be considered when the survey results were available and to review responses from hospital sites, areas and services, to identify where specific targeted work was required to increase response rates for future surveys. To also review the Trust's position nationally.

ACTION: Review results of the NHS National Staff Survey (NSS), the Trust's position nationally against response rate, and review responses from hospital sites, areas and services, to identify areas for specific targeted work to increase response rates for future surveys. CPO

The Board of Directors discussed and **NOTED** the Chief Executive's report.

23/130 **WINTER PLAN 2023/24**

The Interim COO UEC highlighted the following key points:

- Continued close collaborative working with system partners, Integrated Care Board (ICB), community and mental health providers, and social care in respect of accessibility to alternative and appropriate services outside the Emergency Departments (EDs) for patients to access;
- Update on Tier 1 visits (higher level of scrutiny for UEC services), with positive feedback on the system working;
- Continued significant demand and challenges on ED services;

- Improving patient flow continued to be monitored to ensure this was appropriate and efficient;
- Continued focussed work to reduce patient length of stay (LoS) in hospital (SAFER Bundle) against good practice, ensuring patients received treatment required quickly, timely discharges working with partners around this, reducing demand for beds and pressure in EDs;
- Reviewing ambulance conveyances and what was needed to ensure prompt handovers enabling ambulances efficient return to the community, with Single Point of Contact (SPOA) care co-ordination hub pilot implemented resulting in good progress. Currently 90% of ambulances were returning to the community within 30 minutes of arrival at the EDs;
- Plan aligned with the National framework to increase capacity, including growing the workforce, patients received the right care at the right time and had access to other services needed;
- Despite the interventions put in place there would remain a daily gap of 45 beds unless additional improvements and funding was provided. Risk with additional community capacity reliant on achieving growth in workforce that would continue to be monitored;
- Commended the Trust staff and teams in managing patients during this significant demand safely and for their continued hard work.

The Associate NED raised the provision of escalation beds during the summer period and whether these were still being used during the winter period. The Interim COO UEC reported currently no escalation beds in ED corridors were being used but there remained some additional beds in ward areas. She noted there was a need for a full capacity protocol that all staff adhered to, in respect of safely and effectively managing patients in appropriate areas during peak periods of demand. The NEDs raised the importance that staff were aware and managed health and safety (H&S) elements in respect of fire, exit requirements when escalation corridor care was used. It was noted primary care were working with nursing and care homes proactively and monitoring these providing support in managing patients, to avoid ED admissions. As well as increasing capacity over the Christmas and New Year period in the Urgent Treatment Centres (UTCs).

The NEDs enquired what support could be provided from Trust clinical staff to community, nursing and care homes staff to increase confidence in managing patients to reduce unnecessary admissions. The Interim COO UEC recognised the additional workforce required to be recruited to enable the community and nursing homes to manage patients in the community and keeping unnecessary admissions to a minimum. It was noted the Trust was working with PRISM and KPMG to improve patient flow, discharge processes, and embedding SAFER bundle principles across acute wards. The Executive Team were reviewing the plan, what was being effectively managed, delivered and working and addressing any areas that were not working.

The NEDs enquired whether a fortnightly briefing could be considered circulating to the Board providing an update on the winter plan. It was noted the benefits of undertaking a post-winter plan review to identify any lessons learnt and any themes for future years. The Interim COO UEC reported fortnightly updates were not operationally manageable.

ACTION: Undertake a post-winter plan review to identify any lessons learnt, any themes for future years and evaluate the additional funding provided where this had been utilised and its effectiveness. — Interim COO UEC

The NEDs raised the unmitigated bed gap of 45 beds, use of escalation beds, and whether there was any potential impact and risk to reducing elective activity to free up beds to manage the demand. The Interim COO UEC reported the winter plan was around managing demand during the winter period and ensuring patients requiring care received the care and treatment they needed. The CSPO commented the proportion of beds allocated for elective patients was small and during high demand focus on delivering cancer activity.

The Chairman thanked the Interim COO UEC and all staff for their continued hard work in managing demand and working with system partners on the winter plan.

The Board of Directors **NOTED** the 2023/24 Winter Plan.

23/131 **INTEGRATED PERFORMANCE REPORT (IPR)**

The CSPO reported on the following points:

- Continuing to work hard to improve the cancer 28 day faster diagnosis pathway performance currently at 63.9% and below the target. Improvement in diagnostics performance to 60.7%, with issues remaining in endoscopy, focussed improvement plan work continued to further improve this position;
- Increase in overall size and number of patients on waiting lists with demand from new referrals, resulting in increased waiting time for patients;
- Business planning currently being progressed to understand the Trust's baseline capacity to deliver against activity, identifying where there were gaps, and what was needed to return to a sustainable delivery position.

The NEDs raised the increased number of patients waiting longer than 62 days for cancer treatment and what actions there were to support these patients. It was commented it be considered identifying a timeline against trajectory of improvement in respect of the impact of the actions being taken forward. It was noted the sustained reduction in the number of super stranded patients, and whether there was any learning that could support improvement in other areas. The Interim CMO commented patients referred under the two week wait referral, and some were diagnosed with not having cancer. The CSPO reported an improvement in reducing waits was anticipated to be achieved in quarter 4, and agreed to look at how to present a timeframe for improved trajectory for cancer performance in future reports.

ACTION: Look at and identify how the IPR could provide a presentation of the timeframe for improved cancer performance trajectory. CSPO

Urgent and Emergency Care

The Interim COO UEC highlighted the following key elements:

- All type ED performance was behind plan at 70.6% and Type 1 ED performance was under plan at 45.8%;
- Length of time patients spent in ED continued to increase with focussed work ongoing to reduce and sustain reduction.

Quality and Safety

The CNMO highlighted the following key points:

- Number of overdue incidents increased in month by 373, due to a data issue that was being addressed, number of incidents was still high;
- Complaint response times below target threshold, trajectory in place to improve within three months, focus on ensuring quality responses provided, and complainants had been written to explaining the reasons for delay in responding;
- C-dif threshold breached for year by four cases, trajectory remained a concern for the Trust and a national concern;
- Safeguarding training, commitment to improve and achieve 90% by December, with a trajectory to achieve compliance by January 2024. Current compliance for level 2 (children at 83% and adults at 84%), and level 3 (adults at 70%).

The Interim CMO reported on the following key elements:

- Hospital Standardised Mortality Ratios (HSMR) continued to reduce, remaining below 100, plateaued at an index figure of around 93. The Morbidity and Mortality Steering Group (MMSG) reviewed deaths looking at and identifying any trends.

People

The CPO reported on the following key areas:

- Increased sickness absence for fifth month in succession, now breaching the alerting threshold of 5.4%, chief contributor was stress, anxiety, and depression. Funding provision from East Kent Hospitals Charity for psychological support for staff, anticipated to have a positive impact on reducing level of sickness absence. Deep dive being undertaken to identify reasons for sickness and what help was needed to further support staff;
- Staff turnover continued to remain in line with previous month at 9.1% (against 10% national standard);
- NSS closed on 24 November, disappointedly it was anticipated the response rate of around 41% similar to the previous year, this would be reviewed against the national participation rate. The results and outcome of the survey would be published early next year;
- Statutory training currently good position of 94% for Health & Safety (H&S), 94.4% for Equality, Diversity and Inclusion (EDI), 92% for Infection, Prevention and Control (IPC), and 91% for safeguarding;
- Appraisal rates remained around 73%, completed staff appraisals that had previously not been updated on the Electronic Staff Record (ESR) had now been updated, with engagement and training support for managers to ensure ESR was updated going forward.

The NEDs queried whether a review of the vacancy and turnover rate threshold was needed for the following financial year to ensure this was set appropriately to reduce the level of spend on locum and agency staff. It was noted this would be discussed further outside this Board meeting with the CPO and NED.

The NEDs enquired whether the increase in sickness absence seen in October (earlier than the normal winter sickness pressures) had been factored within the Winter Plan, and whether there was more that could be done to mitigate this. The CPO reported in October there had been a spike in staff sickness absence due to

new Covid variant. It was noted the proactive programme to encourage staff to receive their flu and Covid vaccinations, uptake had not been as high as hoped and was better than peers within Kent, there was also the provision of psychology support. The CPO agreed to confirm staff uptake numbers of those that had received their flu and Covid vaccinations.

ACTION: Confirm the staff uptake numbers of those that had received their flu and Covid vaccinations. CPO

The Board of Directors discussed and **NOTED** the metrics reported in the Integrated Performance Report.

23/131.1 **MONTH 7 FINANCE REPORT**

The Interim CFO highlighted the following key areas:

- Trust's extremely challenging financial position, deficit was a National outlier, significant issue for Trust and system partners, working collaboratively on actions to support to improve the financial performance;
- Control measures put in place included, vacancy panels, non-pay panels, and increased reporting and monitoring of Care Groups expenditure;
- Review of cost baseline that would provide the information and identify where the issues were that needed to be addressed to reduce the level of spend. Initial report expected to be produced late December;
- Provision of additional experienced financial resource support to assist with the financial performance improvement work;
- Year to Date (YTD) position £68.2m against plan of £45.5m, giving a YTD variance to plan of £22.7m;
- Aligned with the financial improvement work included looking at the infrastructure and operational impact.

The NEDs emphasised it was important to look at and start the 2024/25 Cost Improvement Programme (CIP) annual process early in respect of identifying potential cost efficiency projects. The Interim CFO confirmed work had already commenced, would be a key area of focus for the additional support along with further assistance in respect of Programme Management Office (PMO) around best practice that would report into the Financial Improvement Programme Board.

The NEDs enquired when a clear forecast position for Year-End (YE) would be available and assurance of that reported was achievable. The Interim CFO emphasised the need to have stretched targets that were deliverable and confirmed discussions with detailed plans would be held at the FPC, and reported to the Board.

The Board of Directors **NOTED** the Month 7 finance report, financial performance and actions being taken to address issues of concern

23/131.2 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

- **TERMS OF REFERENCE (ToR)**

The FPC Chair reported on the following key issues:

- Very little progress made in achieving savings on a recurrent basis, only £1.0m YTD against the 2023/24 £40 YE target, noting some additional non-recurrent savings identified of £6.5m YTD;
- PricewaterhouseCoopers (PwC) undertaking a full reforecasting review, including financial controls, CIP and reforecast for YE. Additional FPC meeting scheduled for early in January 2024 to review and discuss the reforecast review report;
- Patients No Longer Fitting the Criteria to Reside (PNLFCR) at 193 in October with a marginal improvement from September's position. Super Stranded Patients (>21d LoS) had improved in October at 235, a reduction from that in September of 245, and best reported position since June 2022;
- Patient flow improvement work was now in its implementation phase and expected to see improvements in reducing patient LoS;
- Month 7 finance position £8.9m against plan of £4.6m, deficit variance of £4.4m;
- Approval of the Digital Pathology Short Form Business Case;
- Concern about the increased number of cancer patients waiting longer than 62 days (506 patients) or 104 days (107 patients), increased breaches in Referral to Treatment (RTT) waiting times for 52 weeks increased by around 16% and 65 weeks by 26%. Action plans in place to reduce these;
- FPC ToR recommended for approval by the BoD.

DECISION: The Board of Directors:

- **NOTED** the 31 October and 28 November 2023 FPC Chair Assurance Report.
- **APPROVED** the FPC Terms of Reference.

23/132 **REPORT ON JOURNEY TO EXIT NHS OVERSIGHT FRAMEWORK (NOF4) AND INTEGRATED IMPROVEMENT PLAN (IIP)**

The CSPO highlighted the following key points:

- Four programmes rated amber, significant progress had been made in Quality & Safety, Maternity and People & Culture programmes;
- Two programmes continued rated red, Operational Performance and Finance, biggest risk in delivering and exiting NOF4;
- In the process of gathering evidence to support and provide assurance for the self-assessment in meeting the NOF4 exit criteria. An 'Evidence Review and Assurance Panel' would be set up in January 2024 chaired by the CSPO to review progress, challenge and confirm the quality of evidence, assess and identify any gaps;
- All programmes were reviewing milestones for phase two, due to be finalised in December 2023 to ensure key areas of work were progressed to address meeting exit criteria and improve metrics.

NHSE's Improvement Director commented phase two was focussed on the exit criteria and providing evidence supporting this of the Trust's improvement. A central repository in place of the evidence gathered. The red rated Finance programme would be reviewed in detail by the Interim CFO in respect of milestones and the work required. Additional support from the Recovery Support Programme (RSP) team to assist to make progress on the two red rated programmes.

The NEDs raised the two red rated programmes and that these were unlikely to meet the exit criteria requirements by YE and enquired about the impact of this for the Trust. NHSE's Improvement Director commented a National Oversight meeting would be held the following week commencing 11 December, where the exit date would be discussed and an achievable timeframe, noting the current scheduled exit date of 31 March 2024. There would also be a discussion about the actions that had had an impact, areas of limited progress and potential areas of further improvement if additional support was provided.

The CE stated the need to look at and discuss the areas where the exit criteria had been meet, recognising this was a staged process, acknowledging the good work by staff, the progress and improvements made in some areas particularly in Maternity, whilst recognising the areas where more significant work was needed. NHSE's Improvement Director commented on the Maternity and Neonatal Support Programme (MNSP) and for consideration exiting the Maternity programme as a result of the significant improvements made within the Maternity services, moving from improvement to stability.

The NEDs noted the challenges during the current FY, i.e. industrial action that had impacted the recovery programme, it was important to recognise this and the hard work and commitment of Trust staff in achieving the current position.

The Board of Directors discussed and **NOTED** the IIP report.

23/133 **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS:**

23/133.1 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

The P&CC NED member, Ms Sykes, highlighted the following key points:

- Detailed breakdown report on statutory and mandatory training requested for presentation at next Committee meeting, to ensure oversight and monitoring against compliance;
- Correction in report on appraisals as partial assurance received and not assured, in respect of compliance although the rate overall had improved this remained below the 80% threshold. Noted the focussed targeted work by the Interim CMO had resulted in improving the medical appraisal rate increased to 76%;
- Assurance of the experiences of Black, Asian and Minority Ethnic (BAME) doctors, recognising there was still more work and actions needed to address feedback from doctors from minority ethnic backgrounds. The issues raised were around lack of trust, being treated differently and to address microaggression. As well as support for staff that experienced racial abuse from patients, addressing this and to consider displaying notices throughout the sites that abusive language or threatening behaviour would not be tolerated.

The Board of Directors **NOTED** the 7 November 2023 P&CC Chair Assurance Report.

23/133.2 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

- **TERMS OF REFERENCE (ToR)**

The Q&SC Chair highlighted the following key points:

- Key quality elements had already been discussed, showing the commitment of the Board to continue to make improvements and that these were sustained;
- Revised ToR presented for Board approval, noting future monthly meetings would continue to be held, alternating discussion on quality assurance and quality improvement. Also looking at Care Groups attending meetings on a rotational basis.

The Chairman enquired how the Trust performed compared to others in respect of antimicrobial stewardship. The Q&SC Chair commented this had also been raised at Q&SC, it was recognised more work was needed to ensure robust management and clinical ownership.

The CNMO reported the contamination issue of the identification of "holes in wraps" which may have contributed to infection rates. The Interim CMO commented the high scrutiny processes in place and the Trust had met with the Company. There had been no evidence of deliberate intent tampering with the wraps and had been identified as a possible transport issue that was being looked at.

The Board of Directors:

- **NOTED** the 28 November 2023 Q&SC Chair Assurance Report
- **APPROVED** the Q&SC Terms of Reference.

23/133.3 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR ASSURANCE REPORT**

The IAGC Chair highlighted the following key points:

- Improvement in the overall assurance received from the previous meeting;
- Review looking at lessons learnt from the 2022/23 Annual Audit, scope of the work discussed, ToR once agreed would be circulated to IAGC members for information;
- Concern about the number and value of Single Tender Waivers (STWs), with ongoing work with Procurement to support reducing the numbers raised throughout the Trust;
- Risk Management Policy and Strategy, and Emergency Preparedness, Resilience and Response (EPRR) Assurance Outcome and EPPR Report presented for approval;
- Concern about non-compliance of Senior Managers' Risk Management Training and that this had deteriorated against that in 2022/23, important that non-compliant staff complete training as soon as possible;
- Trust's External Auditors appointed on a one plus one year contract, covering the current 2023/24 and up to 2024/25 annual audit.

The Associate NED raised the partial assurance received in respect of the study leave 2022/23 report and whether a deep dive report would be received providing assurance around diversity and no bias. The IAGC Chair reported challenges with providing this data with how information was collected, assurance reported of the provision of study leave equitably, and next year's report would include Equality, Diversity and Inclusion (EDI) data.

DECISION: The Board of Directors:

- **NOTED** the 7 November 2023 IAGC Chair Assurance Report.
- **APPROVED** the Emergency Preparedness, Resilience and Response (EPRR) Assurance Outcome and EPPR Report;
- **APPROVED** the Risk Management Policy;
- **APPROVED** the Risk Management Strategy.

23/133.4 **CHARITABLE FUNDS COMMITTEE (CFC) – CHAIR ASSURANCE REPORT**

- **EAST KENT HOSPITALS CHARITY (EKHC) ANNUAL ACCOUNTS AND REPORT 2022/23**

The CFC Chair highlighted the following key points:

- EKHC 2022/23 Annual Accounts and Report, and Audit Representation Letter approved and recommended for Board approval;
- Thanks to the Charity team for their excellent and hard work in producing the report within a very quick turnaround, as well as thanks to the new External Auditors, Azets.

DECISION: The Board of Directors:

- **NOTED** the CFC Chair Assurance Report from the meeting held on 28 November 2023;
- **APPROVED** the annual East Kent Hospitals Charity 2022/23 annual accounts and report for signing and filing;
- **APPROVED** the audit representation letter for signing;
- **NOTED** the contents of the Azets Audit Findings report.

23/134 **CHIEF NURSING AND MIDWIFERY OFFICER'S (CNMO) REPORTS**

23/134.1 **MATERNITY INCENTIVE SCHEME YEAR 5 SUBMISSIONS – REPORT FROM MATERNITY AND NEONATAL ASSURANCE GROUP (MNAG)**

- **MATERNITY DASHBOARD**
- **PERINATAL QUALITY SURVEILLANCE TOOL (PQST)**
- **MIDWIFERY WORKFORCE**
- **OBSTETRIC WORKFORCE**
- **CARE QUALITY COMMISSION (CQC) UPDATE**
- **MATERNITY AND NEONATAL IMPROVEMENT PROGRAMME (MNIP)**
- **CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) CLAIMS**
- **TRAINING UPDATE**
- **AVOIDING TERM ADMISSIONS INTO NEONATAL UNITS (ATAIN) REPORT**

The Deputy DoM reported on the following key matters:

- Maternity dashboard detailing areas of positive performance as well as areas for improvement that the team were addressing;
- Rate of reportable neonatal and perinatal deaths remained lower than the Trust comparator group average, rolling 12 month Stillbirth rate now at 1.57 per 1000 births compared to comparator average of 3.92/1000, and extended perinatal rate (Stillbirths and Neonatal deaths up to 28 days) now at 2.62 per 1000 births compared to the comparator average of 5.87 per 1000 births;

- Sadly one incidental maternal death, woman was not pregnant at the time and unrelated to maternity care;
- One:One care in labour and supernumerary status of the co-ordinator achieved 100% compliant in month ensuring oversight, with ongoing work to ensure this was maintained;
- Some of the workforce metrics were falling below the required thresholds linked to staffing challenges that were predominantly at William Harvey Hospital (WHH);
- Safeguarding training compliance increased to 86%;
- CNST threshold now at 80% for PRactical Obstetric Multi-Professional Training (PROMPT), anaesthetic training compliance increased to 83% for consultant attendance and had fallen for all other anaesthetic staff. Meetings would continue to be held to ensure compliance was maintained;
- Four reported moderate harm incidents in October, three at Queen Elizabeth the Queen Mother Hospital (QEQM) and one at WHH;
- Two Healthcare Safety Investigation Branch (HSIB) referrals for October;
- Two Serious Incidents (SIs) reported for maternity in September;
- Friends and Family Test (FFT) received 12% response rate;
- Following review of 24 hour consultant on call rota at WHH, there would be a change to this starting in January 2024;
- Due to a traditional consultant post not being recruited to, this would be changed to a specialist grade post;
- Dissemination of communications publicising the opening of the improved Midwifery Led Unit facilities;
- Learning and addressing improvements from incidents and complaints;
- CQC update, out of the 20 must do requirements of which 14 were complete, four were on track and two were off track relating to training with an action plan in place to complete compliance. Monthly stop the clock meetings in place to monitor the action plan, as well as weekly meetings with the Estates, Chief Nurse and Maternity teams. Monthly update reports shared with the CQC and bi-weekly meetings held by the CNMO;
- Maternity and Neonatal Improvement Programme (MNIP) progress report providing assurance on the governance arrangements and management of this programme;
- Safety action 9 report providing evidence of maternity and neonatal quality dataset, the Trust's claims scorecard, incident and complaint data;
- Safety action 8 training, Trust reporting compliance, the Trainee Nursing Associate (TNA) three year maternity training plan had been reviewed by the Local Maternity and Neonatal System (LMNS);
- Safety action 3 Avoiding Term Admissions into Neonatal Units (ATAIN), Q2 admission rate for WHH 3.4% and 4.5% at QEQM, national average currently 4.4%. Identified main reason for admissions was respiratory causes, deep dive of these cases to identify any lessons learnt.

The Interim COO UEC commented on the Stillbirth rate reported per 1000 births and the benefits of understanding the number of Stillbirths to be presented in future overarching reports compared to previous months.

ACTION: Include in future overarching reports the number of Stillbirths compared to previous months along with the current reported Stillbirth rate reported per 1000 births. — CNMO

The Chairman requested an update on recruitment of midwifery and medical staff. The Deputy DoM reported the team at QEQM were fully staffed for midwifery, with

two vacant consultant posts currently out to advertisement, at WHH there were 27 Whole Time Equivalents (WTEs) vacancies for midwives, this would be reduced by 13 following onboarding of the Internationally Educated Midwives. Regular long term agency staff were utilised covering staffing gaps. Positive interest from midwives wanting to work in the Midwifery Led Unit (MLU), and staffing in labour wards, MLU and the community (home births) being robustly managed. Publicising the opening of the MLU to encourage recruitment of core staff to this unit.

The NEDs enquired how staff were currently feeling and whether there had been an improvement in the culture. The Deputy DoM stated staff were engaged, positive about making a difference and improvements, open to make changes and owning these, felt they were being heard, with positive engagement from the obstetrics team. The CNMO reported she would be meeting with the senior leadership team and the Interim CMO later in December to discuss next steps in respect of the multi-disciplinary team working and extending this to the operational teams.

The Associate NED raised the element in the overarching report in respect of the development and submission of a business case for four additional middle grades (trainees) that would facilitate the development of a two tier on call rota for WHH. He raised concern about this as there were a specific number of trainees on rotation and that any additional numbers would be required to be sourced from another rotation and that this was unlikely due to limited resources. The Interim CMO reported Locally Employed Doctors would be appointed to cover rota gaps.

The Associate NED enquired whether there were roles for Physician Associates within Maternity services and whether any individuals were in post within the Trust. The CE stated she was unaware there were any Physician Associates in the Trust's Maternity services and that this needed to be considered by the Associate Medical Director for Women's Services in liaison with the WHH and QEQM Maternity Clinical Leads.

ACTION: Associate Medical Director for Women's Services in liaison with the WHH and QEQM Maternity Clinical Leads consider the provision and appointment of Physician Associates within Maternity services to support additional staffing resources. — Interim CMO

The Chairman thanked the Maternity leadership team and all the staff for their hard work and dedication in achieving the improvements within a short period.

DECISION: The Board of Directors:

- **NOTED** the Maternity Incentive Scheme Year 5 Submissions – Report from MNAG;
- **APPROVED** the Safety Action 3 ATAIN action plan;
- **APPROVED** the Safety Action 5 Maternity Workforce paper;
- **APPROVED** the Safety Action 8 Trainee Nursing Associate (TNA) and three year training plan.

The Interim COO UEC left the meeting at this point.

23/135 **SERIOUS INCIDENTS AND SAFE NURSING STAFFING:**

23/135.1 **SERIOUS INCIDENT (SI) REPORT**

The CNMO reported on the following key points:

- Provided oversight of SIs declared, 13 in September, good position against compliance with investigations and Duty of Candour (DoC);
- Continuing to embed learning from incidents across the Trust.

The Board of Directors **NOTED** the contents of the SI report, assurance of the efficacy of the overall incident management and Duty of Candour compliance processes in place within the Trust.

23/135.2 **SAFER NURSING STAFFING**

The CNMO reported on the following key points:

- Provided the Board with assurance of the Trust's safety of the staff nursing levels, as well as the process implemented to gain control and manage bank and agency shifts and expenditure on temporary staffing;
- Future reports would provide triangulation of staffing levels against harm;
- High level and good position in respect of care hours per patient day (CHPPD) against peers;
- Nursing establishment review being undertaken against the updated National tools that would be reflected in future reports.

The Board of Directors:

- **NOTED** the content of the Safer Nursing Staffing report;
- Received **ASSURANCE** the hospital was safely staffed or had mitigations in place;
- **NOTED** the progress being made in relation to the recruitment pipeline and the actions that were being taken to mitigate potential foreseen issues.

23/136 **CHIEF MEDICAL OFFICER'S (CMO's) REPORT:**

23/136.1 **RESEARCH AND INNOVATION (R&I) UPDATE**

The Director of R&I and CTU reported on the following matters:

- All key objectives were achieved for 2022/23, a real successful achievement for the team and staff;
- 2,098 patients recruited;
- Important to encourage and enable more multi-professional staff across all clinical specialities, to engage with R&I to ensure embedded throughout the organisation to deliver excellence;
- 20% more studies set up in 2023/24 than the same period the previous year;
- Oncology and Haem-oncology teams at Kent & Canterbury Hospital (K&C) had been merged, providing improved efficiency, increased cross cover, and enabling offering more patients interventional treatment;
- CTU facility opened in June 2022, had received three national grants totalling £445k, with an income 2023/24 YTD of £193,433.33, and overall £458,818.44. Trust continued to apply for grants;

- Trust working with Kent and Medway Health NHS and Social Care Trust (KMPT) in respect of mental health support;
- Trust was first to recruit to a number of complex interventional studies nationally and internationally, i.e. SAPHIAIRE (haematology study and first global patient).

The Board of Directors thanked the Director of R&I and CTU and all Trust staff in R&I for their commitment and hard work, acknowledging the successful R&I showcase event held in September displaying the outstanding R&I work, and their commitment to continue to support the provision of R&I and its vital work.

The Board of Directors reviewed and **NOTED** the contents of the R&I report.

23/137 **ANY OTHER BUSINESS**

There were no other items of business raised.

23/138 **QUESTIONS FROM THE PUBLIC**

Ms C Heggie asked about cancer waiting times for diagnosis and then treatment, whether there was any data or way of knowing if anyone in the 3% expected showed that they did have cancer, that their illness had changed in grade or that they may have died before being seen? The CE emphasised it was important for patients to receive a diagnosis and the Trust's actions to improve access to diagnostics and working towards meeting the waiting time standards, noting the data was not available and would be difficult to identify whether illness had deteriorated due to the waiting time.

Ms Heggie noted as a Union representative had seen an increase in staff in the NHS and 2gether being called to attend capabilities meetings, whilst awaiting NHS treatment, and the feasibility of these being put on hold until they had received their treatment, including elective surgery, or having a system in place for these staff to be higher up on the waiting list? The CPO reported it was not within the Trust's gift to make any changes to waiting lists, confirmed there were triggers in place governed by sickness absence for when meetings were needed to be held, that was around a supportive process for staff to understand and explore reasons for absence and any additional necessary support that could be provided.

Mr D Esson asked why the Trust had called in external consultants (PwC) to help tell it the drivers of its deficit, or if it was the case that part of PwC's role was to explain how and why the Trust had failed to make planned savings. The Interim CFO emphasised it was important that the Trust identified its baseline and that this was independently verified and validated, providing the required assurance to system partners, stakeholders and regulators that the Trust could build upon to improve its financial performance. This baseline would assist with identifying the reasons why efficiencies were not being achieved and what actions were needed.

The Chair closed the meeting at 4.20 pm.

Date of next meeting: Thursday 1 February 2024.

Signature _____

CHAIR'S INITIALS ……

Date _____

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Matters Arising from the Minutes on 7 December 2023**

Meeting date: **1 February 2024**

Board sponsor: **Acting Chairman**

Paper Author: **Board Support Secretary**

Appendices:

NONE

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The Board is required to be updated on progress of open actions and to approve the closing of implemented actions.
Summary of key issues:	An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales. The Board is asked to note the updates on the action log.
Key recommendations:	The Board of Directors is asked to **NOTE** the action log, **NOTE** the updates on actions, **NOTE** the actions for future Board meetings, and **APPROVE** the four actions recommended for closure.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	None
Link to the Corporate Risk Register (CRR):	None
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: None

East Kent Hospitals University NHS Foundation Trust

MATTERS ARISING FROM THE MINUTES ON 7 DECEMBER 2023

1. Purpose of the report

1.1. The Board is required to be updated on progress of open actions and to approve the closing of implemented actions.

2. Background

2.1. An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales.

2.2. The Board is asked to note the updates on the action log as noted below:

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/17/22	Amend the IAGC Terms of Reference (ToR) reflecting the substitute Board Committee member attendance if Committee Chair was unable to attend an IAGC meeting. Circulate for virtual IAGC approval and once approved to be presented to the Board for approval.	~~Oct-23~~/ May-24	Integrated Audit and Governance Committee (IAGC) Chair/ Group Company Secretary (GCS)	Open	Item for future Board meeting.
B/06/23	01.06.23 - On completion of the ED works review the UEC services, front door patient pathways, management of patients, and patient flow to develop a sustainable Trust strategy. 05.10.23 - Provide a progress update in December 2023 on progress in respect of redesigning patient pathways at the front door, management of these patients, and patient flow.	~~Dec-23~~/ Feb-24	Interim Chief Operating Officer (COO)	Open	Verbal update to be provided at 01.02.24 Board meeting.

B/21/23	Consider for a future Board of Directors meeting for the families engaged with the Reading the Signals Oversight Group being invited to present, as part of the Patient Experience Story, their feedback and comments about the Group, discussions, achievements, and whether they felt progress and improvements had been made.	Feb-24	Chief Strategy & Partnerships Officer (CSPO)	Open	Verbal update to be provided at 01.02.24 Board meeting.
B/22/23	Present annually a Patient Advice and Liaison Service (PALS) report (December 2023), providing details about themes of complaints, timeline of responding to complaints, numbers of complaints and compliments received, lessons learnt, and any actions as a result of feedback received.	~~Dec-23~~/ Feb-24	Chief Nursing and Midwifery Officer (CNMO)	Open	Maternity complaints report to be presented to next meeting of the Maternity and Neonatal Assurance Group (MNAG) and following this will be presented and appended to the Board actions log at its next meeting.
B/27/23	Update to be provided to the Board following a review of the Patient Story.	Mar-24	Chief Medical Officer (CMO)/CNMO	Open	Item for future Board meeting.
B/28/23	Provide a progress update on implementation of the estate and minor work elements of the Care Quality Commission (CQC) must and should do recommendations, and any additional support required to ensure these works were expediated at pace.	~~Dec-23~~/ Feb-24	CNMO	Open	Quarterly CQC Report presented to the Board meeting held on 1 February 2024 including update on Must and Should do recommendations. Detailed report on the implementation of the estate and minor work elements of the CQC Must and Should do recommendations to be presented to next meeting of the Maternity and Neonatal Assurance Group (MNAG) and following this will be presented and appended to the Board actions log at its next meeting.

B/29/23	Provide an update on the actions to support women who experienced birth trauma, provision of trauma informed care, and specific support requirements in maternity care for women with mental health conditions.	Feb-24	CNMO	To Close	This was requested by the Chair of the Reading the Signals Oversight Group, a full presentation was provided at the meeting of this Group held on 16 January 2024. Presentation attached for information (Appendix 7) provided in the Reading Room (documents for information) of the Board meeting held on 1 February 2024. **Action for agreement for closure at 01.02.24 Board meeting.**
B/30/23	Provide an update on progress to identify additional senior appraisers, to ensure the Trust's Appraisal Lead was sufficiently supported and that assurance was provided in overseeing appraisals.	Feb-24	CMO	Open	Verbal update to be provided at 01.02.24 Board meeting.
B/31/23	Provide a short update report by the December Board meeting, focussed summary detailing the specific work and actions of the winter support schemes with a timeline when these would be implemented, breakdown of how the winter funding had been utilised, and summary of the refreshed Trust's winter and escalation plans when completed aligning these with the revised Operational Pressures Escalation Levels (OPEL) framework.	~~Dec-23~~/ Feb-24	Chief Executive (CE(/Interim COO/Deputy COO for Unplanned Care	To Close	Update included in the Winter Plan – Financial Assessment Report presented to the Board at the 1 February 2024 meeting. **Action for agreement for closure at 01.02.24 Board meeting.**
B/32/23	Consider including in future IPR reports a brief summary highlighting areas of good performance and areas achieving target standards.	~~Dec-23~~/ Feb-24	CSPO	Open	Verbal update to be provided at 01.02.24 Board meeting.

B/33/23	Present an update to the Board on progress monitoring the gap analysis, action plan, work needed and any additional support to enable implementation of the ten Sexual Safety in Healthcare - Organisational Charter commitments.	Mar-24	Chief People Officer (CPO)	Open	Lead Freedom to Speak Up Guardian working on a paper to be presented to the March 2024 Board meeting.
B/34/23	Review results of the NHS National Staff Survey (NSS), the Trust's position nationally against response rate, and review responses from hospital sites, areas and services, to identify areas for specific targeted work to increase response rates for future surveys.	Apr-24	CPO	Open	Comprehensive review of results and response rates complete. 2024 People Plan in development. Identification of key areas of challenge and areas for specific targeted work underway. Detail will be provided in April 2024 when restrictions relating to the National embargo are lifted.
B/35/23	Undertake a post-winter plan review to identify any lessons learnt, any themes for future years and evaluate the additional funding provided where this had been utilised and its effectiveness.	Feb-24	Interim COO	To Close	Update included in the Winter Plan – Financial Assessment Report presented to the Board at the 1 February 2024 meeting. **Action for agreement for closure at 01.02.24 Board meeting.**
B/36/23	Look at and identify how the IPR could provide a presentation of the timeframe for improved cancer performance trajectory.	Feb-24	CSPO	Open	Verbal update to be provided at 01.02.24 Board meeting.
B/37/23	Confirm the staff uptake numbers of those that had received their flu and Covid vaccinations.	Feb-24	CPO	To Close	Vaccination uptake numbers noted below. **Action for agreement for closure at 01.02.24 Board meeting.**

EKHUFT Staff Total -	**Flu Uptake**	**% Flu uptake**	**Covid Uptake**	**% Covid uptake**
Clinical staff uptake - 7430	3342	45%	2609	35.1%

No direct patient contact - 1952	840	43%	804	41.2%	
Total - 9382	4182	44.6%	3413	36.4%	

B/38/23	Include in future overarching reports the number of Stillbirths compared to previous months along with the current reported Stillbirth rate reported per 1000 births.	Apr-24	CNMO	Open	This is included in the quarterly reports and the monthly Perinatal Quality Surveillance Tool (PQST). Will ensure is pulled through in the cover sheets, for next report to be presented in April 2024.
B/39/23	Associate Medical Director for Women's Services in liaison with the WHH and QEQM Maternity Clinical Leads consider the provision and appointment of Physician Associates within Maternity services to support additional staffing resources.	Feb-24	CMO	Open	Verbal update to be provided at 01.02.24 Board meeting.

East Kent Hospitals University NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (BoD)

Report title: **Patient Story for the Board**

Meeting date: **1 February 2024**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO)**

Paper Author: **Head of Patient Voice and Involvement**

Appendices:

Appendix 1: Carer's Story
Appendix 2: New Visitors Charter

Executive summary:

Action required:	Discussion
Purpose of the Report:	To hear the story of the carer of a frail older patient who was admitted through the Emergency Department (ED) at Queen Elizabeth the Queen Mother Hospital (QEQM) and who later died.
Summary of key issues:	The report is a carer's story of a frail older person's admission through the ED at QEQM. The carer felt that despite their repeated efforts to make sure staff were aware that this patient was nearly blind and could not manage solid food, they were not listened to in the ED or once this patient was on the ward. The carer felt that an unnecessary and painful procedure was carried out that was not in the patient's best interest and was repeated the day before the patient sadly died. Despite many staff showing kindness and compassion, the carer feels that had they been listened to, this patient would have received better nutrition and hydration, not experienced unnecessary pain and have had their communication needs understood. The lesson we need to learn is that by working in partnership with carers and families we can keep the patient at the centre of their care, particularly when they are vulnerable and may be unable to advocate for themselves.

We care

Key recommendations:	The Board of Directors are asked to discuss and **NOTE** the carer story and support actions being taken to ensure that: • We uphold the NHS Commitment to carers. • We have a carers policy that provides staff with a framework and guidance to put the policy into practice. • We provide staff with access to information about carers and carer awareness training. • We work in partnership with carers and families to ensure the patient is also at the centre of their care.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our quality and safety
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.
Link to the Corporate Risk Register (CRR):	**CRR 159**: Detriment to patients with a disability as we are non-compliant with the mandatory Accessible Information Standards.
Resource:	Yes, for carer awareness sessions for staff.
Legal and regulatory:	The Trust must implement the mandatory Accessible Information Standard and the Equality Act 2010, including the Public Sector Equality Duties. We must comply with the Care Quality Commission Regulations.
Subsidiary:	No

Assurance route:

Previously considered by: Not applicable. Patient/family stories come direct to the Board.

NHS
East Kent
Hospitals University
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CARER EXPERIENCE STORY

1. Purpose of the report

1.1 The report provides the story of the carer of a frail older patient who was admitted through the Emergency Department (ED) at Queen Elizabeth the Queen Mother Hospital (QEQM) and who later died.

1.2 The carer felt that despite their repeated efforts to make sure staff were aware that this patient was nearly blind and could not manage solid food, they were not listen to in the ED or once this patient was on the ward.

1.3 The carer felt that an unnecessary and painful procedure was carried out that was not in the patient's best interest and was repeated the day before the patient sadly died.

1.4 Despite many staff showing kindness and compassion, the carer feels that had they been listened to, this patient would have received better nutrition and hydration, not experienced unnecessary pain and have had their communication needs understood.

2. Background

2.1 Involving patient's carers and family can support an episode of care to go well, improve patient experience and help our staff to provide more person-centred care.

2.2 The Care Quality Commission (CQC) Regulation 9 – person centred care, and the Quality Statement related to independence, choice and control requires that people are supported to maintain relationships and networks that are important to them, and that people have access to their friends and family while they are using a service. This does not only mean whilst an in-patient, but also when using emergency care, day care and at out-patient appointments.

2.3 Under the CQC domain 'Responsive" there is a quality statement that "People who use services and those close to them (including carers and dependants) are regularly involved in planning and making shared decisions about their care and treatment, so it is centred around them and their needs."

2.4 The CQC 'I' statement that supports the patient's carer and family to be involved refers to "I am in control of planning my care and support. If I need help with this, people who know and care about me are involved."

2.5 Feedback from carers using the Trust's carers survey indicates high levels of dissatisfaction due to the lack of involvement of carers and family members, both whilst the patient is in our care and when we are planning their discharge. Carers also say they are not listened to when they raise concerns about the care of the person they care for.

2.6 The carer story provides an example of how the Trust failed to deliver person-centred care, including involving and listening to the person who knew the patient well and cared about them. By working in partnership with carers and families we can keep the patient at the centre of their care, particularly when they are vulnerable and may be unable to advocate for themselves.

3. The Carer's story

3.1 This story is written in the carer's own words:

"I was the friend, carer, health LPA[1] of a 95 year old lady who was admitted via Accident & Emergency (A&E) (ambulance) in September 2023.

Like most people, she was popped on a bed in the corridor whilst waiting to be processed – the care and consideration here was lovely bearing in mind you cannot escape from the fact it is a corridor. She had her tests and was moved into Majors.

I alerted the teams to the known health conditions of my friend and told anyone I could who was part of her clinical and care teams that she was registered blind and could only just about tolerate pureed food and small sips of water. When visiting, her water jug and tissues etc. were not within easy reach for her to feel so I would adjust the position of the overbed table. She was only offered yoghurts whilst she was in Majors, I think this was around 48 hours or maybe more.

She was then moved into St Margaret's ward. Everyone was lovely BUT I had to say time and again that my friend was registered blind and couldn't tolerate solid food or even something more liquid like jelly, ice cream or yoghurt. She would retch and bring everything back up which was very distressing for her, but she was hungry, so she kept trying. Only nil by mouth was put up prior to a test (no further opportunity for food for at least another 24 hours). I asked for the whiteboard by her bed to be written up regarding her visual impairment and nutritional needs, this didn't happen until something like day four. The impact of this was the other ladies in the ward thought my friend was rude as she wasn't responding to them as she couldn't tell if they were addressing her as she couldn't see them looking at her and she was hungry.

It was decided that she should have an endoscopy to see what was going on – this is a woman who by this stage couldn't tolerate swallowing tea. I asked whether the clinical teams felt this was really necessary, and distressingly the endoscopy was attempted. She was violently sick and there was a fear of her aspirating. Another test was booked in three days' time. I asked for this not to take place as I felt strongly that it was not in her best interest. The test was completed. I was pretty much told there and then that she would not recover and she would be moved on to the End of Life care pathway and would be moved to a side room. She died the next day.

There were aspects of her care that was fantastic – kind and caring staff, especially Alicia who was part of 2gether Support Solutions for meals/drinks. I'm sure the trainee nurse was called Liam, he was great too, very responsive to my needs as my friend's carer. I do feel that simple things like writing up the whiteboard would have made a huge difference to us both.

Once on Sandwich ward in a side room her passing was quick (within 24 hours). Everyone was very kind, considerate and made sure her death was peaceful and dignified.

3.2 The carer is planning to attend the Board meeting when this is discussed.

[1] LPA – Lasting Power of Attorney

4. Carers Task and Finish Group

4.1 The Trust set up a Carers Task and Finish Group in July 2023. The group is co-chaired by the Head of Patient Voice and Involvement and a member of staff from Carers Support East Kent. The group's membership includes some Heads of Nursing, the Lead Nurse for Dementia, the Head of Allied Health Professions (AHP) Workforce and Education, a number of voluntary and community organisations working with unpaid carers, and some current carers.

5. Actions taken to date

5.1 The Carers Task and Finish Group has agreed a time limited action plan, which includes developing a carers policy, raising staff awareness of the NHS Commitment to Carers, and developing some carer awareness sessions for staff. The group has also included the Trust's well-being team as data suggests around a third of NHS staff are carers for a relative or friend.

5.2 The group is building on work already undertaken as part of the Dementia Strategy and the Trust's commitment to John's Campaign, which promotes carer and family involvement when people with dementia are in hospital, including open visiting. The Dementia team has also launched a Carers Passport for carers of in-patients with dementia.

5.3 We have a Carers page on the Trust public website that sign-posts people to sources of support for carers. There is a page on Staff Zone that signposts staff to this page.

5.4 The Trust introduced extended visiting times for patients' family and friends from 30 October 2023. Visiting times on wards are now 7am to 8pm, with some different arrangements in Maternity, Intensive Care Units and for patients at End of Life, with more flexible visiting outside of the new extended hours by arrangement. This extended visiting was part of a new Visitor's Charter (see appendix 2).

5.5 The Critical Care Outreach team launched Call4Concern, so that patient's relatives or friends can raise concerns if they feel they are not being listened to when they share their concerns with the team currently caring for the patient. This provides a contact phone number and email.

6. Action planned for the next three to 12 months

6.1 The Carers Task and Finish Group are planning to promote wider access to the Carers Passport, with ward staff being able to print off and validate a passport for a carer of any patient.

6.2 The group will oversee the co-design of a carer awareness session for staff, and subject to funding have sessions delivered by carers organisations, with carer involvement.

6.3 The draft Carers policy is currently out for comments.

6.4 The Trust needs to ensure that we can identify and flag carers who have a contingency plan in place to provide care for the person they normally care for, when they themselves are admitted to hospital in an emergency. This will require some changes to patient record systems by adding the NHS England carers code, so it flags if a patient is a carer. This is likely to take some time to put in place.

7. Conclusion

7.1 Whilst staff were kind and compassionate in the care they gave to the patient, they did not listen to the carer about the patient's sight loss, the patient's swallowing difficulties and the carer's request that information about these were shared with ward staff. The patient was left hungry, which was a failure of a fundamental element of the patient's care. The carer was upset that the endoscopy carried out twice on her friend caused her unnecessary pain and suffering.

7.2 We need to learn from this carer's story. Not just the in-patient wards at QEQM, but in-patient wards and other services Trust wide. By working in partnership with carers and families we can keep the patient at the centre of their care, particularly when they are vulnerable and may be unable to advocate for themselves.

8. Recommendations

8.1 The Board of Directors are asked to discuss the carer story and support actions being taken to ensure that:

- We uphold the NHS Commitment to carers.
- We have a carers policy that provides staff with a framework and guidance to put the policy into practice.
- We provide staff with access to information about carers and carer awareness training.
- We work in partnership with carers and families to ensure the patient is also at the centre of their care.

Our Visitor's Charter

Visiting is from 7am - 8pm in most areas

Please note, some areas may offer different visiting times

NHS
East Kent Hospitals University
NHS Foundation Trust

We expect our staff to:	We ask our visitors to:
Be respectful, polite and welcoming to all visitors.	Be respectful and polite to staff and other patients and visitors. Avoid disturbing staff who are carrying out clinical duties. Be respectful of patients' privacy and dignity and leave the bedside if asked to do so. Please do not film or photograph staff or other patients.
Be supportive of visitors who wish to participate in the care of their loved one.	Let us know if you would like to help with the care of your loved one. If you would like to support your loved one during mealtimes, please speak to the ward team who will support you. Check with the ward team that it is safe before helping your loved one to get out of bed or move around.
Create a calm and relaxing environment to help patients recover.	Please keep noise levels to a minimum and put your phone on silent, to help patients who need to rest. Return any chairs you have borrowed, but let us know if you need help to do this. Your loved one may need to rest more than usual. Please remember to take breaks from the bedside to allow them to rest if needed.
Do their best to ensure mealtimes are about the same time every day and are free from unnecessary distractions.	Please try to visit outside mealtimes to allow your loved one to eat without being disturbed. If you would like to support your loved one at mealtimes, please let us know.
Keep each patient's next-of-kin well informed (with the patient's permission).	Please arrange for one person to act as liaison between the ward staff, family, and friends. Feel free to ask us if you feel you have not been given enough information.
Do all we can to prevent infection – this may mean restricting or suspending visiting at times.	Please do not visit if you have cold or flu symptoms, or vomiting or diarrhoea. Wait at least two days after your symptoms have gone before visiting. Wash your hands on entering and leaving the ward and use alcohol gel or foam where provided. Use chairs provided for visitors rather sitting on the patient's bed. If you cannot find a chair, please feel free to ask. Use visitor toilets and leave patient's toilet or bathrooms free for patients.
Provide a clean hospital environment.	To help us keep a clean and safe environment, please pick up all rubbish and put it in a bin. Please keep the over-bed table clear of items so that it can be used for patients to eat or drink. Please allow staff to clean effectively. Please tell us if any areas need to be cleaned.
Prioritise the planning of care to our patients and communicate our decisions.	Inform staff of any specific needs that the patient has such as a Patient Passport or Communication Passport, for example 'This is me'.
Be willing to listen and open to feedback.	Please speak to us if you have any questions and tell us what you think about the care the patient is receiving.
Welcome carers and work in partnership with you.	Feel free to ask for details of how to receive a Carer's Passport which confirms you can come and go outside normal visiting times.

Please feel free to ask if you need help or have any queries

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We care

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Acting Chairman's Report**

Meeting date: **1 February 2023**

Board sponsor: **Acting Chairman**

Paper Author: **Acting Chairman**

Appendices:

None

Executive summary:

Action required:	Information
Purpose of the Report:	The purpose of this report is to: • Report any decisions taken by the BoD outside of its meeting cycle; • Update the Board on the activities of the Council of Governors (CoG); and • Bring any other significant items of note to the Board's attention.
Summary of key issues:	Update the Board on: • Current Updates/Introduction.
Key recommendations:	The Board of Directors is requested to **NOTE** the contents of this Chairman's report.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Board Assurance Framework (BAF):	N/A
Link to the Corporate Risk Register (CRR):	N/A

East Kent Hospitals University NHS Foundation Trust

Resource:	No
Legal and regulatory:	No
Subsidiary:	No

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

CHAIRMAN'S REPORT

1. Purpose of the report

To report any decisions taken by the Board outside of its meeting cycle. Update the Board on the activities of the CoG and to bring any other significant items of note to the Board's attention.

2. Introduction

I would first like to thank Niall Dickson for his time as Chairman of the Trust. Niall's leadership, experience and input to the Board was invaluable, and I am extremely privileged to be acting Chairman whilst the Trust engages in a recruitment process for Niall's successor. Niall will be missed by all colleagues from the Trust, and we all wish him the very best in his future endeavours.

As reported previously, the pressures on the Trust continues to build, with a significant increase over the winter period. In December, we saw a 10% increase in attendances across our Emergency Departments, compared to the previous month. This is the largest number of arrivals we have had in the last 12 months, with one of our sites, Queen Elizabeth the Queen Mother Hospital (QEQM), reporting the highest number of conveyances since 2022. In addition to our busy front door, our cancer backlog has increased, with the number of patients waiting over 62 days rising up to 642 patients. In addition, our length of stay across the Trust within non-elective patients continues to be a priority. The Trust has a higher average length of stay compared to our peers, which means we have beds occupied by patients who not only want to leave, but should be cared for away from an acute hospital. However, as we have reported previously, we are struggling to find appropriate pathways for these patients and as such they remain in our care.

Our staff are working under extremely pressured environments, in already busy, and stretched services. However, despite this, they are working hard to implement additional measures to tackle our backlog, increase the sustainability of our services, and importantly, support our patients. However, the Trust must also pull on its resources from our neighbouring health and social care services, and wider partners. This is not a challenge the Trust can tackle by itself, nor is it a challenge that East Kent is facing alone, indeed all Trusts up and down the country are facing similar operational challenges. With all of this, there has unfortunately been times where we have not been able to provide the best possible care to our patients across the Trust, nor see people in a timely manner. I do apologise for these lapses in our performance and assure everyone that we are doing everything in our power to improve the services we provide.

As many will be aware, the Trust also had Care Quality Commission (CQC) Inspections across May 2023 (Core Services Inspection) and July 2023 (Well Led Inspection). These reports were published just before the new year. The overall ratings for the William Harvey Hospital (WHH) and QEQM remained the same, however, there are some changes to specific services. This includes a positive increase in rating for our Children and Young People (CYP) services at QEQM, and a decrease for Medical Services at the same site. WHH remains unchanged. In addition, our Well Led inspection in July rated the trust as 'Requires Improvement' which is consistent with the Trust's last rating. Not for one moment does the Board think any rating of 'Requires Improvement' is acceptable and through the plans we have in place, we are confident that we will see improvements this year.

The Trust's Care Group and Corporate leads have developed action plans in response to the inspection findings, which have clear oversight from our Executive colleagues. These plans will be submitted to the CQC by the end of January 2024. The Board of Directors will receive quarterly reports moving forward, to assure the Board on progress of the implementation of the required improvements, the first of which will be discussed at today's meeting.

Despite the pressures outlined above, the Trust continues to make strives of improvement, and one of those areas is across our Maternity and Neonatal services. I am pleased to say that at our last meeting in January, the Board signed off our declaration for the national Maternity Incentive Scheme for year 5, within the Clinical Negligence Scheme for Trusts (CNST). Our submission included compliance with all 10 safety actions, which shows a significant improvement in our maternity services since the last submission. I would personally like to thank all of our maternity staff for their hard work in the delivery of these safety actions, and we have already started to see the impact with positive patient feedback from patients, and their families.

Alongside our operational pressures, the Trust continues to tackle its underlying financial deficit. At our last Board meeting in January, the Board agreed to sign off a forecast year end deficit of £117.4m. This forecast was discussed and acknowledged by NHS England on 19 January 2024.

The Board will be the first to admit this is a significant deficit, however, we are pleased to say there are already some early signs of improvement. For example, the Trust has implemented significant grip and control across our agency usage and vacancy control process. As a result, the pay position for Month 9 is the lowest it has been since April 2023, nine months ago, with month-on-month reduction over the past three months.

However, there still remains much more the Trust needs to do to tackle its underlying financial deficit, with the Trust's focus continue to remain on delivery of financial savings, whilst providing the best care for our patients. As we look forward to next financial year, we know there is a significant target for the Trust to hit with a minimum of £49m of savings to deliver. Work on these efficiency saving is underway and we expect the associated detailed plans to be submitted for Board approval by the end of March.

As we look forward into the Trust, it is imperative for us to gain stability across our senior leadership. We know all too well the impact this can have on our patients, the services we provide, and the morale of our staff. I am pleased to say that our Executive Team has filled all of its positions. We welcome Dr Des Holden as our new Chief Medical Officer and Rob Hodgkiss as our Interim Chief Operating Officer.

Now we have a complete Executive Team, the Board is working to develop how it operates and how it communicates and engages with leaders and staff across the Trust. The Board has committed to three key priorities for the coming year:

1) Improving our Emergency Department performance – key to driving this will be reducing the length of stay of patients across the Trust to free up more beds;
2) Improving our Cancer pathway performance and supporting diagnostic services so patients can get a diagnosis and if necessary treatment far faster; and

3) Tackling our financial performance, reducing our deficit and increasing cost savings whilst improving the services we provide.

As a Board, we will be more focused on individual patients and their experiences of being treated by us. We are determined to see the great work underway in our maternity services, repeated across the Trust and we will report back at these Board meetings in a simple, open and transparent way, how we are doing.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Chief Executive's Report**

Meeting date: **1 February 2024**

Board sponsor: **Chief Executive**

Paper Author: **Chief Executive**

Appendices:

N/A

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	The Chief Executive provides a monthly report to the Board of Directors providing key updates from within the organisation, NHS England (NHSE), Department of Health and other key stakeholders.
Summary of key issues:	This report will include a summary of the Clinical Executive Management Group (CEMG) as well as other key activities.
Key recommendations:	The Board of Directors is requested to **DISCUSS** and **NOTE** the Chief Executive's report.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	The report links to the corporate and strategic risk registers.
Link to the Corporate Risk Register (CRR):	The report links to the corporate and strategic risk registers.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: N/A

CHIEF EXECUTIVE'S REPORT

1. Purpose of the Report

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

2. Background

This report will include a summary of the Clinical Executive Management Group (CEMG) as well as other key activities.

3. Clinical Executive Management Group (CEMG)

There were no Business Cases approved or recommended for approval at the meetings of the CEMG on 20 December 2023 or 3 January 2024.

4. Operations update

In December, the overall reported performance saw a decline across all types, attributed to an uplift in type 1 arrivals to the Emergency Department (ED) and an increase in ambulance arrivals - the highest reported in the last 12 months, with Queen Elizabeth the Queen Mother Hospital (QEQM) notably reporting the highest number of ambulance conveyances since 2022. Despite heightened pressure across sites, December's reported performance showed a 6% improvement over the same period last year, positioning the Trust in the upper third nationally for all type performance.

At both acute sites, strategic efforts were made to optimise space, focusing on maximising inpatient capacity and minimising corridor care. The William Harvey Hospital (WHH) team successfully co-located the Medical Assessment Unit (MAU) and Same Day Emergency Care (SDEC) services, resulting in an additional 12 inpatient beds and two available side rooms for End of Life patients in the newly established Acute Medical Unit (AMU-C) area. This initiative, undertaken in response to extreme pressures in early December, successfully prevented the need for ED corridor care throughout the month. However, due to recent demand increases, coupled with low discharge rates and a full extended bed base in January, ED corridor care has unfortunately been reinstated in extreme circumstances. Clinical site management teams continue their efforts to escalate and de-escalate patients into the ED corridors in response to demand.

Key focus areas for Q3 include:

- A priority focus on the reduction of the number of patients spending more than 12 hours in our emergency departments, supported by an internal emphasis on non-admitted 12-hour cases, with the QEQM team implementing an action plan owned by Urgent and Emergency Care (UEC). This plan utilises the DIA model, Clinical Decision Unit (CDU), SDEC review, and Direct Access pathways. The Single Point of Access (SPOA) is also set to go live at the QEQM on 29 January 2024.

- A Length of Stay (LoS) program is in development, supported by consultancy-led programs until the end of February 2024. Discharge task force teams on both sites have been established, meeting weekly to

identify opportunities for patients to be discharged to the most appropriate care setting outside of the Trust, with the aim to release bed capacity and improve patient flow.

- Additionally, collaboration with wider healthcare providers is underway to review mental health attendances and optimise pathways for these patients who present at the Trust's EDs.

4.1 Strike planning

Substantial efforts were made by all teams to manage and maintain Doctor rotas during the recent Junior Doctors' strike (3 - 9 January 2024). Despite challenges arising from the longer duration of this strike, the immediate post-Christmas/ Bank holiday timing, which is historically a challenging time for the Trust, well-planned rotas minimised the impact to the Trust's patients and care. The Trust recorded 37 cancelled elective procedures, 106 cancelled outpatient appointments, and 5 diagnostic procedures, with efforts made to rebook patients promptly.

Preparations are now underway for the upcoming 2gether Support Solutions (2gether) industrial action, which is scheduled for 30 January - 1 February 2024. Compared to the previous 24-hour strike, the extended duration poses additional challenges, requiring careful consideration for the sustained provision of services, particularly during a period of increased patient volume.

4.2 Maintaining planned care

A core part of the Trust’s strategy, particularly during the winter months, is to preserve elective activity, protect our cancer patient pathways, and continue to improve access to our core diagnostic services to ensure timely and essential care for the Trust's patients. This winter, our strategy revolves around a structured escalation plan, balancing the demands of emergency care while protecting elective procedures and capacity.

In December, the Trust has seen an improvement in our Cancer Faster Diagnosis Standard to a year high of 69.5%. Notable improvements were observed across all tumour sites. Furthermore, there was a stabilisation of our DM01 (Diagnostics Standard) position at 55.8%.

The Trust's elective recovery position however continues to deteriorate; this aligns to our revised trajectories for planned care factoring in capacity and demand. The Trust currently has seven patient breaches at 104 weeks and 865 undated patients at risk of breaching 78 weeks. The primary driver of this position relates to our ongoing Endoscopy backlog (12,339 scopes) and capacity challenges within ENT. Additionally, our patients are experiencing long wait times for first outpatient appointments within Gastrointestinal (GI), Max-Fax and Cardiology.

Some key workstreams to address these challenges have commenced and include:

- The creation of weekly recovery meetings to support focus on 78-week risks and revised Trust governance to oversee the recovery plans that are being developed by Care Groups.

- A Task and Finish Group for Endoscopy Recovery supported by the Integrated Care Board (ICB) has been in place since 9 October 2023 looking

at wider system capacity and the commencement of Quantitative Faecal Immunochemical Test (QFIT) testing for the existing backlog.

- £345K of cancer funding utilised to support cancer performance improvement which has included the recruitment of a locum Radiologist to reduce reporting turnaround times, administrative support around benign letter completion and additional hysteroscopy clinics.

- The consultancy-led (Prism) theatre improvement programme is now in the implementation support phase, re-launching the Trust's 6-4-2 processes, and establishing the Theatre Improvement Group.

- An ICB-led Acute Provider Collaborative has commenced to review ENT demand and capacity with deliverables expected in February 2024.

- An identified need for short-term support to validate all patients waiting over 12 weeks and those on a DM01 waiting list and a medium-term plan, supported by an NHS England (NHSE) developed proposal, to provide a training programme for Patient Tracking List (PTL) management and validation for all Trust employees.

5. Financial performance and NHSE control measures

When the Board met on 11 January 2024, it signed off a forecast year end deficit for the Trust of (£117.4m). This forecast position included £13.1m of improvements made to the Trust's underlying run rate, which is a stretching savings target to deliver in the final three months of the year.

These savings were somewhat offset by additional non-pay costs associated with treating more patients over winter (£3.5m), the financial impact of industrial action (£1.9m), additional costs required to manage the Trust's significant endoscopy backlog (£1.9m), and other risks that impact the Trust's year end position (£2.0m).

This forecast was discussed and acknowledged by NHSE on 19 January 2024.

At the end of month 9 the Trust posted a year to date deficit of (£84.0m), which is in line with the forecast described above.

Whilst this is clearly a significant deficit, there were some early signs in the month of financial improvement. For example, the in-month pay spend in December for the Trust (£49.9m) was the lowest it has been since April 2023, following the enhancement of agency controls and the implementation of an enhanced vacancy control panel. Whilst the Trust expects its pay position to increase again in January (due to the impact of industrial action), this, alongside the fact that the pay spend in both November (£50.9m) and October (£50.4m) was less than the H1 average monthly spend (£51.4m), does indicate the start of an underlying trend of financial improvement.

That said, there remains much, much more work to do, and the Trust's focus will remain on delivery, whilst also turning to the next financial year, for which we have set a necessarily ambitious target of £49m of savings to deliver. We have a programme of work ahead of us as an Executive and Board to develop and deliver this.

6. Publication of the Care Quality Commission (CQC) reports following inspections in May and July 2023

Inspection reports and associated action plans from the most recent CQC visits in May 2023 (Core Services Inspection) and July 2023 (Well Led domain) were published on 20 December 2023.

The overall ratings for the Trust, the WHH and QEQM have remained static following these inspections, however, there have been some changes within services, notably a positive increase in ratings for the Children and Young People's service at the QEQM and a decrease in rating for the Medical Services at the same site. The ratings for those services inspected at the WHH remain unchanged.

The report which followed the Medical Care, UEC and Children and Young Peoples Services at the WHH and QEQM inspection in May 2023, recognised many areas of good practice across both sites, including outstanding practices in the paediatric resuscitation room and Cambridge K Ward at WHH, and the Specialist Palliative Care Team and End of Life Pilot beds at the QEQM.

A number of common challenges were however, also identified within the report including concerns about statutory and mandatory training rates (with an emphasis on safeguarding and resuscitation training), appraisal rates, staffing in UEC and some medical wards, as well as the reporting of near misses in line with Trust policy. Overcrowding in the EDs on both sites was also highlighted as a concern, impacting patient privacy and dignity.

The Well Led domain inspection in July and subsequent report resulted in a 'requires improvement' rating, consistent with the 2018 inspection. The report acknowledged a focus on continuous learning and improvement at all levels, with improvements in involving service users in the business of the organisation. It was however noted that there is further work to be done, with four 'Must Do' actions associated with well-led practices listed.

Care Group and Corporate leads have developed action plans in response to the inspection findings, which have been signed off by the lead Executive. These plans will be submitted to the CQC by 29 January 2024. The oversight of these action plans will be managed by the Regulatory Compliance Group, chaired by the Chief Nursing and Midwifery Officer, with the Board of Directors receiving quarterly reports on the progress of the implementation of the required improvements, the first of which will be discussed at today's meeting.

7. Indonesian Stroke Tour visit

A delegation of leading healthcare professionals from Indonesia will visit Kent and Canterbury Hospital on 25 January 2024, as part of an international partnership organised by NHS England.

The Trust's Stoke Care Services have been chosen as an important case study for the group, who will be visiting the UK for three days, attending workshops with experts and leaders to facilitate strategic advice and knowledge exchange. This collaboration will deliver a programme of work focused on stroke care workforce, training and education in Indonesia and the visitors will be given an overview of stroke prevention, hyperacute urgent care, acute care, inpatient rehabilitation, stroke community rehabilitation and life after stroke support, before a walk-through of the unit.

8. Re-opening of the Singleton Unit

I am pleased to advise that the Singleton Unit, the midwife-led unit at the WHH has re-opened, following its temporary closure in August 2021.

The Singleton Unit offers a midwife-led birthing environment for those at low risk of complications, with eight birthing rooms equipped to support active and natural birthing.

The unit has undergone a full upgrade and refurbishment to provide expectant mums and partners with greater birth choices and to create a 'home-from-home' environment for families to welcome their new arrivals.

9. Leadership Awayday

A Leadership Team awayday was held on 17 January 2024, attended by 165 leaders from across the Trust. The agenda was focussed on the Trust's financial position, the re-launch of the Quality Improvement (QI) methodology 'We Care' and concluded with a session facilitated by A Kind Life focussed on embedding kinder ways of leading and managing, to improve culture supporting safer care and better outcomes.

10. Executive Team update

I would like to take this opportunity to welcome Des Holden, Chief Medical Officer, Rob Hodgkiss, Interim Chief Operating Officer, and Jamie O'Callaghan, Interim Director of Corporate Governance to the Trust and to their first public Trust Board meeting.

Interviews have been held for the substantive Chief Operating Officer and Director of Corporate Governance roles, with significant interest and applications received. An update on this recruitment exercise will be provided at the meeting.

11. Conclusion

The Board of Directors is requested to **DISCUSS** and **NOTE** the Chief Executive's report.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Integrated Performance Report (IPR)**

Meeting date: **1 February 2024**

Board sponsor: **Chief Strategy & Partnerships Officer (CSPO)/Interim Chief Finance Officer (CFO)**

Paper Author: **Chief Strategy & Partnerships Officer (CSPO)**

Appendices:

APPENDIX 1: December 2023 IPR

Executive summary:

Action required:	Discussion
Purpose of the Report:	The report provides the monthly update on the operational performance, Quality & Safety, Workforce and Financial organisational metrics. The metrics are directly linked to the We Care Strategic and Annual objectives. The reported metrics are derived from: 1. The Trust Integrated Improvement Plan. 2. Other Statutory reporting. 3. Other agreed key metrics.
Summary of key issues:	The IPR has been subject to a review and refresh with a revised format to include a wider view of metrics. The reported metrics have been expanded significantly within the report to provide clear visibility on all metrics associated with the Integrated Improvement Plan programmes of work, statutory reporting and other agreed key metrics. The attached IPR is now ordered into the following strategic themes: • **Patients,** incorporating operational performance metrics. • **Quality and Safety (Q&S),** incorporating Q&S metrics and • **People,** incorporating people, leadership & culture metrics. • **Sustainability.** Incorporating finance and efficiency metrics. • **Maternity,** incorporating maternity specific metrics for quality and safety, Friends and Family Test (FFT) and engagement. At the start of each strategic theme section is a performance summary followed by a more detailed page for each of the reported metrics. Key performance points (December Reported Month):

	Patients • All type Emergency Department (ED) performance is now behind plan at 69.0%. • Type 1 ED performance is under plan at 43.5%. • Cancer 28 Faster Diagnosis Standard (FDS) has further improved to 69.5%. • Diagnostics performance has deteriorated to 55.8% with key issues remaining in endoscopy. **Quality & Safety** • Seven Serious Incidents (SIs) declared in the month. • 0 never events reported in December. • The number of overdue incidents increased in month by 321. • Hospital Standardised Mortality Ratio (HSMR) remains below 100 and appears to have plateaued at an index figure of around 93. **People** • Sickness absence remains over the 5% threshold in month at 5.8%. • Vacancy rate remains below the desired threshold at 7.7%. • Staff turnover remains in line with the previous month at 9.3% and has now sat below the national standard (10%) for 12 consecutive months. • Staff engagement score is not reported on during the National Staff Survey window. • Completed medical job plans remains below the target at 58.8% but is showing some improvement. • Appraisal rates remain around 73%. **Sustainability** • The financial position Year to Date (YTD) is £27.7m away from a plan of £56.3m, with a total deficit YTD of £84.0m. • The Trust recognised recurrent savings of £1.0m in December, and £2.9m on a YTD basis, which is significantly below plan. • The current value of the pipeline is £14.0m, an increase of £1.1m vs. the prior month. • Premium pay remains below the mean of the 24 month period for the third consecutive month. **Maternity** • Two SIs declared in the month of December in Maternity. • Complaint response times are below the target threshold. • Perinatal mortality remains low and in line with the prior month. • FFT recommend rate is 91.0% for the month.
Key recommendations:	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the metrics reported in the Integrated Performance Report

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Board Assurance Framework (BAF):	**BAF 32**: There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 34**: Failure to deliver the operational constitutional standards due to the fluctuating nature of the Covid-19 pandemic necessitating a localised directive to prioritise P1 and P2 patients. **BAF 31:** Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements and Covid-19, leading to harm, including death, breaches of externally set objectives, possible regulatory action, prosecution, litigation and reputational damage.
Link to the Corporate Risk Register (CRR):	**CRR 77:** Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 78:** There is a risk that patients do not receive timely access to emergency care within the Emergency Department (ED).
Resource:	N
Legal and regulatory:	N
Subsidiary:	Y - Working through with the subsidiaries their involvement and impact on We Care.

Assurance route:

Previously considered by: N/A

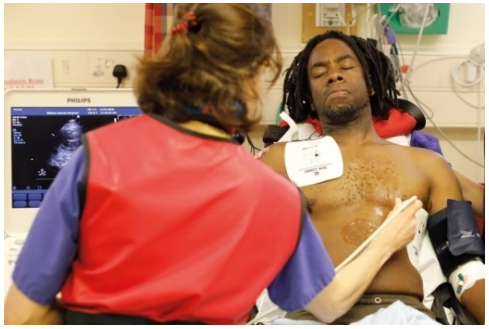
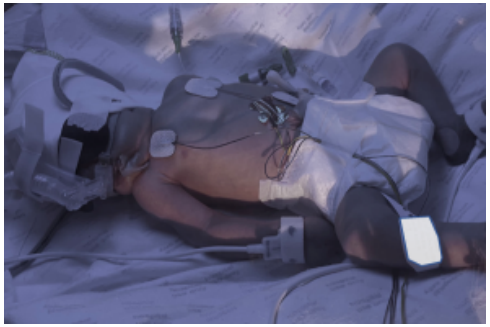
East Kent Hospitals University NHS Foundation Trust

Integrated Performance Report
December 2023







Patients

Operational Performance

Integrated Improvement Plan

NHS East Kent Hospitals University NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Operational Performance	IIP		ED Compliance		73.0%	68.4%	67.3%	67.1%	70.7%	71.7%	73.2%	74.3%	71.9%	70.7%	70.6%	70.3%	69.0%
	IIP		Type 1 Compliance 4hrs		55.0%	41.5%	40.7%	39.1%	44.0%	45.1%	48.1%	51.6%	46.5%	45.5%	45.8%	45.2%	43.5%
	IIP		12 Hr Total Time in Department		7.0%	11.8%	11.5%	12.4%	10.4%	10.5%	9.6%	8.7%	9.7%	10.2%	10.7%	10.4%	11.4%
	IIP		12Hr Trolley Waits (MTD unvalidated)	H	0	1,168	1,021	1,189	989	1,136	929	769	908	867	1,079	1,168	1,260
	IIP		Ambulance Handovers within 30m	H	95.0%	80.8%	81.1%	80.5%	86.0%	86.2%	90.4%	91.8%	89.7%	90.0%	90.3%	88.7%	89.4%
	IIP		Super Stranded >21D		107	310	307	296	280	272	260	246	241	245	235	260	244
	IIP		Not Fit to Reside (pats/day)		100.0	240.7	255.7	232.8	226.1	213.4	218.5	192.3	193.0	199.8	193.5	207.0	176.7
	IIP		Cancer 28d Combined Performance		75.0%	53.6%	66.3%	65.6%	62.3%	61.8%	64.7%	63.2%	60.5%	59.5%	63.6%	62.3%	69.5%
	IIP		Cancer Over 62d on PTL	H	67	342	233	230	379	371	371	386	431	519	506	499	597
	IIP		Cancer Over 104d on PTL	H	0	64	57	54	49	77	66	73	84	98	107	95	100
	IIP		RTT 52w Breaches	H	Traj.	3,317	3,187	2,997	3,027	3,608	3,907	4,575	4,767	5,113	5,966	6,194	6,459
	IIP		RTT 65w Breaches	H	0	1,175	976	707	766	984	1,023	1,148	1,292	1,499	1,900	1,942	2,360
	IIP		DM01 Compliance	L	75.0%	57.6%	62.0%	60.3%	56.3%	58.6%	59.0%	55.9%	53.6%	54.1%	60.7%	59.1%	55.8%

December Performance Summary

Emergency Department: Performance for December deteriorated for all types, this was against an increase in the number of type 1 arrivals to ED and an increase in ambulance arrivals the highest number reported in the last 12 months, with QEQM reporting the highest number of conveyances since 2022. EKHUFT reported a slight improvement on the type 3 performance in month 97.9% v 97.2%. Ambulance handover< 30 mins continues to show an improving trend with SDEC and UTC showing increased activity through the units. Total time in department for admitted patients deteriorated in month but an improvement on the numbers of patients waiting over 24 hours. December saw the highest number of 12 hour trolley waits reported, but showing improvement on the total time > 24 hours.

Cancer: : FDS performance improved to 69.5% in December which is the highest it has been this financial year. The number of patients waiting over 62 and 104 days however did deteriorate in the month. The highest contributing factors remain within the Lower GI, Urology and skin Cancer Pathway, with the backlog of endoscopy delays remaining the highest contributing factor, followed by radiology delays and biopsy delays. The performance framework for Trust wide assurance is being finalised as part of the Tier 1 support and remedial action plans by tumour sites has been requested by the COO.

Diagnostics: December has seen a decline in the DMO1 performance. Whilst further improvement was noted in cardiac CT, deterioration was noted across the three main modalities of endoscopy, MRI and CT. Vetting and backlog in reporting remain the primary causes of delays within radiology, as well as capacity constraints in endoscopy. The trust however continues to see Endoscopy demand far outweigh capacity at 30% DM01 with 5,316 breaches at the end of November.

Referral to Treatment Waiting Times: Tier One support has commenced and work is ongoing in Care Groups to develop recovery plans for RTT to deliver zero 78 weeks by March. It is to be noted the position may worsen before it improves as focus on these pathways will identify incorrect clock stops or patients added to working pathways. This is a known impact and NHSE aware. Loss of activity, as excepted, in December due to bank holidays and unplanned for loss of activity due to IA. 104+ remain a concern with an average of 10 patients being in this cohort. Additional focus on these has commenced via Tier One support. The trust is currently the fourth worst performer for 78 weeks across England, based on December data.

Type 1 Emergency Department 4h Compliance

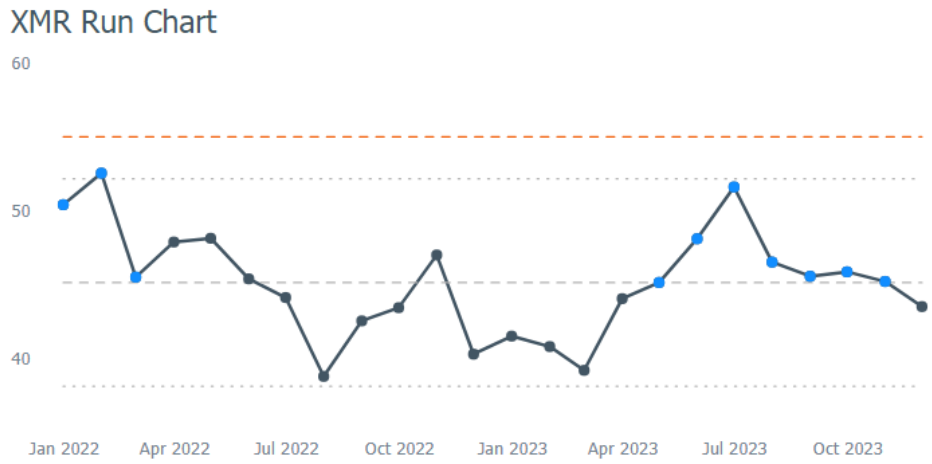
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This four-hour standard measures the total time patients spend in the emergency department from arrival time to admission, transfer [to another provider] or discharge. For patients arriving by ambulance, the clock starts when the patient is handed over from the ambulance staff to hospital staff or 15 minutes after the ambulance arrives at A&E (whichever is earlier). This metric only contains Type 1 (ED) attendances.

Type 1 Compliance 4hrs

Timescale	Value	SPC
Jan-23	41.5%	
Feb-23	40.7%	
Mar-23	39.1%	
Apr-23	44.0%	
May-23	45.1%	
Jun-23	48.1%	
Jul-23	51.6%	
Aug-23	46.5%	
Sep-23	45.5%	
Oct-23	45.8%	
Nov-23	45.2%	
Dec-23	43.5%	



Understanding the most recent data point

Performance

43.5% — Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
ED Single point of access for all patients requiring urgent and emergency care	• Further work to undertake to increase the number of DAP and include the MAU's on both sites • SPOA – Pilot; WHH November, QEQM launch Jan • SECAMB pathways to be developed to directly access SDEC/UTC	• DCOO/ CG Tri leads	• Weekly meetings in place	• Support from ICB requested to extend the project for winter . ICB funding SPOA end March • Working group established for SPOA expansion • Review of WHH UTC pathways to identify pts criteria to enhance utilisation • Working group (SPOA) to embed AI-tED & and align DoS
Internal processes not fully aligned to operational delivery	• Implementation of internal escalation processes • External support to review internal escalation processes: daily rhythm: OPEL actions; Site team structure and review the Full Capacity protocol commences in Oct-Nov • Updated FCP with review of bed capacity – conversion of areas to increase bed base	• COO • MDs	• Nov 23 • Jan 24	• Internal plans for UEC both sites completed – • Review of escalation/surge/super surge capacity across the 3 sites – to align to the FCP /winter plan . • -draft completed , awaiting review
Whole Hospital Response Establishing CDUs at WHH/QEQM	• Trust wide development of IPS. GIRFT recommendation • CDU Models agreed for QEQM and in place Sept 23 . • CDU Model being explored at WHH – Design completed , WHH CG overseeing development	• CMO/ Med Dir • CG Tri	• Jan 24 • Jan 24 • Jan 24	• Work the GIRFT team to support IPS implementation still in progress . Med Directors in place to support roll-out of IPS • QEQM expanding CDU criteria • Further work to reduce the number of speciality patients in the proposed WHH CDU | working group established with key actions

Emergency Department 4h Compliance (all types)

Integrated Improvement Plan

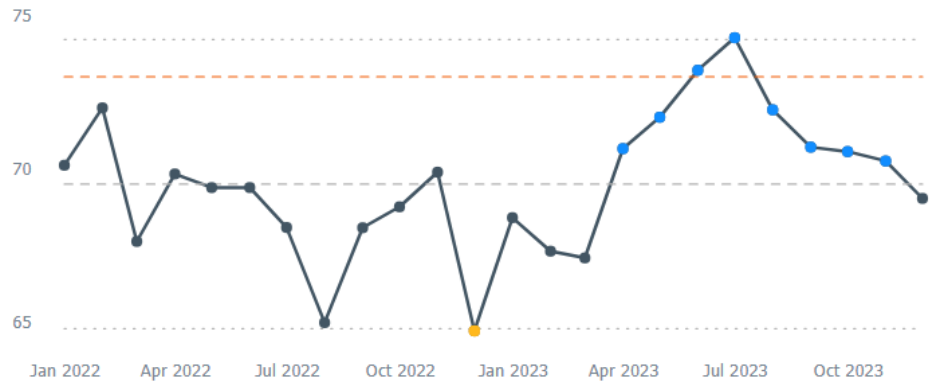
East Kent Hospitals University NHS Foundation Trust

This four-hour standard measures the total time patients spend in the emergency department from arrival time to admission, transfer [to another provider] or discharge. For patients arriving by ambulance, the clock starts when the patient is handed over from the ambulance staff to hospital staff or 15 minutes after the ambulance arrives at A&E (whichever is earlier). This metric combines Type 1 (ED) and Type 3 (UTC) attendances.

ED Compliance

Timescale	Value	SPC
Jan-23	68.4%	
Feb-23	67.3%	
Mar-23	67.1%	
Apr-23	70.7%	
May-23	71.7%	
Jun-23	73.2%	
Jul-23	74.3%	
Aug-23	71.9%	
Sep-23	70.7%	
Oct-23	70.6%	
Nov-23	70.3%	
Dec-23	69.0%	

XMR Run Chart



Understanding the most recent data point

Performance

69.0% — Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Lack of timely UTC pathways and direct access from the front door. Requirement for direct access pathways GP/Secamb.	• Review of the UTC pathways supported by the ICB Clinical Lead completed • Further work progressing to increase activity and cohort into the UTC at WHH • Implement Alt-ED model led by ECIST	• Clinical ED leads /UTC leads/ Head of Ops	• Complete • Dec 23 – Jan 24	• Work in train to develop DAP for GPs, linked to the work in West Kent (SPOA) . • QEQM training for streaming nurses to identify pts against criteria to UTC/SDEC from front door • BI work to identify opportunity for UTCs – greater opportunity at WHH identified • Progressing the Alt-ED and aligning the DoS with Secamb
Use of the ED as a single point of access. Develop direct access pathways, assessment units and optimise Same Day Emergency Care (SDEC) inc Paediatrics.	• Review SDEC criteria using the Ambulatory Care Condition Directory completed . • Expansion of hours to be established (both sites) • DAPs commenced June – September with further work planned to include DAPs to SDEC and MAU	• Care Groups	• Sep 2023 and ongoing	• Highest number of patients seen in SDECs (Jul). • CAU pathway development to be progressed at QEQM and pilot completed September with a improvement plan in place across WHH /QEQM to enhance pathway and utilisation of CAU
Safety of the ED when in overcapacity | Review new models in place with external guidance on plans to improve alt pathways, access.	• On site GIRFT visit July | recommendations reviewed and progress report to EK UEC board • Develop and implement Ambulance Handover process in-line with FCP • Frailty GIRFT recommendations supported by HCP	• DCOO/ CG Tri • HCP leads	• Oct 23 - 6 months	• Action plan submitted to EK UEC Board October • Shared action plan outlining the joint approach and task & finish action plan via the HCP delivery group • Follow up review with GIRFT in Jan 24

Ambulance Handovers within 30m

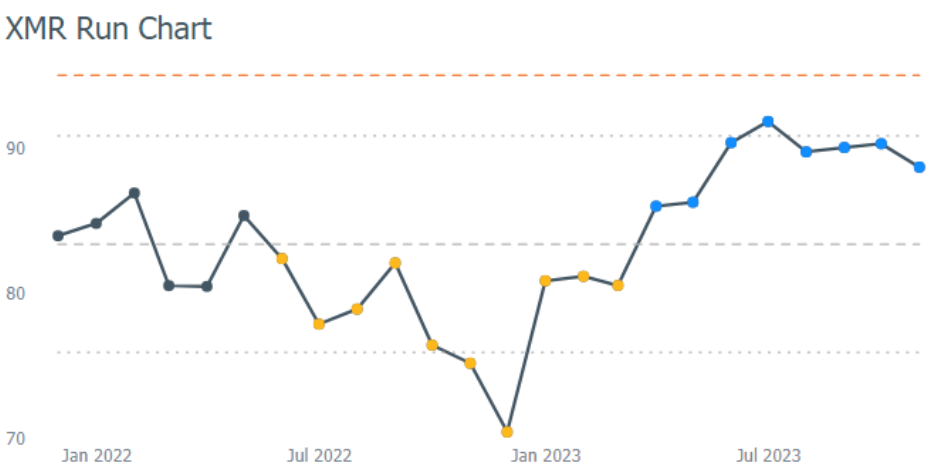
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The proportion of Ambulance handovers completed within 30 minutes of arrival. Incomplete timestamps are excluded from the performance.

Ambulance Handovers within 30m

Timescale	Value	SPC
Dec-22	70.4%	
Jan-23	80.8%	
Feb-23	81.1%	
Mar-23	80.5%	
Apr-23	86.0%	
May-23	86.2%	
Jun-23	90.4%	
Jul-23	91.8%	
Aug-23	89.7%	
Sep-23	90.0%	
Oct-23	90.3%	
Nov-23	88.7%	



Understanding the most recent data point

Performance

88.7% — Variation indicates consistently falling short of the target

Variation

Variation: Special cause of improving nature or lower pressure due to higher values

Flags: Above Mean Run Group; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
High numbers of ambulance conveyances to the Emergency Departments at QEQM/WHH (national outlier)	• Working with the HCP and SECAMB partners . Implementation the Alt-ED model • Support from GIRFT – one of the key recommendations following the review in July • Implement SPOA	• HCP/ Hospital Site teams/ Secamb	• Sep 2023; 6 month plan	• Establishing the HCP action plan to support the Alt-ED roll-out and the GIRFT action plan to support UCR pathways • SPOA pilot commenced Nov WHH with plans to roll-out to QEQM Jan 24
ED used as a single point of access increasing the risk of overcapacity and reduce the ability to manage handover Patients waiting outside the department due to process and space concerns at the WHH site	• Introduction of front door streaming and RAT to support early handover of patients. Early ED triggers in place to reduce risk for off-loading . • Streaming in place to support direct access to SDEC//SAEU/CAU/UTCs against patient criteria • Review of the process . To review environment and reception /streaming process and review the direct access for paediatrics to the Paeds ED	• Clinical lead ED and Head of Ops • MDs • WHH CG	• In place • October 23 – 6 month plan	• ED reviewing their internal plans to ensure early triggers resolve potential issues with off loads /Over capacity EDs • Plans to be developed for improving waiting environment / direct to paeds pathways / reception cover to reduce waits. Number of ambulance conveyances triaged to Waiting Room | review as part of GIRFT recommendations
Wait times to be seen by a senior clinician were over the standard 1 hour – with potential risks associated with waits	• Introduction of the Dr Initial Assessment(WHH) to support timely reviews and assessment of pts arriving on ambulances • Model in place at QEQM from September	• Clinical lead ED and Head of Ops	• In place and on-going	• Metrics in place

>12h Total Time In Emergency Department

Integrated Improvement Plan

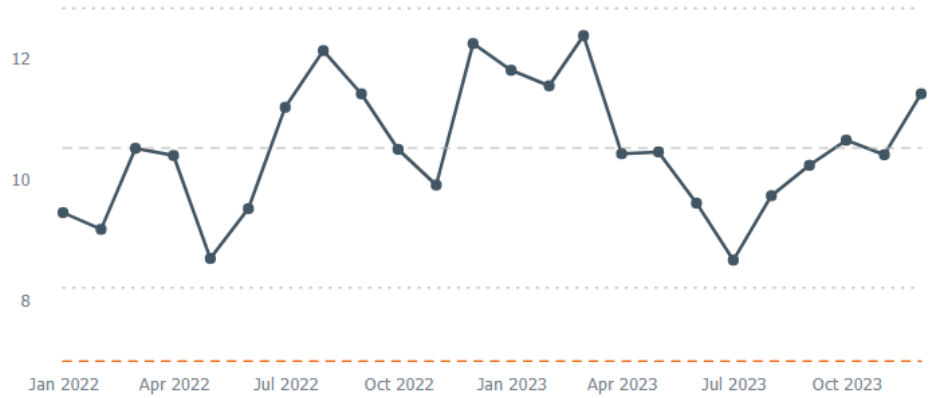
East Kent Hospitals University NHS Foundation Trust

This measure counts the proportion of patients whose total time in the emergency department exceeded 12 hours.

12 Hr Total Time in Department

Timescale	Value	SPC
Jan-23	11.8%	
Feb-23	11.5%	
Mar-23	12.4%	
Apr-23	10.4%	
May-23	10.5%	
Jun-23	9.6%	
Jul-23	8.7%	
Aug-23	9.7%	
Sep-23	10.2%	
Oct-23	10.7%	
Nov-23	10.4%	
Dec-23	11.4%	

XMR Run Chart



Understanding the most recent data point

Performance

11.4% — Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Number of patients waiting for a bed (admitted cohort)	Implementation of; • Daily pathway zero meeting • Specialty in-reach to the front door • Frailty units established –both site • Clinical forums to right size bed base and ensure appropriate configuration WHH in place QEQM November	• COO • Clin Leads/ MDs/Head of Ops	• October for 6 months	• COO focus on reducing incidents of 12 hours in ED - COO commenced Jan 24 • Creation of integrated hubs at the front door with access to domiciliary care to reduce P1 admissions • SAFER Bundle roll-out WHH | Commenced July – reviewed September with a plan to utilise KPMG to continue work • Trustwide discharge Task Forces to focus on internal delays • From February Exec lead to work on LoS across all 3 sites
Use of corridor to manage high numbers of pts in ED	• Implement SAFER Bundles • Protection of the DAP pathways and assessment units • Increase UTC/SDEC activity • Increase capacity – bed head service review • Review of internal triggers aligned to the new OPEL Framework, work with HCP to align system wide response	• COO/CNO • Clinical lead/MDs /Head of Ops • HCP/MDs	• On going • Nov 23 • Sep 2023 for 3 months	• Internal triggers and access and use of escalation areas completed WHH pending approval. QEQM – in development • MDs and DoNs reviewing their sites – proposal for increasing capacity to the CNO • OPEL framework goes live Dec 23
High number of Mental Health (MH) patients in ED with long waits	• Daily external escalation processes to be approved by the HCP to support oversight and planning • External ICB support to EKMHT to manage OOA access • SAFEHAVEN in place Dec QEQM with a plan to provide same service at WHH (2024)	• CG Tri WHH/QE QM	• On-going • Oct/Nov 2023 • Dec 23 – March 24	• ED internal processes in place to support patients Plans in place with HCP/MH to put in 24/7 LPS to the sites/ Safehavens to be co-located at QEQM with plans to be established fully by Q4

Super Stranded Patients (>21d LoS)

Integrated Improvement Plan

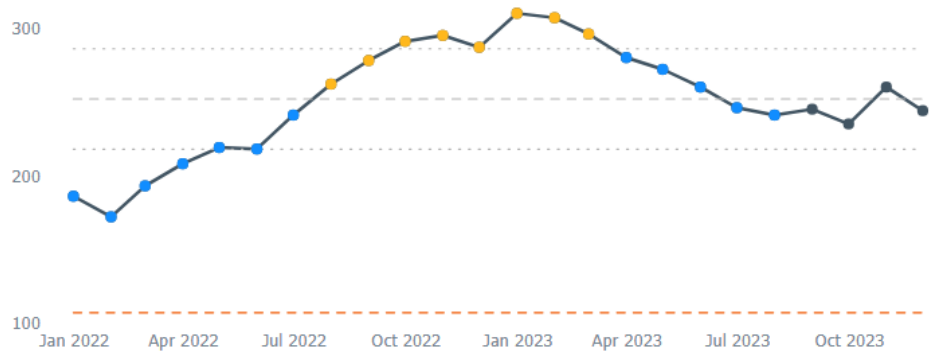
East Kent Hospitals University NHS Foundation Trust

The NHS defines a super stranded patient as someone who has spent 21 days or more in hospital.
This metric counts the number of Super Stranded patients at the time snapshot was taken, in this case the last day of the month.

Super Stranded >21D

Timescale	Value	SPC
Jan-23	310	
Feb-23	307	
Mar-23	296	
Apr-23	280	
May-23	272	
Jun-23	260	
Jul-23	246	
Aug-23	241	
Sep-23	245	
Oct-23	235	
Nov-23	260	
Dec-23	244	

XMR Run Chart



Understanding the most recent data point

Performance

244 — Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)
Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Long Stay Patients	• Roll out of SAFER bundle. Under the 'R' – 'Regular Review' principle patients with a LoS of more than 14 days will be reviewed at a weekly Super Stranded MDT	• Site MDs	• End Oct	• SAFER Board Round Bundle launched at WHH w/c 21st August. The programme will run from August to October 2023. Further support from KMPG will come online from early November. • Revised practice to include >14 day patients in the MFFD weekly RTS huddle. Roaming LoS management commenced at WHH where all patients >14d discussed with action workbook and accountable owners • QEQM PRISM Inpatient Flow Improvement Project commenced on 2nd October and is in the initial 4-week evaluation phase.
Access to community capacity	• East Kent Health and Care Partnership Urgent and Emergency Care Plan for 23/24 is structured with 5 priority areas of work: Increasing urgent and emergency care capacity, Making it easier to access the right care, Improving discharge, Expanding pro-active care outside of hospital, Increase workforce size and flexibility.	• HCP/COO	• 23/24 Year End	• Development of generic Health and Social Care (Home First Support Worker) | 7 of the 25 are due to start on the 18th October, another seven posts have been offered this week. Introduction of this service will increase pathway 1 capacity. • Proposed capacity supporting P2, P3 discharges across KCHFT, Broadmeadow, Westview and Westbrooke facilities. Included as part of the EK HCP Winter Plans providing up to an additional 48 beds spaces. The Trust are working on close partnership will HCP to determine start dates and phased opening plans.

Patients No Longer Fit to Reside in Hospital

Integrated Improvement Plan

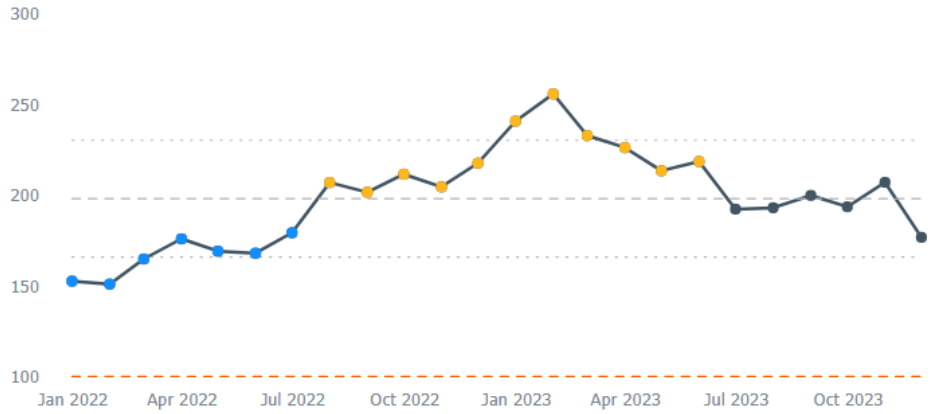
East Kent Hospitals University NHS Foundation Trust

The status of a patient is captured and recorded by clinical teams on a daily basis. Where a patient is deemed 'no longer fit to reside' (nlftr) this means that their care could be safely given in a setting outside of the acute hospital.
This metric measures the number of patients classified as nlftr each day in the month and expresses this as an average over the month.

Not Fit to Reside (pats/day)

Timescale	Value	SPC
Jan-23	240.7	
Feb-23	255.7	
Mar-23	232.8	
Apr-23	226.1	
May-23	213.4	
Jun-23	218.5	
Jul-23	192.3	
Aug-23	193.0	
Sep-23	199.8	
Oct-23	193.5	
Nov-23	207.0	
Dec-23	176.7	

XMR Run Chart



Understanding the most recent data point

Performance

176.7 — Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)
Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Access to community capacity	• East Kent Health and Care Partnership Urgent and Emergency Care Plan for 23/24 is structured with 5 priority areas of work: Increasing urgent and emergency care capacity, Making it easier to access the right care, Improving discharge, Expanding pro-active care outside of hospital, Increase workforce size and flexibility.	• HCP/ COO	• 23/24 Year End	• Development of generic Health and Social Care (Home First Support Worker) – 7 of the 25 are due to start on the 18th October, another seven posts have been offered this week. Introduction of this service will increase pathway 1 capacity. • Proposed capacity supporting P2, P3 discharges across KCHFT, Broadmeadow, Westview and Westbrook facilities. Included as part of the EK HCP Winter Plans providing up to an additional 48 beds spaces. The Trust are working in close partnership will HCP to determine start dates and phased opening plans.
Long Stay Patients	• Roll out of SAFER bundle. Under the 'R' – 'Regular Review' principle patients with a LoS of more than 14 days will be reviewed at a weekly Super Stranded MDT	• Site MDs	• End Oct	• SAFER Board Round Bundle launched at WHH w/c 21st August. The programme will run from August to October 2023. Further support from KMPG will come online from early November. • QEQM PRISM Inpatient Flow Improvement Project commenced on 2nd October and is in the initial 4-week evaluation phase.
Ward/RTS comms.	• PTL improvements provide the ward and RTS with a traffic light system highlighting the patient status on the RTS caseload. Alert system rolled out to provide two-way communication between ward and RTS for patient reviews.	• GS and Gastro DHoN	• End Oct	• PTL updates complete for RTS discharge PTL which now feeds into the main discharge planning PTL. • A single referral form is in development for enhanced discharge pathway planning. The Trust are seeking to attain the position where all enhanced discharge pathways are determine by RTS and Integrated Hubs.

Cancer 28d Faster Diagnosis

Integrated Improvement Plan

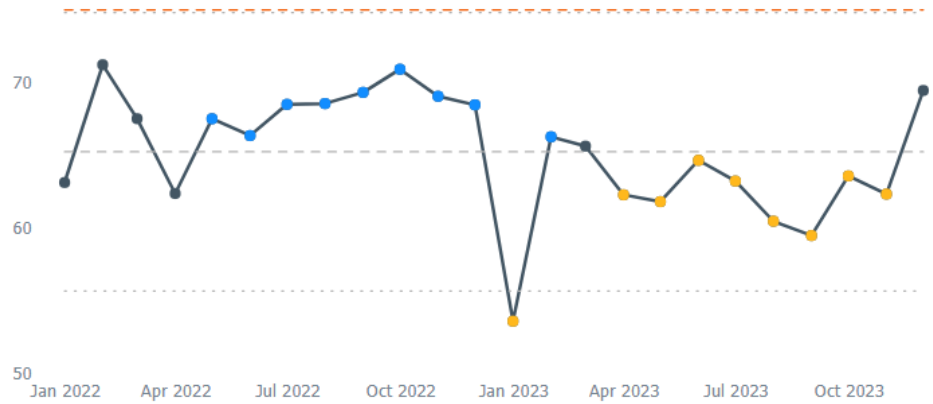
East Kent Hospitals University NHS Foundation Trust

There is a national requirement to diagnose or rule out cancer for patients referred on a cancer pathway within 28 days of receipt of referral.
This metric measures the % pf patients discharged or given a diagnosis in each month within 28 days of their referral.

Cancer 28d Combined Performance

Timescale	Value	SPC
Jan-23	53.6%	
Feb-23	66.3%	
Mar-23	65.6%	
Apr-23	62.3%	
May-23	61.8%	
Jun-23	64.7%	
Jul-23	63.2%	
Aug-23	60.5%	
Sep-23	59.5%	
Oct-23	63.6%	
Nov-23	62.3%	
Dec-23	69.5%	

XMR Run Chart



Understanding the most recent data point

Performance

69.5% — Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)
Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Diagnostic reporting for CT's & MRI's (current reporting time is 2 weeks for CT's and 6 weeks for MRI's) Ref to exam - CT- 2-3 days if bloods done, if not 14 days. MRI 11 days.	Reduce referral to reporting to 10 days for CT and MRI	• Radiology • Cancer Trackers • Phlebotomy	• Jan 2024	• Improved escalation process being piloted for bloods, vetting, booking and reporting • CT biopsy and Ultrasound Guided Biopsy has seen some improvement • Locums for radiology pulled out, alternative solution being investigated
Qfit process not consistently applied and current waiting time for endoscopy booking is 4 weeks.	Qfit process to be consistently applied and sustained. To reduce waiting time to Scope to 10 days for 2ww and screening patients	• Endoscopy • Qfit Facilitator • AMD Surgery	• Feb 2023	• Task and finish group established that includes actions for Endoscopy and Qfit • STT implemented for Lower GI SOP criteria expanded, learning from other orgs. • The endoscopy request form is being updated to include Qfit result as is the 2ww referral form within the community • Lead GP is contacting practices who are showing zero utilisation of Qfit to encourage them to utilise Qfit current utilisation 70% by GP's • Nurse seconded from cancer team to support QFIT process – patients to be contacted during Jan/ Feb (2700) and due diligence regarding capacity to process tests at MTW in progress with DCOO
Waits for typing of cancer patient clinic letters , typing for Urology, Upper and Lower GI. Averaging 8-12 weeks	Typing of letters for those tumour sites to be completed within 7 days.	• Care Group Lead Medical Secs	• Jan 2024	• Updates on progress circulated to teams 3 times a week to support improvement • Additional funding to support improvement secured from NHSE (345K which includes admin funding) A lead GM has been allocated to support turning this around

Cancer Patients >62d on PTL

Integrated Improvement Plan

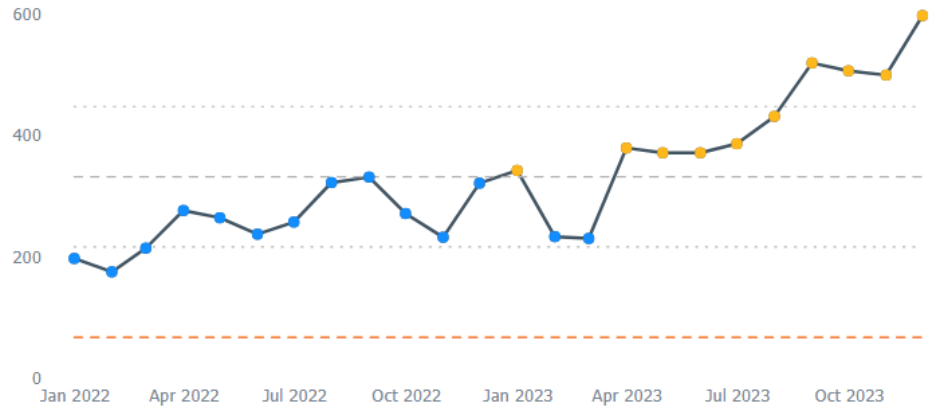
East Kent Hospitals University NHS Foundation Trust

The number of patients on a Cancer Pathway who have been waiting 62d or more from point of referral and have not yet received treatment. This metric is a snapshot count of patients as at month end.

Cancer Over 62d on PTL

Timescale	Value	SPC
Jan-23	342	
Feb-23	233	
Mar-23	230	
Apr-23	379	
May-23	371	
Jun-23	371	
Jul-23	386	
Aug-23	431	
Sep-23	519	
Oct-23	506	
Nov-23	499	
Dec-23	597	

XMR Run Chart



Understanding the most recent data point

Performance

597	Variation indicates consistently falling short of the target

Variation

Variation	Special cause of concerning nature or higher pressure due to higher values
Flags	Above Mean Run Group Astronomical Point Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Diagnostic waiting time for U/S Guided Biopsies. Average wait time 4-5 weeks	• Capacity and demand analysis considering scanning and workforce capacity to meet 10 day pathway	• Radiology • Cancer	• Feb 2024	• Radiology Improvement plan in place awaiting new interventionalists to start • Ultrasound guided biopsy waiting times decreased slightly • Options for dedicated lists on the K&C site being explored • Demand and capacity planning partial completeness as part of overall business planning
Delays with radiology vetting, booking and reporting adding weeks to suspected cancer patient pathway	• Demand and capacity plan and job plan reviews to understand sustainable waiting list size and backlog clearance • Targeted waiting lists and prioritisation • Data quality overview	• MD DC&B • Cancer	• Feb 2024	• Backlog included in weekly feeder pack, for update and discussion at Performance meetings and PTL's to ensure weekly improvement • Additional improvement funding of £345K secured from NHSE to support improvement
Inadequate capacity within out-patients for F2F appointments post MDM to discuss treatment options post MDM	• Increase Outpatient capacity for decision to treat (DTT) OPA's. OPA to be available within 5 days following the MDM. • Provide Increased straight to test (STT) capacity to release medical time for F2F OPA's etc	• FDS Lead Clinician • Out-patient Lead	• Oct 2023	• 2ww Transformation and longer waiter Working Group established • Issue resolved and requires monitoring for sustainable assurance

Cancer Patients >104d on PTL

Integrated Improvement Plan

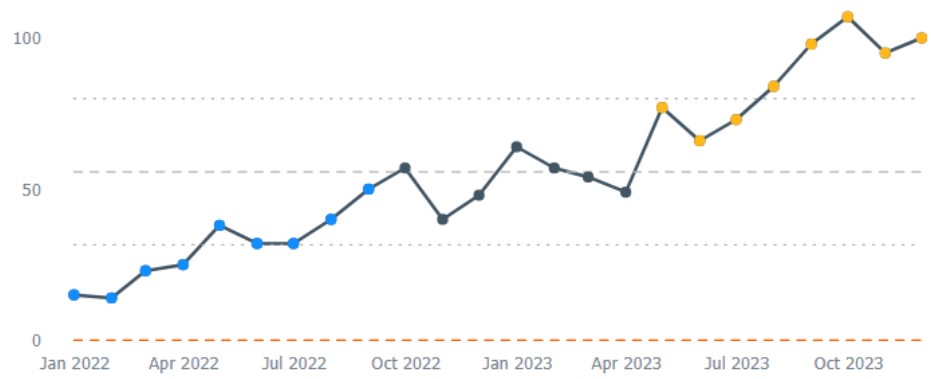
East Kent Hospitals University NHS Foundation Trust

The number of patients on a Cancer Pathway who have been waiting 104d or more from point of referral and have not yet received treatment.
This metric is a snapshot count of patients as at month end.

Cancer Over 104d on PTL

Timescale	Value	SPC
Jan-23	64	
Feb-23	57	
Mar-23	54	
Apr-23	49	
May-23	77	
Jun-23	66	
Jul-23	73	
Aug-23	84	
Sep-23	98	
Oct-23	107	
Nov-23	95	
Dec-23	100	

XMR Run Chart



Understanding the most recent data point

Performance

100	Variation indicates consistently falling short of the target

Variation

Variation	Special cause of concerning nature or higher pressure due to higher values
Flags	Above Mean Run Group Astronomical Point Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Urology Surgical capacity and high levels of breaches for patients needing active surveillance	Increase surgical capacity by exploring mutual aid options with MFT for RALP and Cystectomy. Team asked to find alternative plans before STT team appointed	• MD • AMD and MD K&C • MDT Lead for Urology	• Jan 2024	• Pathway agreed with MFT and local team. • K&M Cancer Alliance meeting being arranged. So far patients not engaging in having surgery elsewhere, but this is being reviewed to maximise offer • Clinical team reviewing potential additional actions needed to reduce delays for active surveillance
Tertiary referral – delays with receiving communication back from tertiary centres.	Improved collaboration between EKHUFT and tertiary centres.	• Senior Service Managers EKHUFT • Tertiary Centres • EKHUFT Compliance Managers	• Jan 2024	• Established weekly PTL meetings for UGI with our London colleagues. • Meetings with Kings taking place regularly to review IPT transfers, and correct completion of documents. • Joint Kent & Medway Escalation PTL to be set up with GSTT as issues across all Trusts.
Patient engagement throughout pathways, multiple cancellations/DNA's	Ensure GP's are informing the patients they are being referred on a cancer pathway and not all investigations will be at the hospital nearest to them.	• Care Group Leads/ CNS's • GP's/Support Workers/Patient Engagement Officer K&M Cancer Alliance	• Jan 2024	• 2ww Transformation Working Group. • Working with our GP Cancer Lead to ensure patients are being told they are on a cancer pathway at referral • STT implementation • Early escalation to Cancer CNS's to support patients • Development of 2ww information of Trust web page to support patients and their relatives/carers on a cancer pathway, being designed

Diagnostic Waiting Times: DM01

Integrated Improvement Plan

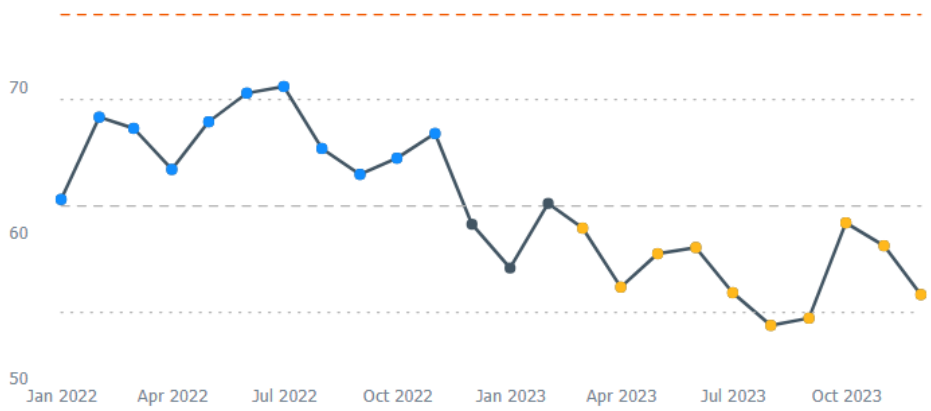
East Kent Hospitals University NHS Foundation Trust

Diagnostic tests/procedures are used to identify and monitor a person's disease or condition and which allows a medical diagnosis to be made. The national waiting time standard states that no more than 1% of patients should wait more than 6 week for their diagnostic test. The Trust currently has a stretch target to hit 75% by March 2024.

DM01 Compliance

Timescale	Value	SPC
Jan-23	57.6%	
Feb-23	62.0%	
Mar-23	60.3%	
Apr-23	56.3%	
May-23	58.6%	
Jun-23	59.0%	
Jul-23	55.9%	
Aug-23	53.6%	
Sep-23	54.1%	
Oct-23	60.7%	
Nov-23	59.1%	
Dec-23	55.8%	

XMR Run Chart



Understanding the most recent data point

Performance

55.8% — Variation indicates consistently falling short of the target

Variation

Variation — Special cause of concerning nature or higher pressure due to lower values

Flags — Below Mean Run Group

KEY ISSUE(S)	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
CT issues; • CT Cardiac • CT Vetting • Ranzac protocol	• Cardiac | awaiting review of external funding • Vetting | Clearance of backlog • Ranzac | agree protocol	• DCOO • Head of Imaging • Head of Imaging	• Awaiting approval • March '24 • Dec '24 for implementation	• CT Cardiac beaches reduced again in Oct from 371 in Nov to 303 in Dec due to support from Chaucer. Awaiting grey list funding from CDC. • Vetting numbers continue to be a challenge declining slightly to 1686 for CT • Ranzac protocol implemented in Dec – review meeting scheduled to identify impact and concerns
MRI scanning capacity	Review of internal booking procedures within MRI Development of improvement plan for MRI	• Head of Imaging • Business Manager	• Completed – Sept 24 • End Jan '24	• MRI breaches reduced 2,464 in November to 2361 in Dec but due TO demand and increase in total waiting list size, compliance has deteriorated slightly to 71.9% • Prolonged scanner downtime (20 days plus) in Jan/Feb will impact performance next month.
CT issues; • CT Cardiac • CT Vetting • Ranzac protocol	• Cardiac | awaiting review of external funding • Vetting | Clearance of backlog • Ranzac | agree protocol	• DCOO • Head of Imaging • Head of Imaging	• Awaiting approval • March '24 • Dec '24 for implementation	• CT Cardiac beaches reduced again in Oct from 371 in Nov to 303 in Dec due to support from Chaucer. Awaiting grey list funding from CDC. • Vetting numbers continue to be a challenge declining slightly to 1686 for CT • Ranzac protocol implemented in Dec – review meeting scheduled to identify impact and concerns

Referral to Treatment Waiting Times: 65w Waits

Integrated Improvement Plan

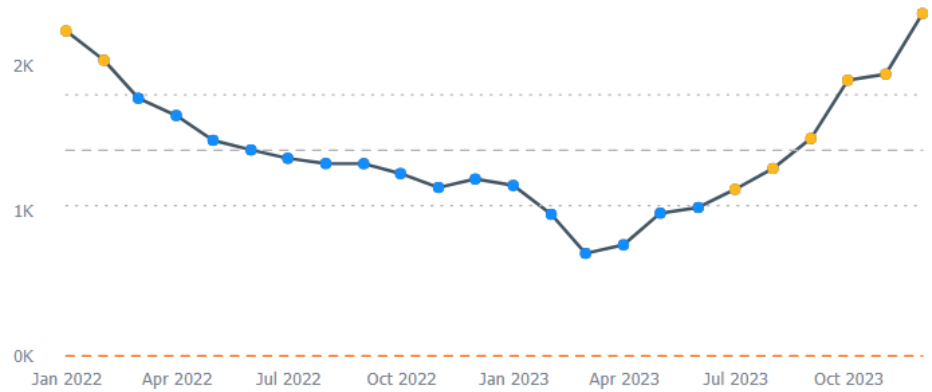
East Kent Hospitals University NHS Foundation Trust

This metric measures the number of RTT reportable patients waiting in excess of 65 weeks to start treatment.
The Trust has a stretch target to eliminate 65w waits by the end of March 2024.

RTT 65w Breaches

Timescale	Value	SPC
Jan-23	1,175	
Feb-23	976	
Mar-23	707	
Apr-23	766	
May-23	984	
Jun-23	1,023	
Jul-23	1,148	
Aug-23	1,292	
Sep-23	1,499	
Oct-23	1,900	
Nov-23	1,942	
Dec-23	2,360	

XMR Run Chart



Understanding the most recent data point

Performance

2,360 — Variation indicates consistently falling short of the target

Variation

Variation	Special cause of concerning nature or higher pressure due to higher values
Flags	Astronomical Point Ascending Run Group Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Non-admitted pathway delays impacting ability to reduce breaches	• Weekly recovery meetings re-set with MD's focussed on recovery actions (65 week risk cohort & specialities with long 1st apt waits)	• DCOO • Interim MD	• Jan 2024 • End Nov	• Implementation of recovery Meetings commenced in January to deep dive per Care Group into this issue. All Care Groups are compiling recovery plans. • Out patient transformation group refreshed aligned to national transformation requirements with first draft programme due in January.
Diagnostic delays – impacting ability to scan/scope routine (longer waiting RTT patients) creating significant increase in 78 week breaches	• Endoscopy Insourcing provision to be increased following conclusion of procurement process • Internal Diagnostic Improvement Board to be established in line with Planned Care Governance refresh	• DCOO • MD DCB	• Dec 2023 • Jan 2024	• Priority agreed in first Tier One meeting with system is validation of patient list. The system has then agreed to support outsourcing/Mutual Aid etc when actual numbers are confirmed. • Substantive MD for Cancer and Diagnostic Care Group commenced on 8th January 2023.
Admitted pathway delays – volume of 65 and 78 week breaches increasing (104 weeks breaches have not been eliminated)	• Delays driven by Endoscopy capacity. • All specialities to create urgent recovery plans. • Focus on Orthopaedic delays through Prism productivity review.	• DCOO • DCOO • MD SS	• Jan 2024 • Jan 2024	• Forecasting indicates increasing volumes of 65 and 78 week breach risks monthly continues. • All Care Groups are compiling recovery plans. • Prism diagnostic completed, Implementation phase to commence in Jan with clear trajectories.

Referral to Treatment Waiting Times: 52w Waits

Integrated Improvement Plan

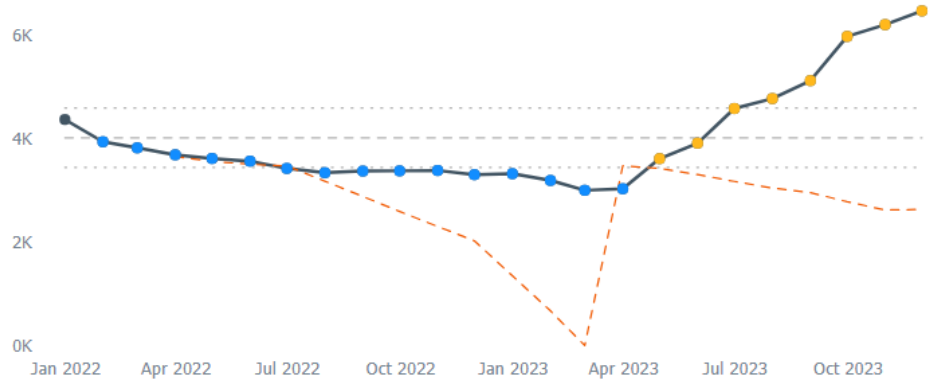
East Kent Hospitals University NHS Foundation Trust

This metric measures the number of RTT reportable patients waiting in excess of 52 weeks to start treatment.

RTT 52w Breaches

Timescale	Value	SPC
Jan-23	3,317	
Feb-23	3,187	
Mar-23	2,997	
Apr-23	3,027	
May-23	3,608	
Jun-23	3,907	
Jul-23	4,575	
Aug-23	4,767	
Sep-23	5,113	
Oct-23	5,966	
Nov-23	6,194	
Dec-23	6,459	

XMR Run Chart



Understanding the most recent data point

Performance

6,459

Variation indicates consistently falling short of the target

Variation

Variation: Special cause of concerning nature or higher pressure due to higher values

Flags: Astronomical Point; Ascending Run Group; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Business Plan 23/4 Elective activity (IP and DC) below plan – delivering circa 92% of plan and OP FU above 75% threshold	• Current business planning to agree clear demand management plans for 2024/25. • Independent sector utilisation to increase to deliver > 3,000 cases by end of year. • Specialities to quantify plans to deliver 5% PIFU and 25% OP FU (national out patient transformation requirement)	• MD's • DCOO • MD's	• Mar 2024 • Mar 2024 • Nov23 - Jan24	• Process underway and plans to be completed in Feb 2024. • All IS providers met, capacity discussed and Spencer hospitals to increase utilisation to mitigate strike action impact. • GIRFT Further Faster Programme commenced in November to inform PIFU and 25% FU reduction plan. Clinically led.
Validation - inability to deliver 90% target to clinically/administratively validate every patient over 12 weeks/every 12 weeks	• Implement two way text messaging for all patients to support requirement to validate requirement • Additional funding secured from NHSE to support initial validation requirement - £100K. • Validation strategy to be agreed to include sustainable training plan.	• Elective Recovery Director • DD of Info • DCOO/NHSE	• Oct 2023 • Nov 2023 • Dec 2023	• Agreed to recruit 3 FTE's to support validation from £100K, interviews to be held 18th January. Risk that this is not sufficient for pace required before end of March. Additional 35K sourced that can help support additional validation • External validation support being reviewed • IST commenced in December and working through validation plan and to set-up Access Group to deliver validation strategy. Validation is a complex programme and will take some time to generate rhythm and pace

Cancer Performance

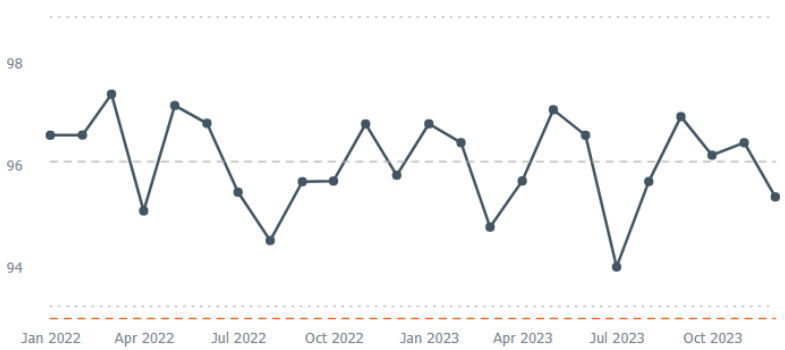
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Cancer 2ww Performance

Timescale	Value	SPC
Jan-23	96.8%	
Feb-23	96.4%	
Mar-23	94.8%	
Apr-23	95.7%	
May-23	97.1%	
Jun-23	96.6%	
Jul-23	94.0%	
Aug-23	95.7%	
Sep-23	97.0%	
Oct-23	96.2%	
Nov-23	96.4%	
Dec-23	95.4%	

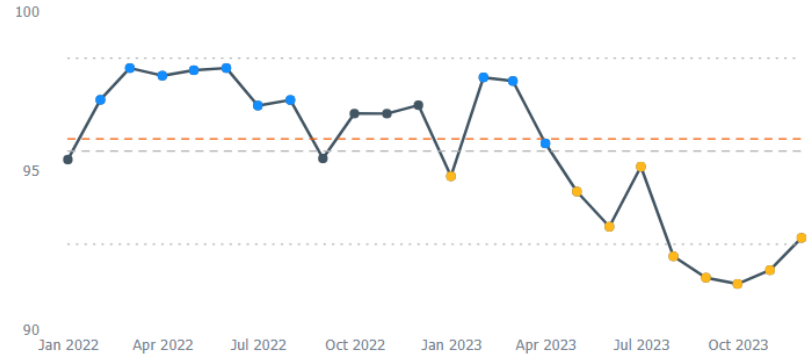
XMR Run Chart



Cancer 31d Combined Performance

Timescale	Value	SPC
Jan-23	94.8%	
Feb-23	97.9%	
Mar-23	97.8%	
Apr-23	95.9%	
May-23	94.3%	
Jun-23	93.2%	
Jul-23	95.1%	
Aug-23	92.3%	
Sep-23	91.6%	
Oct-23	91.4%	
Nov-23	91.9%	
Dec-23	92.9%	

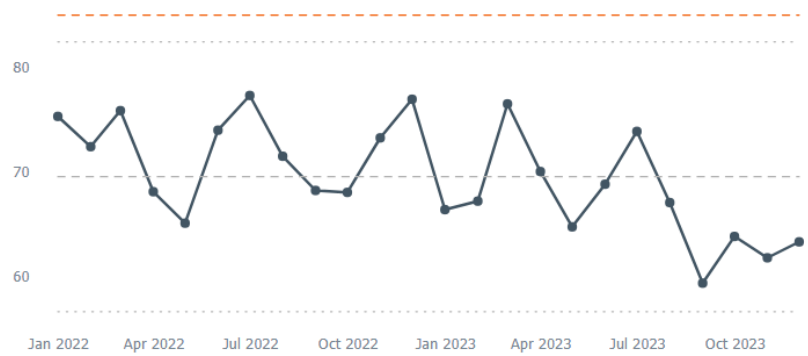
XMR Run Chart



Cancer 62d Combined Performance

Timescale	Value	SPC
Jan-23	66.4%	
Feb-23	67.2%	
Mar-23	76.5%	
Apr-23	70.0%	
May-23	64.7%	
Jun-23	68.8%	
Jul-23	73.9%	
Aug-23	67.1%	
Sep-23	59.4%	
Oct-23	63.8%	
Nov-23	61.8%	
Dec-23	63.3%	

XMR Run Chart



PERFORMANCE UPDATE

2ww performance has declined slightly in month remaining compliant with the national standard. 2WW working group and weekly capacity meetings in place

31 Day Performance improved within month again and is highlighted weekly within Cancer Performance Feeder pack and daily escalation to influence continued improvement

62d performance improved in month – main delays within the backlog remain within endoscopy, radiology and urology.
Improvement actions include:

- Additional escalation for radiology now include Clinical lead to help support prioritisation
- Endoscopy backlog reducing beginning to see an improvement within Lower GI, but the backlog still significant and being addressed within the weekly performance meeting
- Straight to Test (STT) pathways for Lung, Lower GI, Upper GI and Haematuria being reviewed to share learning and improve further
- Enhanced escalation process in place for Consultant reviews, tertiary referrals, surgical dates and diagnostics to reduce the number of days on the pathway
- Engagement with Care Groups to support booking of patients through weekly feeder pack and PTL meetings to support teams juggling multiple demands
- Improving access to blood tests for cancer patients so that diagnostics can be booked earlier, this has made a huge improvement hand will continue to take days out of the pathway.
- Educational event organised with GP Colleagues in Nov to support learning and earlier diagnostics
- Radiology have been asked for an action plan to ensure long waiting backlog is cleared asap

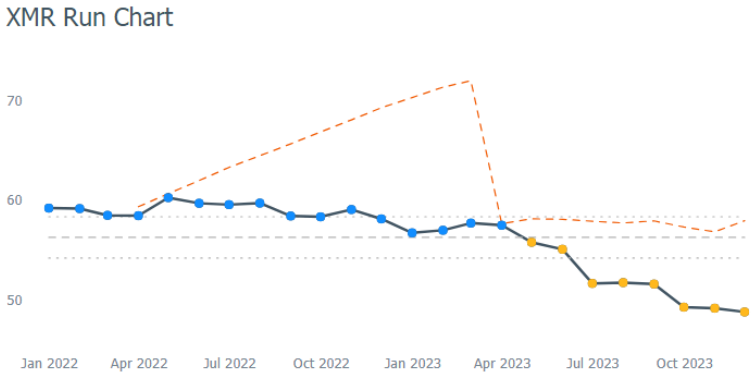
RTT Performance

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

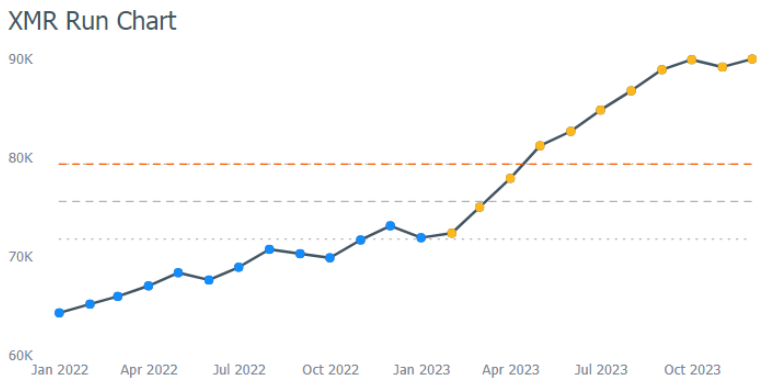
RTT Incomplete Performance

Timescale	Value	SPC
Jan-23	56.7%	
Feb-23	56.9%	
Mar-23	57.7%	
Apr-23	57.5%	
May-23	55.7%	
Jun-23	55.0%	
Jul-23	51.6%	
Aug-23	51.7%	
Sep-23	51.5%	
Oct-23	49.2%	
Nov-23	49.1%	
Dec-23	48.7%	



RTT Total Incomplete Pathways

Timescale	Value	SPC
Jan-23	71.9K	
Feb-23	72.4K	
Mar-23	75.0K	
Apr-23	77.9K	
May-23	81.2K	
Jun-23	82.7K	
Jul-23	84.8K	
Aug-23	86.8K	
Sep-23	88.9K	
Oct-23	89.9K	
Nov-23	89.2K	
Dec-23	90.0K	



PERFORMANCE UPDATE

All teams were advised on 11th January that there is zero tolerance for 78+ waits after 31st March (all pathways). Teams are currently compiling recovery plans. Risk that there are patients with future dates that will also breach 78+ and these need to be identified and pulled forward.

A key initiative is to develop a validation strategy to address the current patients awaiting validation > 12 weeks.
A draft proposal has been made and a working group formed in January to operationalise a validation plan utilising text and e-mail technology to commence from February 2024.

December saw impact of Bank Holidays and therefore loss of activity as expected. There was also IA which had impact on long waits as P2 and cancers prioritised. Due to January strikes there was limited opportunity to re-date patients as quickly as was required to not have breaches.

The volume of 52, 65 and 78 week breaches are increasing weekly and are forecast to continue growing due to demand for cancer and lack of capacity to treat routine patients. Pressure to deliver cancer FDS and reduce long waits may add further pressure to diagnostic modalities.

Validation has been a key focus for speciality teams since last year, approximately 50% of the total RTT PTL is validated. The plan to roll out a digital solution, to support teams validating, is progressing but needs significant investment to support validation/training in the short/medium/long term. Furthermore the option to utilise the patient portal to support this programme of work is being reviewed and considered but requires further investment and support to develop the system to its full potential.

The development of an RTT training strategy alongside core learning from validation errors is required to drive demonstrable increases in clock stops to manage the size of the waiting list. This will require support from senior teams as admin and clinical teams will be required to engage.

Efficiency Metrics

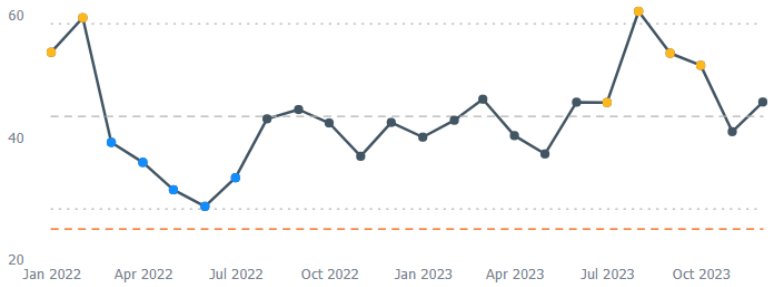
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Theatre Session Opp.

Timescale	Value	SPC
Jan-23	40	
Feb-23	43	
Mar-23	46	
Apr-23	40	
May-23	37	
Jun-23	46	
Jul-23	46	
Aug-23	61	
Sep-23	54	
Oct-23	52	
Nov-23	41	
Dec-23	46	

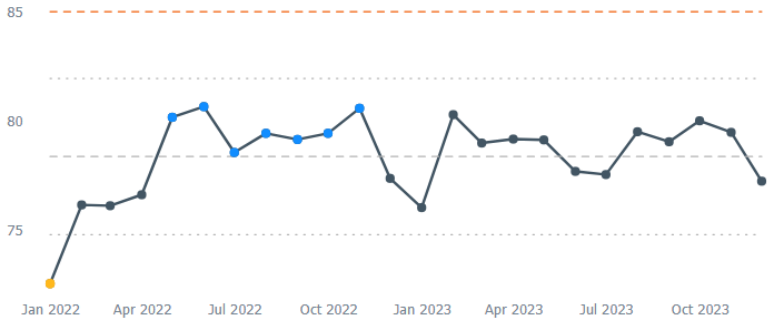
XMR Run Chart



Theatre Uncapped Utilisation

Timescale	Value	SPC
Jan-23	76.0%	
Feb-23	80.3%	
Mar-23	79.0%	
Apr-23	79.2%	
May-23	79.1%	
Jun-23	77.7%	
Jul-23	77.5%	
Aug-23	79.5%	
Sep-23	79.0%	
Oct-23	80.0%	
Nov-23	79.5%	
Dec-23	77.2%	

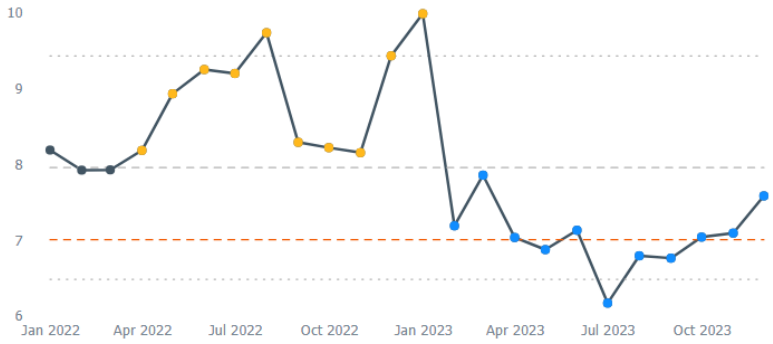
XMR Run Chart



DNA Rate OP New

Timescale	Value	SPC
Jan-23	10.0%	
Feb-23	7.2%	
Mar-23	7.9%	
Apr-23	7.0%	
May-23	6.9%	
Jun-23	7.1%	
Jul-23	6.2%	
Aug-23	6.8%	
Sep-23	6.8%	
Oct-23	7.0%	
Nov-23	7.1%	
Dec-23	7.6%	

XMR Run Chart



PERFORMANCE UPDATE

Doctor strike action continues to be a contributing factor to the high session opportunity and has continued with 51 cases cancelled due to strike action w/c 18th December.

Theatre actual utilisation remains within normal variation around 78-79% utilised. Teams are being asked to book up to a minimum of 90% utilised in order to meet the aim of 85% actual utilisation moving forward. The Elective Orthopaedic Centre is aiming for an actual utilisation of 90%.

The theatre improvement group met on 14th December with clear improvement trajectories agreed to commence from the start of January.
Improvements are focussed around the implementation of strong 6-4-2 processes and in session utilisation.

Peri-operative programme in development with system partners (KCHFT) and Graph net to include use of a shared care record to enable pre-op teams to better plan cases and reduce cancellations on the day.

Trial to commence in January.

Increasing numbers of patients now have the ability to choose their appointment date as specialties are moving back to the electronic referral service (ERS) which appears to be having a positive impact and decreasing capacity lost due to DNA.

Further development of the patient portal continues.

East Kent Hospitals University NHS Foundation Trust

Quality & Safety

Quality & Safety

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Quality	IIP		Serious Incidents		Sigma	16	16	34	10	5	13	11	12	12	13	15	7
	IIP		Incidents - Moderate / Severe		Sigma	65	48	54	29	35	32	36	23	33	43	31	39
	IIP		Overdue Incidents		0	6,635	5,716	4,755	3,897	3,340	2,938	2,395	2,669	2,980	3,353	3,293	3,614
	IIP		Serious Incidents Breached exceed 60...		0	0	2	6	10	13	6	6	2	3	1	2	3
	IIP		HSMR		96.0	93.1	93.3	95.1	94.1	94.2	93.7	92.3	92.1	91.4			
	IIP		Pressure Ulcers		Sigma	89	74	78	75	85	92	78	76	62	103	81	82

December Performance Summary

Incident Reporting: There were 2,070 patient incidents reported in December, of which 7 were declared as serious incidents at the Serious Incident Declaration Panel, which is chaired by the Chief Nursing and Midwifery Officer, the Chief Medical Officer or the Director of Quality Governance. The number of incidents compares with 2,134 in November and 2,517 in October. A detailed report on serious incidents will be presented to CEMG and the Trust Board , however a summary of each is presented on the next two slides. Commentary on the overdue incidents can be found on slide 7. The increase in moderate harms seen in October 2023 has reduced to the average number of moderate harms reported since May 2023.

Mortality: Results from the October to September reporting period demonstrated a continued decline (improvement) in HSMR, demonstrating a statistically lower than expected mortality. The full mortality report was shared with the Trust on 15 January and is to be discussed in the next Mortality Surveillance Steering Group.

Harm Events: The number of harm events continues to show a plateauing trend this financial year with a subsequent increase in cases taken to the Serious Incident Declaration Panel, although not all cases presented resulted in an SI being declared. There was a significant spike in numbers during 4th quarter of 2022/2023 which was followed by a levelling up period in the first and second quarters of 2023/2024. This appears to be returning to a similar baseline. On initial review, the Patient Safety Team has not identified any specific themes and will be reviewing the figures for moderate harm during the past 12 months to establish any problems requiring additional investigation and support.

Serious Incidents

Integrated Improvement Plan

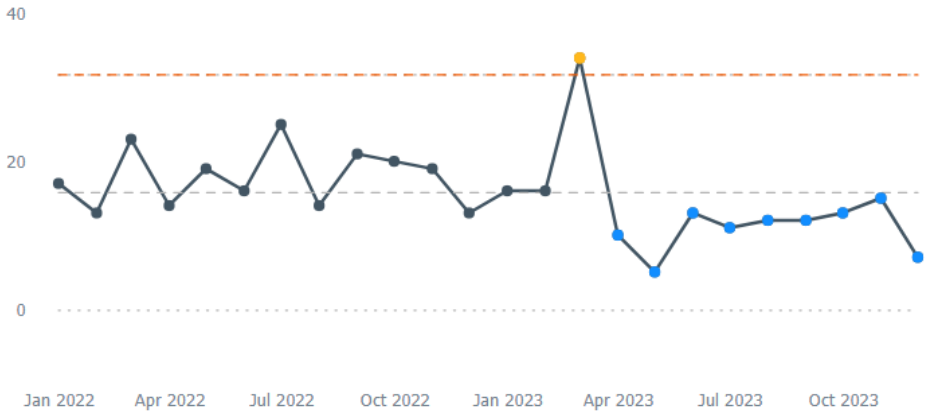
East Kent Hospitals University NHS Foundation Trust

This metric measures any incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System). Any incidents that are subsequently downgraded are removed retrospectively therefore this number is subject to change. Serious Incidents are reported by the date the investigation started and not the date the incident occurred or was reported.

Serious Incidents

Timescale	Value	SPC
Jan-23	16	
Feb-23	16	
Mar-23	34	
Apr-23	10	
May-23	5	
Jun-23	13	
Jul-23	11	
Aug-23	12	
Sep-23	12	
Oct-23	13	
Nov-23	15	
Dec-23	7	

XMR Run Chart



Understanding the most recent data point

Performance

7 — Variation indicates inconsistently passing and falling short of the target

Variation

Variation	Special cause of improving nature or lower pressure due to lower values
Flags	Below Mean Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	Progress Update
• Maternity incident: baby only	• Baby born in unexpectedly poor condition and required therapeutic hypothermic treatment (cooling). Referred to and accepted by MNSI to investigate externally.	• Care Group Leadership Team	• MNSI will provide timescales and appropriate extensions will be sought via ICB accordingly.	• This investigation is in progress.
• Maternity incident baby only	• Early neonatal death of a baby delivered via caesarean section at 35 weeks gestation. Does not meet criteria for MNSI investigation but the Trust has requested an external review of care to identify maximum learning.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• This investigations is in progress.
• Please see next slide				

→

Serious Incidents

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures any incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System). Any incidents that are subsequently downgraded are removed retrospectively therefore this number is subject to change. Serious Incidents are reported by the date the investigation started and not the date the incident occurred or was reported.

StEIS Category	Issues Identified	OWNER	TIMESCALE	PROGESS UPDATE
• Four care and treatment incidents	• Unexpected death of a one year old child following 2 cardiac arrests as an inpatient where he was receiving treatment for constipation. Post mortem is awaited and the case is with the coroner. • Incorrect follow up from MDM when the margins were not clear following a cancer treatment. • Incident raised via the SJR process as acts/omissions in care lead to a delay in treatment for sepsis. • Patient had MRI to exclude bowel perforation but was discharged home before reported on. MRI suggestive of perforation but not acted upon. Patient re-admitted 23 days later in collapsed state due to septic shock.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• These investigations are in progress.
• Medical devices/equipment	• An advanced locking set was opened directly from the sterile packaging in theatres and found to be contaminated with blood. This was immediately identified. Theatre instrument management processes are being reviewed.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS	• The investigation is in progress.

Overdue Incidents

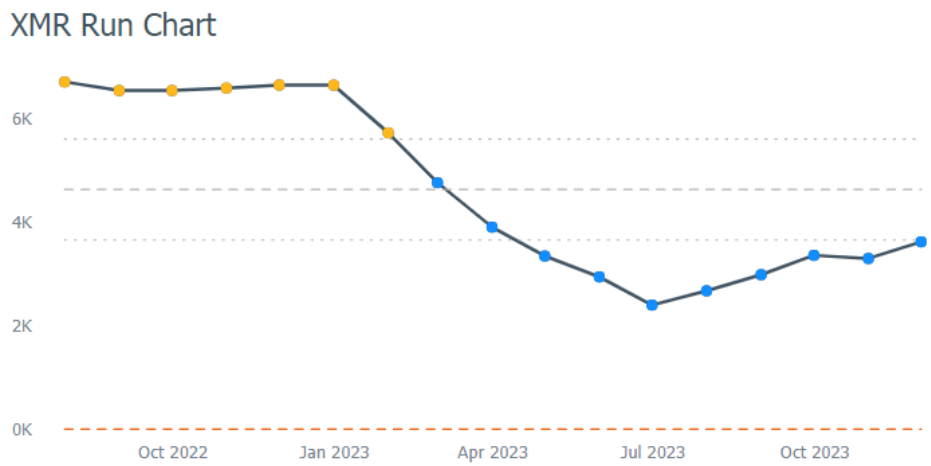
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of incidents which are overdue their agreed timescale for closure (all types) both overall and at each key stage of the investigation process: Awaiting review (AWAREV), In Review (INREV) and Awaiting Final Approval (AWAFA)

Overdue Incidents

Timescale	Value	SPC
Jan-23	6,635	
Feb-23	5,716	
Mar-23	4,755	
Apr-23	3,897	
May-23	3,340	
Jun-23	2,938	
Jul-23	2,395	
Aug-23	2,669	
Sep-23	2,980	
Oct-23	3,353	
Nov-23	3,293	
Dec-23	3,614	



Understanding the most recent data point

Performance

3,614	Variation indicates consistently falling short of the target

Variation

Variation	Special cause of improving nature or lower pressure due to lower values
Flags	Below Mean Run Group Astronomical Point Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Despite ***best*** efforts by care group and central governance staff there has been little progress with reducing overdue incidents.	• There is currently one central governance staff member working on overdue incidents 7.5 hrs per week, addressing the WHH backlog of 659 • Agency Band 7 commenced role 15/01/2024 to work full time to address the backlog. • A new governance interim has commenced at Kent and Canterbury Hospital who will also support addressing the backlog at QEQM • The new management plan aims to reduce the number of overdue incidents by 50% by 16/02/2024. • To fully resolve the overdue incidents by 31/03/2023	• Director of Quality Governance	31/03/2024	The rising number of overdue incidents reported last month was caused by an admin error in generating the figures. Now that this has been corrected it has emerged that the formula utilised in generating this data for the scorecard has an anomaly which requires a new formula. The Head of Patient Safety and BI Lead are working on changes to the formula however this will require executive approval before the changes can be officially applied. This has been escalated to CEMG via December Quality Governance report.

Incidents Causing Harm

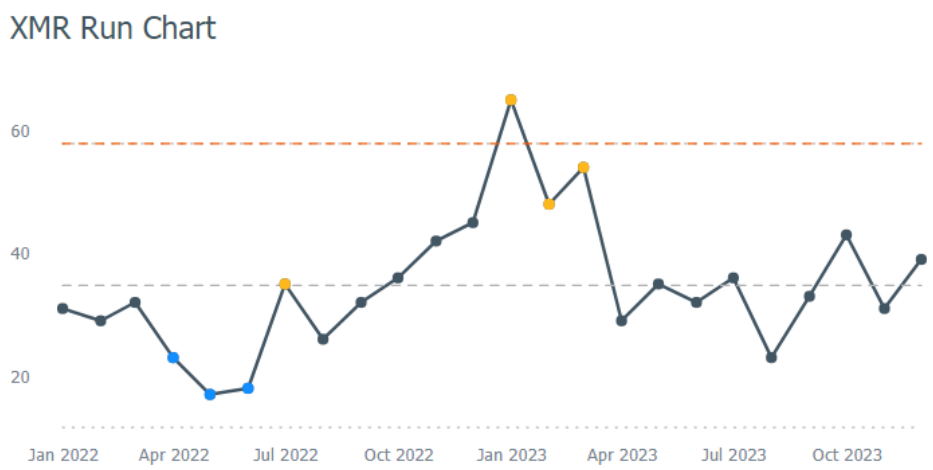
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of clinical incidents where the harm status was moderate or above.

Incidents - Moderate / Severe

Timescale	Value	SPC
Jan-23	65	
Feb-23	48	
Mar-23	54	
Apr-23	29	
May-23	35	
Jun-23	32	
Jul-23	36	
Aug-23	23	
Sep-23	33	
Oct-23	43	
Nov-23	31	
Dec-23	39	



Understanding the most recent data point

Performance

39

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patient developed significant bradycardia /complete heart block with HR 20bpm 24 hrs post PCI. Given Atropine, started on isoprenaline IVI and went to the cath lab for temporary pacing wire but upon review of angiogram images decision made to repeat the angio which showed an occlusive thrombus.	• Patient underwent further PCI and balloon pump was inserted, Was safely discharge following treatment • Case discussed at Cardiology M&M • Confirmed known complication of initial procedure • Duty of Candour completed with patient • No omissions in care identified	Cardiology Consultant	31/01/2024	Final Doc being drafted for patient.
Patient mobilising in bay with staff present, grabbed onto curtain and fell over resulting in a fractured Pubic Rami	• Falls team review of incident completed • Discussed at Pressure Ulcer and Falls MDT Panel • Had not indicated need for enhanced observation/1:1 support prior to incident making the fall unforeseeable • All relevant assessments completed pre fall • No omissions in care identified therefore did not meet SI threshold for reporting • Good examples of nursing care identified and acknowledged • Patient for conservative management and analgesia	Lead Nurse for Falls	31/01/2024	Hot debrief and assessment tool completed and attached to Datix. Findings to be shared with team at safety huddles.

Hospital Standardised Mortality Ratio (HSMR)

Integrated Improvement Plan

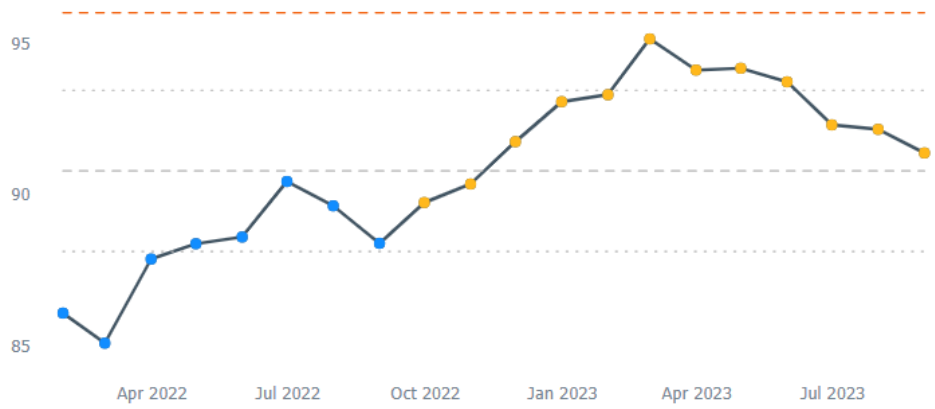
East Kent Hospitals University NHS Foundation Trust

HSMR is a statistical number that enables the comparison of mortality rates between hospitals. This prediction takes account of factors such as the age and sex of the patient, their primary diagnosis, specialist palliative care and social deprivation of the area they live in. It is based on the 56 diagnostic groups which contribute to 80% of in-hospital deaths in England. HSMR is based on the likelihood of a patient dying of the condition with which they were admitted to hospital. If a Trust has an HSMR of 100 it means the number of patients who died is exactly as expected.

HSMR

Timescale	Value	SPC
Oct-22	89.7	
Nov-22	90.3	
Dec-22	91.7	
Jan-23	93.1	
Feb-23	93.3	
Mar-23	95.1	
Apr-23	94.1	
May-23	94.2	
Jun-23	93.7	
Jul-23	92.3	
Aug-23	92.1	
Sep-23	91.4	

XMR Run Chart



Understanding the most recent data point

Performance

91.4 — Variation indicates consistently passing the target

Variation

Variation: Special cause of concerning nature or higher pressure due to higher values

Flags: Above Mean Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
To agree, develop and implement a Trust-wide Fractured Neck of Femur Pathway that will address and improve the eight Key Performance Indicators on the National Hip fracture database	• Confirm comments from WHH regarding fast track process • Launch ring fencing/fast track pilot on Seabathing & Kings C1	• KCVH CG	• Ongoing	• Ongoing work to understand and mitigate risks of recent rise in mortality and identification of surgical site infection.
HSMR by site of discharge (January update): • K&C remains statistically lower than expected: 68.6 • QEQM improved to 'lower than expected': 91.2 • WHH remains 'as expected': 99.0	• Compare new data (January report) with previous and incorporate into current workstreams • Review impact of higher than avg patient complexity (Charlson Comorbidity) score.	• CMO	• Ongoing	• Identified at previous MSSG meeting for further investigation analysis.
WHH Relative Risk is statistically higher than expected for emergency weekday admissions for Acute MI and Pleurisy, pneumothorax, pulmonary collapse. It is also statistically higher than expected for emergency weekend admissions for Skin and subcutaneous tissue infections	• Continue to review and analyse data in MSSG • Identify any areas of concern and develop countermeasures for this to address relative risk above 100.	• CMO	• Ongoing	• Analysis ongoing • Progress noted at November MSSG but not able to finalise analysis at present.

VTE Assessment Compliance

Integrated Improvement Plan

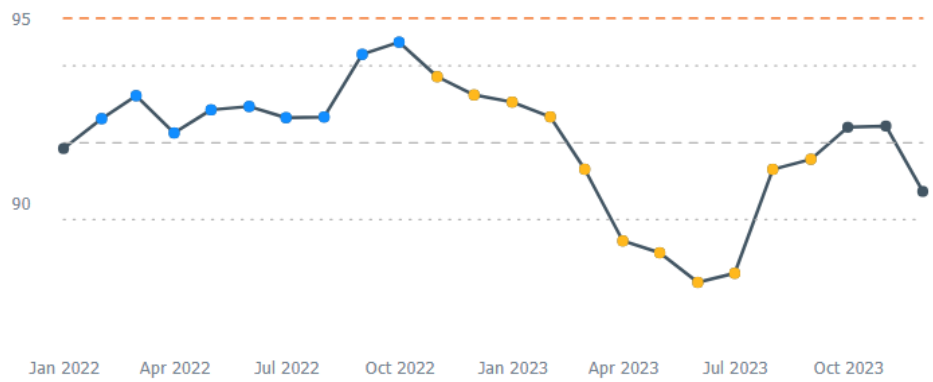
East Kent Hospitals University NHS Foundation Trust

This metric counts the proportion of adults (16+) who have had a Venous Thromboembolism (VTE) risk assessment at any point during their admission. The measure assumes patients in the following cohorts are automatically assigned as compliant; 1. Patients admitted for less than 6 hours, 2. Low-Risk cohort day case patients, 3. Acute medical unit (previously clinical decision units) admissions less than 13 hours & 4. Observation bay admissions less than 24hrs.

VTE Assessment Compliance

Timescale	Value	SPC
Jan-23	92.7%	
Feb-23	92.3%	
Mar-23	90.9%	
Apr-23	89.0%	
May-23	88.6%	
Jun-23	87.8%	
Jul-23	88.1%	
Aug-23	90.9%	
Sep-23	91.2%	
Oct-23	92.0%	
Nov-23	92.1%	
Dec-23	90.3%	

XMR Run Chart



Understanding the most recent data point

Performance

90.3%

Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE

Pressure Ulcers

Integrated Improvement Plan

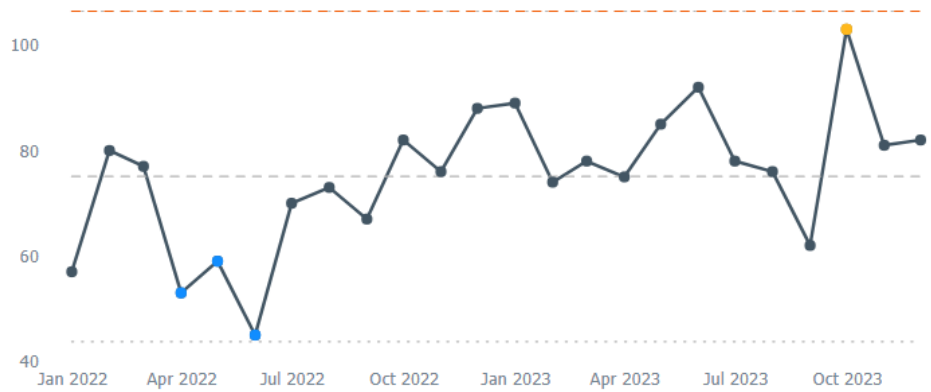
East Kent Hospitals University NHS Foundation Trust

Pressure ulcers (also known as pressure sores or bedsores) are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. They can happen to anyone, but usually affect people confined to bed or who sit in a chair or wheelchair for long periods of time.
This measure counts the number of hospital acquired pressure ulcers graded 1 to 4, inc DTI & Unstageable.
Datasource: DATIX

Pressure Ulcers

Timescale	Value	SPC
Jan-23	89	
Feb-23	74	
Mar-23	78	
Apr-23	75	
May-23	85	
Jun-23	92	
Jul-23	78	
Aug-23	76	
Sep-23	62	
Oct-23	103	
Nov-23	81	
Dec-23	82	

XMR Run Chart



Understanding the most recent data point

Performance

82

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)
Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Inaccurate Risk assessment resulting in delays or inappropriate pressure ulcer (PU) prevention interventions	• To rollout PURPOSE T risk assessment to replace Waterlow trust wide. • Risk assessment section included in all Tissue Viability Training • Discussed at monthly TV champion WEBEX meetings in November and December.	• Lead TVN Specialist.	• Trust wide Rollout Jan 2024	• Training has been completed in both EDs • Maternity: to commence training underway. • AMU training commenced • To be rolled out on Sunrise firstly at K&C in January 2024
Increased pressure damage noted to the face from the increased use of Oxygen therapy	• PURPOSE T risk assessment, will provide prompts to examine all areas susceptible to damage. Includes section on medical devices not considered on previous risk assessment tool. • Medical Device care bundle updated and disseminated.	• Tissue Viability Team	• Jan 2024	• Discussed at Bi annual tissue Viability Study day. • Trust wide Stop the Pressure awareness campaign in November. • Requested for the medical device care bundle to be uploaded to Tissue Viability Intranet page.
Key issue in delayed skin inspection.	• Ward audits for areas with ward based teaching as targeted approach. • PURPOSE T documentation continues detailed prompt for skin inspection including areas such as elbows, ankles that are often missed.	• Lead TVN Specialist.	• Feb 2024	• New document has been uploaded to Allscripts. • Discussion at latest Bi annual Tissue Viability Study Day • As per the progress of PURPOSE T rollout. • TV team conducting spot check skin checks.

Falls

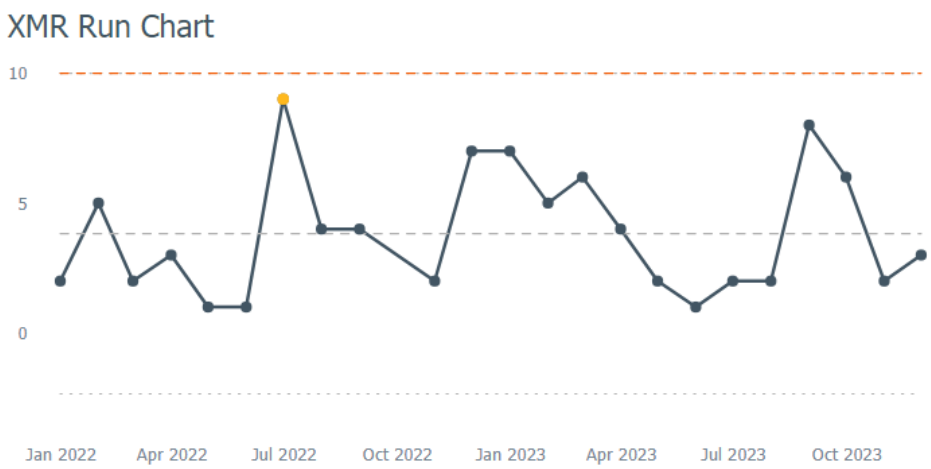
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Falls in hospital are the most commonly reported patient safety incidents, with more than 280,000 safety incidents reported in inpatient settings in England every year. Falls in older people are more likely to result in harm and when harm occurs it is three times more likely to be severe.
This metric measures the number of reported incidents classified as falls where a harm level of moderate or above was identified.
Datasource: Datix

Falls

Timescale	Value	SPC
Jan-23	7	
Feb-23	5	
Mar-23	6	
Apr-23	4	
May-23	2	
Jun-23	1	
Jul-23	2	
Aug-23	2	
Sep-23	8	
Oct-23	6	
Nov-23	2	
Dec-23	3	



Understanding the most recent data point

Performance

3

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)
Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
One severe harm fall resulting in fractured neck of femur. Lack of Enhanced observations.	• Embed cohort culture across EKHUFT • Embed yellow tabards • Embed door bell help system • Collaboration with safeguarding to deliver targeted training	• Lead Nurse for Falls • CNS	• April 2024 • Ongoing	• Discussions with care group leads. Roll out of tabard and door bell system has commenced. • Safeguarding lead has been unable to arrange targeted training collaboration. To review in January 2024.
Increase in unwitnessed falls continues, particularly at QEQM. Repeat unwitnessed patient falls in our most vulnerable patients.	• Embed cohort culture across EKHUFT • Collaborative working of specialist teams including dementia and safeguarding team. • Provision of targeted support by Falls team.	• Lead Nurse for Falls • CNS	• April 2024	• Discussions with care group leads and areas have begun to roll out tabard and door bell system. • Discussions with specialist teams continue to support enhanced care. • Targeted support by Falls team provided to areas with high levels of unwitnessed falls.
Inability to embed consistent change through learning from incidents. Limitations to deliver targeted training.	• Identify high risk areas with repeat harm events and deliver consistent support. • CNS presence to support clinical areas trust wide	• Lead Nurse for Falls • CNS	• July 2024 • July 2024	• Roll out of training trust wide, one clinical area at one time. Limitations due to priority of work load. • Lead nurse and CNS cross site support where able.

Incident Reporting

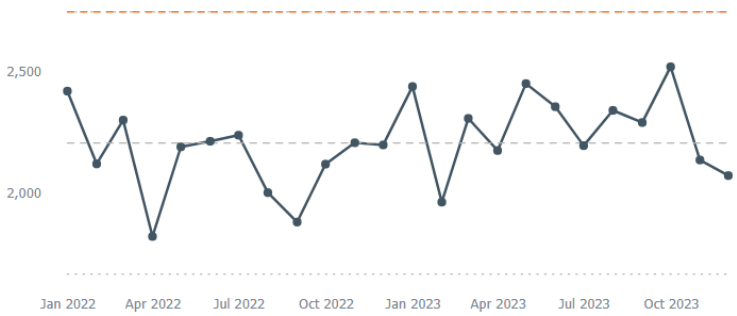
Statutory Metrics

NHS
East Kent Hospitals University
NHS Foundation Trust

Clinical Incidents

Timescale	Value	SPC
Jan-23	2,436	
Feb-23	1,961	
Mar-23	2,305	
Apr-23	2,173	
May-23	2,448	
Jun-23	2,353	
Jul-23	2,193	
Aug-23	2,338	
Sep-23	2,288	
Oct-23	2,517	
Nov-23	2,134	
Dec-23	2,070	

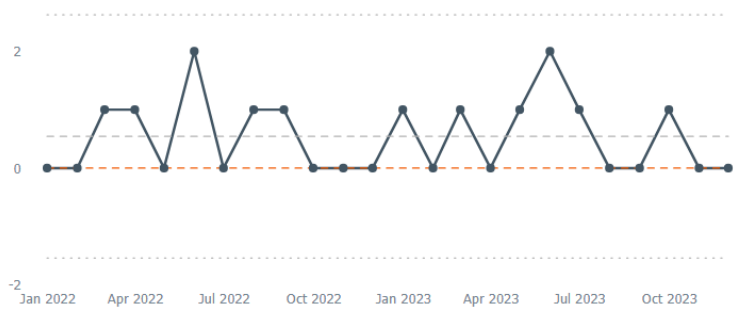
XMR Run Chart



Never Events

Timescale	Value	SPC
Jan-23	1	
Feb-23	0	
Mar-23	1	
Apr-23	0	
May-23	1	
Jun-23	2	
Jul-23	1	
Aug-23	0	
Sep-23	0	
Oct-23	1	
Nov-23	0	
Dec-23	0	

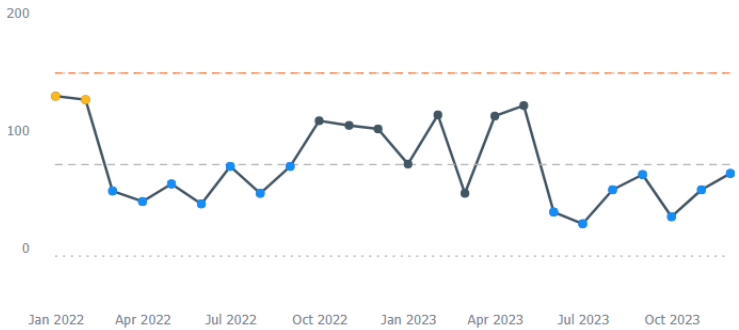
XMR Run Chart



Mixed Sex Breaches

Timescale	Value	SPC
Jan-23	71	
Feb-23	113	
Mar-23	46	
Apr-23	112	
May-23	121	
Jun-23	30	
Jul-23	20	
Aug-23	49	
Sep-23	62	
Oct-23	26	
Nov-23	49	
Dec-23	63	

XMR Run Chart



PERFORMANCE UPDATE

Clinical Incident reporting continues to show common cause variation and no significant change. It remains below the upper threshold set for clinical incidents. Ensuring that no-harm events are scrutinised gives assurance that all of these events are captured.

There were no never events in December 2024.

Duty of Candour

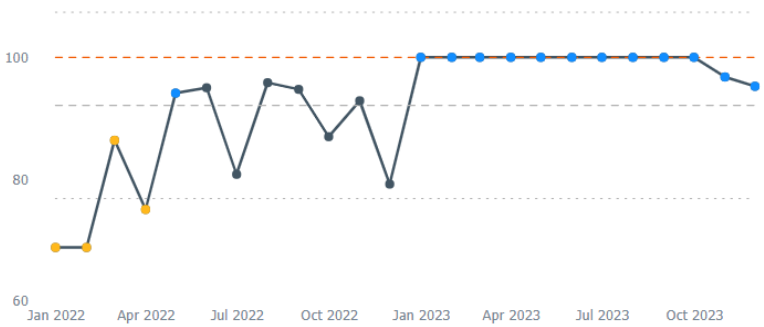
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Duty of Candour - Verbal

Timescale	Value	SPC
Jan-23	100%	
Feb-23	100%	
Mar-23	100%	
Apr-23	100%	
May-23	100%	
Jun-23	100%	
Jul-23	100%	
Aug-23	100%	
Sep-23	100%	
Oct-23	100%	
Nov-23	96.8%	
Dec-23	95.2%	

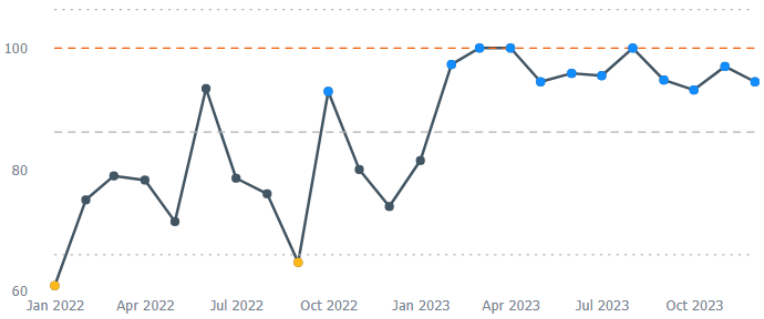
XMR Run Chart



Duty of Candour - Written 15wd

Timescale	Value	SPC
Jan-23	81.5%	
Feb-23	97.3%	
Mar-23	100%	
Apr-23	100%	
May-23	94.4%	
Jun-23	95.8%	
Jul-23	95.5%	
Aug-23	100%	
Sep-23	94.7%	
Oct-23	93.1%	
Nov-23	97.0%	
Dec-23	94.4%	

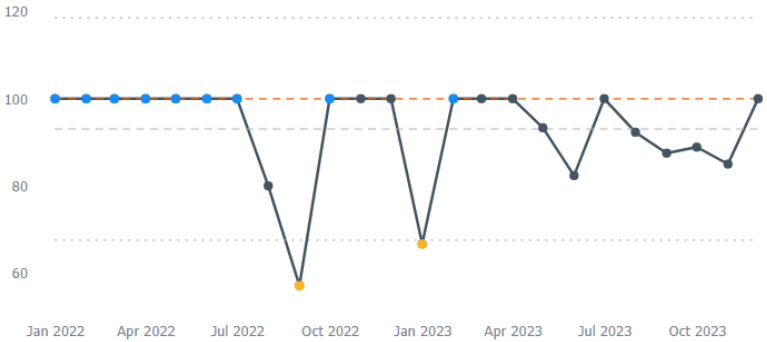
XMR Run Chart



Duty of Candour - Findings

Timescale	Value	SPC
Jan-23	66.7%	
Feb-23	100%	
Mar-23	100%	
Apr-23	100%	
May-23	93.3%	
Jun-23	82.4%	
Jul-23	100%	
Aug-23	92.3%	
Sep-23	87.5%	
Oct-23	88.9%	
Nov-23	85.0%	
Dec-23	100%	

XMR Run Chart



PERFORMANCE UPDATE

Verbal Duty of Candour 95.2% compliant. One outstanding WHHCG DoC, arrangements being made to complete.

Written DoC within 15 working days non-compliance in 1 case, but was fully completed within 20 days.

The final DoC letter which accompanies the completion of the investigation report was 100% compliant

Twice weekly meetings between Governance leads and Heads of Patient Safety continue to address non-compliance and barriers to completion.

Complaints

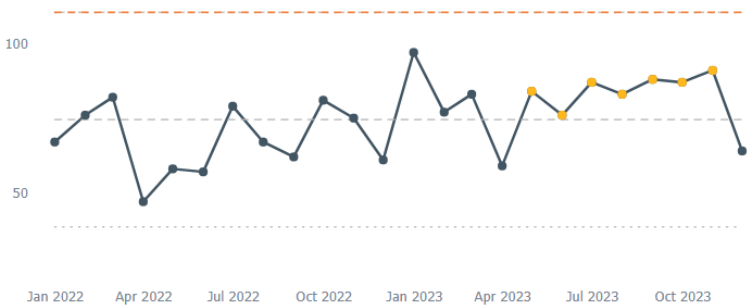
Statutory Metrics

East Kent Hospitals University Trust

Complaints Number

Timescale	Value	SPC
Jan-23	97	
Feb-23	77	
Mar-23	83	
Apr-23	59	
May-23	84	
Jun-23	76	
Jul-23	87	
Aug-23	83	
Sep-23	88	
Oct-23	87	
Nov-23	91	
Dec-23	64	

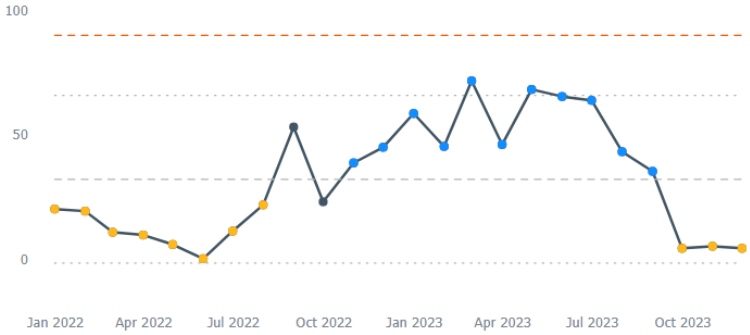
XMR Run Chart



Complaint Response

Timescale	Value	SPC
Jan-23	58.5%	
Feb-23	45.2%	
Mar-23	71.6%	
Apr-23	46.0%	
May-23	68.2%	
Jun-23	65.3%	
Jul-23	63.8%	
Aug-23	43.1%	
Sep-23	35.2%	
Oct-23	4.2%	
Nov-23	5.0%	
Dec-23	4.2%	

XMR Run Chart



PERFORMANCE UPDATE

December 2023 saw 838 contacts to the department resulting in 64 new formal complaints and 366 new PALS contacts being taken forward. 7.5% of contacts in December 2023 were taken forward as new formal complaints. 92% of the new complaints were acknowledged within three working days, this is above the target of 90%.

As a seasonal comparison, in December 2022 there was 63 complaints and 505 PALS; a 1.6% increase in complaints. This equates to a 27.5% decrease in new PALS cases. Between November 2022 to April 2023, the PALS team set up the temporary Waiting Patient Service, as part of the service review projects coming out of the Covid-19 pandemic. The service dealt with enquiries about delays to surgery and waiting times. In April 2023 this service was closed and the resource withdrawn from PALS. During this period the Waiting Patient contacts were recorded as PALS and this reflects the increased number of PALS recorded during December 2022.

The month of December, prior to the pandemic, had been historically a quieter month for complaints and PALS, which appears to be the case for December 2023.
December 2023 saw a slight decrease in performance of responses within timescales from 5% in November 2023 to 4%.

There continues to be, albeit slight, an increase in the number of new complaints. The complexity of the complaints continues to impact on complaint response performance.
The drive by the CNMO to ensure the quality of complaints responses continues. This was reinforced by a complaints report submitted to CEMG in early December 2023, to outline the project and actions being taken to improve complaints standards and performance.

The care groups are being supported by two interims in post to help improve their responses. A training programme has been started and a master class, with more specialist training for governance staff will start this month.

Safeguarding

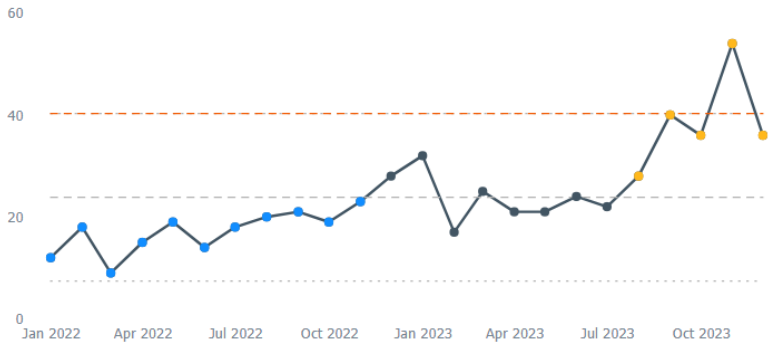
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Safeguarding Incidents

Timescale	Value	SPC
Jan-23	32	
Feb-23	17	
Mar-23	25	
Apr-23	21	
May-23	21	
Jun-23	24	
Jul-23	22	
Aug-23	28	
Sep-23	40	
Oct-23	36	
Nov-23	54	
Dec-23	36	

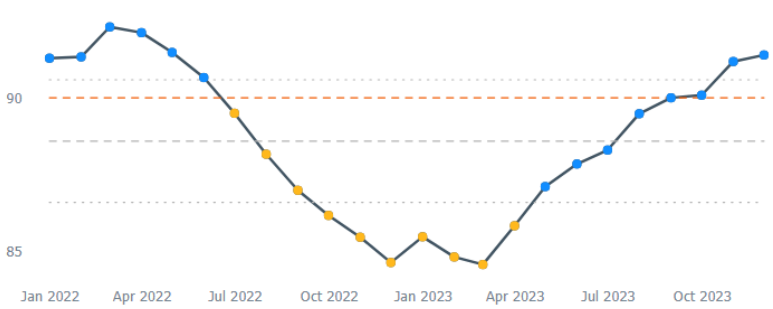
XMR Run Chart



Safeguarding Children Training

Timescale	Value	SPC
Jan-23	85.5%	
Feb-23	84.8%	
Mar-23	84.6%	
Apr-23	85.8%	
May-23	87.1%	
Jun-23	87.8%	
Jul-23	88.3%	
Aug-23	89.5%	
Sep-23	90.0%	
Oct-23	90.1%	
Nov-23	91.2%	
Dec-23	91.4%	

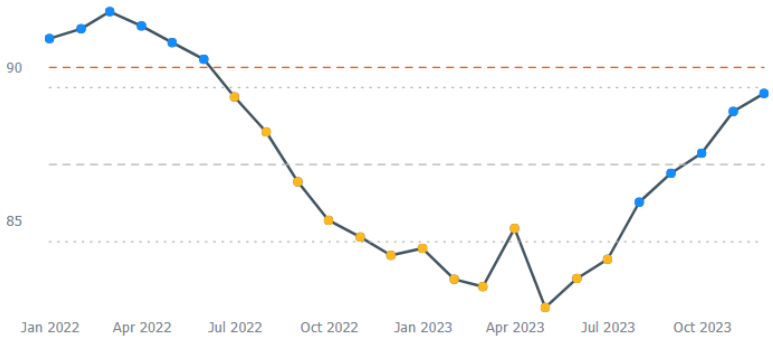
XMR Run Chart



Safeguarding Adults Training

Timescale	Value	SPC
Jan-23	84.1%	
Feb-23	83.1%	
Mar-23	82.9%	
Apr-23	84.8%	
May-23	82.2%	
Jun-23	83.1%	
Jul-23	83.7%	
Aug-23	85.6%	
Sep-23	86.5%	
Oct-23	87.2%	
Nov-23	88.6%	
Dec-23	89.1%	

XMR Run Chart



PERFORMANCE UPDATE

The reporting of all safeguarding metrics is outlined in the Business report and safeguarding dashboard with KPIs. This report goes to the Safeguarding Operational Group with exception to the Safeguarding Assurance Committee. Safeguarding metrics were also reported in the last Schedule 4 to the ICB.

The number of safeguarding concerns raised has remained consistent across the Trust in December in line with seasonal variants. The highest catergory of incidents related to neglect .

Following the last report, the outstanding S42s have been sourced out and 40 of these were completed by the and of December. The Safeguarding team continue to complete new requests. There continues to be a delay in receiving Terms of Reference from the local authority and that has had an impact on the completion of reports. The interim Head of Safeguarding is meeting with the ICB and the Director of Safeguarding in the Local Authority to identify a process of assessing and expediting the S42 investigations. In the New Year, the completion od S42s will be handed back to the care groups and support is being provided to enable this transition and meet the statutory responsibility of 'Making Safeguarding Personal'

With regards to training, compliance at level 2 for both children and adults and level 3 children across the Trust is above the agreed local level of **85% in line with national level** (end of Dec compliance). Level 3 adult compliance is currently 77%.

There has been some improvements by Care Group, the safeguarding team has increased the number of training weekly and training is delivered jointly with the 'Think Family' ethos

Training is on the Trust Safeguarding Risk Register and progress is presented monthly at the ICB oversight meetings and the CQC must do requirements relating to safeguarding training. A recovery plan for training was presented at the last oversight meeting with trajectories for achieving required standard

IPC - Infections

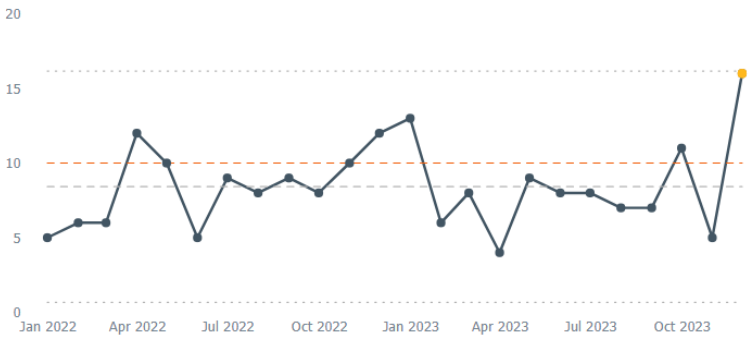
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

IPC: EColi Infections

Timescale	Value	SPC
Jan-23	13	
Feb-23	6	
Mar-23	8	
Apr-23	4	
May-23	9	
Jun-23	8	
Jul-23	8	
Aug-23	7	
Sep-23	7	
Oct-23	11	
Nov-23	5	
Dec-23	16	

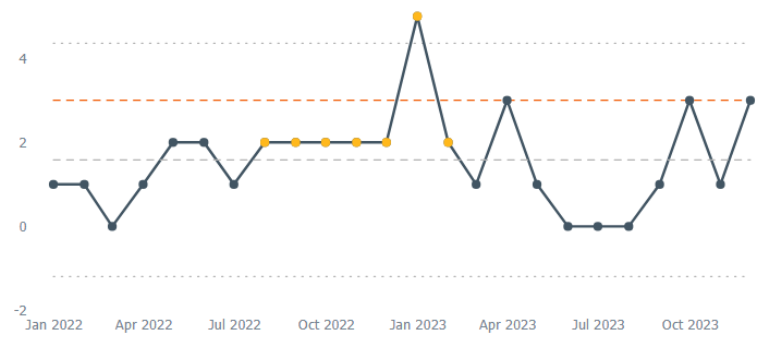
XMR Run Chart



IPC: Pseudomonas Infections

Timescale	Value	SPC
Jan-23	5	
Feb-23	2	
Mar-23	1	
Apr-23	3	
May-23	1	
Jun-23	0	
Jul-23	0	
Aug-23	0	
Sep-23	1	
Oct-23	3	
Nov-23	1	
Dec-23	3	

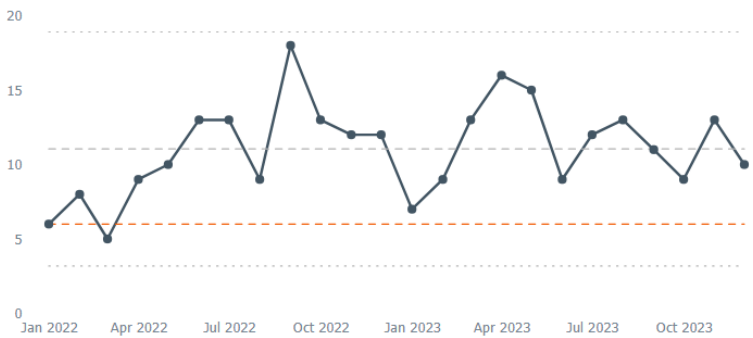
XMR Run Chart



IPC: CDiff Infections

Timescale	Value	SPC
Jan-23	7	
Feb-23	9	
Mar-23	13	
Apr-23	16	
May-23	15	
Jun-23	9	
Jul-23	12	
Aug-23	13	
Sep-23	11	
Oct-23	9	
Nov-23	13	
Dec-23	10	

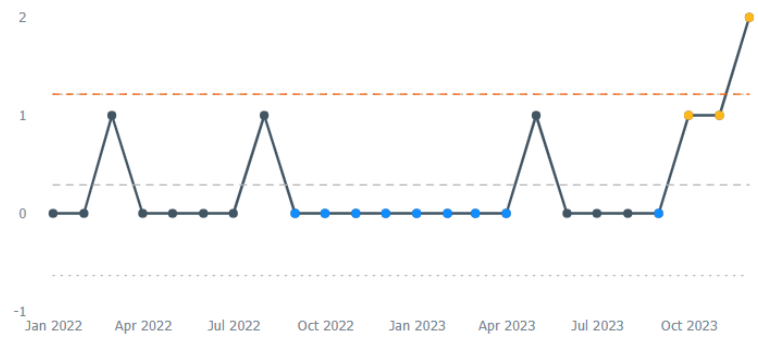
XMR Run Chart



IPC: MRSA Infections

Timescale	Value	SPC
Jan-23	0	
Feb-23	0	
Mar-23	0	
Apr-23	0	
May-23	1	
Jun-23	0	
Jul-23	0	
Aug-23	0	
Sep-23	0	
Oct-23	1	
Nov-23	1	
Dec-23	2	

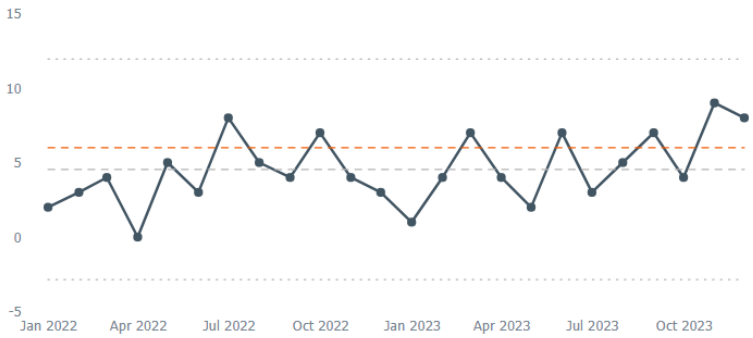
XMR Run Chart



IPC: Klebsiella Infections

Timescale	Value	SPC
Jan-23	1	
Feb-23	4	
Mar-23	7	
Apr-23	4	
May-23	2	
Jun-23	7	
Jul-23	3	
Aug-23	5	
Sep-23	7	
Oct-23	4	
Nov-23	9	
Dec-23	8	

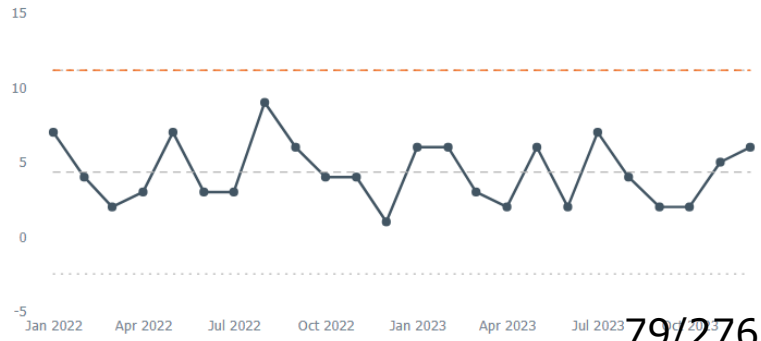
XMR Run Chart



IPC: MSSA Infections

Timescale	Value	SPC
Jan-23	6	
Feb-23	6	
Mar-23	3	
Apr-23	2	
May-23	6	
Jun-23	2	
Jul-23	7	
Aug-23	4	
Sep-23	2	
Oct-23	2	
Nov-23	5	
Dec-23	6	

XMR Run Chart



IPC - Infections

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

PERFORMANCE UPDATE

Performance against trajectories for the gram negative bacteraemias remains above threshold, with ongoing monitoring and local actions underway where incidences occur.

- A focussed improvement project in K&C has successfully reduced Klebsiella infections in urology wards, so will be rolled out across the site then Trust.
- A joint cross profession training programme for care of lines used for feeding successfully reduced line infections in K&C, so has now been rolled out to both WHH and QEQM.

The apparent 'spike' in infections this month appears to have been brought about by community onset infections, which have previously not been reported in this manner. Whilst E-coli remains above trajectory for the national target threshold, the rates have reduced by 15% compared to the same time last year. Klebsiella however has increased significantly, predominantly associated with urinary tract infections, therefore teams are targeting improvements in these areas.

The Trust has now breached the threshold for C-dif this year by 27 cases. C-dif rates remain a national and regional concern, with other local Trusts reporting similar rates to ours, the Trust are active participants in the regional c-dif reduction collaborative lead by the ICB. All cases are reviewed for learning, and the main focus remains antimicrobial stewardship and environment and equipment cleaning.

MSSA bacteraemias continue to be within parameters, and we are still seeing a reduction compared to the previous year. The apparent spike in MRSA bacteraemias is due to 2 cases, one an outpatient, who had been treated, and joint investigation underway with the Trust and community, and the second a Trust apportioned case, to be fully investigated.

IPC – Training Compliance

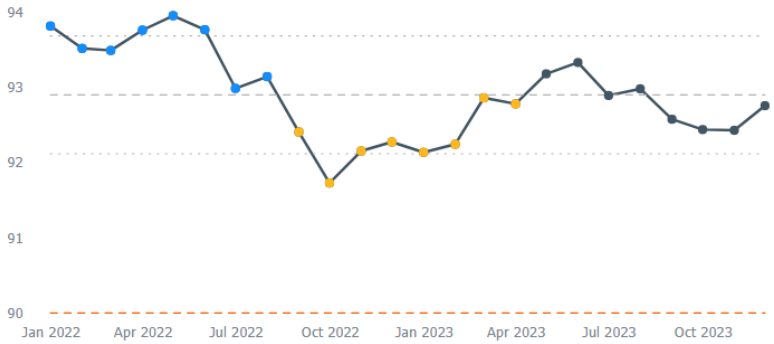
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Infection Control Training

Timescale	Value	SPC
Jan-23	92.1%	
Feb-23	92.2%	
Mar-23	92.9%	
Apr-23	92.8%	
May-23	93.2%	
Jun-23	93.3%	
Jul-23	92.9%	
Aug-23	93.0%	
Sep-23	92.6%	
Oct-23	92.4%	
Nov-23	92.4%	
Dec-23	92.8%	

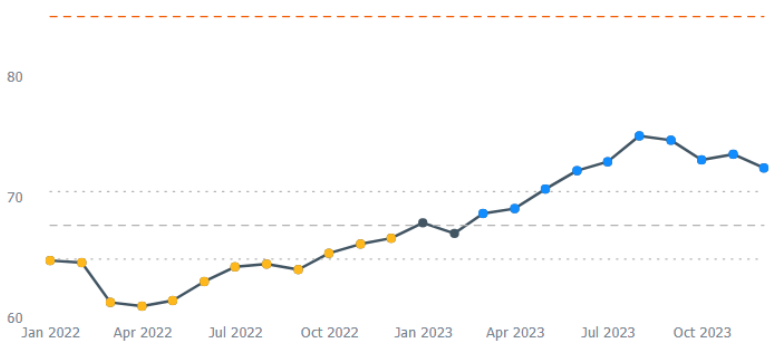
XMR Run Chart



Hand Hygiene Training

Timescale	Value	SPC
Jan-23	67.9%	
Feb-23	67.0%	
Mar-23	68.7%	
Apr-23	69.1%	
May-23	70.7%	
Jun-23	72.2%	
Jul-23	73.0%	
Aug-23	75.1%	
Sep-23	74.7%	
Oct-23	73.1%	
Nov-23	73.6%	
Dec-23	72.4%	

XMR Run Chart



PERFORMANCE UPDATE

The Trust compliance with Infection prevention and control training remains at a good level , the IPC team are supporting areas where compliance is lower.

Hand Hygiene training is undertaken annually by all patient facing staff, rates continue to fluctuate, as many areas had 'en masse' training, and are out of date at once. Currently the IPC team are focussing those areas with the least amount of compliant staff, and about to embark on a hand hygiene campaign. Focus continues on ensuring there are adequate staff trained to complete the hand hygiene training within the clinical settings, and the IPC team support local link workers in completing this.

Friends & Family Test

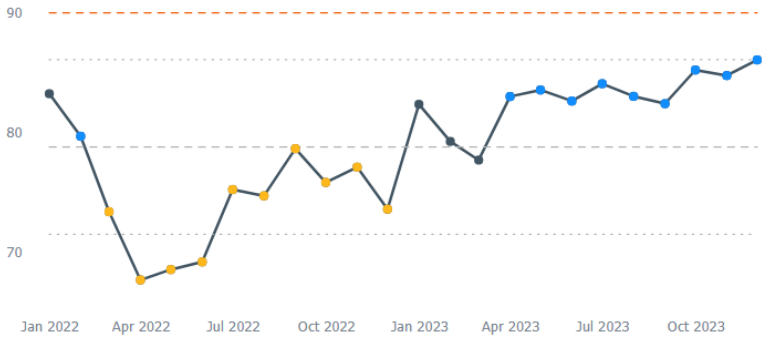
Statutory Metrics

NHS
East Kent
Hospitals University
NHS Foundation Trust

FFT Satisfaction Level - ED

Timescale	Value	SPC
Jan-23	82.4%	
Feb-23	79.3%	
Mar-23	77.7%	
Apr-23	83.0%	
May-23	83.6%	
Jun-23	82.6%	
Jul-23	84.1%	
Aug-23	83.0%	
Sep-23	82.4%	
Oct-23	85.2%	
Nov-23	84.8%	
Dec-23	86.1%	

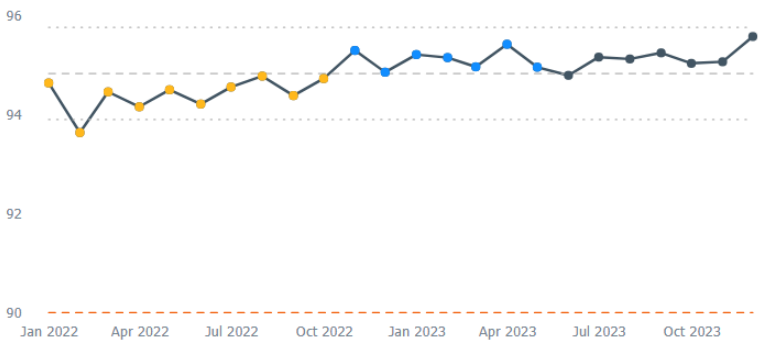
XMR Run Chart



FFT Satisfaction Level - Outpatient

Timescale	Value	SPC
Jan-23	95.2%	
Feb-23	95.2%	
Mar-23	95.0%	
Apr-23	95.4%	
May-23	95.0%	
Jun-23	94.8%	
Jul-23	95.2%	
Aug-23	95.1%	
Sep-23	95.2%	
Oct-23	95.0%	
Nov-23	95.1%	
Dec-23	95.6%	

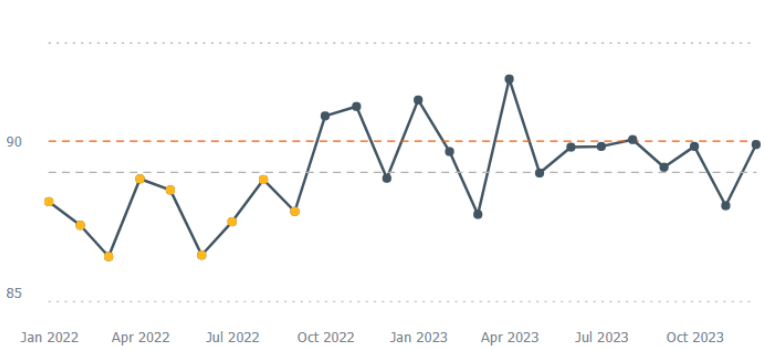
XMR Run Chart



FFT Satisfaction Level - Inpatient

Timescale	Value	SPC
Jan-23	91.4%	
Feb-23	89.7%	
Mar-23	87.6%	
Apr-23	92.1%	
May-23	88.9%	
Jun-23	89.8%	
Jul-23	89.8%	
Aug-23	90.0%	
Sep-23	89.1%	
Oct-23	89.8%	
Nov-23	87.9%	
Dec-23	89.9%	

XMR Run Chart



PERFORMANCE UPDATE

The trust's overall satisfaction level has remained over our target level of 90% for the past two years. **In December 2023 it was 93.6%.** Looking at overall satisfaction by hospital Care Groups, it varied from 90.5% for WHH Care Group to 90.4% at QEQM Care Group and 95.8% for K&CH/RVH Care Group.

For out-patients the satisfaction level was 95.6% overall, a slight increase. This is based on 10,499 responses – 20.4% of people sent the FFT survey. The highest satisfaction level was at Buckland Hospital – 97.5% and lowest at William Harvey 95.1%. QEQM was 95.2%, Kent and Canterbury was 95.9% and Royal Victoria was 97.3%. Whilst satisfaction levels with clinical care remain high, the less positive themes include time waiting to be seen on site, buildings and facilities and administration.

For in-patients the overall satisfaction score across the three sites was 89.9%, a 2% increase compared to November. This is based on 897 responses, which is 18.1% of those sent the FFT survey. The highest satisfaction level for in-patients was 95.9% at Kent and Canterbury, followed by 90.6% at QEQM and 85.6 at William Harvey. Triangulation of theming from FFT, the national in-patient survey and our Trust in-patient survey shows that patients are dissatisfied with the discharge process and information given when leaving hospital.

For Urgent and Emergency Care our FFT satisfaction level in November was 86.1% overall, which is an increase of 1.3% overall. When breaking this down by site, QEQM ED scored 85.1%, William Harvey ED scored 82.3% , KCH Urgent Treatment Centre scored 91.5%, and Buckland UTC scored 96.6%.

How we compare with national data:

The most recent national data available is for November 2023. For Emergency Departments, Urgent Treatment Centres and Minor Injury Units the overall satisfaction level nationally is 79%. **This means our Urgent and Emergency Care satisfaction level is 6.1% higher than nationally.**

For in-patient care, the **national** satisfaction level is **94%** and for outpatient care it is **94%.** Therefore, our satisfaction level for in-patients in November of **89.9% overall is significantly lower** and for outpatients at **95.6% overall** is slightly higher.

Friends and Family Test free text comments: the qualitative data (patient's comments) is a rich source of insight that satisfaction levels alone do not give. Our FFT Theming Tracker enables our services to theme free text comments as positive or negative and by subject. In December 2023, the top positive themes were care given by staff, communication, staff attitude, and quality of treatment. The most common negative themes were waiting time to be seen on site, poor communication and information, and buildings/facilities.

East Kent Hospitals University NHS Foundation Trust

People

People, Leadership & Culture

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
People	IIP		Sickness		5.0%	5.1%	4.9%	5.1%	4.3%	4.0%	4.2%	4.6%	4.7%	4.9%	5.2%	5.2%	5.8%
	IIP		Vacancy Rate		10.0%	9.1%	8.7%	8.4%	8.2%	8.2%	7.9%	7.2%	7.9%	7.4%	6.7%	7.5%	7.7%
	IIP		Staff Turnover Rate		10.0%	10.0%	9.9%	10.0%	9.8%	9.7%	9.6%	9.5%	9.2%	9.0%	9.1%	9.1%	9.3%
	IIP		Premature Turnover Rate		25.0%	15.1%	15.1%	15.0%	15.0%	14.1%	14.0%	13.8%	13.7%	13.3%	13.6%	13.9%	14.7%
	IIP		Staff Engagement Score		6.80	6.17	6.17	6.17	6.20	6.20	6.20	6.27	6.27	6.27			
	IIP		Statutory Training		91.0%	90.5%	90.5%	91.0%	91.4%	91.9%	91.9%	91.7%	92.1%	91.9%	90.1%	90.6%	90.8%
	IIP		Infection Control Training		90.0%	92.1%	92.2%	92.9%	92.8%	93.2%	93.3%	92.9%	93.0%	92.6%	92.4%	92.4%	92.8%
	IIP		Hand Hygiene Training		85.0%	67.9%	67.0%	68.7%	69.1%	70.7%	72.2%	73.0%	75.1%	74.7%	73.1%	73.6%	72.4%
	IIP		Medical Job Planning Rate		90.0%	50.1%	31.2%	38.3%	46.4%	50.4%	50.5%	58.7%	52.3%	58.1%	60.3%	58.3%	58.8%

December Performance Summary

People Metrics: Sickness absence has increased further and now sits considerably above the alerting threshold at 5.8%. This appears to be a system-level challenge, with the K&M People Programme Board reporting a similar increase (of 0.3%) - and counterparts in MFT and KCHFT reporting a similar position. Stress, anxiety & depression continues to represent the primary reason for sickness. To begin to deliver improvement (and mitigate any further rises), steps have been taken to re-introduce on-site clinical psychology from 13/02/24. Vacancy rate has, again, increased slightly to 7.7% following recent improvements and is being monitored closely by HoPC. Whilst staff turnover (9.3%) continues to achieve a gold standard position (10%), it is risen for a third month in succession and appears to be stabilising at/around 9.3%. Premature turnover has also risen and now sits just below the new performance standard (15%). Almost a third (29%) of this turnover is coming from one Care Group (Diagnostics, Cancer & Buckland). Statutory training rates have improved again and are now 0.2% away from the desired threshold. Compliance for medical staff remain significantly (17%) below the expected threshold.

Engagement Metrics: The 2023 National Staff Survey results have now been received, albeit under the national embargo. It is possible to report that there has been significant improvement against over a quarter of all questions and no significant deterioration against a single question. Staff Engagement has improved again (from Q2 to Q3) and returned to levels seen in NSS 22. There have been marked improvements in; appraisals, learning & development, work-life balance and line management. Challenges remain against; advocacy, raising concerns and some cultural markers. More granular detail can be provided when the national embargo is lifted in March.

Leadership Metrics: There has been further deterioration against markers of advocacy in Q3. It represents the only domain of staff engagement that isn't improving or stabilising – and is furthest from the national standard. Further question-level detail can be provided when the national embargo is lifted in March. Following a deep-dive in 2023, it is recommended that We Care is rolled out across further frontline teams. There was clear evidence to demonstrate advocacy levels are significantly higher in We Care areas against their non-We Care counterparts.

Staff Sickness

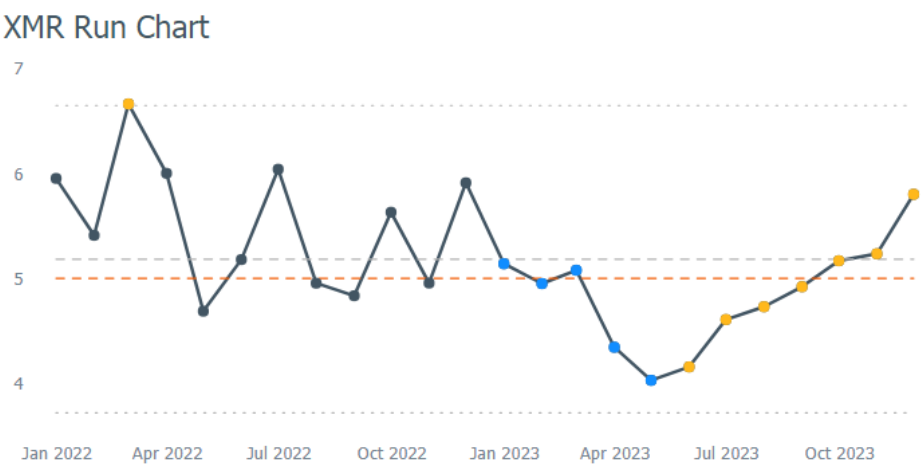
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The percentage of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs).
Data Source: Healthroster, eRostering for the current month (unvalidated) with previous months using the validated position from ESR.

Sickness

Timescale	Value	SPC
Jan-23	5.1%	
Feb-23	4.9%	
Mar-23	5.1%	
Apr-23	4.3%	
May-23	4.0%	
Jun-23	4.2%	
Jul-23	4.6%	
Aug-23	4.7%	
Sep-23	4.9%	
Oct-23	5.2%	
Nov-23	5.2%	
Dec-23	5.8%	



Understanding the most recent data point

Performance

5.8%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Special cause of concerning nature or higher pressure due to higher values

Flags: Ascending Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining **sickness absence** below 5%, and improved against our fellow Trusts in the ICB	• Working with NHSEI on the Absence Tool Kit to review current sickness management processes and develop actions for improvement.	• Heads of P&C, P&CBPs	• Mar 24	• Sickness Absence policy relaunched. Agreed removal of loop holes to support more effective and timely absence management. Comms re: sickness absence are being circulated and training updated.
Keeping Anxiety & Stress related absence to a minimum, and below 15% of all absences.	• Support from Health & Wellbeing Team and Occ Health to focus on areas of high stress related sickness. Improved Return To Work interviews to support intervention.	• Heads of P&C, P&CBPs, OH	• Ongoing	• Pro-Active Sickness Absence Working Group set up, improved support through EAP for anxiety and adding in support for H&W through training Connectors. Reintroduction of Clinical Psychology from February 24.
Improved pro-active absence management	• New P&C Care Group Teams to focus on absences through a Care Group deep dive, and P&C support.	• P&C Care Group Teams	• Ongoing	• Additional resource added in for 12 month focus on Sickness Absence with each Care Group identifying the target areas.

Staff Vacancy Rate

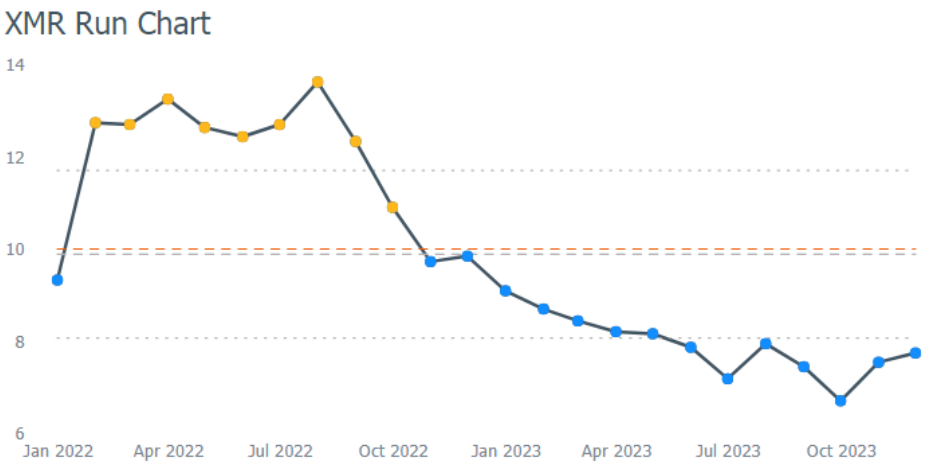
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The proportion of vacant positions against the number of Whole Time Equivalent (WTE) funded establishment.
Datasource: ESR

Vacancy Rate

Timescale	Value	SPC
Jan-23	9.1%	
Feb-23	8.7%	
Mar-23	8.4%	
Apr-23	8.2%	
May-23	8.2%	
Jun-23	7.9%	
Jul-23	7.2%	
Aug-23	7.9%	
Sep-23	7.4%	
Oct-23	6.7%	
Nov-23	7.5%	
Dec-23	7.7%	



Understanding the most recent data point

Performance

7.7%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Special cause of improving nature or lower pressure due to lower values

Flags: Below Mean Run Group
Astronomical Point
Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring vacancy rate remains below the Trust threshold of 10%.	• Monthly monitoring of vacancies across Care Groups, ensuring that active recruitment is taking place.	• Heads of P&C • P&CBPs	• Ongoing	• Working with Finance, Temp Staffing and CMO office to target areas of long term and high cost medical agency, and alternative ways of working.
Reduction in Premium Pay by focusing on hard to recruit roles.	• Workforce Strategies developed for care Groups, focusing on those areas with hard to recruit posts, and a plan to address this.	• Strategic Workforce Lead • Heads of P&C • P&CBPs	• Mar 24	• Hard to recruit roles out to advert with social media campaigns. Support from ID Medical. ID Medical meeting with HOP&C and care Group Tri's to target areas for improvement.
Minimising risk of turnover by improving retention and reducing time to hire.	• Focus on time to hire, with Dashboard set up to monitor.	• Head of Resourcing	• Ongoing	• Time to hire reduced to 8 weeks. • Band 5 Nursing vacancy rate down to 8.1% - lowest level in 5 years • HCSW vacancy rate down

Staff Turnover Rate

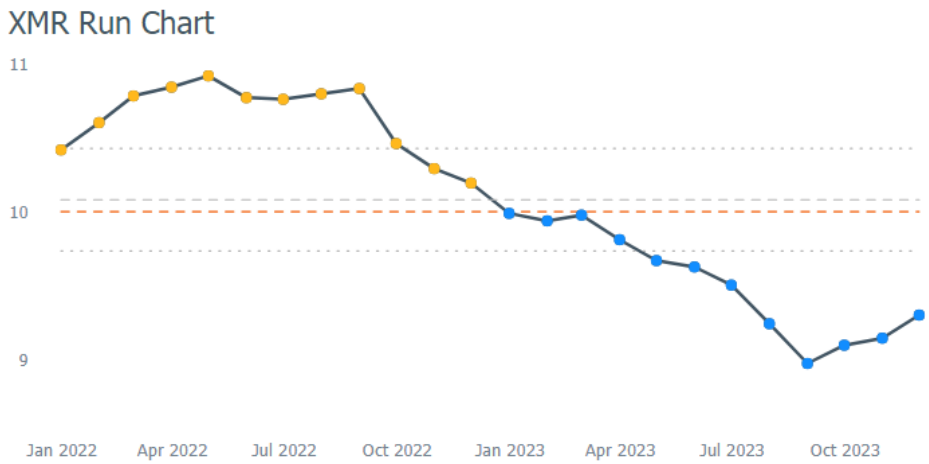
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The number of staff leaving & joining the Trust against Whole Time Equivalent (WTE).
Metric excludes; Doctors in training, fixed term and bank staff and the following leaving reasons, Death in Service, Employee Transfer, Dismissal, Flexi Retirement, Pregnancy & Redundancy.

Staff Turnover Rate

Timescale	Value	SPC
Jan-23	10.0%	
Feb-23	9.9%	
Mar-23	10.0%	
Apr-23	9.8%	
May-23	9.7%	
Jun-23	9.6%	
Jul-23	9.5%	
Aug-23	9.2%	
Sep-23	9.0%	
Oct-23	9.1%	
Nov-23	9.1%	
Dec-23	9.3%	



Understanding the most recent data point

Performance

9.3%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Special cause of improving nature or lower pressure due to lower values

Flags: Below Mean Run Group
Astronomical Point
Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining **Staff Turnover** against a gold standard of 10%	• Improving HCSW, Nurse & Premature retention which are the main contributors to overall turnover	• Head of Staff Experience	• Ongoing	• Staff Turnover has achieved the gold standard (10%) for over a year and is showing signs of stabilising/ inflecting upwards. It is currently at **9.3%**.
Maintaining **Nurse Turnover** against a gold standard of 10%	• Implementation of actions against the Nursing Workforce Retention Action plan	• Associate Director of Nursing	• Ongoing	• Nurse Turnover continues to improve and has been outperforming the target (10%) for >18 consecutive months. It now stands at **8.5%.**
Reducing **Healthcare Support Worker** Turnover below 13.5%	• Introduction of the HCSW Voice Programme and continued delivery of the Ready to Care programme	• Matron for Recruitment & Career Dev.	• Ongoing	• HCSW Turnover has been improving for around 18 months and appears to be stabilising at/ around **11.4%** - achieving the desired standard.

Premature Staff Turnover Rate

Integrated Improvement Plan

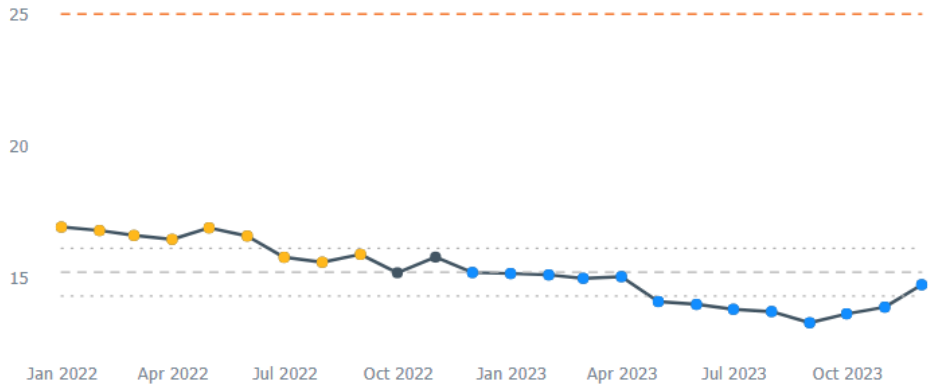
NHS
East Kent Hospitals University
NHS Foundation Trust

The number of staff leaving the Trust within their first year of employment as a proportion of the total number of staff in the organisation with less than 12 months' service.
Metric excludes; Doctors in training, fixed term and bank staff and the following leaving reasons, Death in Service, Employee Transfer, Dismissal, Flexi Retirement, Pregnancy & Redundancy.

Premature Turnover Rate

Timescale	Value	SPC
Jan-23	15.1%	
Feb-23	15.1%	
Mar-23	15.0%	
Apr-23	15.0%	
May-23	14.1%	
Jun-23	14.0%	
Jul-23	13.8%	
Aug-23	13.7%	
Sep-23	13.3%	
Oct-23	13.6%	
Nov-23	13.9%	
Dec-23	14.7%	

XMR Run Chart



Understanding the most recent data point

Performance

14.7%	Variation indicates consistently passing the target

Variation

Variation	Special cause of improving nature or lower pressure due to lower values
Flags	Below Mean Run Group Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Update calculation used to denote premature turnover as acutely sensitive to improvements in total turnover	• New method of calculation agreed bringing PT in-line with other methods of measure & reducing sensitivity to wider improvements	• Head of Staff Experience	• Complete	• Premature turnover has inflected upwards and is approaching the threshold. Total premature leavers have, however improved from 21.5 (Nov) to 17.8 (Dec) WTE.
Reduction in **Premature Turnover** below desired threshold of 15%	• Efforts to improve the new starter experience through onboarding and induction	• Head of Staff Experience	• End Feb' 24	• New Starter Experience Survey being brought internally following withdrawal of system funding. East Kent leading on development of system-level line manager toolkit – publishing Feb 24.
Improvement in the **New Starter Experience** (as denoted by the Kent & Medway NSES)	• Efforts to improve the new starter experience through onboarding and induction	• Head of Staff Experience	• End Feb' 24	• 972 respondents to the NSES. Overall net engagement score for EKHUFT new starters (69%) 14% ahead of the K&M average (55%) as at 16/01/24

Staff Engagement Score

Integrated Improvement Plan

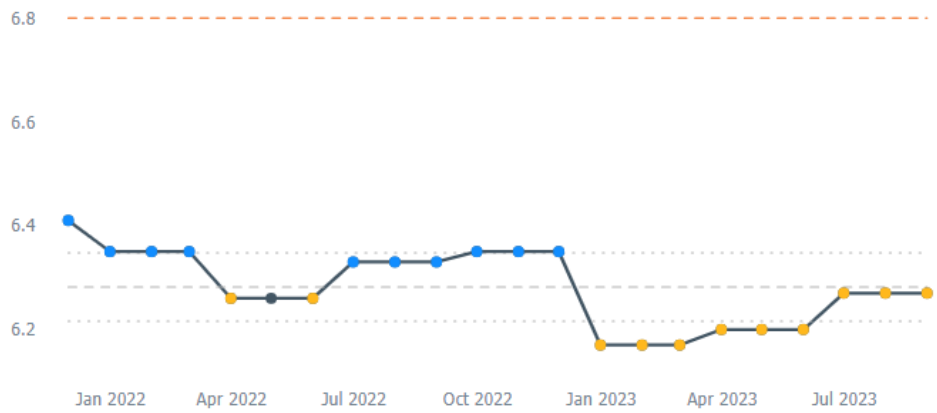
East Kent Hospitals University NHS Foundation Trust

National annual staff survey results provided by Picker March each year.
Staff engagement questions added to Staff Friends and Family quarterly surveys commencing March 2021.
9 questions in staff survey and replicated in quarterly staff FFT (3 x motivation, 3 x involvement and 3 x advocacy) which provide overall engagement score.

Staff Engagement Score

Timescale	Value	SPC
Oct-22	6.35	
Nov-22	6.35	
Dec-22	6.35	
Jan-23	6.17	
Feb-23	6.17	
Mar-23	6.17	
Apr-23	6.20	
May-23	6.20	
Jun-23	6.20	
Jul-23	6.27	
Aug-23	6.27	
Sep-23	6.27	

XMR Run Chart



Understanding the most recent data point

Performance

6.27 — Variation indicates consistently falling short of the target

Variation

Variation: Special cause of concerning nature or higher pressure due to lower values

Flags: Below Mean Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Engagement levels (6.3) are below the national average (6.5)	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated	• Head of Staff Experience	• Results available Mar 24 (post-NSS embargo)	• NSS 23 results received, albeit under national embargo. SE scores have improved again from Q2 to Q3 and returned to levels seen in NSS 22.
Actions/ interventions initiated to improve staff engagement	• Examples include; the introduction of a brand-new benefits platform to tackle satisfaction with pay, and a brand-new EAP to take more positive action on HWB	• Head of Staff Experience	• End Mar 24	• A holistic People Plan is being developed to ensure actions against the people agenda take place based on NSS feedback along with wider, critical people metrics.
National Staff Survey 2023	• Driving response rates across the 2023 NSS is key to improving engagement and the credibility of associated results	• Head of Staff Experience	• End Mar 24	• A brand-new People Dashboard is being developed to visualise results and enable clarity around priorities and necessary actions for improvement.

Statutory Training

Integrated Improvement Plan

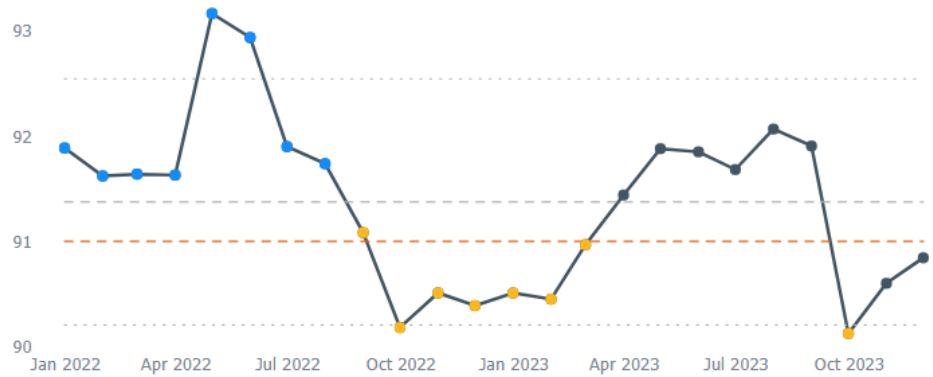
East Kent Hospitals University NHS Foundation Trust

The proportion of staff who have successfully completed Mandatory training in; Child Protection, Equality and Diversity, Fire Safety Awareness, Health and Safety Awareness, Infection Control, Information Governance and Manual Handling Awareness.
Data source: ESR

Statutory Training

Timescale	Value	SPC
Jan-23	90.5%	
Feb-23	90.5%	
Mar-23	91.0%	
Apr-23	91.4%	
May-23	91.9%	
Jun-23	91.9%	
Jul-23	91.7%	
Aug-23	92.1%	
Sep-23	91.9%	
Oct-23	90.1%	
Nov-23	90.6%	
Dec-23	90.8%	

XMR Run Chart



Understanding the most recent data point

Performance

90.8% — Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)
Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Medical staff levels of compliance are consistently low at an average of 75%. Has been below 80% for 4 years.	• Identifying those staff who are not compliant, and working with GMs and Clinical Leads to address compliance.	• CMO	• Feb 24	• Policy to be updated to allow withholding of study leave if statutory training not complete. WHH CG targeting medical compliance with direct support from Care Group Medical Director.
Capacity within face to face statutory learning, particularly Resus.	• Resus team currently at 50% capacity due to vacancies and sickness absence. Being addressed through the Corporate Team	• Deputy Chief Nurse	• Ongoing	• Care Groups ensuring that the most essential, non-compliant staff are booked on Resus training first.
Low compliance with Trainee Drs, as they do not complete this on arrival, and no agreement to who chases this especially after rotation.	• P&C Leads to work with Med Ed on supporting improvements with this, particularly focusing on induction and rotation.	• DME	• End Mar 24	• Head of P&C to work with Care Groups to seek support from Med Ed management team.

Medical Job Planning Rate

Integrated Improvement Plan

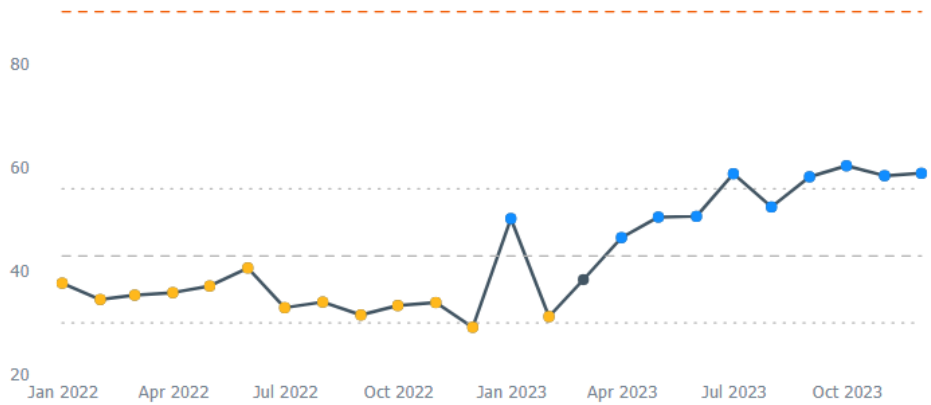
East Kent Hospitals University NHS Foundation Trust

Number of staff who have a fully signed off job plan in the current job planning cycle (1 April - 31 March), as a proportion of the total number of staff. A signed off job plan requires approval from the local Specialty Lead, the Care Group Clinical Director, and the Hospital Medical Director. Exclusions: This job planning data refers to non-training consultant and SAS grade doctors only and is not required by other doctor grades.

Medical Job Planning Rate

Timescale	Value	SPC
Jan-23	50.1%	
Feb-23	31.2%	
Mar-23	38.3%	
Apr-23	46.4%	
May-23	50.4%	
Jun-23	50.5%	
Jul-23	58.7%	
Aug-23	52.3%	
Sep-23	58.1%	
Oct-23	60.3%	
Nov-23	58.3%	
Dec-23	58.8%	

XMR Run Chart



Understanding the most recent data point

Performance

58.8%

Variation indicates consistently falling short of the target

Variation

Variation: Special cause of improving nature or lower pressure due to higher values

Flags: Above Mean Run Group; Astronomical Point; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Job planning compliance continues to improve across specialities, there are approximately 180 doctors (19%) that remain in discussion and 23% in the sign-off stages.	• Continue frequent reminders • Continue contact with sign off leads to provide recommendations and advice	• CMO	• End Mar 24	• Job Planning compliance has now reached 65% (Jan 24) with 25% in sign off stages. Aim to achieve 90% by April is on track.
The new structure hierarchies for specialities have been created on e-JobPlan however they have not yet been migrated	• Wait until next cycle in April 2024 to move all into discussion and back to their correct hierarchy.	• CMO	• Apr 24	• Migration plan complete • Sign-off and compliance issues noted by Allocate. Mitigations to occur in April due to issues in transferring DCC element.
Job plans have been signed off sporadically and have not followed a job planning cycle. This impacts the Trusts ability to ensure its job plans are discussed and delivered with a demand and capacity focus that is also fair and transparent.	• Job planning policy updated to include job planning cycles • Job planning cycle to launch June 2024 commencing with clinical lead & management planning to scope demand, capacity, and resources.	• CMO	• Jun 24	• Template for Clinical Leads/Managers in development with the dCMO • 90% compliance of current cycle on track (see above) • Levels of Attainment improvement project continues in order to fully realise the benefits of addressing this issue.

Staff Advocacy Score

Integrated Improvement Plan

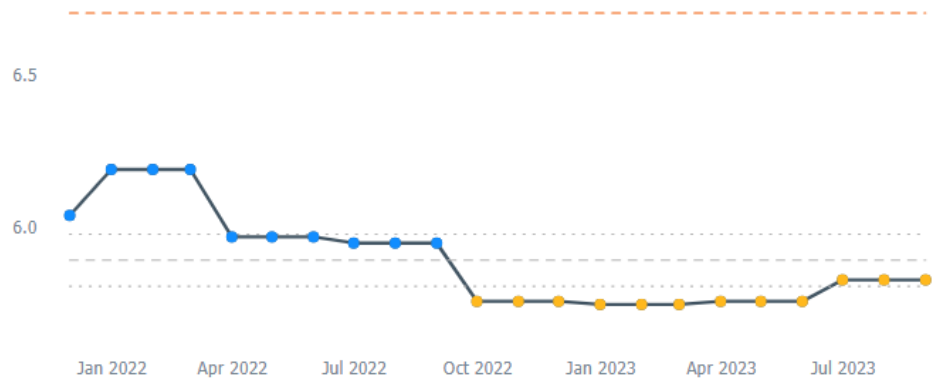
East Kent Hospitals University NHS Foundation Trust

National annual staff survey results provided by Picker March each year.
Staff advocacy questions added to Staff Friends and Family quarterly surveys commencing March 2021.
3 advocacy questions in staff survey and replicated in quarterly staff FFT, these are a subset of the staff engagement score.

Staff Advocacy Score

Timescale	Value	SPC
Oct-22	5.76	
Nov-22	5.76	
Dec-22	5.76	
Jan-23	5.75	
Feb-23	5.75	
Mar-23	5.75	
Apr-23	5.76	
May-23	5.76	
Jun-23	5.76	
Jul-23	5.83	
Aug-23	5.83	
Sep-23	5.83	

XMR Run Chart



Understanding the most recent data point

Performance

5.83

Variation indicates consistently falling short of the target

Variation

Variation: Special cause of concerning nature or higher pressure due to lower values

Flags: Below Mean Run Group; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Advocacy levels (5.8) are significantly below the national standard (6.4)	• Continued action is required to repair the reputation of the organisation & the extent to which staff would recommend as a place to work and be treated	• Executive Team	• End Mar 24	• Staff Advocacy levels will be updated following the release of the NSS embargo in March 2024. It continues to represent the most concerning domain of staff engagement.
Staff Advocacy levels remain in Quartile 1 when benchmarked nationally	• Increased rollout of We Care as a programme to drive staff engagement levels	• Head of Transformation	• Ongoing	• Staff Advocacy levels are higher in We Care areas than non-We Care counterparts. Continued work takes place to increase roll-out across frontline teams.
The extent to which staff would recommend the Trust as a place to work or be treated	• Consider implementation of a multi-level 'People Plan' to tackle improving the staff experience at organisational, care group and specialty levels	• Head of Staff Experience	• End Sept 24	• MDT took place 04/01/24 with three sub-groups established to develop improved plans, actions and reporting across 2024.

Appraisal Rates

Statutory Metrics

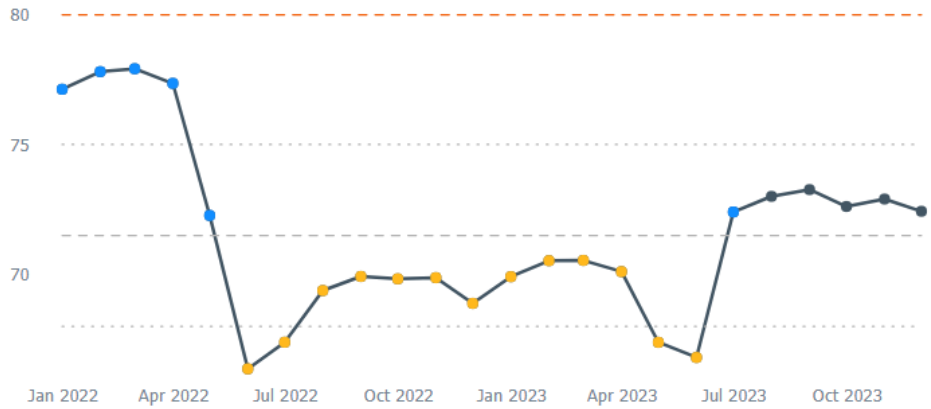
East Kent Hospitals University NHS Foundation Trust

Number of staff who have completed an appraisal and objective setting meeting in the preceding 12 months, as a proportion of the total number of staff.
Exclusions: Doctors, Secondary Assignments, Career Break, Maternity & Adoption, External Secondment and Unpaid Suspensions. Staff who have worked at the Trust for less than 12 months.
Datasource: ESR

Appraisals Compliance

Timescale	Value	SPC
Jan-23	69.9%	
Feb-23	70.5%	
Mar-23	70.5%	
Apr-23	70.1%	
May-23	67.4%	
Jun-23	66.8%	
Jul-23	72.4%	
Aug-23	73.0%	
Sep-23	73.3%	
Oct-23	72.6%	
Nov-23	72.9%	
Dec-23	72.4%	

XMR Run Chart



Understanding the most recent data point

Performance

72.4% — Variation indicates consistently falling short of the target

Variation

Variation Flags: Common cause (no significant change) — No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Managers not uploading completion dates to ESR	• Each Care Group identifying the areas where no or few uploads to ESR have been identified. Supporting those managers with ESR self service training.	• Heads of P&C	• End Feb 24	• Identifying areas where support needed for updated ESR training. Paper written for P&C Committee on recommendations for improvement.
Admin & Clerical appraisal rates remain below threshold, with 600 outstanding appraisals.	• Focus within the new Care Groups on improving A&C appraisal rates, and ensuring they are uploaded to ESR.	• Care Group MDs	• Ongoing	• New P&C Care Group teams to work locally with targeting areas of low A&C appraisal compliance. Paper written for P&C Committee on recommendations for improvement.
Quality of appraisal remains low, according to staff survey	• F2F meetings with line managers re: appraisal and Slido sent out to 600 staff asking for feedback on individual appraisals to identify reasons for low quality.	• Heads of P&C	• End Mar 24	• Approximately 70 responses to requests for suggested improvements to appraisal. These have been fed back to the OD team for action.

East Kent Hospitals University NHS Foundation Trust

Sustainability

Financial Sustainability

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Finance	IIP		I&E Monthly Variance Group (£M)		Traj.	-4.415	5.380	4.264	-9.826	-9.826	-9.244	-10.0...	-11.314	-9.030	-8.929	-6.461	-9.325
	IIP		Efficiencies Green Schemes (£M)		40	20	20	20	0	1	4	3	10	9	9	11	11
	IIP		Efficiencies YTD Variance (£M)		0.0	-6.4	-8.8	-10.4	-1.5	-2.9	-4.8	-8.0	-6.3	-9.5	-11.8	-14.8	-17.2
	IIP		Premium Pay		Traj.	9,034	8,689	9,058	8,839	10.2K	9,666	9,687	10.7K	8,847	8,179	8,404	8,258

December Performance Summary

Financial Position: The financial position YTD is £27.7m away from a plan of £56.3m, with a total deficit YTD of £84.0m. The key drivers behind the deficit variance are unfunded impact of the Strike action £1.1m by the Junior doctors and Consultants (above ERF guidance and IA System funding), shortfall in funding for AfC & Medical and Dental pay award £4.0m, non-delivery of efficiency savings £17.2m YTD. The agency spend YTD is £34.9m which is £14.1m away from the agency cap.

Efficiencies: The submitted Efficiencies plan for 2023/24 is £40m. The Trust recognised recurrent savings of £1.0m in December, and £2.9m on a YTD basis, which is significantly below Plan. YTD underperformance is primarily due to timing of schemes in Agency, Workforce, Theatres, and Care Groups currently being developed. There was however a schemes relating to income which are delivering, with £0.9m in month, and £4.6m forecast for 23/24

The current value of the pipeline is £14.0m, an increase of £1.1m vs. the prior month, and this also includes efficiencies being confirmed as reduction to run-rate overspends from FY23, rather than CIPs. The current value of the pipeline is £11.2m, a decrease of £2.8m vs. the prior month, and this also includes efficiencies being confirmed as reduction to run-rate overspends from FY23, rather than CIPs. There are various theme based workstreams including vacancy and non-pay panels. The PMO is now supported by PWC and financial recovery director to maximise delivery of CIPs for the current financial year and develop a programme of CIPs for delivery in 24-25.

Theme Executive Owners Theme leads have been agreed to carry this work forward to develop a long list of schemes by the end of January and refine this to a short list of quantified schemes expected to deliver in FY24/25.

I&E YTD Actual Group (£m)

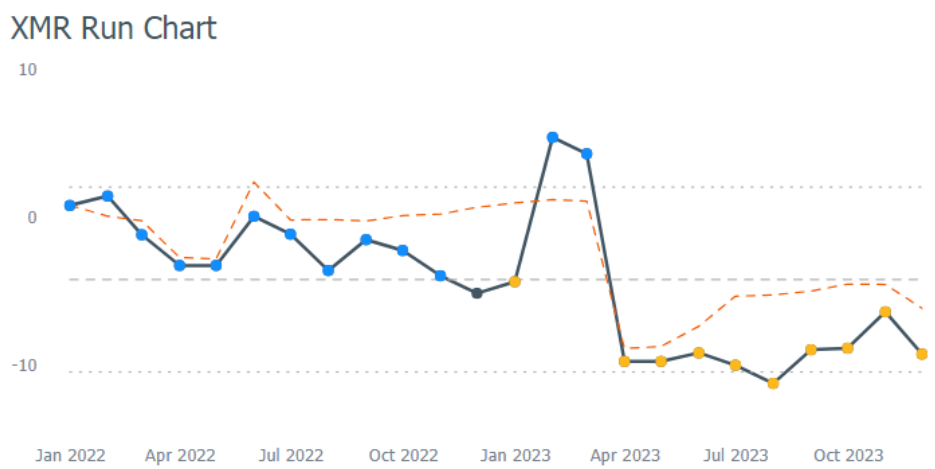
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The I&E Margin (£M) is the Group's technically adjusted profit or loss shown as a percentage of its technically adjusted Income result for each month. If the number is positive the Group is making a surplus

I&E Monthly Variance Group (£M)

Timescale	Value	SPC
Jan-23	-4.415	
Feb-23	5.380	
Mar-23	4.264	
Apr-23	-9.826	
May-23	-9.826	
Jun-23	-9.244	
Jul-23	-10.081	
Aug-23	-11.314	
Sep-23	-9.030	
Oct-23	-8.929	
Nov-23	-6.461	
Dec-23	-9.325	



Understanding the most recent data point

Performance

-9.325 — Variation indicates inconsistently passing and falling short of the target

Variation

Variation — Special cause of concerning nature or higher pressure due to lower values

Flags — Below Mean Run Group; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensure national grip and control level 4's are embededd into the Trust for pay & non pay areas	• All level 4 grip and controls are being rolled out to the wider Trust for both pay and non pay.	• CFO	• On-Going	• Vacancy panel for embedded led by CPO. Nursing workforce review embedding led by CNMO. • Investment panel implemented led by CFO • Finance Improvement Programme Board Embedding (FIPB)
Run rate continues to be above plan due to utilisation in excess of establishment and non delivery of CIP	• Nursing deep dives continue. Golden key has been implemented • CMO has reviewing high cost agency for Medical & Dental	• CNMO & CMO	• On-Going	• Launch of non pay controls agreed at FIPB • Launch of increased workforce controls at FIPB
Non delivery of CIP to date and non achievement of a robust in year CIP plan.	• Workforce & Financial Sustainability Recovery meetings commenced. • Further work is needed on the corporate areas to ensure CIP delivery • PMO working closely with Financial Recovery Director on forecast CIP	• Care group MD's • PMO • Exec Team	• On-Going	• External support to be commission to help and support the Trust in the delivery of a robust CIP plan. Commenced January 2024. • Financial Improvement kick-off session attended by PWC, Exec Directors, Care Group Management Teams and other members of the Trust leadership team – 10th January 2024

Financial Efficiencies: Green Rated Schemes

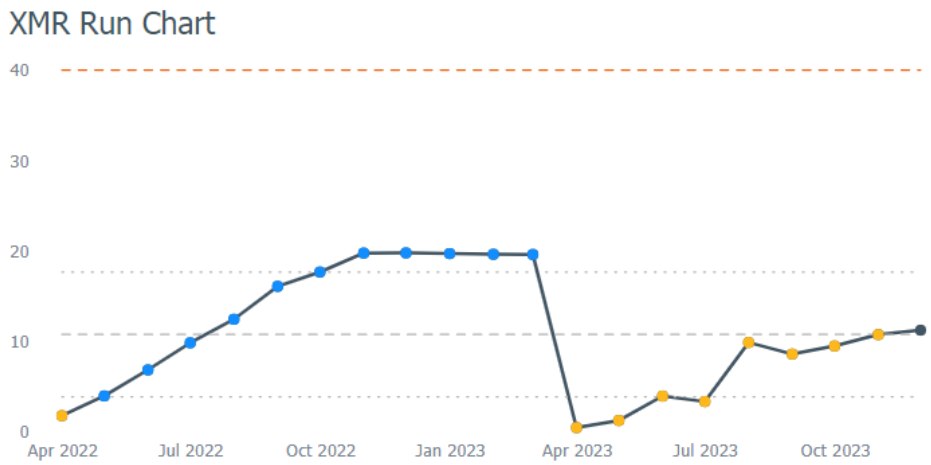
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Efficiencies Green Schemes is the sum of delivered schemes YTD plus the sum of forecast of green rated schemes as a percentage of the annual efficiencies target. If the percentage rated Green is < 90% then overall rating is RED.

Efficiencies Green Schemes (£M)

Timescale	Value	SPC
Jan-23	20	
Feb-23	20	
Mar-23	20	
Apr-23	0	
May-23	1	
Jun-23	4	
Jul-23	3	
Aug-23	10	
Sep-23	9	
Oct-23	9	
Nov-23	11	
Dec-23	11	



Understanding the most recent data point

Performance

11 — Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining organisational focus during restructure	• Continue CEO and CFO messaging to organisation on finance and efficiency; • PMO roles & responsibilities reinforced ad re-aligned to care group structure and themes, plus attendance at finance and workforce recovery meetings • Financial Improvement kick-off session held with senior staff to set the scene for 2024-25 whilst not losing sight of the current position. • Change to fortnightly Improvement Board meetings to monitor CIP progress and improve traction	Finance/PMO	Underway	• CFO released enhanced controls 08/08. • CIP targets for new care groups have been re-calculated and issued. Schemes identified/in the pipeline realigned to new care groups. • Additional and greater controls in place for pay and non pay spend
Pace of scheme development	• Engagement with PWC to work with the Trust to delivery CIP's • Target of 80% achievement of CIP identification for 24/25 by 31st of March 24	CFO	Underway	• PWC commenced on site November 23 for drivers of the deficit & forecast review. Support to PMO has begun in earnest from 8th January
Identification of opportunities sufficient to reach the required £40m	• EMT agreed 17 themes for focus with Exec and Theme leads; • New Turnaround Director appointed, meeting with PMO • New Interim CFO appointed • PWC Commissioned with clear agenda	EMT/ADFI TD/PMO	Ongoing	• Theme values being developed. • FRD/ADFI meeting weekly with PMO • Regular engagement with PMO / PWC

Financial Efficiencies YTD Variance

Integrated Improvement Plan

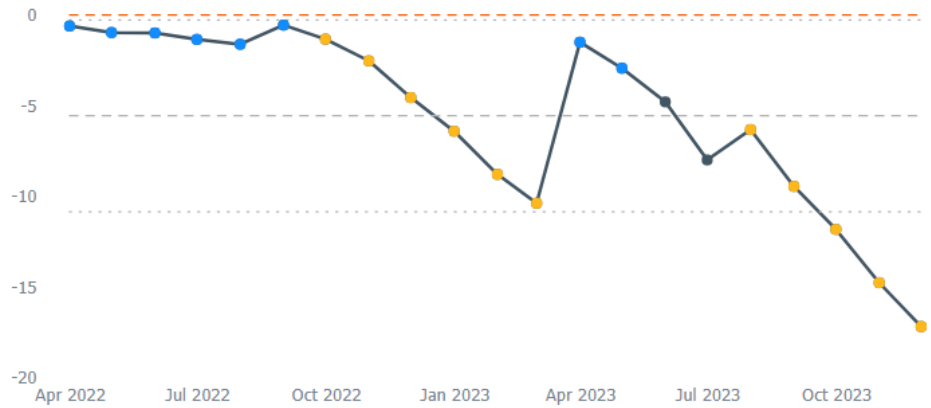
East Kent Hospitals University NHS Foundation Trust

Efficiencies YTD Variance (£M) is the difference between the YTD delivered efficiencies and YTD efficiencies target. If that number is zero or positive, the Trust is delivering the expected efficiencies.

Efficiencies YTD Variance (£M)

Timescale	Value	SPC
Jan-23	-6.4	
Feb-23	-8.8	
Mar-23	-10.4	
Apr-23	-1.5	
May-23	-2.9	
Jun-23	-4.8	
Jul-23	-8.0	
Aug-23	-6.3	
Sep-23	-9.5	
Oct-23	-11.8	
Nov-23	-14.8	
Dec-23	-17.2	

XMR Run Chart



Understanding the most recent data point

Performance

-17.2

Variation indicates consistently falling short of the target

Variation

Variation: Special cause of concerning nature or higher pressure due to lower values

Flags: Astronomical Point; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring finance and CIP transparency while reflecting underlying organisational improvement	• Additional non-recurrent efficiencies of £6.8m have been achieved YTD when taking into consideration the reported financial position adjusted for the known overspends (such as pay award funding shortfall, impact of strike action, increased levels of utilisation for nursing & medical staffing above plan and 1-2-1 specialling). Work is underway to understand if these non-recurrent efficiencies are able to be turned into recurrent efficiencies.	CFO/PMO PMO	Oct-23 On-going	• Methodology and calculation agreed at FPC, used for Mth5 reporting onwards - Completed • PMO continue to work with care groups to establish whether there are any recurrent savings inherent in the underspends
Agency usage and cost at a similar level to this time last year	Nursing agency costs remain high • Action: Greater controls through authorisation and "golden key" process • Action: Super-numery period reduced to two weeks for IENs • Context: High cost medical agency (HCMA) use remains high, ongoing issue. • Action: CPO/FRD/PMO working with care groups to review HCMA value add.	• CNMO • CNMO • FID/PMO	• Ongoing • 22/09 • Sept/Oct 23	• Golden Key went live 18/09/23 • Reduced supernumerary period implemented in inpatient areas • To combine deep dives to include medical and nursing, and to feed into Workforce and Financial Sustainability recovery meetings.

Premium Pay

Integrated Improvement Plan

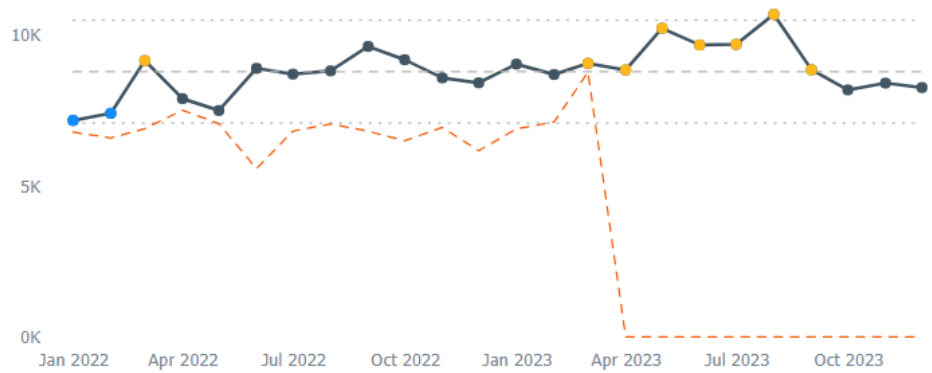
East Kent Hospitals University NHS Foundation Trust

Summary metric of Trust premium pay items Agency (NHSP and direct engagement), Bank, WLI payments, Locally Agreed Group, Medical Short Sessions, Other Medical Locum costs and Overtime (excl additional basic) in £.

Premium Pay

Timescale	Value	SPC
Jan-23	9,034	
Feb-23	8,689	
Mar-23	9,058	
Apr-23	8,839	
May-23	10.2K	
Jun-23	9,666	
Jul-23	9,687	
Aug-23	10.7K	
Sep-23	8,847	
Oct-23	8,179	
Nov-23	8,404	
Dec-23	8,258	

XMR Run Chart



Understanding the most recent data point

Performance

8,258 — Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Timely information that can be used to target areas of high premium pay usage.	• Premium Pay Dashboard now live, and updated regularly.	• Information Lead • Strategic Workforce Lead • Heads of P&C	• End Jan 24	• CMO, Heads of P&C and P&CBPs to use this Dashboard and information to support Care Group Exec Efficiency meetings. • Some DQ issues affecting WTE reported are being followed up with NHSP directly.
Reduction in Premium Pay by focusing on hard to recruit roles.	• Workforce Strategies developed for care Groups, focusing on those areas with hard to recruit posts, and a plan to address this.	• Strategic Workforce Lead, Heads of P&C, P&CBPs	• End Feb 24	• First draft Workforce Strategies in place for phase 1 and 2 specialties, to be reviewed regularly with Care Groups and Resourcing • Phase 3 being drafted • QEQM & WHH currently being reviewed on a monthly basis.
Appointment of managed service provider to reduce agency spend as above the Trust agency spend cap.	• Seek Board approval for procurement. • Onboard provider.	• CPO/ Procurement • Deputy CPO	• End Nov 23	• Obtained Trust approval • Implementation of ID Medical Managed service due to launch 03/12/23 with full handover over and use of system from 29/01/24

East Kent Hospitals University NHS Foundation Trust

Maternity

Maternity

Integrated Improvement Plan

NHS
East Kent Hospitals University
NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Maternity	IIP		Serious Incidents Maternity		Sigma	2	4	4	4	1	3	2	0	2	2	1	2
	IIP		Maternity Incidents Moderate / Severe		Sigma	6	5	6	0	3	2	0	1	1	4	0	2
	IIP		Maternity Complaints		Sigma	9	12	8	11	8	4	6	2	17	5	9	5
	IIP		Maternity Complaint Response		90.0%		0.0%	75.0%	25.0%	16.7%	38.9%	50.0%	66.7%	60.0%	0.0%		0.0%
	IIP		Extended Perinatal Mortality		5.87	4.33	4.53	4.44	4.62	4.47	3.87	3.40	3.58	3.11	2.62	2.29	2.64
	IIP		FFT Maternity Response Rate		15.0%	16.2%	14.0%	12.2%	11.6%	11.7%	12.8%	13.0%	11.1%	9.3%	11.9%	12.6%	12.1%
	IIP		FFT Maternity Recommended		90.0%	95.2%	91.6%	92.2%	93.7%	92.1%	92.3%	91.6%	88.8%	90.8%	96.2%	92.9%	91.0%
	IIP		FFT Maternity (IP) Recommended		90.0%	95.2%	91.7%	96.2%	95.1%	92.6%	94.3%	94.3%	89.3%	90.7%	96.7%	93.7%	92.8%
	IIP		WH Engagement Score		6.90	5.45	5.45	5.45	5.87	5.87	5.87	6.15	6.15	6.15			

December Performance Summary

Incidents: There were 2 serious incidents reported in December in Women's Health for Maternity, and 2 moderate harm incidents.

Complaints: 5 Stage 1 complaints were received in December for Maternity. This is a decrease on the previous month.

Patient Involvement: FFT Response rate increased to 12.1% - 91.0% extremely likely or likely to recommend

Staff Engagement: Score 6.15

Maternity Serious Incidents

Integrated Improvement Plan

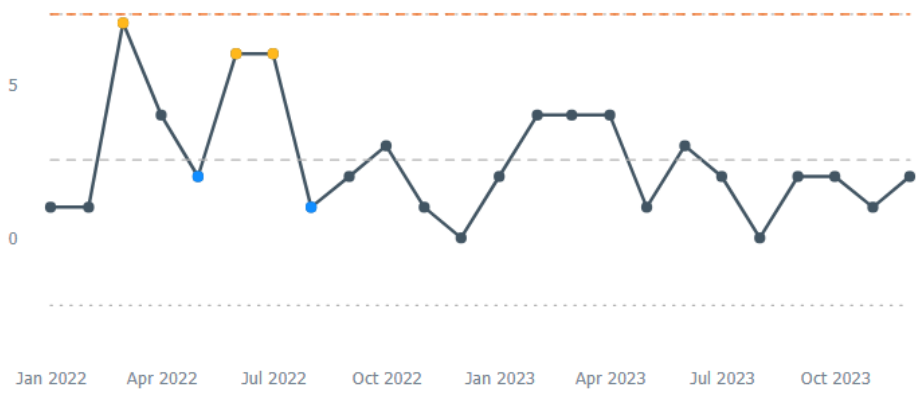
East Kent Hospitals University NHS Foundation Trust

This metric measures any maternity incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System). Any maternity incidents that are subsequently downgraded are removed retrospectively therefore this number is subject to change. Serious Incidents are reported by the date the investigation started and not the date the incident occurred or was reported.

Serious Incidents Maternity

Timescale	Value	SPC
Jan-23	2	
Feb-23	4	
Mar-23	4	
Apr-23	4	
May-23	1	
Jun-23	3	
Jul-23	2	
Aug-23	0	
Sep-23	2	
Oct-23	2	
Nov-23	1	
Dec-23	2	

XMR Run Chart



Understanding the most recent data point

Performance

2

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
There were 2 serious incidents reported in December for Maternity.	1. Baby therapeutic cooling - MNSI Investigation. ENS case. 2. Neonatal death. External support for investigation by the Local Maternity and Neonatal System requested.	Interim Head of Gov.	02/07/24 07/03/24	Investigations commenced. Immediate actions implemented: Hot Debrief for all staff involved. TRIM support offered to all staff involved Working group established by Intrapartum Midwife for production and roll out of Neonatal Resuscitation proforma. Case to be used for fetal heart monitoring training to familiarise staff with rare abnormal CTG traces. Safety Thread about spurious vs. true accelerations disseminated. Resuscitaire checked and no issues.
At month end there are 9 open SI's in Maternity.	For all SI investigations to be completed within agreed timeframes.	Interim Head of Gov.	Monthly – ongoing	All Maternity open SI's under investigation are within agreed timeframes. There are no SI breaches within Maternity (There is 1 neonatology breach occurring in December).
Closure of actions from SI's on the datix actions module.	• Focussed work to close open actions on datix module with action owners • Weekly progress reporting of original June backlog and current position	Interim Head of Gov.	31/03/24	The number of overdue actions from the original backlog (June) has reduced from 345 to 49 at 15/01/24. The overall current overdue actions has decreased to 143. There is additional agency resource focussing on open actions from October-February and further sprint days with NHSE Maternity Improvement Advisor in December and January. Patient Safety Matron vacancy is backout to advert. Substantive Head of Governance appointed.

Maternity Incidents Causing Harm

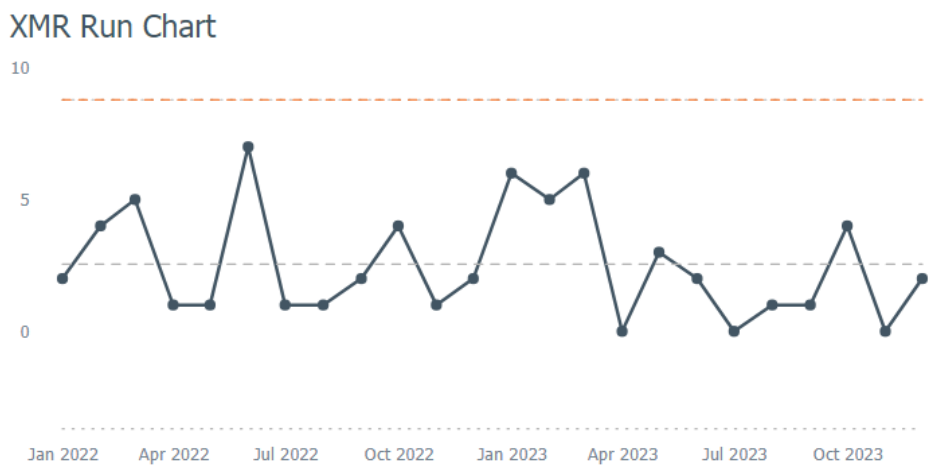
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of maternity incidents where the harm status was moderate or above.

Maternity Incidents Moderate / Severe

Timescale	Value	SPC
Jan-23	6	
Feb-23	5	
Mar-23	6	
Apr-23	0	
May-23	3	
Jun-23	2	
Jul-23	0	
Aug-23	1	
Sep-23	1	
Oct-23	4	
Nov-23	0	
Dec-23	2	



Understanding the most recent data point

Performance

2 — Variation indicates inconsistently passing and falling short of the target

Variation

Variation Flags: Common cause (no significant change); No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Rapid review of moderate incidents and other incidents on maternity trigger list.	• Rapid review process reviewed • MDT attendance • Learning identified	Interim Head of Governance	Monthly - ongoing	• Both incidents reported as serious in incidents. • Themes and learning identified from rapid reviews disseminated via Message of the Week and Safety Threads.
Closure of datix open more than 6 weeks	• Focussed work to close open actions on datix module with action owners • Weekly progress reporting of backlog and current position	Interim Head of Governance	31/01/2024	The number of open datix from the original June backlog for Maternity has reduced from 686 to 30 at 15.01.24. The overall current overdue datix has reduced to 214 within Maternity. This is a priority for the Patient Safety Team to close these open datix, all of which have had an initial review at the time of reporting.

Maternity Complaints

Integrated Improvement Plan

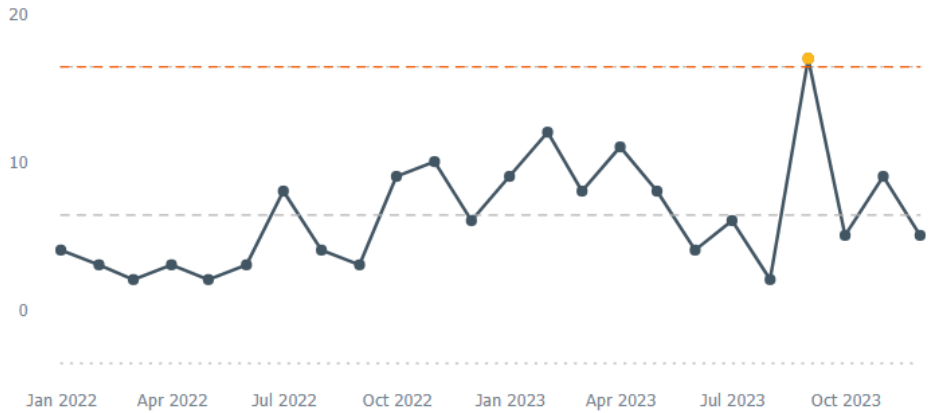
East Kent Hospitals University NHS Foundation Trust

This metric measures the number of complaints made to Obstetrics, Midwifery or New-born Hearing Screening Services.

Maternity Complaints

Timescale	Value	SPC
Jan-23	9	
Feb-23	12	
Mar-23	8	
Apr-23	11	
May-23	8	
Jun-23	4	
Jul-23	6	
Aug-23	2	
Sep-23	17	
Oct-23	5	
Nov-23	9	
Dec-23	5	

XMR Run Chart



Understanding the most recent data point

Performance

5

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
5 Stage 1 complaints received in December 2023 for Maternity	Decrease from the number of complaints received in previous month.	Patient Experience and Complaints Coordinator	Monthly reporting	
Recurrent themes	The main themes are: Women reporting their Birth Preferences Document has not been read. Lack of communication about 'complicated' births, or when babies need 'assistance' at birth – lack of debrief. Limited antenatal support for HG sufferers. Post-natal ward – busy, attitude of staff, discharge delays. Delays in antenatal referrals; mental health, physio.	Adaline Smith DDOM	Monthly	We have commenced leave your troubles at the door initiative and posters can be seen at every entry point to support immediate response and action of any concerns.

Maternity Complaints Response Rate

Integrated Improvement Plan

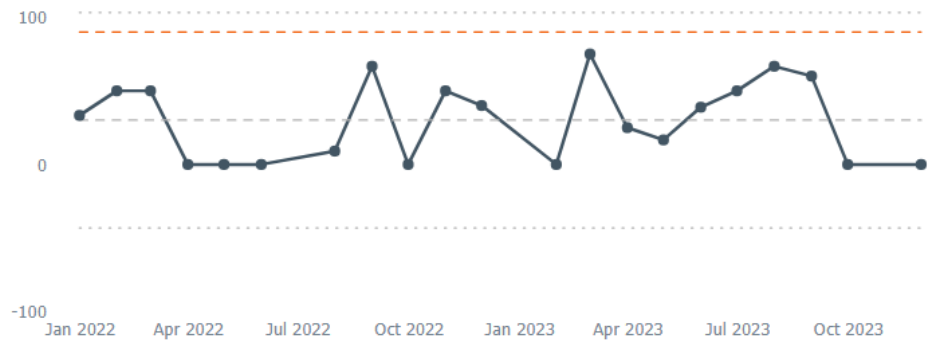
East Kent Hospitals University NHS Foundation Trust

This metric measures the proportion of complaints which were responded to within the agreed timescale of the complaint being received. This includes both 30 and 45 working day timescale targets.
Complaint Types included are Formal, External and MP Formal that have not been rejected.
Complaint Stages included are extensions 1,2,3 and extensions agreed by Chief Nurse, Local Resolution, On Hold and Withdrawn.

Maternity Complaint Response

Timescale	Value	SPC
Nov-22	50.0%	
Dec-22	40.0%	
Feb-23	0.0%	
Mar-23	75.0%	
Apr-23	25.0%	
May-23	16.7%	
Jun-23	38.9%	
Jul-23	50.0%	
Aug-23	66.7%	
Sep-23	60.0%	
Oct-23	0.0%	
Dec-23	0.0%	

XMR Run Chart



Understanding the most recent data point

Performance

0.0% — Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)
Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Competing priorities of clinical staff cause delays in case reviews and providing the Complaint Coordinator with comments for content	Complaint Coordinator has set up weekly 'huddle' meetings with HOMs and newly appointed Clinical Lead to try and spotlight urgent cases .	Patient Experience and Complaints Coordinator	• Weekly and • Bi-Weekly meetings	• Care group has robust process in place for ensuring quality of responses within timeframes. • Positive feedback has been received on the quality of the complaint responses. • At 08/01/2024 there were 32 open first complaints of which 16 had breached but submitted To CPBS by care group.

Extended Perinatal Mortality

Integrated Improvement Plan

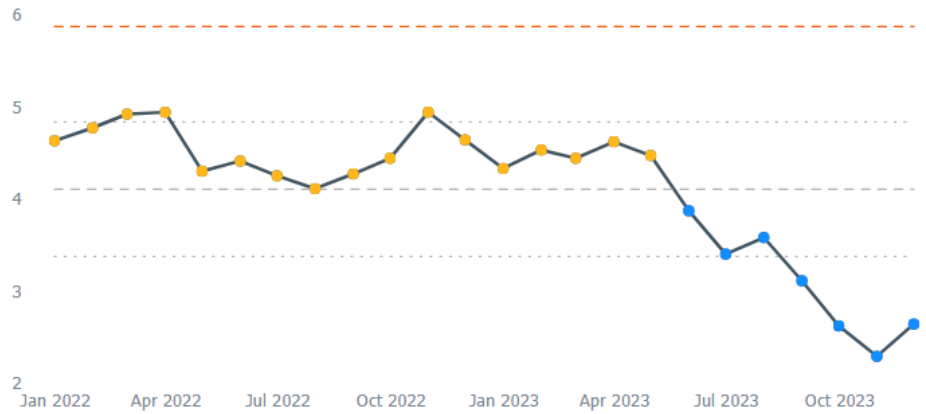
East Kent Hospitals University NHS Foundation Trust

Extended perinatal mortality refers to all stillbirths and neonatal deaths, MBRRACE methodology is used, which excludes births <24+0 weeks gestation and terminations (even if over 24+0w). The rate is per 1000 total births.
Datasource: Euroking & PAS
Threshold based on the average of the Trust's comparator group (Trust with level 3 NICU) from the 2021 MBRRACE report.

Extended Perinatal Mortality

Timescale	Value	SPC
Jan-23	4.33	
Feb-23	4.53	
Mar-23	4.44	
Apr-23	4.62	
May-23	4.47	
Jun-23	3.87	
Jul-23	3.40	
Aug-23	3.58	
Sep-23	3.11	
Oct-23	2.62	
Nov-23	2.29	
Dec-23	2.64	

XMR Run Chart



Understanding the most recent data point

Performance

2.64 — Variation indicates consistently passing the target

Variation

Variation: Special cause of improving nature or lower pressure due to lower values

Flags: Below Mean Run Group; Astronomical Point; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
In December there were 2 neonatal deaths reportable to MBRRACE: 1. 35+6 week baby born at WHH 2. 26+1 week baby born at WHH (SGA and under fetal medicine).	The 2 neonatal deaths in December have pushed the 12 month rate above the upper confidence limit – with 7 NNDs in the past 12 months. The rate remains below the threshold of 1.96 deaths per 1000 livebirths, which is set at the average of the Trust's comparator group from the most recent MBRRACE data	PMRT Lead Midwife	Monthly	1. Serious incident in December figures. 2. Numerous co-morbidities for this baby prior to birth – discussed at rapid review and did not meet the threshold for serious incident
In December there were 0 stillbirths reportable to MBRRACE.	The rolling 12 month rate for stillbirths remains lower than both the threshold and average at 1.41 neonatal deaths per 1,000 livebirths.	DDoM	Monthly	
Perinatal Mortality Review Tool	All neonatal deaths and stillbirths are reviewed through the Perinatal Mortality Review Tool by a multidisciplinary panel and external attendees.	PMRT Lead Midwife	Monthly	100% of perinatal mortality reviews include an external reviewer

Maternity Friends & Family Test: Response Rate

Integrated Improvement Plan

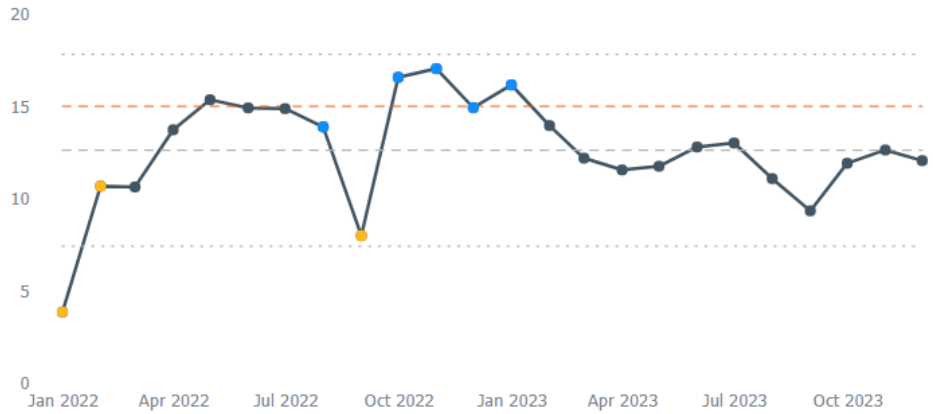
East Kent Hospitals University NHS Foundation Trust

This metric measures the number of responses to the maternity friends and family questionnaires and displays as a % of the total questionnaires sent.

FFT Maternity Response Rate

Timescale	Value	SPC
Jan-23	16.2%	
Feb-23	14.0%	
Mar-23	12.2%	
Apr-23	11.6%	
May-23	11.7%	
Jun-23	12.8%	
Jul-23	13.0%	
Aug-23	11.1%	
Sep-23	9.3%	
Oct-23	11.9%	
Nov-23	12.6%	
Dec-23	12.1%	

XMR Run Chart



Understanding the most recent data point

Performance

12.1%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Response rates are typically low for FFT therefore only reflect a minority of women, birthing people and their families, and their experiences	Embedded communications plan and Patient Voices Model to improve service user and workforce engagement, feedback and experience	Patient Experience Midwives	March 2024	• This is a milestone within the Maternity and Neonatal Improvement Plan presented to Trust Board for approval in September 2023 • The 2023/2024 work plan has now been finalised with next steps including walking the patch and 15 steps. • Feedback is being continually gathered through YVIH and FFT.

Maternity Friends & Family Test: Recommended

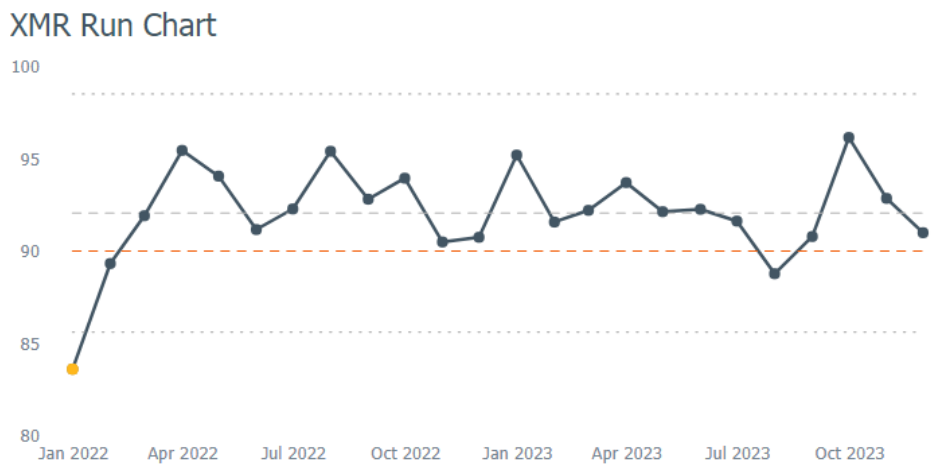
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric is a summary of all Maternity Friends & Family responses which indicated that the woman would recommend the Trust's Maternity Services.

FFT Maternity Recommended

Timescale	Value	SPC
Jan-23	95.2%	
Feb-23	91.6%	
Mar-23	92.2%	
Apr-23	93.7%	
May-23	92.1%	
Jun-23	92.3%	
Jul-23	91.6%	
Aug-23	88.8%	
Sep-23	90.8%	
Oct-23	96.2%	
Nov-23	92.9%	
Dec-23	91.0%	



Understanding the most recent data point

Performance

91.0% — Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
The responses show 91.0% extremely likely or likely to recommend which is a decrease in month.	PEM feedback to staff on a regular basis via personalised email and update posters on the units/community offices and in the monthly newsletter. The top 3 areas to improve are: 1. Communication and Information- the way things are explained in tone and what is happening- this is even across both sites 2. Staff Attitude- this has been seen more about the doctors and midwives on the PN ward at night at – across both sites 3. Quality of treatments (majority being about the Postnatal ward at WHH specifically)	PEM	Monthly	• There is now a PN steering groups which has led on from the discharge steering group to look at PN care • Exploring a NIPE rota for midwives to increase the NIPEs and speed up discharges. • Redecoration of both units. • In November there has been a standard of care embedded at WHH PN ward where the is an expectation of what should happen at what time. At 11 o'clock as well there is a safety pause where concerns can be escalated to those in charge and also any issues with discharged can be discussed. • There are now two Hubs on the wards- which are in 2 of the bays, this is to ensure and increase viability of the staff looking after the families in those bays. • Increase in comments concerning the attitude and communication of doctors will be reported back to the lead consultants of each site.

Maternity Friends & Family Test: Inpatient Recommended

Integrated Improvement Plan

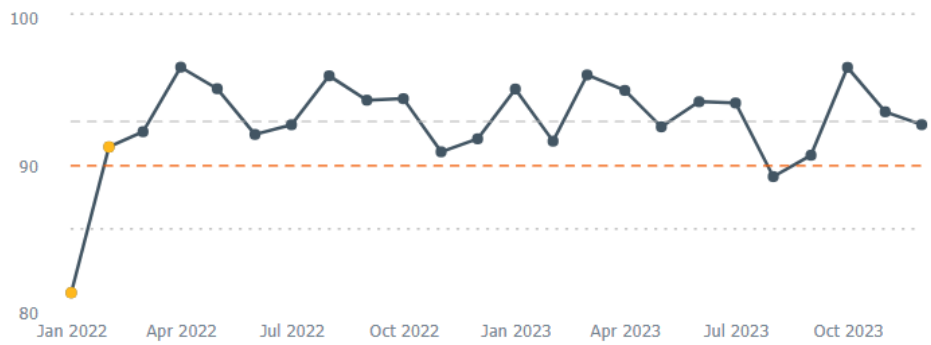
East Kent Hospitals University NHS Foundation Trust

This metric is a summary of Inpatient Maternity Friends & Family responses which indicated that the woman would recommend the Trust's Maternity Services.

FFT Maternity (IP) Recommended

Timescale	Value	SPC
Jan-23	95.2%	
Feb-23	91.7%	
Mar-23	96.2%	
Apr-23	95.1%	
May-23	92.6%	
Jun-23	94.3%	
Jul-23	94.3%	
Aug-23	89.3%	
Sep-23	90.7%	
Oct-23	96.7%	
Nov-23	93.7%	
Dec-23	92.8%	

XMR Run Chart



Understanding the most recent data point

Performance

92.8%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
The responses show 92.8% extremely likely or likely to recommend which is a decrease in month.	• Embedding in discharge process with the introduction of the new post natal discharge process . • Increase awareness via Maternity Voice Partnership • Include in Walking the Patch and standard work for the Discharge coordinators • Explore use of link to QR code • Matron worked clinically for 2 weeks in November to embed good practice.	Liane Ashley	December 23	This is a milestone within the Maternity and Neonatal Improvement Plan presented to Trust Board for approval in September 2023

Women's Health Staff Engagement Score

Integrated Improvement Plan

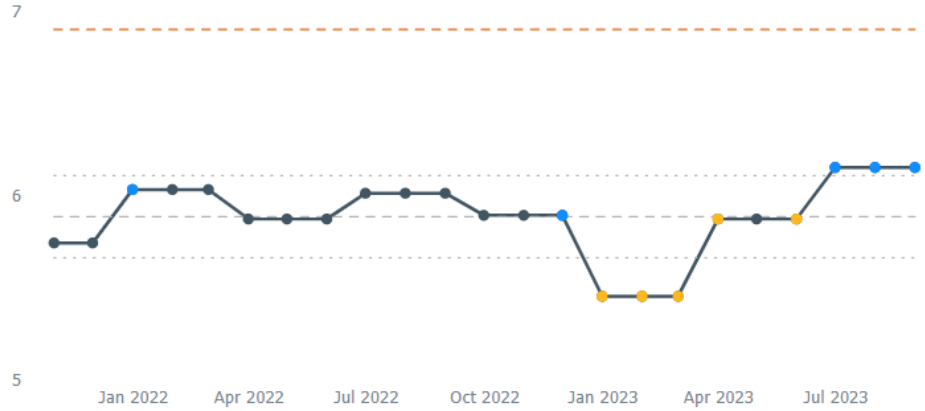
East Kent Hospitals University NHS Foundation Trust

National annual staff survey results provided by Picker March each year.
Staff engagement questions added to Staff Friends and Family quarterly surveys commencing March 2021.
9 questions in staff survey and replicated in quarterly staff FFT (3 x motivation, 3 x involvement and 3 x advocacy) which provide the overall engagement score.

WH Engagement Score

Timescale	Value	SPC
Oct-22	5.89	
Nov-22	5.89	
Dec-22	5.89	
Jan-23	5.45	
Feb-23	5.45	
Mar-23	5.45	
Apr-23	5.87	
May-23	5.87	
Jun-23	5.87	
Jul-23	6.15	
Aug-23	6.15	
Sep-23	6.15	

XMR Run Chart



Understanding the most recent data point

Performance

6.15

Variation indicates consistently falling short of the target

Variation

Variation: Special cause of improving nature or lower pressure due to higher values

Flags: Astronomical Point
Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Opportunities for Staff Engagement	• Introduction of " We Hear You " providing platform for feedback • Embedding Safety Champions Forum • Band specific Meetings /away days • Increase Appraisal rates and SMART objectives • Promoting Freedom to Speak Up Guardians and arrange dedicated walkarounds • Embedding retention conversations • Compassionate attendance at work conversations following absences	Adaline Smith DDOM	December 23	Score survey in progress. Results expected end of January 2024.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: MONTH 9 (M9) FINANCE REPORT

Meeting date: 1 FEBRUARY 2024

Board sponsor: INTERIM CHIEF FINANCE OFFICER (CFO)

Paper Author: INTERIM DEPUTY CHIEF FINANCE OFFICER

Appendices:

APPENDIX 1: M9 FINANCE REPORT

Executive summary:

Action required:	Information
Purpose of the Report:	This report provides an update to the Trust Board on the current financial performance and actions being taken to address issues of concern.
Summary of key issues:	**Context:** When the Board met on 11 January 2024, it signed off a forecast year end deficit at the Trust of (£117.4m). This forecast position included £13.1m of improvements made to the Trust's underlying run rate, which is a stretching savings target to deliver in just three months. These savings were somewhat offset by additional non-pay costs associated with treating more patients over winter (£3.5m), the financial impact of industrial action (£1.9m), additional costs required to manage the Trust's significant endoscopy backlog (£1.9m), and other risks that impact the Trust's year end position (£2.0m). This forecast was discussed and acknowledged by NHS England on 19 January 2024. At the end of month 9 the Trust posted a year to date deficit of (£84.0m), which is in line with the forecast described above. Whilst clearly this is a significant deficit, there were some early signs in the month of financial improvement. For example, the in month pay spend in December at the Trust (£49.9m) was the lowest it has been since April 2023 following the enhancement of agency controls and the implementation of an enhanced vacancy control panel. Whilst the Trust expects its pay position to increase again in January (due to the impact of industrial action), this, alongside the fact that the pay spend in both November (£50.9m) and October (£50.4m) was less than the H1 average monthly spend (£51.4m), does indicate the start of an underlying trend of financial improvement at the Trust.

We care

That said, there remains much, much more work to do, and the Trust's focus needs remain on delivery, whilst also turning to next financial year. We have set a necessarily ambitious target of £49m of savings to deliver next year. We have a programme of work ahead of us as an Executive and Board to develop and deliver this.

The Finance Report:
The Group reported an in-month position of £9.3m against a plan of £6.2m, resulting in a deficit variance of £3.1m. The Year to Date (YTD) position is £84.0m against a plan of £56.3m, giving a YTD variance to plan of £27.7m.

The agreed financial plan for 2023/24 is a £72m deficit. Delivery of the 2023/24 financial plan is based upon some extremely challenging assumptions as it requires that the Trust:

1) Delivers £40m of efficiency savings on a cash releasing efficiency basis.
2) Delivers a stretch activity target.
3) Reduces not medically fit to reside patients.
4) Eliminates 65-week breaches.
5) No additional unknown cost pressures are presented without mitigation in year.
6) Non-elective pressures are within planning tolerances.
7) Full control measures are reintroduced.

The key drivers to the Group's YTD deficit are:

Key Drivers	**£000**
Non-delivery of recurrent efficiency savings, against recurrent Cost Improvement Programme (CIP) plan	(£23,099)
Nursing drivers (Escalation Beds £854k / 1:1 care £2,232k / Supernumery Nurses £1,437k)	(£4,523)
Unfunded Pay Award (Medical and Dental, Agenda for Change (AfC) and AfC Bonus)	(£3,986)
Strike Action impact unfunded (Above Elective Recovery Funding (ERF) guidance and IA system funding)	(£1,070)
Internationally Educated Nurses (IEN) Backpay 2022/23 above plan	(£869)
Non-recurrent savings, above non-recurrent CIP plan	£5,860
Group YTD Deficit	**(£27,687)**

Trust Pay is overspent by £23.1m YTD due to:

- Non-delivery of Pay CIPs.
- Shortfall in funding for pay awards (£4m).
- High cost of agency premium to cover escalation areas still open above plan (£0.9m).
- Increased levels of 121 nursing care (£2.2m).
- IEN supernumery cover above plan (£1.4m). This relates to the 6-month supernumery period for 2022/23 Q3/4 cohorts .

	• IEN backpay relating to 2022/23, paid in September and October (£0.9m above plan). • Increased levels of staffing utilisation/high cost agency in Medical & Dental. Whole Time Equivalent (WTE) over-utilisation decreased in month by 36 WTE from 117 WTE to 81 WTE, mainly relating to nursing staff. Over-utilisation reflects the adverse variance to plan for escalation beds and 1:1 care. Trust Non-Pay is overspent by £23.0m primarily driven by: • Non-delivery of Non-Pay CIPs. • Rechargeable drugs costs (offset by corresponding increase in income). • Operating Healthcare Facility (OHF) contract increased costs relating to catering supply issues, generator hire, supplies and Electronics and Medical Engineering (EME). • IT systems contracts relating to Laboratory Information Management System (LIMS) (again, offset by an increase in income). Trust Income is above plan YTD by £17.9m mainly due to: • The Trust has benefitted non-recurrently from national guidance decreasing ERF baselines by 4% (£6.4m for the full year). This brings the year to date over performance on ERF to (£3.4m). • funded service developments not in plan, including Cancer Alliance income (Targeted lung checks, £1.1m), additional allocation from the Integrated Care Board (ICB) for Healthcare Partnership projects for virtual ward and schemes targeted at discharges (£1.6m), vascular reconfiguration (£0.5m) and Continuous Glucose Monitoring funding (£0.6m) and Pathology LIMS (£0.6m). These are all offset by an increase in expenditure. • overperformance in high cost drugs (£4.6m) and devices (£1.6m) - matched by a corresponding increase in expenditure. • favourable prior year income benefit/non-recurrent CIP (£0.8m). The Group cash balance (including subsidiaries) at the end of December was £40.5m. The Trust drew £8.6m of working capital (public dividend capital (PDC)) in the month, making a YTD total of £74.5m. Total capital expenditure at the end of December was £12.9m spend against a plan of £19.6m; this represents a £6.8m net underspend YTD. However, the Trust is forecasting capital spend of £30.1m in 2023/24. The Trust has achieved very little efficiency savings so far this year, with £4.2m achievement against the £28.2m YTD plan, of which £2.9m is recurrent. Additional non-recurrent efficiencies of £6.8m have been achieved YTD when taking into consideration the reported financial position adjusted for the known overspends (such as pay award funding shortfall, impact of

East Kent Hospitals University NHS Foundation Trust

	strike action, increased levels of utilisation for nursing & medical staffing above plan and 1:1 care).
Key recommendations:	The Board of Directors is asked to review and **NOTE** the financial performance and actions being taken to address issues of concern.

Implications:

Links to Strategic Theme:	Having Healthy Finances by providing better, more effective patient care that makes resources go further.
Link to the Board Assurance Framework (BAF):	**BAF 38**: Failure to deliver the financial breakeven position of the Trust as requested by NHS England.
Link to the Corporate Risk Register (CRR):	**CRR 137**: There is a risk that the Trust will not be able to meet its 2023/24 efficiencies target equating to £40m.
Resource:	N - Key financial decisions and actions may be taken on the basis of this report.
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: Finance and Performance Committee (FPC), 23 January 2024.

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East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2023/24

December 2023

Chief Finance Officer
Tim Glenn

Contents

CFO Message

Month 09 (December) 2023/24

When the Board met on 11 January 2024, it signed off a forecast year end deficit at the trust of (£117.4m). This forecast position included £13.1m of improvements made to the trust's underlying run rate, which is a stretching savings target to deliver in just three months.

These savings were somewhat offset by additional non-pay costs associated with treating more patients over winter (£3.5m), the financial impact of industrial action (£1.9m), additional costs required to manage the trust's significant endoscopy backlog (£1.9m), and other risks that impact the trust's year end position (£2.0m).

This forecast was discussed and acknowledged by NHS England on 19 January 2024.

At the end of month 9 the trust posted a year to date deficit of (£84.0m), which is in line with the forecast described above.

Whilst clearly this is a significant deficit, there were some early signs in the month of financial improvement. For example, the in month pay spend in December at the trust (£49.9m) was the lowest it has been since April 2023 following the enhancement of agency controls and the implementation of an enhanced vacancy control panel. Whilst the trust expects its pay position to increase again in January (due to the impact of industrial action), this, alongside the fact that the pay spend in both November (£50.9m) and October (£50.4m) was less than the H1 average monthly spend (£51.4m), does indicate the start of an underlying trend of financial improvement at the trust.

That said, there remains much, much more work to do, and the trust's focus needs remain on delivery, whilst also turning to next financial year. We have set a necessarily ambitious target of £49m of savings to deliver next year. We have a programme of work ahead of us as an Executive and Board to develop and deliver this.

Income and Expenditure Summary
Month 09 (December) 2023/24

Unconsolidated

£000	This Month Plan	This Month Actual	This Month Var.	Year to Date Plan	Year to Date Actual	Year to Date Var.
Income						
Electives	8,260	7,151	(1,109)	79,889	73,770	(6,119)
Non-Electives	22,551	17,594	(4,957)	204,093	169,231	(34,863)
Accident and Emergency	4,239	4,315	76	38,707	34,146	(4,562)
Outpatients	8,949	10,307	1,358	88,349	93,660	5,312
High Cost Drugs	4,070	4,582	512	36,628	41,190	4,561
Private Patients	14	9	(5)	128	275	147
Other NHS Clinical Income	17,996	22,960	4,963	156,266	204,513	48,247
Other Clinical Income	133	214	81	1,198	1,322	124
Total Income from Patient Care Activities	**66,212**	**67,132**	**920**	**605,259**	**618,106**	**12,847**
Other Operating Income	4,381	5,735	1,354	39,462	44,513	5,051
Total Income	**70,594**	**72,867**	**2,273**	**644,721**	**662,619**	**17,898**
Expenditure						
Substantive Staff	(41,598)	(43,275)	(1,678)	(377,948)	(394,316)	(16,368)
Bank	(3,534)	(3,783)	(249)	(31,367)	(33,525)	(2,157)
Agency	(2,949)	(2,820)	129	(27,208)	(31,769)	(4,561)
Total Employee Expenses	**(48,081)**	**(49,879)**	**(1,798)**	**(436,524)**	**(459,610)**	**(23,086)**
Other Operating Expenses	(28,057)	(31,981)	(3,924)	(258,522)	(282,222)	(23,700)
Total Operating Expenditure	**(76,137)**	**(81,860)**	**(5,722)**	**(695,046)**	**(741,833)**	**(46,786)**
Non Operating Expenses	(859)	(761)	98	(7,759)	(7,035)	725
Income and Expenditure Surplus/(Deficit)	**(6,403)**	**(9,754)**	**(3,351)**	**(58,085)**	**(86,249)**	**(28,164)**

Consolidated

£000	This Month Plan	This Month Actual	This Month Var.	Year to Date Plan	Year to Date Actual	Year to Date Var.
Income						
Income from Patient Care Activities	67,804	68,482	678	619,524	631,142	11,618
Other Operating Income	4,506	5,853	1,347	40,588	42,886	2,298
Total Income	**72,310**	**74,335**	**2,025**	**660,112**	**674,028**	**13,916**
Expenditure						
Employee Expenses	(51,854)	(54,016)	(2,162)	(472,631)	(496,456)	(23,825)
Other Operating Expenses	(25,804)	(29,612)	(3,808)	(236,001)	(255,902)	(19,901)
Total Expenditure	**(77,658)**	**(83,628)**	**(5,970)**	**(708,632)**	**(752,358)**	**(43,726)**
Non-Operating Expenses	(930)	(104)	826	(8,376)	(6,545)	1,831
Income and Expenditure Surplus/(Deficit) (pre Technical adjs)	**(6,278)**	**(9,397)**	**(3,119)**	**(56,896)**	**(84,875)**	**(27,979)**
Technical Adjustments	67	72	5	547	839	292
Consolidated I&E Position (incl adjs)	**(6,211)**	**(9,325)**	**(3,114)**	**(56,349)**	**(84,036)**	**(27,687)**

Income from Patient Care Activities

The majority of commissioner income is paid on a block basis with the exception of the Elective Recovery Fund (ERF) Activity, additional service development funding received in year and NHS England high cost drugs and devices. A breakdown of the year to date overperformance of £12.8m is as follows:

- The Trust has benefitted non-recurrently from national guidance decreasing ERF baselines by 4% (£6.4m for the full year) to compensate Trusts for the impact of Doctors strikes April to August. This brings the year to date over performance on ERF to £3.4m
- Additional Cancer Alliance (Targeted Lung Health Checks) new income stream confirmed (£1.1m).
- One-off funding for Pathology LIMS from the ICB to cover expenditure on digital Pathology system and subsequent costs (£0.6m).
- K&M Healthcare Partnership funding for Virtual Wards and schemes targeted at discharges (£1.6m).
- Vascular reconfiguration (£0.5m) and Continuous Glucose Monitoring funding (£0.6m) and System support funding (£1.5m) not included in plan.
- Prior year income benefit (£0.8m).
- The Trust has an additional overperformances in High cost drugs (£4.6m) and Devices (£1.6m) - which matches a corresponding increase in expenditure.

Other Operating Income and Expenditure

Other operating income is favourable to plan in December by £1.4m and by £5.1m YTD. The in month variance is driven by a net favourable adjustment to capital goods scheme income for current and prior years of £0.5m, a grant of £0.2m for low carbon schemes and income for recovery support and improvement programmes totalling £0.4m.

Total operating expenditure is adverse to plan in December by £5.7m and by £46.8m YTD, including CIPs which are reported as £3.7m adverse in month and £26.0m adverse YTD.

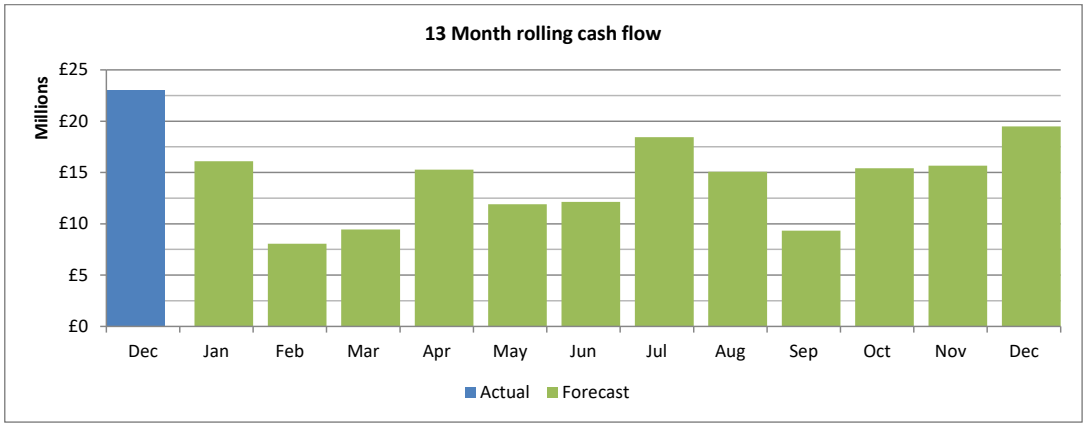
Employee expenses performance is adverse to plan in December by £1.8m and by £23.1m YTD. Pay CIP schemes are adverse to plan in month by £1.9m and by £14.7m YTD. The adverse variance due to the medical and dental and AfC pay award shortfall is £0.4m in month and £4.0m YTD. The cost of IEN payments relating to prior years is negligible in month and £0.9m YTD. The adverse position also reflects the impact of cover during strike action by Junior Doctors and Consultants, which is estimated at £0.3m in month £2.8m YTD. Wte over-utilisation reduced by 36 wte from 117 wte to 81 wte, mainly relating to nursing staff. Over-utilisation reflects the adverse variance to plan for escalation beds of £0.9m YTD, and 1:1 care of £2.2m YTD.

Total expenditure on employee expenses in December was £49.9m, a reduction of £1.0m when compared to November. The reduction relates mainly to substantive staff with reduced IEN arrears costs month on month of £0.2m and a reduction in consultant costs, including locum sessions, of £0.5m. Nursing temporary staffing usage reduced by £0.2m and the total agency run rate is unchanged

Other operating expenditure is adverse to plan by £3.9m in December and by £23.7m YTD. CIP schemes relating to all other operating expenditure headings are adverse to plan by £1.7m in December and by £11.3m YTD. In month and YTD, pressures remain on the Operating Healthcare Facility (OHF) contract which is adverse to plan by £1.1m in month and £7.0m YTD, reflecting the identified risks for catering and generator hire, supplies and EME. Drugs and clinical supplies are adverse to plan by £0.6m in month and £5.9m YTD.

Other operating expenditure reduced month on month by £2.6m, mainly relating to drugs and clinical supplies which fell by a total of £1.3m, and OHF costs which reduced by £0.9m. Establishment costs fell by £0.3m, mainly relating to mobile phones and postage, following high costs in November.

Cash Flow
Month 09 (December) 2023/24



Unconsolidated Cash balance was £23.1m at the end of December 23, £11.8m above plan.

Cash receipts in month totalled £95.7m (£15.6m above plan):

- K&M ICB paid £60.6m in December (£3.5m above plan)
- NHS England paid £13.2m in December (£2.0m above plan)
- Other NHS receipts totalled £1.9m (£0.7m above plan)
- Non NHS Receipts totalled £2.2m (£0.7m above plan)
- Revenue Support received in month was £8.6m (£2.9m above plan)

Cash payments in month totalled £84.4m (£7.4m above plan)
Creditor payment runs including Capital payments were £24.9m (£4.3m above plan). £15.7m payments to 2gether were £0.9m above plan. Payroll was £2.2m above plan primarily due to an increase in PAYE and NI Contributions in year.

YTD cash receipts total £802.4m (£70.6m above plan) largely driven by receipts from NHS England above plan (£31.3m, of which £17.2m was unconsolidated pay award in June) and revenue support above plan by £23.1m.

YTD cash payments total £798.0m (£58.8m above the plan) driven by payments to 2gether below plan (£11.1m), Payroll over plan (£37.6m, predominantly due to the unconsolidated pay award) and creditor payments over plan (£33.1m, due to increase in bank and agency spend)).

2023/24 Plan

The revised plan submitted to NHSE in May 2023 shows a technically adjusted deficit position at the end of 2023/24 of £72.8m. Revenue support for the full deficit amount is forecast in the year.

Forecast

The Trust has submitted a request for £13.8m Q4 revenue support. £5.0m has been requested for January, £3.9m for February and £4.8m for March, in line with the original planned £72m deficit.

In addition, the Trust submitted a request for exceptional working capital for a further £7.5m to NHSE (£5.8m in January, £0.7m in February and £1.1m in March), which was the value required to clear outstanding creditor balances overdue by more than 90+ days. The Trust is awaiting confirmation that our request has been successful.

Creditor Management

The Trust stayed at 30 day creditor terms in Month 9.

In prior months, payments to one key supplier were being held and invoices cleared only if the funds were available. As at 30th December 2023, £1.6m was overdue for payment with a further £2.5m falling due next month.

At the end of December 2023, the Trust was recording 53 creditor days (Calculated as invoiced creditors at 31st December / Forecast non-pay expenditure x 365).

Statement of Financial Position
Month 09 (December) 2023/24

£000	Opening	To Date	Movement	
Non-Current Assets	**402,107**	**395,909**	**(6,198)**	▼
Current Assets				
Inventories	6,749	8,334	1,585	▲
Trade Receivables	11,677	10,284	(1,392)	▼
Accrued Income and Other Receivables	29,981	13,190	(16,791)	▼
Assets Held For Sale			-	
Cash and Cash Equivalents	18,618	23,072	4,455	▲
Total Current Assets	**67,025**	**54,881**	**(12,144)**	▼
Current Liabilities				
Payables	(41,537)	(46,641)	(5,104)	▲
Accruals and Deferred Income	(46,653)	(39,412)	7,241	▼
Provisions	(2,887)	(3,782)	(895)	▲
Borrowing	(4,838)	(2,606)	2,232	▼
Net Current Assets	**(28,892)**	**(37,561)**	**(8,669)**	▼
Non Current Liabilities				
Provisions	(3,405)	(3,282)	124	▼
Long Term Debt	(77,371)	(74,046)	3,326	▼
Total Assets Employed	**292,439**	**281,021**	**(11,418)**	▼
Financed by Taxpayers Equity				
Public Dividend Capital	454,994	529,825	74,831	▲
Retained Earnings	(217,590)	(303,839)	(86,249)	▼
Revaluation Reserve	55,035	55,035	-	
Total Taxpayers' Equity	**292,439**	**281,021**	**(11,418)**	▼

Non-Current asset values reflect in-year additions (including donated assets) less depreciation charges. Non-Current assets also includes the loan and equity that finances 2gether Support Solutions.

Trust closing cash balance was £23.1m (11.8m in November) £11.8m above plan. See cash report for further details. Cash has been supported in year by £74.5m of revenue PDC, this along with £0.3m of capital PDC accounts for the £74.8m total increase to PDC.

The current I&E adverse variance to plan is having an impact on cash - and the Trust's ability to pay creditors - this impact is clearly seen in the Better Payment Practice Code figures. The additional working capital received in month has helped the Trust to reduce the age and value of outstanding creditors.

Trade and other receivables have decreased from the 2023/24 opening position by £1.4m (£2.2m reduction in November). Key drivers are detailed on the Cash report.

Payables have increased by £5.1m (£9.5m increase in November), we continue to reduce payables as and when we receive working capital support, See Working Capital sheet for more detail on debtors and creditors.

The long-term debt entry relates to the long-term finance lease debtor with 2gether.

Capital Expenditure
Month 09 (December) 2023/24

Capital Programme	Annual	Annual	Year to Date		
£000	**Plan**	**Forecast**	**Plan**	**Actual**	**Variance**
Emergency Department Expansions	4,271	6,270	4,271	6,269	(1,998)
Community Diagnostics Centre	2,845	1,600	1,624	41	1,583
Mechanical Thrombectomy	2,608	1,191	1,208	71	1,137
Diagnostics Clinical Equipment	2,550	2,550	1,275	0	1,275
Information Development Group	2,000	2,000	1,850	1,075	775
Medical Devices Group	1,666	1,666	1,242	639	603
Electronic Medical Records	1,545	1,526	1,165	1,389	(224)
Stroke HASU	1,463	1,463	592	722	(130)
Diagnostics Imaging Capacity	1,433	1,428	1,433	(0)	1,433
Patient Environment Investment Committee	3,771	4,273	3,071	177	2,894
Charity Donations	900	700	654	321	333
Other Build	736	1,764	686	1,047	(361)
Subsidiaries	519	827	312	218	94
Other IT	375	2,098	0	412	(412)
Other Medical Equipment	259	244	259	244	15
Trust IFRS16 Acquisitions	0	174	0	174	(174)
Lease Cars	0	71	0	30	(30)
All Other	0	217	0	13	(13)
	26,941	**30,062**	**19,642**	**12,842**	**6,800**

Funded By:	**Plan**	**Forecast**	**Change**
Operational Cash	21,515	21,515	0
System Set Underutilisation	(2,850)	(2,896)	(46)
Donations	900	700	(200)
Disposals	250	250	0
System Capital PDC	1,463	2,576	1,113
PDC	5,663	7,336	1,673
Carried Forward PDC	0	131	131
New Lease Loans	0	0	0
New Lease Repayments	0	(85)	(85)
	26,941	**29,527**	**2,586**

Under/(Over) Commitment	**0**	**(534)**

The Trust submitted the final 5-year Capital Plan to NHSE on 4th May 2023, the programme totalling £26.94m in 2023/24.

The latest forecast for the year, as at M9, is £30.06m, representing a £3.12m net increase from the original plan; this represents the net impact of:

- increases totalling £3.37m, of which £1.1m was additional CDEL approved by NHSE in December 2023, £1.69m external PDC funding for the 23/24 Digital Histopathology project, £0.534m due to New Lease Loans taken in-year and £0.04m additional external PDC funding under the Diagnostic Digital Capability Programme;
- reductions totalling £0.25m, of which £0.05m was due to a reduction in the Diagnostic Imaging Capacity PDC funding assumed (and associated spend plans) to align it to the final funding figure provided in the MOU and £0.2m forecast reduction in the assumed Charity Donations expenditure.

YTD Capital Spend

The Group's gross capital year-to-date spend to the end of Month 9 was £12.8m, against a YTD plan of £19.6m. This represents a £6.8m net underspend, as a result of:

- Underspends totalling £10.1m (of which most notably £2.9m on PEIC, £2.7m on Diagnostics Equipment, £2.7m on CDC and Mechanical Thrombectomy and a further £1.8m on IDG, MDG and other schemes)
- Overspends totalling £3.3m (including £2m on the ED Expansion programme, £0.6m on EMR and Other IT Projects, £0.5m on Stroke Hasu and other build schemes and £0.2m on IFRS16 Lease items and other smaller schemes)

Risks and Mitigations

Following the slippage risks reported at the Capital Investment Group (CIG) meeting in December 2023, the Committee endorsed the proposed mitigating actions and recommended the Trust rejects the £2.3m additional CDEL offered by the ICB in November 2023. This was subsequently escalated to and endorsed by the Chief Finance Officer.

Following the M9 reported position, further risks of slippage have surfaced to an estimated net total of £2m (which includes the currently unfunded IFRS16 items). The team is working to finalise a set of recommended options to mitigate the slippage across financial years, by bringing forward a corresponding level of planned expenditure on both clinical and non-clinical equipment and releasing the capital in 2024/25 for the completion of the schemes that have slipped into the next financial year.

The £0.534m overcommitment reported as at M9 relates to IFRS16 schemes, for which NHSE and the ICB are yet to confirm the additional funding support. However, in the light of the latest slippage risk reported, it is likely the Trust will be able to absorb this cost pressure internally.

Cost Improvement Summary

Month 09 (December) 2023/24

Delivery Summary	This Month			Year to Date			Forecast	
Programme Themes £000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Outturn**	**Variance**
Agency	737	40	(697)	5,463	510	(4,953)	6,690	(644)
Bank	-	-	-	-	-	-	6	6
Workforce	1,359	79	(1,280)	10,343	361	(9,982)	5,218	(9,028)
Outpatients	-	22	22	-	43	43	136	136
Procurement	81	40	(41)	394	473	79	3,875	3,166
Medicines Value	102	50	(52)	666	448	(218)	624	(376)
Theatres	234	-	(234)	1,674	-	(1,674)	517	(1,983)
Care Group Schemes *	1,410	929	(481)	9,614	2,339	(7,275)	16,139	1,928
Sub-total	**3,923**	**1,161**	**(2,762)**	**28,154**	**4,174**	**(23,980)**	**33,205**	**(6,795)**
Central	-	416	416	-	6,795	6,795	6,795	6,795
Grand Total	**3,923**	**1,577**	**(2,346)**	**28,154**	**10,969**	**(17,185)**	**40,000**	**0**

* Smaller divisional schemes not allocated to a work stream

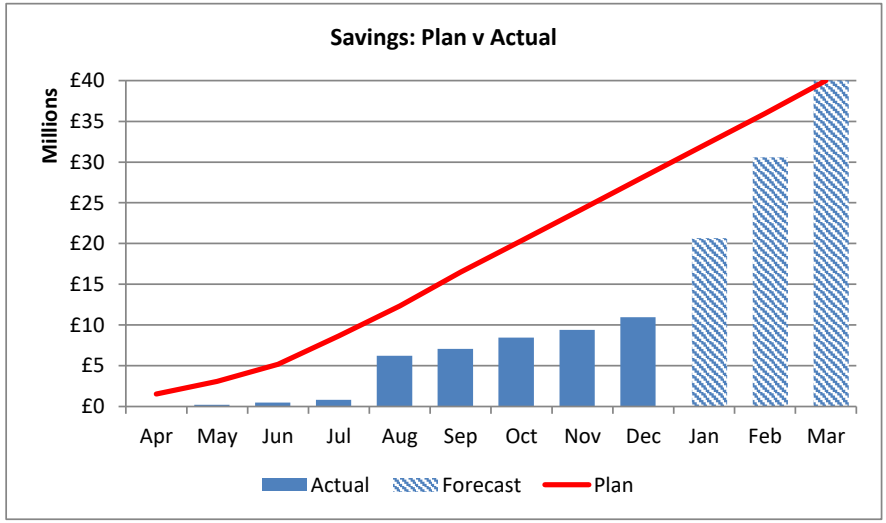
Delivered £000		
Month	**Target**	**Actual**
April	1,532	58
May	1,550	149
June	2,100	290
July	3,474	311
August	3,684	5,422
September	4,174	842
October	3,852	1,379
November	3,865	940
December	3,923	1,577
January	3,931	
February	3,879	
March	4,036	
	40,000	**8,452**

Efficiencies

The submitted Efficiencies plan for 2023/24 is £40m. The Trust recognised recurrent savings of £1.0m in December, and £2.9m on a YTD basis, which is significantly below Plan. YTD underperformance is primarily due to timing of schemes in Agency, Workforce, Theatres, and Care Groups currently being developed. There was, however, schemes relating to income which are delivering, with £0.9m in month, and £4.6m forecast for 2023/24

The current value of the pipeline is £11.2m, a decrease of £2.8m vs. the prior month, and this also includes efficiencies being confirmed as reduction to run-rate overspends from FY23, rather than CIPs. There are various theme based workstreams including vacancy and non-pay panels. The PMO is now supported by PWC and financial recovery director to maximise delivery of CIPs for the current financial year and develop a programme of CIPs for delivery in 2024/25.

Executive Owners Theme leads have been agreed to carry this work forward to develop a long list of schemes by the end of January and refine this to a short list of quantified schemes expected to deliver in FY24/25.



East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Report on Journey to Exit NHS Oversight Framework (NOF4) and Integrated Improvement Plan (IIP)**

Meeting date: **1 February 2024**

Board sponsor: **Chief Executive**

Paper Author: **NHS England (NHSE) Improvement Director**

Appendices:

Appendix 1: IIP Update
Appendix 2: IIP Risk Register

Executive summary:

Action required:	Discussion
Purpose of the Report:	This report has been provided to update the Board of Directors on delivery progress of the Integrated Improvement Plan (IIP) and offers assurance based on evidence gathered for how this is influencing the exit criteria set within the NHS England Recovery Support Programme National Oversight Framework Segment 4 (NOF4). The report also acknowledges the key risks to delivery of the IIP, highlighting current mitigations in place.
Summary of key issues:	The report includes an update by programme and project. Four programmes are rated as amber with significant progress being made in Quality & Safety, Maternity and People & Culture programmes. Two programmes continuing to be rated as red in this period which are the biggest risk to delivery and exit from NOF4. Robust evidence continues to be gathered against the IIP and the Strategic Improvement Committee (SiC) have implemented a robust self-assessment process to offer assurance in meeting the NOF4 exit criteria which is shared in the IIP Board report based on current evidence gathered. Three 'Evidence Review and Assurance Panels' (accountable to the Strategic Improvement Committee(SiC)) have taken place during January 2024 with three more to take place in February. These ensure that there is a thorough assessment of evidence provided and to confirm and challenge its quality, ensuring the organisation is assured of its progress, whist agreeing next steps.
Key recommendations:	The Board of Directors is invited to **DISCUSS** and **NOTE** the report.

We care

East Kent Hospitals University NHS Foundation Trust

Implications:

Links to Strategic Theme:	This report aims to support: • Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	**BAF 32** – There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered. **BAF 34** – There is a risk that our constitutional standards are not met. **BAF 38** – Failure to deliver the financial plan of the Trust as requested by NHS England (NHSE).
Link to the Corporate Risk Register (CRR):	N/A
Resource:	No
Legal and regulatory:	Yes – regulatory impact.
Subsidiary:	Yes – in the overall provision of services within the resources available to the Trust.

Assurance route:

Previously considered by: Strategic Improvement Committee (SiC).

East Kent Hospitals University Foundation Trust
Report on Integrated Improvement Plan (IIP)

Journey to Exit NHS Oversight Framework (NOF4) – IIP Update
January 2024 Summary

Purpose of Report

NHS
East Kent Hospitals University
NHS Foundation Trust

This report has been provided to update the Board of Directors at EKHUFT on delivery progress of the Integrated Improvement Plan and offers assurance based on evidence gathered for how this is influencing the exit criteria set within the NHS England Recovery Support Programme National Oversight Framework Segment 4 (NOF4). The report also acknowledges the key risks to delivery of the IIP, highlighting current mitigations in place.

Delivery of the Integrated Improvement Plan is overseen by the EKHUFT Strategic Improvement Committee (SiC) which is chaired by the Chief Executive. Programmes continue to ensure the level of evidence meets EKHUFT and other stakeholder requirements i.e., system partners and region.

The Board of Directors receive a monthly update on delivery of the Integrated Improvement Plan focusing on successes, challenges and actions to mitigate any key risks to delivery which may affect NOF4 exit criteria. Impact and demonstrable progress against the overall programme objectives set by the national team are provided on a quarterly basis through a deep dive presentation.

High-level Assurance on Programme/Project Delivery

Programme	Project	Summary
Leadership & Governance	**Executive Leadership**	• Commencement of substantive Chief Medical Officer (CMO). • Interim Chief Operating Officer (COO) in post with interview dates agreed for substantive COO post. • This workstream remains amber based the vacant substantive Executive posts detailed within the milestones.
	Governance	• Good Governance Institute (GGI) review has been completed with feedback shared at Board Development Day on 11 January 2024. Recommendations and a plan for delivery is agreed following these discussions. • This workstream has moved from red to amber based on completion of a number of milestones, the finalisation of the GGI review and the work that has begun around the implementation of the Organisational governance structure.
	Comms & Engagement	• This project remains rated green as the milestones have been met to develop and roll out a communications and engagement strategy including a monthly rolling programme of activity now Business As Usual (BAU). Included in the last period: Trust achievements during 2023, Length of Stay (LoS) reduction, celebration of teams supporting winter plan, engagement on financial position and controls, improvements in maternity linked to opening of Midwifery Led Unit (MLU). Quality improvements and success stories have also been shared, along with promotion of staff health and wellbeing initiatives. Executive team engagement grid developed to promote the visibility of the Executive team and to promote the golden thread between the Board, staff and patient experience and being delivered. • Continued engagement of care group leadership teams and support for care group cascade and continued relationship building with Integrated Care Board (ICB)/NHS England (NHSE)/system partners, risks and concerns escalated.
	Transformation Programme	• Workstream remains amber, with some significant pieces of work underway. These include the scoping exercise for the organisations Strategy (including the Clinical Strategy) and the work on the plan to how the organisation embeds and communicates its improvement methodology.
People and Culture	**Attract and Retain**	• The project remains rated as green. Significant work has commenced to look at sickness hotspots and trends. So far, within this project a reduction of sickness has been recorded within Emergency Department (ED), from 7% to 4%. Current area of focus is Maternity and Acute Medical Unit (AMU) with the next substantial sickness figures. Appraisal plan being worked through as themes have now been identified. Executives are being requested to support in with organisational strategic priorities.
	Culture Leadership & Development	• The project remains rated at green with good progress throughout this programme. National Staff Survey (NSS) results embargoed until March 2024. Quarterly pulse survey has now been launched. New organisational dashboard has been written to replace the NSS one currently used. Culture Leadership Programme progressing towards the end of the discovery phase in March 2024. Preparation of development of the change team to support the full analysis of discovery taking place, this will enable one team with one plan.
	Medical Workforce	• There has been a significant improvement in leadership and engagement from the Medical Office which has enabled the reduction in risk score this month. Whilst the programme RAG remains red, the team are confident that the right mitigating milestones have been put in place for the progression of Phase 2. A new risk has emerged hoever over funding for rostering this month.

High-level Assurance on Programme/Project Delivery

Programme	Project	Summary
Quality & Safety	Quality Governance	• Serious Incident (SI) performance continues to demonstrate a month-on-month improvement, with just two SIs breaching the 60-day deadline in November (one historic SI pre-April 2023). The Risk Review Oversight Group has been established with the first meeting held on 22 December. New milestone have been written to have oversight of the programmes of work within the risk register review project, with work progressing to enable some risk scores to reduce. Project RAG remains amber due to the nature of the red milestones and ensuring appropriate governance is embedded, however this is not a reflection on significant amount of work being produced and the demonstration in outputs.
	Safeguarding	• The team continue to increase visibility across the trust, including walk arounds and a weekly presence across sites to ensure that staff are making safeguarding personable for patients. Work continues with the staffing agency providers to ensure there is robust oversight implemented. Safeguarding training compliance is now appropriately aligned to relevant staffing profiles and has positively improved with Children's Level 1- 100%, Level 2 - 84%, Level 3 - 87% and Adults Level 1 - 100%, Level 2 - 85% and Level 3 - 72%. New trajectories have been agreed with the ICB. Discussions continue with the Integrated Care Board (ICB) monthly to offer assurances and evidence of sustained safeguarding processes, including safeguarding risks and learning from incidents. The substantive Head of Safeguarding commenced in post on 15 January 24.
	Fundamentals of Care	• The governance formulating the Fundamentals of Care (FOC) framework is progressing to ensure relevant and appropriate workstreams and metrics are monitored and implemented by the FOC Committee during 2024. Following on from the success of the first Ward Accreditations, phase 2 of the programme and development of an accreditation tool beyond ward areas, eg Critical Care, ED, Outpatients has commenced. The first Dementia Strategy Oversight Committee is planned for early January 24 which will oversee the progress of the implementation of the Dementia Strategy.
	Deteriorating Patient	• The Q2 Commissioning for Quality and Innovation (CQUIN) audit is now complete with positive results noted with the results to be shared through the Deteriorating Patient Steering Group with recommendations. The alignment of staffing profiles on Electronic Staff Record (ESR) to the NEWS2 e-learning mandatory training is now complete. The first training report is expected to be released mid-January which initially will show low compliance however, the report will enable where focus needs to occur. The Call4Concern (national initiative) still continues with positive feedback received. The team continue to review the data and report back to the Deteriorating Patient Steering Group to ensure service is sustainable in the future and becomes BAU.
Operational Performance	UEC and Whole System Interface	• Performance for December deteriorated for all types (69.04% v 69.9% in November) with the region reporting a 1-2% decline in some trusts: this was against a substantial increase in the number of type 1 arrivals to ED (13.2Kv 12.6k Nov) and an increase in ambulance arrivals (5,298 v 5,032 Nov) the highest number reported in the last 12 months. EKUFT reported a slight improvement on the type 3 performance in month 97.9% v 97.2%. Ambulance handover< 15 mins continues to show an improving trend with Same Day Emergency Care (SDEC) and Urgent Treatment Centre (UTC) showing increased activity through the units. Total time in department for admitted patients deteriorated in month (11.7% V 10.7% Nov) but an improvement on the numbers of patients waiting over 24 hours (53% v 69% Nov) single point of access (SPOA) saw a reduction in ambulance conveyances to William Harvey Hospital (WHH) Nov/Dec, but QEQM reports the highest number of conveyances since 2022 (2,635 v2,297 Nov). Plans to set up SPAO across both sites are in place for January. Medical SDEC activity increased across both sites, with further review and work planned to further develop the DAP. The work with PRISM and KPMG continues the roll-out of SAFER across the wards, with LoS being a key EKUFT workstream, Senior Responsible Officer (SRO) led to improve flow and 12-hour ED waits supported by Site Care Group Triumvirate Internal Discharge Workforce. To prepare for the doctors strikes in January, plans involve detailed action to provide support to all critical services including the Urgent & Emergency Care (UEC) and will be overseen by COO and Hospital triumvirates . MADE events planned in readiness together with close working with the Health and Care Partnership (HCP) on rolling out the winter schemes.

High-level Assurance on Programme/Project Delivery

Programme	Project	
Operational Performance Continued…	**Elective Recovery (including Diagnostics)**	• The Elective position remains red as the organisation continues to see a deterioration in 65-week performance. Tier 1 meetings commenced on 10 January and a clear expectation that all 78-week risk cohort patients would be treated by the end of March 2024. Several key actions have been taken to deliver this challenge: - • Trust Tier 1 recovery meetings commenced from 11 January with care Groups focused on delivery of the 78-week clearance plan and development of their recovery plans. • Targeted investment into Endoscopy to increase utilisation of existing internal capacity and appointment of Endoscopy Recovery Lead. • Quantitative Faecal Immunochemical Test (QFIT) programme to commence for existing patients and immediate controls to be placed on referrals from Primary Care to ensure referrals are not accepted without QFIT test. • Targeted proposal being created to address validation backlog and separately address 12-week validation targets. • DM01 performance in November stabilised at 59.1%. Key challenges remain around Endoscopy and the CT vetting backlog which currently stands at 1,874 patients. • Positive engagement continues with Prism who have now agreed their improvement trajectories from 4 January 2024. • Further Faster programme now well underway with all specialities engaged and reviewing playbooks. Improvement plans to be presented at Planned Care Meeting in February with core targets driven to reduce follow-ups, increase Patient Initiated Follow-Up (PIFU) and enhance clinic utilisation.
	Cancer	• Good progress had been made resulting in above trajectory performance for the Faster Diagnosis Standard (FDS) (69.2% Vs 60% forecast in December). This is being further strengthened with the introduction of new stretch targets for Skin, Breast, Lower and Gynae to support added assurance of delivery by the end of March 2024. Governance structures have been agreed with all Managing Directors (MD's) and new weekly recovery meetings established. The teams continue to address the high priority themes that have influenced the 62-day backlog that unfortunately increased to 525 (trajectory 409 for December) due to the increase within Urology and Skin and the ongoing back log within Lower GI although Lower GI did deliver trajectory and continues to move in a positive direction. • The specific asks to address the backlogs for each team are embedded in the weekly Cancer Performance Feeder pack and the agreed actions plans to make improvements sustainable are being agreed and signed off at the new weekly recovery meeting to support/prioritise and maximise the assurance of compliance by March 2024.
Maternity	**Team Working**	• Frontier Leadership/Strength of the pack culture session delivered on 19th December to Maternity Management Team. Feedback survey and evaluation received and shared with senior leaders and with the provider. Given the success of this session, there has been a request to deliver similar at the B7 away day. SCORE survey complete, response rate of 34% against the 40% target. Awaiting results, which will feed into the third phase of the NHSE Perinatal Culture and Leadership programme.
	Clinical Escalation & Handover	• Enhanced Maternal Care (deteriorating woman) fundamentals training has commenced with a completion rate of 34% and trajectory to achieve 82% against a localised target of 75% by March 24. This supports roll out of the redesigned EMC care pathway, due to launch from 1 April 24. Designated space identified at each acute site with specialist equipment on order. This pathway includes the embedded use of the Modified Early Warning Score (MEWS2) assessment tool.
	Clinical Assessment & Care Pathways	• Task and finish group established to implement centralised telephone triage by the end of March 2024 - 2 of the 4 Year 1 Maternity and Neonatal Improvement Programme (MNIP) priorities under clinical pathways (workstream 3) is due to complete by March 24. The remaining two priorities are to be carried over as year 2 priorities, in addition to the identified care pathway developments for 2024/25.
	Governance & Patient Safety	• Work continues to reduce the patient safety related backlogs, under management of the MNIP and with oversight of Maternity and Neonatal Assurance Group (MNAG). • Care group Quality Standards Framework (QSF) meeting booked for 25 January to align to the Trust level governance structure. This will enable further progress of several milestones within the IIP.
	Engagement, Listening & Leadership	• Maternity and Neonatal Voices Partnership (MNVP) workplan has been shared, which includes site visits booked throughout 2024. Joint working on MNVP feedback log to ensure service user input to service redesign/improvements. • MNIP Comms plan is in draft and due for publication March 2024. • MNIP six-month engagement event to take place in January 2024.

High-level Assurance on Programme/Project Delivery

Programme	Project	
Finance	**Financial Governance**	• Revised financial governance processes are now in the embedding stage with regular comms in place with the care group triumvirates. There is regular review of the Trusts financial performance by the Board of Directors and the Finance and Performance sub-committees. Enhanced controls of pay and non-pay were approved by the Executives on 15 November and are in the embedding stage. A financial control review was commissioned from PricewaterhouseCoopers (PWC) to compare current processes with best practice. Draft report now received.
	Financial Improvement	• Improvements in run rate have been noted with several benefits due online in next coming months, however, whilst an Financial Recovery Plan (FRP) has been drafted, the trust has significantly diverged from the trajectory within. Drivers of the deficit review commissioned from PWC which will provide a clear picture of the deficit at the trust i.e. what is structural, what is operational efficiency with the draft report received. Immediate priority is to continue with grip and control to stabilise the position and then developing the detailed cost improvement plans to improve financial and operational performance with PWC support to drive forward. The trust is £24.6m worse than plan at the end of month 8.
	Financial Consciousness	• Continued engagement and comms aligned to the Comms strategy is now BAU. Development of sessions take place with the clinical workforce & leaders regularly.

Impact to NOF4 Exit Criteria – Leadership and Governance

Exit Criteria 1	Exit Criteria 2	Exit Criteria 3	Exit Criteria 4	Exit Criteria 5	Exit Criteria 6
Executive leadership team posts filled.	Executive leadership development plan in place.	Trust board sighted on key risks and actions taken via appropriate escalation routes.	Evidence of effective comms and engagement channels between the frontline and the Board and outwards to ICB/NHSE/system partners, inclusive of routes of escalation for risks and concerns.	In response to the 2022 Independent Investigation into Maternity Services, evidence of Board oversight and leadership of a structured transformation programme approach with a clear Quality Improvement methodology to address culture, psychological safety and teamworking within the maternity service.	The Trust is making a full contribution to the HCP for East Kent, the provider collaboratives and the ICS.

Suggested Evidence

• Executive leadership team posts filled.	• Board development programme in place and evidenced, which places equal importance on the internal leadership of the Trust as the external leadership within the East Kent HCP, and the Kent and Medway ICS. • Evidence of clear focus and internal traction on key priorities against transparent improvement methodology.	• Evidence of robust governance processes in place with clear Board ownership of risks and mitigating actions. • Evidence of 5 months of BAF and corporate risk register being actively used at sub-committee and Trust Board with appropriate and timely response. • Evidence of governance review recommendations implemented.	• Evidence of improved communication processes. • Evidence of timely communication between key stakeholders and specifically ICB and NHSE colleagues. • Evidence of a 'golden thread' running through the organisation from Board to ward, where executives are fully sighted on what it feels like to be a patient and be a member of staff receiving and delivering services.	• Evidence of improvement measured by workforce, FTSU, leadership and cultural measures across maternity and wider services and ability to demonstrate learning across the Trust where applicable.	• Evidence that the Trust is making a full contribution to the HCP for East Kent, the provider collaboratives and the ICS.

Exit Criteria RAG Definitions	
	Exit Criteria achieved and embedded
	On track, and with clear evidence, to meet the exit criteria by the planned exit date
	Emerging risk of inability, or no clear evidence of ability to meet exit criteria by the planned exit date.
	Off track with high risk of inability to meet exit criteria by planned date.

Impact to NOF4 Exit Criteria – Quality and Safety

NHS East Kent Hospitals University NHS Foundation Trust

Exit Criteria 1

Evidence of an improved process based on best practice and in accordance with framework standards for the management of serious incidents with evidence of delivery, leadership and learning from incidents, reflecting a single approach which aligns to the Trust governance process.

Exit Criteria 2

Evidence of sustained improvement in safeguarding compliance with the NHS Safeguarding Accountability and Assurance Framework 2022 overseen by the Trust Board, including oversight of any sub-contracted activity, with continuous cycle of review, assessment and implementation of best practice and learning.

Suggested Evidence

Governance

- Evidence of improved transparency and timeliness of communication, reporting and information sharing with ICB partners.
- Evidence of SI ownership, improvement methodology, learning and training programme with a focus on detecting and responding to 'missed opportunities' promptly, with no delay in the immediate actions arising out of 72 hour reports.
- Evidence of a Clinical Harm Review process that supports future learning, improved risk assessment and process improvements so that patients at risk of ongoing/future harm can be identified in advance and care prioritised in order to prevent harm occurring.
- Timely identification, effective investigation and closure of SIs within national guidelines.
- Clear documented up to date process/policy for reporting serious incidents (SI) and never events (NE) (SIs and NEs) which includes the governance of SIs from front line to Board and demonstrating how the Board oversees the management of Serious Incident and Never Event framework including how learning is implemented for all services.
- Evidence of training on SI and NE delivered in induction for all new staff.
- Focus on recognising, responding and escalating the deteriorating patient, diagnostic delays in reporting, safer medicines administration.

Reporting and Investigation of SIs

- Reduced number of SIs over the 60 day deadline for completion of investigation. The only overdue SIs are those held up by external investigations or waiting for ICB to close.
- Significant reduction in SI investigations returned following request for closure for more information.

Learning from SIs and Never Events

- Clear evidence of the identification of learning from serious incidents influencing change in practice.
- Evidence from the trust of the process of training and identifying an investigator, reinforcing ownership of the issues and improvements to the front line there needs to be alignment of the SI process so that maternity and general SI's are not managed in silos.
- Evidence of how trust wide action plans for falls and pressure ulcers are resulting in improvements to patient safety.
- Evidence that the Board assures themselves of improvements in practice as a result of learning from SIs relating to patient deterioration.
- Evidence of an audit programme presented to the Board demonstrating improvements in patient safety as a result of serious incident management.

Safeguarding

- Workforce: Evidence that Substantiative leadership for the safeguarding team has been recruited to, and workforce plan.
- Annual reports: Evidence of 'Looked after Children' in annual reporting, and continued evidence of annual reports for safeguarding adults and children. Evidence of a safeguarding audit plan aligned to safeguarding SIs and statutory reviews.
- Policy: Evidence that enables the rag rating of the requisite policies to underpin safeguarding can move from red on the plan and risk register.
- Supervision: Evidence of increased uptake.
- Training: Evidence of safeguarding and mental capacity training needs analysis with compliance trajectory.
- Evidence to show sustainability of improvements made in the last 6 months.
- Provide a copy of the most recent safeguarding improvement plan showing compliance against the NHS Safeguarding Accountability and Assurance Framework

Impact to NOF4 Exit Criteria – People and Culture

NHS
East Kent Hospitals University NHS Foundation Trust

Exit Criteria 1	Exit Criteria 2	Exit Criteria 3	Exit Criteria 4	Exit Criteria 5
Evidence of staff and user involvement in improvements and changes made through methods of capturing feedback e.g., use of template proformas asking staff how they have been involved in specific improvements.	Staff survey demonstrating an improvement in staff engagement and Trust leadership in line with National/ peer/ICS.	Staff sickness and vacancy trajectories tracked and responded to in line with regional and national position with no evidence of being a significant outlier across the ICS.	Improvement in the retention and turnover rates for all staff groups and sustained improvement in vacancy rate trajectory in the hard to recruit specialties.	International nursing and Clinical Support Worker recruitment trajectories agreed and evidence of delivery against these by March 2024.

Suggested Evidence

• Evidence of improved FTSU processes and reduction in whistle-blowing • Increasing inclusion and diversity awareness and response • Staff/User Involvement improvement e.g. use of template proformas asking staff how they have been involved in specific improvements, Pulse surveys.	• Staff surveys showing improvement in response rate (41.9% in 2020, national average was 45.4%) and outcomes for engagement, morale, safe environment: bullying and harassment, safety culture (outliers nationally).	• Reduction in sickness rate and plans in place for staff wellbeing.	• HCSW - pipeline/progress and tracking retention of these staff at 3/6/12 months. • RN recruitment and tracking retention of these staff at 3/6/12 months. • Evidence of medical workforce job planning and demonstration of compliance against the levels of attainment with trajectory to achieve level 4. • Evidence of a Trust recruitment and retention strategy to support all areas. • Evidence of workforce plans • Sustained reduction in use of agency staff trajectory.	• Improvement in the retention and turnover rates for all staff groups and sustained improvement in vacancy rate trajectory in the hard to recruit to specialties. • Reduction in overspend for work permits.

Impact to NOF4 Exit Criteria – Operational Performance

NHS East Kent Hospitals University NHS Foundation Trust

Exit Criteria 1	Exit Criteria 2	Exit Criteria 3	Exit Criteria 4
Evidence of an improved grip and realistic refreshed improvement trajectory in UEC whole pathway performance and out of hospital flow, benchmarked both nationally and regionally, by March 2024	Embedding of essential operational management including rota management, job planning, waiting list oversight and theatres scheduling.	Sustained improvement in cancer 62-day performance by March 2024	Elective recovery plan implemented with evidence of delivery against trajectory and continued reduction in 52ww and P2 patients by March 2024.

Suggested Evidence

- Evidence of sustained improvement in delivery trajectories, process, leadership and grip across UEC, elective and cancer.
- Implement a patient flow model, that gives the trust consistent capacity to meet demand.
- Comprehensive UEC plan which aims to deliver 76% by end of year for all types, with type 1 at 50% or above and consistent reduction in 12 hour in department.

- Evidence the Trust embeds the basics of operational management; rota management, job planning, waiting list oversight, and theatre scheduling.

- Evidence that the Trust is delivering against the operational plan trajectories (RTT, Cancer, Diagnostics).

- Evidence the Trust understands what is driving performance and what they are trying to address with clear plans for consistent improvement and path to sustainability.
- Improvement delivery towards zero 65 week waits, and a drop in waiting list size.

Impact to NOF4 Exit Criteria - Maternity

East Kent Hospitals University NHS Foundation Trust

Exit Criteria 1	Exit Criteria 2	Exit Criteria 3
Evidence of improved and sustained maternity governance process in place.	Evidence of improvements in service with clear process for providing evidence of compliance and completed regulatory actions by March 2024.	Evidence of improved culture, behaviours, relationships and communications between all relevant teams and frontline staff.

Suggested Evidence

- Robust policies in place with internal audit undertaken to show their effectiveness and compliance.

- Feedback from service users and staff to provide evidence of impact of improvements.
- Evidence that the Trust has complied with all the actions from the HEE & NMC report into Canterbury Christ Church Midwifery BSC programme in improving the learning environment.
- Evidence of delivery against the revised maternity transformation programme (MTP) which has been developed through engagement and co-production with clinical staff.
- Benchmark and evidence against all national standards - CQC, NHSEI (Ockenden), NICE etc.
- Compliance with Ockenden and Clinical Negligence Scheme for Trusts (CNST).
- Evidence of sustained improvement as demonstrated by feedback, assurance visits and monthly reports from Maternity Safety Support Programme.

- Evidence that the culture and working relationship between midwives and obstetric staff has improved, as measured by staff Pulse services.
- Evidence that there are effective freedom to speak up guardians in place and staff trust that they can escalate to them and that their concerns will be listened to and acted on.
- Evidence of the approach being taken to improve the culture within the Trust, accepting the findings of 'Reading the Signals' and demonstrating the beginning of a restorative process.

Impact to NOF4 Exit Criteria - Finance

NHS East Kent Hospitals University NHS Foundation Trust

Exit Criteria 1	Exit Criteria 2	Exit Criteria 3	Exit Criteria 4	Exit Criteria 5	Exit Criteria 6	Exit Criteria 7	Exit Criteria 8
Agreed financial recovery plan in place supported by a clear evidence base, approved off by the board and agreed with the ICB that is compliant with financial improvement trajectories agreed by NHSE and system.	Delivery of the 23/24 planned deficit or better.	Evidence of improved delivery against agreed financial plans, trajectories, and envelopes.	The Trust fulfils its statutory duties with regard to financial management.	Robust oversight, financial controls and processes are in place and overseen through appropriate financial governance procedures.	That the Trust benchmarks well against the model hospital financial efficiencies, or where this is not the case has a trajectory which brings alignment as soon as possible.	The trust and system have a shared understanding of risks to the financial plan and have agreed mitigations in place.	Control of the costs of overseas recruitment against plan.

Suggested Evidence

• Financial Recovery plan (FRP) and any supporting documentation • Evidence that the FRP has been approved by the ICB and NHSE.	• Delivery of the 23/24 planned deficit or better.	• Evidence of delivery of financial trajectories set out in the FRP.	• Evidence that there is regular oversight by the Board and sub-committees on the progress against delivery against the FRP.	• Robust oversight, financial controls and processes are in place and overseen through appropriate financial governance procedures.	• Clear view on the drivers of deficit- what is structural, what is operational efficiency etc. and a plan for what is in the Trust's gift to change.	• System wide alignment of risks to the financial plan and shared view of mitigations, by both Trust and ICB.	• Evidence of a cash management plan in place.

High Level IIP Risk Summary

Definitions

Movement in month – Key:

★	New Risk	⬇	A decrease in risk score
⬌	The score remains the same	⬆	A rise in risk score

East Kent Hospitals University NHS Foundation Trust

Key risks to delivery in this period:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Mitigating Actions	Date of Last Review	Residual Risk Score	Risk Trend
2.102	22.09.23	Maternity	Sarah Hayes	Unfilled vacancies, combined with high levels of maternity leave and short-term sickness will have an effect on patient outcomes and quality and safety. Inadequate midwifery staffing levels may result in women receiving sub-optimal care during labour.	20	a) Daily site-wide SitRep to assess safe staffing and ensure escalation policy is appropriately followed b) Line bookings of NHSP and agency, framework and off framework with applied incentive c) Specialist midwives redeployed to fill gaps d) Suspension of continuity of carer e) Utilisation of managers on call and community midwives	18.12.23	12	⬌
4.4.02	14.06.23	Quality & Safety	Sarah Hayes	The build of the deteriorating dashboard is dependent on the current integration of VitalPAC functionality within Sunrise which is a very complex process. The predicted timeline for rolling out this functionality is later this year or early next year with dates yet to be confirmed. This links with milestone 4.408 with a target date to achieve by March 24 and also CQC action on Sepsis screening. In the meantime, questions relating to deteriorating patient compliance have been included in Tenable and will be ready for reporting from July 23.	12	a) Continue to discuss at Sunrise Vitals Integration Steering Group. b) Deteriorating patient is now available on the Tenable Ward platform (from August 23) as an interim measure posing additional challenging questions. Care Groups will be able to produce their own reports on deteriorating patients. Although this will not be as robust as Sunrise it will provide assurances against Trust Policy i.e. escalation. c) Risk owner member of Sunrise Vitals Integration Steering group – any changes to predicted timeline will be included in PSC deteriorating patient report, along with Tenable deteriorating patient reports.	18.12.23	12	⬌
6.1.03	07.08.23	Finance	Tim Glenn	Risk to the delivery of the Trusts 2023/24 Efficiency Plan.	20	a) Enhanced Controls measures have been issued to all care groups to ensure adherence to the national controls required for a level 4 organisation.	18.12.23	12	⬌
6.1.04	07.08.23	Finance	Tim Glenn	Risk of identifying and prioritising the development of “harder to achieve” improvements from Care Groups.	16	a) Conversations are ongoing with care groups to fully understand areas which could be explored to reduce spend but with a clear understanding of the clinical impact on the decisions.	18.12.23	12	⬌
3.4.01	23.08.23	Operational Performance	Ben Stevens	Delays to eliminate 78 week waits due to inability to secure additional endoscopy and otology capacity immediately before January 2024.	15	a) No immediate mitigation to reduce 78 week breaches before January 2024.	18.12.23	15	⬌

High Level IIP Risk Summary

Definitions

Movement in month – Key:

★	New Risk	⬇	A decrease in risk score
⬌	The score remains the same	⬆	A rise in risk score

NHS East Kent Hospitals University NHS Foundation Trust

Key risks to IIP delivery in this period continued:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Mitigating Actions	Date of Last Review	Residual Risk Score	Risk Trend
2.402	22.09.23	Maternity	Sarah Hayes	Inadequate Estates in Maternity. Delivery rooms are too small to accommodate essential equipment, ventilation is poor, triage is cramped. Overall capacity does not support delivery. Poor estate means that maternity are unable to provide appropriate care, privacy and dignity and staff are not able to work effectively.	20	a) Induction rates standardised across sites - Daily SitReps for induction demand and capacity b) Introduction of quality rounds on both units that includes estate elements against CQC compliance c) Neonatal service attend postnatal ward daily to facilitate discharges d) Portable suction unit available in each labour room e) Pure air scavenging unit and ventilation in labour rooms on both sites f) Risk assessments for the resuscitaires are undertaken to ensure maximum safety within constraints of the room size	18.12.23	12	⬌
3.3.01	14.06.23	Operational Performance	Ben Stevens	Diagnostic delays in cancer pathways due to increase in activity.	20	a) Radiology improvement meeting weekly now embedded & Radiology reports waiting longer than 15 days post diagnostic are prioritised and cleared. b) Specific focus on Endoscopy and Urology pathways with heavy sedation capacity for Endoscopy to be agreed. Pending confirmation of Endoscopy insourcing funding and ICB bid to secure underspend via CDC budget. Endo improvement meetings now in place. c) Mutual Aid plan for urology to be agreed.	18.12.23	12	⬌

High Level IIP Programme Risk Summary

East Kent Hospitals University NHS Foundation Trust

IIP Opened risks in this period:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Update	Date of Last Review	Residual Risk Score	Risk Trend
6.1.05	05.01.24	Financially Sustainable	Tim Glenn	Trust is unable to reach agreement with the National Team for financial outturn 23/24	20			10	
6.1.06	05.01.24	Financially Sustainable	Tim Glenn	Trust is unable to agree our financial plan with the National Team for 24/25	20			16	
6.1.07	05.01.24	Financially Sustainable	Tim Glenn	Trust is unable to develop and deliver a sufficient stretching CIP for 24/25	20			16	
6.1.08	05.01.24	Financially Sustainable	Tim Glenn	Trust fails to agree a reasonable trajectory for future financial improvement with the National Team	20			16	
5.2.06	04.01.24	People & Culture	Andrea Ashman	Failure to secure funding of £32k for rostering training	20			20	
3.8.01	11.01.24	Operational Performance	Rob Hodgkiss	Ability to deliver, at pace, the removal of all 78 week breaches is heavily impacted by the quality of our overall waiting list and urgent need for targeted validation	20			9	
3.9.01	09.01.24	Operational Performance	Rob Hodgkiss	Likely to not achieve national performance target for UEC performance of 76% by March 24.					

IIP Closed risks in this period:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Update	Date of Last Review	Residual Risk Score	Risk Trend
4.1.01	14.06.23	Quality & Safety	Sarah Hayes	Not upgrading our system to the most up to date version (as with all Trusts using Datix) will delay the PSIRF transition. The Trust has been supported in this work with an agency Datix Project Lead. This post was initially funded by NHSE for 6 months until March 23. As there is not the specialist capability within the Trust to continue managing the Datix upgrade without this support. This specialist remains in post supporting the Trust, however in doing so is incurring a financial overspend.	20	**20.09.23** - roadmap produced inline to deliver plan to implement. Residual score reduced at SiC. **06.11.23** - Roadmap approved and work progressing to deliver. Residual score reduced as roadmap on track. **29.11.23** - Business case still awaiting approval, to be presented at Dec BCSG **04.01.24** - Datix system now compliant with LFPSE reporting requirements. Risk now mitigate and closed on the CRR refer to sic to close.	04.01.24	9	

Summary

- At the beginning of this reporting period 20 risks were recorded on the IIP risk register.
- **7** new risks have been added during this reporting period. 4 within Finance, 1 for People and Culture and 1 for Operational Performance
- In total 27 key areas of risk were discussed in this period relating to delivery against the IIP with 1 risk closed relating to updating the Datix system..
- 3 risks during this period have decreased their inherent scores.
- 26 risks remain open on the IIP risk register, summary per programme is as follows; 6 Finance, 2 Leadership & Governance, 4 Maternity, 9 Operational Performance, 3 People & Culture, 2 Quality & Safety risks.
- There is strengthened risk monitoring within the IIP with particular focus on ‘confirm & challenge’.
- Please see Appendix A for a full detailed IIP Risk Register.

IIP Open Risk Register (as at 18 December 2023)

Risk Ref	Date Raised	Risk Register	Workstream	Risk Author	Risk Owner	Risk Description	Likelihood	Impact	Inherent Risk Score	Mitigating Actions	Progress Notes	Likelihood	Impact	Residual Risk Score	Date of Last Review	Date Risk Closed
Risk reference number	Date identified	IIP / BAF or Corporate risk	IIP Workstream	Risk raised by	Risk responsibility of	What is the risk to delivery? This is a risk that "something happens" due to the "cause" leading to "consequence/impact".	(1-5) & category	(1-5) & category	Severity of risk before controls implemented	What are the mitigating actions (ensure clear dates are provided)	Progress notes including date of update	(1-5) & category	(1-5) & category	Severity of risk after controls implemented	Date risk was last reviewed at SIC	Date risk was closed at SIC
1.101	14.06.2023	IIP	Leadership & Governance	Ben Stevens	Tracey Fletcher	Unable to appoint CFO substantively due to unsuitable candidates posing potential instability to executive team and financial workstreams / improvements required.	4 - likely	4 - likely	16	a) Working with NHSE and SE Regional team to support the appointment of a suitable individual for the longer term as CFO	**14.09.2023** - Financial Recovery Director funded by RSP starts in October 2023 to support financial delivery **08.11.23** - Interim CFO joined Trust on **06.11.23** for seconded for a 12 month period with the support of NHSE SE Region, Residual score reduced to 6 due to experience of postholder	3 - possible	2 - low	6	19.01.24	
1.103	25.09.2023	IIP	Leadership & Governance	Andrea Ashman	Tracey Fletcher	No substantive COO following the resignation from the current postholder.	4 - likely	4 - likely	16	a) Interim COO in place for unplanned care who has experience, knowledge and understanding of the organisation	**25.09.2023** - Trust have engaged with an agency to start the recruitment process for the COO **08.11.23** - Trust progressing with advert over the coming months **14.12.23** - Substantive COO out to advert, interim in place. Residual risk score reduced from 9 to 6.	3 - possible	3 - moderate	6	19.01.24	
2.101	29.06.2023	IIP	Maternity	Michelle Cudjoe	Sarah Hayes	Work commissioned to external adviser whose contract expired April/May 2023. Work incomplete, draft document still not received mid June 2023. This framework sets out Governance structures throughout the service, without which there are insufficient systems of control.	4 - likely	2 - low	8	a) The service is currently working towards V2.0 of the Maternity Quality & Safety Framework (Risk Management Strategy) until the refreshed version is available to ensure there continues to be structures for maintaining oversight, and managing of overdue governance related activities. b) Work progresses internally with an MDT to produce the final QSF. This will be ratified at the Women's Health Guidelines Group in Aug and assurance/ratification at MNAG in September. c) New QSF will be published by end August 2023.	Next MNIP governance group meeting 17th August (postponed from 10th) **15.09.23** Governance Review is complete at Trust level. Work to be undertaken with the Care Group to embed the process. **20.09.23** - residual score reduced. **14.12.23** - New milestone written to align with Organisational Governance Structure.	2 - unlikely	1 - negligible	2	19.01.24	
2.301	29.06.2023	IIP	Maternity	Michelle Cudjoe	Sarah Hayes	The original model for this service has been revised by the incoming substantive DoM meaning that systems which underpin this service need to be reconsidered and revised. Until agreed and implemented, the current triage system remains in place.	3 - moderate	3 - moderate	9	a) Existing telephone triage system remains operational with supporting guideline in place. b) A planning meeting was held 06/07 to redefine the scope of work to be completed to enable centralisation. c) Weekly meetings to be reformed to facilitate revised model with much of the work completed through delivery of the original plan and other elements are underway i.e. triage PTL boards. d) This will appear as an agenda item on the next Women's Health Care Group Governance meeting on 28th July for agreement of way forward with a revised date for completion.	**15.09.23** DoM/DDoM to discuss way forward with Matrons and HoMs **20.09.23** - residual score reduced.	3 - moderate	1 - negligible	3	19.01.24	
2.102	22.09.2023	IIP	Maternity	Michelle Cudjoe	Sarah Hayes	Unfilled vacancies, combined with high levels of maternity leave and short term sickness will have an effect on patient outcomes and quality and safety. Inadequate midwifery staffing levels may result in women receiving sub-optimal care during labour.	5 - almost certain	4 - likely	20	a) Daily site-wide SitRep to assess safe staffing and ensure escalation policy is appropriately followed b) Line bookings of NHSP and agency, framework and off framework with applied incentive c) Specialist midwives redeployed to fill gaps d) Suspension of continuity of carer e) Utilisation of managers on call and community midwives	This is also on the Corporate Risk Register -CRR122.	3 - possible	4 - significant	12	19.01.24	
2.402	22.09.2023	IIP	Maternity	Michelle Cudjoe	Sarah Hayes	Inadequate Estates in Maternity There are numerous issues with estates. A few examples are delivery rooms being too small to accommodate essential equipment, ventilation is poor, triage is cramped. Overall capacity does not support delivery. Poor estate means that maternity are unable to provide appropriate care, privacy and dignity and staff are not able to work effectively.	4 - likely	4 - significant	20	a) Induction rates standardised across sites - Daily SitReps for induction demand and capacity b) Introduction of quality rounds on both units that includes estate elements against CQC compliance c) Neonatal service attend postnatal ward daily to facilitate discharges d) Portable suction unit available in each labour room e) Pure air scavenging unit and ventilation in labour rooms on both sites f) Risk assessments for the resuscitaires are undertaken to ensure maximum safety within constraints of the room size	This is also on the Corporate Risk Register -CRR144.	4 - likely	3 - moderate	12	19.01.24	
3.1.01	14.06.2023	IIP	Operational Performance	Sandra Cotter	Rob Hodgkiss	The current process for accounting for the NLFTR has been reviewed in partnership with HCP in which there are a number of recommendations to be considered and taken forward. This will impact reducing the NLFTR position to support emergency flow and 12 hour breach reduction.	3 - possible	4 - significant	12	a) The recommendations will be monitored via the ECDG/HCP delivery groups. b) SAFER across QEQM /WHH on track c) Additional resource secured to support enhanced discharging. d) Future of the integrated hubs to determine pathways for patients will continue to be evolved over the next 6 months. e) Admission avoidance schemes to include front door Virtual ward pathways and Pilot of the Single Point of Access to reduce ambulance conveyances	**11.01.24** Safer roll-out and embedding continues A-TED completion Nov Discharge Task forces set up 3 sites- SRO led SPOA -Nov pilot WHH roll out to QEQM Jan Frail- ED roll-out plan for Jnauary to support alterntive pathways HCP Winter plan schemes sees the increase in community capacity and Home First services (D2A)	3 - possible	3 - moderate	9	19.01.24	
3.2.01	14.06.2023	IIP	Operational Performance	Sunny Chada	Rob Hodgkiss	Inability to comply with 2023/24 activity plan at Trust level in order to stabilise waiting list and reduce long waiters due to increased theatre activity (cases per session), staffing issues, competency impacting on ability to deliver head & neck activity, consultant sickness in ENT, volume of paediatric patients due to limited access to paeds provision at K&CH and no elective provision at QEQM and WHH.	3 - possible	4 - significant	12	a) Embedded PTL meetings agreeing daily/weekly tasks and actions to support breach reduction at pace. b) Analysis of cases per session completed for each speciality to review reason for reduced activity per session (based on slight increase in theatre time compared to pre covid) and quantify theatre actions to increase activity levels. c) Refreshed activity plan in Q2 23/24for each speciality now approved. d) Specialities to articulate robust recovery actions through weekly activity/performance meetings and agree transformational actions to improve planned care across the trust through the monthly Planned Care Improvement Meeting.	**26.06.23** - Out patient activity is above plan in Q1 (year to date position). Elective and diagnostic activity is approximately 94% of plan. Referrals are not above plan and are in line with predicted levels based on the previous years(2019- 2022) referral pattern and growth. **12.01.24** - alongside targeted plan to clear all 78 weeks breaches and the implementation of the further faster programme, we anticipate the activity plan being closer to year end target. Residual score reduced.	3 - possible	3 - moderate	9	19.01.24	
3.3.01	14.06.2023	IIP	Operational Performance	Sarah Collins	Rob Hodgkiss	Diagnostic delays in cancer pathways due to increase in activity.	5 - almost certain	4 - significant	20	a) Radiology improvement meeting weekly b) Radiology reports waiting longer than 15 days post diagnostic are prioritised and cleared. c) All diagnostics are aimed to be booked within 5-10 days of receiving referral. d) Specific focus required on Endoscopy and Urology pathways and capacity e) Heavy sedation capacity for Endoscopy to be agreed. Pending confirmation of Endoscopy insourcing funding and ICB bid to secure underspend via CDC budget.	**12.01.24** - Mutual aid plan for urology now in place, targeted endoscopy plan in place with weekly meetings. Radiology reporting remains challenged, recovery plan has been requested to be shared through Teir 1 programme.	4 - likely	3 - moderate	12	19.01.24	
3.4.01	23.08.23	IIP	Operational Performance	Sunny Chada	Rob Hodgkiss	Delays to eliminate 78 week waits due to inability to secure additional endoscopy and otology capacity immediately before January 2024.	5 - almost certain	3 - moderate	20	a) Remap of capacity aligned to trajectory to eliminate breaches by the end of January 2024. b) Remodelled capacity with returning long term sickness absent consultant. c) Capacity mapping and recovery plan expected to be completed as priority and presented to Planned Care meeting.	**14.09.23** - No system capacity available to support EKHUFT otology recovery. **19.10.23** - due to impact of IA/theatre equipment/increasing volume of more urgent p2 patients the trajectory has been refreshed and projects otology 78 week breaches will not be eliminated at the end of March 2024 **12.01.24** - Revised recovery plan in place and monitored through Tier 1 structure	5 - almost certain	3 - moderate	15	19.01.24	
3.5.01	23.08.23	IIP	Operational Performance	Sunny Chada	Rob Hodgkiss	Inability to fully validate all patients from 12 weeks wait as per Board Assurance letter received 4 August due to lack of capacity.	4 - likely	3 - moderate	12	a) System wide challenge acknowledged at Planned Care Board 22nd August 23. b) Proceed with two way text message roll out. Increased spend to be approved before roll out can commence c) Review of EKHUFT Access Governance/Validation workforce compared to MFT/MTW/DGH. Agreed to recruit at risk 3WTE validation staff members. Recruitment being progressed through Trust vacancy panel. d) Progress patient portal opportunities with IT to consider role in validation. e) Funding notification received 23.10.2023. £300k from national CDC underspend to be utilised on diagnostic validation only. £100k received from Regional team to be allocated to elective validation - funding being used for new staff members.	**14.09.23** - Elective Leads across K&M unable to deliver/achieve national requirement. System review of Access Governance support in place confirms EKHUFT, based on size of Trust/PTL, have a significantly reduced team compared to neighbouring Trusts. **24.10.23** - Increased risk score from 8 to 12 as the completion of the validation exercise may not be completed within the due timeframe. **12.01.24** - Received a validation proposal from the BI team. Currently under review by the National Intensive Support Team with a view to fianalise an implementation plan from Feb 24.	3 - possible	2 - low	6	19.01.24	
3.6.01	24.10.2023	IIP	Operational Performance	Sunny Chada	Rob Hodgkiss	Inability to ensure that all endoscopy surveillance patients which have been identified beyond a breach date will be treated within target 6 weeks post clinical validation	4 - likely	4 - significant	16	a) Weekly task and finish group has been set up from October and now embedded. Aim to ensure all overdue surveillance patients (3527) are clinically validated and clear treatment plan in place. 772 patients now fully validated (22.4% of backlog). b) Weekly meeting with ICB to provide assurance and support to EKHUFT with the recovery plan. Particularly clinical support has been requested due to lack of resources in EKHUFT. c) ID Medical additional capacity has been secured, commencing November 23 to assist with the backlog d) Surveillance project being considered by other departments to ensure this is not a wider problem	**24.10.23** - Identified admin validation team. Agreed clinical validation criteria. Assessment underway for resource required for clinical validation. **12.01.24** - Against the 3449 patients on the backlog, 1283 have been validated (37.8%). Remaining validation to be complete by end of Feb 24.	3 - possible	2 - low	6	19.01.24	
4.4.02	14.06.2023	IIP	Quality & Safety	Ian Setchfield	Sarah Hayes/ Nic Goodyear	The build of the deteriorating dashboard is dependent on the current integration of VitalPAC functionality within Sunrise which is a very complex process. The predicted timeline for rolling out this functionality is later this year or early next year with dates yet to be confirmed. This links with milestone 4.408 with a target date to achieve by March 24 and also COC action on Sepsis screening. In the meantime, questions relating to deteriorating patient compliance have been included in Tenable and will be ready for reporting from July 23.	4 - likely	3 - moderate	12	a) Continue to discuss at Sunrise Vitals Integration Steering Group. b) Deteriorating patient is now available on the Tenable Ward platform (from August 23) as an interim measure posing additional challenging questions. Care Groups will be able to produce their own reports on deteriorating patients. Although this will not be as robust as Sunrise it will provide assurances against Trust Policy i.e. escalation. c) Risk owner member of Sunrise Vitals Integration Steering group – any changes to predicted timeline will be included in PSC deteriorating patient report, along with Tenable deteriorating patient reports.	**05.09.23** - discussions at SIC at length, Deteriorating Patient programme to discuss with ICB to ensure this action is appropriate and will be suffice as this is a quarterly RSP requirement. **06.12.23** - Steering Group has confirmed that dashboard will be completed by March/April 24. To be reviewed next month with new data to be able to reduce score.	4 - likely	3 - moderate	12	19.01.24	
5.2.03	14.06.2023	IIP	People & Culture	Andrea Ashman	Andrea Ashman	Culture and Leadership Programme currently not fully aligned with wider IIP programmes (including 'we care' programmes). This means there could be two separate culture pieces of work taking place causing conflicts for the organisation.	3 - possible	3 - moderate	9	a) Discussions continue regularly with IIP SRO & Programme SRO re: new strategy to align CLP with existing programmes and to reduce duplication.	**20.06.23** - Venue and budget code now booked to hold launch days in July 2023. **05.09.23** - residual score reduced.	3 - possible	2 - low	6	19.01.24	

5.2.04	14.06.2023	IIP	People & Culture	Andrea Ashman	Andrea Ashman	Capacity is limited (only 3.6wte available) in order to scale up delivery of the Leadership Development Programmes at each of the levels required (Leading Others, First Line Leader, Mid-level Leader) as planned. Each of these 5-day programmes are scheduled to run 3x per annum and to do so will require more facilitators. The team are also holding a vacancy due to the required financial efficiencies.	4 - likely	4 - significant	16	a) Consultation now complete with appointments made however some vacancies still remain which are to be advertised in September 23. b) Post recruitment the OD team will prioritise delivering the Leadership Development Programme fully as capacity will be available.	**05.09.23** - residual score reduced.	3 - possible	3 - moderate	9	19.01.24	
5.02.05	09.08.23	IIP	People & Culture	Louise Goldup	Andrea Ashman	Lack of leadership and engagement from Medical Office to drive forward pace of People and Culture milestones for medical workforce and ensure this is consistently applied.	4 - likely	4 - significant	16	a) New interim CMO fully engaged in P&C workstreams and regular meetings in place to review milestones. b) Appointment of medical workforce lead in August 23, regular meetings in place to increase engagement and review milestones. c) Detailed plans currently being produced by medical office to support milestones with clear timescales and leads being identified. d) Medical workforce dashboard being progressed. e) Medical Office have implemented regular meetings with Care Group Medical Directors to drive pace.	**05.09.23** - residual score added. **27.09.23** - Nature of risk updated	2 - unlikely	4 - significant	8	19.01.24	
6.1.03	07.08.23	IIP	Financially Sustainable	Michelle Stevens	Tim Glenn	Risk to the delivery of the Trusts 2023/24 Efficiency Plan.	4 - Likely	4 - Significant	20	a)Enhanced Controls measures have been issued to all care groups to ensure adherence to the national controls required for a level 4 organisation	**03.10.23** - Inherent Risk Score increased to 20 as per the CRR	4 - Likely	3 - moderate	12	19.01.24	
6.1.04	07.08.23	IIP	Financially Sustainable	Michelle Stevens	Tim Glenn	Risk of identifying and prioritising the development of "harder to achieve" improvements from Care Groups.	4 - Likely	4 - Significant	16	a)Conversations are on going with care groups to fully understand areas which could be explored to reduce spend but with a clear understanding of the clinical impact on the decisions	**05.09.23** - discussion at SIC, residual score reduced.	4 - Likely	3 - moderate	12	19.01.24	
4.1.02	09.11.23	IIP	Quality & Safety	Katy White	Sarah Hayes	There are a significant number of risks at Care Group and Specialty level currently scored at 15 or above which, due to the current risk management processes and reporting arrangements, had not escalated from Specialty level or Care Group risk registers or to the Corporate Risk Register meaning that the Executives, and consequently the Board and its' sub-committees have not previously been sighted on.	4 - likely	4 - significant	16	a) Review and refresh of all risk registers taking place with dedicated resource aligned to progress 2 days per week b) Executive oversight meetings established to continue for at least 2 months c) TOR for operational risk register group being drafted for approval at CEMG in Dec 23 d) Board and subcommittees to receive monthly update	**04.01.24** - New milestone written within Phase 2 detailing all actions to be undertaken relating to this risk. Score reduced to '9' based on these actions.	4 - likely	3 - moderate	9	19.01.24	
6.1.05	05.01.24	IIP	Financially Sustainable	Tim Glenn	Tim Glenn	Trust is unable to reach agreement with the National Team for financial outturn 23/24	5 - Extreme	4 - Significant	20	a) Independent wiew commissioned by PWC to be agreed with National Team by end of Jan 24. b) Additional support to enhance PMO and grip & control measures c) Continued discussions with the National Team		5 - Extreme	2 - Unlikely	10	19.01.24	
6.1.06	05.01.24	IIP	Financially Sustainable	Tim Glenn	Tim Glenn	Trust is unable to agree our financial plan with the National Team for 24/25	5 - Extreme	4 - Significant	20	a) Independent wiew commissioned by PWC to be agreed with National Team by end of Jan 24. b) Additional support to enhance PMO and grip & control measures c) Continued discussions with the National Team		4 - Likely	4 - Significant	16	19.01.24	
6.1.07	05.01.24	IIP	Financially Sustainable	Tim Glenn	Tim Glenn	Trust is unable to develop and deliver a sufficient stretching CIP for 24/25	5 - Extreme	4 - Significant	20	a) Independent wiew commissioned by PWC to be agreed with National Team by end of Jan 24. b) Additional support to enhance PMO and grip & control measures c) Continued discussions with the National Team		4 - Likely	4 - Significant	16	19.01.24	
6.1.08	05.01.24	IIP	Financially Sustainable	Tim Glenn	Tim Glenn	Trust fails to agree a reasonable trajectory for future financial improvement with the National Team	5 - Extreme	4 - Significant	20	a) Independent wiew commissioned by PWC to be agreed with National Team by end of Jan 24. b) Additional support to enhance PMO and grip & control measures c) Continued discussions with the National Team		4 - Likely	4 - Significant	16	19.01.24	
3.7.01	12.12.23	IIP	Operational Performance	Jane Dickson	Rob Hodgkiss	Junior Drs strike in January 24 will affect UEC and whole system pathway performance.	4 -likely	4-significant	16	a) Robust strike planning in place b) Reduce bed occupancy in preparation c) Work with HCP to encourage alternative pathways	**12.01.24** - MADE events in place Discharge Task forces led by Care group triumverites in place 3 sites Sites review of escalation procedures and dedicated approved escalation areas	3 possible	3- moderate	9	19.01.24	
3.8.01	11.01.24	IIP	Operational Performance	Sunny Chada	Rob Hodgkiss	Ability to deliver, at pace, the removal of all 78 week breaches is heavily impacted by the quality of our overall waiting list and urgent need for targeted validation.	4 -likely	5. Extreme	20	Interim COO has requested targeted investment potentially via outsourcing company, immediate proposal requested		3 possible	3- moderate	9	19.01.24	
3.9.01	09.01.24	IIP	Operational Performance	Sandra Cotter	Rob Hodgkiss	Likely to not achieve national performance target for UEC performance of 76% by March 24.				a) Initiatives to improve whole pathway performance commenced including SPOA, further developing direct access pathways, optimising access to SDEC, UTC and assessment units. However, due to increased demand, capacity constraints, staffing impacts i.e. strikes/vacancies some initiatives have not exceeded expectation. Review of effectiveness for completed programmes to be undertaken through improvement drives to maximise performance opportunities. b) Close liaison with system partners to influence alternative pathways. c) Continue to work with consultant agencies PRISM and KPMG to roll-out improvement initiatives. d) Regular updates to national teams including RSP & Tier 1. e) Estates works to increase and improve utilisation of space.					19.01.24	
5.2.06	04.01.24	IIP	People & Culture	Louise Goldup	Andrea Ashman	Failure to secure funding of £32k for rostering training	4 - likely	4 - significant	16	No mitigations as specific expertise required to implement		4 - likely	4 - significant	16	19.01.24	

RISK MATRIX

Impact						
	5. Extreme	5. L	10. M	15. H	20. E	25. E
	4. Significant	4. L	8. M	12. M	16. H	20. E
	3. Moderate	3.V L	6. L	9. M	12. M	15. H
	2. Low	2. VL	4. L	6. L	8. M	10. M
	1. Negligible	1. VL	2. VL	3. VL	4. L	5. L
		1. Rare	**2. Unlikely**	**3. Possible**	**4. Likely**	**5. Almost certain**
		Likelihood				

E	Extreme Risk
H	High Risk
M	Moderate Risk
L	Low Risk
VL	Very Low Risk

IIP Closed Risks

Risk Ref	Date Raised	Risk Register	Workstream	Risk Author	Risk Owner	Risk Description	Likelihood	Impact	Inherent Risk Score	Mitigating Actions	Progress Notes	Likelihood	Impact	Residual Risk Score	Date of Last Review	Date Risk Closed
2,303	29.06.2023	IIP	Maternity	Michelle Cudjoe	Jane Dickson	Postnatal guideline supporting implementation of improved discharge pathways was not reviewed as planned by the WH guideline group on 16 June 2023. This poses a threat to the milestone target date of July 23 and until approved the service will continue to operate the current discharge model.			12	a) Postnatal Ward Manager (QEQM) to work with Guideline Midwife to circulate the postnatal guideline for review and approval. b)The postnatal guideline will be circulated via email, by exception for chairs action to agree the new model for implementation by end of July 23.	**18.07.23 -** Discussed with programme manager, obtain approval at SiC on 26.07.23 that this risk is a duplicate and is now merged with risk 2.302 to enable closure. 26.07.23 - risk agreed to be closed at SiC as a duplication.				26.07.23	26.07.23
2,401	29.06.2023	IIP	Maternity	Michelle Cudjoe	Jane Dickson	Whist pending development and approval of the new maternity Quality & Safety framework, the service is working to the draft V2 of the QSF. Structures for maintaining oversight, and managing of overdue governance related activities require further work particularly to ensure there are no overdue/breached governance related activities including SIs/HSIB investigations.			16	a) To ensure there is some strengthened governance in the interim the maternity service is working to V2 of the QSF until the final version is published in August 2023. b) There are trackers being used to monitor progress of all governance related activities, including backlogs. c) In addition there is now a dedicated patient safety team progressing with overdue governance to ensure focus.	**18.07.23 -** Discussed with programme manager, obtain approved at SiC on 26.07.23 that this risk is a duplicate and is now merged with 2.302 to enable closure. 26.07.23 - Risk agreed to be closed at SiC as now a duplication.				26.07.23	26.07.23
4.4.01	14.06.2023	IIP	Quality & Safe	Ian Setchfield	Jane Dickson/ Rebecca Martin	Unable to support deteriorating patient training across the organisations as proposed due to funding provided by HEE not available.	3 - possible	3 - moderate	9	a) Plan is to utilise money for additional resuscitation training provided by an external supplier, which improves the deteriorating patient pathway. b) Full resuscitation training needs and costings to be finalised & submitted to HEE. c) Funding since received in June 23 to enable rollout of training across the organisation (funding supports both training and posts). Allocation of remaining funding to support additional deteriorating patient workstreams need to be agreed with CNMO.	**19.06.23 -** Funding agreed for £300k one off via HEE (which supports both training and posts). Money has been transferred to the Trust from the ICB - risk can therefore now be closed. **18.07.23 -** Project Lead to requested for closure to be submitted to the SiC on 26.07.23. **26.07.23 -** Risk agreed to be closed at SiC now funding is received risk is removed.	2 - unlikely	3 - moderate	6	26.07.23	26.07.23
2,302	29.06.2023	IIP	Maternity	Michelle Cudjoe	Jane Dickson	Postnatal guideline was not reviewed as planned by the WH guideline group on 16 June 2023. This poses a threat to the milestone date of July and until the service will continue to operate the current discharge model.	3 - possible	5 - extreme	15	a) Corresponding postnatal guideline has been updated which sets out the improved model for the discharge pathway. However, the guideline was not reviewed as planned by the Women's Health Guideline Group on 16 June 2023 due to insufficient time on the agenda to consider and approve. b) The postnatal guideline was planned to be circulated via email, by exception for chairs action however it has since been agreed for wider discussion at the Women's Health Audit Group on 18/07 for ratification.	**16.08.23 -** guidance published on 4th August. Request to SiC to close risk.	3 - possible	3 - moderate	9	16.08.23	24.08.23
5.2.01	14.06.2023	IIP	People & Culture	Andrea Ashman	Andrea Ashman	In order to support Culture and Leadership Programme trust wide, additional funding for 1 Programme Director and 1 seconded Programme Manager was requested from NHSE (RSP funding). Currently funding has not been approved and received however, NHSE confirmed to 'go at risk' to ensure the project is not delayed. If funding is not received this will be an overspend for the organisation.	3 - possible	3 - moderate	9	a) NHSE confirmed to go 'at risk' with budget codes so not to hold project up and regular updates received from RSP team. b) Posts are recruited to and programme has commenced, moving forward to diagnostics.	**20.06.23 -** still awaiting if funding has been allocated and amount. **07.09.23 -** funding now agreed from RSP, residual risk score reduced. Request to SiC on 20th Sep to close. **20.09.23 -** risk agreed to be closed.	2 - unlikely	2 - low	4	05.09.23	20.09.23
5.2.02	14.06.2023	IIP	People & Culture	Andrea Ashman	Andrea Ashman	Due to insufficient funding within Culture and Leadership Programme unable to undertake practical arrangements for launch of Culture and Leadership Programme trust wide including events / booking venues.	3 - possible	3 - moderate	9	a) NHSE confirmed to go 'at risk' with budget codes so not to hold project up for posts to progress with programme. Internally also 'gone at risk' to account for additional revenue required to support events. b) Launch days and conference centre now booked to enable diagnostics to be commenced. b) Working with SRO to realign budgets to support future funding.	**07.09.23 -** funding now agreed from RSP, residual risk score reduced. Request to SiC on 20th Sep to close. **20.09.23 -** risk agreed to be closed.	2 - unlikely	2 - low	4	05.09.23	20.09.23
4.3.01	20.6.23	IIP	Quality & Safe	Wendy-Ling Relph	Jane Dickson/ Rebecca Martin	Ward Accreditation Team are currently small in number with a team member having long term sickness. They may not be able to complete a first accreditation for all inpatient wards by end of November 2023 as the original trajectory anticipated.	5 - almost certain	4 - significant	20	a) Alternative solutions are being explored, including the potential of utilising additional internal staff and reviewing the current accreditation timetable. b) One staff member now returned from long term sick and progressing with plans.	**15.09.23 -** Sickness within the team has now resolved. Working practices and priorities have been reviewed. The first accreditation for all wards is now planned to be completed before the end of December, meaning that completion of this action will be delayed, but by only 3 weeks. The risk of lack of completion of the whole section of Quality & Safety is therefore greatly reduced. Residual score now reduced.	4 - likely	4 - significant	2	10.10.23	10.10.23
6.1.01	14.06.2023	IIP	Financially Sustainable	Michelle Stevens	Michelle Stevens	Due to vacancies within the Finance team there are currently no project leads within the IIP finance workstream. This is a risk to ensuring there is pace and delivery of the programme and could cause delays to ensuring financial savings and improvements are achieved in the organisation.	3 - possible	3 - moderate	9	a) Deputy CFO commenced in post 17th July of which a full handover has been undertaken with clear objectives. b) The CFO is currently both SRO and project lead for the finance programme within the IIP. c) RSP team offered urgent financial recovery support which has been approved and will be available from October 23 in order to bring pace to financial programme.	**05.09.23 -** discussion at SiC, RSP support available from October 23. **03.10.23 -** Additional resources have commenced in this period to support the delivery of the IIP (Turnaround Director, ADOF Financial Planning). Request SiC to close.	2 - unlikely	3 - moderate	6	10.10.23	10.10.23
6.1.02	14.06.2023	IIP	Financially Sustainable	Michelle Stevens	Michelle Stevens	In order to support updating Financial Recovery Programme additional support is being explored. Current post holder leaving end of July 23, organisation off plan and further grip required.	3 - possible	3 - moderate	9	a) Deputy CFO commenced in post 17th July of which a full handover was undertaken with clear objectives. b) A draft version of the FRP was presented to the Trust Board in July 23, it was agreed further work with key stakeholders is required to finalise draft aimed at presenting again in October to achieve target date of Jan 24. c) RSP team offered urgent financial recovery support which has been approved and will be available from October 23. d) Comms to support with staff engagement to support financial consciousness.	**05.09.23 -** discussion at SiC, RSP support available from October 23. **22.11.23 -** resource now aligned to the financial programme to drive plans. Request closure at SIC on 27th Nov.	2 - unlikely	4 - significant	8	10.10.23	22.11.23
4.3.02	09.08.23	IIP	Quality & Safety	Wendy-Ling Relph	Jane Dickson	Head of Nursing for FoC & Quality (who is also clinical Lead for Nutrition) is currently recruited on an interim arrangement until end December 23 as a secondment. Post holder is chair of key quality strategic meetings, project lead for IIP FoC, line manager of specialist nurses, coach & mentor to nursing teams. Risk of instability to lead on FoC workstreams if future of post is not agreed promptly.	4 - Likely	4 - significant	16	a) Corporate team restructure is currently being reviewed. b) There is a plan to substantively recruit and submit to vacancy panel prior to December 23 to ensure work continues.	**10.11.23 -** Request to close risk from CNMO. Review of the post currently underway, however, if there were no post holder, Gare Group would ensure the work would continue.	4 - likely	3 -moderate	6	10.11.23	10.11.23
6,105	22.11.23	IIP	Financially Sustainable	Michelle Stevens	Tim Glenn	Delivery of 23/24 reforecast or better	3 - possible	4 - significant	12	a) Support from PWC now online & additional resource aligned to finance programme to drive plans		3 - possible	2 - low	6	27.11.23	22.11.23
1,102	14.06.2023	IIP	Leadership & Governance	Ben Stevens	Tracey Fletcher	The current restructure has the potential to detract from the BAU operations of the Trust and impact on progress against the IIP.	3 - possible	3 - moderate	9	a) Ensure restructure is concluded by 16th August 2023 and appointment to leadership posts to progress IIP programmes at pace.	**22.08.23 -** new organisational structure went live on 14th August 23. **25.09.23 -** Some vacant positions are await recruitment. Residual score to remain the same at this time. **08.11.23 -** Adverts are now closed and shortlisting is underway for Medical Director at QE. Managing Director post at QE continuing on an interim basis. Residual score to remain the same at this time. **14.12.23** All positions recruited to, BAU resuming, **risk to close**	3 - possible	2 - low	6	14.12.23	18.12.23

4.1.01	14.06.2023	IIP	Quality & Safety	Katy White	Sarah Hayes/ Nic Goodyear	Not upgrading our system to the most up to date version (as with all Trusts using Datix) will delay the PSIRF transition. The Trust has been supported in this work with an agency Datix Project Lead. This post was initially funded by NHSE for 6 months until March 23. As there is not the specialist capability within the Trust to continue managing the Datix upgrade without this support. This specialist remains in post supporting the Trust, however in doing so is incurring a financial overspend.	5 - almost certain	4 - significant	**20**	a) This has been escalated to a Director at Datix for their intervention. It is unlikely that we will meet the deadline for September 23 (as with all Trusts using Datix). b) Full cost of overspend being costed for the agency Datix Project Lead. c) A business case is being developed to secure an alternative system, which will be aligned to other Kent and Medway Trusts. d) A roadmap for delivery is to be presented to relevant governance committees in September 23. e) updated datix fields	**20.09.23** - roadmap produced inline to deliver plan to implement. Residual score reduced at SiC. **06.11.23** - Roadmap approved and work progressing to deliver. Residual score reduced as roadmap on track. **29.11.23** - Business case still awaiting approval, to be presented at Dec BCSG **04.01.24** - Datix system now compliant with LFPSE reporting requirements. Risk now mitigate and closed on the CRR refer to sic to close.	4 - likely	3 - moderate	**12**	18.12.23	

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: Nominations and Remuneration Committee (NRC)

Meeting date: 12 December 2023

Chair: Stewart Baird, Non-Executive Director/Vice Trust Chairman

Paper Author: Board Support Secretary

Quorate: Yes

Appendices:

None

Declarations of interest made:

No new interests declared

Assurances received at the Committee meeting:

Agenda item	Summary
Succession Planning Interim Update – December 2023	• The Committee received and discussed an updated Interim succession planning report, and noted this will be further reviewed by the Executives and Care Group Senior leadership teams to formulate a 12 to 18 months plan. Once completed a further update report will be presented to a future Committee meeting. • The Committee noted the recruitment process in place to appoint substantively to the roles of Chief Operating Officer and Director of Corporate Governance.
Executive Directors' and Chief Executive Objectives and Appraisals 2023/24: Near Year End Reviews	• The Committee noted near year end appraisal reviews to be conducted in March 2024 and a final annual appraisal review report will be presented at the May 2024 Committee meeting.
Board Skills and Effectiveness Self-Assessment	• The Committee received and discussed a report on the survey results from the Board skills and effectiveness self-assessment. This will be further considered in relation to the findings from the Good Governance Institute (GGI) governance review. • The Committee noted the areas of gaps identified that will be prioritised for strengthening over the next three years. • The Board Development Programme had been updated reflecting feedback from the survey.
Board Development Programme 2023 – 2025	• The Committee received and agreed the Trust's Board Development Programme for 2023 – 2025.

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	• The Committee noted the agreed programme to be shared as evidence as part of the Recovery Support Programme (RSP). • The programme will be revised reflecting financial elements to be covered in 2024, a session covering Unitary Board, and all areas to include a brief description of what will be covered for each individual session.
NEDs – Terms of Office 2023/24	• The Committee received and discussed a report of the NEDs in post whose term of office was up for renewal in the next six months. • The Committee noted discussions will take place with the individuals due for renewal to confirm their intentions if they wished to continue in post for consideration of extensions to their term of office.

Other items of business

- The Committee noted the 2024 Annual NRC Work Programme.
- The Committee noted the Board Register of Interests.

Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
The Committee asks the BoD to receive and **NOTE** this assurance report.	Assurance	To Board on 1 February 2024

We care

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Quality and Safety Committee (Q&SC)**

Meeting date: **23 January 2024**

Chair: **Dr Andrew Catto, Non-Executive Director (NED)**

Paper Author: **Executive Assistant**

Quorate: **No**

This was the first of the new-style committee meetings alternating quality governance with improvement and learning meetings. The Q&SC Chair encouraged presenters to focus on the highlights and key risks, leaving the available time for questions and discussion.

Appendices:

None

Declarations of interest made:

No declaration of interest was made outside the current Board Register of Interest.

In attendance: Acting Head of Clinical Quality, NHS Kent and Medway

Assurances received at the Committee meeting:

Agenda item	Summary
Integrated Performance Report (IPR) – We Care Breakthrough Objectives & Watch Metrics	**Partial assurance** was received by the Committee in considering the Integrated Performance Report (IPR). The following key points were noted: – there were seven serious incidents (SIs) declared in December 2023, four of which were around care and treatment, one SI was around medical devices, and two SIs were declared in maternity; – there was a decrease in the complaints response rate in December 2023; however, the team's focus is on improving the quality of complaints responses (which is impacting on the response rate); – rollout of the new pressure ulcer risk assessment tool (PURPOSE) commenced in December 2023; – Hospital Standardised Mortality Rate (HSMR) continues to be below expected; – the Committee noted that cancer performance, endoscopy capacity and demand, and 12-hour wait in the Emergency Department (ED) were key priorities for the new Interim Chief Operating Officer (COO) and the Q&SC continued to express ongoing concern over the cancer performance standards.

Care Quality Commission (CQC) Update Report	– The Committee received the latest assurance report on progress with open CQC actions and updates on Section 29A requirements and actions relating to the Section 31 enforcement notice. – The Committee acknowledged the positive progress with closing more outstanding CQC actions and noted a reduction in monthly CQC enquiries.
Equality Delivery System (EDS) Assessment Report – Domain 1 (Patients)	– The Committee received the report on the Trust's approach to addressing inequalities for patients in health access, experience and outcomes, which is an annual assessment of four outcomes that make up Domain 1 of the EDS. – The Committee noted that three services (Maternity, Cancer and Maxillofacial) were reviewed this year and acknowledged the proposed EDS actions. It was disappointing that the primary determinant of poor EDS performance appeared to a lack of Equality & Diversity (E&D) patient data which automatically resulted in the lowest score. The Q&SC noted steps being taken to improve data collection.
Deep dive results into the risks around renal dialysis provision	The Committee received the report on the risks around renal dialysis provision and noted the following: – dialysis capacity is a national problem and Kent Kidney Care Dialysis Services have been unable to meet increasing capacity for the past two years; – due to issues with funding, the Renal Unit at Queen Elizabeth the Queen Mother Hospital (QEQM) had suffered periods of downtime owing to the failure of the reverse osmosis (RO) unit, the spare parts of which are no longer supported by the manufacturer. – the Executive confirmed that whilst the RO unit has been subject to breakdowns, there is no evidence of any water contamination and any associated patient safety incident – the funding for the RO unit replacement was approved and the unit will be replaced by the end of March 2024. The Executive was confident that the new unit would be functioning at this time; – the Chair asked the Executive what learning there had been relating to the escalation of risk by the renal team and how management responded to that escalation. It was clear that the reflections had contributed to the improvement of Trust risk management processes. – The Deputy COO agreed to have a follow up discussion with the Q&SC NEDs.
Corporate Principal Mitigated Quality Risks	The Committee received the progress report on the ongoing comprehensive review of risk registers across the Trust and noted the following: – work is ongoing to review risk at care group and speciality levels currently scored at 15 or above for adding to the Significant Risk Register;

	– the inaugural meeting of the Risk Group was held in December 2023 chaired by the Chief Nursing & Midwifery Officer (CNMO); – a closure of risks within the risk tolerance level set by the Board of Directors over two years old was agreed; – the newly created significant risk register will be reviewed by the Clinical Executive Management Group (CEMG) monthly with onward reporting to Board sub-Committees and quarterly to the Trust Board. The Q&SC Chair expressed concern at the relatively high number of risks scored at 15 and above, although Q&SC were reassured there were systems in place to deal with this volume of risk.
Serious Incidents (SIs) Report	– The Committee received the SIs Report representing the November 2023 data and noted the efficacy of the overall incident management and Duty of Candour compliance processes in place within the Trust.
Patient Safety Committee (PSC) Chair's Report	The Committee considered the assurance report on the activities of the PSC and noted the following: – the Midwifery-Led Unit (MLU) was re-opened at William Harvey Hospital (WHH); – the Trust launched the targeted lung health checks to improve early diagnosis and survival for those diagnosed with lung cancer; – Call 4 Concern (C4C) patient safety programme enabling patients and families to call for immediate help if they felt that the health care team were not recognised the changes in their conditions, had been rolled out across the Trust.
Fundamentals of Care (FoC) Chair's Report	– The Committee received the assurance report on the activities of the FoC Committee with discussion around Dementia Care Strategy and caring for patients in corridors/escalation areas. The Q&SC Chair asked that progress on implementing the dementia strategy was given later in 2024.
Mortality Steering and Surveillance Group (MSSG) Chair's Report	The Committee considered the assurance report on the activities of the MSSG noting the following: – 48 Structured Judgement Reviews (SJR) were completed, only four of which were completed by surgical specialties; – poor engagement by surgical specialties in the SJR process was addressed directly with the clinical leads by the interim CNMO; – a further Transfusion Associated Circulatory Overload (TACO) incident had been reported. The Q&SC Chair asked the Chief Medical Officer (CMO) to reflect, given the number of incidents in 2023.
Maternity and Neonatal Assurance Group	The Committee received an assurance report on the activities of the MNAG and noted the following: – the service achieved full compliance with all 10 Clinical Negligence Scheme for Trusts (CNST) safety actions;

(MNAG) Chair's Report	– out of 40 CQC must-do and should-do actions, only four must-do actions remain incomplete, these are around building projects, but each action has plan in place; – ongoing risks around obstetric theatre at QEQM were escalated to the Committee. The Q&SC Chair probed the actions that were being taken as this the second time that this risk had been escalated to Q&SC. It emerged that circa £40K had been allocated to 'scoping works' to identify the extent of the challenge. The Director of Midwifery reassured Q&SC that obstetric staff undertake practice drills using alternative theatre accommodation as part of the risk mitigation strategy. This risk would be kept under review and specifically raised at the Board of Directors.
Safeguarding Assurance Committee Chair's Report	The Committee received the assurance report on the activities of the Safeguarding Assurance Committee noting the following key matters: – as of January 2024, Section 42 investigations moved back to the Care Groups but the Safeguarding team will provide support as necessary. The Q&SC was keen to ensure that the new arrangement is working well; – the frequency of the oversight meetings with external regulators reduced to monthly and supportive nature of these meetings was acknowledged; – meeting communication needs of deaf people and safeguarding people with mental health issues were highlighted as challenges. – The safeguarding team now had access to expert mental health input and the Interim Mental Health Lead updated on mental health pathway changes in the ED.
Safe Staffing Review	– The Committee received the Safe Staffing Report and noted that the Trust continued to monitor Nursing and Midwifery numbers and skill mix in response to clinical needs daily. The Q&SC Chair sought clarity as to why usual staff staffing heat map by ward area was not presented. [*In subsequent email correspondence with the Director of Governance, it emerged that an incorrect staffing paper was submitted in error*].
Committee Specific Review of new Draft Board Assurance Framework (BAF)	– The Committee received the updated BAF following the review of the Trust Strategic Objectives and risk appetite and discussed the section of the BAF that relate to the Committee's area of accountability. The Q&SC Chair commended the Governance Lead on progress with the BAF and noted the version seen today was under development.

Referrals from other Board Committees

No referrals from other Board Committees were considered at this meeting.

The Committee asks the BoD to discuss and **NOTE** this Q&SC Chair Assurance Report.	Assurance	1 February 2024

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The Committee asks the BoD to **DISCUSS** the issues around the obstetric theatre at QEQM.	Discussion	1 February 2024

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Finance and Performance Committee (FPC)**

Meeting date: **23 January 2024**

Chair: **Richard Oirschot, Non-Executive Director**

Paper Author: **Deputy Group Company Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

None

Assurances received at the Committee meeting:

Agenda item	Summary
PricewaterhouseCoopers (PWC) Financial Review and Drivers of Deficit Analysis (2019/20 – 2022/23)	A report was provided by PWC which reviewed drivers which contributed to, and analyse the, deficit from Financial Year (FY) FY19/20 to FY22/23. The report highlighted that the Group's underlying deficit deteriorated from £43.8m to £90.8m. One of the factors was a significant amount of non-recurrent funds introduced over the reporting period, however, as many of these streams reduced – the Group's cost base continued to grow in excess of inflationary pressures. There were five key drivers highlighted which caused the underlying deficit, which included: ○ **Workforce** – Increase in substantive staff of 1,649 Full Time Equivalent (FTE) (£164m), there was also a significant increase in bank (£20m) & agency (£17m). ○ **Non-Pay** – A significant increase of £92m increase over period. ○ **Business Case Investments -** There were a significant number of business cases over the reporting period. ○ **Cost Improvement Programme (CIP) delivery –** Failure to deliver £14.3m over period. ○ **No Criteria Fit to Reside patients. –** 205 beds occupied, against a plan of 60 beds. The report also included a number of recommendations including; a review of CIPs & planning for 24/25, an internal review of Programme

	Management Office (PMO) resources and structure, review of Business Case process & internal financial services (including processes, policies & wider financial training), stronger grip and control across pay & non-pay and an extensive communication's plan to ensure the financial position of the Trust is understood at all levels. The report was received by the Executive Management Team the same week as FPC, and as such, a full management response had yet to be devised which will include a full action plan to address the recommendations. However, the Executive agreed on the importance of the report, and its analysis. The Committee received **LIMITED ASSURANCE** on the PWC Financial Review and Drivers of Deficit Analysis, as a full management response was due at its next meeting. However, the Committee received **ASSURANCE** on the understanding of drivers for the Trust's underlying deficit to date.
PMO and Savings Programme Update	A verbal report was provided by the Trust's Financial Recovery Director: • The Trust had undergone a process to review the process and capacity across the internal PMO team to deliver the significant financial savings needed. • There is a significant amount of work for this financial year to ensure the Trust meets its new agreed forecast, with 17 themes created across the programme, each with an assigned executive lead to ensure delivery. Alongside this, there will be new weekly reporting dashboard seen at an executive level to update real time on CIP delivery, which will inform a future monthly paper to the committee. • A focus remains on delivery of CIPs for 23/24, alongside planning for next year. Alongside this, there will be new weekly reporting dashboard seen at an executive level to update real time on CIP delivery, which will inform a future monthly paper to the committee. • There has been some slow progress on delivery of workforce CIPs across the Trust, however, this will be a focus over the next few months. There has been significant progress on non-pay with the introduction of a non-pay panel, which has created a significant reduction in stock line orders and Purchase Orders (POs) raised since last month. • A full paper on the CIP plan, progress, and PMO governance will come to next FPC.

	The Committee received **LIMITED ASSURANCE** on the PMO and Savings Programme Update, as a full dashboard, and governance update, taking place next meeting.
Length of Stay (LoS) and Flow Update *(PRISM/KPMG)*	The Chief Operating Officer (COO) provided an update on the work being completed by PRISM/KPMG regarding Length of Stay and Flow across the hospital sites. The update included a significant amount of analysis and deep dive of data across the Trust. The report provided analysis on the current Average Length of Stay (ALOS) for patients across EKHUFT at 11.49days, which on average, is 1.85 days longer compared with peer Trusts at their top 50% performance. This suggests a significant opportunity for bed capacity for non-elective patients. The reported that additional work was required to understand the elective opportunity, benchmarking against recommended targets. The opportunities vary across each main acute site, given the varied nature of services provided. However, Queen Elizabeth the Queen Mother Hospital (QEQM) and William Harvey Hospital (WHH) have similar non-elective Average LOS (ALOS) with Kent & Canterbury Hospital (K&C) higher, notably due to the rehabilitation services and specialist nature at K&C but a significantly high elder people ALOS compared to the other sites. Further work will be required to be able to plan, and deliver, opportunities at site level. The Committee received **LIMITED ASSURANCE** on the work which can be completed for ALOS across the Trust, including the potential opportunities at site level.
Month 9 Finance Report / Cash Report & Business Planning 24/25	The Chief Finance Officer (CFO) began the report with confirmation for the Trust's new revised forecast for 23/24 of £117.4m, which has been acknowledged by NHS England (NHSE), and is in line with the independent forecast by PWC. In line with the new forecast, there is still a strong CIP requirement for this financial year of £13.1m. The Committee received **LIMITED ASSURANCE** on the ability to deliver these CIP requirements, given the earlier requirement for a further paper on the revised internal PMO team to deliver. The M9 Finance Report showed early signs of progress, with the Trust's pay position being the lowest since April 2023, nine months ago, with month-on-month reduction over the past three months.

	The upcoming strike action will have potential impact on the Trust's finances, however, this has been factored into the revised forecast agreed with NHSE. The Committee received an update on the cash position of the Trust, given the current planned deficit. As a result of the newly revised forecast, the Trust request additional support to support the cash management position. The Committee received **LIMITED ASSURANCE** on the cash position, and have referred the Cash Position item to the Board of Directors for oversight of the Trust's current financial position. The Committee received **ASSURANCE** on the Month 9 Finance Report.
Board Assurance Framework (BAF) and Risk Register Review Update	The Committee received a draft updated BAF, and an update on the work undertaken for the Trust's Risk Register. The Committee discussed the level of risk score across finance on the BAF, and the **LIMITED ASSURANCE** received on steps which will be triggered for high-level risk, and the associated governance to ensure risk is managed and maintained.
Integrated Performance Report (IPR)	The Chief Operating Officer (COO) provided an update on the performance across the Trust: • The Committee noted the extreme pressures on the Trust, which has resulted in over a 10% increase in attendances across all types within our Emergency Departments for December. This has resulted in QEQM reporting the highest number of ambulance handovers since 2022. • Cancer Backlog continues to be a priority; however, the improvement will take time to see results. Although the performance had improved between November and December, since the report, the backlog has grown due to increased pressures on the Trust's services. • Referral to Treatment (RTT) Waiting Times have increased, with Tier One Support now commencing and work underway to develop recovery plans for RTT to deliver zero 78 weeks by March. The Committee noted **LIMITED ASSURANCE** on the levels of operational performance across the Trust.
Meeting Assurance Report's	The Committee noted the assurance report from the Capital Investment Group (CIG) and Business Case Scrutiny Group (BSCG) and received

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	ASSURANCE on the work they had untaken since the last reporting period.

Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
The BoD is asked to receive and **NOTE** this assurance report	Information	1 February 2024
The BoD is asked to **NOTE** the current Cash Position of the Trust	Information	1 February 2024
The BoD is asked to **APPROVE** the Integrated Performance Report (IPR)	Decision	1 February 2024
The BoD is asked to **NOTE** the Month 9 Financial Position	Information	1 February 2024

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Finance and Performance Committee (FPC)**

Meeting date: **9 January 2024**

Chair: **Richard Oirschot, Non-Executive Director**

Paper Author: **Director of Finance**

Quorate: **Yes**

Declarations of interest made:

None

Agenda item	Summary
UPDATE FROM PRICEWATERHOUSE COOPERS (PWC) Financial Controls Update paper **Management (Trust) Response /Financial Grip and Controls Report**	- Grip and control processes slow to be implemented and PWC are here to support the embedding process; - Cultural impacts/changes required to senior level to make current controls effective; - Communication strategy being drafted for completion within the next few weeks; - Cost Improvement Programme (CIP) events to be launched; - Vacancy Control Panel (VCP) would contain the vacancies in a more stronger and robust way and include weekly data monitoring to ensure executive oversight; - Work was being carried out to reset staffing levels against the safer staffing assessment; - Further work was needed to ensure clarity around priorities for the organisation; - Programme Management Office (PMO) has been strengthened and additional resources to review CIP planning, outpatient and diagnostic services and there was the potential for additional resources from the Centre, providing the Trust can prove it was making a difference. The Committee discussed and **NOTED** the Financial Controls Update report from PricewaterhouseCoopers and the Management (Trust) Response.
UPDATE FROM PRICEWATERHOUSE COOPERS – Independent forecast and drivers of the deficit	- NHS England (NHSE) are working with Kent & Medway Integrated Care System (K&M ICS) on the original plan submitted in May of last year. Due to the financial position of EKHUFT NHSE are working with both the Trust and the Integrated Care Board (ICB) for a clear understanding of the forecast for 23/24. The Committee discussed and **NOTED** the Independent forecast and drivers of the deficit report.

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UPDATE ON THEATRE UTILISATION (PRISM)	- Governance has been established through launching both the operational Theatres Optimisation Group (TOG) that will deliver the programme workstreams, and the Theatres Improvement Group (TIG) that provide assurance and support facilitation of theatre improvement initiatives. - The large surgical waiting list is being addressed through focusing on addressing dropped funded sessions and increasing patient booking towards ICB targets. - Programme Key Performance Indicators (KPIs) have been agreed. Specialty targets are being set with overall revenue benefit to the Trust. - Deep dives underway within core specialties to drive up throughput in the services with greatest opportunity. - Notably, patient throughput has increased since commencing the programme, with November delivering the highest number of cases in a single month since pre-pandemic.
LENGTH OF STAY (LoS) AND FLOW UPDATE (PRISM/KPMG)	The top three internal flow delay reasons identified by the workstream are as follows, and for each delay reason a cause and countermeasure has been identified. A full discussion was had to understand the cause and affect and the mitigating counter measures that the Trust are undertaking. Both sites were discussed at length. The Committee discussed and **NOTED** the Length of Stay (LoS) and Flow Update (PRISM/KPMG) report.
MONTH 8: ***FINANCE REPORT*** ***FORECAST UPDATE***	- The Committee discussed and **NOTED** the Trust's financial performance and actions being taken to address issues of concern; the following key points being noted: - The Group reported an in-month position of £6.5m against a plan of £4.6m, resulting in a deficit variance of £1.9m. The Year to Date (YTD) position is £74.7m against a plan of £50.1m, giving a YTD variance to plan of £24.6m. - Run-rate has reduced in Month 8 by £2.5m compared to Month 7, predominantly due to the change in Elective Recovery Fund guidance actioned in Month 8. The key drivers to the Group's YTD deficit are:

	Key Drivers / **£000** Non-delivery of recurrent efficiency savings, against recurrent CIP plan / (£20,027) Nursing drivers (Escalation Beds £864k / 1:1 care £2,198k / Supernumery Nurses £1,325k) / (£4,387) Unfunded Pay Award (Medical and Dental, Agenda for Change (AfC) and AfC Bonus) / (£3,554) Strike Action impact unfunded (September/ October – excludes April- August as now funded through new Elective Recovery Funding (ERF) guidance) / (£910) Internationally Educated Nurses (IEN) Backpay 2022/23 above plan / (£990) Non-recurrent savings, above non-recurrent CIP plan / £5,296 **Group YTD Deficit** / **(£24,572)** The Group cash balance (including subsidiaries) at the end of November was £28.7m. The Trust drew £17.3m of working capital (PDC) in the month, making a YTD total of £65.9m. Total capital expenditure at the end of November was £11.9m spend against a plan of £16.5m; this represents a £5.6m net underspend due to slippage on a major scheme. The Trust is forecasting capital spend of £29.5m in 2023/24. The Committee discussed and **NOTED** the Month 8 Group Finance Report.
WINTER PLAN UPDATE	The Committee discussed the Winter plan including reviewing the current position of the winter schemes and the reported demand position on the Trust's Emergency Departments. The discussion reviewed the proposed schemes across the Heath Care Partnership (HCP) to mitigate the anticipated uplift in demand this winter Significant progress has been achieved in enhancing the Trust's reporting and bed management systems to provide a precise overview of live bed usage. Ward-level and bed-level amendments have been made to the Trust's Patient Administration System (PAS), facilitating accurate reporting and identification of escalation beds. Ongoing monitoring ensures the effectiveness of these changes. At both acute sites, efforts have been made to reconfigure space, aiming to maximise inpatient (IP) capacity and minimise corridor care. Both projects are receiving ongoing support and updates to the bed-base reporting will be implemented as they materialise.
BOARD ASSURANCE FRAMEWORK (BAF)	The Committee noted the following matters in relation to the BAF:

AND PRINCIPAL MITIGATED ***FINANCIAL AND PERFORMANCE RISKS*** ***Progress Report***	Version 1 of the newly formatted BAF was presented to Board in December. That contained a BAF Risk: "There is a risk that the Trust, as part of the Kent and Medway ICS, is unable to deliver the scale of financial improvement required in order to achieve a breakeven or better financial performance within the funding allocation that has been set for the next three years, leading to regulatory action and/or impacting on the ability of the Trust to invest in its strategic priorities and provide high quality services for patients." The BAF Risk was rated as 25 – i.e. at the highest level possible. A updated BAF has been added to the agenda for the next FPC in late January. The Committee discussed and **APPROVED** the Board Assurance Framework (BAF) and Principal Mitigated Financial and Performance Risks report.
BUSINESS PLANNING UPDATE	The update focuses on key points of progress made in December 2023 on the development of the Trust's 2024/25 business plan and the focussed actions that will be undertaken during January 2024. The Committee discussed and **NOTED** the verbal Business Planning verbal Update.
BUSINESS CASES	No business cases were submitted.
WE CARE INTEGRATED PERFORMANCE REPORT (IPR) (M8): NATIONAL CONSTITUTIONAL STANDARDS FOR EMERGENCY ACCESS, REFERRAL TO TREATMENT (RTT), CANCER AND DIAGNOSTICS	- All members agreed the importance to focus on the priorities. - The FPC Chair asked what additional support the Trust would receive to achieve the priorities listed within the IPR. In response, the Chief Strategy and Partnership Officer confirmed discussions had been had of what this would look like and what was needed and resources were already in place. - All members agreed it was important to get the message wider with the demonstrable progression with the achievement of the IPR metrics. The Committee discussed and **NOTED** the 'We Care Integrated Performance Report' (IPR) with **PARTIAL ASSURANCE** being received with regard to performance against key metrics for 2023/24.

CAPITAL REQUIREMENT UPDATE	- Equipment or estate may impact on the Trust's ability to deliver activity. One of the areas also being reviewed was the revenue implications with regards to estates, i.e. high energy costs due to current estates. This was a work in progress. - Trust were prioritising the limited amount of capital held. Work had started on drafting a medium term strategic perspective of the capital requirement. - A need to remind stakeholders that historically the Trust had been given capital in a sporadic matter, which had not reduced the liability, and the long term commitment was essential to ensure when it was delivered it reflected value for money. The Committee discussed and **NOTED** the Capital Requirement Update report.
COMMISSIONING FOR QUALITY AND INNOVATION PROGRAMME (CQUIN)	- For 2023/24, the ICB agreed that there will be no financial penalty for failure to meet the national CQUIN targets but that evidence of improvement will be expected. - Specialised commissioners are reserving the right to impose a financial penalty for any underperformance (total contract value £913K), although this was not imposed for 2022/23 and there has not been any challenge received in relation to evidence provided. The Committee discussed and **NOTED** the Commissioning for Quality and Innovation Programme (CQUIN) report.
WORKFORCE GROWTH REVIEW	- The budgeted establishment growth March 2020 to March 2023 was 1,676.92 Whole Time Equivalent (WTE) and a line by line review has grouped the increase by theme such as Business cases (1242.71 WTE), Externally funded posts (105.01 WTE), increased demand/premium pay to substantive (83.09 WTE) etc. An action plan, including timelines, for each theme of increase has been developed. - WTE being utilised above establishment, as at October 2023, was 88.83 WTE, however it should be highlighted that this has reduced significantly since September as a result of the workforce controls put in place. August 2023 worked WTE above budget was 321.38 WTE. A summary of the workforce controls in place and those being further strengthened were discussed. - Changes in the banding profile of workforce from March 2020 to March 2023 has been analysed by grade and also compared to other providers in Kent and Medway. Comparing across the four

	Acute providers, EKHUFT's proportions of March 2023 Total are middle range, across all grade groupings. The Committee discussed and **NOTED** the Workforce Growth Review report.
CAPITAL INVESTMENT GROUP	The Committee **received** an assurance report and minutes of the Capital Investment Group on 16 November 2023.

Other items of business

None

Actions taken by the Committee within its Terms of Reference:

None

Items to come back to the Committee outside its routine business cycle:

There was no specific item over those planned within its cycle that it asked to return.

Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
The BoD is asked to receive and **NOTE** this assurance report.	Assurance	1 February 2024

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Charitable Funds Committee (CFC)**

Meeting date: **14 December 2023**

Chair: **Claudia Sykes, Non-Executive Director**

Paper Author: **Committee Chair**

Quorate: **Yes**

Appendices:

No

Declarations of interest made:

None received

Assurances received at the Committee meeting:

Agenda item	Summary
Grant applications	The Committee received **ASSURANCE** on the delivery of previous grants awarded, including the Talking Wellness programme to support staff wellbeing, and the Leadership Programme for staff from Ethnic Minorities which will both start in January 2024. The Committee **NOTED** the length of time between grant award and delivery of funded items and services, due to protracted Trust procurement timelines. The Committee **NOTED** concerns around delays in spending the £195k Roche Ophthalmology grant received, and this was **REFERRED** for Executive intervention.
Charity finance report	The Committee received **ASSURANCE** over the Charity's financial position at 31 October 2023, noting a net asset position of £1.9m. £700k has been committed from previous grant approvals. The Committee received **ASSURANCE** that the Charity cost base was reasonable when compared with peers. The Committee **NOTED** that EKH Charity operates on a Full Cost Recovery basis for staffing and overheads, which is not the case for all NHS Charities. The Charity team also supports the League of Friends with procurement and some grant applications.

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Actions taken by the Committee within its Terms of Reference:

The Committee approved grant applications for:

- Cardio Stress Test Machine Queen Elizabeth the Queen Mother Hospital (QEQM) - £33k
- QEQM Critical Care Upgrade to Patient and Staff areas - £56k

Items to come back to the Committee outside its routine business cycle:

Potential grant applications which may need fast-tracking before the March Committee.

Items referred to the BoD or another Committee for approval, decision or action:

None

Item	Purpose	Date
The Committee asks the BoD to receive and **NOTE** this assurance report.	Assurance	To Board on 1 February 2024
The Committee **REFERRED** concerns around the delays in spending the £195k Roche Ophthalmology grant received, to the Executive Management Team (EMT).	Action	14 December 2023

East Kent Hospitals University NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (BoD)

Report title: **Serious Incident (SI) Report**

Meeting date: **1 February 2024**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO)**

Paper Author: **Acting Joint Head of Patient Safety**

Appendices:

APPENDIX 1: Serious Incident Report

Executive summary:

Action required:	Assurance
Purpose of the Report:	This report is to enable the BoD to have greater oversight of all Patient Safety Incidents that have occurred in the Trust during the month of November 2023 and take assurance that these have been/are being managed in accordance with the NHS England (NHSE) Serious Incident Framework and that lessons have been learned and shared.
Summary of key issues:	Assurance of the efficacy of the overall incident management and Duty of Candour (DoC) compliance processes are currently reported to the BoD as part of the monthly Quality Governance Compliance Report (QGCR). • In November 2023 the Trust declared 15 Serious Incidents (SIs). • One of these 14 incidents is being investigated by the Maternity and Newborn Safety Investigations Special Health Authority (MNSI). • In November 2023 the Trust held eight SI Declaration Panels and four SI Investigation Approval Panels, the purpose of these panels is described in the body of the report. • As of the 30 November 2023 the Trust had 79 open SIs, 59 (75%) are under investigation and 20 (25%) have been submitted to the Integrated Care Board (ICB) for closure, 11 were submitted in November. Two of these SI reports breached the 60-day date or their extension date, one of which was declared prior to 1 April 2023. • During October there were 29 cases for which verbal DoC applied with 100% compliance. One letter was a day late making the compliance 96.9%. • Final Duty of Candour following submission of the SI report was delayed in three cases making compliance 83.3%. • Last month, an additional section was added to the report to reflect the learning shared in the Trust from Clinical Audit. In future publications, this will be included bi-monthly to ensure regular oversight.

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Key recommendations:	It is recommended that the Board of Directors review and **DISCUSS** the information contained within this report and takes assurance of the efficacy of the overall incident management and Duty of Candour compliance processes in place within the Trust.

Implications:

Links to 'We Care' Strategic Objectives:	• **Our people** • **Our quality and safety**
Link to the Board Assurance Framework (BAF):	BAF33: There is a risk of failure to adequately resource, implement and embed effective governance processes throughout the Trust.
Link to the Corporate Risk Register (CRR):	CRR 107: Inability to embed learning from incidents, complaints and claims across the Trust. CRR 118: There is a risk that the underlying organisational culture impacts on the improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace. CRR133: Patients will not be informed of incidents where the Trust may have caused/contributed to harm (DoC). This risk has recently been deescalated and is now risk CRR 2799 on the Quality Governance Risk Register.
Resource:	N
Legal and regulatory:	Yes. The Trust is required to comply with NHSE Serious Incidents Framework.
Subsidiary:	N

Assurance route:

Previously considered by
Clinical Executive Management Group (CEMG) - December 2023
Quality & Safety Committee (Q&SC) - January 2024

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Serious Incident REPORT

December 2023
(November Data)

By
Acting Joint Head of Patient Safety and Improvement

Executive Sponsor
Chief Nursing and Midwifery Officer

CONTENTS

Patient Safety Incidents

The Trust is committed to ensuring the safety of everyone who uses its services and to improving the quality of care to patients. EKHUFT recognises the importance of reporting all incidents as an integral part of the risk management strategy, and follows the current national frameworks in understanding why an incident has occurred. Learning from reported incidents can improve patient experience and quality of care, lessons can be learnt and shared across the organisation to prevent recurrence and reduce the risk of harm. This report has transitioned to the new Care Groups. The governance teams migrated to the new Care Groups on 09/10/2023.

THE FIGURES

NOVEMBER 2023

2134

Patient Safety Incidents

82% of 2612

total incidents reported

THE HARM

NOVEMBER 2023

No Harm 1233

Low Harm 867

Moderate 26

Severe 5

Death 3

Harm ungraded (under review) 0

TOTAL 2134

The figures for this report were validated on 01/12/2023 and at that time there were three deaths reported on Datix in November and remain on the Scorecard figures for the month:

1. In hospital cardiac arrest was reported as a death harm but investigation identified no acts or omissions in care and the case was downgraded.
2. Unexpected death was reported as a death harm but investigation identified no acts or omissions in care and the case was downgraded.
3. In hospital cardiac arrest of a paediatric patient referred which was referred to Rapid Review panel and reported as serious incident in December. It is currently being investigated via the comprehensive level two investigation process and was referred to the Coroner at the time.

Serious Incidents Reported on the Strategic Executive Information System (StEIS) by Category

Serious Incidents declared in November 2023

CATEGORIES OF HARM on StEIS

01/11/23 – 30/11/23

	No harm	Low	Moderate	Severe	Death	Total
Diagnostic incident incl delay	0	0	1	1	0	2
Maternity/Obstetric incident: baby only	0	0	1	0	0	1
Maternity/Obstetric incident: mother only	0	0	0	1	0	1
Medication incident	0	0	0	1	0	1
Pressure ulcer	0	0	1	0	0	1
Slips/trips/falls	0	0	1	2	0	3
Sub-optimal care of deteriorating patient	0	1	1	1	0	3
Treatment delay	1	1	1	0	0	3
Total	1	2	6	6	0	15

**Please note: Table above shows incidents reported on StEIS from 1 to 30 November 2023, hence death figures are not comparable with those from the table on page 3, which shows incidents reported on Datix in November 2023. None of the deaths reported on Datix have been reported on StEIS during the same month.*

Serious Incident Investigations

(Process and Overview)

When an incident is identified that is significant in nature, both in terms of potential learning or if it potentially reaches the threshold for declaring as a Serious Incident (SI), it is presented by the Care Group governance team and the representing clinician at the Serious Incident Declaration Panel (SIDP). This is an Executive-led panel chaired by either the Chief Nursing and Midwifery Officer (CNMO), Chief Medical Officer (CMO) or the Director of Quality Governance (DQG). These meetings are held twice weekly.

The Care Group governance team identify a lead investigator from senior medical, nursing or allied health professionals in that clinical area and facilitate a meeting to review the incident with the facts available using the current root cause analysis templates. The investigation team will identify a root cause, prepare an SI report and develop an action plan alongside any actions already commenced or completed since the incident occurred. The completed report is scheduled for the Serious Incident Investigation Approval Panel (SIIAP) two weeks before it is due to the Integrated Care Board (ICB) at which the CNMO, CMO and DQG to quality assure the report, make recommendations for changes or approve the report for Integrated Care Board (ICB) submission. The Care Group governance team and lead investigator attend this meeting.

Once the report has been closed by the ICB a date is set three months hence for the action plan to be returned to the SIIAP meeting to ensure all actions are completed. This allows the CNMO and CMO full oversight of the actions and improvements being undertaken and completed.

In November 2023 there were eight SIDP meetings and four SIIAP meetings.

There were 11 Serious Incident reports submitted to the ICB in November 2023 of which four had extensions granted. Of those with extension, three were submitted before the new date breached and one breached the extension date (the breached incident had been reported on StEIS in November 2022). One report breached the original target date by three days.

INVESTIGATIONS Declared/Submitted

Activity and performance in November 2023

Non-SI investigations commenced during November 2023

(Investigations overview by type)

Investigation type	No.		Incident category
After Action Review (AAR)	2	1 1	Care/treatment Facilities/Estates
Cancer 104-day Harm Review	0		
Clinical Case Review	1	1	Unexpected problem/outcome for baby
Infection Prevention and Control Root Cause Analysis (IPC RCA)	0		
Mortality and Morbidity (M&M) review, Perinatal Mortality Review	1	1	Care/treatment
Patient Safety Incident Investigation Report (PSIIR)	1	1	Pathology (lab tests)
Structured Judgement Review (SJR)	1	1	Adult safeguarding
Thematic review	0		

After Action Review is a shorter investigation process than the comprehensive SI report and aims to capture maximum learning in a timely way. A standard template is used.

Clinical Case Review: The Trust is in the process of designing a Clinical Case Review Form so that clinicians can capture salient contributing factors in an incident to elicit timely learning and clear outcomes.

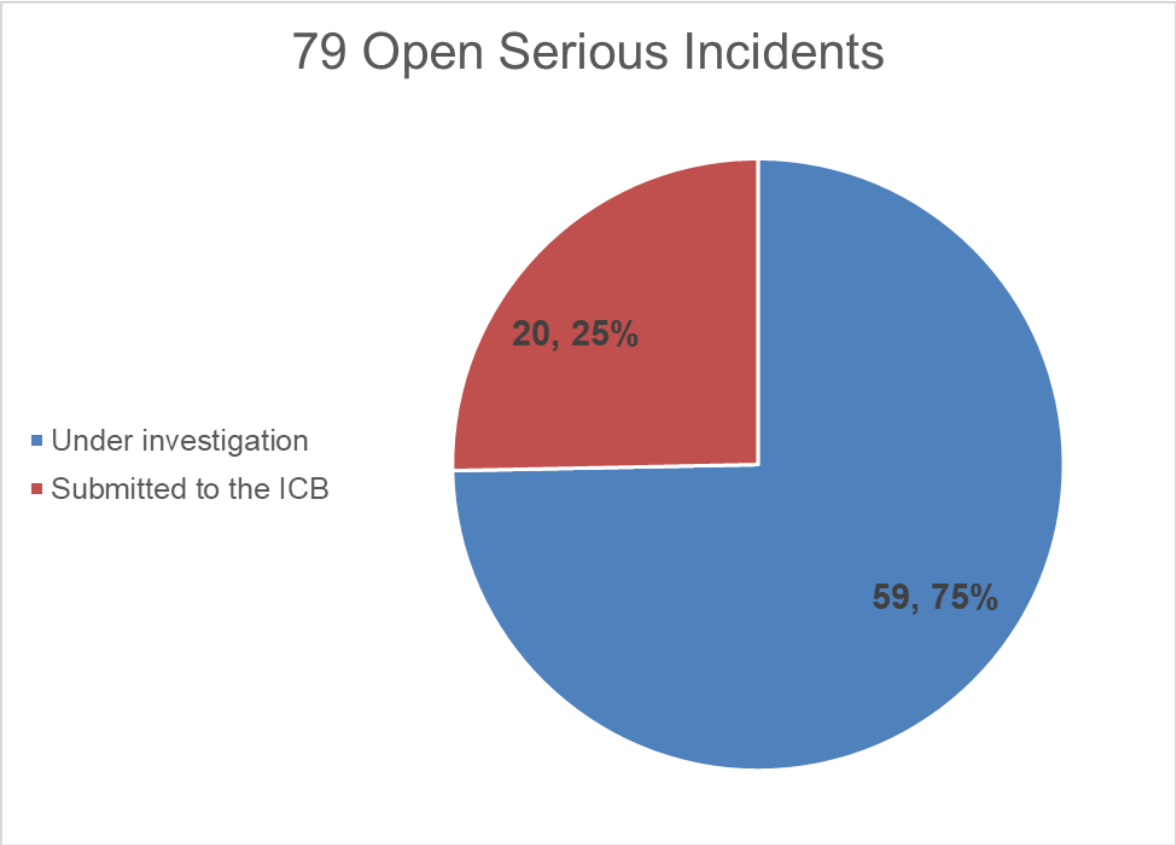
Cancer 104-day Harm Review: Any patient exceeding 104 days on a cancer pathway is subject to a clinically led investigation of potential harm which is known as a clinical harm review. This applies to all specialities managing patients on cancer pathways.

Mortality and Morbidity (M&M) review and Perinatal Mortality Review: Clinically led, multidisciplinary review of care to identify learning. External review is required for Perinatal Mortality Review.

Structured Judgement Review blends traditional, clinical-judgement methods with a standard format. The approach requires trained reviewers to make safety and quality judgements over phases of care and to make explicit written comments about care for each phase and to score for each phase to identify if appropriate care was given throughout.

Thematic review uses a specific methodology to identify patterns and themes within data, both quantitative and qualitative. Learning is drawn from the themes.

Total number of open Serious Incidents per Care Group as at 30 November 2023.



Of the 79 open Serious Incidents, the chart above shows 20 PSIIRs sit with the ICB. Of these, two were submitted to the ICB during September, seven in October and the remaining 11 in November.

Of the 59 under investigation: 44 are not yet due, 13 have NCRs pending and two cases have breached. Both breaches are under the old care group General and Specialist Medicine (GSM), due to the resource issues they have experienced. This is being dealt with in the short term with additional staffing and in the longer term with the centralisation of the Care Group governance teams so that workload can be better managed.

Table to show open SIs in last three months as the new Care Groups will have been operational for three months by that point.

Care Group	September	October	November
Corporate	1	0	2
Critical Care, Anaesthetics and Specialist Surgery	5	4	6
Diagnostics, Cancer and Buckland Care Group	3	1	2
Kent and Canterbury and Royal Victoria Hospital Folkestone (RVHF) Care Group	16	17	15
Queen Elizabeth the Queen Mother Care Group	15	14	13
William Harvey Care Group	14	14	21
Women, Children and Young People Care Group	18	20	20
Grand Total	72	70	79

Never Events

No Never Events were reported on StEIS in November.

Duty of Candour

Between 1 and 30 November 2023 using the Duty of Candour documented on Datix, a total of 29 moderate, severe or death harm incidents (or declared as a Serious Incident) potentially required Duty of Candour. The Trust has achieved an 100% compliance rate for verbal Duty of Candour this month.

One letter was not sent to the patient within our 10-day deadline giving the Trust a 96.9% compliance rate.

For Serious Incident cases submitted to the ICB, the final duty of candour had an 83.3% compliance rate as three case were outstanding within the time frame although verbal communication had been shared with the family so that they were up to date.

Work continues with the Care Groups to promote continuous improvements that will ensure the Trust consistently achieves 100% compliance across all three elements.

Learning from Clinical Audit

As part of the NHS England (NHSE) Recovery Support Programme exit criteria for quality and safety, a key milestone to be implemented by quarter three was the production of an audit programme presented to the Board demonstrating improvements in patient safety as a result of serious incident management with a clear cycle of continued reporting (at least bi-annual).
A programme of patient safety audits has been established and has been incorporated into this report, reflecting the learning shared in the Trust from Clinical Audit.

The December report, presented in January 2024, will include the next audit information on WHO Safer Surgery.

Name of Audit	Date to be reported for evidence	Learning
Safer Surgery (WHO) monthly documentation audit	December 2023	Shows consistent improvement of compliance with the Surgical Safety Checklist measures of team brief, sign in, time out, sign out and team de-brief all currently above 95% compliance
Duty of Candour	February 2024	
Stop Before You Block	April 2024	
Penicillin Allergy	June 2024	

Learning from Incidents

There were five cases closed on StEIS in November 2023. Below are two examples of the Learning Bulletins which are generated at the completion of an investigation to provide a concise learning tool for teams to share. The cases below have been anonymised as far as possible to make appropriate for sharing in a public forum.

The Incident – what happened?

This incident involved a patient with concerns that they were fitted with a pacemaker which was inputted incorrectly resulting in their having to be transferred to Kings College Hospital (KCH) where they were told they may need to have open heart surgery. The patient was sent home from the William Harvey Hospital (WHH) with a discharge letter, after the pacemaker had been fitted. It stated there was "No need for routine chest x-ray". Three days later, the patient experienced intense pain and came back to the department. The patient was concerned that they were made to wait outside the unit in pain for two and a half hours before being reviewed.

Following their return to the department, the patient was admitted as an emergency and, following investigation, it was found that the pacemaker wires had perforated the anterior walls of the right atrium. The patient was transferred to Kings College Hospital by emergency ambulance for a corrective procedure. The medical team at KCH stated that not having a post-op x-ray was the opposite of their practice.

There is no standard operating procedure (SOP) in place within East Kent University Hospitals (EKHUFT) recommending post-op x-rays in all cases, although the Consultant Cardiac Electrophysiologist has said that this is a minimum requirement in all other centres in which he has worked.

Lead perforation is a recognised complication of pacemaker implantation but no guidance surrounding the mandatory minimum post procedure care for pacemaker implants was in place and no guidance for the identification and management of high-risk procedures or high-risk patients existed.

The patient has stated that the incident had a profound impact, both physically and emotionally, causing anxiety.

The Learning – what we found

Good practice to share:

Lead perforation is a recognised complication of pacemaker implantation. International guidance mandates a suite of post-procedure investigations to be performed after the implantation of any cardiac rhythm management device to enable early detection of various complications including cardiac perforation. Despite the existence of clear international guidelines in this area, these checks were not routine practice within EKHUFT.

This is in the process of being rectified with a SOP being produced.

The recommendations – how we can prevent recurrence

- A SOP is to be produced to provide guidance on the correct procedures to be followed, and investigations performed, post pacemaker implantation
- The case was presented and discussed at the cardiology device complications meeting for learning.
- Supervised practice for the performing consultant was undertaken and no further incidents of cardiac perforation have occurred since. He has since left the trust.

- The case was discussed with cardiac catheter Suite team regarding the wait the patient had and lack of pain relief.
- A ward attender form to be created to document patient details including arrival time and treatment required.

What do we need to do?

- Adhere to the SOP once it has been produced.
- Ensure patients are not left to wait in pain in department waiting rooms.

The Incident – what happened?

This incident was identified through the complaints process and then subsequently reported as a Never Event on 31 July 2023. It involved a patient who had three previous hysteroscopies, one for the removal of a polyp and two others to investigate post-menopausal bleeding (PMB).

A transvaginal scan showed a retroverted uterus with endometrial thickness of 8.4 mm with multiple small fibroids.

04 January 2023 hysteroscopy and biopsy of lesion was described as: history of PMB, previous polyps removed a year ago. Declined insertion of Mirena. Uncomplicated hysteroscopy. Flat based polyp excised and sent for histology Biopsy taken via curettage (benign histology).

She was referred by her GP on 26 May 2023 with PMB. Seen in rapid access clinic (RAC) on 07 June 2023 and hysteroscopy & polypectomy planned.

On 13 June 2023 she attended QEQM for the above surgery.
As she had the same procedure three times before the consenting consultant suggested she have a Mirena coil fitted as treatment for the PMB. They discussed this and, the consultant recalls, the patient was ambivalent regarding the fitting of a Mirena coil but did not consent to this procedure. The insertion of a Mirena coil was not added to the consent form.

A registrar completed the hysteroscopy and inserted a Mirena coil when prompted by the consultant. The registrar did not check the consent form. Insertion of a Mirena coil at this procedure was recommended by the consultant as being in the patient's best interest.

The theatre staff provided the Mirena coil when requested and did not challenge this request.

15 June 2023 Governance Lead spoke to the consultant who said the patient was ambivalent about the coil at the pre-op discussion but was not consented for the fitting of Mirena. The consultant who consented the patient did not perform the surgery.

There has been an acknowledged delay in reporting this incident:
Initially the incident was not reported and the care group only learnt of this on receipt of the formal complaint.
The Datix was completed in retrospect and discussed at the Women's Health rapid Review on 16 June 2023.
There was no conclusion at this meeting and the case was to re-discussed in a week once further information was available.
On 29 June 2023 the incident was referred to SIDP. The case was taken to SIDP three times and initiated extensive debate regarding the classification of the incident.
A meeting was arranged on 27 July 2023 to discuss this case in more depth and it was agreed to report this as a never event.

The learning - what we found
The insertion of a Mirena coil was not added to the consent form as a result of a human error. Theatre lists are amended/changed regularly on the day of surgery which can cause confusion between the team members. Theatre staff did not challenge the request for a Mirena coil as they are routinely used in this surgery.
The recommendations – how we can prevent recurrence
Strengthening of the consent process for hysteroscopy cases: Review the current Patient Information Leaflet to ensure the information is relevant and robust, discussion with wider team regarding pre-printed consent forms. Amendments/changes on the day of surgery to be clearly communicated between teams: Discussion of any changes made to be included at team brief, all changes to theatre lists needing to be reprinted to be recorded on the traffic light system. Theatre staff confident to challenge clinicians during surgery: Theatre staff to complete Human Factors training (including assertiveness), a registered scrub practitioner to stay in theatre at all times. Unacceptable professional behaviour to be reported via Datix for recording & monitoring, Multi-Disciplinary Team (MDT) Training/Workshops for Human Factors/Civility/Reinforcing Standards, introduction of the "Below 10,000 Feet" safety initiative. Share the learning: Learning to be shared amongst the teams by relevant manager. Incident to be shared via the Perinatal & Governance Meeting. Learning bulletin to be completed and shared. Minutes of Care Group Governance meetings evidencing escalation of non-compliance and closure of improvement plans.
What do we need to do?
Ensure all women are provided with the relevant patient information leaflet at RAC. All clinicians to complete the relevant consent training module on Electronic Staff Record (ESR). Be involved in discussions with the wider team regarding pre-printed consent forms. Discussion of any changes to theatre lists made to be included at team brief. All changes to theatre lists needing to be reprinted and recorded on the traffic light system. Theatre staff to complete the Human Factors training (including assertiveness). Report any unacceptable professional behaviour on Datix for recording & monitoring Take part in multidisciplinary training/workshops for Human Factors/Civility/Reinforcing Standards.

RECOMMENDATION: The Board of Directors is asked to review and discuss this report which details the management of Serious Incidents.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Patient Safety Incident Response Framework (PSIRF)**

Meeting date: **1 February 2024**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO)**

Paper Author: **Acting Head of Patient Safety**

Appendices:

None

Executive summary:

Action required:	Information
Purpose of the Report:	The report shows the progress the Trust has made to achieving the 1 April 2024 deadline for full implementation of PSIRF.
Summary of key issues:	• Reasonable progress has been made over the last month, however, to achieve the deadline for 1 April 2024 the pace needs to be expedited. • The final elements of the key themes across the Trust are being worked on and the PSIR Plan and Policy are key documents that need to be completed by end of January 2024. • The Trust's LfPSE training video and supporting guidance will be circulated to all staff on 26 January 2024, with a go live date planned for 19 February 2024 . • The Learn from Patient Safety Events (LfPSE) training video will be accessed via the Electronic Staff Record (ESR) for all staff to enable monitoring of compliance with completion. To make this a mandatory requirement, an application has been submitted to the Training and Education Steering Group for approval, however, this will not delay the rollout of the video on ESR. • Two roles have been presented to the Vacancy Control Panel with one being approved, Band 3 PSIRF Programme Administrator role has interview date booked for 1 February 2024 and the Band 6 role is going through the Job Matching process. • Work around understanding our Safety Culture, in particular the blame element across the organisation has been adapted from the original plan. Some of the data will be obtained from other sources rather than a separate questionnaire. The focus will now be on ensuring that the Just Culture Assessment tool has been fully implemented and a plan to ensure it is embedded over the next six months will be made. • A one-hour training session on PSIRF was presented to the Board on the 7 December 2023. This generated a good level of discussion around the

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	implementation and level of transformation the new framework will require across the system.
Key recommendations:	The Board of Directors is asked to consider the information and **NOTE** the deadlines for implementation and the progress against these.

Implications:

Links to 'We Care' Strategic Objectives:	• **Our quality and safety** • **Our patients**
Link to the Board Assurance Framework (BAF):	BAF 32: There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered. BAF 33: There is a risk of failure to adequately resource, implement and embed effective governance processes throughout the Trust.
Link to the Corporate Risk Register (CRR):	CRR 107: Inability to embed learning from incidents, complaints and claims across the Trust. CRR 118: There is a risk that the underlying organisational culture impacts on the improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace. CRR 139: Trust fails to adequately investigate clinical incident in a timely manner and I identify themes in order to action change and avoid future repetition.
Resource:	Yes • The Trust is required to have an independent investigation team that is highly trained. • There is a significant level of training and development required for the Governance Teams across the Trust in order to adopt the new approaches to patient safety. • The Datix system has required the appointment of an interim with the required technical expertise to undertake the work within our Datix system to meet the new requirements of the LfPSE fields. • In order to meet the deadline of the 31 March 2024 implementation date a Band 6 project support manager post has been created, from a vacancy within the Corporate Governance Budget, that will support the Trust to achieve this deadline.
Legal and regulatory:	Yes • The Trust is required to have our system signed off as compliant for the LfPSE fields by NHS England (NHSE) before 30 September 2023, we have agreed to go live with the LfPSE fields on 19 February and transition to the PSIRF by the 31 March 2024.
Subsidiary:	N

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Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

PSIRF Road Map to Success

1. Introduction

This report is presented to the Board of Directors as part of an update on the progress with the Implementation of Patient Safety Incident Response Framework (PSIRF) across the Trust.
The deadline for full implementation has been agreed as the end of March 2024.
PSIRF is a new national incident response framework that will replace the Serious Incident Framework (2015). The initial document was prepared for the Pilot sites (15 in total). The pilot framework was eventually shared with the wider NHS as a preparation document for the NHS to start to familiarise themselves with the key concepts, approximately 18 months prior to the first draft being released to the NHS in August 2022.

2. Purpose of the Report

The report shows the progress that the Trust has made to achieving the 1 April 2024 deadline for full implementation of PSIRF.

3. Progress against the road Map covering November and December 2023

3.1 Patient Safety Partners Policy has been drafted together with all associated documentation and is in the process of being finalised in January for submission to the Clinical Executive Management Group (CEMG) in February and the Patient Safety Committee as soon as possible after this.

3.2 Work on the identification of the three key themes is progressing apart from Medication Safety. Further discussion has been required to obtain agreement to be able to focus on this theme. It is expected that this will progress at pace in January 2024.

3.3 For All specialties apart from Maternity these will include:

- Medication: (Improving prescribing and administration safety through focus of addressing digital clinical safety issues).
- Tissue Viability (scoping both internal and external cases as the impact is the same on the Trust).
- Delay in diagnosis and Treatment.

All these themes are in the latter phases of the scoping exercise.

4. Support/Resource

A band 6 full time (FT) PSIRF and Centralising Resource Programme Facilitator and a Band 3 (22.5 hours) Programme Administrator posts were presented to the Vacancy Control Panel (VCP) this month. The Band 3 post was agreed and been out to advert and shortlisting is in progress, however, we are required to go through job matching process for the Band 6 role, which is currently being addressed. These posts are critical to supporting the Deputy Director of Quality Governance (DDQG) in achieving the deadline for the successful implementation of PSIRF at the end of March 2024.

5. **PSIR Plan and Policy**

5.1 Work is progressing on the PSIR Plan in relation to how the organisation will respond to incidents that do not relate to the key themes that we have identified above. A two-hour session has been held with maternity and the central team to explore different approaches to the key themes that have emerged from the data.

6. **Development of the Just Culture** – Work continues with the Employee Relations Team to develop a workstream around the cultural aspects of Patient Safety, particularly the Just Culture. We continue to link in with the Associate Director of Organisational Development, who is leading the Trust wide work on Culture following the Kirkup Review, sharing information to ensure that where there is overlap both parties are briefed.

7. **Integrated Care Board (ICB) Oversight** - We continue to await further information in relation to how the ICB will have oversight and gain assurance. We are expecting an outline plan soon**.**

8. **Communications** - Board Training was booked for January 2024, however, it was moved to 7 December 2023. This was a successful session which generated a lot of discussion around the requirements. Further sessions will be required and are in the process of being booked.

9. Training Requirements for PSIRF

9.1 Datix and LfPSE training video has now been developed and is being uploaded to ESR to enable compliance monitoring of staff viewing. The link to the ESR video, a staff user guide and the LfPSE overview video will be circulated in TrustNews on 26 January 2024. Specific communications will go out to Ward Managers, Matrons, Medical staff, and the Triumvirates.

9.2 An application to make the viewing of the LfPSE video a mandatory requirement has been submitted to the Training and Education Steering Group for approval.

9.3 The Super Users are currently testing these and then they will be launched. These will go live in the first week of February 2024.

9.4 There is a communications plan around this work. We have set up a helpline within the central Datix team that will covered 9 am – 5 pm five days per week, providing support for Datix users. Posters for the clinical areas has been agreed with a QR code that will enable staff to easily log onto the training as well as the helpline number. Specific communications will go out to Ward Managers, Matrons, Medical staff, and the Triumvirates.

9.5 There has also been a guidance manual developed for those staff who would prefer to read instructions.

9.6 The Governance Matrons and their teams have also been asked to undertake final testing of the system to ensure that they are familiar with the updated system should staff contact them for support within the Care Groups.

9.7 Investigation practice sessions continue with the corporate Patient Safety Leads who will become the independent investigation oversight team, using the new System Engineering Initiative for Patient Safety (SEIPS) framework. We aim to pilot the new methodology from 2024 and share the

new style reports for comments both internally and with the ICB. The SEIPS methodology has commenced in December for one Serious Incident which should be completed and submitted in January 2024 to the ICB. This has identified further training requirements and this is in progress.

9.8 Staff are being guided to Healthcare Safety Investigation Branch (HSIB) Investigation training resources which are free to access and available online, until the Trust has devised inhouse PSIIR training based on SEIPs methodology.

9.9 Patient Safety Training, provided by Health Education England, levels 1 and 2 continues to be promoted for all staff. Levels 3 and 4 have been launched and several of the central patient safety team and key staff within the Maternity Governance Team are booked onto this training. The training is free. Key members of the Executive team will be required to undertake training and we are currently undertaking a training needs assessment for these staff members.

10. DATIX - Learning from Patient Safety Events (LfPSE)

10.1 The deadline given to the ICB for full implementation of LfPSE was 30 November 2023. Owing to extraneous factors the Trust was unable to be compliant by this date. Datix were asked to make it clear to NHSE that the delay in our being compliant was owing to issues within Datix which they did. The Trust is now complaint and the LfPSE fields have been fully implemented and tested by successfully uploading incidents to the LfPSE portal.

10.2 The Trust is planned to commence training on 26 January 2024 and plan for a go live date for the end of 19 February 2024.

Conclusion

Although progress has been made more pace is required to ensure that the Trust is fully prepared for the Transition on the 1 April 2024. The support of the Band 6 PSIRF and Centralising Resource Programme Facilitator role is essential and we are working hard to ensure that this can be progressed as soon as possible. The Trust should make good progress now that the Datix LfPSE field have been signed off by NHSE and the training will be ready to launch on 26 January 2024 with a go live date for the end of 19 February 2024.

The focus will now be on the Plan and Policy over the next few months which will enable the Trust to achieve sign off by the ICB and readiness for the transition on the 1 April 2024.

11. The original Road Map to successful implementation presented at CEMG (for Reference)

11.1 The road map outlined below provides an overview of the main features of the Trust's journey to full implementation by March 2024. Please see Figure 1. Below.

Figure 1. PSIRF Road Map.

PSIRF ROADMAP FOR EKHUFT		
	SEPTEMBER 23	Engage with Key stakeholders.
		Confirm roles and responsibilities within PSIRF.
		Training designed for Datix/LfPSE and key staff identified into training groups.
		Oversight training for the Board to be agree and booked.
		Complete work for recruitment of Patient Safety Partners.
		Launch PSIRF Communications Strategy and the Website for the next year.
		Agree Quality Improvement involvement and partnership in PSIRF.
Develop PSIR Plan for the coming year and agree key areas of focus. Three for maternity and three for the wider Trust and our processes for managing our incidents.	OCTOBER 23	
Recruit Patient Safety Partners.		
Commence delivery of new Datix training for staff groups.		
Complete all testing for new Datix LfPSE fields.		
Agree approach to improving the Patient Safety culture, linking in with the current culture programme.		
Agree templates to be used within the PSIR Plan.		
Agree with the ICB how they will gain assurance and have oversight of our improvements.		
Start to develop expertise in the new investigation methodology across the Patient Safety Team.		
Set up engagement sessions/feedback methods from staff on the front line.		
	NOVEMBER 23	1 November 'Go Live on New Datix'
		PSIR Plan to be shared with the Patient Safety Committee and signed off by CEMG

		Consider/develop training for patient engagement within Patient Safety Incident Investigation.
		Source/develop After Action Review Training.
		Developing the process for engaging with our patients when responding to incidents.
PSIR Plan to be signed off by the Trust Board and shared with the ICB.	DECEMBER 23	
PSIR Policy to be shared with the Patient Safety Committee and signed off by CEMG		
Pilot new methodology for PSII.		
Ongoing training for new Datix and new Investigation processes and methods.		
	JANUARY 24	PSIR Policy to be signed off by the Trust Board and shared with the ICB.
		Communications and further training to staff on the PSIR Plan and how to respond to incidents.
		HSIB training on investigating for key staff.
Feedback from ICB on the PSIR Plan and Policy.	FEBRUARY 24	
Communications and ongoing training for relevant staff on PSIR Plan.		
	MARCH 24	1 March 24 is our 'Go Live' date for transition to our PSIR Plan.
		Training and support continue for all staff as well as gaining feedback.

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REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Safeguarding All Age Annual Report 2022/23**

Meeting date: **1 February 2024**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO)**

Paper Author: **Interim Head of Safeguarding**

Appendices:

Appendix 1: Outpatient data
Appendix 2: Safeguarding Adult report to Kent and Medway Safeguarding Adults Board (KMSAB)

Executive summary:

Action required:	Information
Purpose of the Report:	The purpose of the annual report covering April 2022 – March 2023 is to inform the Board of the safeguarding structures, governance arrangements and activity undertaken to fulfil the responsibilities to safeguard both our patient's and EKHUFT's continued registration with the Care Quality Commission (CQC), it has to ensure the responsibilities under the Accountability and Assurance Framework (NHS England (NHSE) 2022) are fulfilled.
Summary of key issues:	Key achievements: • Achieved deliverable plan moved to sustainability plan. • In August 2022 NHSE determined sufficient assurance was in place around our safeguarding systems and processes as part of National Recovery Support Programme. • Training compliance at level 1 and 4 for child and adult over 85. • Female Genital Mutilation (FGM) reporting to Department of Health achieved. • Prevent reporting achieved. • Safeguarding Policies reviewed and updated. • Joining up of safeguarding teams to an All Age team. • Development of Safeguarding Operational Group and Mental Capacity Act/Deprivation of Liberty Safeguards (DoLS) task and finish group to deliver key workstreams. • Increase in safeguarding awareness from the EKHUFT workforce demonstrated by an increase in duty contacts to the team. Key challenges: • Training compliance at level 2 and 3 for adult and child is below the expected 85% Level 2 Child 74%, Adult 75%, Level 3 Child 81% Adult 64%.

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	• Sustainability deliverance including vacancies in adult section of team. • Attendance at Midwifery Supervision is 25% which is below the 75% expectation.
Key recommendations:	The Board of Directors is asked to **NOTE** the Safeguarding All Age Annual Report 2022/23.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our sustainability • Our quality and safety
Link to the Board Assurance Framework (BAF):	None
Link to the Corporate Risk Register (CRR):	None
Resource:	N
Legal and regulatory:	Yes: Statutory duties relating to seeking safeguarding assurance at all levels and how these fits in within the context of the Children Act, Care Act, Health and Social Care Act, Domestic abuse Act, Homelessness Reduction Act. legislation and statutory guidance.
Subsidiary:	N

Assurance route:

Previously considered by: Annual Report has been signed off by relevant Committees.

East Kent Hospitals University NHS Foundation Trust

Annual All Age Safeguarding Team Report

1. Purpose of the report

1.1 Safeguarding is everyone's responsibility. Fundamentally it remains the responsibility of every NHS organisation and each individual healthcare professional working in the NHS to ensure that the principles and duties of safeguarding children are holistically, consistently and conscientiously applied with the needs of children and adults at risk of abuse or neglect at the heart of all that we do.

1.2 The purpose of this Annual report, covering the period April 2022 - March 2023 is to provide assurance to the Board that East Kent Hospitals University Foundation NHS Trust (EKHUFT) is fulfilling its statutory duties in relation to safeguarding children and adults. (Children Act 1989 and 2004, Care Act 2014, Mental Capacity Act 2005 and 2019, Homelessness Reduction Act 2017, Domestic Abuse Act 2021). The report also highlights the outstanding risks and their current mitigations.

1.3 The definition of safeguarding is necessarily broad as there are a wide range of risks of abuse or neglect that can result in harm to both children and adults. Effective safeguarding arrangements seek to protect individuals from harm caused by abuse or neglect occurring regardless of their circumstances.

1.4 To safeguard EKHUFT's continued registration with the Care Quality Commission, it has to ensure the responsibilities under the Accountability and Assurance Framework (NHS England 2022) are fulfilled. These include:

- Those who use services are safeguarded.
- Staff are suitably skilled and supported.
- There is safeguarding leadership.
- Commitment at all levels of the Organisation for Safeguarding including full engagement and support of local accountability and assurance structures.
- Ensuring a culture exists where safeguarding is everybody's business.
- Poor practice is identified and tackled.

2. Introduction

2.1 Whilst executive accountability sits with the Chief Nursing and Midwifery Officer, in order to support this role, there is an All Age Safeguarding Team who provide both strategic, clinical and operational leadership for safeguarding within the Organisation. During this time period, the team have been supported by an Interim Joint Head of Safeguarding funded by NHSE as part of the National Recovery Support Programme until December 2022 and funded by the Trust since then (post currently ceasing in November 2023).

2.2 During this reporting period, EKHUFT has remained in the National Recovery Support Programme. In relation to safeguarding, regular assurance was provided to NHSE and in August 2022, it was determined that sufficient evidence around systems and processes primarily around adult safeguarding had been received. Our NHSE partner continued to

attend the Safeguarding Assurance Committee until December 2022 when further assurance has given.

2.3 To support delivery of the plan the two teams formally merged during this time period and changed their name to the All Age Safeguarding team. Systems and processes are in the process of being further aligned. Interim roles were set up to support the team management operationally from a management and admin perspective, in addition one of the substantive Learning Disability Nurses acted into a lead clinical role for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)/Liberty Protection Safeguards (LPS). The team sit within the Corporate care group, clinical quality and patient safety.

2.4 The team has carried a significant deficit of staffing numbers during the year and this continues to be the case for adult side of the team. It has proved challenging recruiting to the team but we welcomed two part time Band 6 nurses, a full time Band 6 nurse and a full time Band 3 admin. A Deputy Head of Safeguarding (Adult) has also been recruited and is joining the team in the new financial year. All of the team posts have been reviewed and there is a plan underway to re-band the Named Midwife post, and substantiate the MCA Interim post and Office Manager post. There is also a business case underway to enable the team to deliver the safeguarding sustainability plans.

2.5 There was also a Safeguarding adult workforce development programme from August 2022 - March 2023, which focused on enabling the staff to develop further skills and knowledge and competencies in safeguarding leadership. This was achieved through undertaking skills analysis using the domains from the Intercollegiate Document (ICD) to identify gaps in competencies to ensure that roles and responsibilities were aligned to this and that the team could demonstrate progression in this.

3. Local Context

3.1 During this report period, EKHUFT sat within the area covered by one Integrated Care Board (ICB). We are a large hospitals Trust, with five hospitals and a number of community clinics serving around 700,000 people in east Kent. We also provide some specialist services for a wider population, including renal services in Medway and Maidstone and a cardiac service for all of Kent based at William Harvey Hospital (WHH), Ashford. In Kent there were 346,282 children and young people, with 50,252 under 16s living in poverty (KSCMP 2021).

3.2 Locally at EKHUFT, in the financial year 2022/23, there were 6,088 babies born with 32 born to mothers aged under 18. In addition, 7939 babies, children and young people were inpatients in our Neonatal Intensive Care Unit (NICU)/Special Care Baby Unit (SCBU) and inpatient Children's wards and day unit and 2605 attended the Children's Assessment Units. A further 1680 were inpatients on wards outside of Child Health. Children and young people also attended 99,147 initial and follow up outpatient appointments for under 18s. This data is utilised to determine the level of training required by staff across the organisation (Appendix 1). Adults attended 676,131 outpatients' appointments. Across all sites, 72,192 under 18s and 215,057 were seen in the Emergency Departments (EDs) and Urgent Treatment Centres (UTCs).

4. Governance and accountability arrangements

4.1 Safeguarding accountability sits within the portfolio of the Chief Nursing and Midwifery Officer. During this period, she had delegated representation on the Kent Safeguarding Children Multi Agency Partnership (KSCMP) through Dame Eileen Sills, the Kent and Medway Chief Nurse from the ICB, who was the safeguarding executive lead.

4.2 Work commenced in March 2022 to address the recommendations from the Independent Safeguarding Review, which focused on the need to develop of an All Age Safeguarding Deliverables Action Plan that would replace the then Improvement Safeguarding Plan. safeguarding oversight and accountability at governance, executive, strategic, operational and frontline levels. The safeguarding governance included the Safeguarding Assurance Committee, which reported directly to the Quality and Safety Committee and then the Board, therefore, ensuring that all safeguarding activities and risks were cited through this process.

4.3 The Safeguarding Assurance Committee met bi-monthly during the report period, chaired by a Non-Executive Director, Stewart Baird, being replaced by Andrew Catto in January 2023. The purpose of the meeting is to provide assurance and identify risks and mitigations of all age safeguarding issues across the Trust. It also provides progress of actions identified from the deliverables, safeguarding strategy and sustainability plan, as well as Domestic Abuse and PREVENT strategies. Progress from recommendations from the Child Practice case reviews/Safeguarding Adult Reviews/ Domestic Homicide Reviews /Local reviews is shared and the data which is necessary for statutory reporting for example, FGM (Female Genital Mutilation) and PREVENT. Any issues from this committee are escalated/reported to the Quality and Safety Committee and Trust Board.

4.4 A Safeguarding Operational Group has been established. The Trust also developed key performance indicators for safeguarding and a dashboard that was linked to this, which would enable practitioners to regularly review their safeguarding activities and also provisions to monitor safeguarding activities at Care Group level by completing safeguarding reports which are completed by the Heads of Nursing. These reports are shared and discussed at the monthly Safeguarding Operational Group and any issues escalated to the Safeguarding Assurance Committee.

4.5 A Mental Capacity Act/Deprivation of Liberty task and finish group was established to prepare for the planned implementation of Liberty Protection Safeguards by strengthening the existing workstreams. This work has fed into the Operational Group and Safeguarding Assurance Committee and been led by the Interim MCA/DoLS lead with support from NHSE and ICB leads for this area.

4.6 The Interim Joint Head of Safeguarding attends the Fundamentals of Care Committee, where information about themes/trends from a safeguarding perspective are shared with the Care Groups. The Deputy Head of All Age Safeguarding also attends the Children's Services Improvement & Assurance Board and reports upon training compliance alongside the above issues. This Trust wide meeting provides the forum for improvement of services for children across EKHUFT and our membership ensures that safeguarding forms an explicit part of service development.

4.7 The Deputy Head of All Age Safeguarding is an active participant of the Clinical Governance process within the Children's care group. The Safeguarding Midwife also attends clinical governance meetings with the Women's health.

4. In addition, the team works closely with the Patient Advice and Liaison Service and Patient Experience Team regarding any complaints or concerns that come into the Trust where safeguarding may be a factor for consideration. At the same time, there is team representation at the Serious Incident (SI) Panel meetings and safeguarding SIs are discussed at the weekly team case management meetings.

4.9 During this period, the Trust has been in the process of implementing a Safeguarding deliverable plan, the focus was on ensuring that these were aligned to the gaps in safeguarding statutory duties which the Trust sought to address through the support of the Interim Joint Head of Safeguarding. There has been significant progress and there has been a phased move over to a safeguarding sustainability plan.

4.10 In February 2023, the Interim Joint Head of Safeguarding undertook a self-assessment audit aligned to the NHSE Safeguarding Accountability and Assurance Framework (SAAF) to review the ongoing progress and outstanding activity required by the Trust, this was presented to the Safeguarding Assurance Committee and the Quality and Safety Committee. The self-audit tool focused on the systems and processes in place to ensure effective safeguarding response identified the gaps in the benchmark indicators in each of the nine domains relating to this. Most of the areas were rated as amber, as further assurance is required with regards to the quality of the evidence to ensure that this is robust and reflects the current systems and processes in place. This is under constant review and the Committee has ongoing oversight as evidence of the gaps identified is provided for assurance.

4.11 An external audit of safeguarding was also commissioned by the Trust from RSM auditors in March 2023. The review aimed to provide assurance that the Trust had suitable systems and processes in place in relation to Safeguarding from ward to Board level following the implementation of the All Age Safeguarding Deliverables plan throughout 2022.The outcome of this has been presented to the Safeguarding Assurance Committee (outside timescale of report).

4.12 Externally, the Interim Joint Head of All Age safeguarding is an active member of and participates in the Kent and Medway Safeguarding Adults Board (KMSAB) and sub-groups and Domestic Homicide Local Partnership Board, the annual report submit for this year's activity and progress has been submitted (Appendix 2).

4.13 The Chief Nursing and Midwifery officer or their representative is an active member of the Health Safeguarding and Looked After Children Group. The Deputy Head of All Age safeguarding is an active member of the Policies and Procedures group of Kent Safeguarding Children Multi-Agency Partnership (KSCMP) and she and the Named Doctors and Midwife are regular attenders at both the child and all age health reference group.

4.14 Information from both Boards is shared across the Trust at the Safeguarding Operational group, through 'Safeguarding Matters' and is added onto the Trust staff intranet. In addition,

when views are sought from practitioners by the Board, then various stakeholders across the Trust are selected and requested to participate.

5. Assurance activity undertaken at EKHUFT

5.1 **Policies and guidelines** relating to all age safeguarding were reviewed and the following actions were taken (as per 03/23):

In date, no action required:

- Safeguarding Children and their families supervision policy.
- Was not brought to health appointments for infants, children and young people.
- Child death review guideline.
- Existing policy/guideline/strategy, updated and ratified.
- Safeguarding children policy.
- Safeguarding training strategy and training needs analysis.
- Maternity support form guidance.
- Fabricated and induced illness guideline.
- Missing person policy.

Existing policy/guideline/strategy, updated and going through ratification process:

- Safeguarding adult policy – replacing People at risk policy.
- All age restraint and safe holding policy.
- Managing Allegations of Abuse Neglect or Harm Against People in a Position of Trust (PiPoT).

New policy/guideline/strategy, written and ratified:

- Domestic Abuse for patients and staff

New policy/guideline/strategy, written and going through ratification process:

- Mental Capacity Act/Deprivation of Liberty Policy.
- PREVENT policy.
- Safeguarding Adult Supervision guideline.

5.2 Statutory Reporting and activity

5.2.1. FGM

A total of 24 women were data reported to the Department of Health as per statutory reporting requirements. This is an increase of ten in comparison to last year.

5.2.2. PREVENT

No referrals were made to the channel panel for patients of any age, however requests for information were responded to for 23 under 18s and 13 over 18s. PREVENT data returns were completed and sent quarterly as per our statutory reporting requirements. The Interim Joint Head of Safeguarding continues to be the PREVENT lead for the Trust. The safeguarding team trained 2135 staff in PREVENT.

5.2.3 **Child protection medicals**

There were 81 child protection medicals undertaken in the Community. A further 31 babies and children under two were reviewed in the acute setting as they are pre-verbal and require an additional set of medical investigations for suspected non- accidental injuries.

5.2.4 **Child Practice Safeguarding Reviews**

During this period, the team completed eight rapid reviews and two child safeguarding practice reviews where the Trust were involved with either the child or a family member. The overriding themes were injuries/death of small infants. Any action following these reviews is added to the Case review action log and progress against these actions has been monitored by the Safeguarding Assurance Committee.

5.2.5 **Safeguarding Adult Reviews (SAR)**

The team participated in five SARs in this time period. In addition, a further eight summary of agency involvements were provided. The primary themes identified were homelessness, poor mental health and self -neglect. EKHUFT also referred two cases for considerations of SARs but neither were accepted.

5.2.5.1 When Kent SARs are published, they are reviewed for thematic learning, if this is pertinent to EKHUFT it is added to our SAR workstreams and progress against these actions has been monitored by the Safeguarding Assurance.

5.2.6 **Domestic Homicide Reviews**

The Domestic Violence, Crime and Victims Act 2004, Section 9, requires that, following a domestic homicide, the local area should organise a multi-agency review. This is a statutory requirement for EKUHFT and any subcontractors. The lead responsibility for co-ordinating Domestic Homicide Reviews (DHRs) lies with the local Community Safety Partnership (Police). The multiple agencies that had contact with the perpetrator and/or victim reflect on the contact and interventions each organisation has had, in order to see if opportunities were missed that may have prevented the homicide.

5.2.6.1 During this time frame, there were requests for three Kent cases. There was minimal specific learning identified for EKHUFT which has been actioned within the timeframes identified. An updated Domestic Abuse Policy for staff and Patients was ratified in March 2023.

5.2.7 **Deprivation of Liberty**

The number of referrals for Deprivation of Liberty Safeguards (DoLS) remains proportionate to the size of the Trust since mitigation was put in place in July 2020 for low levels of referrals. These figures are supplied by the DoLS office (Kent County Council (KCC)), these differ from the notifications we receive from staff, it is not clear why we are not informed of all referrals. The need to inform the team is part of all training packages and on the staff intranet (Table 1).

5.2.7.1 The outcome of DoLS applications by EKHUFT has been notified to the Care Quality Commission (CQC), since January 2023.

	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
K&C	16	29	10	10	10	14	18	15	24	26	11	19
WHH	48	55	51	48	47	49	44	43	36	64	33	15
QEQM	39	42	23	36	41	42	23	32	43	42	45	15
Total	103	126	84	94	98	124	85	90	103	132	89	79
Number received by team	85	103	76	82	89	83	83	94	93	116	91	102

Table 1. Number of DoLS at EKHUFT (Kent and Canterbury Hospital (K&C), William Harvey Hospital (WHH), and Queen Elizabeth the Queen Mother Hospital (QEQM)

5.3 **Duty activities**

5.3.1 There continues to be a good level of contacts to the All Age team which provides assurance evidence that staff at EKHUFT have good awareness of what to do if they have concerns about a patient. The team continue to provide advice and expertise to other staff at EKHUFT through the operation of a duty system, Monday to Friday 9-5, this includes midwifery, learning disability, homeless specialists, domestic abuse advisors and mental capacity and DoLS. This means both staff and outside multi agency partners receive a prompt response when they have a safeguarding concern.

5.3.2 During the time period of the report the team undertook 18190 consultations by phone, email, careflow or written format about children's safeguarding and 2966 for adult safeguarding, 509 for learning disability, 203 for domestic abuse and 321 for homelessness. There continues to be year on year growth.

5.3.3 Maternity safeguarding which sits within the team, received 3886 Maternity Support forms (previously known as Concern and Vulnerability forms) from Midwifery and determined safeguarding action plans for these families. This continues the increase observed since pre-pandemic times, it does not correlate to an increase in birth rate but does reflect the local and national picture of increased vulnerability which is still evident. 215 women and their babies and families were given additional support via a multi- agency pre- birth plan at the time of delivery.

5.3.4 EKHUFT undertook 531 Referrals for Support (RFS) to the Local Authority, the Urgent Treatment Centre undertook a further 66. In addition, the process of quality assurance of the 305 written referrals into Social Services undertaken by EKHUFT staff was undertaken. A Quality Assurance checklist has been devised, scoring referrals out of a possible 10 and this has been incorporated into the Safeguarding Children Policy since 2018. As a result of recording, I am able to provide assurance out of the 305 written referrals undertaken by our staff that 301 scored over 5/10 with 221 scoring 8/10 or above. This demonstrates similarity in the quality of referrals from the previous year.

5.3.5 EKHUFT raised 634 Kent Adult Safeguarding Concern Forms (KASCF) to the Local Authority.

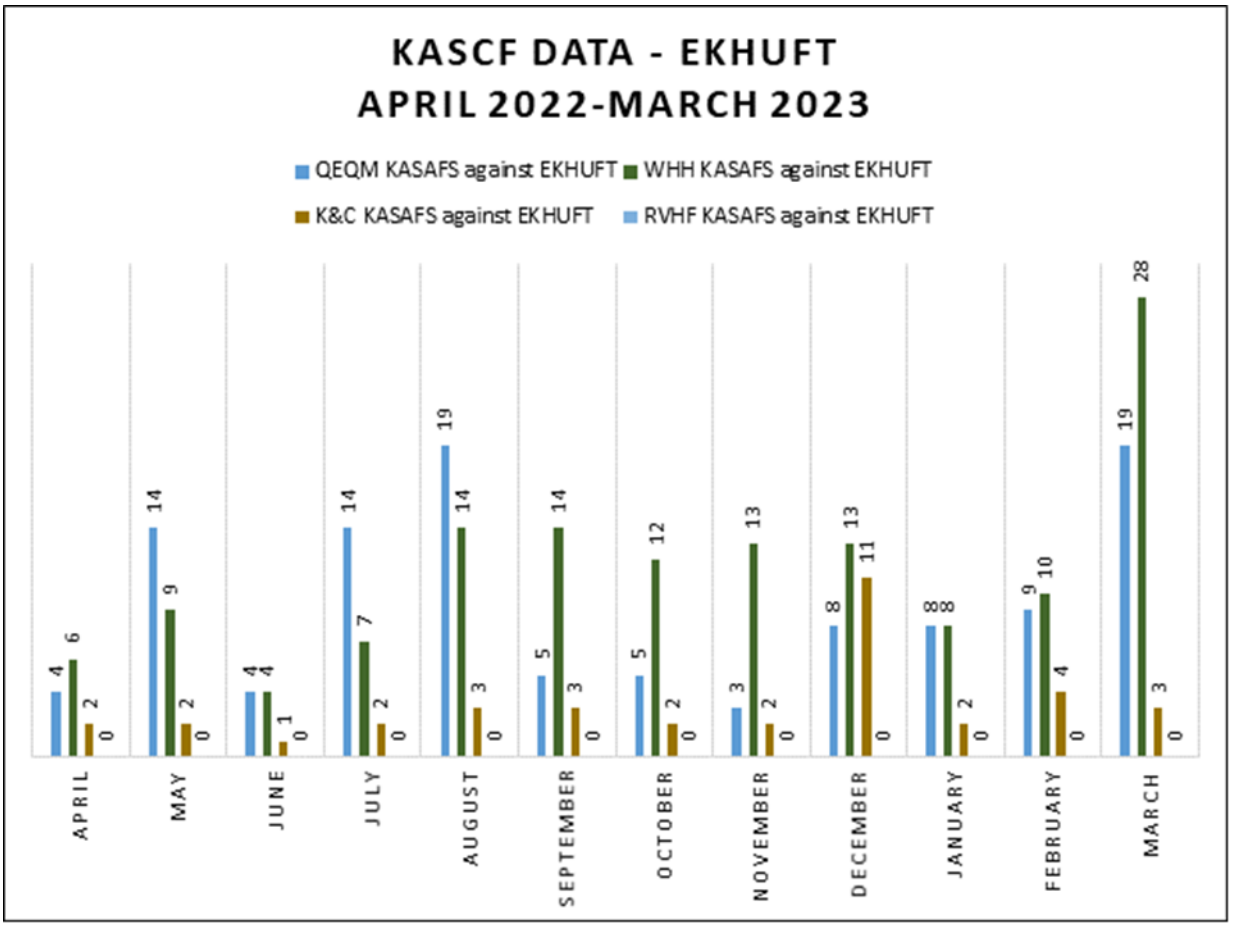

Table 2 KASCFs raised against EKHUFT per site

5.3.5.1. There continues to be a high number of KASCFs raised against the Trust (Table 2). A new process for quality assurance of these has been instigated from April 23.

5.3.5.2 At WHH, there were 117 raised, ten had the abuse confirmed, nine abuse was discounted, three no further action, 28 did not meet the threshold for Section 42 (S42), we are awaiting the outcome of nine further cases and the rest have been closed.

5.3.5.2 The cases where the abuse was confirmed five related to pressure sores, four to falls and one for neglect.

5.3.5.3 At QEQM, there were 75 raised, three had abuse confirmed, five abuse was discounted, three no further action, 13 did not meet the threshold for S42, we are awaiting the outcome of four cases and the rest have been closed.

5.3.5.4 The cases where the abuse was confirmed, one related to an assault by staff and two omissions in care leading to neglect.

5.3.5.5 At K&C, there were four raised all relating to pressure sores, one had abuse confirmed this related to a pressure sore, one did not meet the threshold for S42 and two abuse was discounted.

5.3.5.6 The Interim Joint Head of Safeguarding attends the Fundamentals of Care Committee where themes emerging for individual care groups from S42 investigations are highlighted and discussed. In addition, the Operational Safeguarding meeting is being developed and this forum is where assurance will be gathered and then shared with the Safeguarding Assurance Committee.

5.3.5.7. All S42 Enquiries are notified to CQC by Social services. All cases raised as Care Act Section 42 Enquiries are logged on Datix and those meeting the criteria for a Serious Incident (STEIs) reported to the ICB. All allegations against staff are managed as per the Managing Allegations Against Staff Policy and are STEIs reported and investigated by the Police where appropriate.

5.3.5.8. Improved reporting processes during the second half of the year demonstrated that over half of these referrals are immediately closed by the Local Authority.

5.3.5.9 The number of KASCFs raised by the Trust in relation to issues in the Community which is positive and shows that staff are recognising omissions of care for patients coming into hospital (Table 3).

5.3.5.10 A thematic review was undertaken following concerns of recurrent themes were being identified in incidents, safeguarding serious incidents (SIs) and S42s in August 2022. The key findings and action plan and progress have been shared and reported upon at the Safeguarding Operational Group, Safeguarding Assurance Committee and Quality and Safety Committee and system wide issues shared with the Kent and Medway Safeguarding Adult Board.

5.3.5.11 A thematic review of physical and chemical restraint was undertaken in March 2023 following seven S42s being raised about these issues. The key findings and action plan and progress have been shared and reported upon at the Safeguarding Operational Group, Safeguarding Assurance Committee, Patient Safety Committee and Quality and Safety Committee.

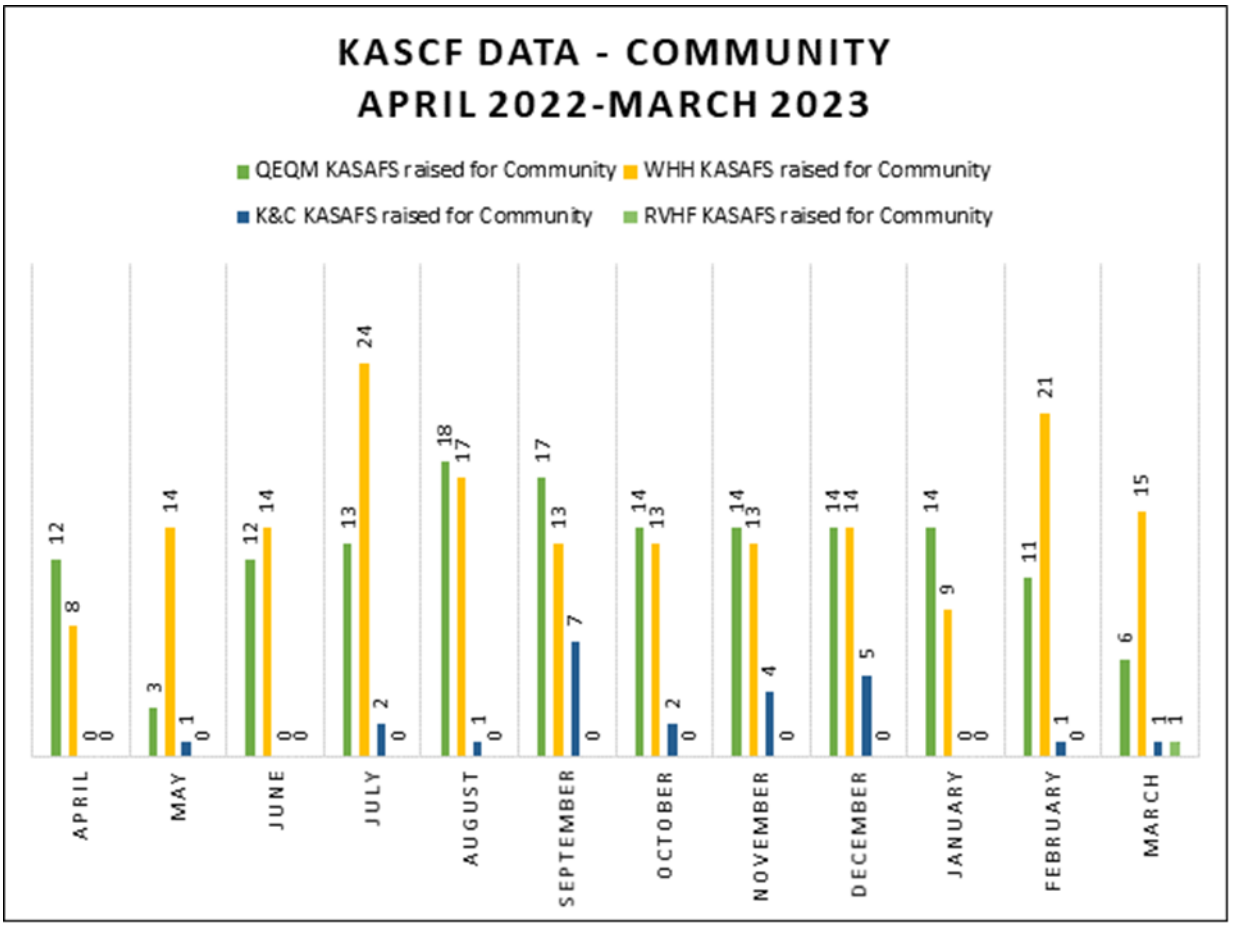

Table 3. KASCFs raised by EKHUFT per site for community issues

5.3.5.11 The main themes for Community KASCFs were:

- Self- neglect.
- Neglect.
- Financial abuse.
- Domestic abuse.
- Physical abuse.

5.4 **Paediatric Liaison**

As part of information sharing arrangements identified in the Children Act (2004), all ED attendances to EKHUFT are shared with our primary care partners, i.e. GPs, Health Visitors and School Nurses. These is primarily undertaken electronically with the support of our IT team. However, for those children who do not have an identifiable Kent postcode, this is managed manually by the Safeguarding team, this year this was for 214 children.

5.5 **Was not brought (WNB)**

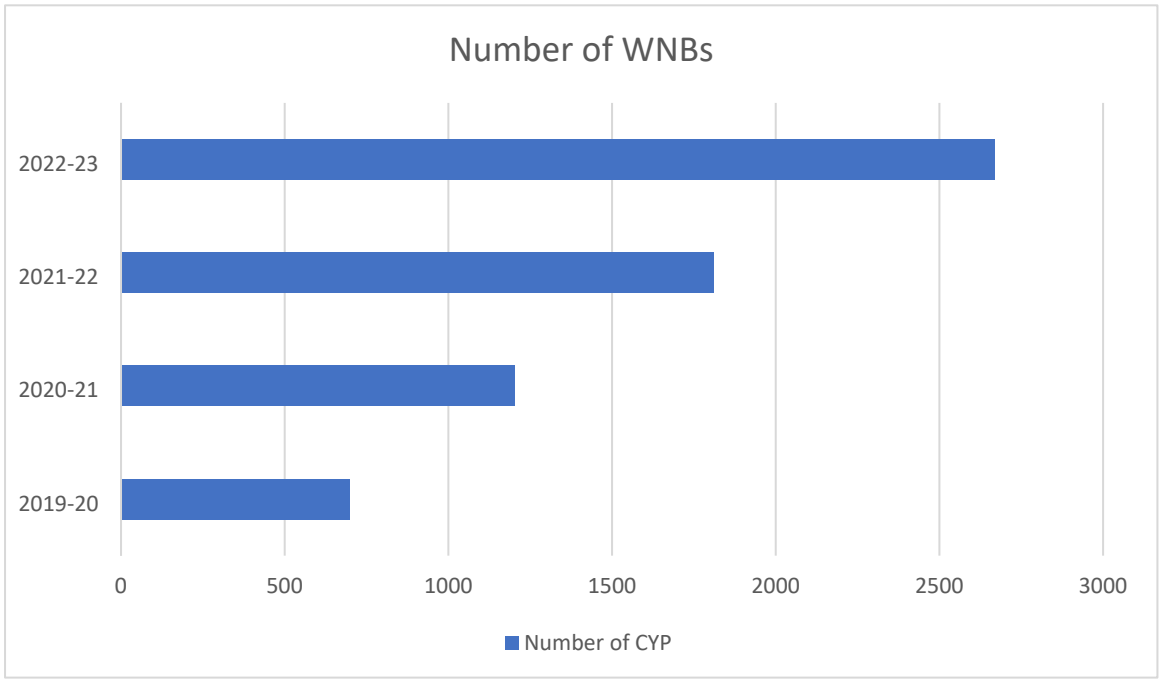

Table 4. Increase in WNB 2019 - 2023

There has been a significant year on year growth in the volume of correspondence regarding children not being brought to their health appointments (Table 4). This provides evidence of the volume of assurance activity being undertaken around this particular safeguarding issue. This year, 2669 missed appointments were reviewed by the team. This particular work has had some hugely significant outcomes for individual children ensuring that there has been re-engagement with the health provision they require to achieve their own individual potentials. This work has frequently required the support of our multi-agency partners.

5.6 **Training and Training Compliance**

5.6 .1 The annual figures show there has been a gradual reduction over the year and we are no longer meeting the agreed local compliance standard of over 85% at both level 2 and 3 (Table 5). Training at level 2 and 3 has been delivered face to face during this period via 46 new starter and 48 refreshers, this offered 3010 spaces. The did not attend rate for training has been between 10-28% during the year with 429 staff not attending on the day, most staff cite clinical pressures as the reason for non-attendance. This has been raised with Heads of Nursing at the Safeguarding Operational Group regularly.

	April	May	June	July	August	Sep	Oct	Nov	Dec	Jan	Feb	Mar
L1 C	100	100	100	100	100	100	100	100	100	100	100	100
L2 C	88	87	89	83	81	81	79	75	74	74	75	74
L3C	86	87	88	86	84	84	83	84	81	81	83	81

L4 C	100	100	100	100	100	100	100	100	100	100	100	100
L1 A	100	100	100	100	100	100	100	100	100	100	100	100
L2 A	88	87	87	84	83	83	80	77	76	76	77	75
L3 A	66	68	68	69	65	65	64	65	65	65	65	64
L4A	100	100	100	100	100	100	100	100	100	100	100	100

Table 5. Training compliance levels

5.6.2 There remains constant drilling down into the data to ensure pockets of non-compliance in wards and departments are highlighted to care groups so action to improve and maintain compliance is undertaken. Support with data cleansing and bespoke training sessions has been provided by the Safeguarding team. During this timeframe progress for training compliance was monitored closely as part of the Safeguarding Improvement plan.

5.6.3 The training strategy and training needs analysis has been reviewed and updated against the current intercollegiate documents (RCPCH 2019 and RCN 2018). A significant change has been as a result of the Health and Care Act (2022) which now requires all staff to have training in learning disabilities and Autism. This has been added to the strategy and staff will be able to achieve this via Oliver McGowan e- learning on Electronic Staff Record (ESR). This will be added to all staff statutory competency requirements on ESR following approval and staff will be expected to undertake this from May 2023. Additionally, the requirement for level 3 adult has been expanded to a greater number of staff, which will in the short term likely reduce the level 3 compliance figures further.

5.6.4 Mitigations: There has been an increase of training sessions offered by the team, in addition staff who require only level 2 training are now able to achieve this through online training. There are more spaces available for the following year than those requiring level 3 training. All courses are overbooked.

5.7 **Audit Activity**

5.7.1 EKHUFT undertook the self-assessment Section 11 audit from the Kent Safeguarding Multi Agency Partnership in September 2022, a small plan of three actions was identified to ensure our full compliance with this. Delivery on these actions has been monitored by the Safeguarding Assurance Committee. There remains one outstanding action around levels of supervision.

5.7.2 EKHUFT undertook a self-assessment thematic Self-Assessment Framework (SAF) from Kent and Medway Safeguarding Adult Board in June 2022. All key areas were rated as amber and further evidence has been supplied throughout the year to move these to green. There remain outstanding actions in the report timescale which are being monitored by the Safeguarding Assurance Committee.

5.7.3 A formal audit programme has been in place this year, with planned activity for quality assurance of safeguarding processes, guidance and policy, as well as assurance that

recommendations undertaken for Serious Case Reviews and Rapid Reviews. In addition, audit results have been able to provide tangible assurance for the ICB metrics and will provide ongoing evidence for the S11 and SAF submissions. The team were fully supported by the audit team.

5.7.4 In August 2022 an MCA/DoLS Audit (supported by NHSE & ICB) found the workforce could not adequately demonstrate adherence of MCA. The actions were: MCA/DoLS policy, systematic changes to MCA/DoLS documentation, a clear DoLS Application & Tracking Process and to consider a bespoke MCA/DoLS training package with overarching training strategy.

5.7.5 The Learning Disability Team completes the statutory Learning from the Lives and Deaths of People with a Learning Disability (LeDER) and an annual NHSE Learning Disability Improvement Standards Benchmarking audits.

5.7.6 Child Protection – Information Sharing (CP-IS) audits in ED and children's wards were undertaken during the year. Overall the data showed that the staff on the wards consistently accessed CP-IS during the admission process, a 'message of the week' has been undertaken to re-enforce this practice. The ED team have also shown over 90% of attendances had CP-IS checked.

5.7.7 The quality of the completion of the maternity support form and safeguarding action plan has been audited quarterly. The results have been fed back to the women's health audit meetings and all actions from the identified recommendations have been delivered. This Quality Improvement Programme (QIP) will continue.

5.7.8 Determining the efficacy of the Was Not Brought Policy for infants, children and young people. The audit start date was delayed due to the delay in ratification of the policy, but this has been undertaken and the final results are being shared in October 2023 with the Child health audit meeting and then the subsequent children and young person's committee.

5.7.9 A baseline audit of the delivery of ICON at three agreed touchpoints during the maternity period to all pregnancies recorded on E3 (except where they opted out of data collection). We identified that the most utilised point was when the person moved from the hospital to community care after delivery. A full action plan and further audits have been agreed to improve upon our findings

5.7.10 Audits of the completion of the Safeguarding RAG tools within children's ward and NICU/SCBU have been undertaken. Feedback is shared with the ward's and child health clinical governance group.

5.8 **Supervision**

5.8.1 Safeguarding Children Supervision has continued virtually across all specialities, with some teams returning to face to face sessions. Supervision is available in different formats and all staff are also able to access 'individual supervision' through the duty system. For reporting purposes this is recorded as a 'Consultation' rather than a supervision episode. However, when consultation figures are included, the numbers provide assurance that many staff are accessing the Safeguarding team effectively for support. The number of staff requiring group

supervision has increased from 220 to 250 and further scoping is currently being undertaken to identify paediatric case-holding staff, with four sessions being offered to those staff, as per the policy, the expectation is that they will attend three of those sessions meaning we would achieve attendance at 75% by the end of the year. The figure for attendance was 49% and is currently on the risk register.

5.8.2 As a result of poor compliance with supervision in Midwifery, it has been agreed to change the time of the sessions and reduce the volume of them to encourage more Community Midwives to attend. The CNMO and Director of Midwifery have been very supportive of implementing these changes. They are due to be reviewed in August 2023.

5.8.3 A reduction in ED figures was expected as the model of supervision has been reviewed with fewer cases being discussed but more emphasis on learning from the cases. 355 cases were discussed over the four sites. The change has had very positive feedback from the ED staff.

5.8.4 In addition, any member of staff who is involved in a safeguarding children/adult incident is able to request support or debrief from a member of the team. An adult supervision guideline has been written and supervision will be commenced in the next financial year. Members of the All Age safeguarding team receive Safeguarding supervision.

5.8.5 Paediatricians also attend 'Peer Review' where case discussion, learning and support are offered. This is run by the Designated and Named Doctors quarterly and is well supported by the Paediatric Medical teams from both the Acute and Community sector with 172 people attending during the year. Members of the safeguarding team and health professionals from across child health attend these sessions.

5.8.6 EKHUFT have a cohort of Trauma Risk Management (TRiM) practitioners and managers, this is an initiative which is designed to provide psychological support to staff in the aftermath of potentially traumatic incidents. Trim practitioners are trained to help individuals who may be distressed and to facilitate onward referral for specialist support if this is deemed necessary. The Safeguarding team have one member of staff trained as a practitioner and they have been available to support teams across the Trust when incidents have occurred.

6 Partnership Working

6.1 Homeless Nurse and ICB Homeless Pilot Project

6.1.1 EKHUFT have a statutory legal duty (Homelessness reduction Act 2017) to assist that individual; with their consent, to make a homelessness approach to the local authority. There is close liaison with all relevant Local Housing Authorities including the 'Rough Sleeper Teams' that sit within those local authorities. Encouraging Multi agency working when an individual is admitted to hospital and requesting complex discharge planning meetings, has enabled staff to address the complex issues, that often mean individuals have multiple attendances to the acute EKHUFT setting.

6.1.2 There is one homeless nurse (Band 7), who covers all sites across the Trust, offering advice support and guidance when an individual is identified as being homeless. Staff are supported and signposted if an individual is identified as having Adult Safeguarding/ Self neglect issues and assist with suggestions re appropriate referrals interventions. Many individuals whom are

homeless, have been excluded from GP practice, or have difficult registering – the Nurse is in communication with Integrated Care System (ICS) (Clinical Commissioning Group (CCG)) special GP allocations scheme, if an individual is struggling to register it may be possible to assist. The Homelessness Adults Safeguarding Practitioner presented a session alongside Michael Preston Shoot relating to the interface between safeguarding and homelessness.

6.1.3 The Trust was involved in a pilot relating to people who were homeless, and the outcome of this was completed which indicated that there was much need to continue this project, as such it was extended by the ICB. The Safeguarding team worked closely on this project with the Homelessness Adult Safeguarding Practitioner providing support on the interface between homelessness and safeguarding, as such this had resulted in work being strengthened by the Trust to address this.

The ICB have secured funding for the pilot project for homelessness to continue. EKHUFT will continue to host the team and manage the Band 7 Nurse and Band 4 admin post. These jobs are currently going through the recruitment process.

6.1.4 Many individuals who are homeless have had significant past Trauma, EKHUFT staff are encouraged to adopt a trauma informed approach and to consider Adverse Childhood experiences. Awareness of this is included in level 3 training and is regularly highlighted in 'Safeguarding Matters' in Trust news.

6.2 **Police**

6.2.1 The Trust continue to be proactive working with our police partners to support the Missing Person agenda. The teams have undertaken reviews of people who went missing for the Police MCE Team to identify if any of these children have had engaged with the Trust at the point of the missing episodes. The adult team are also contacted on a daily basis for vulnerable missing adults (Table 6).

Activity	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Missing and Child Exploitation reviewed children	167	181	135	258	328	129	124	107	97	112	88	67
Missing and Child Exploitation shared information	1	7	4	5	2	4	2	0	4	2	0	1
Missing Adults reviewed	_	_	_	_	_	102	101	59	74	76	92	45
Missing adults	_	_	_	_	_	0	0	0	0	0	0	0

shared information												

Table 6 : Number of missing contacts from Kent Police

6.3 **Domestic Abuse and Multi Agency Risk Assessment Committee (MARAC)**

6.3.1 The Domestic Abuse Hospital Independent Violence Advocates (HIDVA) project continues providing support to families and staff who are the subject of physical or psychological abuse via the provision of a dedicated hospital Domestic Abuse Advocate. They have continued to provide support to staff and patients. The numbers of referral remain consistent, these are reported via the care flow system (Table 7). During this timeframe all HIDVAs were in post and covered all sites.

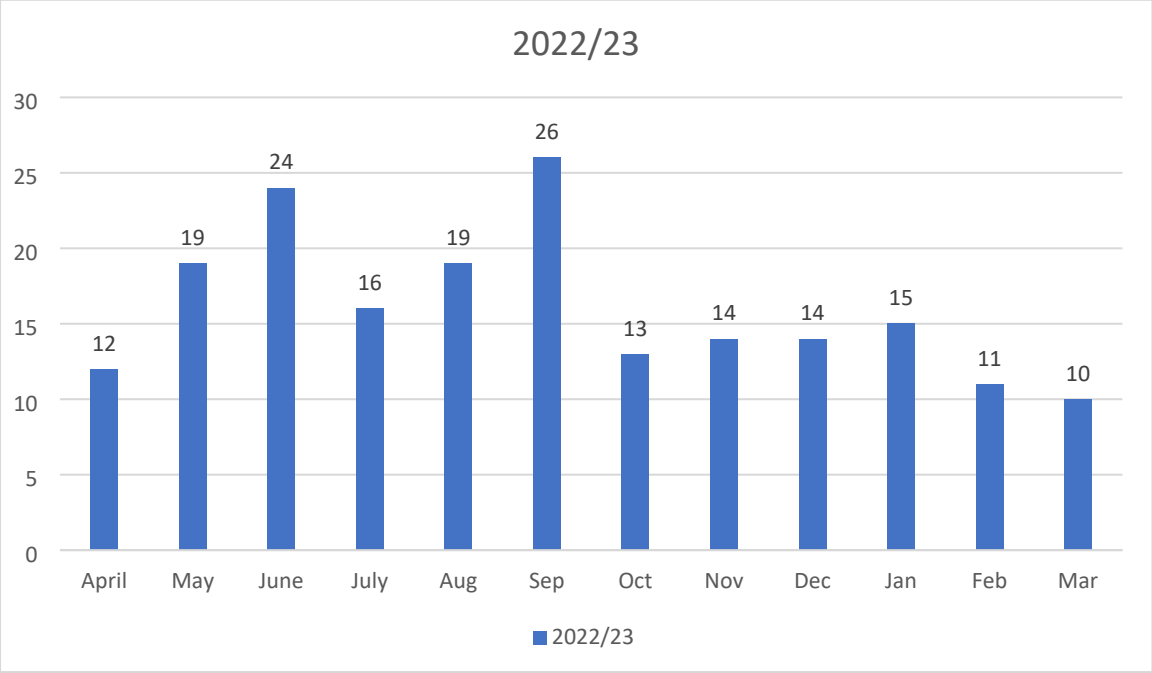

Table 7 Number of DA referrals

6.3.2 The HIDVAs have also undertaken promotional work across the Trust, including a session in the hub at WHH, networking event at K&C with the wellbeing team and participating with the Safeguarding All Age team for walkabouts and raising awareness across all sites during Safeguarding Adults week in November 2022.

6.3.3 The Joint Interim Head of Safeguarding and Head of Safeguarding Children continue to participate in health meetings led by the ICB regarding the proposed changes to the MARAC process. Interim arrangements still remain the same, currently the Safeguarding team spend 1-4 hours a week supporting the process, the Interim Joint Head of Safeguarding currently holds the lead for this workstream.

6.3.4 The following number of cases had data provided for the victim, perpetrator and any children for the family shared with the MARAC service around recent attendances to EKHUFT (Table 8), this helps support the safety planning for the victims. All victims and their children are

flagged for one year from the start of their safety plan via the alert system on Allscripts, allowing practitioners to be aware of this information and to incorporate this into their assessment of the patient at their attendance.

	April	May	June	July	August	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Ashford	4	15	17	19	11	20	13	13	11	14	13	23
Canterbury	5	18	21	17	16	17	10	9	11	7	11	24
Dover	10	11	17	14	15	7	18	21	7	20	21	18
Folkestone	3	13	9	4	12	5	8	6	5	9	7	10
Thanet	11	11	26	15	17	17	13	31	5	33	24	17

Table 8

6.3.5 As part of the Domestic Abuse workstream devised to strengthen and deliver the Trust's statutory duties on domestic abuse, a stand-alone domestic abuse policy for patients and staff is currently going through the ratification process to reflect the Domestic Abuse Act 2021 and the National Institute for Health and Care Excellence (NICE) guidance (ph50). This will incorporate training requirements, strategies for staff to use with patients and information for people managers supporting staff including the Trust's well- being services for staff. The HIDVA service are making podcast training videos for EKHUFT staff in support of the policy with practical hints and tips for staff

6.4 **Community Safety Partnership**

6.4.1. Although demand and supply of drugs underpins county lines offending, exploitation remains integral to the business model. Offenders recruit, transport and exploit vulnerable individuals including children to carry out low level criminal activity essential to their operations. County lines drugs supply remains the most frequently identified form of coerced criminality, with children representing the vast majority of victims (NCA 2021).

6.4.2 Reachable moments project was initially undertaken in the ED at QEQM. Young people attending hospital following suspected assaults will be offered support as part of a scheme launched by the Kent and Medway Violence Reduction Unit (VRU). As part of the 'Reachable Moments' project, youth workers were stationed at accident and emergency departments in Medway and Thanet to engage with those who may have been injured at the hands of others, including through the use of weapons. Their role was to understand how they came to be hurt and what support they or their families may need to help them move away from criminal activity such as carrying knives or being involved in county lines or gang activity. Funded by the Home Office for an initial three-month period, the project is a partnership between the VRU, Kent County Council, Medway Council, NHS and the domestic abuse charity Oasis. The formal feedback from the project has allowed the project to restart.

6.4.3 In November 2022 the project resumed at WHH due to it being the local trauma centre and has extended beyond the ED setting to the whole site and the age range extended from 14-25 years. Staff in their bright orange shirts have engaged with young people throughout the hospital, in this time period they received 28 referrals to the service, three people changed their minds, 20 cases were under 18 and five were over 18 years old.

6.4.4 EKHUFT still have significant challenges in being able to submit data to the Violence Reduction Unit around knife crime and injuries. This is primarily down to a mismatch between

Emergency Care Data Set (ECDS) codes and the information being required. In addition, EKHUFT staff do not record locations of incidents routinely and may put in patient identifiable data into free text areas meaning the transfer of EKHUFT information into the proforma provided is problematic. Data has started to be submitted and sent retrospectively from September 2022 data onwards. There remain issues about this across the Kent health economy.

7 Other Regulated Activity

7.1 LADO

7.1.1 When an allegation is made against a member of the children's workforce, the needs of the child and other children with whom the professional comes into contact are considered paramount as advocated by the Children Act 1989. Employers however, have an additional duty of care towards their staff and thus the complexities involved in responding to such allegations require balance and careful judgement in order to ensure risk and support are measured at both levels. During the year there have been seven cases where EKHUFT have been supported by the Kent Local Authority Designated Officer to enable us to support staff via a risk assessment in the workplace where there are safeguarding concerns and they are part of the wider children's workforce. There were no themes/departments overly identified, except the majority of cases have been where staff 's own children have been subject to child protection investigations or plans. In addition, a referral was undertaken to another Local Authority in January 2023 in relation to a serious criminal incident at QEQM hospital involving an agency Doctor.

7.2 PiPOT

7.2.1 The Managing Allegations of Abuse Neglect or Harm Against People in a Position of Trust (PiPoT) policy was strengthened to include all staff, volunteers and contractors at the Trust. A formal process to support and manage the staff member to mimic the role of the Local Authority Designated Officer (LADO) service has been devised.

7.2.2 There were 37 cases raised, 13 of these were around substantive staff, of this one case was partially substantiated, one case substantiated, five cases did not progress with either a Local Authority or Police investigation and six cases were not substantiated. The remaining cases related to 20 agency staff and four 2gether Support Solutions (2gether) staff, the employing services were informed of the concerns and requested to instigate their own PiPOT processes, appropriate safety planning around these staff and support for affected patients was undertaken.

7.2.3 5.2. EKHUFT has an up to date policy in place in relation to the undertaking of Disclosure and Barring Service (DBS) checks.

7.3 CP-IS and FGM-IS

7.3.1 The National CP-IS project was implemented at EKHUFT in early 2018. Staff in unscheduled settings such as ED, children's wards and maternity access the system using their smart card through an icon on the zenworks desktop. This allows the staff member to see if the child is on a child protection plan or is 'looked after 'and sends a message back to the Local Authority

informing them of the attendance to EKHUFT. Audits of the use of the system have been undertaken on the children's wards and ED. The Urgent Treatment Centres (UTCs) now have a fully automated system so this area is no longer audited.

7.3.2 Children within the Kent County Council (KCC) cohort continue to be flagged on Allscripts. All children with this flag continue to be alerted to the safeguarding team in real time. In addition, there are a small cohort of children who are additionally flagged at the request of our multi-agency partners or the safeguarding team. There are governance arrangements in place around the flagging.

7.3.3. Pregnant people under the age of 18 years can also be checked on the FGM-IS system which alerts the practitioner to FGM being within females in the family. If baby girls are born at EKHUFT to a mother with FGM then their details are added to FGM-IS, as a further safeguarding measure information about familial FGM is put in the baby's red book as per national guidance.

8 Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS)

8.1 In August 2022 an Acting Named Nurse for MCA/DoLS & Liberty Protection Safeguards (LPS) role commenced to strengthen EKHUFT's understanding, application and compliance of the Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS) and support preparation for LPS. [Please note that subsequently DHSC announced in April 2023 that LPS will be suspended for the lifetime of the current Parliament].

8.2 A Trust wide MCA/DoLS audit, supported by NHSE & ICB was completed (see audit section of report) and a scoping of current MCA/DoLS documents was undertaken to inform the work stream.

8.3 An MCA & DoLS Policy was written and passed through the necessary ratification stages and a training strategy devised.

8.4 An IT request was submitted in September to add mental capacity assessment, best interests' checklist and decision recording and DoLS checklist documents to sunrise along with a request to revise the daily ward round and daily nursing care plan documents already on Sunrise. In addition, a request to devise a DoLS tracker board to identify patients who had a DoLS in place and the status of the DoLS.

8.5 Bespoke MCA/DoLS training package has been devised with a planned rollout to care groups from April 2023. Level three safeguarding training around MCA/DoLS has been strengthened and now incorporates lessons learnt from Trust incidents. An MCA competency framework is being planned.

8.6 A pod cast featuring the ward manager of Harbledown Ward discussing pertinent MCA matters relating to the wards with the MCA lead was recorded and has been uploaded onto the staff intranet. This received positive feedback from the ICB Associate Director for Safeguarding.

8.7 The acting Named Nurse attended local and national MCA/LPS (NHSE/ICB led) working groups to prepare for LPS. As an outcome of these meetings the Acting MCA Named Nurse created a south east acute MCA lead network to provide peer support.

9 **Learning Disability**

9.1 The Learning Disability Team continues to support patients aged 18 or over diagnosed with learning disabilities who have complex needs who are attending the Emergency department, admitted in an emergency or planned to a ward, or outpatients and offers advice and support during admission and identifying reasonable adjustments. The Team consists of one x Whole Time Equivalent (WTE) Band 7 Learning Disability Nurse.

9.2 In July 2022 The Learning Disability Team incorporated the above service to include Autistic patients. The Autism register rose by 61 (42%) patients (175 overall). During this period there were 66 accident & emergency attendances, 43 admissions and 270 outpatient appointments.

9.3 For the period April 2022 – March 2023 the learning disability register rose by 255 (12%) patients (2124 overall). During this period there were 811 accident & emergency attendances, 620 admissions and 2683 outpatient appointments.

9.4 The Learning Disability (LD) Team have strong links with the Community LD health and KCC Social Services Team with admission and discharge information is sent on a daily basis (Monday to Friday) alongside a weekly Acute LD Liaison Multi-Disciplinary Team (MDT) meeting to discuss admissions and share information to support admission and safe discharge with the aim of reducing length of stay and health inequalities. This Acute Liaison MDT is unique to EKHUFT and as yet not replicated by other Acute Trust's in Kent & Medway.

9.5 As part of the statutory requirements the Learning Disability Team complete Learning from Death of People with Learning Disabilities (LeDeR) notifications when a person with learning disabilities and/or Autism dies in hospital, during this reporting period there were 23 notifications (ten QEQM and 13 WHH) made and the team contributed to the local LeDeR Operational meetings.

References:

National Crime Agency (2021) National Strategic Assessment of Serious and Organised Crime.

Royal College of Nursing (2018) Adult Safeguarding: Roles and Competencies for Health Care Staff Inter-Collegiate Document (2018).

Royal College of Paediatrics and Child Health (2019) Safeguarding children and young people roles and competences for health care staff Intercollegiate Document.

Outpatient data for children and young people by speciality (Initial and follow up)

100 - General Surgery	326
101 - Urology	155
103 - Breast Surgery	137
104 - Colorectal Surgery	21
107 - Vascular Surgery	7
110 - Trauma & Orthopaedics (T&O)	6,356
120 - Ear, Nose & Throat	2,302
130 - Ophthalmology	1,310
140 - Maxillo Facial	2
141 - Restorative Dentistry	284
143 - Orthodontics	4,290
145 - Oral & Maxillo Facial Surgery	1,154
171 - Paediatric Surgery	152
190 - Anaesthetics	4
211 - Paediatric Urology	717
214 - Paediatric T&O	132
215 - Paediatric ENT	3,188
216 - Paediatric Ophthalmology	2,462
223 - Paediatric Epilepsy	497
251 - Paediatric Gastro.	1,205
252 - Paediatric Endocrinology	376
254 - Paediatric Audiological Med	1,051
255 - Paediatric Clinical Immunology and Allergy	292
257 - Paediatric Dermatology	882
258 - Paediatric Respiratory Medicine	519
259 - Paediatric Nephrology	234

260 - Paediatric Medical Oncology	409
262 - Paediatric Rheumatology	127
263 - Paediatric Diabetic Medicine	1,090
264 - Paediatric Cystic Fibrosis	131
290 - Community Paediatrics	20,545
291 - Community Paediatric Neuro-Disability	10,110
300 - General Medicine	2
301 - Gastroenterology	117
302 - Endocrinology	49
303 - Clinical Haematology	12
307 - Diabetic Medicine	4
309 - Haemophilia	563
320 - Cardiology	561
321 - Paediatric Cardiology	691
324 - Anticoagulation Service	81
326 - Acute Internal Medicine	62
328 - Stroke Medicine	2
329 – Transient Ischaemic Attack (TIA)	1
330 - Dermatology	1,681
340 - Respiratory Medicine	35
361 - Renal	75
400 - Neurology	167
410 - Rheumatology	64
420 - Paediatrics	17,399
421 - Paediatric Neurology	23
422 - Neonatology	1,017
424 - Well Babies	432

501 - Obstetrics	200
502 - Gynaecology	383
503 - Gynaecology Oncology	11
650 - Physiotherapy	7,083
651 - Occupational Therapy	1
655 - Orthoptics	7,709
658 - Orthotics	237
800 - Clinical Oncology	12
811 - Interventional Radiology	2
959 - Stoma Nurse	4
Grand Total	**99,147**

Kent & Medway Safeguarding Adults Board -

Annual Agency Safeguarding Reporting Template 2023

- The Care Act 2014 requires that Safeguarding Adult Boards produce an annual report detailing what the SAB has done during the year to achieve its main objectives and implement its strategic plan, and what each member has done to implement the Board's strategy.
- To meet this requirement and as part of the Board's quality assurance framework, all KMSAB partner agencies are required to complete this document annually, regarding adult safeguarding activity in the previous calendar year **(April 2022 to March 2023).** Agencies must detail how they met the Board's priorities. A good response provides examples of activity that has been undertaken and the difference it has made.
- Reports will be peer reviewed at the Quality Assurance Working Group. Following this, a report will be made available to Board and Business Group Members.
- Sections of the return will also be made available in the Board's annual report, **please note that this is a public document**. Please ensure that you have relevant permission, and all examples are suitably anonymised for all inclusions. If you include any information which you do not want in the public domain, it is important that this is stated clearly on the return.
- **Please note that this report is for adult safeguarding only.** Whilst Children's safeguarding is very important, the Board is not involved in overseeing this work.
- KMSAB members would recommend that other agencies with a responsibility for safeguarding complete this as a matter of good practice.

Please see appendix one for guidance for completion

Our Vision – "Protect and prevent adults with care and support needs from the risk of abuse, or neglect; supporting and promoting their wellbeing, with all partners working together effectively, ensuring that the safeguarding system is always improving through learning"
Our Priorities – **Priority One** - Promoting person centred safeguarding – this means putting adults at the centre of our work.
Priority Two - Strengthening system assurance – this means we will check that organisations are working well together to support adults.

Priority Three -Embedding improvement and shaping future practice – this means helping the organisations we work with to keep getting better

Report Sign-off

Organisation	**East Kent Hospitals University Foundation Trust**

Details of person completing this return

Name	**Pat Hobson**
Role	**Interim Joint Head of Safeguarding**
Signature	
Email Address	**pat.hobson5@nhs.net**

Return Approved by Accountable lead for Safeguarding Adults

Name	**Jane Dickson**
Role	**Interim Chief Nursing and Midwifery Officer**
Signature	**Jane Dickson**
Email Address	**jane.dickson5@nhs.net**

Priority 1	**Promoting person centred safeguarding**

- Raise awareness of adult safeguarding to ensure that people understand what abuse is, how to recognise the signs and how to seek help
- Enable residents of Kent and Medway to voice their opinions on the work of the Board
- Ensure the voice of the person (or their representative) who has been involved in our safeguarding system is heard in respect of their safeguarding experience
- Seek assurance that each agency's workforce demonstrates 'professional curiosity' and has processes in place to allow them to reflect on their practice and receive appropriate supervision

Please describe what you have done to meet this priority during 2022-2023, with evidence

The key focus for 2022-2023 for the Trust was to address the recommendations as outlined in the Independent Safeguarding Consultant review which was undertaken in February 2022. This was achieved through the development and implementation of an All Age Safeguarding Deliverables (AASD) action plan.
One of the main outputs from the AASD action plan was the development of the All Age Safeguarding strategy which addressed the second recommendation from the Independent Safeguarding review. The Strategy outlined 5 key priorities for the Trust which were aligned to the Trust's core values and were used to address and maintain compliance for the Care Act, Domestic abuse, Mental Capacity Act and Deprivation of Liberty Safeguards **(**MCA/DoLS) and Prevent.

A review of the patient website, patient hospital magazine and easy to read information that patients are required to have was also undertaken as part of the AASD action plan and it indicated that this needed to be strengthened with regards to how patients could access this information. Although there were details on the website relating to the complaint process and also evidence of patient experience reference and Friends and Family Tests, this was

considered within the context of the quality assurance process, and not safeguarding. Therefore, this work was to be mitigated through strengthening of safeguarding activities and governance at operational level. The Trust has strengthened its governance at operational level through the development of a Safeguarding Operational Group that was aligned to the Care Groups Governance, Patient Safety, Patient Experience and Complaints and this commenced in September 2022. All key aspects relating to patient experience are mitigated at this group and there is now a system in place where any complaints that have evidence of safeguarding concerns are overseen by the Safeguarding team. The Safeguarding team also attends the Patient Participation Group to update the Group on any key developments relating to safeguarding.

The following was implemented throughout 2022-2023:

1. The Trust was able to utelise existing safeguarding policies which were either updated and new ones developed to reflect how and what staff are required to do to support patients. The Safeguarding Adults policy now concludes details relating to Section 9 and Carer assessments that patients can be referred to, a section on Making Safeguarding personal, as well as how patients and staff can be empowered to speak out about safeguarding. The new MCA/DoLS policy, Clinical Restraint policy, Missing Persons policy, new Prevent policy, new Domestic abuse policy all include key areas that will enable staff to strengthen professional curiosity e.g MCA/DoLS policy now has a section on the differences between functional and executive capacity and what staff are required to do in the event that a patient demonstrates functional capacity, however, how they may need to consider if they lack executive capacity. All policies now reflect the need to involve families and carers in safeguarding activities.
2. The MSP is reflected on safeguarding reports and the new updated safeguarding policy and the 6 principles are now on the patient facing website. The IO reports reflect a section on MSP which is now being used to ensure that the wishes of patients are captured.
3. A safeguarding leaflet to be provided to patients on admission is being developed and a new bedside leaflet that is given to patient on admission contains a section on safeguarding and how patients can contact the safeguarding team to raise concerns if they have any.
4. Furthermore, there are now posters on advocacy and safeguarding and MCA and Mental Health act, which all departments now have in place and staff can refer to this to support patients.
5. Safeguarding now attends the Patient Participation Group, reviews all patient experience surveys and Patient Experience attends the Safeguarding Operational Group and provide updates on patient experience activities and agree how any gaps will be mitigated and more targeted areas, such as deaf patients and safeguarding, as a result of patients and relatives raising concerns for this to be addressed.
6. There is now a new process to capture information relating to Think Family coordinated jointly with the Safeguarding Children team and an increase in capturing details where there is potential parental mental health and or domestic abuse.
7. Work commenced to support trauma informed approaches with initial scoping of this being undertaken and arrangements in place for the Safeguarding team to support Care Groups with this.
8. The Trust took part in the Safeguarding Awareness week in November 2022, which sent out details through the Trust news, social media and also set up a Hub were staff and patients were able to take part in this.
9. There is now more evidence of relatives and patients raising safeguarding concerns with evidence of an increase in this through complaints and relatives citing issues identified on the wards, which although the majority were not substantiated, it indicated an increase awareness to ensure that patients and staff are empowered to continue to question practice where indicated.

Therefore, the focus for the coming year will be on evaluating the impact and effectiveness of these policies, and changes in systems and processes to see the difference this continues to have on patients and relatives.

Flowchart for Statutory Advocacy.pc

All Age Safeguarding Strategy V6 March 20

Evidence 3. Completed All Age Sa

Priority 2 **Strengthening system assurance**

- Establish a mechanism to identify system issues and risks and provide assurance to Kent and Medway residents that effective safeguarding arrangements are in place
- Improve public understanding of the roles and responsibilities of partners
- Improve interagency understanding of the roles and responsibilities of other partner organisations
- Agencies discharging their respective responsibilities to safeguard people

Please describe what you have done to meet this priority during 2022-2023, with evidence

The AASD action plan that was implemented in 2022 built upon the existing safeguarding systems and processes and was aligned to the 17 recommendations from the Independent Safeguarding Consultant review of February 2022 to address the gaps identified in systems and processes, particularly those relating to governance.

It was implemented on 1 May 2022 with a key focus on strengthening the processes and systems mainly relating to safeguarding adults to ensure that by June 2022, the Trust was able to achieve deliverable 1 only out of the 9 identified. One of the main outputs from the AASD was the development of the All Age Safeguarding strategy which addressed the second recommendation from the Independent Safeguarding review. The Strategy outlined 5 key priorities for the Trust mapped across the next 3 years, which included addressing compliance for the Care Act, Domestic abuse, Mental Capacity Act and Deprivation of Liberty Safeguards **(**MCA/DoLS) and Prevent and these were aligned to the Trust's core values. Furthermore, the Trust also identified all safeguarding risks with clear mitigating factors that were addressed as part of this.

The AASD also enabled the Trust to address the gaps that were outstanding from the 2021 Self-Assessment Framework (SAF) and the 2022 Thematic SAF, which outlined how the Trust was able to not only contribute and fulfil the Kent and Medway safeguarding Adults Board (KMSAB) requirements, but also work with other agencies. The Trust Board also commissioned an external audit which focused on the governance and systems and processes, and one of the key areas examined related to multiagency working and how the Trust worked with partners to safeguard patients. The audit took place in March 2023, and all the KMSAB Subgroup activities and contributions were submitted as evidence to support this audit. The Trust was able to demonstrate the following in relation to KMSAB core activities:

1. KMSAB Board – provided evidence of how the Trust was addressing the recommendations from the Independent Safeguarding review and the challenges relating to this. The Trust attended all KMSAB Board meetings throughout 2022-2023 and all relevant information and updates from KMSAB is cascaded to staff.
2. Board Business Working Group - contributed to the KMSAB Strategic plan and the Trust safeguarding strategy was aligned these.
3. KMSAB Policy and Procedures Working Group - contributed to the development of the KMSAB policies and procedures and ensured that these were cased to staff when required.
4. Safeguarding Adults Reviews (SAR) Working Group – contributed to all SARs commissioned for 2022 -2023 and the implementation of the recommendations from the SARs.
5. Learning and Development Working Group - contributed to the review of training and this resulted in the Trust safeguarding training being updated to reflect the learning from SARs, Domestic Homicide Review (DHRs), section 42 enquiries and safeguarding serious incidents.
6. Communicating and Engagement Working Group – contributed by promoting the resources provided in relation to communicating safeguarding activities to patients and how the Trust was able to use these and evidence the effectiveness of these during the Safeguarding Adults week in November 2022.
7. The Quality Assurance Working Group- was able to contribute by participating in the SAFs and providing evidence as required to demonstrate how the Trust was meeting its statutory duties relating to safeguarding adults.
8. The KMSAB escalation policy was used when there were differences in the manner in which the LA Safeguarding and Trust safeguarding were interpreting the threshold for safeguarding referrals and this led to a series of meetings and an agreement on how this would be mititgated. The escalation policy was also used with the ICB and LA in relation to patients with complex mental health, learning disabilities and or autism resulting in a more coordinated multi agency approach to supporting patients who required specialist support.
9. The Trust also regularly participated in the Integrated Care Board (ICB) Health Reference Group where all local health related issues were addressed through this Group and engaged in system wide workstreams that included those relating to addressing training compliance issues which is one of the core challenges for the Trust.
10. The Trust was part of the NHSE Improvement (NHSEI) Recovery Support Programme (RSP) which continues. Therefore, there was a Trust Integrated Improvement Plan: Journey from Safeguarding Oversight Framework (SOF) 4 to SOF3 that was overseen by the Trust Board, of which one of the main domains for this was safeguarding. The first meeting to agree how the domains would be addressed took place with the Chief Nursing and Midwifery Officer in March 2023. The Exist criteria for the safeguarding domain was for the Trust to provide evidence that they had systems and processes aligned to the NHSE Safeguarding Accountability and Assurance Framework (SAAF), therefore this was being addressed through the All Age Safeguarding Sustainability plan.
11. The Trust had a targeted CQC inspection in January 2023, which focused mainly on the Maternity services. The outcome of this was that there were mainly patient safety concerns, however, scoping was undertaken to ensure that there were no safeguarding concerns relating to patients with care and support needs. There were also concerns in relation to safeguarding adults training which was being mitigated as part of the risk register and monitored through the ICB quality and safeguarding workstreams.
12. The Trust also had an external audit undertaken in March 2023, which was commissioned by the Trust Board, as part of the agreed internal audit plan for 2022/23. The review aimed to provide assurance that the Trust had suitable systems and processes in place in relation to Safeguarding from ward to Board level following the implementation of the All Age Safeguarding Deliverables plan throughout 2022. This had been in response to the Independent Safeguarding Review of February 2022 and currently waiting for the outcome of this.
13. The first output from the All Age Safeguarding Sustainability plan was the Organisational Self Audit which the Trust developed and was aligned to the NHSE SAAF, and the first full audit took place in February 2023, which identified the gaps in the benchmark indicators in each of the 9 domains relating to this. The

Organisational self-audit will be used to evidence how the Trust will be able to achieve the benchmark gaps through audits, reviews, deep dives and thematic reviews and how they will be able to sustain safeguarding systems and processes and work will commence in April 2023 to address the gaps.

14. Feedback from patients and relatives regarding safeguarding activities was provided through the Patient Participation group workstreams, where safeguarding now attends and the Patient Experience team attends the Safeguarding Operational Group. The Safeguarding team also attends the Fundamentals of Care Committee and reviews all patient surveys report, Family and Friends Tests and Healthwatch reviews to identify any concerns and one of the key areas that has resulted in this is work being undertaken in relation to Deaf People and Safeguarding.
15. The Trust also had the support of HIDVAs who have continued to support patients and staff in all matters relating to domestic abuse and now has a new domestic above policy.
16. The Trust in conjunction with the ICB and NHSE developed an MCA/DoLS Implementation plan to strengthen systems and processes relating to this and an audit was jointly undertaken in August 2022, which resulted in a number of core workstreams to include the development of an MCA/DoLS policy and new documentation being developed and waiting for this to be uploaded onto the electronic systems. The effectiveness of the new systems will be the focus for the coming year when further audits will be undertaken.

All Age Safeguarding Strategy V6 March 20

Priority 3 **Embedding improvement and shaping future practice**

- The voice of the person is listened to, and there is evidence their wishes are respected
- Learn from experience and have a workforce that is knowledgeable and confident in the application of their safeguarding adults roles and responsibilities
- Develop the right balance between support and challenge, aimed at system improvement
- Partners are able to contribute to safeguarding at a national and regional level

Please describe what you have done to meet this priority during 2022-2023, with evidence

The leaflet that is given to patient on admission now contains a section on safeguarding and how patients can raise concerns relating to this and a safeguarding leaflet is currently in progress of being developed. Furthermore, there are now posters on advocacy and safeguarding and MCA and Mental Health act, which all departments now have in place and staff can refer to this to support patients.

The safeguarding policies have all been updated to reflect what staff are required to do to support patients and now concludes section 9 and carer assessments that patients can be referred to, and Making Safeguarding personal. Furthermore, training competencies were identified and will be implemented in 2023-2024.

The following were achieved:

1. A new risk register for safeguarding adults and children, which include the roles and responsibilities and safeguarding leadership at Care Group level and the mitigations for this.
2. A scoping paper was developed to outline and address the capacity issues in safeguarding adults, which demonstrated the need to have robust strategic, operational and frontline leadership arrangements in place. Two focus groups were undertaken with both adults and children safeguarding teams. This resulted in the development of an Options paper and a Business case to increase the safeguarding workforce capacity.
3. There was also a Safeguarding adult workforce development programme from August 2022-March 2023, which focused on enabling the staff to develop further skills and knowledge and competencies in safeguarding leadership. This was achieved through undertaking skills analysis using the domains from the Intercollegiate Document (ICD) to identify gaps in competencies to ensure that roles and responsibilities were aligned to this and that the team could demonstrate progression in this.
4. Safeguarding supervision guidance were developed, which would be used with staff to support with the coaching and mentoring of safeguarding activities.
5. The Trust also developed safeguarding competencies for all staff which will be rolled out in 2023, and have updated safeguarding training to reflect learning from the safeguarding reviews and section 42s.
6. The Trust was involved in a pilot relating to people who were homeless, and the outcome of this was completed which indicated that there was much need to continue this project, as such it was extended by the ICB. The Safeguarding team worked closely on this project with the Homelessness Adult Safeguarding Practitioner providing support on the interface between homelessness and safeguarding, as such this had resulted in work being strengthened by the Trust to address this. The Trust has identified key resources that they will be implementing to support the homelessness workstream and this includes the following:

1. Implementing the recommendations from the Michael Preston Shoot Toolkit based on national SARs.
2. The Homelessness Adults Safeguarding Practitioner presented a session alongside Michael Preston Shoot relating to the interface between safeguarding and homelessness.
3. The Trust identified the NHSE Toolkit in Homelessness and Rough Sleeping to be implemented within the ED departments.
4. Strengthening the use of executive capacity based on the learning from SARs and was included in the new MCA/DoLS policy.
5. Following learning from published SARs and DHRs, section 42s and safeguarding SIs and safeguarding thematic reviews, there was scoping of the care of people with mental health against the Care Quality Commission (CQC) 2019 Inspection into 100 NHSE acute Trusts, and the systems wide gaps were identified, as well as internal governance relating to this, which has resulted in improvements being identified for the coming year to support people with mental health, learning disabilities and or autism.
6. The Trust Safeguarding team were approached by the KMSAB to present the outcome of the pilot and the interface between safeguarding and homelessness, which they agreed to do in May 2023.

Throughout 2022-2023, the Trust was under the NHSEI RSP, in which they had to provide the completed AASD action plan as the main form of evidence for the safeguarding domain to demonstrate how they had robust systems and processes in place. However, it was the effectiveness and sustainability of these that the Trust needed do focus on, therefore the Trust Board Integrated Improvement Plan: Journey from SOF 4 to SOF3 developed as part of the NHSI RSP will be used to evidence this and the Trust will be working with NHSEI, NHSE Regional Safeguarding team and the ICB to support with this.

Flowchart for Statutory Advocacy.pc

Further evidence of Safeguarding activity throughout Kent and Medway

1. Strategic adult safeguarding issues for organisation over the previous year (April 2022 – March 2023) Please give your organisations **Top 3 adult safeguarding strategic** issues in the previous year. How did you deal with them? What actions did you take?	1. **Restoration, recuperation and recovery** 2. **Quality of the care delivery** 3. **Workforce and resilience and capacity**, **Progress:** 1. Development, implementation and completion of the AASD action plan and evidence generated from this. 2. The development and implementation of the All Age Safeguarding Sustainability plan of which the Trust will continue generating evidence in 2023-2024 as indicated in the details provided in this report.
2.Safeguarding adults review recommendation in respect of Leon It is recommended that all relevant agencies completing the KMSAB annual agency report, include how they have acted in relation to their initial response to self-neglect situations	1. The Trust has updated the Safeguarding Adults policies to strengthen the implementation of the self-neglect protocol. 2. The Trust now has a new MCA/DoLS policy which includes a section on executive capacity following the outcome from the SARs to determine the impact of severe self-neglect on capacity. 3. Safeguarding adults and MCA/DoLS training updated to reflect the lessons learnt in relation to self-neglect**.** 4. All patients who demonstrate evidence of self-neglect are not to be discharged unless safeguarding have been involved and assessment undertaken in relation to care and support needs and to explore other legal powers that may be used. 5. Incidents and section 42s enquiries relating to self-neglect to be monitored. 6. Implementation of the NHSE Homelessness and Rough Sleeping Toolkit in ED, which also indicates self-neglect to be considered with regards to the interface between self-neglect and homelessness. 7. Mental Health Strategy being developed which strengthens the interface between self-neglect,

	substance misuse and this includes the training of staff in mental health
3.Any safeguarding priorities your organisation would like the Board to add to its forward plan for 2023-4	1. Evidence of the effectiveness of the All Age Safeguarding Sustainability plan and how the Trust works with other partners to address system wide safeguarding issues impacting on the Trust's ability to delivery and sustain high quality care for patients. 2. Evidence of the progress of the safeguarding 'Exist criteria' on the Trust Integrated Improvement Plan: Journey from SOF 4 to SOF 3, as part of the RSP in conjunction with NHSEI. 3. The Trust in conjunction with the ICB Safeguarding and NHSE Regional Safeguarding Team evidence the Trust's progress in addressing safeguarding business as usual activities and priorities. This will be based on the outcomes of the new Strategic Safeguarding Oversight Meetings of which the evidence generated from the Trust's Integrated Improvement Plan will feed into this.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Quarterly Care Quality Commission (CQC) Report**

Meeting date: **1 February 2024**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO)**

Paper Author: **Interim Director of Quality Governance/Head of Quality Assurance and Improvement**

Appendices:

None

Executive summary:

Action required:	Discussion
Purpose of the Report:	This report provides a quarterly update on CQC inspection activities, oversight, assurance and related improvement work. This report covers the period November 2023 to January 2024. The next report will be presented at the May 2024 Board of Directors meeting. This report covers an: • Update on recent CQC inspection reports (May and July 2023) published in December 2023 and associated action plans; • Update on refreshed governance arrangements; • Update on Maternity Section 31 Enforcement Notice; • Current performance against open CQC action plans; • Brief overview of the CQC new Single Assessment Framework.
Summary of key issues:	• The overall ratings for the Trust and William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) have remained static following the May and July 2023 inspections. There has been some change within services, notably a positive increase in ratings for the Children and Young People's Service at the QEQM and a decrease in rating for the Medical Services at the same site. The ratings for services at the WHH remained the same. • The Trust level well led inspection led to a rating of 'requires improvement' which is the same as the last inspection in 2018. • Action plans will be submitted to the CQC by the 29 January 2024. • Refreshed governance arrangements will be in place from February 2024. • Work is underway to understand CQC inspection readiness within the Maternity service with particular reference to the areas outlined in the Section 31 Enforcement Notice. • There has been improvement in month in closure of CQC actions from the current open plans – most noticeably in Maternity. Pace is

East Kent Hospitals University NHS Foundation Trust

	required in other areas and this will be supported by the strengthened oversight arrangements. • The CQC have published their new Single Assessment Framework which is now live in the South East region and will form the basis of inspection activity from now.
Key recommendations:	Board members are invited to discuss and **NOTE** the report and progress of delivery of improvements related to CQC compliance to date.

Implications:

Links to Strategic Theme:	This report relates to the below strategic themes: • **Quality and Safety** • **Patients**
Link to the Board Assurance Framework (BAF):	**BAF 32** – There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered.
Link to the Corporate Risk Register (CRR):	The risk related around CQC compliance on the Significant Risk Register is being re-articulated and will be formally approved at the Risk Review Group on 2 February 2024. As appropriate, service level risks are captured on the Care Group Risk Registers. These specialty and care group level risks are being updated in line with the May 2023 and July 2023 inspection reports published in December 2023.
Resource:	N
Legal and regulatory:	Y. Inability to provide assurance to our regulators impacting on the quality and safety of care provided to our patients and service users.
Subsidiary:	Y. The Well Led inspection action plan contains actions for 2gether Support Solutions in partnership with the Trust.

Assurance route:

Previously considered by:

A monthly update is provided to the Quality and Safety Committee (Q&SC). The last paper was presented on the 23 January 2024.

CQC oversight and assurance arrangements are being refreshed. From February 2024 the Regulatory Oversight Group, chaired by the CNMO, will meet bi-monthly, reporting into the Clinical Executive Management Group (CEMG) and to the Quality and Safety Committee. A quarterly report will be received by the Board of Directors.

East Kent Hospitals University NHS Foundation Trust

Quarterly Care Quality Commission (CQC) Report

1. Purpose of the report

1.1 This report provides a quarterly update on CQC inspection activities, oversight, assurance and related improvement work. This report covers the period November 2023 to January 2024. The next report will be presented at the May 2024 Board of Directors meeting.

1.2 This report covers an update on recent CQC inspection reports (May and July 2023) published in December 2023 and associated action plans;

1.3 An update on refreshed governance arrangements;

1.4 Maternity Section 31 Enforcement Notice;

1.5 Current performance against open CQC actions plans;

1.6 Brief overview of the new CQC Single Assessment Framework.

2. Background

2.1 The CQC has rated our Trust as 'requires improvement'. Improving our CQC rating is a Trust Strategic Initiative, a key part of our Quality Strategy and is referenced in the Integrated Improvement Plan (IIP) in particular in relation to improvements in maternity, quality and safety and leadership and governance.

3. Recent Inspection Activity – Core Services Inspection, May 2023

3.1 The Trust was last inspected in July 2023. This inspection focused on the Well Led domain at Trust level. This followed a Core Service Inspection of Medical Care, Urgent and Emergency Care and Children and Young People's Services at the William Harvey Hospital (WHH) and Queen Elizabeth Queen Mother (QEQM) Hospital site in May 2023. The Trust received a Section 29A Warning Notice in June 2023. This was responded to formally as required in September 2023, providing evidence of the immediate improvements that had been made since the inspection, and outlining a trajectory for remaining work. The Warning Notice is referenced in the CQC reports, which were published on 20 December 2023, but no further enforcement action was taken.

3.2 The ratings for the WHH and QEQM are below. In summary the overall rating for the WHH site remained the same ('requires improvement') as did the ratings for Medical Care and Children and Young People. At the QEQM the overall rating for the site remained the same ('requires improvement'). The rating for Children and Young People's Services increased to 'good' (from 'requires improvement'). The rating for Medical Care decreased to 'requires improvement' from a 'good' rating. Although Urgent and Emergency Care (UEC) was inspected on both sites it was not rated.

East Kent Hospitals University NHS Foundation Trust

Rating for William Harvey Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement → ← Dec 2023	Good → ← Dec 2023	Requires Improvement ↓ Dec 2023	Requires Improvement → ← Dec 2023	Requires Improvement ↓ Dec 2023	Requires Improvement → ← Dec 2023
Services for children and young people	Good → ← Dec 2023	Requires Improvement → ← Dec 2023	Good → ← Dec 2023	Requires Improvement → ← Dec 2023	Requires Improvement ↓ Dec 2023	Requires Improvement → ← Dec 2023
Critical care	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
End of life care	Requires improvement Sep 2018	Requires improvement Sep 2018	Good Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018
Outpatients and diagnostic imaging	Good Nov 2015	Not rated	Good Nov 2015	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015
Surgery	Good Sep 2018	Good Sep 2018	Good Sep 2018	Requires improvement Sep 2018	Good Sep 2018	Good Sep 2018
Urgent and emergency services	Not rated	Not rated	Good Jul 2020	Not rated	Not rated	Not rated
Maternity	Inadequate May 2023	Requires improvement May 2023	Requires improvement May 2023	Inadequate May 2023	Inadequate May 2023	Inadequate May 2023
Overall	Requires Improvement → ← Dec 2023	Requires Improvement → ← Dec 2023	Requires Improvement ↓ Dec 2023	Requires Improvement → ← Dec 2023	Requires Improvement → ← Dec 2023	Requires Improvement → ← Dec 2023

Rating for Queen Elizabeth The Queen Mother Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement → ← Dec 2023	Good → ← Dec 2023	Good → ← Dec 2023	Requires Improvement ↓ Dec 2023	Requires Improvement ↓ Dec 2023	Requires Improvement ↓ Dec 2023
Services for children and young people	Good → ← Dec 2023	Good ↑ Dec 2023	Good → ← Dec 2023	Good ↑ Dec 2023	Requires Improvement ↓ Dec 2023	Good ↑ Dec 2023
Critical care	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
End of life care	Requires improvement Sep 2018	Requires improvement Sep 2018	Good Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018
Outpatients and diagnostic imaging	Good Nov 2015	Not rated	Good Nov 2015	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015
Surgery	Requires improvement Sep 2018	Good Sep 2018	Good Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018
Urgent and emergency services	Not rated	Not rated	Good Jul 2020	Not rated	Not rated	Not rated
Maternity	Inadequate May 2023	Requires improvement May 2023	Requires improvement May 2023	Good May 2023	Inadequate May 2023	Inadequate May 2023
Overall	Requires Improvement → ← Dec 2023	Requires Improvement → ← Dec 2023	Good → ← Dec 2023	Requires Improvement → ← Dec 2023	Requires Improvement → ← Dec 2023	Requires Improvement → ← Dec 2023

3.3 Many areas of good practice were found across the services. In UEC the CQC found good evidence of team work amongst health professionals and said that staff felt respected, supported and valued and focused on the needs of patients receiving care. The design and

the layout of the paediatric resuscitation room at the WHH was noted as an area of outstanding practice.

3.4 In Medical Care, staff treated patients with care and compassion, understood how to protect patients from abuse and acted on risks to patients. Cambridge K Ward was noted to have outstanding leadership which led to a significant improvement in recruiting and retaining staff.

3.5 In Children and Young People's Services the service had enough staff to care for children and young people and keep them safe. The service understood how to protect children and young people from avoidable harm and managed safety well, learning from incidents. Staff treated children and young people with compassion and kindness and worked well together to support their patients make decisions about their care. At the QEQM, staff understood the service's vision and values and felt respected, supported and valued.

3.6 The CQC were highly complementary of the specialist end of life care team, commenting on the accessibility of the team 7 days per week enabling high quality and timely patient care. They also referenced the end of life beds pilot at the QEQM as an example of outstanding practice.

3.7 There were some areas of common challenge within the reports – in particular statutory and mandatory training rates (with particular reference to safeguarding and resuscitation training), appraisal rates, staffing (urgent and emergency care and some medical wards) and the reporting of near misses in line with Trust policy. Overcrowding was a concern in the Emergency Department (and the impact on escalation areas and wards where patients were 'boarded') as was the impact of overcrowding on the privacy and dignity of patients, fire safety and infection, prevention and control.

3.8 The Trust is required to submit action plans to the CQC by 29 January 2024 detailing a response to all of the Must Do and Should Do findings. The plan will be signed off at Executive Management Team on 24 January 2024 and subsequently shared with CEMG, Q&SC and the Board.

4. Recent Inspection Activity – Well Led Inspection, July 2023

4.1 In July 2023 the CQC undertook an announced inspection of the well-led domain at a Trust level. The CQC used findings from this inspection in addition to their findings relating to the leadership of individual services (May 2023 inspection) to provide an overall rating of 'requires improvement'. This represents no change from the last well-led inspection at Trust level in May 2018. The well-led inspection report was published, alongside the core service inspection reports, in December 2023.

4.2 The CQC noted that there was a focus on continuous learning and improvement at all levels of the organisation, including through the use of external accreditation and participation in research. There had been improvements in how users of the service were involved in the business of the organisation and there was clear evidence of appropriate performance information being used at Board level.

4.3 It was recognised that there had been significant turnover in the executive and that many

of the improvements required, that had been articulated as part of the inspection (leadership, strategy, risk management and quality governance) would take time to embed.

4.4 There are four Must Do actions associated with the well-led inspection – the trust must operate an effective complaints procedure which includes providing timely responses and updates to complainants, the trust must ensure all staff report incidents via the trust reporting systems, the trust must ensure the risks associated with reported safety concerns are mitigated promptly and the trust must ensure medical staff complete exception reports to identify trends and themes and use these to improve services for patients and staff.

4.5 The Trust is required to submit an action plan to the CQC by 29 January 2024 detailing a response to the Must Do findings. The plan will be signed off at Executive Management Team on 24 January 2024 and subsequently shared with CEMG, Q&SC and the Board.

5. Refreshed Governance Arrangements

5.1 Work is underway to improve CQC governance and assurance arrangements. The previous Journey to Outstanding Care Programme Board will be superseded by a Regulatory Oversight Group, which will oversee CQC plus other regulatory requirements. This bi-monthly meeting will be chaired by the CNMO and will commence in February 2024. The Regulatory Oversight Meeting will report to CEMG and Q&SC with quarterly reporting via a Chairs report to the Board of Directors as part of the CQC update.

5.2 The CQC Oversight and Assurance Group, chaired by the Director of Quality Governance, will focus on deep dive reviews and a programme of self-assessments based around the new CQC single assessment framework. A check and challenge meeting attended by the CNMO, Chief Medical Officer (CMO) and Chief Operating Officer (COO) will happen on a bi-monthly basis to ensure there is pace behind the closure of Must and Should Do actions and to oversee self-assessment activities and associated improvement work.

5.3 Regular monthly reporting on the open CQC action plans will continue as a key component of specialty and care group governance meetings and executive led performance management reviews.

5.4 To further support quality assurance work and front-line engagement and ownership, the ward accreditation tool has been mapped to the CQC domains and single assessment framework and the visit invites extended to enable peer review.

6. Maternity Section 31 Enforcement Notice

6.1 The Trust continues to submit monthly Section 31 returns. The CQC has recently advised of their wish to agree an approach to evaluate the improvement work to date. This will be discussed at the next engagement meeting between the CNMO and CQC (date to be confirmed due to changes in personnel at the CQC). In the meantime, an internal quality review visit is being arranged.

7. Open Action Plans

7.1 There are currently open CQC improvement action plans relating to Urgent and

Emergency Care, Medical Services, Maternity, End of Life Care and Children and Young People. These all relate to inspection prior to 2023, with the exception of Maternity which was last inspected in January 2023. The status of these action plans is shown below.

MUST DO REQUIREMENTS % COMPLETE	
	Dec-23
• UEC – 9 Must Dos	• 46%
• Maternity – 20 Must Dos	• 71%
• End of Life Care (EOLC) – 1 Must Do	• 0%
• General & Specialist Medicine (GSM) – 7 Must Dos	• 57%
SHOULD DO REQUIREMENTS % COMPLETE	
	Dec-23
• UEC – 13 Should Dos	• 36%
• Maternity - 18 Should Dos*	• 83%
• EOLC – 11 Should Dos	• 64%
• GSM – 4 Should Dos	• 50%
• Children & Young People (CYP) – 6 Should Dos	• 50%

7.2 Further closures are forecast for January 2024 after which time all remaining open actions will be migrated to the new action plans for Urgent and Emergency Care, Medical Services and Children and Young People's Services.

7.3 The refreshed governance arrangements will ensure there is appropriate pace around closure of long-standing actions and oversight of any associated risks to the delivery of high-quality care and implementation of mitigations.

8. Update on CQC Single Assessment Framework

8.1 The CQC are implementing their new single assessment framework and changes to the regulatory framework. Providers in the CQC's South of England region went live with the new framework in November 2023. All assessments for EKHUFT will now follow the new approach.

8.2 The new framework includes 34 Quality Statements (written from the perspective of 'good'), detail about the regulations relevant to the Quality Statement, which of the six evidence categories are relevant to each Quality Statement and the corresponding 'I' statements, written from the perspective of a patient. This will replace the previous Key Lines of Enquiry (KLOEs).

8.3 Local self-assessment and peer review tools are in the process of being updated to reflect this guidance and the refreshed governance arrangements outlined in Section 5.

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9. Recommendations

9.1 Board members are invited to discuss the report and status of the delivery of improvements related to CQC compliance to date. It is recognised that there is significant work to deliver and embed the changes required – with ownership required at all levels of the organisation and leadership from the Care Group Triumvirate Teams, Executives and Board.

9.2 Quarterly progress reports will now be received by the Trust Board with the next report in May 2024.

East Kent Hospitals University NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (BoD)

Report title: **Medical Appraisal and Revalidation**

Meeting date: **1 February 2024**

Board sponsor: **Chief Medical Officer (CMO)**

Paper Author: **Senior Business and Operations Manager to the CMO**

Appendices:

None

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	As part of the Trust's duty as a Designated Body, the Trust is required to ensure it is able to execute the responsibilities of the Medical Profession (Responsible Officers) Regulations 2010 (and its amendments). The purpose of the report is to provide updates and assurance that the responsibilities are being met and improvements are being delivered as agreed by the Statement of Compliance (SoC) report submitted to the Board of Directors in November 2023.
Summary of key issues:	• Appraisal compliance has improved from 68% to 85%. • The rate of positive revalidation recommendations has improved from 48% to 72%.
Key recommendations:	The Board of Directors is asked to **NOTE** this report and the: • Agreed actions following the last SoC report are on track for delivery and will be captured in this year's SoC report due in September with an interim report in May 2024 called the Annual Organisational Audit (AOA). • Recommendations are to review this report and provide any comments or feedback that will help continue to realise the improvements being sought.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People

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Link to the Board Assurance Framework (BAF):	BAF 35 - There is a risk of failure to recruit and retain high calibre staff.
Link to the Corporate Risk Register (CRR):	CRR 123 - Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate medical staffing levels and skill mix to meet patients' needs.
Resource:	N
Legal and regulatory:	Y: Impacts our functions regulated by the Higher-Level Responsible Officer (NHS England).
Subsidiary:	N

Assurance route:

Previously considered by: The contents of this paper have been subject to ongoing review and monitoring by the Responsible Officers Advisory Group (ROAG).

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Medical Appraisal and Revalidation

1. Purpose of the report

1.1 To provide assurance that the Trust is meeting its requirements to deliver the Medical Profession (Responsible Officers) Regulations (2010).

2. Background

2.1 Revalidation and appraisal are carried out in the NHS to ensure doctors are licensed to practice medicine and supported to develop so care continuously improves. This report summarises the Trust's position in respect to its performance as a Designated Body.

3. Appraisal Compliance

3.1 The Trust currently has 925 connected doctors, with 785 (85%) appraisal completed/within guidelines. This compliance demonstrates an improved position from 68% achieved in July 2023.

3.2 Actions agreed by the Board of Directors following the previous Statement of Compliance report (November 2023) will be updated and presented to the Board of Directors through the Annual Organisational Audit (AOA) report due in May 2024. These actions have been written to include the recommendations/outcomes of the Higher-Level Responsible Officer visit the Trust received in November 2022.

4. Revalidation

4.1 All recommendations for revalidation are discussed at the monthly Responsible Officers Advisory Group (ROAG).

4.2 Since August 2023, 92 doctors have required revalidation recommendations. 66 (72%) have received a positive recommendation; 23 (25%) have had recommendations deferred due to insufficient evidence; and three (3%) have had recommendations deferred as they are subject to an ongoing process. The most common cause for deferring a recommendation due to insufficient evidence continues to be lack of 360 Multi-Source Feedback. The number of positive recommendations has improved from a position of 48% of all revalidations due since the last report (32 positive recommendations out of 66).

4.3 Previously, portfolios were reviewed one month prior to the revalidation due date at ROAG. To reduce the number of deferrals due to lack of 360MSF, portfolios will be reviewed two months ahead of their due date from February's ROAG meeting. This will provide medical staff with around eight weeks to complete the exercise, if this element is found to be missing at the time of review.

5. Maintaining Accurate Records

5.1 Connection check is performed twice a month to maintain an accurate list of our prescribed connections with medical practitioners.

5.2 The connection checking process has also been adopted to improve the job planning workstream which has seen improvements related to a number of appraisal and revalidation actions (see section 6 and 7).

5.3 Actions linked to improving records management will be addressed by the roll-out of our new e-portfolio platform, which will be launched this year. The new platform, which was acquired through competitive procurement process, has demonstrated desired functionality while maintaining current costs. Old contract will cease in August 2024 with transition to new platform commencing from April 2024.

6. Job Planning

6.1 As of December 2023, there were 725 doctors that required a job plan and 474 had completed/had a job plan reviewed in the previous 12 months. This makes the current position on job planning compliance 65%.

6.2 In the sign-off stages of the job planning process there is currently: 5% in third sign-off, 5% in second sign-off, and 15% in first sign-off. We are therefore confident that we will achieve the 90% job planning compliance by 1 April 2024. Achieving 90% will mean we have met the requirements of level 1 of the Levels of Attainment and Meaningful Use Standards.

7. Levels of Attainment and Meaningful Use Standards

7.1 There are 17 standards to meet across five levels (level 0 – level 4), each standard/level is sequential and must fully met before the next level can be obtained.

7.2 Our current position against these standards are as follows: 5/17 standards met, 6/17 partially met, 5/17 not met.

7.3 Level 0 (e-job planning): 1/1 standards met.

7.4 Level 1 (basic individual job planning): 3/4 standards met (remaining standard: achieve 90% job planning compliance).

7.5 Level 2 (advanced individual job planning): 1/3 standards met.

7.6 Level 3 (team job planning): 0/5 standards met.

7.7 Level 4 (organisational job planning): 1/4 standards met.

8. Conclusion

8.1 The Trust's medical appraisal position has improved from 68% to 85% with identified actions for improvement due for feedback to the Board of Directors in May 2024.

8.2 Revalidation recommendations continue to be reviewed and provided by the Responsible Officers Advisory Group (ROAG) and the group continue to review and improve processes in response to data and feedback from the General Medical Council (GMC).

8.3 The governance around maintaining accurate data relating to medical practitioners continues to meet the expectations of the Higher-Level Responsible Officer and the Trust is continually seeking ways to improve and respond to local and national changes.

8.4 Actions developed to improve appraisal and revalidation are impacting other workstreams within the Chief Medical Officer portfolio, such as job planning and the Levels of Attainment.

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REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Equality Delivery System (EDS) Report 2023

Meeting date: 1 February 2024

Board sponsor: Chief Nursing and Midwifery Officer (CNMO), Chief Medical Officer (CMO), and Chief People Officer (CPO)

Paper Author: Head of Patient Voice and Involvement and Head of Equality, Diversity, and Inclusion

Appendices:

Appendix 1: Equality Delivery System (EDS) Report 2023

Executive summary:

Action required:	**Approval**
Purpose of the Report:	To provide an assessment of the Trust's approach to addressing inequalities for patients in terms of access, experience, and outcomes, addressing inequalities and improving health and wellbeing for our workforce and assessing how our leadership understands and promotes equality, diversity, and inclusion (EDI). This is an annual assessment using the NHS England (NHSE) Equality Delivery System (EDS) framework.
Summary of key issues:	The EDS is an improvement tool for patients, staff, and leaders of the NHS. It supports NHS organisations to review and develop their approach in addressing inequalities in health access, experiences, impact, and outcomes through three domains: services (patients), workforce health and wellbeing and leadership. It is driven by data, evidence, engagement, and insight and was amended in 2022 to be brought into line with the NHS Long Term Plan, and in response to Covid-19. The EDS assessment requires us to look at access, experience, and outcomes for patients based on eight of the nine protected characteristics under the Equality Act 2010. We are also encouraged to review access, experience, and outcomes for 'health inclusion groups' such as carers and homeless people. **Domains, Scoring and Findings:** The EDS Domain 1 relates to patient care. Patient equalities is part of the remit of the Patient Voice and Involvement team. The four outcomes assessed are: • 1A: Patients have required levels of access to the service. • 1B: Individual patient's health needs are met. • 1C: When patients use the service, they are free from harm. • 1D: Patients report positive experiences of the service.

	Where evidence and insight are only available for two or less protected characteristics for an outcome, then the EDS rating for that outcome will automatically be 'undeveloped'. This approach is deliberately designed to drive the collection of evidence and insight that is currently unavailable. Each outcome score is based on the evidence provided. Once each outcome has a score, they are added together to gain domain ratings. We are required to use the middle score out of the three services from Domain 1. The score for Domain 1 is based on our assessment of the scores for the three services reviewed this year – Maternity, Cancer and Maxillo-facial. It also includes proposed EDS actions at a Trust-wide level, that once implemented will enable the Trust to better assess how every service is striving to provide equity of access, experience and outcomes for our patients, families, and communities. **Our EDS Domain 1 overall rating is 3 out of a potential score of 12. This means that we are 'undeveloped' overall for Domain 1.** For the workforce health and wellbeing (Domain 2) and Leadership (Domain 3) the EDI team have led the assessment with people and culture colleagues. These assessment of these domains was considered by the EDI Steering Group and virtually by People and Culture Committee as the January meeting was rescheduled. **Domain 2: Workforce health and wellbeing – assessment led by the EDI Team:** • 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, chronic obstructive pulmonary disease (COPD) and mental health conditions (impact of Covid-19). • 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source. • 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source (impact of Covid-19). • 2D: Staff recommend the organisation as a place to work and receive treatment. **Domain 3: Inclusive leadership – assessment led by the EDI Team:** • 3A: Board members, system leaders (Band 9 and Very Senior Manager (VSM)) and those with line management responsibilities routinely demonstrate their understanding of, and commitment, equality, and health inequalities. • 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed.

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	• 3C: Board members, system, and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients. **The score for EDS Domain 2 was 3 and for Domain 3 was 2, making a total of 5. These scores, added to the score for Domain 1 gives a total score of 8, which means the Trust is rated 'Developed', but at the lowest possible score for 'Developed' as the range is 8 to 21.** **The overarching request is for year-on-year improvement**. This means sharing the outcomes, good practice, and areas for improvement across our Trust and the wider health and care system in East Kent and Kent and Medway for learning and improvement considerations in other areas. We are required to publish our EDS report on our Trust website by 28 February each year. **Next Steps** The scores for each domain indicate the current strengths and areas for improvement. Actions for Domain 1 to be overseen through the Patient Experience Committee and the Quality and Safety Committee. Actions for Domains 2 and 3 to be overseen by the People and Culture Committee.
Key recommendations:	The Board of Directors are asked to: • discuss the report and **APPROVE** the findings, the proposed objectives, and actions; • Receive an update report on progress of EDS actions at the Board of Directors in September 2024.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our quality and safety

Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 40:** There is a risk of failure to address inequality, lack of diversity and injustice for staff working at East Kent Hospitals.

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Link to the Corporate Risk Register (CRR):	**CRR 118**: There is a risk that the underlying organisational culture impacts on improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace. Specifically, there is a requirement for urgent and significant improvement in relation to staff attitudes and behaviours.
Resource:	No
Legal and regulatory:	The Trust must implement the statutory guidance on Working with People and Communities July 2022 and the Equality Act 2010, including the Public Sector Equality Duties. The Trust is required to publish an annual Equality Delivery System (EDS) report.
Subsidiary:	No

Assurance route:

Report on Domain 1 previously considered by: the Patient Participation and Action Group on 25 September 2023 and the Inequalities and Unwarranted Variations Committee on 4 October 2023, the Fundamentals of Care Committee on 16 November 2023, the Clinical Executive Management Group (CEMG) on 3 January 2024 and Quality and Safety Committee on 23 January 2024.

Report on Domains 2 and 3 previously considered by the EDI Steering Group in November 2023 and virtually by People and Culture Committee in January 2024.

Classification: Official

Publication approval reference: PAR1262

NHS England

NHS Equality Delivery System 2023

EDS Reporting Template

The Equality Delivery System Report gives an overview of an organisation's approach to addressing health inequalities.

Version 1, 24 November 2023

Patient Equality Team
NHS England and NHS Improvement
england.eandhi@nhs.net

Contents

About the NHS Equality Delivery System (EDS)

Implementation of the Equality Delivery System (EDS) is a requirement of both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance with the EDS guidance documents.

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

EDS rating and scores

Please refer to the Rating and Score Card supporting guidance before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly.

First, score each outcome out of 3.

- 0 = Undeveloped activity
- 1 = Developing activity
- 2 = Achieving activity
- 3 = Excelling activity

Then, add the scores of all outcomes together. This will provide you with your overall score, or your EDS organisation rating:

- total score under 8 = Undeveloped
- total score between 8 and 21 = Developed
- total score between 22 and 32 = Achieving
- total score 33 = Excelling

.

Section 1 – Your information

Name of organisation: **East Kent Hospitals University NHS Foundation Trust**

Organisation Board Sponsor/Lead: **Chief Nursing and Midwifery Officer / Chief People Officer**

Name of Integrated Care System: **Kent and Medway**

EDS Lead: **Head of EDI / Head of Patient Voice and Involvement**

EDS engagement date(s): November to December 2023

Which level has this EDS tool been completed at?

Individual organisation level

Completed actions/activity from previous year

Action 1: Put a process in place to gather evidence to assess and score all outcomes in Domains 1, 2 and 3 using the refreshed EDS 2022 process.

Related equality objective: Promote inclusion in both patient care and employment in line with our Public Sector Equality Duties.

Action 2: Engage with key stakeholders, both internal and external, and with patients and staff to help score each outcome under the three Domains.

Related equality objective: Involve people who receive healthcare, our staff and local communities in order to identify opportunities to tackle health inequalities and improve equity of access, experience and outcomes.

Section 2 – Outcomes and evidence

Domain 1 – Maternity, Cancer, and Maxillo-facial services

Outcome	Evidence	Score / rating	Owner (Department/Lead)
1A: Patients (service users) have required levels of access to the service	Whilst there is evidence that people of all ages and sexes can access services, and some evidence based on ethnicity and wider health inclusion groups, there is incomplete data to provide evidence for other protected characteristics, including disability, gender reassignment, religion and belief and sexual orientation.	1	Care Group senior teams
1B: Individual patients (service users) health needs are met	There is evidence that people of all ages and sexes have their health needs met and that some disabled people have their health needs met, but a lack of data to provide evidence for other protected characteristics, including ethnicity (race), gender reassignment, religion and belief and sexual orientation.	1	Care Group senior teams
1C: When patients (service users) use the service, they are free from harm	There is evidence that people with some protected characteristics are more likely to experience harm, due to age, disability, and ethnicity. There is limited data or evidence for people with other protected characteristics, including gender reassignment, religion and belief and sexual orientation. We monitor incidents, such as falls, by sex and there is no evidence of disproportionate harm.	1	Care Group senior teams

Outcome	Evidence	Score / rating	Owner (Department/Lead)
1D: Patients (service users) report positive experiences of the service	Friends and Family Test (FFT) survey results show a trust-wide score of over 90% satisfaction, but the FFT surveys are not available in other languages or British Sign Language (BSL). Your Voice is Heard (maternity) data indicates equity of positive experience across most ages and ethnicities, but birthing partners who are mostly male report a poorer experience and there is limited data related to disabled people, people who are gender diverse or based on religion and belief or sexual orientation. The national Cancer patient experience survey 2022 data was not analysed by ethnicity, disability, religion or belief or sexual orientation due to low response numbers with these protected characteristics. Patient Advice and Liaison Service (PALS) and complaints provide evidence of no difference of experience across age, disability and sex protected characteristics, however there is a lack of data on complaints by ethnicity, gender reassignment, religion and belief, and sexual orientation which means we cannot be fully assured.	0	Care Group senior teams

Total score
Please total the scores from Domain 1: **3 (three)**

Domain 2 – Workforce health and wellbeing

Outcome	Evidence	Score / rating	Owner (Department/Lead)
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, Chronic Obstructive Pulmonary Disease (COPD) and mental health conditions	**Developing activity** identified for Age, Disability, Pregnancy and Maternity, Race, Sex. **Undeveloped activity** identified for Gender reassignment, Marriage and Civil Partnership, Religion and Belief and Sexual Orientation. Established staff networks for disability, neurodiversity, ethnic backgrounds, women, lesbian, gay, bisexual, transgender, queer, questioning, intersex, or asexual (LGBTQIA+). New workplace adjustments policy, toolkit and passport. We are not currently using the data we have to drive inclusion and identify gaps. For example, we are not monitoring the protected characteristic of wellbeing champions, TRIM practitioners and Mental Health First Aiders. We are not currently monitoring sickness and absence data by protected characteristics, therefore we are unlikely to identify or reduce negative impacts of the working environment where support is needed. However, there is a plan to do this. There is limited to no evidence around our gender diverse (trans, non-binary and asexual) workforce which limits our ability to make inferences and/or improvements to their experience. Male colleagues are less likely to access any mental health or other services available. The data on Electronic Staff Record (ESR) is based on NHS national data sets, which have not been updated for several years e.g. to include gender identity or specific health conditions or disabilities, e.g. neurodiversity.	1	Chief People Officer, EDI team, Wellbeing team, and other People and Culture teams.

Outcome	Evidence	Score / rating	Owner (Department/Lead)
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	**Developing activity identified for Age, Disability, Race, Sex, Sexual Orientation.** **Undeveloped activity** identified for Gender reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Religion and Belief. Launch of See Me First anti-racism campaign. Numerous policies and toolkits for staff and managers. Breakdown of data is available on Datix (incident reporting) based on patient, staff and visitor/other person behavior to another. Total of 2,024 cases reported in 2022. Less than 1% increase year by year. Data available from National Staff Survey, Workforce Race and Disability Equality Standard (WRES and WDES) shows that Black, Asian, and staff of ethnic backgrounds and disabled staff experience higher levels of abuse, harassment and bullying than White and non-disabled staff. Data is unavailable for protected characteristics of Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Religion and Belief. Datix incident reporting is not broken down by protected characteristic.	1	Chief People Officer, EDI team, Wellbeing team, and other People and Culture teams.
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical	**Developing activity** identified for Race, Religion and Belief, Sex, Sexual Orientation. **Undeveloped activity** identified for Age, Disability, Gender reassignment, Marriage and Civil Partnership, Pregnancy and Maternity. Number of services available such as Hospital Independent Domestic Violence Advocate (HIDVA), Vivup platform that provides 2/7 counselling service and resources. Established Freedom to Speak Guardians. New resolution policy and toolkit for staff and managers and Leadership	1	Chief People Officer, EDI team, Wellbeing team, and other People and Culture teams.

Outcome	Evidence	Score / rating	Owner (Department/Lead)
violence from any source	Development Programme for staff in a formal leadership role (TED) Module Team Engagement and Development Tool). Staff Networks do not have protected time which limits their ability to support staff and has an impact on their health conditions due to limited capacity. Specific protected characteristics identified where lack of resources and promotion of information is needed.		
2D: Staff recommend the organisation as a place to work and receive treatment	**Developing activity** Age, Race and Sex. **Undeveloped activity** identified Disability, Gender reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Sexual Orientation. **Achieving activity** identified Religion and Belief. Data from National Staff Survey informs the Trust that in the last 12 months a 6% improvement in relation to positive action on health and wellbeing has occurred. 39% of staff with a disability recommended as a place to be treated and 34.5% as a place to work. 77.78% of Asian/Asian British – Pakistani – African staff recommended as a place to work and 84.62% of Black/African/Caribbean/Black British- any other Black/African/Caribbean background staff were happy with the standard of care if a friend or relative needed treatment. Top 3 reasons for leaving the organisation are (1) Retirement (12.91%) (2) Work-life balance (11.31%) (3) Relocation (6.97%). No data or evidence has been provided for Gender reassignment, Marriage and Civil partnership, Pregnancy and Maternity, Religion and Belief, Sexual Orientation. Exit interview data is not currently monitored by protected characteristics, which means we are less likely to identify if a disproportionate number of staff are leaving with protected characteristics e.g. disabled staff.	0	Chief People Officer, EDI team, Wellbeing team, and other People and Culture teams.

Total score
Please total the scores for Domain 2**: 3 (three)**

Domain 3 – Inclusive leadership

Outcome	Evidence	Score / rating	Owner (Department/Lead)
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• Questionnaire to Board/Executive team • Culture and Leadership Board interviews • Some members of the Exec team who are Exec sponsors of Staff Networks demonstrating some activity due to this role. • Board have identified EDI as a priority. There is currently no system in place to gain feedback from all Band 9 and Very Senior Managers (VSMs) - to be added to the action plan. EDI Board objectives as part of the new EDI strategy should help to address this domain.	1	Chair, Chief Executive Officer and Executive team
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	A random sample of 5 Board papers were selected: **Integrated Performance Report for July (presented at September 2023 Board meeting) -** No mention or reference to EDI. **Chief Medical Officer's Report (presented at July 2023 Board meeting) -** Culture and Leadership Programme mentioned as an action to improve organisational culture. Makes reference to Specialty and Specialist (SAS) Away Day in May 2023 with focus on EDI. Corporate Risk Register (CRR) 118 – There is a risk of failure to address poor organisational culture. **Section 31 reporting**: **Maternity & Midwifery Services William Harvey Hospital (WHH) & Queen Elizabeth the Queen Mother**	0	Chair, Chief Executive Officer and Executive team

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	Hospital (QEQM) (presented at June 2023 Board meeting) - no mention or reference to EDI suggesting underdeveloped activity **We Care progress update (presented at June 2023 Board meeting) –** States there is a requirement for urgent and significant improvement in relation to staff attitudes and behaviours. But no risk mitigation or recommendations on how to address this. **Staff Experience Story (presented at May 2023 Board meeting) -** Makes reference to disability and staff member was supported by Head of EDI. The Board received two EDI sessions in 2023 and the Freedom to Speak Up reports include data by protected characteristics.		
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	The Trust recently had a Care Quality Commission (CQC) well-led inspection, so this evidence was used for this outcome. • The board were updated on progress of delivery of the Integrated Improvement Plan (IIP) and the associated performance metrics including the main risks impacting on delivery and linked to the Board Assurance Framework (BAF). • The Strategic Improvement Committee chaired by the Chief Executive Officer (CEO), with responsibility for overseeing the delivery of the IIP. The Strategic Improvement Committee was planned to meet every 2 weeks, reviewing 3 out of 6 programmes of work at each meeting. • There are systems and processes for managing risk; however, they were not always effective. • The trust had made improvements in how it included and communicated with users of the service and staff.	1	Chair, Chief Executive Officer and Executive team

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	• Breakdown of disciplinary and resolution cases by ethnicity, gender, religion, disability, sexual identity used by ER Team. **Not clear on the findings or actions. Requires further exploration** • Referrals to professional regulators being monitored by ethnicity, gender, religion, disability, sexual identity used by ER Team. **Not clear on the findings or actions. Requires further exploration.** • We are not currently reporting on sickness/absence by equality data**.** • Equality and diversity questionnaire that we send to all complainants to ask them to complete. • The pastoral care for international nurses was awarded the 'NHSE Pastoral Care Quality Award' in July 2023. Some plans in place but unclear on what impact this has had, as measures not consistent. Not clear on plans that sit underneath these. Sharing of good news stories. Achievements. Some clear actions taken but more needed. Staff engaged with on the EDS doubt whether anything will change.		

Total score
Please total the scores for Domain 3: **2 (two)**

Third-party involvement in Domain 3 rating and review: **Staff Experience and Wellbeing, Staff Networks, International Recruitment (IR) / Pastoral support, Occupational Health, Standard Assurance Team (CQC), Chaplaincy Service, Risk Management, Organisational Development (OD) Business Partners, Site Heads of People and Culture, People and Culture Business Partners.**

Trade union reps: **Yes**

Independent Evaluator(s)/Peer Reviewer(s): **External NHS Organisation**

EDS organisation rating (overall rating)

Name of organisation(s): **East Kent Hospitals University NHS Foundation Trust**

Overall score and rating: **8 – Developed (but at lowest level of developed)**

- total score under 8 = Undeveloped
- total score between 8 and 21 = Developed
- total score between 22 and 32 = Achieving
- total score 33 = Excelling

Section 3 – EDS action plan

EDS lead: **Head of Patient Voice and Involvement (Domain 1) / Head of EDI (Domains 2 and 3)**

Years active: **2023/24**

EDS sponsor: **Chief Nursing and Midwifery Officer / Chief People Officer**

Authorisation date: **Trust Board, 1 February 2024**

Domain 1 – Commissioned or provided service

Outcome	Objective	Action	Lead (s)	Completion date
1A: Patients (service users) have required levels of access to the service	Improve the collection and use of patient's demographic data to monitor uptake of services (including Did Not Attends (DNAs)) and waiting times for diagnostics and treatment.	Patient caseload, waiting times and DNAs to be monitored by age, disability, ethnicity, gender identity, religion and belief, sexual orientation and Index of Multiple Deprivation.	Chief Analytics Officer, with support from the Business Information team and Care Group senior teams.	February 2025
1B: Individual patients (service users) health needs are met	Fully implement the Reasonable Adjustments Digital Flag (RADF) and Accessible Information Standard.	Ensure these are on the main patient record systems, and the Patient Portal, with appropriate flags.	IT Care Group senior teams	June 2024
1C: When patients (service users) use the	We can provide evidence that patients with protected characteristics of age, disability, and ethnicity, do not	Patient harms to be reported and monitored based on demographic data including age, disability, ethnicity, gender	Care Group senior teams, corporate teams (falls, pressure ulcers, safeguarding), governance	December 2024

Outcome	Objective	Action	Lead (s)	Completion date
service, they are free from harm	disproportionately experience harm.	identity, religion and belief, sex and sexual orientation.	leads, Business Information teams	
1D: Patients (service users) report positive experiences of the service	Monitor and report patient experience by patients' protected characteristics.	Engage with and consider the different needs of local communities, including reaching people via voluntary, community and social enterprise sector organisations, to hear from people who are underserved, experience greater health inequalities and are less likely to get their voices heard. Pilot patient experience surveys in other languages.	Information team and Patient Voice and Involvement team IT and Patient Voice and Involvement team.	February 2025 February 2025

Domain 2 – Workforce health and wellbeing

Outcome	Objective	Action	Completion date
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	To ensure that all staff access health and wellbeing support in proportion to their representation in the workforce. And that this support is culturally appropriate and inclusive.	- Sickness and absence data monitored by protected characteristics - Monitor protected characteristic of wellbeing champions, TRIM practitioners and Mental Health First Aiders	February 2025
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	To reduce the abuse, harassment, and bullying that staff experience at work from colleagues, managers, patients, and their families, ensuring that staff who are disabled or of ethnic backgrounds do not experience this disproportionately to their representation in the workforce.	- Datix incident reporting to be broken down by protected characteristics. - analysis of Freedom to Speak up cases by protected characteristics. - analysis of grievances by protected characteristics.	February 2025
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Staff Networks are supported and developed to provide a safe space for staff; to act as a voice for staff with protected characteristics; to be able to identify gaps in support for staff with protected characteristics	- introduce a Staff Networks policy that includes protected time for Staff Network officers - Pilot training for managers on cultural competence and inclusion.	February 2025

Outcome	Objective	Action	Completion date
2D: Staff recommend the organisation as a place to work and receive treatment	To provide an inclusive work environment, free from discrimination, where staff's lived experience is seen as an asset and supports inclusive patient care.	- Monitor and report exit interview data by protected characteristics. - Central budget for reasonable adjustments for disabled staff. - Cultural competency training as part of Health Care Support Worker and Admin Staff development.	February 2025

Domain 3 – Inclusive leadership

Outcome	Objective	Action	Completion date
3A: Board members, senior leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	The Trust has Board members, senior leaders and managers who are culturally competent, inclusive and who demonstrate their understanding of, and commitment to workforce equality and reducing health inequalities for patients and their families.	- Board members and senior leaders should provide regular feedback on how they are promoting equality and reducing health inequalities in their area of responsibility - Executive Directors to have an objective related to EDI in their annual objectives.	February 2025
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	EDI to be part of the golden thread from Board to ward.	- An Equality Impact Assessment section to be added to every Board paper setting out the impact, mitigations, and risks in terms of people with protected characteristics.	February 2025
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	To identify inequalities and unwarranted variations in workforce representation and career progression and in patient access by protected characteristics and actions to reduce inequalities and monitor their impact to assess where there are positive changes taking place.	- Career progression and representation monitored by age, disability, ethnicity, gender identity, religion and belief, sex, and sexual orientation, by staff groups – Bands 9 and VSM, Bands 8a to 8d, Bands 6 to 7, Bands 4 to 5, Bands 2 to 3 - Waiting lists, DNAs and Incidents monitored by patient's protected characteristics.	February 2025

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Winter Plan - Financial Assessment**

Meeting date: **1 February 2024**

Board sponsor: **Interim Chief Operating Officer (COO)**

Paper Author: **Programme Manager to the Interim Chief Operating Officer (COO)**

Appendices:

Appendix 1: EKHUFT Winter Plan Summary Report February 2024
Appendix 2: Urgent & Emergency Care (UEC) Improvement Plan

Executive summary:

Action required:	Information
Purpose of the Report:	To respond to the Board request for short summary detailing the specific work and actions of the winter support schemes with a timeline when these would be implemented, breakdown of how the winter funding had been utilised, and summary of the refreshed Trust's winter and escalation plans when completed aligning these with the revised Operational Pressures Escalation Levels (OPEL) framework. Further to this request, and incorporated into Appendix 1, is a costed estimate of the anticipated financial impact this winter related to the opening of escalation beds across the Trust, management of corridor care, and additional patient volumes being seen in the Trust's Emergency Departments (EDs). Note this was presented to the Finance and Performance Committee (FPC) on 9 January 2024.
Summary of key issues:	Winter plan - external support This slide gives you the waterfall breakdown of the schemes in progress and the expected bed impact to mitigate against increases in demand this winter. Those in green indicate the live schemes, and those in orange remain a work in progress. As of 24 January, the Trust reported 1148 General & Acute (G&A) beds open, in addition to 18 (William Harvey Hospital (WHH)) and 16 (Queen Elizabeth the Queen Mother Hospital (QEQM)) additional escalation spaces open across the Trust's ED corridors. The current bed base in use exceeds the 'Revised demand forecast' by 34, suggesting that the implemented schemes are actively working to mitigate a degree of the demand with some of the schemes anticipated impact falling a short of expectation. The detail of the position of each of the winter schemes can be found in the UEC Improvement plan included as Appendix 2.

UEC Additional Funding
The Trust was provided with funding for several schemes at the start of the financial year to support winter pressures. This included Same Day Emergency Care (SDEC) extended the hours of SDEC provision, increased discharge lounge capacity, monies for staffing across newly created bed space following reconfiguration exercises, extended frailty provision and, more recently, the rollout of Single Point of Access trials a both acute sites.

The breakdown of funding is provided in Appendix 1. The Board are asked to note the values listed are subject to review as the Trust evaluates the costed position of each scheme vs the actual spend. This work is in progress with the Trust's finance leads and will report back to the Integrated Care Board (ICB).

'Winter plan - Costings'
A thorough audit of the Trust's bed base over recent months has been conducted. This audit assessed:

- G&A bed capacity currently within budget and staffing establishment;
- G&A bed capacity supported by outturn funding pending an establishment review;
- The use of frequently used and infrequently used escalation beds;
- And a complementary exercise determined additional bed capacity for extreme winter pressures.

This detailed audit forms the basis for a formulaic-based costing model for winter, with key assumptions:

- Additional bed capacity costed using 2022/23 National cost collection, uplifted to 2023/24 cost base – calculated at individual ward level and consisting of variable ward related costs only;
- Additional bed capacity assessed for whether a non-pay only impact (e.g. +1's) or a pay/non-pay impact. Non-pay cost per bed day applied where applicable;
- Diagnostics cost per bed day applied to all additional beds;
- Additional UEC costs and drug spend (non-rechargeable) estimated based on 2022/23 expenditure trend over the December - March winter period;
- Additional Mortuary costs estimated based on 2022/23 cost of additional capacity and uplifted to 2023/24 cost base.

The forecast estimates a total winter pressure uplift of £5,261m, with a worst-case scenario figure of £7,441m, should 'super surge' capacity be triggered.

Should the Trust need to go into Super surge beds (worst case scenario), this would impact elective activity (loss of income), endoscopy (loss of income) and key services across the Trust's EDs (i.e. SDEC, Medical Assessment Units (MAUs)) directly impacting flow. This has not been modelled at this stage.

East Kent Hospitals University NHS Foundation Trust

	Full Capacity Protocol: Work continues to review the Trust's Full Capacity Protocol to develop targeted action plans associated with OPEL and to support Trust wide escalation and de-escalation plans in response to demand. It is anticipated a revised draft will be circulated to site Managing Directors (MDs) in March 2024. Alongside the development of the Full Capacity Protocol, a review of site management systems and processes is underway with an emphasis on the development and implementation of robust Trust wide site management functions and on-call arrangements. It is anticipated that proposals will go to MDs and Site Tris in mid-February 2024 for consideration. The outcome of this review will contribute to the content and development of the Full Capacity Protocol.
Key recommendations:	The Board of Directors is asked to **NOTE**: • the position and impact of the planned winter schemes; • the costed estimate of the anticipated financial impact this winter; • the status of the Full Capacity Protocol review.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	**BAF 34:** Failure to deliver operational constitutional standards.
Link to the Corporate Risk Register (CRR):	**CRR 78:** Risk of overcrowding in ED compromising patient safety and patient experience. **CRR 84**: Deteriorating Patient.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Winter plan presented to Board of Directors in November and December 2023 and Finance and Performance Committee (FPC) 9 January 2024.

We care

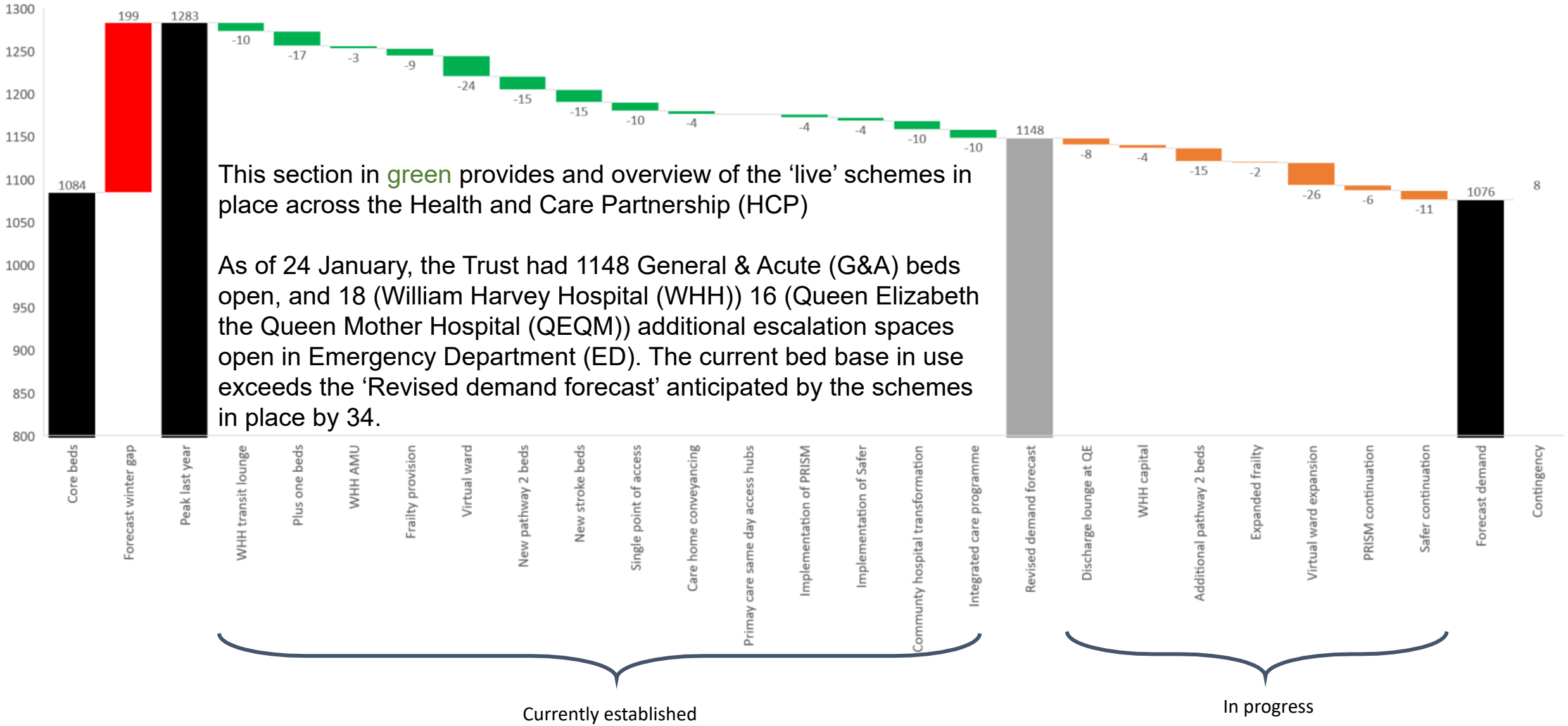
East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals Winter Plan Update

Report to Open Board
February 2024

Winter plan – external support

East Kent Hospitals University NHS Foundation Trust



This section in green provides and overview of the 'live' schemes in place across the Health and Care Partnership (HCP)

As of 24 January, the Trust had 1148 General & Acute (G&A) beds open, and 18 (William Harvey Hospital (WHH)) 16 (Queen Elizabeth the Queen Mother Hospital (QEQM)) additional escalation spaces open in Emergency Department (ED). The current bed base in use exceeds the 'Revised demand forecast' anticipated by the schemes in place by 34.

Note: Version Control - UEC Winter Scheme waterfall position as of 20 December 2023

EKHUFT – Urgent & Emergency Care (UEC) Funding

NHS East Kent | Hospitals University NHS Foundation Trust

Owner	Scheme	Total Funding £000's	
EKHUFT	Discharge lounge	£645	WHH Transit Lounge in since start of the financial year and in use as escalation beds – ten additional beds QEQM discharge lounge area – eight additional beds and includes enhancement of the First Aid Unit (FAU) provision
EKHUFT	WHH and QEQM reconfiguration	£634	20 additional beds – 17 +1s at QEQM, three additional Acute Medical Unit (AMU) beds
EKHUFT	Extended Frailty provision	£155	Increased frailty bed provision and front door services
EKHUFT	Medical Day Unit (MDU) capacity at Kent & Canterbury Hospital (K&C)	£192	Scheme not commenced due to on site capacity, recruitment and health and safety considerations.
EKHUFT	Same Day Emergency Care	£1,010	Extended hours of Same Day Emergency Care (SDEC): WHH 5pm – 11pm 7 days per week QEQM 5pm – 8pm 5 days per week

- The values listed above are subject to review as the Trust assesses the costed position of each scheme (as above) vs the actual spend. This work is in progress with the Trust's finance leads and will report back to the Integrated Care Board (ICB).

- A full breakdown of the UEC additional funding can be found in appendix 2.

Winter plan – Demand increased in December primarily driven by an increase in Type 1 attendances

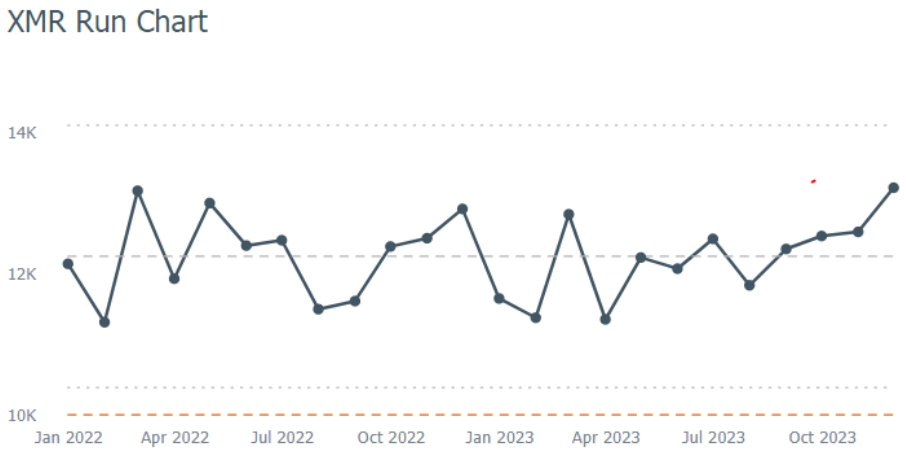
East Kent Hospitals University NHS Foundation Trust

Total Arrivals Inc cMIU

Timescale	Value	SPC
01-Jan	28.5K	
01-Feb	27.8K	
01-Mar	31.4K	
01-Apr	28.4K	
01-May	31.2K	
01-Jun	30.6K	
01-Jul	30.8K	
01-Aug	29.7K	
01-Sep	30.3K	
01-Oct	30.5K	
01-Nov	30.7K	
01-Dec	32.0K	

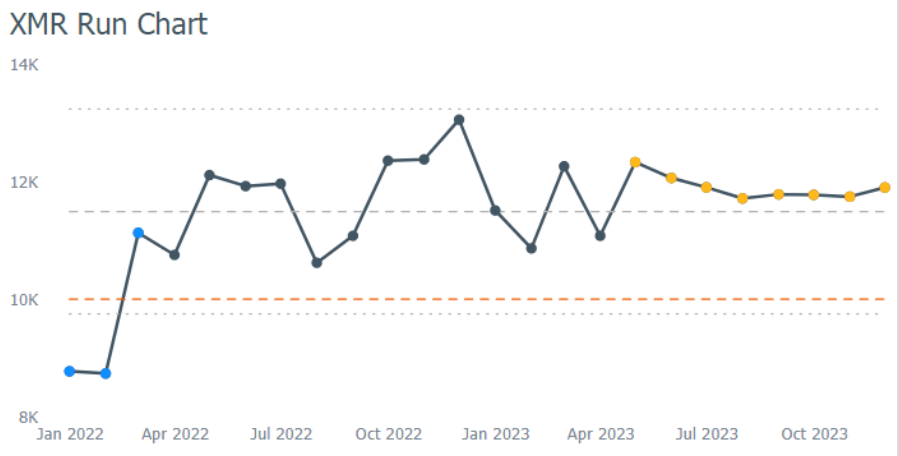
Type 1 Arrivals

Timescale	Value	SPC
01-Jan	11.6K	
01-Feb	11.4K	
01-Mar	12.8K	
01-Apr	11.4K	
01-May	12.2K	
01-Jun	12.1K	
01-Jul	12.5K	
01-Aug	11.8K	
01-Sep	12.4K	
01-Oct	12.5K	
01-Nov	12.6K	
01-Dec	13.2K	



Type 3 Arrivals

Timescale	Value	SPC
01-Jan	11.5K	
01-Feb	10.9K	
01-Mar	12.3K	
01-Apr	11.1K	
01-May	12.3K	
01-Jun	12.1K	
01-Jul	11.9K	
01-Aug	11.7K	
01-Sep	11.8K	
01-Oct	11.8K	
01-Nov	11.7K	
01-Dec	11.9K	



Winter plan Costings

NHS East Kent | Hospitals University NHS Foundation Trust

£5.1m estimate for the increase in costs linked to winter pressures has been included in the forecast, since month 5. This estimate was based on a review by Care Group finance leads on the increase in expenditure trend over the December 2022 to March 2023 winter period. This was a holding position, pending the more detailed piece of work which has now been progressed.

Winter plan bed model

The bed model assumes:

- No improvement to current Length of Stay (LOS)
- Demand at the front door remains consistent

Assumptions in Winter Plan detailed costed model

- Additional bed capacity costed using 2022/23 National cost collection, uplifted to 2023/24 cost base – calculated at individual ward level and consisting of variable ward related costs only
- Additional bed capacity assessed for whether a non pay only impact (e.g. +1's) or a pay and non pay impact. Non pay cost per bed day applied where applicable
- Diagnostics cost per bed day applied to all additional beds
- Additional UEC costs and drug spend (non-rechargeable) estimated based on 2022/23 expenditure trend over the December-March winter period
- Additional Mortuary costs estimated based on 2022/23 cost of additional capacity and uplifted to 2023/24 cost base

Winter plan – Estimated financial impact

NHS East Kent | Hospitals University NHS Foundation Trust

	Beds	Cost £000 December-March	Current run-rate / Winter pressures
Regular Use Core Unestablished	62	£5,600	In current run-rate
Regular use +1s escalation beds	17	£299	In current run-rate
TOTAL already in current run-rate – 4 months	**79**	**£5,899**	
Wards outlined for available capacity on site reports escalation beds	11	£195	Winter pressures
Additional capacity to be used at times of extreme pressure escalation beds	18	£1,659	Winter pressures
Further additional areas used in time of extreme pressure – in regular use	24	£1,727	Winter pressures
Additional UEC winter costs		£1,241	Winter pressures
Additional Drugs winter costs (non-rechargeable)		£376	Winter pressures
Additional Mortuary winter costs		£63	Winter pressures
TOTAL Winter Pressure estimate – 4 months	**53**	**£5,261**	
Further additional areas used in time of extreme pressure. Super surge - used in extreme circumstances only	80	£2,180	Winter pressures – Worse case scenario
TOTAL Winter pressures – worst case scenario – 4 months	**133**	**£7,441**	

To note:
- 62 beds are in regular use throughout the year and are included in our current run rate. These beds have been funded as part of the £72m deficit plan agreed at the beginning of the financial year, however, work is ongoing to establish these beds formally (in terms of Whole Time Equivalent (WTE)) under the new Care Group structure.
- Should we need to go into Super surge beds (worst case scenario), this would impact elective activity (loss of income), endoscopy (loss of income) and key services across the Trust's emergency departments (i.e. SDEC, MAUs) directly impacting flow. This has not been modelled at this stage.

Winter plan – Monitoring

East Kent Hospitals University NHS Foundation Trust

- Further review of escalation bed criteria and reporting
- Reset of core and escalation beds across the Patient Administration Systems (PAS). Centrally held count of core and escalation bed stock
- On-going review of escalation bed usage as the Trust flexes bed capacity
- Site bed reconfiguration actioned to reduce reliance on ED corridor care
- Regular updates provided by the HCP via the EK Urgent Care Delivery Group related to the status and position of proposed schemes to reduce demand
  - HCP widened the criteria to Hilton beds , increasing uptake and throughput of P1/P2 patients
  - Home first initiative Thanet – to reduce the number of pts admitted waiting on care at home support
  - Single point of access (SPOA) WHH – reducing conveyances with plan to roll out to QEQM end of January
  - Focussed work on care home conveyances – top 20 Nursing Homes (NH) reviewed with access to Primary care support to reduce conveyances to ED

Full capacity protocol

NHS
East Kent
Hospitals University
NHS Foundation Trust

- Work continues to review the Trust's Full Capacity Protocol to develop targeted action plans associated with OPEL and to support Trust wide escalation and de-escalation plans in response to demand.
- It is anticipated a revised draft will be circulated to site Managing Directors (MDs) in March 2024.

- Alongside the development of the Full Capacity Protocol, a review of site management systems and processes is underway with an emphasis on the development and implementation of robust Trust wide site management functions and on-call arrangements.
- It is anticipated that proposals will go to MDs and Site Tris in mid-February 2024 for consideration. The outcome of this review will contribute to the content and development of the Full Capacity Protocol.

East Kent UEC Improvement Plan

Priority	Scheme	Description	Lead	Current position	RAG status	Sum of Total funding (£k)	Sum of Bed impact (updated)
1. Increasing Urgent and Emergency Care Capacity	Extended Frailty provision	Extend Frailty Service to 8-8 at QEQM and WHH (extend 2 hours per day)	SC	Extended 8-8 at QEQM and WHH (extend 2 hours per day)	COMPLETED	155	11
	Mental Health Scheme - Implementation of Crisis Houses	Implementation of Crisis Houses to reduced extended stays for mental health patients within ED.	(blank)	• A 12-month contract has been awarded for a 5 bedded house in Medway, plan to open in mid-Jan-24. • Available to all patients across KM patients. • KMPT HTT will gatekeep access to ensure parity of access across KM. • Procurement for additional Crisis Houses underway.	COMPLETED	0	
	WHH and QEQM reconfiguration	Transit lounge at WHH WHH and QEQM capital	SC	30 beds established (17 plus1 beds, 10 Transit Lounge WHH, 3 AMU WHH). A proposal for an additional 4 bed WHH (Capital) is being taken through CEMG in Jan-23	AMBER	634	34
	Implementation of Safer with KPMG	GIRFT recommendations: KPMG Implementation of Safer Bundle including implementation of agreed inter-professional standards for speciality review (inc review of existing general medicine rota).	SC	• This work continues to contribute to a reduction in overall length of stay numbers. • A progress report will be shared with EKHUFT Board in January 2024	AMBER	0	4
	Same Day Emergency Care	To develop and increase SDEC capacity - Extending Hours at QEQM and WHH.	SC	• Extension of medical SDEC hours complete and slots are being provided for patients arriving OOH to attend the next day. • Focussed work and training is taking place to enable front door clinicians to directly access SDEC pathways. • Work to be undertaken to enable SECAMB and SPoA to directly access SDEC.	AMBER	1,210	
	Clinical Decision Unit (CDU)	Location and Model for Clinical Decision Unit (CDU) for both acute sites to be implemented.	SC	QEQM unit in place, WHH will be in place pending the ED build and reduction of DTA position in department.	AMBER	0	

Priority	Scheme	Description	Lead	Current position	RAG status	Sum of Total funding (£k)	Sum of Bed impact (updated)
1. Increasing Urgent and Emergency Care Capacity	MDU capacity at KCH	Establish Medical Day Unit (MDU) provision at Kent & Canterbury Hospital	CS	Based at Kent and Canterbury Hospital. The pathways have been established. Work in progress to recruit as a next step. The pathways element of the action is complete but the service is yet to start.	AMBER	192	
	Mental Health Programme - Review KMPT psychiatric liaison provision	Review KMPT psychiatric liaison provision	SG	• Recruitment to Psychiatric Liaison posts has been challenged however, there has been more interest in latest round of recruitment. • Opportunities to support being explored, review of current staff alignment under consideration, escalation process in place. • Discussions taking places regarding how each of the liaison services is core 24hr compliant, which will mean effectively more resource particularly at WHH.	AMBER	0	
	Health Equity and Population Health Review of ED Attendances	Undertake a Health Equity and Population Health Review of ED Attendances	(blank)	Report presented to IDG and UEC Board.	COMPLETED	0	
3. Improving Discharge	Community hospital productivity and flow	Escalation beds Additional capacity within P2 for re-enablement and rehabilitation.	CT	The number of patients No Longer Fit to Reside (NLFTR) in the Community hospital had been reducing. Prior to Christmas, the service worked to accept referrals off protocol in order to support patient flow . This has caused an temporary increase in patients NLFTR. Work is underway to re-gain a positive position.	GREEN	469	10
	New Pathway 2 beds	Establish 30 beds across Westview and Westbrook sites	CT	Mobilisation of 30 new beds is on track at Westview (x15 beds) and Westbrook (x15 beds). 22 beds are live, the remainder will come on line by 22 January 2024.	AMBER	1,350	30

Priority	Scheme	Description	Lead	Current position	RAG status	Sum of Total funding (£k)	Sum of Bed impact (updated)
3. Improving Discharge	Implement Pathway 2 Transformation Programme	Implement Pathway 2 Transformation Programme to include : Defining pathways 2 and 3(based on the principles of Home First, Discharge to Assess and 'What matters to me'). Maximising the use of in-house bedded capacity within KCHFT and KCC (with clearly defined pathways for rehabilitation, enablement and recovery).	CT	More face-to-face reviews of people who have been placed in a care home (pathway 3) to understand the person's journey and financial/resource impact for the system has validated there are many opportunities within existing resources to improve length of stay and increase the number of people who are supported at home. Meetings taking place and in planning process to explore these opportunities and to undertake process mapping of current pathway.	GREEN	0	
	Develop and implement K&M Setting Expectation Policy.	Develop and implement K&M Setting Expectation Policy (was Choice Policy).	LS	• Policy is drafted and shared with EK organisations to operationalise. • Presenting the policy at the SE ADASS event on the 12th Dec-23 to share the work developed locally. Recognition of the good work undertaken. • There is potential for the east Kent document to be implemented across a wider footprint.	GREEN	0	
	Develop home based pathway with live-in care for people with dementia and delirium	Live-in care involves a dedicated, full-time, carer moving into the home to support with care needs as well as domestic tasks This scheme enables patients stay at home as they wish instead of being discharged to a PW3 bed.	LS	• W/C 11th Dec-23, first two patients discharged from acute with support from the 24-hour live in care service • Initially 24-hour care will be provided for 7-days, with a review of on-going care needs being undertaken. • Access to the scheme is coordinated by EK Carers. Live-in care is provided by Elder.	AMBER	0	

Priority	Scheme	Description	Lead	Current position	RAG status	Sum of Total funding (£k)	Sum of Bed impact (updated)
3. Improving Discharge	Development of existing short-term beds in sheltered housing	Development of existing short-term beds in sheltered housing (Home bridge – Farrow Court) across East Kent	LS	Multi-agency discussions continue to review previous years bed usage as a benchmark for improvement moving forward into this winter. A Task and Finish Group has been formed to consider future criteria, throughput and recognition of recovery element of recent acute episode. A review of people who have been placed in this facility to take place to understand the person's journey with a view to improving flow, address some of the current blockages and articulating how these beds can be accessed.	GREEN	0	
	Discharge lounge at QEQM	Staffing and facilities for QEQM Discharge Lounge	SC	• A paper has been prepared seeking approval to provide an 8 bedded transit lounge at QEQM, this is in addition to the current discharge lounge. • The transit lounge will allow overnight stays; patients can go in there the day before with a planned discharge the next day. • The proposal is being taken through CEMG in Jan-23	AMBER	645	8
	Discharge taskforce	Includes: Agree improving discharge metrics Discharge Support Oversight Group (DSOG)	JS	(blank)	GREEN	0	

Priority	Scheme	Description	Lead	Current position	RAG status	Sum of Total funding (£k)	Sum of Bed impact (updated)
3. Improving Discharge	Homelessness pathway	Implementation of acute based homelessness pathway	HW	Expansion of programme from 2-5 days is underway and fully implemented 92% of consenting homeless patients referred to the Local Authority under the Duty to Refer 100% of patients who do not have a GP assisted to register with a GP that they can access on discharge 100% of inpatients receive a holistic assessment 54% of patients have housing status recorded on BOTH admission and discharge As of July 18, patients rough sleeping on admission 4 out of the 18 discharged to rough sleeping team.	GREEN	0	
	Implementation of Prism	To be added.	SC	• This work continues to contribute to a reduction in overall length of stay numbers. • A progress report will be shared with EKHUFT Board in January 2024	AMBER	0	4
	Intermediate Care Programme - Additional Discharge Co-ordinators	Additional capacity to coordinate the day-to-day process of patient discharge and decrease length of stay for complex discharges. 4 x Band 4/5 in total	(blank)	Awaiting outcome of potential Tier 1 funding.	GREEN	25	
	Intermediate Care Programme - Voluntary Sector capacity	Expand voluntary sector capacity to prevent avoidable admissions and facilitate discharge	LS	• Red Cross transport and settling in service has been recommissioned. • Additional funding provided to Social Enterprise Kent, enabling EK Carers to coordinate access to Live-In Care support (home based pathway enabling live-in care for people with dementia and delirium).	GREEN	477	

Priority	Scheme	Description	Lead	Current position	RAG status	Sum of Total funding (£k)	Sum of Bed impact (updated)
3. Improving Discharge	Intermediate Care Programme - Home First Support Workers	Recruit and develop generic health and social care home first support workers to support pathway 1. Flexible can also support single handed assessment.	LS	• 7 First Home Support workers are employed in Thanet. A further 7 have been recruited to and undertaking induction training with an additional 10 more still to be recruited. • 9 patients have been supported by the service and 2 patients have been discharged from service. • Showing positive outcomes, W/C 4th Dec-23 there was a day when no PW1 patients were awaiting discharge from QEQM.	GREEN	741	
	Intermediate Care Programme - Telecare and Telehealth schemes	Tech facilitators and pharmacy costs	JB	Funding used for tech facilitators in November (£25K) pharmacy costs still to be calculated.	GREEN	165	
	Mental Health Programme - Mental Health IDT	Develop Mental Health IDT (subject to Tier 1 funding)	(blank)	Awaiting outcome of potential Tier 1 funding.	GREEN	110	
	Transfer of Care Hubs	To develop the established Transfer of Care hubs and to provide additional assessment/admin capacity in hubs during winter.	LS	Transfer of Care Hubs in place 7 days. Continued development of service including roll-out of new referral form 'What Matters to Me', enabling Ward staff to refer into ToC hubs earlier in the patient pathway by describing what they believe the patient might need. The patient does not have to be medically fit for discharge at the point of referral.	GREEN	247	
	UEC additional discharge capacity through BCF	To be added.	(blank)	Funding position to be clarified.	(blank)	1,540	10
	New stroke beds	Programme to establish 15 beds	CT	15 new beds currently occupied.	COMPLETED	782	15
	Reporting of Pathway 1-3 patients across EKHUFT & RTS teams	Agreement on "One version of the truth" reporting on Pathway 1-3 patients across EKHUFT & RTS teams.	LS	PTL on Sunrise is now a joint PTL used by the RTS and the Trust which will allow progression towards one version of the truth. Awareness of the need to observe the impact of the Discharge Ready figures in the faster-SUS data as is based on right to reside and the work to-date has been based upon medically optimised patients.	COMPLETED	0	

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3. Improving Discharge	Single handed care training	Completion of Single handed care training for 72 therapy staff across KCHFT and EKHUFT.	LS	The training has been completed. An SBAR will be developed to outline the next steps and work continues with system partners to widen training opportunities / embed in mandatory training. Work continues to widen training opportunities and embed in mandatory training.	COMPLETED	0	
4. Expanding Care Outside Hospital	Care Home conveyancing	Additional support to GP Confederation to prevent attendance Includes: Project team to be formed to lead on implementation of RESPECT forms across acute & community care	OW	Support mobilised 21/12/23 Regular reporting to ICB will be in place	AMBER	0	4
	High Intensity User Programme	Current service is provided by British Red Cross to offer holistic support to frequent attenders of ED.	SL	Work is led by ICB. Service is moving to monthly review of frequent attenders of ED services. PCN level data now available.	GREEN	0	
	Virtual Ward	Review EKHUFT and KCHFT Virtual Ward Pathways and capacity, including Complex Acute Response Team. Review of Programme will also include imaging pathways access both within hospital and direct community pathway.	CB	• 5857 patients treated via Virtual Wards to date. • Acute pathway is delayed at QEQM and subject to confirmation of staffing resource. Timeline to be confirmed • Further engagement required at WHH to progress pathways • Potential reduction in capacity of Cardiology pathway in next few weeks due to planned absences	RED	3,143	24

Priority	Scheme	Description	Lead	Current position	RAG status	Sum of Total funding (£k)	Sum of Bed impact (updated)
4. Expanding Care Outside Hospital	Diabetes MDT Clinics	Expand diabetes MDT clinics across east Kent	CT	Roll out of model underway with planned activity with a forecast of this programme of work to be in 10 PCN's by the end of March 2024. Continuation of funding is required and this project is showing positive patient outcomes. Diabetes peer support- diabetes data prevalence identified in East Kent Service specification written and procurement started. Clinics are live within three to PCN's (Herne Bay, Ramsgate, Romney Marsh). Will continue to expand the service through 2023/24.	COMPLETED	0	
	Pro-active care planning at Farrow Court	Pro-active planning of care being completed at Farrow Court in Ashford to understand health needs to prevent unnecessary primary care & hospital attendances	AF	Post code analysis of EKHUFT attendances (July 22 – Aug23) is complete. Recommendations will be provided and learning taken forward.	COMPLETED	0	
5. Making it Easier to Access the Right Care	Community SDEC Provision	Creation of a community SDEC provision to prevent unnecessary attendance to ED.	SR	Project to be scoped	RED	0	
	Mental Health Programme - reduce exisiting delayed transfers of care (dtoc) within KMPT	Agree management plan to reduce existing delayed transfers of care (DTOC) within KMPT footprint. Multi-disciplinary team approach in place. (ICB led priority)	LC	• A working group has been established under bed strategy reviewing DTOCs • There are currently 54 patients in acute beds that are clinically ready for discharge. • Significant numbers of delays resulting from housing issues (LA responsibility).	AMBER	0	
	Mental Health Programme - Safe Haven at QEQM	Establish Mental Health open access Safe Haven at QEQM site	SC	• Safe Haven mobilised W/C 27 Nov-23, 7 days a week from 6pm to 11pm (working to increase hours to 24-hour cover). • Positive outcomes noted in the first week. 10 patients diverted from ED and a further 12 patients who self-presented at the Safe Haven have accessed the service and gone home. • Acute and mental health teams have met to discuss front door triaging, capacity, and redirection of patients to the Safe Haven.	GREEN	0	

Priority	Scheme	Description	Lead	Current position	RAG status	Sum of Total funding (£k)	Sum of Bed impact (updated)
5. Making it Easier to Access the Right Care	Palliative and End of Life Care (PEOLC) hub	Development of PEOLC hub: includes out of hours specialist triage for PEOLC (Kent & Medway wide)	RP	To be included within KM EOL model and prioritised for Winter 23/24. Part of the Kent and Medway PEOLC Strategy (PEOLC and AW Group). Currently with execs for approval for finance - further HCP conversations following sign off re implementation.	GREEN	0	
	Primary Care Same Day Access Hubs	Short term pathways - Primary care capacity for winter	OW	• All sites, with exception of Deal/ Sandwich PCN are live (10 sites in total covering delivery of the service requirements (ie 7 days, 10hrs daily). • 39,480 pre-bookable appointments planned Dec - March 24. • Formal reporting will commence shortly, potential indication of reduced take up of Sunday appointments • Any unused appointment slots will be redistributed amongst practices	GREEN	1,242	

Priority	Scheme	Description	Lead	Current position	RAG status	Sum of Total funding (£k)	Sum of Bed impact (updated)
5. Making it Easier to Access the Right Care	Single point of access	Establish Single Point of Access in EK to coordinate patient care in alternative settings to Emergency Departments • ensure consistent and rapid access to clinical advice and alternative services • Increase avoidable conveyance, by implementing single points of access (SPOA) for paramedics. • SPOA's are staffed by qualified clinicians, able to ensure patients get referred to the most appropriate service for their needs. The "Perfect Month" and SPOA pilot will test the model and identify opportunities that will drive improvement in East Kent • East Kent Clinicians work together, building on SECAMB's 'perfect month', creating a Single Point of Access. • Throughout November 2023 Advanced Paramedic Practitioners will review all calls with a disposition of ambulance response (Ashford Hub) • Enhancing care opportunities	JS	• Positive impact on reducing conveyances continues via Ashford (WHH) SPOA • EKHUFT, KCHFT and SECAmb collaborating to expand SPOA in Thanet (QEQM) • Working group to agree Clinical workforce model and Governance arrangements to ensure appropriate resource is available to support safe delivery across EK. • Providers continue to refine alternative pathways to ED as point of referral for SPOA • Work will continue at pace post Jnr Dr. Industrial Action Jan 24. subject to Board approval.	AMBER	345	10
	Mental Health Programme - Safe Haven at WHH	Establish MH Open Access Safe Haven at WHH site	LC	Funding is confirmed to provide MH Safe Haven at WHH. Location needs to be identified, potential sourcing of Portakabin facility. Await confirmation of timeline.	GREEN	0	
	Coordinate my Care	Care planning pump priming for patients in last year of life. Pilot in East Kent	RP	Decision has been made to develop existing pathways and available access to records . Identification and Care planning for patients in last year of life will be consumed within KM EOL wide model. This work is underway for Winter 23/24.	COMPLETED	0	
	Integrated Neighbourhood Teams	Plan to set-up Integrated Neighbourhood Teams (INT) via 4 early adopter sites.	CB	Four early adopted sites established and work to embed teams continues.	COMPLETED	0	

Priority	Scheme	Description	Lead	Current position	RAG status	Sum of Total funding (£k)	Sum of Bed impact (updated)
Grand Total						13,470	164