Board of Directors - Open Meeting (Thursday 4 April 2024)

Thu 04 April 2024, 01:00 PM - 04:55 PM

Webinar teleconference

East Kent Hospitals University NHS Foundation Trust

Agenda

OPENING/STANDING ITEMS

01:00 PM - 01:10 PM
10 min

24/1 Welcome and Apologies for Absence

To Note *Acting Chairman*

Verbal

01:10 PM - 01:10 PM
0 min

24/2 Confirmation of Quoracy

To Note *Acting Chairman*

Verbal

01:10 PM - 01:10 PM
0 min

24/3 Declaration of Interests

To Note *Acting Chairman*

24-3 - Board of Directors register of interests - April 2024.pdf (3 pages)

01:10 PM - 01:10 PM
0 min

24/4 Minutes of Previous Meeting held on 1 February 2024

Approval *Acting Chairman*

24-4 - Unconfirmed BoD 01.02.24 Open Minutes.pdf (16 pages)

01:10 PM - 01:10 PM
0 min

24/5 Matters Arising from the Minutes on 1 February 2024

Approval *Acting Chairman*

24-5 - Front Sheet Open BoD Action Log.pdf (4 pages)

People

01:10 PM - 01:55 PM
45 min

24/6 NHS Staff Survey Report (1.10 pm to 1.25 pm)

Discussion *Chief People Officer (CPO)*

- 24-6.1 - Responding to NHS Staff Survey v2.pdf (3 pages)
- 24-6.2 - App 1 NSS23 Benchmark Reports_RVV.pdf (146 pages)
- 24-6.3 - App 2 - Responding to 2023 NHS Staff Survey_v2.pdf (15 pages)

24/6.1
Staff Experience Story – Freedom to Speak Up (FTSU) Service (1.25 pm to 1.55 pm)

- 24-6.1.1 - Staff Experience Story Freedom to Speak Up (FTSU) Service.pdf (2 pages)
- 24-6.1.2 - App 1 EKHUFT Staff Experience Story FTSU checklist.pdf (2 pages)
- 24-6.1.3 - App 2 FTSU case study.pdf (1 pages)

REGULATORY AND GOVERNANCE

01:55 PM - 02:00 PM
5 min

24/7
Acting Chairman's Report

Information *Acting Chairman*

- 24-7 - Acting Chairman BoD Report FINAL April 2024 v2.pdf (4 pages)

02:00 PM - 02:10 PM
10 min

24/8
Chief Executive's (CE's) Report

Discussion *Chief Executive*

- 24-8 - CEO Report to Board - April 2024 V.1.pdf (7 pages)

02:10 PM - 02:40 PM
30 min

24/9
Integrated Performance Report (IPR)

Discussion *Chief Executive / Executive Directors*

- 24-9.1 - Front Sheet Feb IPR.pdf (3 pages)
- 24-9.2 - App 1 Board IPR_v5.0_Feb24_FINAL.pdf (65 pages)

24/9.1
Month 11 Finance Report

Information *Interim Chief Finance Officer (CFO)*

- 24-9.1.1 - Front Sheet M11 Finance Report.pdf (2 pages)
- 24-9.1.2 - App 1 M11 Finance Report FINAL SHORT 202411.pdf (8 pages)

02:40 PM - 02:50 PM
10 min

24/10
Report on Journey to Exit NHS Oversight Framework (NOF4) and Integrated Improvement Plan (IIP)

Discussion *Chief Strategy & Partnerships Officer (CSPO)*

- 24-10.1 - Board Front Sheet IIP Progress Report 26.03.24.pdf (2 pages)
- 24-10.2 - Appendix 1 Board IIP Report FINAL 21.03.24.pdf (18 pages)
- 24-10.3 - Appendix 2 Trust Risk Register IIP Programme 21.03.24.pdf (5 pages)

02:50 PM - 03:00 PM
10 min

24/11
Risk Register Report

Assurance *Chief Nursing & Midwifery Officer (CNMO)*

- 24-11.1 - Risk Report Board of Directors Public 4 April 24.pdf (10 pages)
- 24-11.2 - Appendix 1 Significant Risk Report for BoD 4 April.pdf (63 pages)

03:00 PM - 03:10 PM
10 min

TEA/COFFEE BREAK 2:30 - 2:40

03:10 PM - 04:00 PM
50 min

24/12
Board Committee - Chair Assurance Reports:

Assurance *Board Committee Chairs*

People

24/12.1
Nominations and Remuneration Committee (NRC) - Chair Assurance Report (2.40 pm to 2.45 pm)

Assurance *Chair NRC - Andrew Catto*

- 24-12.1 - NRC Board Chair Assurance Report 12.03.24 FINAL.pdf (2 pages)

24/12.2
People and Culture Committee (P&CC) - Chair Assurance Report (2.45 pm to 2.55 pm)

Assurance *Chair P&CC - Claudia Sykes*

- 24-12.2 - PCC Board Assurance Report 20.02.24.pdf (4 pages)

Patients

Quality and Safety

24/12.3
Quality and Safety Committee (Q&SC) - Chair Assurance Report (2.55 pm to 3.05 pm)

Assurance *Chair Q&SC - Dr Andrew Catto*

- **Patient Safety Incident Response (PSIR) Plan and Policy**

Approval

- 24-12.3.1 - QSC Chair's Report 260324.pdf (3 pages)
- 24-12.3.1.1 - App 1 PSIR Policy and Plan.pdf (2 pages)
- 24-12.3.1.2 - App 1 PSIR POLICY v2 22.03.24.pdf (24 pages)
- 24-12.3.1.3 - App 1 EKHUFT PSIR Plan.pdf (22 pages)
- 24-12.3.2 - QSC Chair's Report 270224 final.pdf (2 pages)

Partnerships

Sustainability

24/12.4

Finance and Performance Committee (FPC) - Chair Assurance Report (3.05 pm to 3.15 pm)

Approval *Chair FPC - Richard Oirschot*

- 24-12.4.1 - FPC Board Chair Assurance Report 26.03.24 FINAL.pdf (5 pages)
- 24-12.4 - FPC Board Chair Assurance Report 27.02.24.pdf (5 pages)

24/12.5
Integrated Audit and Governance Committee (IAGC) – Chair Assurance Report (3.15 pm to 3.25 pm)

Assurance *Chair IAGC - Olu Olasode*

- **Confirmation of final Emergency Preparedness Resilience and Response (EPRR) Assurance Outcome**

- 24-12.5.1 - IAGC Board Chair Assurance Report 26.01.24 FINAL.pdf (5 pages)
- 24-12.5.2 - App 1 EPRR Compliance 26.01.24.pdf (1 pages)
- 24-12.5.3 - App 1.1 2023 EPRR Assurance Outcome letter.pdf (2 pages)

24/12.6
Charitable Funds Committee (CFC) - Chair Assurance Report (3.25 pm to 3.30 pm)

Approval *Chair CFC - Claudia Sykes*

- 24-12.6 - CFC Board report 14.3.24.pdf (2 pages)

Patients

Quality and Safety

04:00 PM - 04:35 PM
35 min

24/13
Chief Nursing and Midwifery Officer (CNMO) Reports:

CNMO

24/13.1
Women's Care Group Maternity and Neonatal Assurance Group (MNAG) Chair's Report - Maternity Incentive Scheme Year 6 Submissions (3.30 pm to 3.45 pm)

Assurance *CNMO/Director of Midwifery (DoM)*

- **Perinatal Quality Surveillance Tool (PQST) and Maternity Dashboard**
- **Maternity and Neonatal Improvement Programme**
- **Kent County Council (KCC) Consultation**
- **Care Quality Commission (CQC) Update**
- **Clinical Negligence Scheme for Trusts (CNST) compliance**
- **Maternity Information System**
- **Listening to Women and Families**
- **Obstetric Medical Workforce**
- **Small Steps Bereavement Team**
- **Matters to escalate to Q&SC and Board**

- 24-13.1.1 - Women's CG MNAG Chair's Assurance report March 24.pdf (5 pages)

24/13.2
Serious Incidents (SI) Report (3.45 pm to 3.55 pm)

Assurance *CNMO*

24-13.2.1 - Serious Incident Report Jan 24 Final.pdf (2 pages)
24-13.2.2 - App 1 EKHUFT SI Report Jan 24 Final.pdf (13 pages)

24/13.3
Care Quality Commission (CQC) Update Report (3.55 pm to 4.05 pm)

Discussion *CNMO*

24-13.3 - CQC Trust Board Report April 2024 Final.pdf (10 pages)

CLOSING MATTERS

04:35 PM - 04:40 PM
5 min

24/14
Any Other Business

Discussion *All*

Verbal

04:40 PM - 04:55 PM
15 min

24/15
Questions from the Public

Discussion *All*

Verbal

Date of Next Meeting: Thursday 6 June 2024

REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM APRIL 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)** 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
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
GOULSTON, JOHN	Special Advisor to the Board (substantive role – Chair, Kent Community Health NHS Foundation Trust)	Chair, Kent Community Health NHS Foundation Trust (1 November 2018) **(1)** Chair, NHS London Procurement Partnership (2019) **(1)** Adviser, Medinet Clinical Services (1 July 2023) **(4)**	1 October 2023

REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM APRIL 2024

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
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	None	2 January 2024
HOLDEN, DES	Chief Medical Officer	International Advisor, Public Intelligence (Denmark) **(5)** (2018) Advisor/Non-Executive Director, South East Health Technology Alliance **(4)** (2017) Visiting Professor, Clinical and Experimental Medicine, University of Surrey **(5)** (2023 to 2026)	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	None	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 – 2024/25 FROM APRIL 2024

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
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) Chair, Kent and Medway VCSE Alliance **(5)** (September 2022)	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

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 SIXTH MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 1 FEBRUARY 2024 AT 1.15 PM IN THE LECTURE THEATRE, EDUCATION CENTRE, QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL, RAMSGATE ROAD, MARGATE CT9 4BG/WEBINAR TELECONFERENCE

PRESENT:

Mr S Baird	Acting Chairman (meeting Chair)	SB
Mr R Anakwe	NED (joined by WebEx at 1.30 pm)	RA
Ms A Ashman	Chief People Officer (CPO)	AA
Dr A Catto	NED/Quality and Safety Committee (Q&SC) Chair/Nominations and Remuneration Committee (NRC) Chair	
Mr S Corben	NED/2gether Support Solutions (2gether) NED In-Common	SC
Ms T Fletcher	Chief Executive (CE)	TF
Ms L Fulci	NED	LF
Mr T Glenn	Interim Chief Finance Officer (CFO)	TG
Ms S Hayes	Chief Nursing and Midwifery Officer (CNMO)	SH
Mr R Hodgkiss	Interim Chief Operating Officer (COO)	RH
Dr D Holden	Chief Medical Officer (CMO)	DH
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 J O'Callaghan	Interim Director of Corporate Governance	JO
Mr B Stevens	Chief Strategy and Partnerships Officer (CSPO)	BS
Ms C Sykes	NED/Charitable Funds Committee (CFC) Chair/*Reading the Signals* Oversight Group Chair/People & Culture Committee (P&CC) Chair (left at 3.00 pm)	CS

ATTENDEES:

Ms M Durbridge	Improvement Director, NHS England (NHSE)	MD
Ms K Edmunds	Head of Patient Voice and Involvement (HPVI) (Patient Story item)	KE
Ms M Enever	Patient Story item	ME
Mr J Goulston	Special Advisor to the Board (Chair of Kent Community Health NHS Foundation Trust (KCHFT))	JG
Professor C Holland	Associate NED/Dean, Kent & Medway Medical School (KMMS)	CH
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

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Ms V Bodley	Member of Staff
Ms M Bonney	Governor (joined by WebEx)
Mr I Child	Member of the Public
Miss L Coglan	Member of Staff (joined by WebEx)
Mr B Davidson	Member of the Public
Mr N Daw	Member of Staff (joined by WebEx)
Mr D Esson	Journalist – Kent Online (joined by WebEx)
Ms C Heggie	Member of the Public
Mrs B Mayall	Governor (joined by WebEx)

MINUTE NO.		ACTION
23/139	**CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE** The Acting Chairman opened the meeting, welcomed everyone present, noted no apologies had been received, members of the public joining the meeting virtually had the opportunity at the end of the meeting to type and ask questions in the Question and Answer function. The Acting Chairman welcomed Mr J Goulston, noted his substantive role of Chair at KCHFT, providing support to the Board. He also welcomed new Board members and Trust staff, Mr R Hodgkiss, Interim COO; Dr Des Holden, CMO; and Mr J O'Callaghan, DCG. The Acting Chairman reported a brief Closed BoD meeting had been held that morning, issues discussed included the Board Assurance Framework (BAF), management of risks, as well as financial performance that would be covered later in this meeting.	
23/140	**CONFIRMATION OF QUORACY** The Acting Chairman **NOTED** and confirmed the meeting was quorate.	
23/141	**DECLARATION OF INTERESTS** There were no new interests declared.	
23/142	**MINUTES OF THE PREVIOUS MEETING HELD ON 7 DECEMBER 2023** **DECISION:** The Board of Directors **APPROVED** the minutes of the previous meeting held on 7 December 2023 as an accurate record.	
23/143	**MATTERS ARISING FROM THE MINUTES ON 7 DECEMBER 2023** **Action B/06/23 – Emergency Department (ED) works review Urgent and Emergency Care (UEC) services, front door patient pathways, management of patients, and patient flow** The Interim COO reported there would be a review looking at front door services to redesign patient pathways through ED, to ensure these were simplified to benefit the care and experience of patients, as well as supporting staff to manage demand. He agreed to provide a further update at a future Board meeting. **Action B/21/23 – Consider families engaged with Reading the Signals Oversight Group being invited to present their feedback and comments to future Board meeting as Patient Experience Story** The CSPO reported he had discussed this with the CNMO noting there were processes that needed to be completed in respect of actions as part of this Group, and on completion consideration of a timeframe to schedule a future presentation to the Board, he requested this action be closed. The BoD **AGREED** to close this action. **Action B/22/23 – Present annually a Patient Advice and Liaison Service (PALS) report** The CNMO commented on the update in respect of maternity complaints, noting the action related to the wider Trust around themes and lessons learnt. She	

reported a Patient Experience Committee (PEC) in place reporting into the Q&SC, and that the action remain open for when the PEC reported to the Q&SC, and an update provided to the Board through the Q&SC Chair Assurance report.

Action B/28/23 – Progress update on implementation of estate and minor work of Care Quality Commission (CQC) must and should do recommendations
The CNMO confirmed an update was provided in the Quarterly CQC report presented at this meeting for discussion later on the agenda. The BoD **AGREED** to close this action.

Action B/30/23 – Update on progress to identify additional senior appraisers and Trust's Appraisal Lead was sufficiently supported in overseeing appraisals
The Board of Directors noted the report presented at this meeting on Medical Appraisal and Revalidation, an update would be provided when this item was discussed later on the agenda. The BoD **AGREED** to close this action.

Action B/32/23 – Consider including in future Integrated Performance Report (IPR) reports brief summary highlighting areas of good performance and achieving target standards
Action B/36/23 – Look at presenting in IPR an identified timeframe for improving cancer performance trajectory
The CSPO commented this was work in progress to incorporate this information within the newly reformatted IPR. He stated there had been a national review of IPRs by the Making Data Count Group, scoring organisation IPRs (between one and five (five being the best), the Trust's IPR had been scored four. The BoD **AGREED** to close these two actions.

Action B/37/23 – Staff uptake numbers for flu and Covid vaccinations
The BoD noted the staff uptake numbers and percentage presented for these vaccinations. The NEDs raised the 44.6% staff total uptake of flu vaccination that appeared to be lower than in previous years (averaged around 75% and above), the reasons for this and what could be done to improve this in future years. The CNMO reported the Trust's vaccination rate was higher than that seen nationally that was low, the uptake rate for the Trust was a concern noting focussed communications work and creative thinking to encourage staff uptake. There would continue to be pre-planning for the next round of vaccination campaigns to encourage and increase staff uptake, as well as any learning from other trusts. The BoD noted the update and **AGREED** this action for closure.

Action B/39/23 – Consider provision and appointment of Physician Associates within Maternity services to support additional staffing resources
The CMO reported he had made enquiries about this as part of the handover from the Interim CMO and would provide an update at the next Board meeting.

The Board of Directors **NOTED** the action log, **NOTED** the updates on the actions, **NOTED** the actions for future Board meetings, and **APPROVED** the nine actions recommended for closure.

The Associate NED highlighted the Lesbian, Gay, Bisexual, and Transgender (LGBT) History Month 2024, from 1 to 29 February, acknowledging and celebrating the diversity of staff and provision of care and services to the East Kent population.

23/144 **PATIENT STORY**

The CNMO introduced the emotional and upsetting story from the Carer of a frail older patient, highlighting it was important for the BoD to hear this story, and that the Trust learnt lessons from this.

The HPVI introduced the Carer, noting the improvement work in progress to support carers had been shared, recognising this was still in its early implementation. There was now in place a carer's survey to provide feedback, with themes identified around lack of involvement and not being listened to. A Task and Finish Group was also in place that the Carer was involved with.

The Carer (Lasting Power of Attorney (LPA) and a Director of a Carer's Society) highlighted the key message from this patient story:

- Very active, engaging older lady, registered blind (this was not obvious), health had deteriorated over the last few years, supported with accessing primary care and couple of previous visits to Queen Elizabeth the Queen Mother Hospital (QEQM) that had been moderate experience;
- Experience had had a profound impact on her ability to grieve and come to terms with the death of her friend;
- Hoped that lessons would be learnt with potential for change;
- Repeatedly alerted teams to the patient's known health conditions (had issues swallowing), registered blind and could only just about tolerate pureed food, small sips of water, and had notified staff patient was hungry;
- An endoscopy was attempted, was distressing, was violently sick and fearful patient would aspirate. A second endoscopy, patient did tolerate and was moved to Sandwich ward, care received on this ward was considerate, dignified and staff were very kind;
- When the Speech and Language Therapy team were involved in patient's case it was then noted on whiteboard patient was registered blind, and at this point she felt she had been listened too;
- Recognised staff on wards were very busy and stretched, it was important staff be given time to listen to carers and relatives who best knew the patient;
- Happy to work with the Trust to make necessary improvements to support carers and the patients they cared for, noting carers provided significant care enabling people to not require admission to hospital;
- Asked how the BoD was going to take action and make a difference for carers and patients;
- Shift in how staff perceived the Carer when informed she had information that would support staff to care for patient and that she was not complaining and wanted to provide assistance;
- Case was not raised as a formal complaint.

The HPVI reported the Task and Finish Group had been implemented in July 2023, this was around raising staff awareness of carers, their support and role in caring for patients, and the importance of staff listening to carers and families. This would support staff knowing about the patient and how best to care for them. This Group included carers and representatives from carer organisations, and it had an action plan. The actions implemented included the following:

- Carer page on Trust website, staff intranet (recognising there were many Trust staff who were also carers), involving carers and families, and enabling them to support patient's at hospital appointments;
- Development of a carers leaflet, already in place a carers leaflet for people with dementia;
- Drafting Carers policy, including staff guidelines around speaking to the patient to confirm their support and people to share information with about their care and treatment. This would be reviewed by the Trust Safeguarding Team;
- Culture change needed that staff listened to carers and families.

The Acting Chairman on behalf of the Board, Trust and its staff apologised and was sorry for the poor experience of the Carer and the patient, and extended thanks for being brave to share this story. He emphasised two key important themes for staff to be compassionate and listen to patients, families and carers, the importance of personalised care and recognising the person behind the patient.

The Associate NED commented on the need for the Trust to consider staff training around sharing information, having conversations about care with carers was appropriate and the Mental Capacity Act confidentiality. This would also be considered as part of his role in KMMS and training provision for healthcare trainee/students professionals.

The Acting Chairman asked the CNMO to contact the Carer in a few months to discuss and evaluate progress of the Task and Finish Group, and the work and actions being taken forward and implemented to support carers.

ACTION: Contact the Carer in a few of months to have a discussion and evaluate progress of the Task and Finish Group, and the work and actions being taken forward and implemented to support carers. — CNMO

The Board of Directors discussed and **NOTED** the carer story and the 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.

23/145 **ACTING CHAIRMAN'S REPORT**

The Acting Chairman highlighted the following key elements:

- Thanks to Niall Dickson, for his time and leadership as the Trust's Chairman and wished him all the very best in his future endeavours;
- Continued pressures with increased attendances (10% compared to the previous month) across the EDs, impacting patient experience and during high demand had resulted in patients being treated in corridors;
- Industrial action of doctors and 2gether Support Solutions (2gether) staff;
- Important role of the BoD in personalising conversations and actions, focussing on patients accessing services and supporting their needs to

receive positive experience, quality and safe standards of care with good patient outcomes. Recognising the patients at the heart of the data and performance;
- Interim CFO's first week in post following a visit to front line services, saw first hand the impact of extended length of stay (LoS) for a patient, unnecessarily resulting in poor experience and outcome, that had also had a detrimental financial impact;
- Recognition there was still much more improvement work to be done that needed to be prioritised with initial discussions held, key priority areas for focus included improving ED waiting times and patient flow, reducing hospital LoS, and reducing waiting list times (particularly cancer waits), addressing the financial performance by reducing the deficit, increasing cost savings and ensuring the Trust operated more efficiently.

The NEDs highlighted the significant improvements achieved in Maternity services.

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

23/146 **CHIEF EXECUTIVE'S (CE's) REPORT**

The CE reported on the following key points:

- Reiterated the continued significant operational pressure on services and looking at transforming how these services worked to be much more efficient. This was around improvement that would have a positive impact on ED and planned care activity performance;
- Key area of focus for the Executive team to improve financial performance and increase efficiencies;
- Planning for the recent junior doctors and 2gether industrial action, there had been some impact for patients in respect of cancellation of outpatient appointments and planned care procedures. Planning around mitigations to ensure minimising as much as possible any potential impact for patients, recognising the rights of staff to take industrial action. 2gether staff had taken industrial action over the past three days (including that day), with the 2gether and operational teams working closely to minimise any disruption. There had been some impact around provision of food and reduced staff providing cleaning services with areas prioritised;
- Re-opening of the midwifery-led Singleton Unit at William Harvey Hospital (WHH), providing a positive environment, close working of the multi-disciplinary team (MDT) who were driving forward improvements in Maternity services.

The NEDs noted the full complement of Executive Directors now in post and whether there were any risks in Care Groups or operational areas where there were gaps in senior leadership. It was also enquired whether there were challenges with recruiting senior staff to roles in the Trust. The CE reported vacancy gaps remained in the Triumvirate Care Groups, in particular Managing Director (MD) roles, with ongoing recruitment to these remaining MD roles and if unsuccessful in recruiting this would identify whether there were challenges. It was noted all clinical roles had been appointed to, and the majority of nursing roles also recruited. The CPO commented there had been a good level of interest from candidates applying for roles advertised.

The Associate NED commented on the successful and really good news story of the visit from leading healthcare professionals from Indonesia to the Trust's Stroke Care and Rehabilitation Services.

The Associate NED raised the Integrated Care Board-led (ICB) Acute Provider Collaborative review of ENT demand and capacity, and enquired about the scope of this work and what were the expected deliverables. The CE reported the ICB was focussing on fragility services and those with long waiting lists, noting successful recruitment to the Trust's ENT services, although there remained a waiting list backlog. Recognising the benefits of collaborative review of fragile services across a wider geographical provision and collaborative working, that might not just be for ENT and extend to other services.

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

23/147 **INTEGRATED PERFORMANCE REPORT (IPR)**

Operational Performance

The Interim COO highlighted the following key elements:

- Month of December 2023 performance had deteriorated for all types, challenging and continued pressures on ED services with increased activity in number of type 1 and ambulance arrivals;
- Endoscopy insourcing provision increasing capacity to address the waiting list backlog would commence that upcoming weekend, with additional funding of £800k secured to reduce the waiting list and length of time patients having to wait to receive treatment;
- Focussed work continued looking at improving LoS and the actions needed to achieve this;
- Addressing escalation and provision of additional beds during this winter period resulting in additional staffing requirements, reviewing the reasons for this to ensure this did not happen during the next winter period 2024/25.

The NEDs asked about a trajectory timeline for performance improvement, the potential level of harm for patients whether this was being identified, and also that demand was being prioritised due to diagnostic capacity challenges. The Interim COO confirmed a performance framework was being finalised as part of the Tier 1 improvement support around remedial action plans against a monthly projected improved trajectory and the IPR would be updated reflecting this. It was assured monthly meetings held in respect of cancer waiting lists to monitor harm reviews. It was noted patients were prioritised as appropriate and Care Groups reporting against these priorities. It was noted a team from London had been asked to review the Trust's cancer diagnostic pathways to ensure these aligned with best practice, and to share learning around any improvements that could be made. It was recognised there was more needed to be done to reduce waiting lists.

The Acting Chairman enquired about how patients were being informed about where they were on the waiting list. The Interim COO confirmed communications with patients confirming their appointment date.

The NEDs asked about progress to improve theatre utilisation. The Interim COO stated he was working with the Interim CFO reviewing and linking theatre activity and income. This would provide a true view of productivity broken down to

individual specialty areas, setting a performance threshold against productivity that needed to be achieved.

The CSPO reported Care Groups would be held to account in respect of performance and challenged if underperforming.

Quality and Safety

The CNMO stated work continued to review and monitor safe staffing, targeting specific areas where there were incidents of harm and pressure ulcers.

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

23/147.1 **MONTH 9 FINANCE REPORT**

The Interim CFO reported on the following key points:

- Key area to ensure staff adhering to best practice, being financially aware of their accountability in respect of expenditure and remaining within budget;
- Increased financial challenges during the winter period, further impacted due to industrial action;
- Controls implemented were having a positive impact on reducing expenditure;
- Trust's forecast for year-end (YE) deficit of £117.4m, this was a stretching and ambitious target to be delivered within three months, acknowledging this level of deficit was not an acceptable position the Trust wished to be in. This YE forecast had been discussed and acknowledged by NHSE;
- To meet the needs of patients, it was necessary to ensure efficient patient flow through the hospital, LoS improved, improvements in diagnostics capacity, and patients were in the right place to receive the care needed.

The CSPO reported in respect of capital funding, if there was any slippage for the current FY, planning was in place to bring forward any projects enabling achieving the annual capital spend plan by YE.

The Board of Directors **NOTED** the Month 9 finance report, financial performance and actions being taken to address issues of concern.

23/148 **REPORT ON JOURNEY TO EXIT NHS OVERSIGHT FRAMEWORK (NOF4) AND INTEGRATED IMPROVEMENT PLAN (IIP)**

The CSPO highlighted the following key points:

- Robust process being undertaken to review and assess evidence providing assurance of progress and position at YE in meeting the NOF4 exit criteria;
- Recognition two programmes continued to be rated red (Finance and Performance) were unlikely to meet exit criteria requirements and would need to rollover to the next financial year;
- Plan would be linked to Trust's objectives the following year.

NHSE's Improvement Director noted the significant progress achieved over the last twelve months in maternity services, and a number of the projects were now rated green. She emphasised the key issues were now ensuring improved financial performance around robust grip and control, further work to improve Quality and

Safety, patient experience and reducing incidents of harm. It was noted the improvement work was aligned to the IPR improvements.

The NEDs enquired about progress to improve culture, particularly with the medical workforce, rated red. The CPO reported there had been improvements in engagement and involvement with medical staff, with a lead and change agents in place with good feedback being received.

The Associate NED raised the new emerged risk over funding for rostering rated red that was important to move this to amber, and what was needed to achieve this. The CMO stated the need to have in place sustainable on-call rotas, and to do this the Trust needed to understand staff numbers on rotas, their status (level of grade and employment). The CPO commented it was important to continue to engage with clinical staff, reviewing and monitoring rosters ensuring staff had been appropriately rostered, and anticipated an improved position within the next six months. The provision for rostering training funding had been submitted through the appropriate process for consideration for approval.

The Board of Directors **NOTED** the Integrated Improvement Plan report.

23/149 **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS:**

23/149.1 **NOMINATIONS AND REMUNERATION COMMITTEE (NRC) – CHAIR ASSURANCE REPORT**

The Board of Directors **NOTED** the 12 December 2023 NRC Chair Assurance Report.

23/149.2 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

The Q&SC Chair reported on the following key issues:

- First new style meeting held alternating between quality assurance and governance, and quality improvement and learning, ensuring robust focussed discussions and effective meeting time management;
- Good progress on maternity 40 CQC must-do and should-do actions, with only four must-do actions remaining incomplete;
- Poor Equality Delivery System (EDS) performance due to lack of Equality and Diversity (E&D) patient data collection, steps being taken to improve this;
- Escalated risks with renal dialysis provision, received and discussed results of the deep dive report. A follow-up discussion about this issue would take place with the Deputy COO and Q&SC NEDs;
- Concern raised about the relatively high number of risks scored at 15 and above, with reassurance provided that these were being appropriately managed and systems in place to deal with this volume of risk;
- Second time escalated to Q&SC about the ongoing risks and access to sufficient obstetric theatre space at QEQM. An allocation of circa £40k provided for scoping works to identify the extent of the challenge, with obstetric staff undertaking practice drills using alternative theatre accommodation as part of the risk mitigation strategy. This risk would continue to be monitored and reviewed.

The CNMO reported the QEQM obstetric theatre risk was around not having access to a second theatre space, which had been discussed by the Executive team. The CSPO stated an outline capital case proposal had been submitted to NHSE and awaiting a response, this would require significant works that would span a couple of years. The NEDs enquired whether a theatre could be rented due to this being a high risk, and continuing to communicate with staff that their concerns had been heard and were being addressed. The CSPO confirmed mitigating actions were in place to reduce the level of risk. The CNMO confirmed listening sessions had been held with staff attended by her and the CE, and the Trust was committed to continuing to listen to staff. The Acting Chairman emphasised it was important to push the need for this funding and the works to be undertaken at pace. It was requested in two months the Board be provided with an update on the actions and progress to address the maternity theatre capacity risk at QEQM.

ACTION: In two months provide the Board with an update on the actions and progress to address the maternity theatre capacity risk at QEQM. — CNMO/ CSPO

The Board of Directors **NOTED** the 23 January 2024 Q&SC Chair Assurance Report.

23/149.3 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

- **INTEGRATED PERFORMANCE REPORT (IPR)**

The FPC Chair reported on the following key issues:

- Work by PwC around the financial grip and controls process and actions would be regularly monitored by FPC;
- Trust's new revised forecast for 2023/24 of £117.4m deficit;
- Continued focus of Cost Improvement Programme (CIP) and review of delivering the 2023/24 programme, and planning on what efficiency projects were needed to deliver the 2024/25 programme. A detailed report on the 2023/24 and 2024/25 CIP delivery along with an internal review of the Programme Management Office (PMO) resources and structure would be presented at the next FPC meeting;
- Current Average Length of Stay (ALoS) for patients was 11.49 days, 1.85 days longer than comparison peer trusts, with ongoing analysis and deep dive work to improve LoS and patient flow;
- Continued concern about cancer performance and the number of patients remained high that were waiting longer than 62 days and 104 days. A report on the action plan addressing cancer waiting times and the actions to reduce this would be presented to the next FPC meeting.

DECISION: The Board of Directors:

- **NOTED** the 9 and 23 January 2024 FPC Chair Assurance Reports;
- **NOTED** the current Cash Position of the Trust and Month 9 Financial Position;
- **APPROVED** the IPR.

23/149.4 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR ASSURANCE REPORT**

The Board of Directors **NOTED** the IAGC Chair Assurance Report from the IAGC meeting held on 26 January 2024 would be presented to the next meeting of the Board of Directors.

23/149.5 **CHARITABLE FUNDS COMMITTEE (CFC) – CHAIR ASSURANCE REPORT**

The Board of Directors **NOTED** the:

- 14 December 2023 CFC Chair Assurance Report;
- CFC had referred concerns to the Executive Management Team (EMT) around the delays in spending the £195k Roche Ophthalmology grant received.

23/150 **CHIEF NURSING AND MIDWIFERY OFFICER'S (CNMO) REPORTS:**

23/150.1 **SERIOUS INCIDENTS (SI) REPORT**

The CNMO reported on the following key points:

- Correction on the front sheet confirming 15 SIs declared in November 2023;
- Continuing to closely monitor Duty of Candour (DoC) compliance, 100% compliance in October for 29 cases where verbal DoC applied, and final DoC following submission of SI report delayed in three cases making compliance 83.3%;
- Recognising learning from SIs and sharing this throughout the Trust, as well as never events;
- Robust processes in place for reporting of incidents, reviewing and investigating SIs, and escalation to ICB and CQC where appropriate, with oversight by the CNMO, CMO or their individual deputies.

The Associate NED raised the first example of learning from incidents in respect of a patient's needs of a post pacemaker implantation, where the performing consultant had supervised practice but had since left the Trust. It was enquired whether the Trust had actively followed up with the Trust they had moved to ensuring they were made aware of the incident and recommendation for supervised practice. The CNMO confirmed contacting the Trust the staff member had moved to was included as part of this process.

The Associate NED raised concern with the second example of learning, considering the details of the case it should have immediately been reported as a never event (NE), concern about the delays in reviewing the incident and it being reported as a NE and whether there were issues around culture and reporting within the women's health services. The CNMO reiterated it was important to follow the incident and SI review process in identifying SIs or NEs, noting no issue with incident reporting or decision making in these services who regularly reported incidents, attended SI panels, with senior leadership oversight by the Director of Midwifery and Associate Medical Director. The CMO emphasised the learning and recommendations.

The NEDs commented on the previous poor compliance with DoC, this had been improved and currently being sustained at 100% verbal compliance, and what the actions were and learning of this being achieved and maintained for dissemination in other areas throughout the Trust. The CNMO stated this was around robust

monitoring that Care Groups were ensuring open discussions were being held with patients.

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

23/150.2 **PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF)**

The CNMO reported on the following key areas:

- Creation of a Project Support Manager post (utilising a vacancy within the Corporate Governance Budget), this role would support the Trust meeting the implementation deadline of 31 March 2024 and that it was where it needed to be with the requirements of this framework.

The Board of Directors **NOTED** the information in the PSIRF report, deadlines for implementation and the progress against these.

23/150.3 **SAFEGUARDING ALL AGE ANNUAL REPORT 2022/23**

The CNMO reported on the following key points:

- Substantive Head of Safeguarding now in post;
- Focus going forward ensuring continued staff communication and engagement and staff were aware safeguarding was everyone's responsibility.

The NEDs commented good progress and improvements had been made around safeguarding.

The Board of Directors **NOTED** the Safeguarding All Age Annual Report 2022/23.

23/150.4 **QUARTERLY CARE QUALITY COMMISSION (CQC) REPORT**

The CNMO reported work continued to embed CQC requirements as part of the day to day work within all services and care provided.

The Acting Chairman raised concern about the percentage of Must Do actions that remained incomplete considering the length of time since the Trust had been inspected. He highlighted those within Urgent and Emergency Care (UEC) and these Must Do actions needed to be addressed and completed at pace. It was requested a briefing with a timeframe against the prioritised actions of when the Must Do and Should Do requirements would be completed by, and identify any potential risks of these not being completed. The CNMO stated the team were working with Care Groups to progress the actions and improvements, noting there had been historical Must Do actions prior to the inspections. There was robust oversight and reporting structures in place, including regular reports presented to Q&SC and escalated to BoD through the Q&SC Chair Assurance Report.

It was noted the benefits of aligning the CQC Must and Should Do actions with IIP.

The Board of Directors discussed and **NOTED** the CQC report and progress of delivery of improvements related to CQC compliance to date.

23/151 **CHIEF MEDICAL OFFICER'S (CMO's) REPORT:**

23/151.1 **MEDICAL APPRAISAL AND REVALIDATION**

The CMO highlighted the following key areas:

- Improved appraisal compliance increased from 68% to 85% (925 connected doctors, with 785 appraisals completed);
- Review of appraisals being undertaken across the Trust;
- Rate of positive revalidation recommendations improved from 48% to 72%.

The Acting Chairman raised a query raised by a Staff Governor related to the action requiring an update about whether there was sufficient provision of appraisers to carry out the appraisals and that the Lead Appraisal was appropriately supported. The CMO confirmed sufficient number of appraisers and the number of required appraisals were evenly distributed to ensure equity of workload. It was noted there was also the provision of Senior Appraisers.

The Board of Directors **NOTED** the Medical Appraisal and Revalidation report and:

- Agreed actions following the last Statement of Compliance (SoC) report on track for delivery and would be captured in this year's SoC report due in September with an interim report in May 2024 called the Annual Organisational Audit (AOA).

23/151.2 **EQUALITY DELIVERY SYSTEM (EDS) REPORT 2023**

The CMO highlighted the following key areas:

- Overall for all three EDS Domains, total score of eight, meant Trust rated 'Developed' and at the lowest range (eight to 12);
- Scores for each Domain provided current strengths and areas for improvement, around improving data collection across all protected characteristics and addressing inequalities for patients.

The NEDs emphasised the disappointing outcome score, reiterated the importance of data collection for patients, staff and leaders, the strong Information team in place to support looking at data available and triangulation of datasets, that needed real focus to support improving the EDS report for the following year. As well as embedding throughout the organisation the benefits of this data collection, and utilising the shared record system.

DECISION: The Board of Directors:

- **NOTED** the EDS Report 2023, **NOTED** an update report on progress of EDS actions to be received in September 2024;
- **APPROVED** the findings, the proposed objectives, and actions.

23/152 **WINTER PLAN – FINANCIAL ASSESSMENT**

The Interim COO reported on the following key areas:

- Re-emphasised the significant operational challenges across the sites in managing activity;

- Positive good news that the Trust was no longer providing corridor care at WHH and QEQM, as of that day. It had also de-escalated from Operational Pressures Escalation Levels (OPEL) level 4 to level 3;
- Schemes funded by winter pressures funding (shown in waterfall chart) supporting activity management over the winter period. Recognised virtual ward progress had not been as that hoped, and this would be taken forward by the CNMO who had significant experience in this area.

The Acting Chairman highlighted it was important that lessons were learnt for consideration for future winter plans. The Interim COO stated lessons learnt (and system wide learning) report would be presented to FPC and reported to the BoD as part of the FPC Chair Assurance Report.

The Board of Directors **NOTED** the:

- Position and impact of the planned winter schemes;
- Costed estimate of the anticipated financial impact this winter;
- Status of the Full Capacity Protocol review.

23/153 **ANY OTHER BUSINESS**

There were no other items of business raised.

23/154 **QUESTIONS FROM THE PUBLIC**

Ms C Heggie raised the poor patient experience story from earlier in the meeting, the continued poor experiences presented, and what action was being taken to address and change the issues raised. The CE acknowledged recent experience stories presented covered similar themes, changes would take time, noting the Trust's culture and leadership programme (CLP) improvements in place to address and change the culture throughout the Trust. It was emphasised the successful and positive improvements made in maternity services, the necessary changes throughout the remainder of the Trust around demonstrating care and compassion. It was important to continue to receive patient stories around listening to and learning from these, noting the CNMO's work 'getting back to basics' and the leadership teams across the hospital sites strengthened to support continued improved CLP across the organisation. Ms Heggie stated the Trust had previously signed up to the British Deaf and Sign Language Charter and the need for the Trust to communicate the Charters signed up to. The CE acknowledged the need for the Trust to incorporate within its Trust Values elements within Charters and that staff were working to these. The CPO stated the collaborative work taking place with the Patient Experience and EDI team. The CNMO reported the Patient Experience Committee now in place and issues escalated to her as the accountable officer for patient experience. She extended the opportunity for Ms Heggie to have a discussion with her and the CPO outside this meeting to provide assurance of the ongoing work. The Acting Chairman reiterated it would take time to make changes, whilst recognising the challenges to make these at pace, and the need for prompt improvements to be achieved. Ms Heggie emphasised the previous poor CQC published reports and these being reviewed and learning from the recommendations. The CE reported recognition the quality of services provided was not at the standard the Trust wished, and the commitment to improve and change the services patients received. This was around empowering staff to make changes, engaging staff with the initiatives and improvements and that there was sustained ownership.

Ms Heggie commented on a question raised by a NED about any affect on cancer patients on waiting lists, whether cancers were increasing in grade or patients dying, that had been more fully answered than the same question she had raised at a previous meeting. The Acting Chairman would liaise with Ms Heggie outside this meeting about this issue.

Ms Heggie commented on the importance of equality and diversity and that the Trust and its staff adhere to the Equality Act requirements.

Mr D Esson asked about the Trust's financial position and whether was expecting to make the £49m savings the next financial year by cutting frontline services in any way, and if not, how these savings would be made. The Interim CFO reported the impact of removing patient corridor care that day, resulting in removal of staff costs and numbers to manage this additional care provision. This meant better experience for patients, better working environment for staff, with cost reductions that would support the necessary savings to be achieved. He stated there were 17 savings schemes to be achieved in the next financial year, led by the Executive Directors, these included reducing LoS, improving theatre utilisation and efficiency, as well as improving out patients and diagnostics, and utilisation of the estate and IT. As well as reviewing and reducing locum and agency staff usage.

Ms M Bonney asked if the Trust was serious about saving money why had it banned staff overtime in the same department (majors (ED)) that regularly had in place locums and agency staff. The CNMO explained where needed the use of bank staff that was more efficient, this included Trust staff whilst recognising the requirement around patient safety and adhering to EU working time directive for staff overtime and working on the staff bank. It was agreed the CNMO would provide a short briefing giving assurance of the use of bank staff around the provision of patient safety and care.

ACTION: Provide short briefing giving assurance of the use of bank staff around the provision of patient safety and care, ensuring adhering to EU working time directive for staff overtime and working on the staff bank. — CNMO

Mr B Davidson recognised the need for cost savings to be made, the concerns about these, the digital elements that could support this as well as collaborative work with the ICB. He commented on the key message from this meeting that patients' needs were being considered.

Ms Bonney asked for an explanation as to why the Board needed to spend time working out priorities of CQC must do actions, not analysing why changes had not happened, and needed to get on and implement the actions. The CNMO reported the regulatory requirement for the Board to have oversight of CQC actions and progress and that these needed to be taken forward at pace. It was emphasised the challenges with some must do's, examples in respect of work on the estate, and meeting ED waiting time targets, increased volume of patient activity and ongoing work to support improvements around LoS and patient flow.

Ms Bonney asked why there was no water fountain in the Urgent Care Centre in Ashford (ED at WHH), there was an expensive and temperamental vending machine, and this issue had been raised previously at a Board meeting. Patients were waiting hours with no easy access to water. The CNMO commented this had been discussed previously with Ms Bonney, had been raised with the Director of Nursing, the machine had been removed for cleaning and checking, and would be

reinstated in the waiting area. She agreed to check and confirm a timeline for when this would be reinstated.

ACTION: Check and confirm a timeline for when the water fountain in WHH's ED would be reinstated. — CNMO

Mr I Child reported the company Liaison Group supplied a contract providing significant cost savings to the Trust and that a new contract with another supplier had been agreed outside the scope of the framework, without any warning to them as the incumbent supplier, who had changed their plans accordingly. He had raised concerns about the framework of the renewal of this service by e-mail with no response received. The CPO apologised for a response not being received. Mr Child commented their company was able to provide the broader range of services and that this had not been in the framework. The Board of Directors noted the right for companies to challenge procurement of contracts, this was not appropriate for discussion at this meeting and a discussion needed to take place outside of the meeting. It was agreed the CPO would liaise with Mr Child outside this meeting.

The Chair closed the meeting at 4.50 pm.

Date of next meeting: Thursday 4 April 2024.

Signature _____

Date _____

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Matters Arising from the Minutes on 1 February 2024**

Meeting date: **4 April 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 one action 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 1 FEBRUARY 2024

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. The ToR will be re-reviewed following completion of the Good Governance Institute (GGI) Governance Review.	~~Oct-23~~/ Jun-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 Emergency Department (ED) works review the Urgent & Emergency Care (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~~/ Jun-24	Chief Operating Officer (COO)	Open	01.02.24 - Trust will be looking at and reviewing the front door services to redesign patient pathways through ED, ensuring these were simplified and less complicated to benefit the care and experience of patients, as well as supporting staff to manage demand. A further update will be provided at a future Board meeting. 04.04.24 – The Trust is reviewing and resetting patient pathways across the Trust. An update will come to Board in June 2024.

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~~/ Jun-24	Chief Nursing and Midwifery Officer (CNMO)	Open	January 2024 - 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. 01.02.24 - Action related to the wider Trust in respect of themes and lessons learnt. Patient Experience Committee (PEC) in place reporting into Q&SC, action to remain open for when PEC reports to Q&SC, and an update provided to the Board through the Q&SC Chair Assurance report. **Item for future Board meeting.**
B/27/23	Update to be provided to the Board following a review of the Patient Story.	~~Mar-24~~/ Apr-24	Chief Medical Officer (CMO)/CNMO	Open	**Verbal update to be provided at 04.04.24 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~~/ Jun-24	Chief People Officer (CPO)	Open	Lead Freedom to Speak Up Guardian working on a paper to be presented to the April 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/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. Stillbirth rate included in Women's Care Group Maternity and Neonatal Assurance Group Chair's Report presented at

					04.04.24 Board meeting. **Action for agreement for closure at 04.04.24 Board meeting.**
B/39/23	Associate Medical Director for Women's Services in liaison with the William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) Maternity Clinical Leads consider the provision and appointment of Physician Associates within Maternity services to support additional staffing resources.	~~Feb-24~~/ Apr-24	CMO	Open	**Verbal update to be provided at 04.04.24 Board meeting.**
B/40/23	Contact the Carer in a few months to have a discussion and evaluate progress of the Task and Finish Group, and the work and actions being taken forward and implemented to support carers.	Jun-24	CNMO	Open	**Item for future Board meeting.**
B/41/23	In two months provide the Board with an update on the actions and progress to address the maternity theatre capacity risk at QEQM.	Apr-24	CNMO/CMO	Open	**Verbal update to be provided at 04.04.24 Board meeting.**
B/42/23	Provide short briefing giving assurance of the use of bank staff around the provision of patient safety and care, ensuring adhering to EU working time directive for staff overtime and working on the staff bank.	Apr-24	CNMO	Open	**Verbal update to be provided at 04.04.24 Board meeting.**
B/43/23	Check and confirm a timeline for when the water fountain in WHH's ED would be reinstated.	Apr-24	CNMO	To Close	Water fountain has been reinstated. **Action for agreement for closure at 04.04.24 Board meeting.**

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: NHS Staff Survey Report 2023

Meeting date: 4 April 2024

Board sponsor: Chief People Officer

Paper Author: Head of Staff Experience

Appendices:

Appendix 1: NHS Staff Survey Benchmark report
Appendix 2: Responding to the NHS Staff Survey presentation
Appendix 3: Organisational-level People Plan (draft) (provided in Reading Room – document for information)

Executive summary:

Action required:	Discussion
Purpose of the Report:	This paper describes the proposed response to the 2023 NHS Staff Survey results and findings from the discovery phase of the Culture & Leadership Programme. A three-level approach is described; trust-wide, targeted and year-round at every level.
Summary of key issues:	The NHS Staff Survey (NSS) was completed by 4011 colleagues with 1121 free text comments. Whilst over 4000 people responding lends credibility to the results, it is important to note that this represents a minority response rate. 41% of colleagues responded, but 5740 people chose not to. In fact, our response rate has fallen for the second successive year and now sits below the national average (46%). This is in itself indicative of engagement levels. A detailed overview of the 2023 results is provided for reference (**see Appendix 1**). A summary of the headlines is provided below: ▪ Less staff completed the survey than in previous years (41%) ▪ The Trust scores below the national average in most questions ▪ The Trust scores the lowest of 122 Acute Trusts in 3 of 9 key domains ▪ This includes staff engagement, where East Kent scores 6.34 / 10 ▪ The three questions with the biggest gap from the national standard all relate to advocacy (*i.e.* recommend as a place to work/ be treated & care being our top priority) ▪ Fewer staff would recommend the organisation as a place to work than at any other Acute Trust ▪ Challenges centre around; advocacy, risk and culture

We care

	▪ Compared to the 2022 survey, there were no scores that went down and 26% of questions were marginally higher. However, any progress is offset by our overall national position, with the Trust scoring below the national average in 87% of questions. These results are not viewed in isolation. Taken alongside the output from the discovery phase of the Culture and Leadership Programme (CLP) and our wider people metrics (*i.e.* turnover, sickness absence), they combine to identify our greatest challenges and where we need to act. This paper sets out the actions needed to respond to these challenges (**see Appendix 2**). Our principal challenges relate to advocacy, risk and culture. Using a robust evidence base, we have identified three key priorities; **values, voice and leadership**. Action associated with these will take place across three levels: 1) A trust-wide, large-scale engagement programme around living our values and behaviours 2) Focussed, intensive support in specific areas where most staff report being 'neither engaged nor disengaged' 3) A year-round focus at every level, through organisation & Care Group Plans, with monthly metrics to assess progress. Feedback from the NHS Staff Survey, Culture & Leadership Programme diagnostic and local listening events indicates that many staff do not feel we are living our values. They are less likely to recommend the organisation, either as a place to work or be treated, and do not feel care represents our top priority. The Trust is embarking on a considerably different approach to how it engages and involves all staff around what good would look and feel like, that demonstrates greater accountability when behaviours fall below expected standards, and closes the loop around actions taken will lay the foundations for wider improvements in the staff experience. It is also recognised that there is considerable variation in experience across Wards, Departments, Specialties and Care Groups. With that in mind, support can be focussed on areas where we need to make the biggest difference with a combination of leadership training, support from our People & Culture and Transformation teams to drive meaningful and measurable improvement. Finally, it is proposed that there is a year-round people focus at every level. This will take the form of organisation and Care Group 'People Plans', supported by a new People Dashboard which displays performance against 12 key metrics, each of which relate to staff engagement – and allows for real-time (monthly) measurement of progress so that progress can be clearly monitored, with clear lines of accountability.

East Kent Hospitals University NHS Foundation Trust

	It is clear that a materially different approach to previous years is essential given the nature of our current staff experience, keeping our actions clear, simple and evidence-based, with three unambiguous priorities: values, voice and leadership. Monitoring (people) progress in real-time (previously only possible quarterly/ annually) allows us to create the conditions needed for a culture of continuous improvement and timely corrective action. When coupled with broader collective action (People Plans), our approach is significantly different to previous years and offers multiple routes through which to drive improvement in staff experience.
Key recommendations:	It is recommended that the Board review the proposed response to the NHS Staff Survey results and **DISCUSS** the programme of work.

Implications:

Links to Strategic Theme:	• Quality and Safety • People
Link to the Trust Risk Register:	N/A
Resource:	Y - Improving the overall staff experience as determined by the NSS will take considerable resource and is a responsibility of everyone.
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: Staff survey results have previously been reported to EMT (24/01/24), CEMG (21/02/24) and Board (07/03/2024)

We care

Survey Coordination Centre

NHS

East Kent Hospitals University NHS Foundation Trust

NHS Staff Survey Benchmark report 2023

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Introduction

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

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About this report

This benchmark report for East Kent Hospitals University NHS Foundation Trust contains results for the 2023 NHS Staff Survey, and historical results back to 2019 where possible. These results are presented in the context of best, average and worst results for similar organisations where appropriate. Data in this report are weighted to allow for fair comparisons between organisations*.

Please note: Results for Q1, Q10a, Q26d, Q27a-c, Q28, Q29, Q30, Q31a, Q32a-b, Q33, Q34a-b and Q35 are not weighted or benchmarked because these questions ask for demographic or factual information.

Full details of how the data are calculated and weighted are included in the Technical Document, available to download from the Staff Survey website.

How results are reported

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

In support of this, the results of the NHS Staff Survey are measured against the seven People Promise elements and against two of the themes reported in previous years (Staff Engagement and Morale). The reporting also includes sub-scores, which feed into the People Promise elements and themes. The next slide shows how the People Promise elements, themes and subscores are related and mapped to individual survey questions.

* The data included in this report are weighted to the national benchmarking groups. The figures in this report may be different to the figures produced by your contractor. Please see Appendix C for a note on the revision to 2019 historical benchmarking for Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts, and Community Trust benchmarking groups.

People Promise elements, themes and sub-scores

Survey Coordination Centre NHS

People Promise elements	Sub-scores	Questions
We are compassionate and inclusive	Compassionate culture	Q6a, Q25a, Q25b, Q25c, Q25d
	Compassionate leadership	Q9f, Q9g, Q9h, Q9i
	Diversity and equality	Q15, Q16a, Q16b, Q21
	Inclusion	Q7h, Q7i, Q8b, Q8c
We are recognised and rewarded	No sub-score	Q4a, Q4b, Q4c, Q8d, Q9e
We each have a voice that counts	Autonomy and control	Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b
	Raising concerns	Q20a, Q20b, Q25e, Q25f
We are safe and healthy	Health and safety climate	Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d
	Burnout	Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g
	Negative experiences	Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c
	Other questions [Not scored]	Q17a*, Q17b*, Q22* *Q17a, Q17b and Q22 do not contribute to the calculation of any scores or sub-scores.
We are always learning	Development	Q24a, Q24b, Q24c, Q24d, Q24e
	Appraisals	Q23a*, Q23b, Q23c, Q23d *Q23a is a filter question and therefore influences the sub-score without being a directly scored question.
We work flexibly	Support for work-life balance	Q6b, Q6c, Q6d
	Flexible working	Q4d
We are a team	Team working	Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a
	Line management	Q9a, Q9b, Q9c, Q9d
Themes	**Sub-scores**	**Questions**
Staff Engagement	Motivation	Q2a, Q2b, Q2c
	Involvement	Q3c, Q3d, Q3f
	Advocacy	Q25a, Q25c, Q25d
Morale	Thinking about leaving	Q26a, Q26b, Q26c
	Work pressure	Q3g, Q3h, Q3i
	Stressors	Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a
Questions not linked to the People Promise elements or themes		
Q1, Q10a, Q10b, Q10c, Q11e, Q15, Q16c, Q18, Q19a, Q19b, Q19c, Q19d, Q26d, Q31b		

Report structure

Survey Coordination Centre NHS

Introduction

This section provides a brief introduction to the report, including how questions map to the People Promise elements, themes and sub-scores, as well as features of the charts used throughout.

Organisation details

This slide contains **key information** about the NHS organisations participating in this survey and details for your own organisation, such as response rate.

People Promise elements, themes and sub-scores: Overview

This section provides a high-level **overview** of the results for the seven elements of the People Promise and the two themes, followed by the results for each of the **sub-scores** that feed into these measures.

People Promise elements, themes and sub-scores: Trends

This section provides trend results for the seven elements of the People Promise and the two themes, followed by the trend results for each of the sub-scores that feed into these measures.

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score. For example, the Burnout sub-score, a higher score (closer to 10) means a lower proportion of staff are experiencing burnout from their work. These scores are created by scoring questions linked to these areas of experience and grouping these results together. Your organisation results are benchmarked against the benchmarking group average, the best scoring organisation and the worst scoring organisation. These charts are reported as percentages. The meaning of the value is outlined along the y axis. The questions that feed into each sub-score are detailed on slide 5.

Note where there are fewer than 10 responses for a question this data is not shown to protect the confidentiality of staff and reliability of results.

People Promise elements, themes and sub-scores: Questions

This section provides trend results for **questions**. The questions are presented in sections for each of the People Promise elements and themes. Not all questions reported within the section for a People Promise element or theme feed into the score and sub-scores for that element or theme. The first slide in the section for each People Promise element or theme lists which of the questions that are included in the section feed into the score and sub-scores, and which do not.

Questions not linked to People Promise

Results for the questions that are not related to any People Promise element or theme and do not contribute to the scores and sub-scores are included in this section.

Workforce Equality Standards

This section shows that data required for the indicators used in the **Workforce Race Equality Standard (WRES)** and the **Workforce Disability Equality Standard (WDES)**.

About your respondents

This section provides details of the staff responding to the survey, including their **demographic and other classification questions**.

Appendices

Here you will find:

- Response rate.
- Significance testing of the People Promise element and theme results for 2022 vs 2023.
- Guidance on data in the benchmark reports.
- Additional reporting outputs.
- Tips on action planning and interpreting the results.
- Contact information.

Using the report

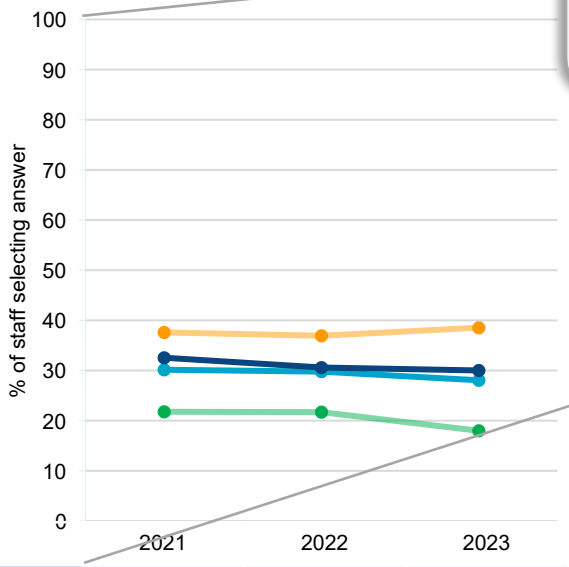
Survey Coordination Centre NHS

Note this is example data

Key features

Question number and text (or summary measure) specified at the top of each slide.

Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Summary measures and sub-scores are always on a 0-10pt scale where 10 is the best score attainable.

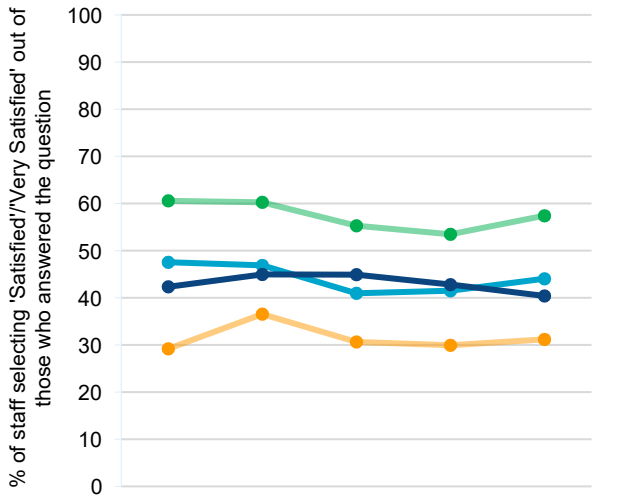


	2021	2022	2023
Your org	32.6%	30.6%	30.0%
Best result	21.8%	21.7%	18.0%
Average result	30.2%	29.8%	28.1%
Worst result	37.6%	36.9%	38.5%
Responses	480	500	515

Colour coding highlights best / worst results, making it easy to spot questions where a lower percentage is a better or worse result.

'Best result', 'Average result', and 'Worst result' refer to the **benchmarking group's** best, average and worst **results.**

Q4b How satisfied are you with each of the following aspects of your job?



	2019	2020	2021	2022	2023
Your org	42.3%	45.0%	44.9%	42.8%	40.4%
Best result	60.6%	60.3%	55.3%	53.5%	57.4%
Average result	47.5%	46.9%	41.0%	41.5%	44.0%
Worst result	29.2%	36.5%	30.6%	29.9%	31.2%
Responses	835	1255	1491	1325	517

Number of responses for the organisation for the given question.

Tips on how to read, interpret and use the data are included in the Appendices

Note charts will only display data for the years where an organisation has data. For example, an organisation with three years of trend data will see charts such as q4b with data only in the 2021, 2022 and 2023 portions of the chart and table.

Survey Coordination Centre

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Organisation details

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Survey Coordination Centre NHS

East Kent Hospitals University NHS Foundation Trust

2023 NHS Staff Surve

Organisation details

Completed questionnaires	4011
2023 response rate	41%

Survey details

Survey mode	Online

This organisation is benchmarked

Acute and Acute & Community Trusts

2023 benchmarking group details

Organisations in group: 122

Median response rate: 45%

No. of completed questionnaires: 477643

For more information on benchmarking group definitions please see the Technical document.

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People Promise elements, themes and sub-score results

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Survey Coordination Centre

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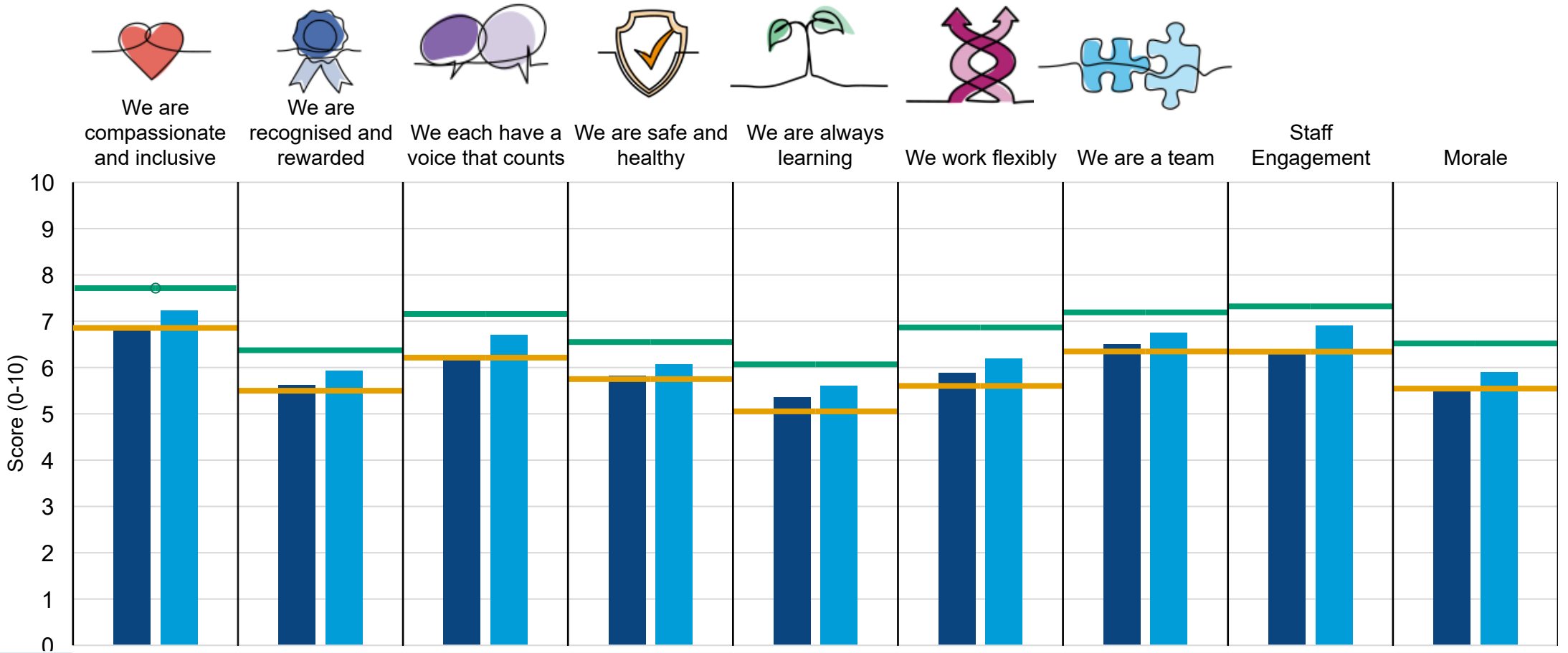
People Promise elements, themes and sub-scores: Overview

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and themes: Overview

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



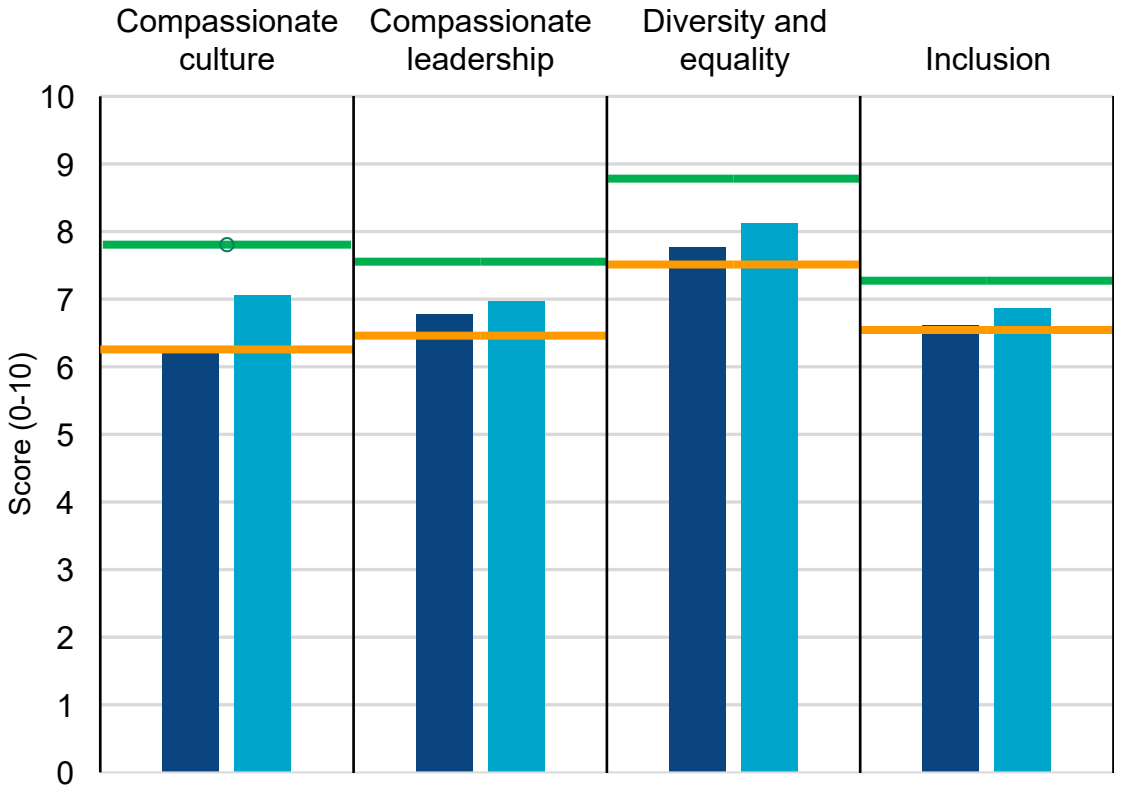
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	6.85	5.62	6.21	5.83	5.36	5.88	6.51	6.34	5.59
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	4003	4000	3972	3974	3756	3983	4002	4006	4007

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre NHS

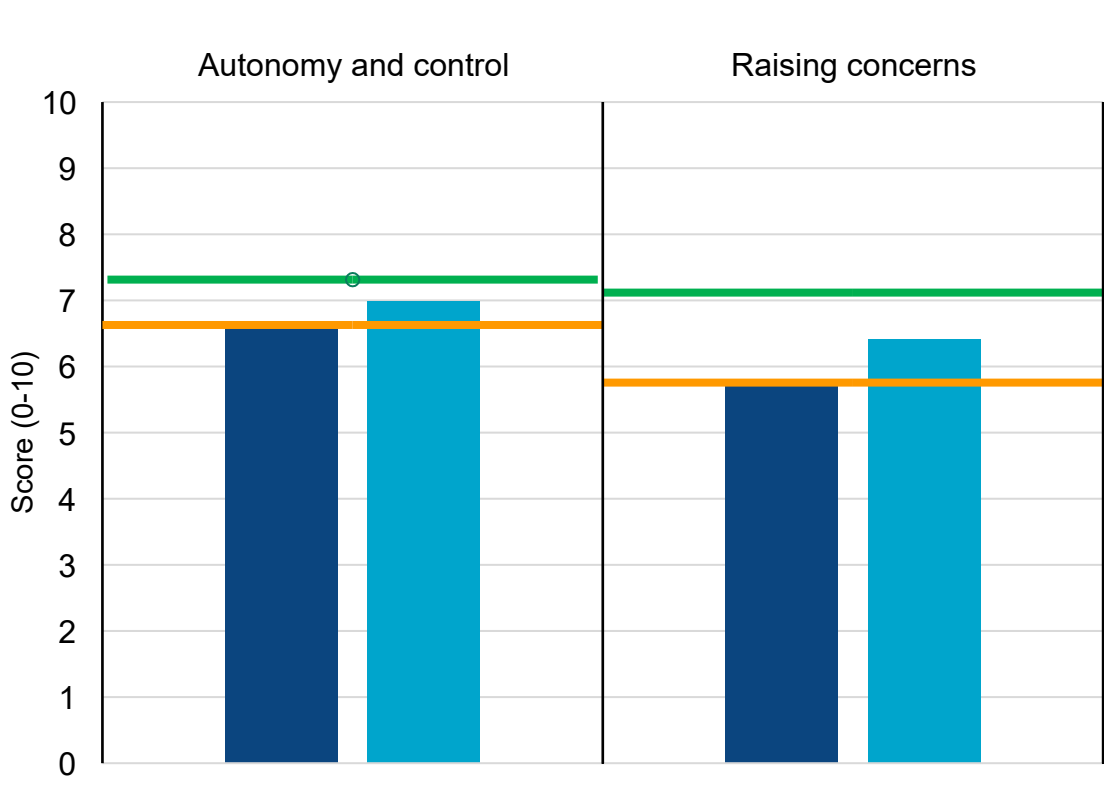
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	6.26	6.77	7.78	6.61
Best result	7.81	7.55	8.78	7.27
Average result	7.06	6.96	8.12	6.86
Worst result	6.26	6.46	7.51	6.54
Responses	3988	3997	4000	3998

Promise element 3: We each have a voice that counts



	Autonomy and control	Raising concerns
Your org	6.63	5.79
Best result	7.31	7.12
Average result	6.99	6.41
Worst result	6.63	5.76
Responses	4003	3978

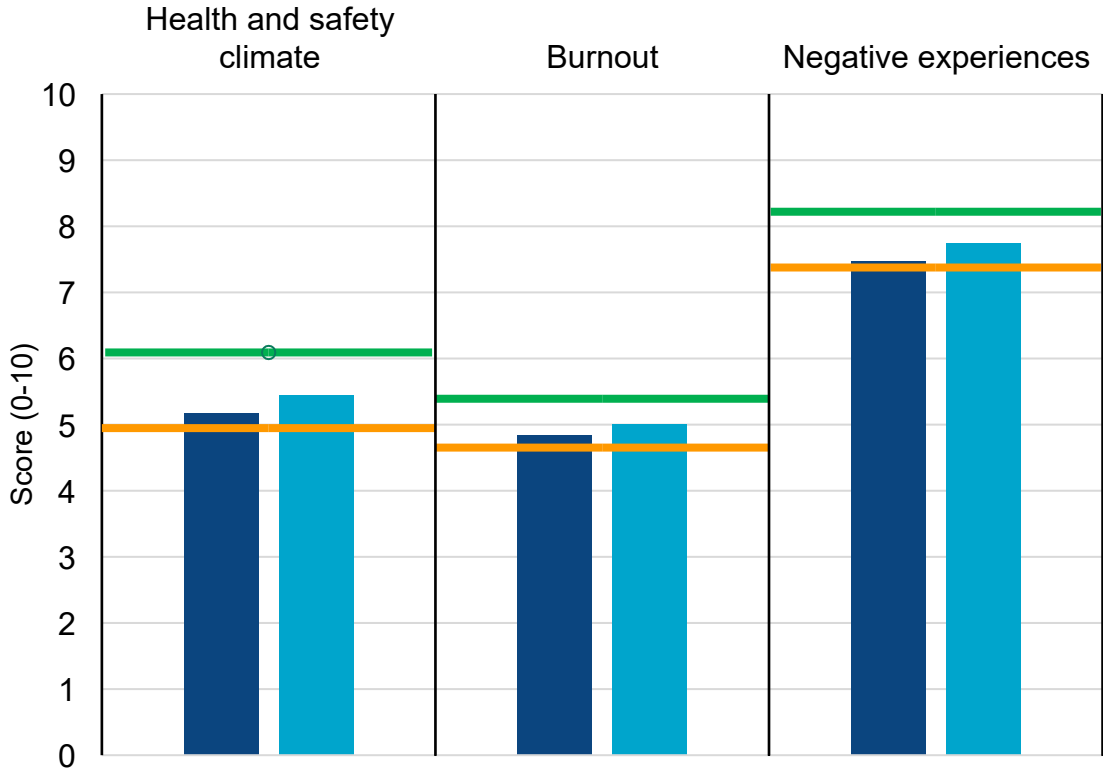
Note. People Promise element 2 'We are recognised and rewarded' does not have any sub-scores. Overall trend score data for this element is reported on slide 21.

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre

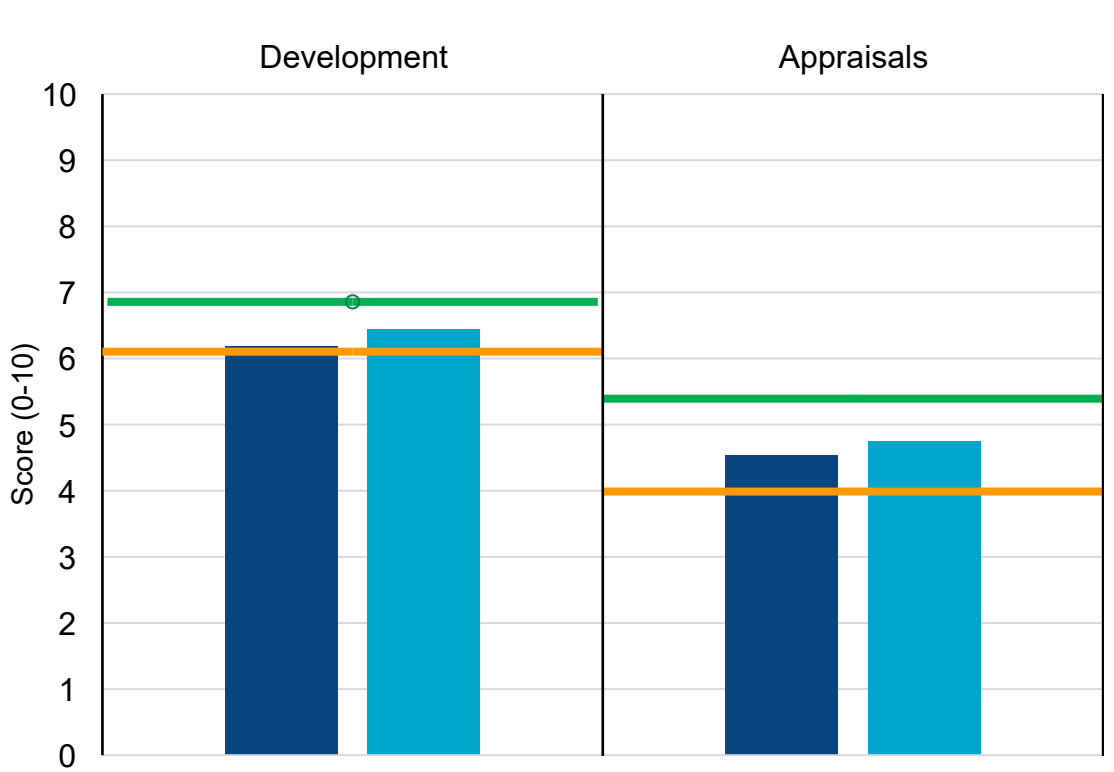
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Your org	5.17	4.84	7.48
Best result	6.09	5.39	8.22
Average result	5.45	5.00	7.75
Worst result	4.95	4.65	7.38
Responses	4002	4005	3984

Promise element 5: We are always learning



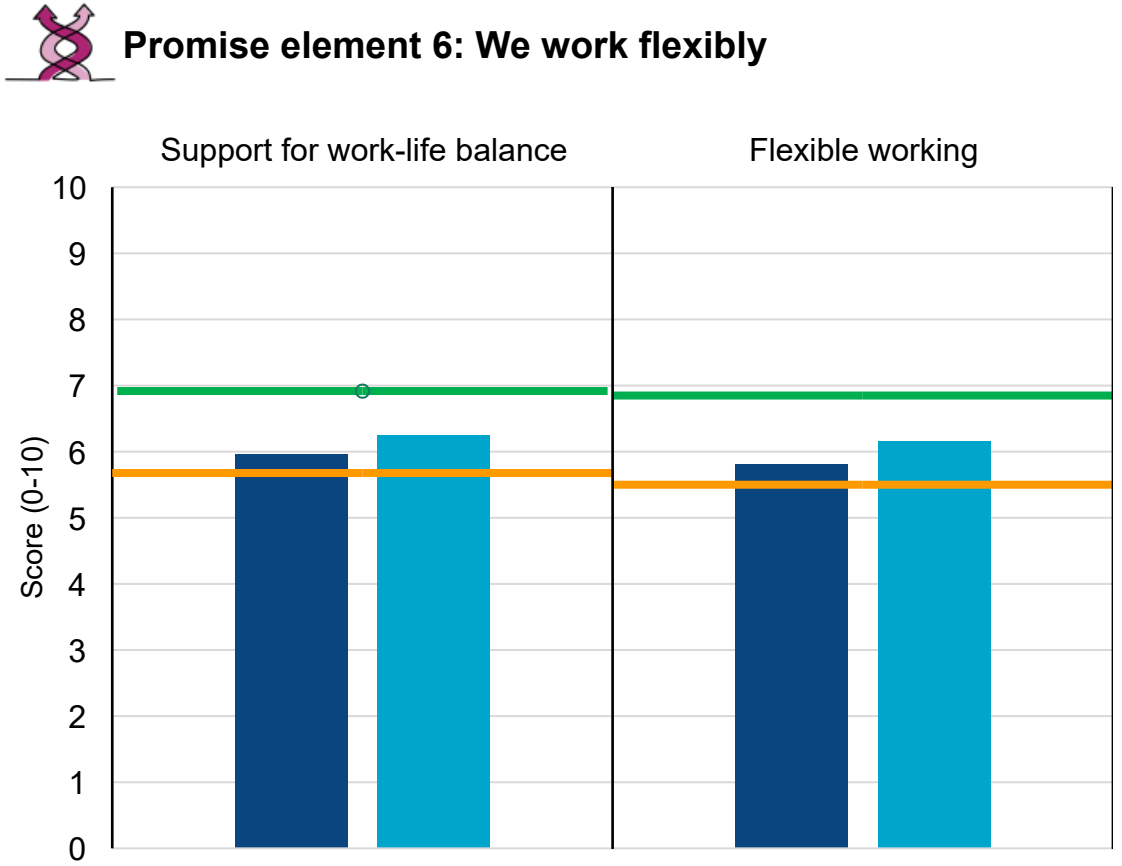
	Development	Appraisals
Your org	6.18	4.54
Best result	6.86	5.39
Average result	6.44	4.74
Worst result	6.10	3.99
Responses	3995	3759

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre NHS

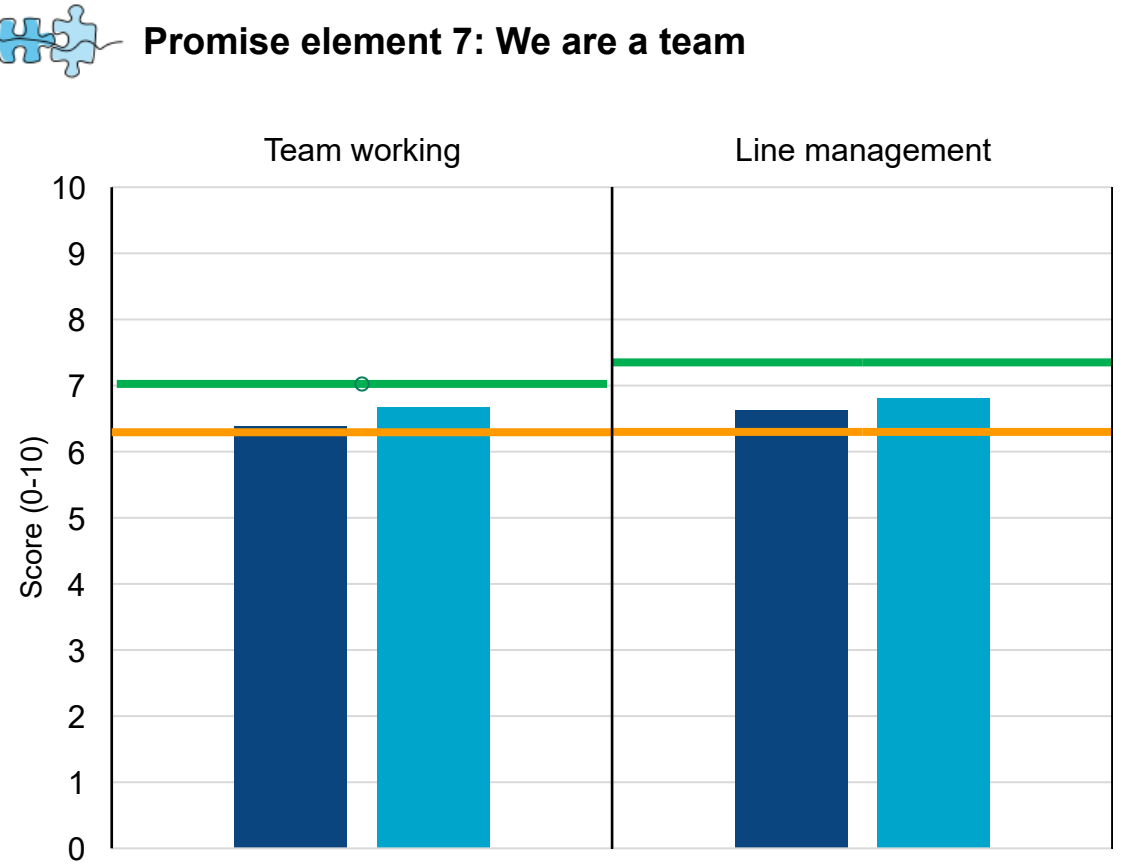
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 6: We work flexibly



	Support for work-life balance	Flexible working
Your org	5.96	5.80
Best result	6.92	6.85
Average result	6.25	6.15
Worst result	5.68	5.50
Responses	4003	3985

Promise element 7: We are a team



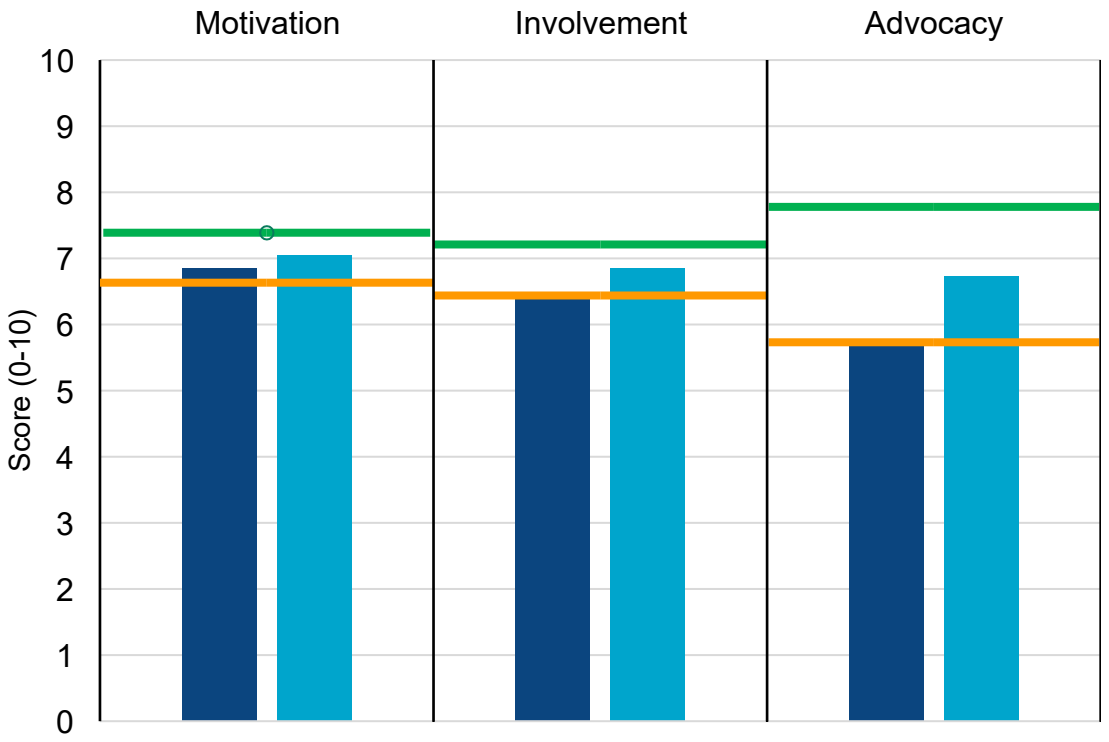
	Team working	Line management
Your org	6.39	6.63
Best result	7.03	7.35
Average result	6.68	6.80
Worst result	6.29	6.30
Responses	4005	4005

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre NHS

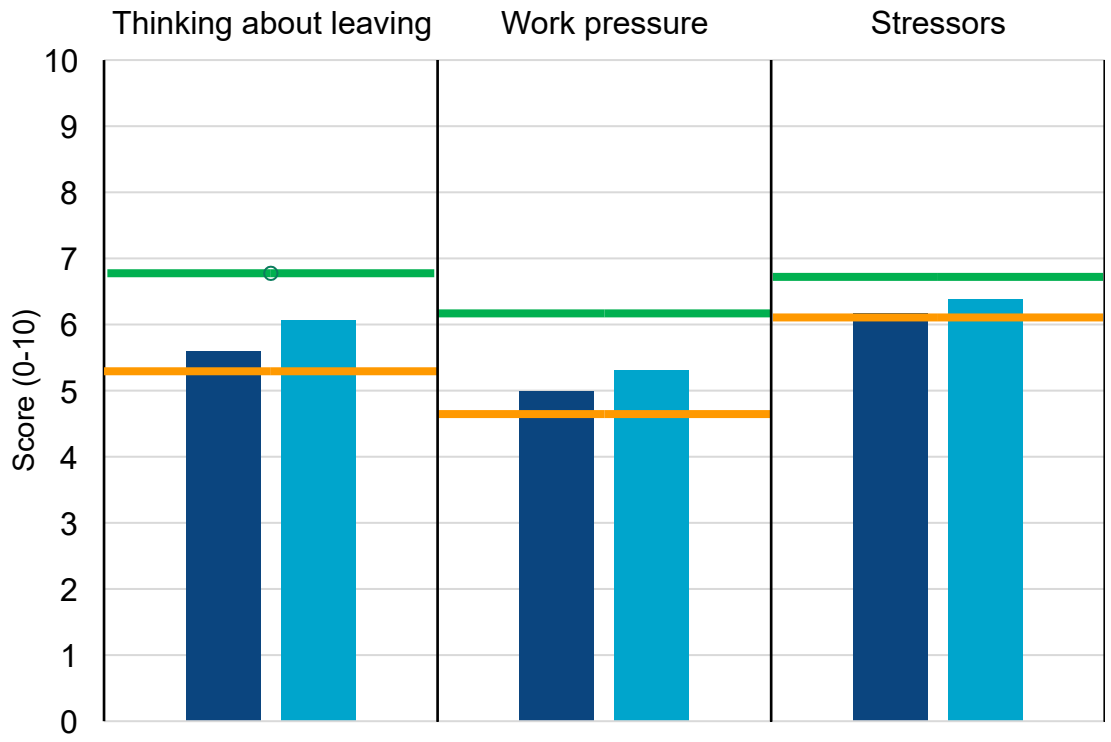
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff engagement



	Motivation	Involvement	Advocacy
Your org	6.84	6.46	5.73
Best result	7.39	7.21	7.78
Average result	7.04	6.86	6.74
Worst result	6.63	6.44	5.73
Responses	3961	4002	3988

Theme: Morale



	Thinking about leaving	Work pressure	Stressors
Your org	5.59	4.99	6.18
Best result	6.78	6.17	6.72
Average result	6.06	5.31	6.38
Worst result	5.29	4.65	6.11
Responses	3997	4001	4002

Survey Coordination Centre

NHS

People Promise elements, themes and sub-scores: Trends

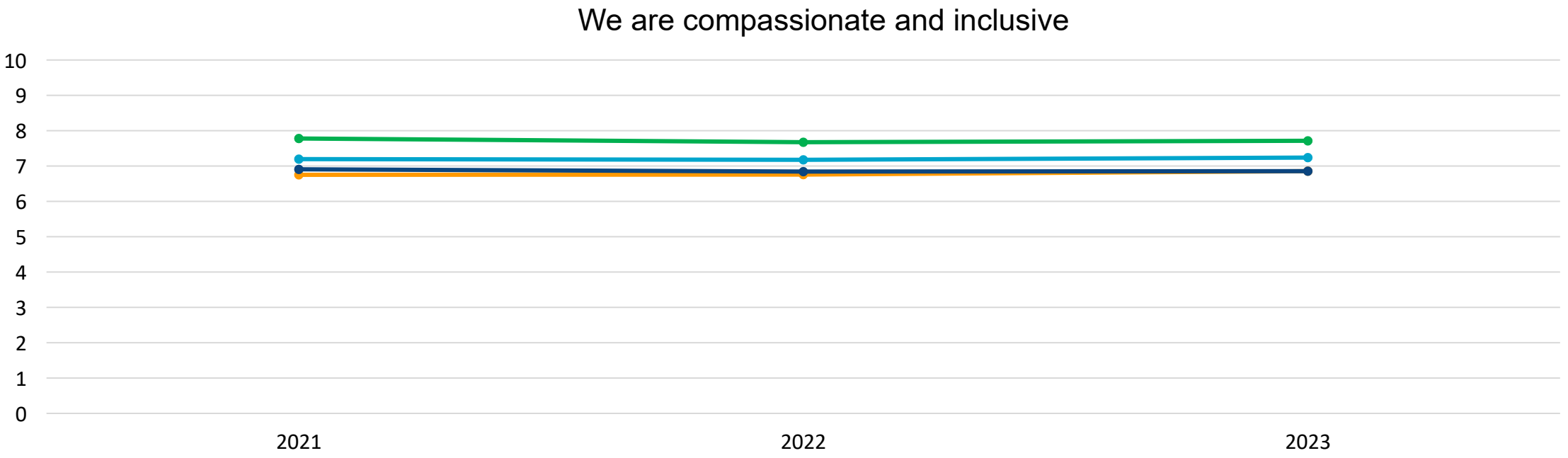
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	2021	2022	2023
Your org	6.91	6.84	6.85
Best result	7.78	7.67	7.71
Average result	7.20	7.18	7.24
Worst result	6.75	6.76	6.85
Responses	4407	4012	4003

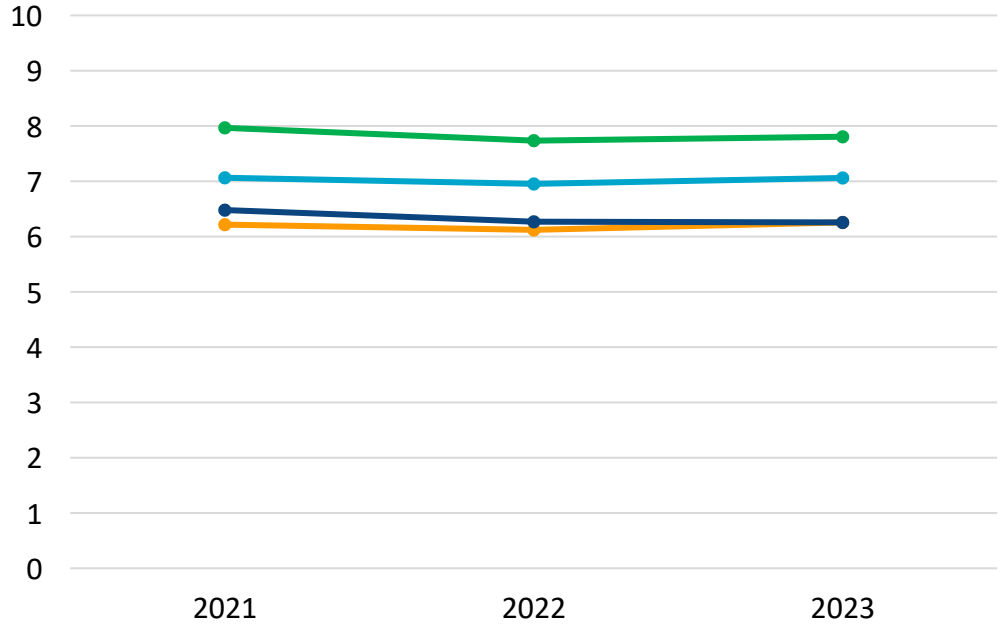
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

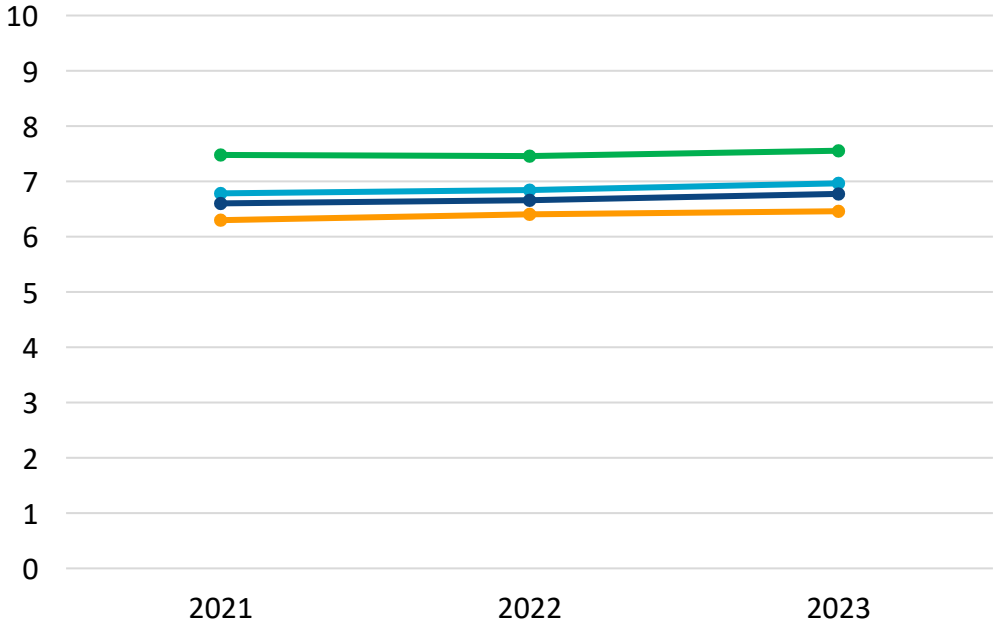
Promise element 1: We are compassionate and inclusive (1)

Compassionate culture



	2021	2022	2023
Your org	6.48	6.27	6.26
Best result	7.97	7.74	7.81
Average result	7.06	6.95	7.06
Worst result	6.22	6.12	6.26
Responses	4334	4001	3988

Compassionate leadership



	2021	2022	2023
Your org	6.60	6.66	6.77
Best result	7.48	7.46	7.55
Average result	6.78	6.84	6.96
Worst result	6.30	6.40	6.46
Responses	4429	4008	3997

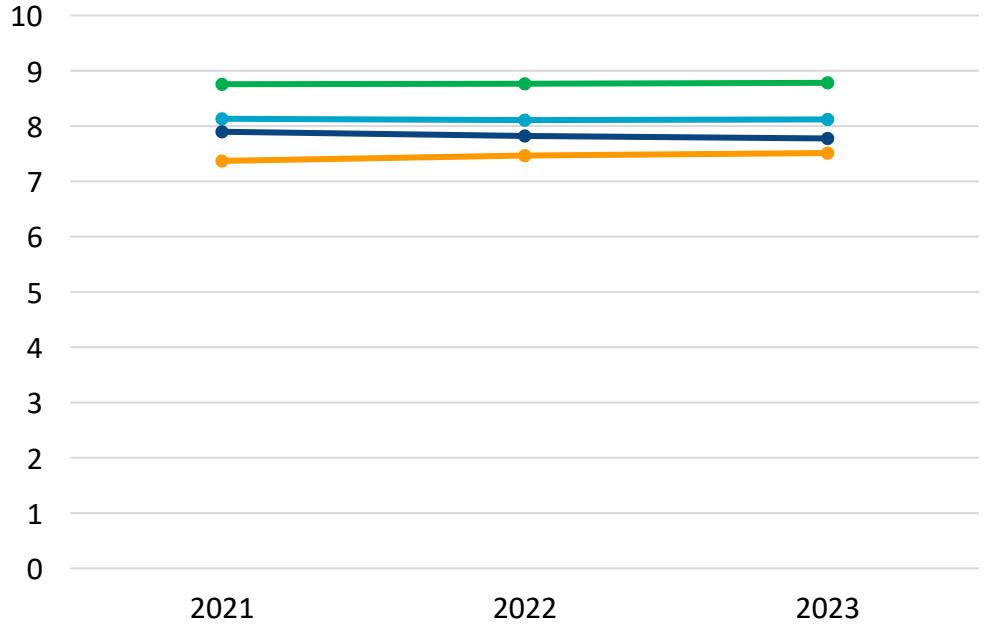
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

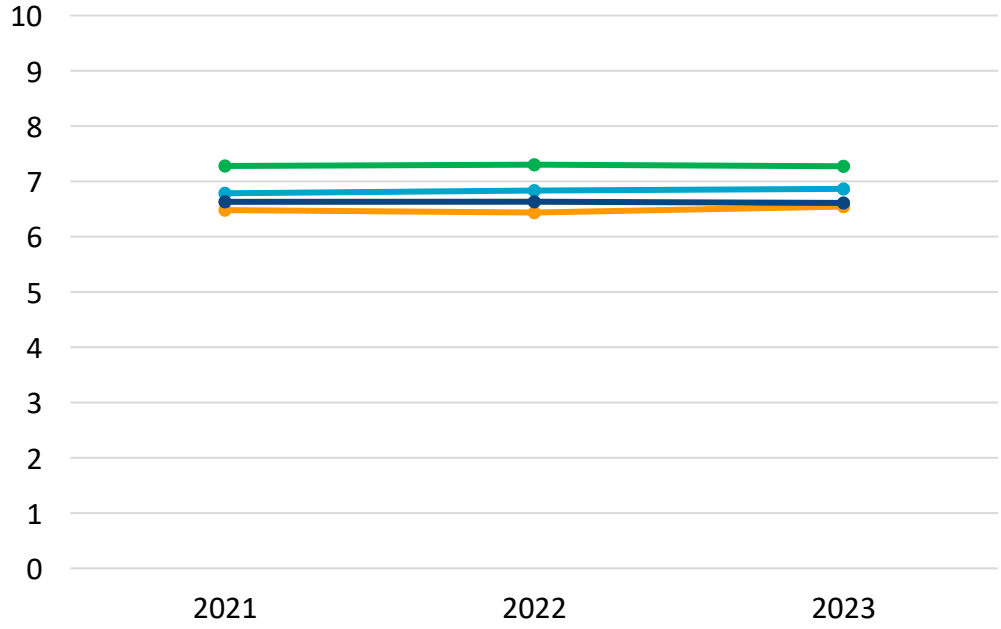
Promise element 1: We are compassionate and inclusive (2)

Diversity and equality



	2021	2022	2023
Your org	7.90	7.82	7.78
Best result	8.76	8.77	8.78
Average result	8.13	8.11	8.12
Worst result	7.37	7.47	7.51
Responses	4404	4001	4000

Inclusion



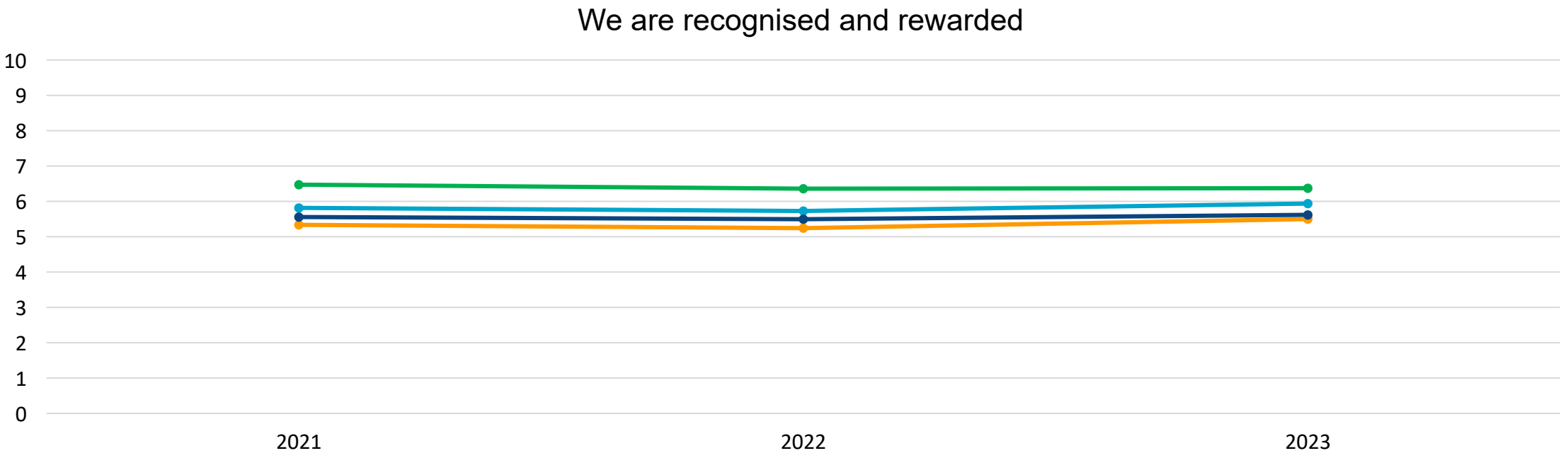
	2021	2022	2023
Your org	6.63	6.63	6.61
Best result	7.28	7.30	7.27
Average result	6.78	6.83	6.86
Worst result	6.48	6.44	6.54
Responses	4457	4012	3998

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 2: We are recognised and rewarded



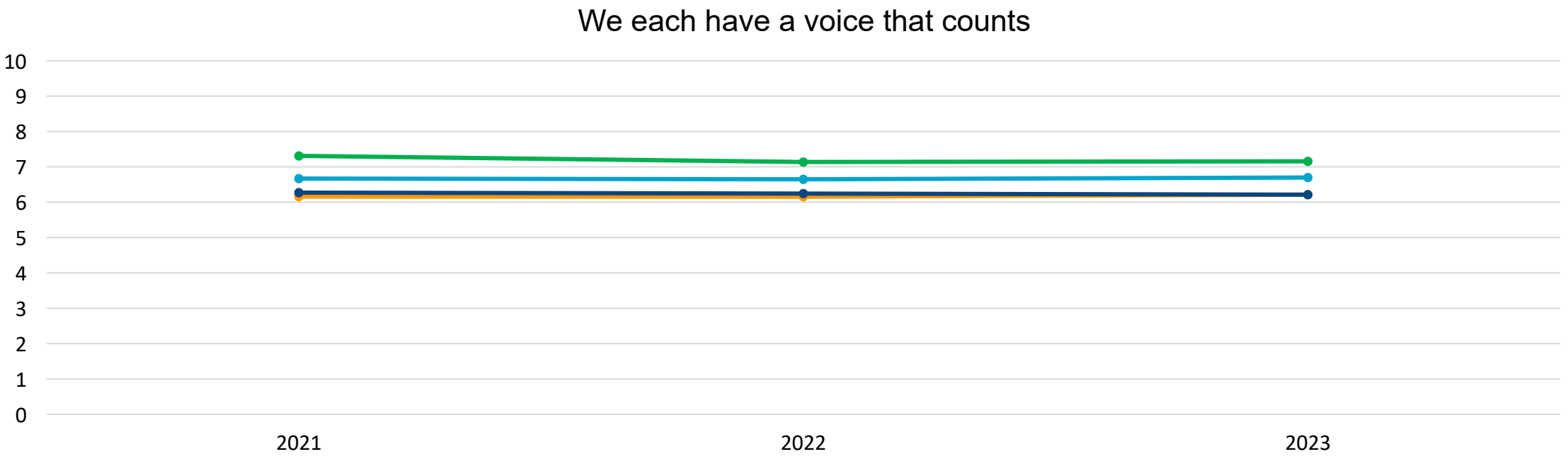
	2021	2022	2023
Your org	5.56	5.50	5.62
Best result	6.47	6.36	6.37
Average result	5.82	5.73	5.94
Worst result	5.34	5.24	5.50
Responses	4515	4015	4000

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 3: We each have a voice that counts



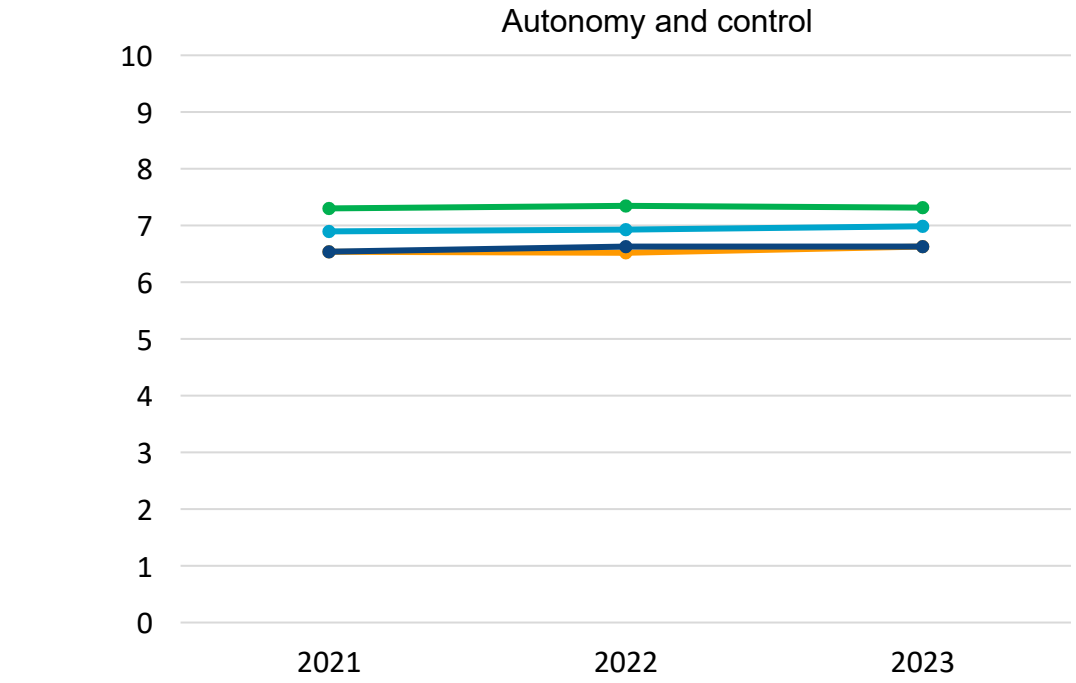
	2021	2022	2023
Your org	6.27	6.24	6.21
Best result	7.31	7.14	7.16
Average result	6.67	6.65	6.70
Worst result	6.16	6.16	6.21
Responses	4319	3988	3972

People Promise elements, themes and sub-scores: Sub-score trends

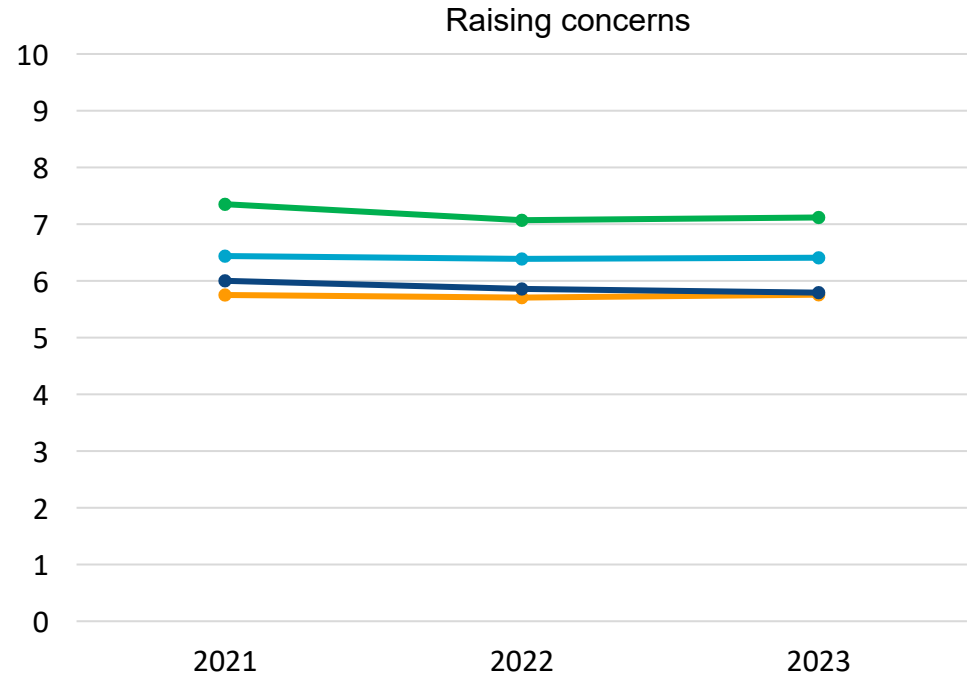
Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 3: We each have a voice that counts



	2021	2022	2023
Your org	6.54	6.63	6.63
Best result	7.30	7.35	7.31
Average result	6.90	6.93	6.99
Worst result	6.54	6.52	6.63
Responses	4523	4014	4003



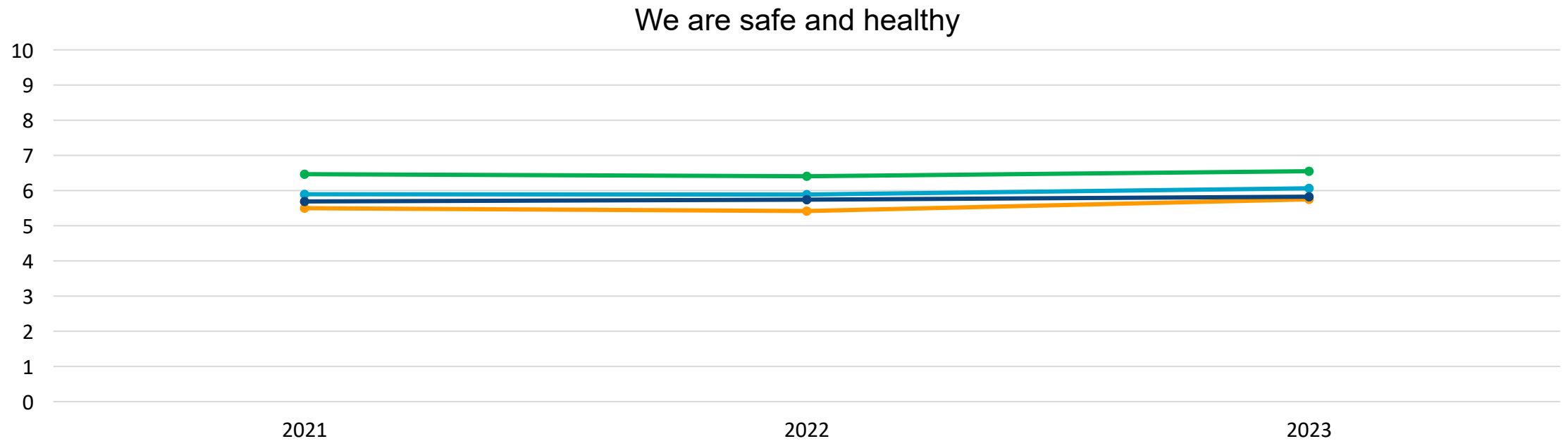
	2021	2022	2023
Your org	6.00	5.86	5.79
Best result	7.35	7.07	7.12
Average result	6.44	6.39	6.41
Worst result	5.75	5.71	5.76
Responses	4322	3993	3978

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



	2021	2022	2023
Your org	5.69	5.74	5.83
Best result	6.47	6.41	6.55
Average result	5.90	5.89	6.06
Worst result	5.50	5.42	5.75
Responses	4398	3998	3974

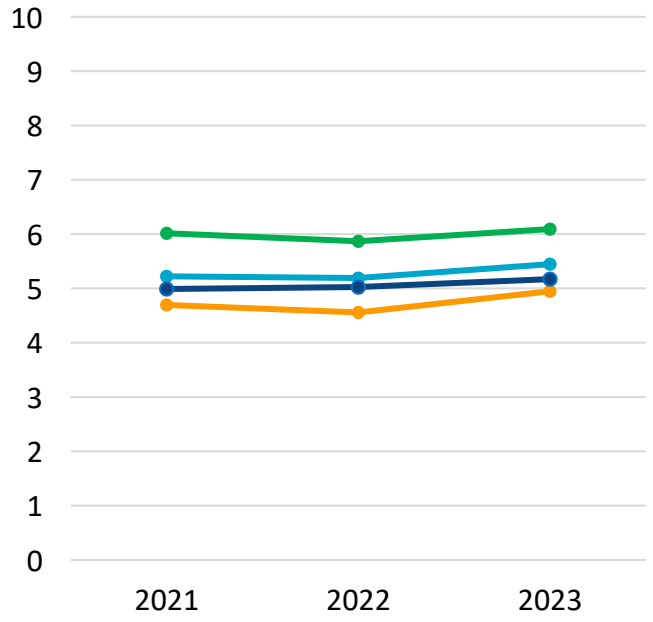
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

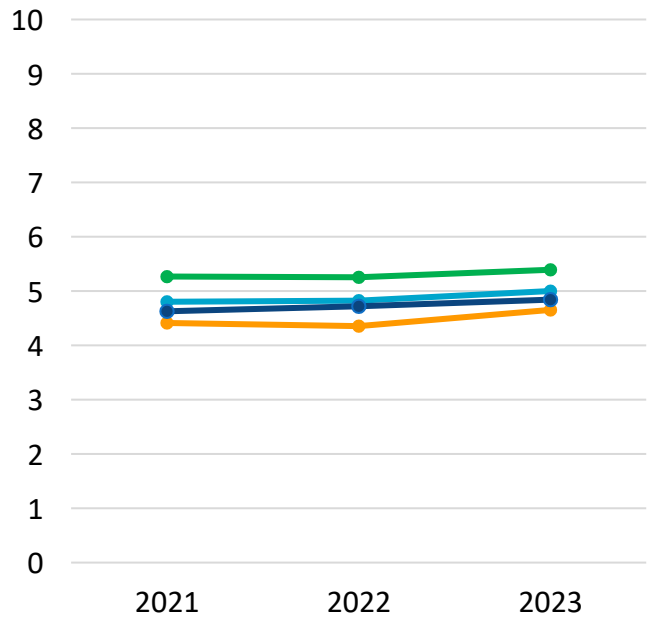
Promise element 4: We are safe and healthy

Health and safety climate



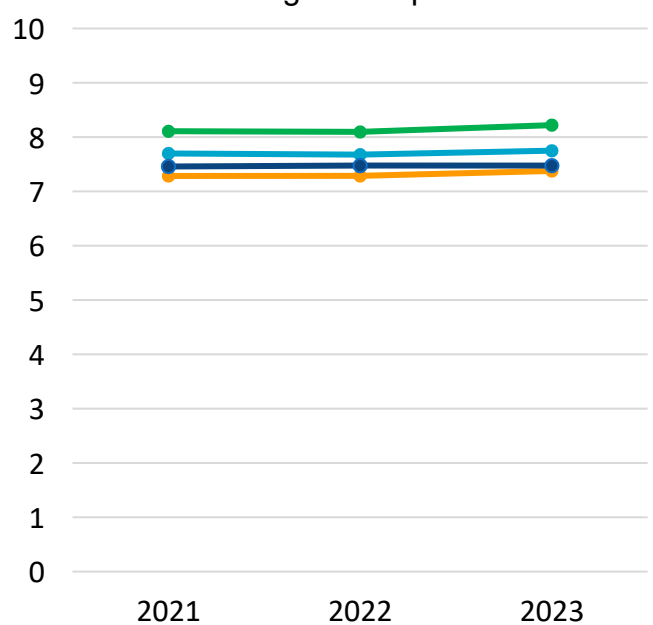
	2021	2022	2023
Your org	4.99	5.02	5.17
Best result	6.01	5.87	6.09
Average result	5.22	5.19	5.45
Worst result	4.69	4.56	4.95
Responses	4524	4016	4002

Burnout



	2021	2022	2023
Your org	4.63	4.72	4.84
Best result	5.27	5.25	5.39
Average result	4.80	4.82	5.00
Worst result	4.41	4.35	4.65
Responses	4412	4011	4005

Negative experiences



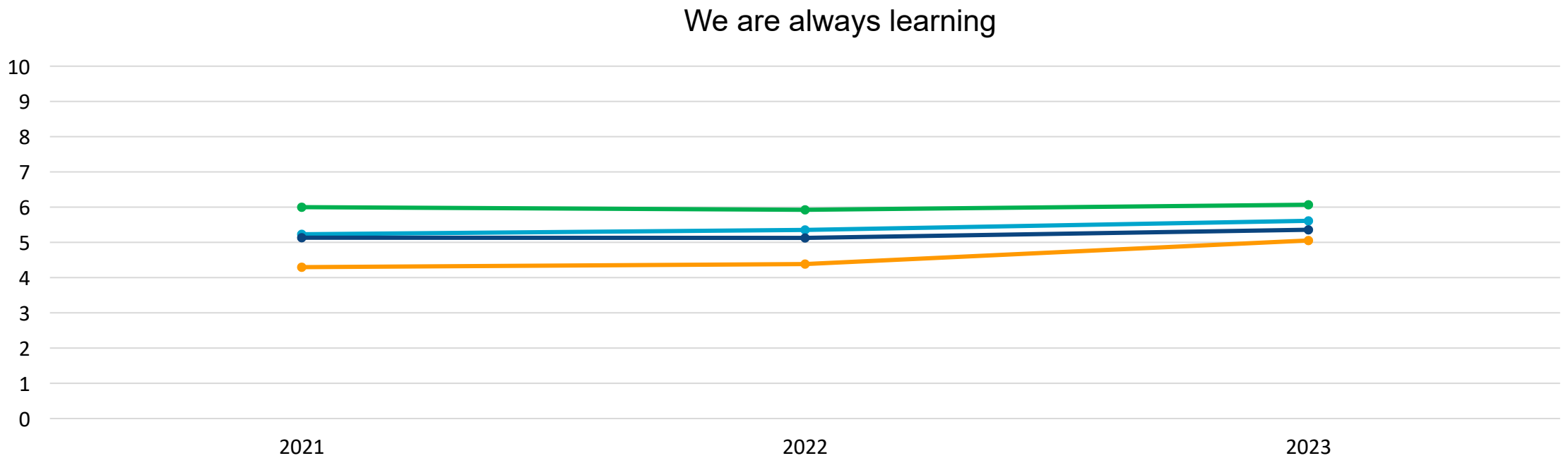
	2021	2022	2023
Your org	7.46	7.48	7.48
Best result	8.11	8.10	8.22
Average result	7.70	7.68	7.75
Worst result	7.28	7.29	7.38
Responses	4408	4006	3984

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 5: We are always learning



	2021	2022	2023
Your org	5.13	5.13	5.36
Best result	6.00	5.92	6.07
Average result	5.23	5.35	5.61
Worst result	4.30	4.38	5.05
Responses	4183	3813	3756

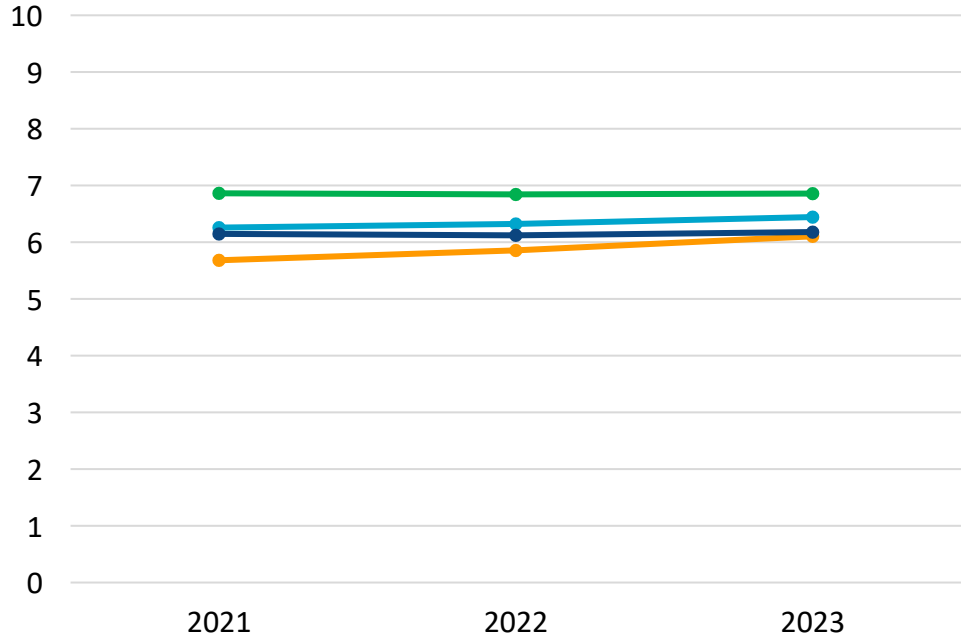
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

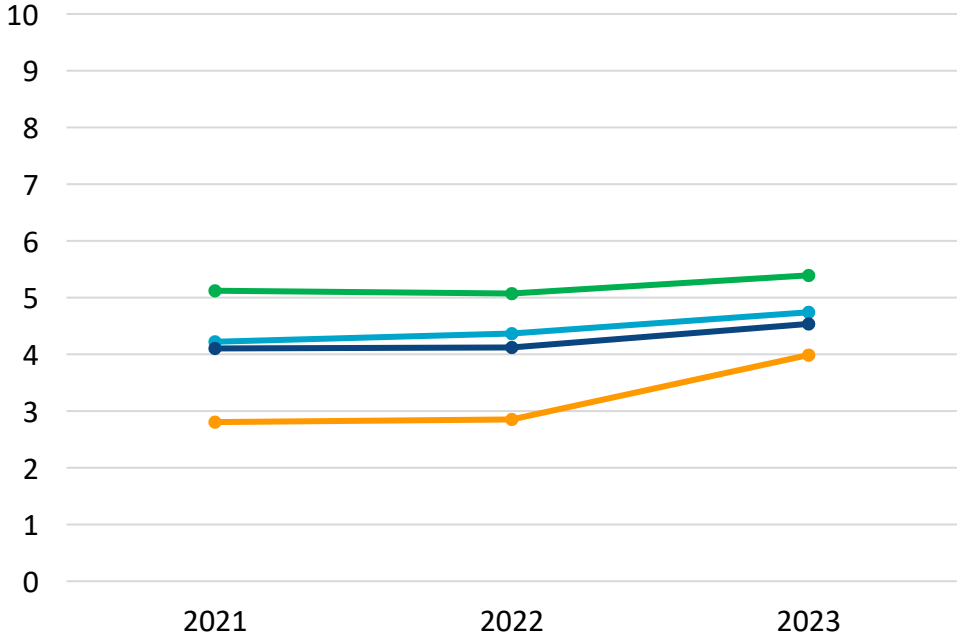
Promise element 5: We are always learning

Development



	2021	2022	2023
Your org	6.15	6.12	6.18
Best result	6.86	6.84	6.86
Average result	6.26	6.32	6.44
Worst result	5.68	5.86	6.10
Responses	4367	3998	3995

Appraisals



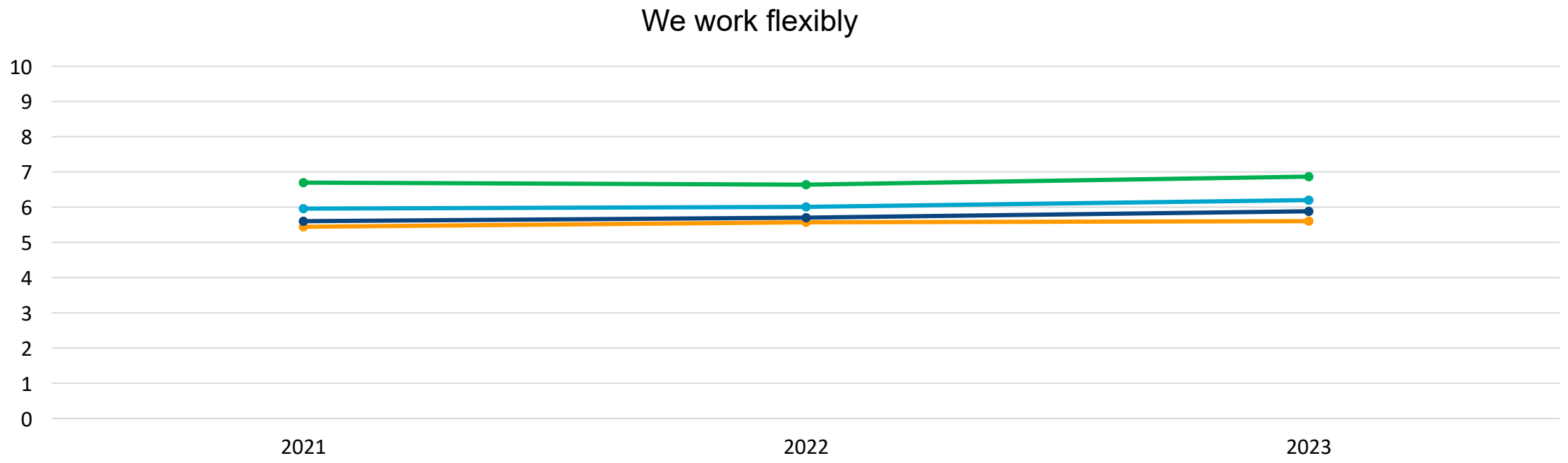
	2021	2022	2023
Your org	4.10	4.12	4.54
Best result	5.12	5.07	5.39
Average result	4.22	4.37	4.74
Worst result	2.81	2.85	3.99
Responses	4213	3829	3759

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 6: We work flexibly



	2021	2022	2023
Your org	5.60	5.70	5.88
Best result	6.70	6.64	6.87
Average result	5.96	6.01	6.20
Worst result	5.44	5.57	5.60
Responses	4486	4009	3983

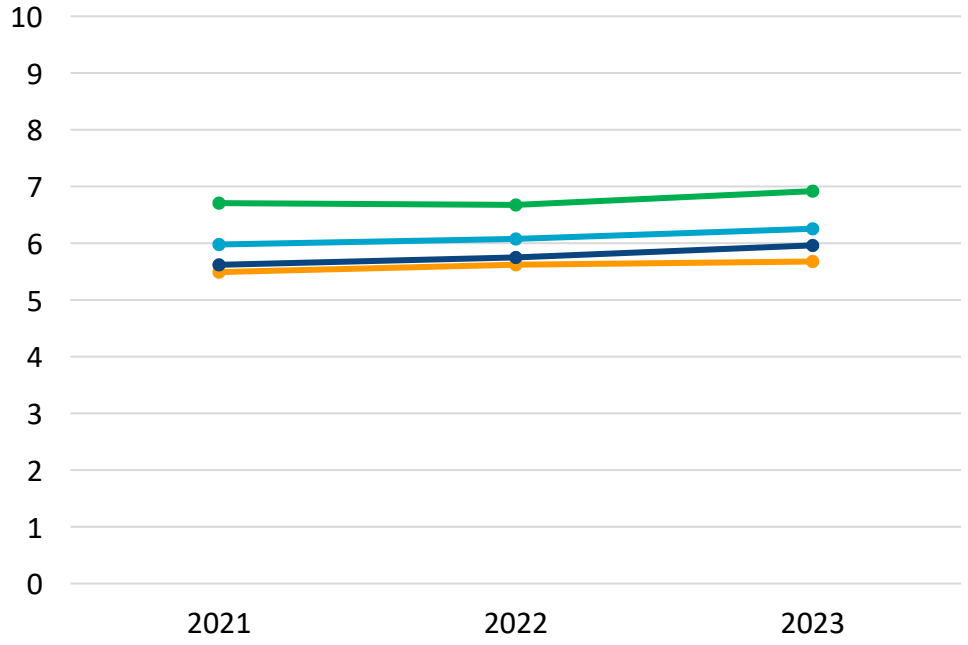
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

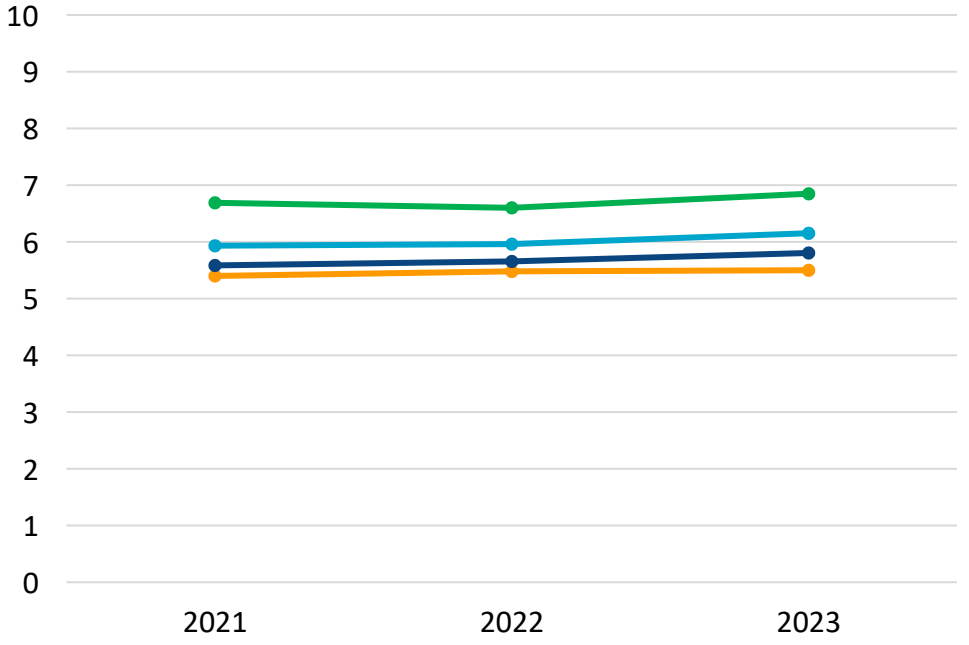
Promise element 6: We work flexibly

Support for work-life balance



	2021	2022	2023
Your org	5.62	5.75	5.96
Best result	6.71	6.68	6.92
Average result	5.98	6.08	6.25
Worst result	5.49	5.62	5.68
Responses	4494	4017	4003

Flexible working



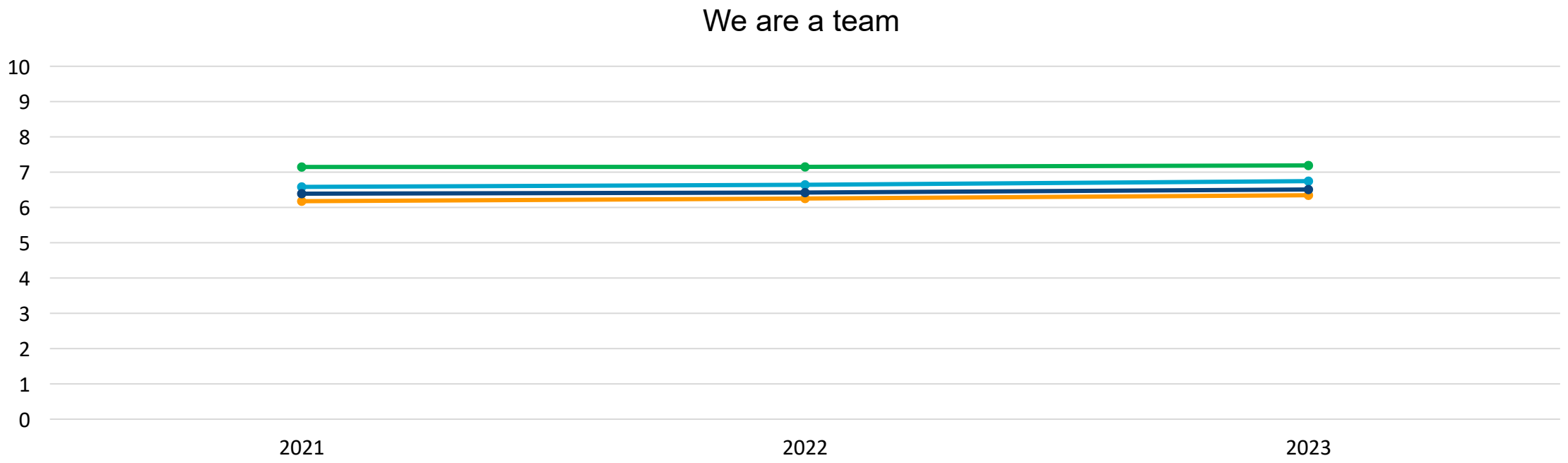
	2021	2022	2023
Your org	5.59	5.66	5.80
Best result	6.69	6.60	6.85
Average result	5.93	5.96	6.15
Worst result	5.40	5.48	5.50
Responses	4509	4012	3985

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 7: We are a team



	2021	2022	2023
Your org	6.39	6.42	6.51
Best result	7.15	7.15	7.19
Average result	6.58	6.64	6.75
Worst result	6.18	6.25	6.35
Responses	4435	4008	4002

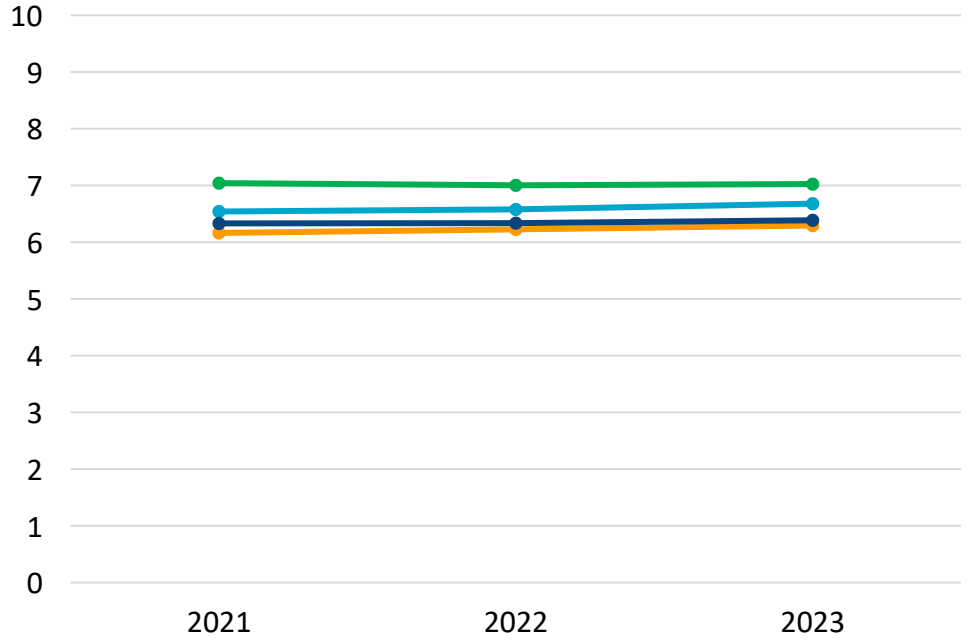
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

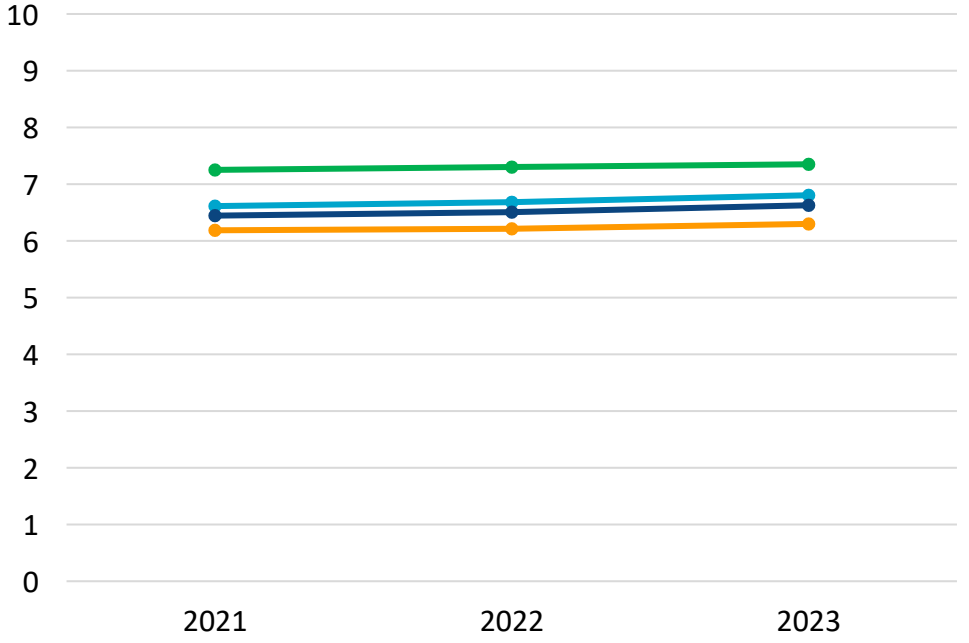
Promise element 7: We are a team

Team working



	2021	2022	2023
Your org	6.33	6.34	6.39
Best result	7.04	7.00	7.03
Average result	6.54	6.58	6.68
Worst result	6.16	6.23	6.29
Responses	4474	4016	4005

Line management



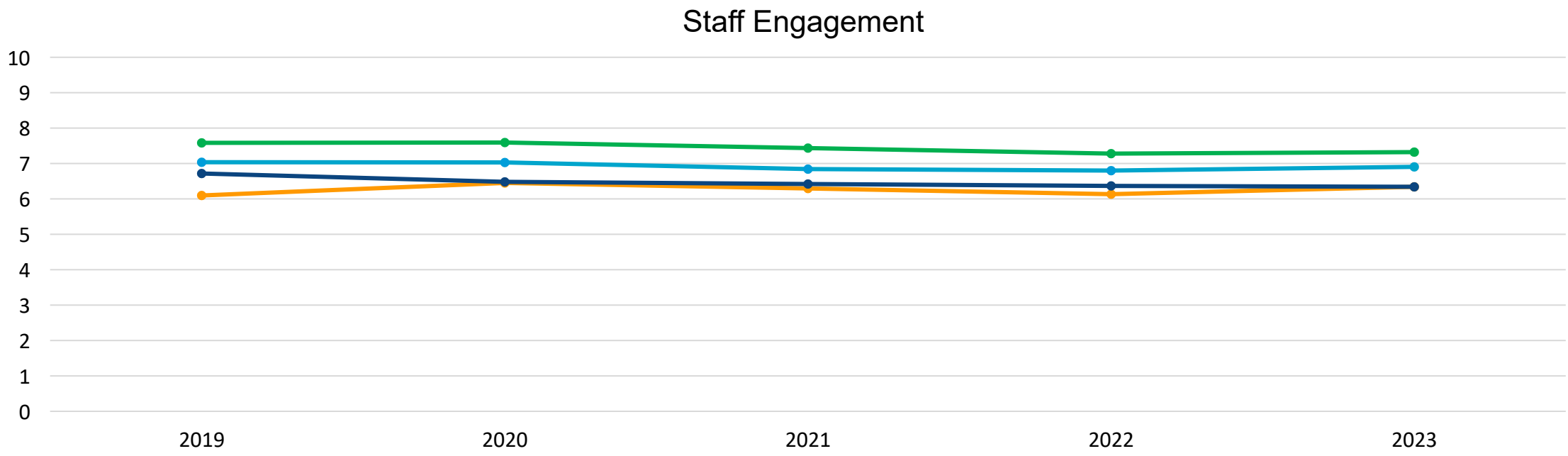
	2021	2022	2023
Your org	6.45	6.51	6.63
Best result	7.25	7.30	7.35
Average result	6.61	6.68	6.80
Worst result	6.19	6.21	6.30
Responses	4436	4010	4005

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff Engagement



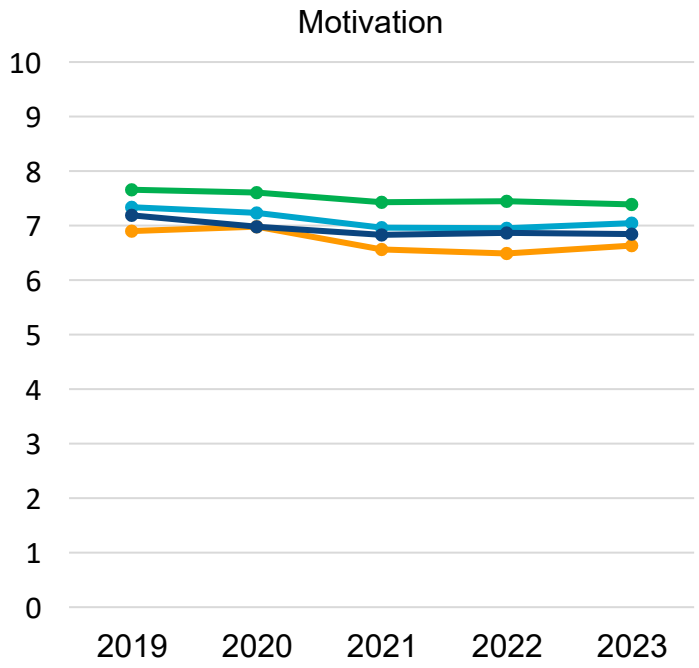
	2019	2020	2021	2022	2023
Your org	6.72	6.48	6.42	6.37	6.34
Best result	7.58	7.59	7.44	7.28	7.32
Average result	7.04	7.03	6.84	6.80	6.91
Worst result	6.10	6.45	6.30	6.13	6.34
Responses	4267	3465	4520	4018	4006

People Promise elements, themes and sub-scores: Sub-score trends

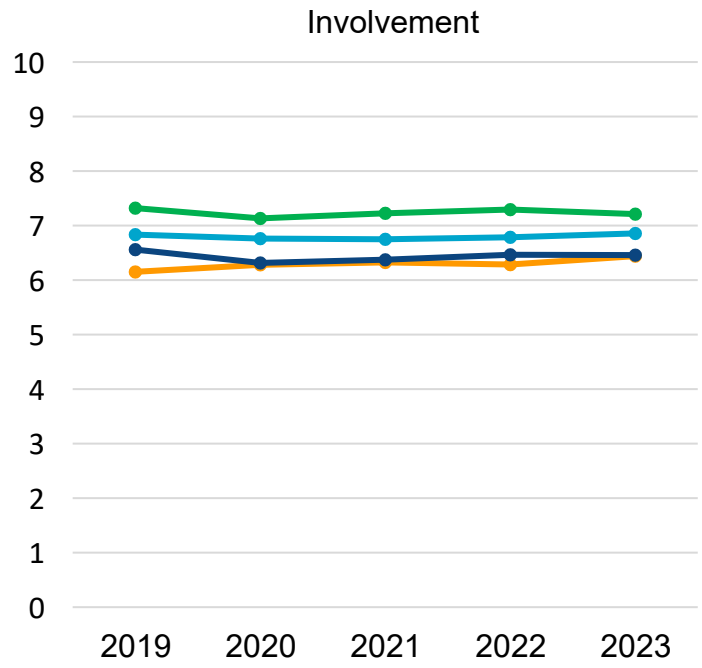
Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

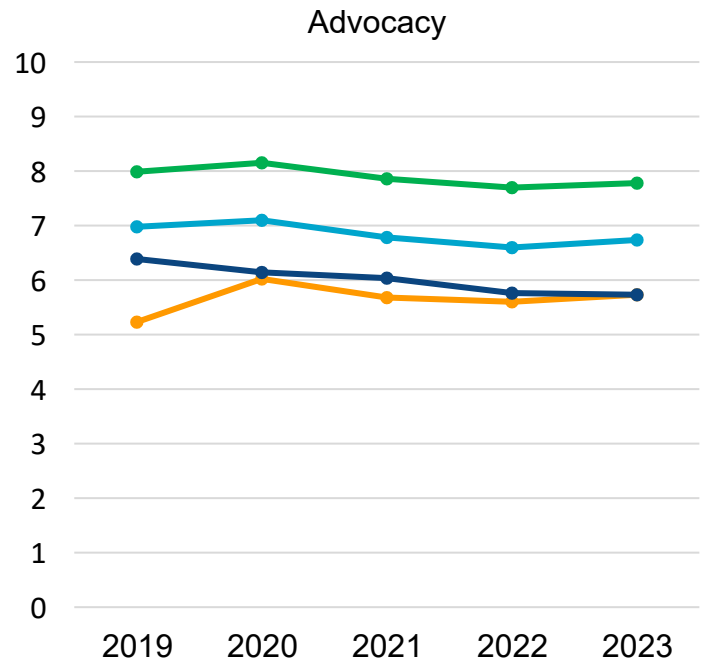
Theme: Staff Engagement



	2019	2020	2021	2022	2023
Your org	7.19	6.98	6.83	6.87	6.84
Best result	7.66	7.61	7.43	7.45	7.39
Average result	7.34	7.23	6.96	6.95	7.04
Worst result	6.90	6.98	6.56	6.49	6.63
Responses	4241	3508	4531	3995	3961



	2019	2020	2021	2022	2023
Your org	6.56	6.31	6.37	6.46	6.46
Best result	7.32	7.13	7.22	7.29	7.21
Average result	6.83	6.76	6.75	6.79	6.86
Worst result	6.15	6.28	6.32	6.29	6.44
Responses	4269	3464	4524	4014	4002



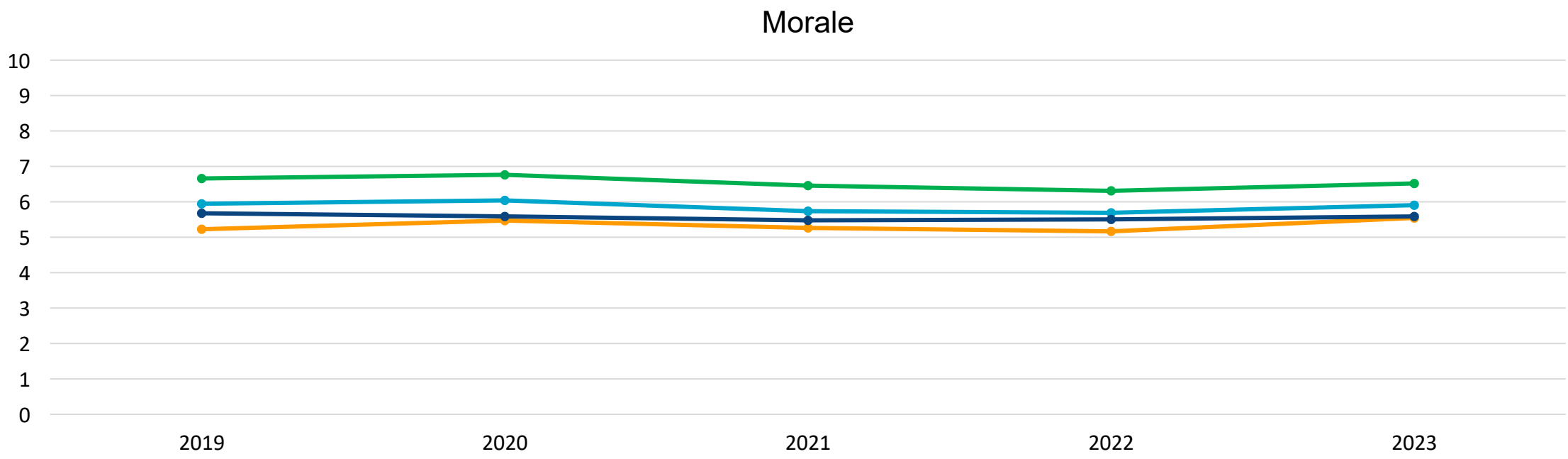
	2019	2020	2021	2022	2023
Your org	6.39	6.14	6.04	5.76	5.73
Best result	7.99	8.15	7.86	7.70	7.78
Average result	6.98	7.10	6.78	6.60	6.74
Worst result	5.23	6.02	5.68	5.60	5.73
Responses	4071	3335	4334	4000	3988

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Morale



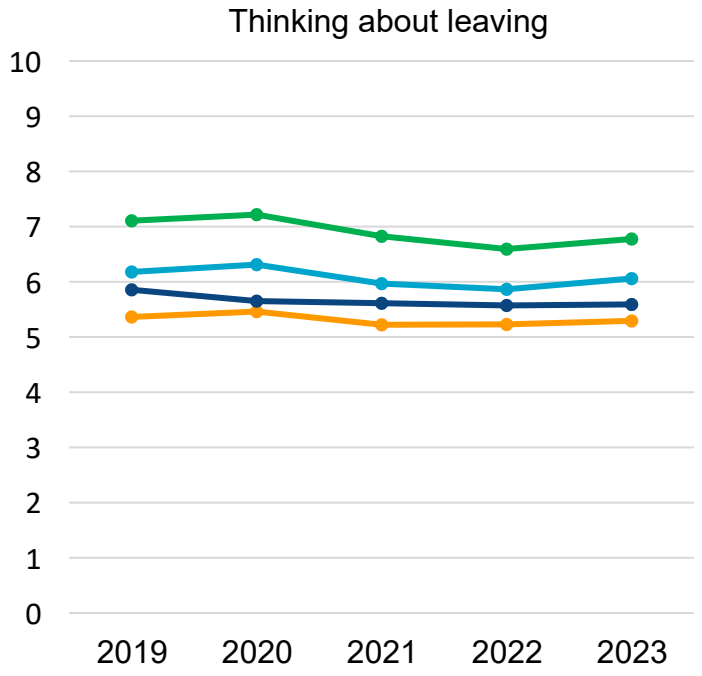
	2019	2020	2021	2022	2023
Your org	5.68	5.59	5.48	5.50	5.59
Best result	6.66	6.76	6.46	6.31	6.52
Average result	5.95	6.04	5.74	5.69	5.91
Worst result	5.23	5.47	5.26	5.17	5.54
Responses	4215	3442	4512	4017	4007

People Promise elements, themes and sub-scores: Sub-score trends

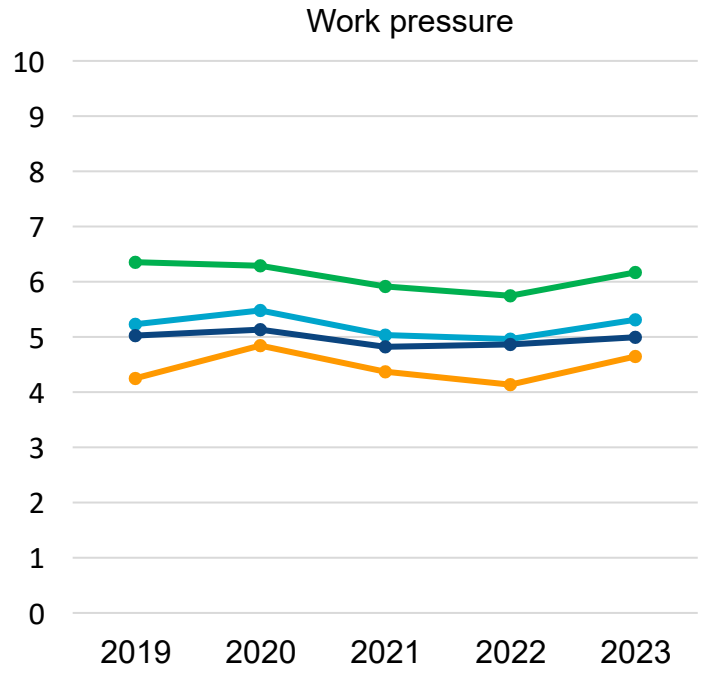
Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

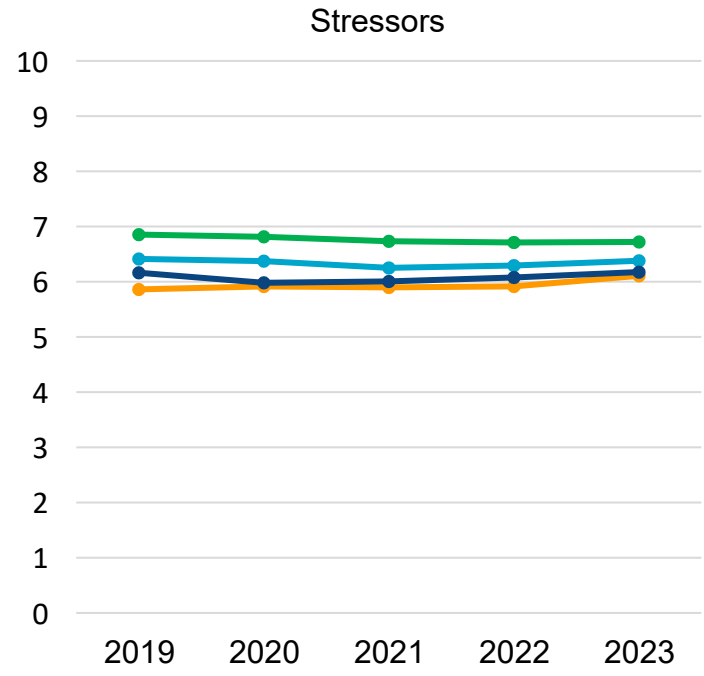
Theme: Morale



	2019	2020	2021	2022	2023
Your org	5.86	5.65	5.61	5.57	5.59
Best result	7.11	7.22	6.83	6.59	6.78
Average result	6.18	6.31	5.97	5.86	6.06
Worst result	5.36	5.46	5.22	5.23	5.29
Responses	4063	3335	4310	3980	3997



	2019	2020	2021	2022	2023
Your org	5.02	5.13	4.82	4.86	4.99
Best result	6.35	6.29	5.91	5.75	6.17
Average result	5.23	5.48	5.03	4.96	5.31
Worst result	4.25	4.84	4.37	4.14	4.65
Responses	4269	3461	4525	4015	4001

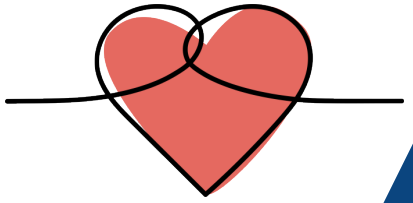


	2019	2020	2021	2022	2023
Your org	6.16	5.98	6.01	6.08	6.18
Best result	6.85	6.81	6.73	6.71	6.72
Average result	6.41	6.37	6.25	6.29	6.38
Worst result	5.86	5.91	5.90	5.92	6.11
Responses	4202	3440	4497	4010	4002

Survey Coordination Centre

NHS

People Promise element – We are compassionate and inclusive



Questions included:

Compassionate culture – Q6a, Q25a, Q25b, Q25c, Q25d

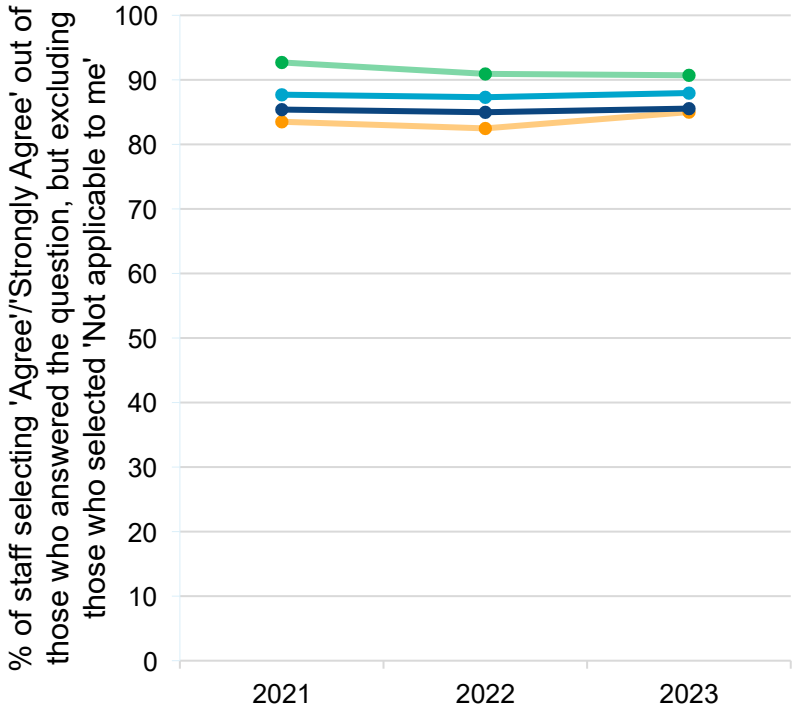
Compassionate leadership – Q9f, Q9g, Q9h, Q9i

Diversity and equality – Q15, Q16a, Q16b, Q21

Inclusion – Q7h, Q7i, Q8b, Q8c

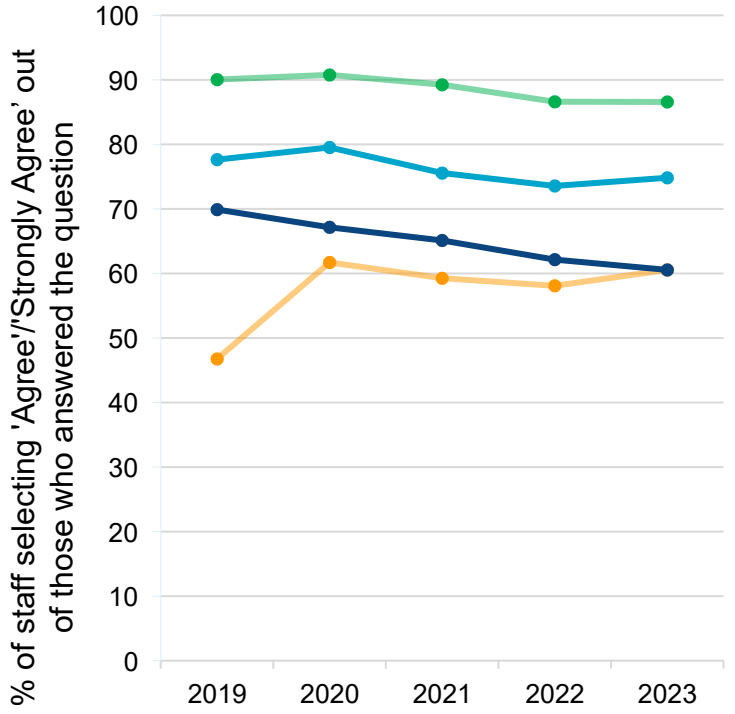
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q6a I feel that my role makes a difference to patients / service users.



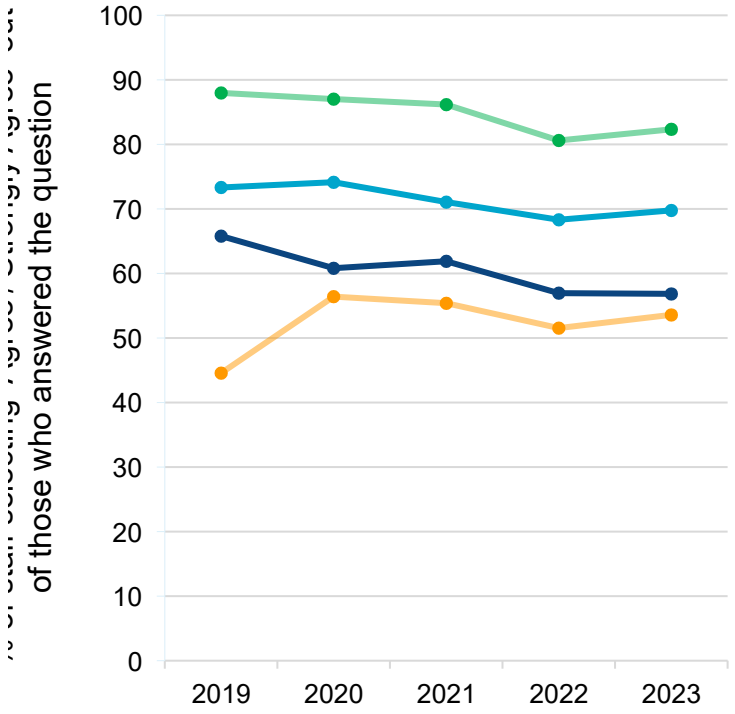
	2021	2022	2023
Your org	85.40%	84.98%	85.55%
Best result	92.70%	90.93%	90.71%
Average result	87.70%	87.31%	87.96%
Worst result	83.51%	82.48%	85.01%
Responses	4364	3916	3900

Q25a Care of patients / service users is my organisation's top priority.



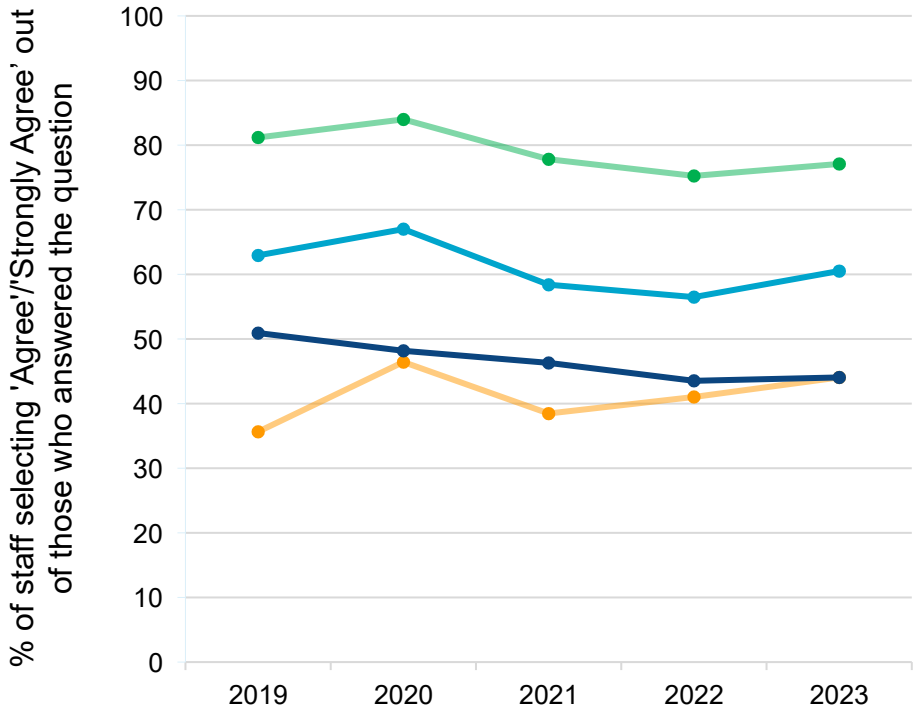
	2019	2020	2021	2022	2023
Your org	69.91%	67.15%	65.11%	62.15%	60.55%
Best result	90.05%	90.77%	89.25%	86.61%	86.57%
Average result	77.64%	79.53%	75.57%	73.56%	74.83%
Worst result	46.76%	61.70%	59.27%	58.09%	60.55%
Responses	4070	3330	4329	3995	3988

Q25b My organisation acts on concerns raised by patients / service users.



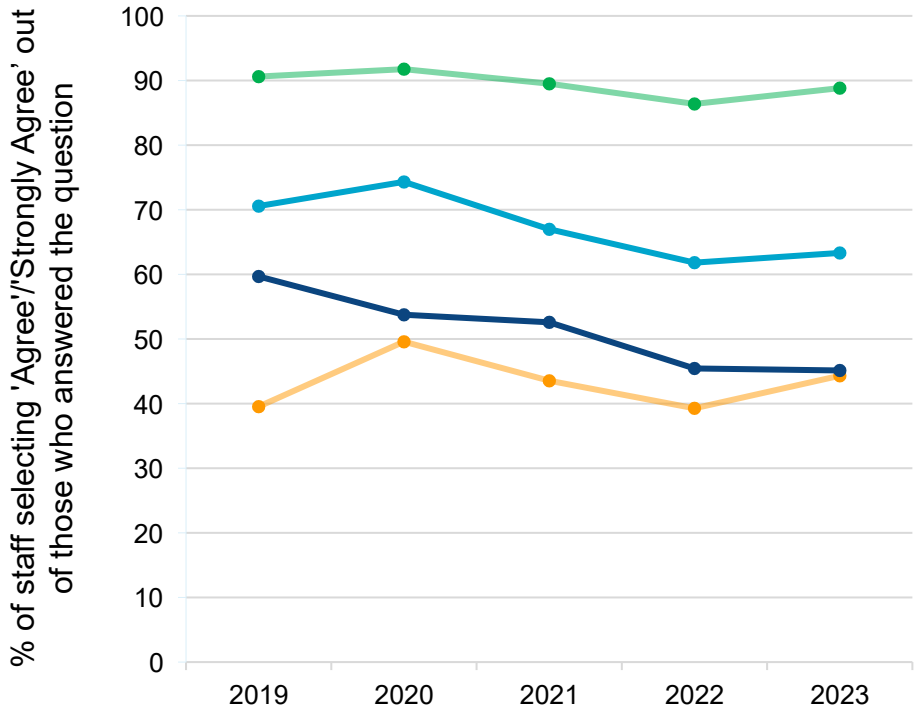
	2019	2020	2021	2022	2023
Your org	65.80%	60.82%	61.89%	56.95%	56.84%
Best result	87.98%	87.02%	86.18%	80.61%	82.34%
Average result	73.32%	74.14%	71.07%	68.32%	69.78%
Worst result	44.56%	56.41%	55.39%	51.54%	53.59%
Responses	4069	3328	4326	3994	3984

Q25c I would recommend my organisation as a place to work.



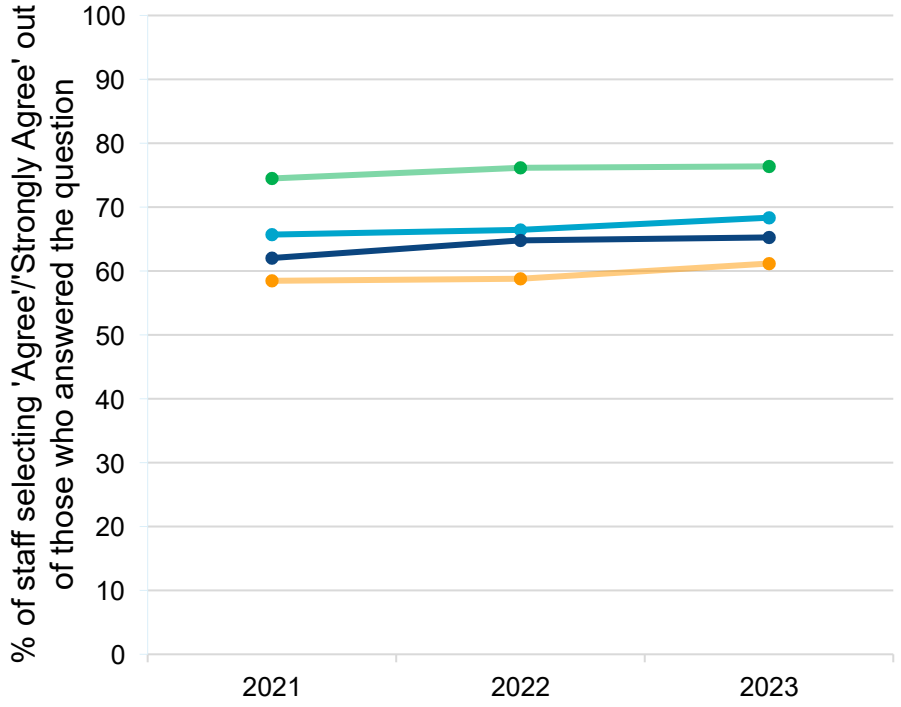
	2019	2020	2021	2022	2023
Your org	50.92%	48.17%	46.30%	43.53%	44.05%
Best result	81.18%	83.99%	77.82%	75.24%	77.09%
Average result	62.94%	67.00%	58.40%	56.48%	60.52%
Worst result	35.64%	46.44%	38.47%	41.03%	44.05%
Responses	4069	3333	4332	3994	3983

Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



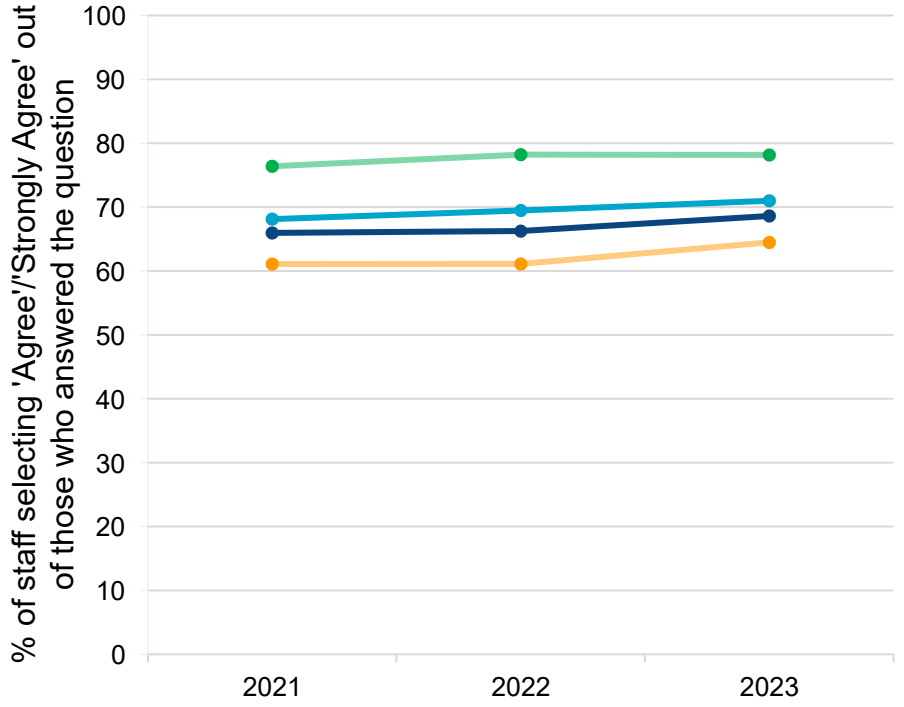
	2019	2020	2021	2022	2023
Your org	59.68%	53.75%	52.58%	45.44%	45.13%
Best result	90.62%	91.76%	89.51%	86.38%	88.82%
Average result	70.57%	74.32%	66.99%	61.82%	63.32%
Worst result	39.54%	49.58%	43.54%	39.27%	44.31%
Responses	4069	3331	4330	3996	3985

Q9f My immediate manager works together with me to come to an understanding of problems.



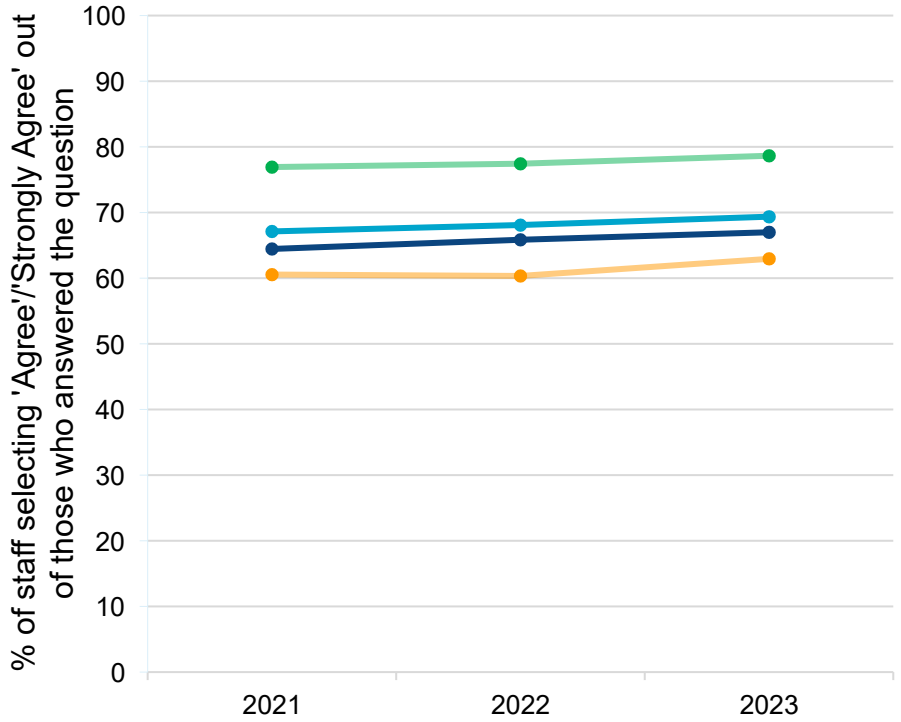
	2021	2022	2023
Your org	62.03%	64.79%	65.26%
Best result	74.49%	76.16%	76.38%
Average result	65.70%	66.44%	68.35%
Worst result	58.47%	58.79%	61.17%
Responses	4421	4006	3992

Q9g My immediate manager is interested in listening to me when I describe challenges I face.



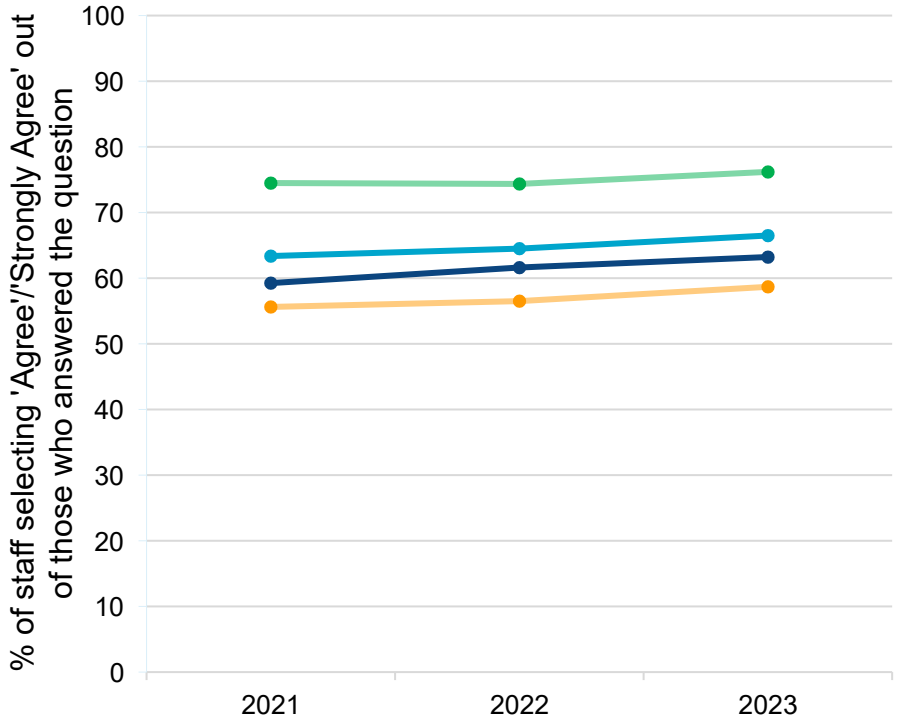
	2021	2022	2023
Your org	65.97%	66.26%	68.61%
Best result	76.39%	78.22%	78.17%
Average result	68.12%	69.47%	70.99%
Worst result	61.09%	61.11%	64.48%
Responses	4429	4004	3992

Q9h My immediate manager cares about my concerns.



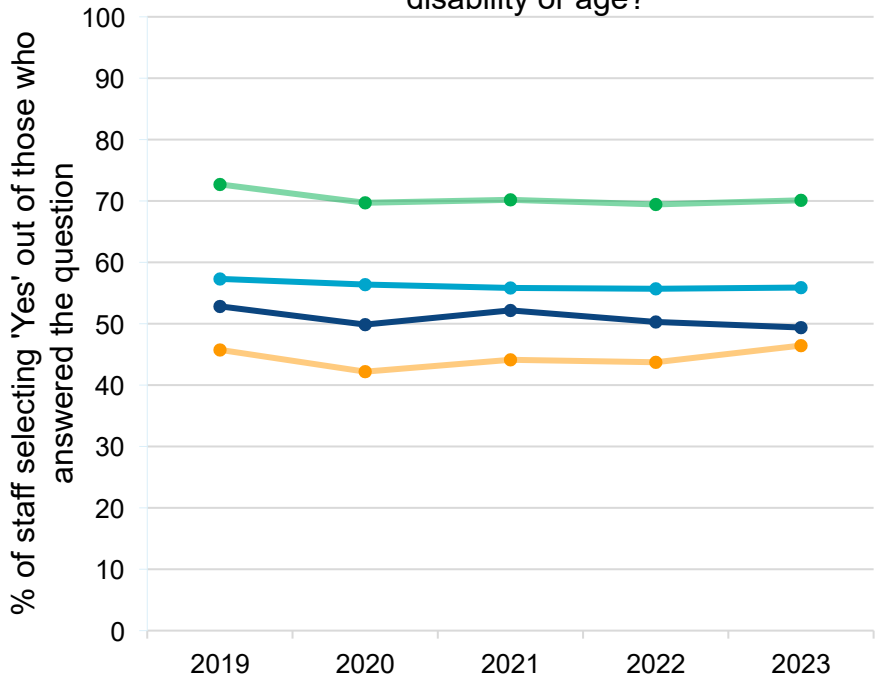
	2021	2022	2023
Your org	64.45%	65.85%	66.99%
Best result	76.92%	77.43%	78.65%
Average result	67.12%	68.10%	69.37%
Worst result	60.55%	60.34%	62.95%
Responses	4427	4006	3995

Q9i My immediate manager takes effective action to help me with any problems I face.



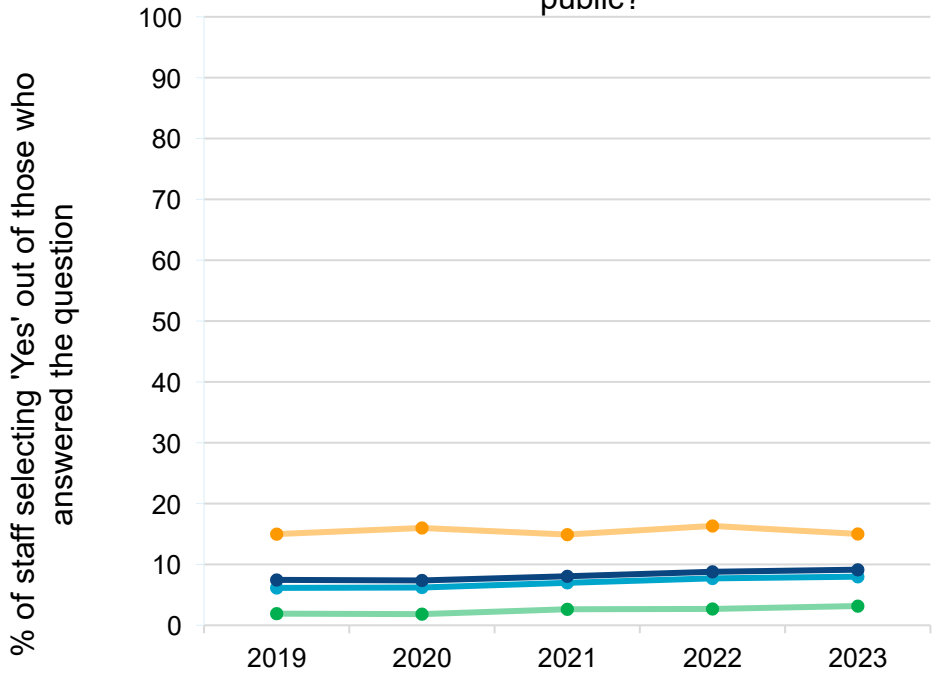
	2021	2022	2023
Your org	59.25%	61.62%	63.22%
Best result	74.49%	74.35%	76.19%
Average result	63.37%	64.50%	66.50%
Worst result	55.62%	56.50%	58.68%
Responses	4428	4001	3992

Q15 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



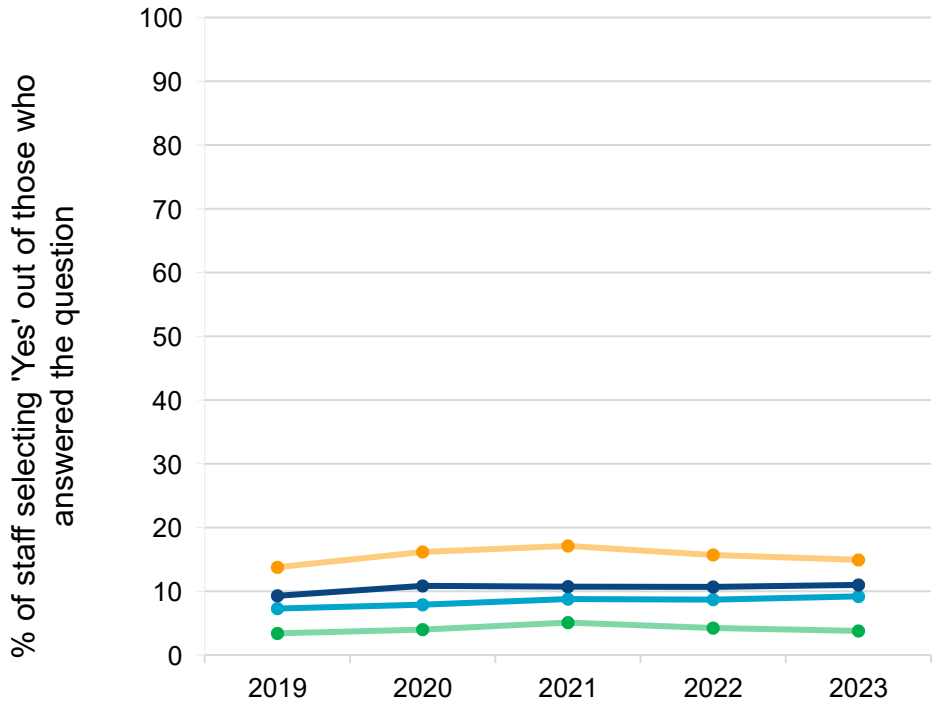
	2019	2020	2021	2022	2023
Your org	52.83%	49.86%	52.17%	50.29%	49.38%
Best result	72.70%	69.70%	70.19%	69.43%	70.11%
Average result	57.31%	56.38%	55.83%	55.69%	55.89%
Worst result	45.74%	42.19%	44.12%	43.72%	46.44%
Responses	4132	3358	4376	3968	3963

Q16a In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



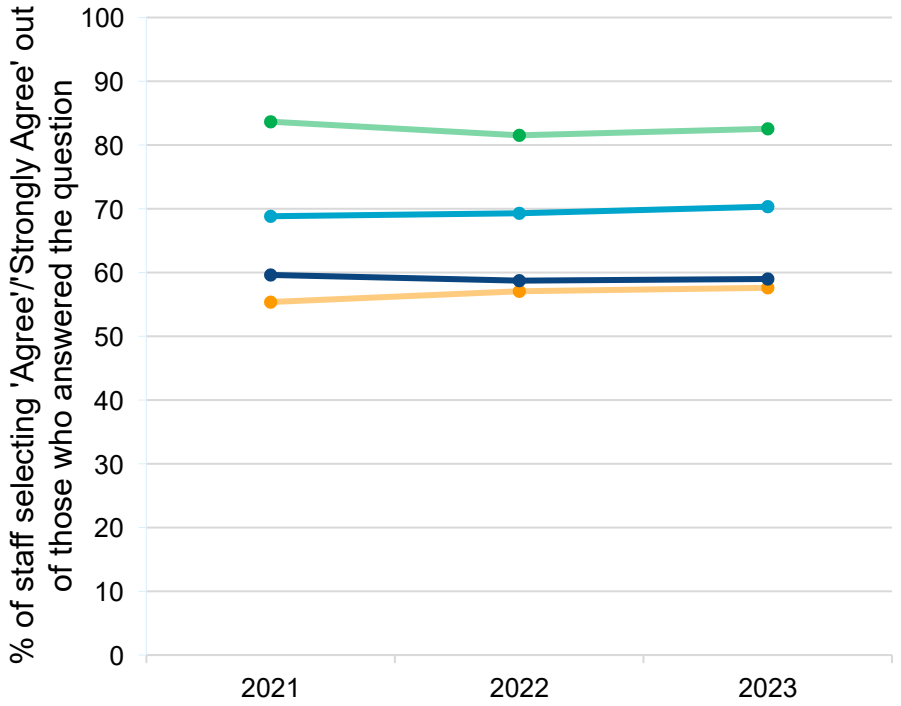
	2019	2020	2021	2022	2023
Your org	7.46%	7.37%	8.06%	8.79%	9.14%
Best result	1.91%	1.83%	2.64%	2.69%	3.17%
Average result	6.15%	6.21%	6.98%	7.71%	7.99%
Worst result	14.99%	15.99%	14.91%	16.33%	15.02%
Responses	4142	3387	4401	3977	3986

Q16b In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



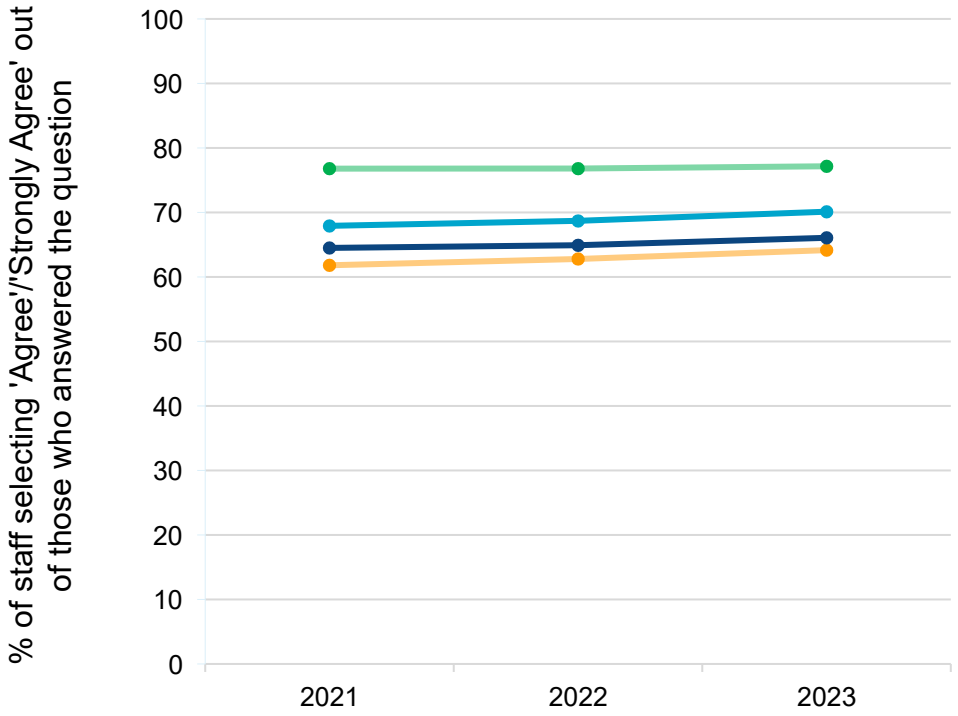
	2019	2020	2021	2022	2023
Your org	9.30%	10.85%	10.73%	10.69%	11.00%
Best result	3.41%	3.99%	5.09%	4.24%	3.79%
Average result	7.29%	7.90%	8.78%	8.69%	9.20%
Worst result	13.78%	16.17%	17.12%	15.70%	14.93%
Responses	4131	3377	4389	3985	3974

Q21 I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).



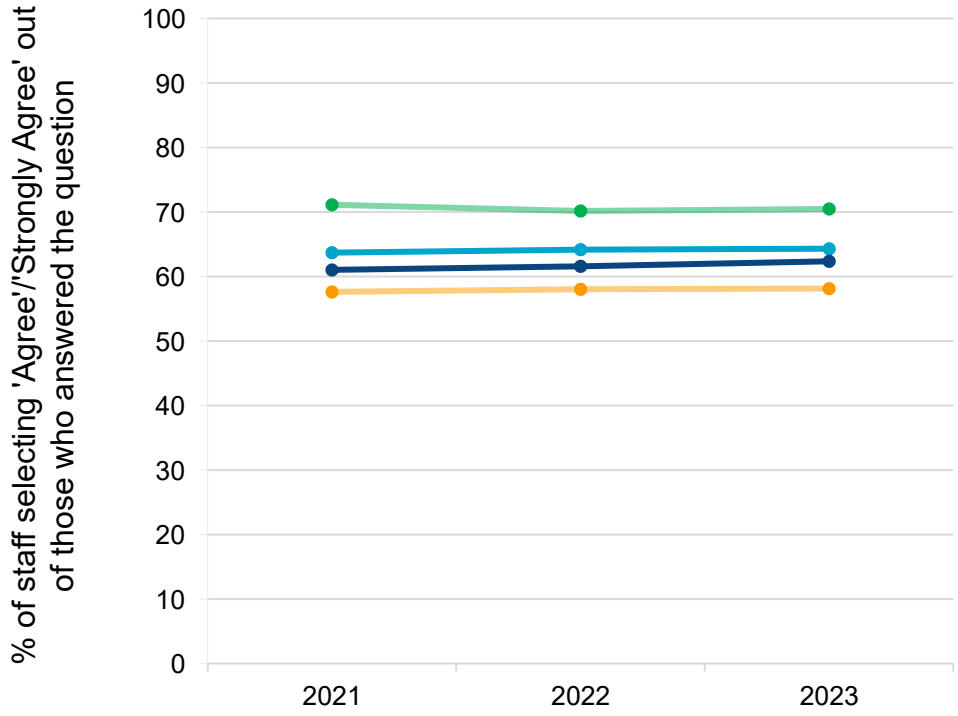
	2021	2022	2023
Your org	59.62%	58.73%	58.99%
Best result	83.66%	81.52%	82.55%
Average result	68.83%	69.29%	70.33%
Worst result	55.37%	57.06%	57.60%
Responses	4376	4002	3998

Q7h I feel valued by my team.



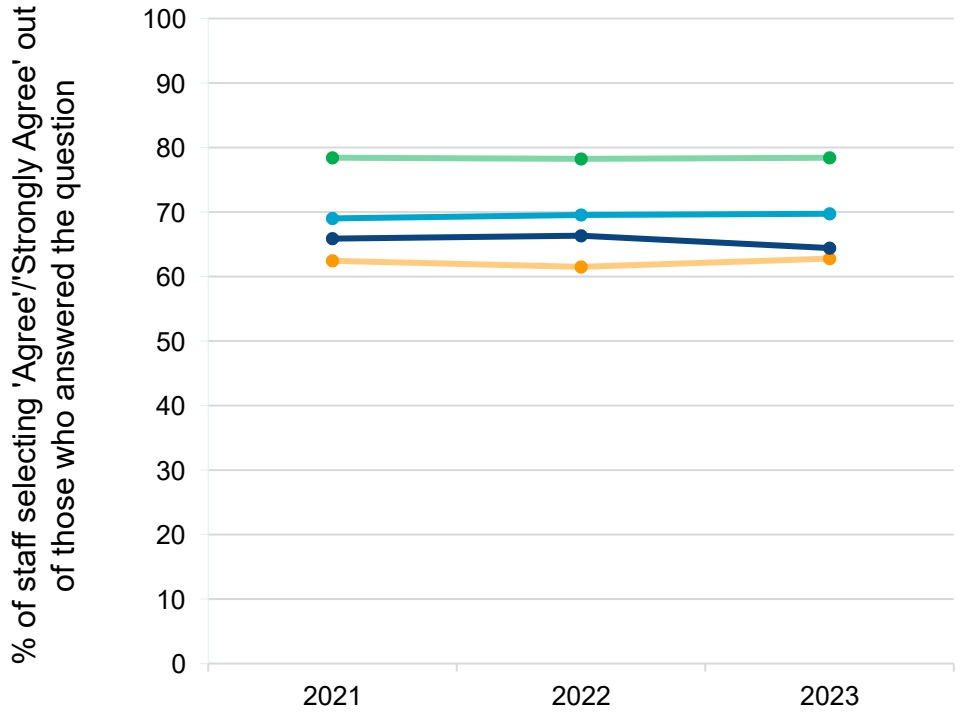
	2021	2022	2023
Your org	64.50%	64.92%	66.07%
Best result	76.79%	76.81%	77.16%
Average result	67.92%	68.70%	70.12%
Worst result	61.81%	62.78%	64.16%
Responses	4462	4014	4001

Q7i I feel a strong personal attachment to my team.



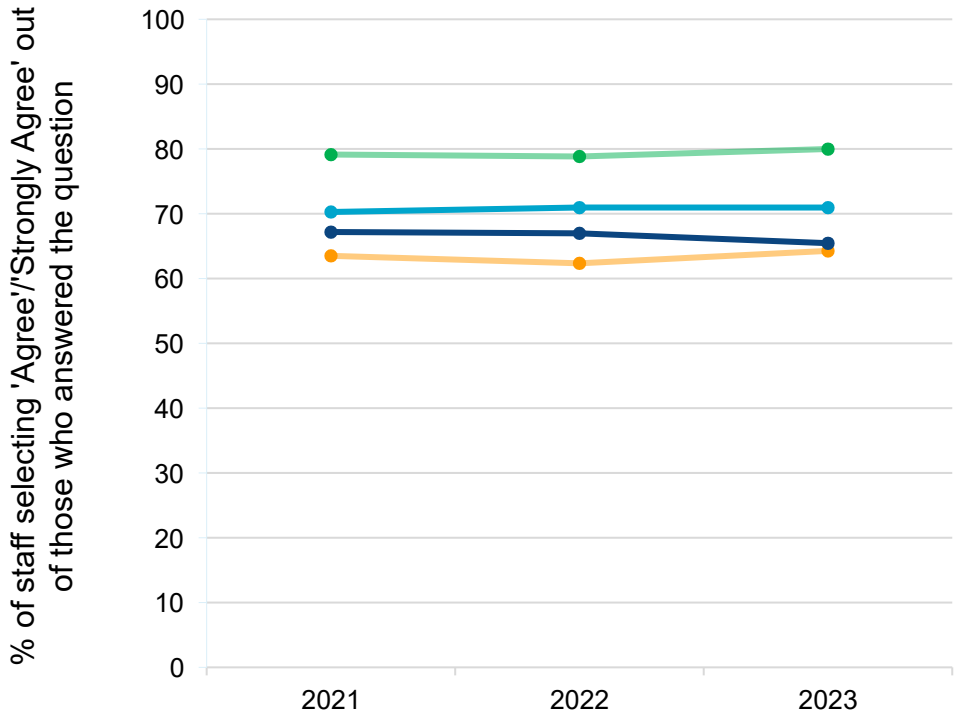
	2021	2022	2023
Your org	61.04%	61.58%	62.36%
Best result	71.13%	70.17%	70.48%
Average result	63.71%	64.17%	64.32%
Worst result	57.63%	58.03%	58.14%
Responses	4466	4011	4001

Q8b The people I work with are understanding and kind to one another.



	2021	2022	2023
Your org	65.88%	66.33%	64.42%
Best result	78.43%	78.25%	78.42%
Average result	69.01%	69.54%	69.73%
Worst result	62.44%	61.50%	62.78%
Responses	4457	4011	3996

Q8c The people I work with are polite and treat each other with respect.



	2021	2022	2023
Your org	67.18%	66.97%	65.45%
Best result	79.13%	78.83%	79.99%
Average result	70.27%	70.96%	70.95%
Worst result	63.50%	62.35%	64.27%
Responses	4459	4010	3999

Survey Coordination Centre

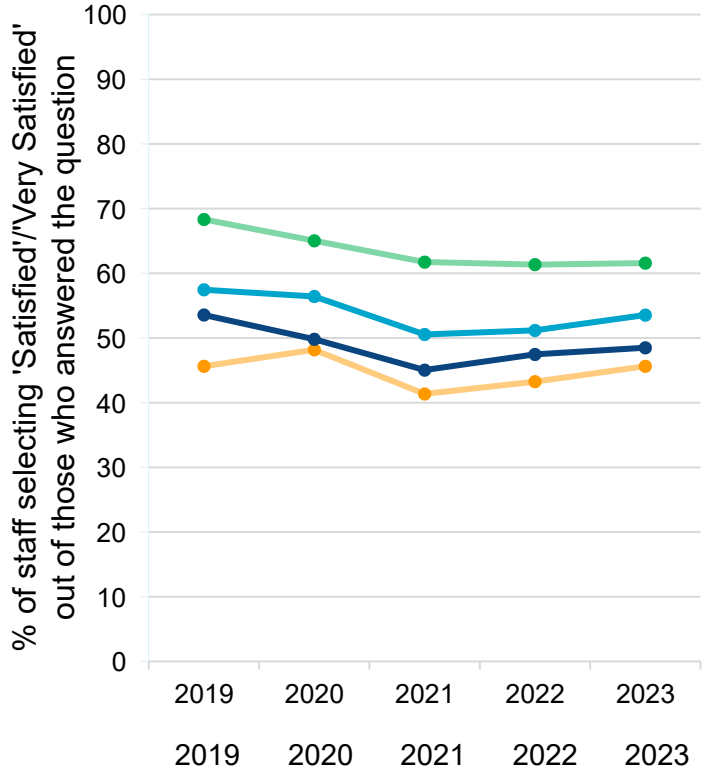
NHS

People Promise element – We are recognised and rewarded

Questions included:
Q4a, Q4b, Q4c, Q8d, Q9e

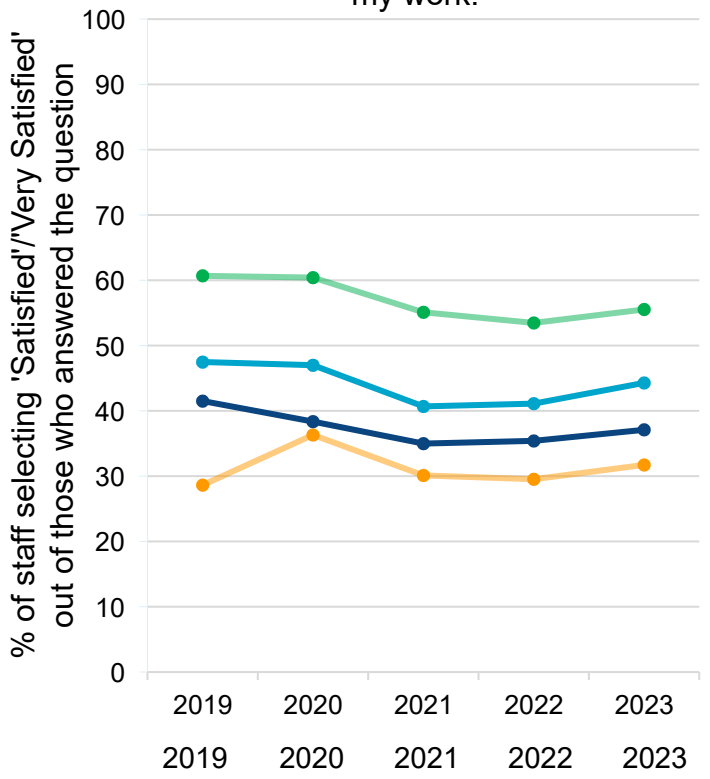
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q4a How satisfied are you with each of the following aspects of your job? The recognition I get for good work.



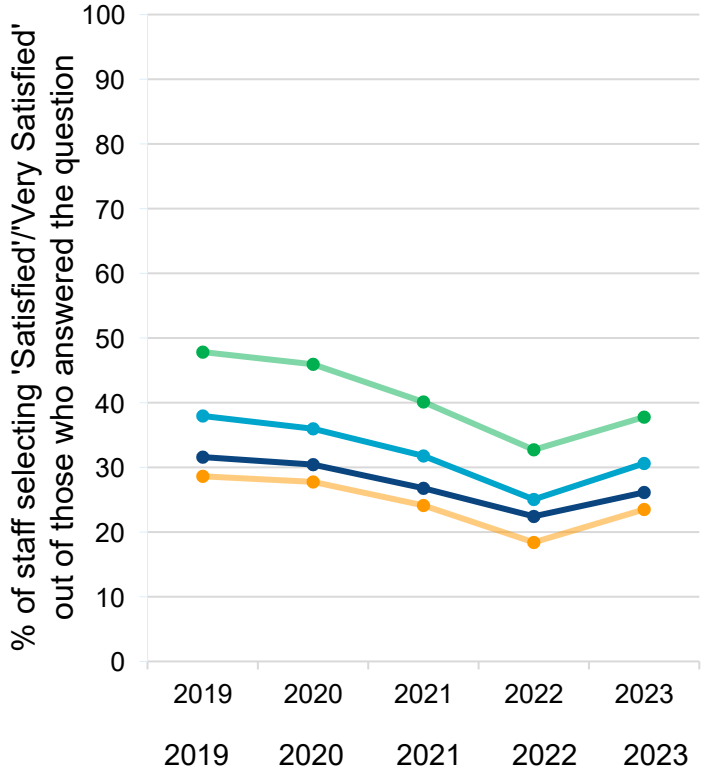
	2019	2020	2021	2022	2023
Your org	53.56%	49.81%	45.05%	47.47%	48.50%
Best result	68.34%	65.04%	61.75%	61.35%	61.58%
Average result	57.46%	56.42%	50.55%	51.18%	53.55%
Worst result	45.63%	48.18%	41.36%	43.25%	45.64%
Responses	4215	3437	4510	4009	3993

Q4b How satisfied are you with each of the following aspects of your job? The extent to which my organisation values my work.



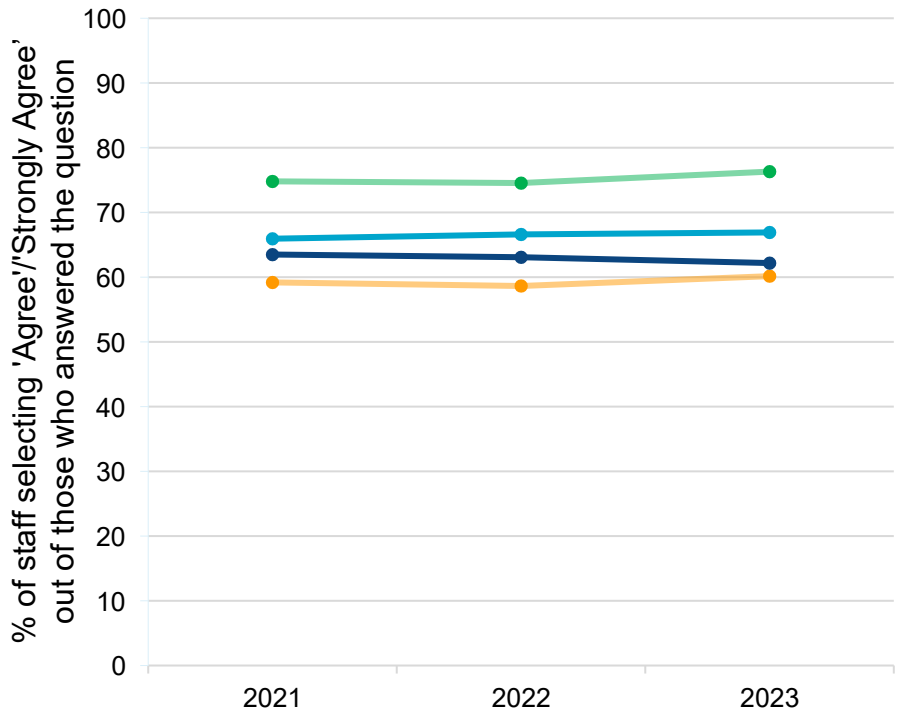
	2019	2020	2021	2022	2023
Your org	41.50%	38.36%	34.99%	35.41%	37.10%
Best result	60.68%	60.41%	55.10%	53.47%	55.53%
Average result	47.48%	47.00%	40.68%	41.11%	44.28%
Worst result	28.63%	36.32%	30.11%	29.53%	31.72%
Responses	4211	3440	4512	4012	3989

Q4c How satisfied are you with each of the following aspects of your job? My level of pay.



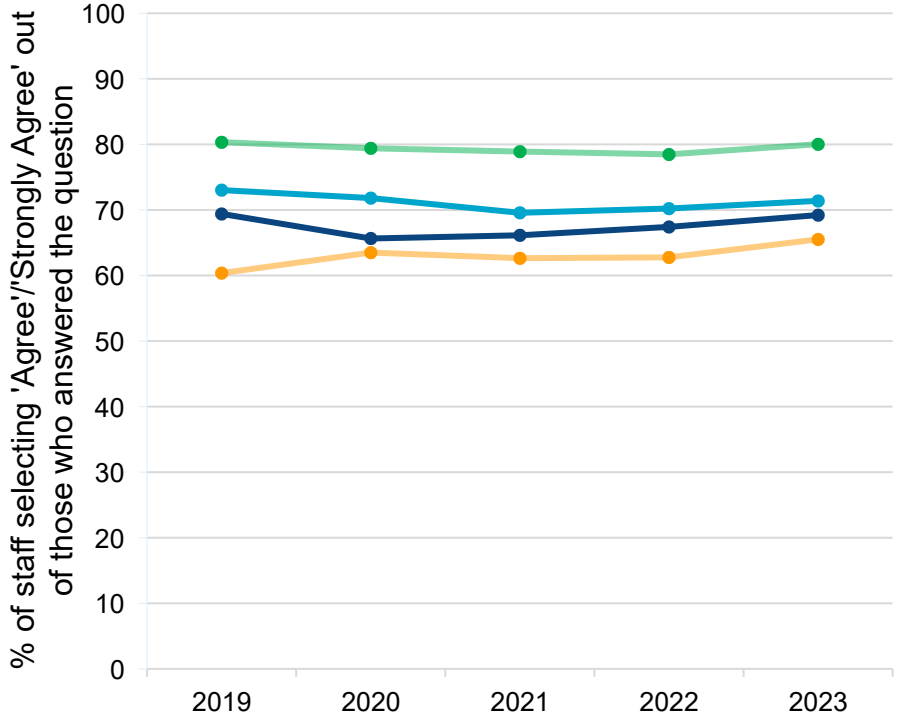
	2019	2020	2021	2022	2023
Your org	31.59%	30.43%	26.78%	22.43%	26.13%
Best result	47.83%	45.94%	40.11%	32.72%	37.78%
Average result	37.95%	35.97%	31.78%	25.05%	30.61%
Worst result	28.62%	27.76%	24.12%	18.41%	23.49%
Responses	4213	3439	4506	4013	3993

Q8d The people I work with show appreciation to one another.



	2021	2022	2023
Your org	63.50%	63.08%	62.18%
Best result	74.80%	74.54%	76.31%
Average result	65.94%	66.61%	66.91%
Worst result	59.19%	58.63%	60.16%
Responses	4454	4008	3990

Q9e My immediate manager values my work.



	2019	2020	2021	2022	2023
Your org	69.40%	65.65%	66.13%	67.42%	69.22%
Best result	80.34%	79.41%	78.91%	78.48%	80.03%
Average result	73.03%	71.81%	69.57%	70.22%	71.39%
Worst result	60.37%	63.50%	62.64%	62.77%	65.51%
Responses	4161	3410	4423	4006	3994

Survey Coordination Centre

NHS

People Promise element – We each have a voice that counts

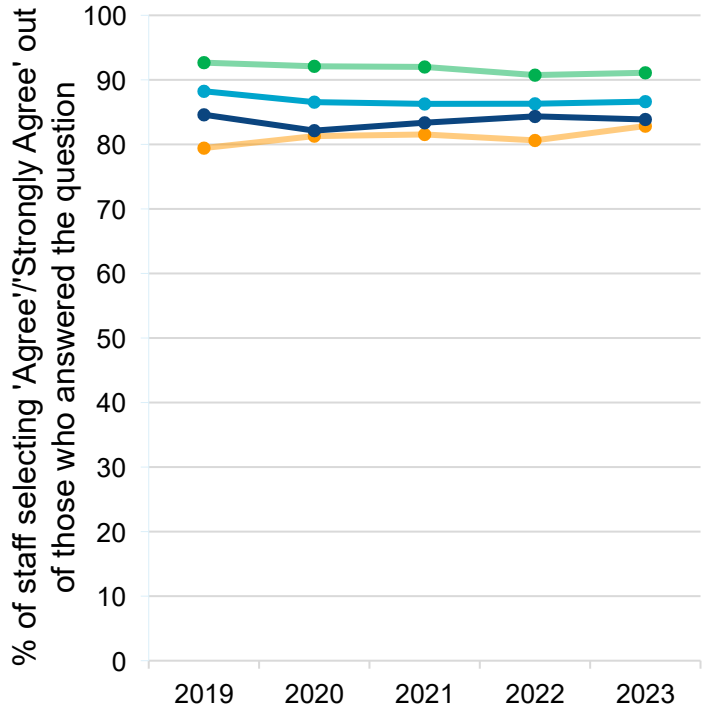
Questions included:

Autonomy and control – Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b

Raising concerns – Q20a, Q20b, Q25e, Q25f

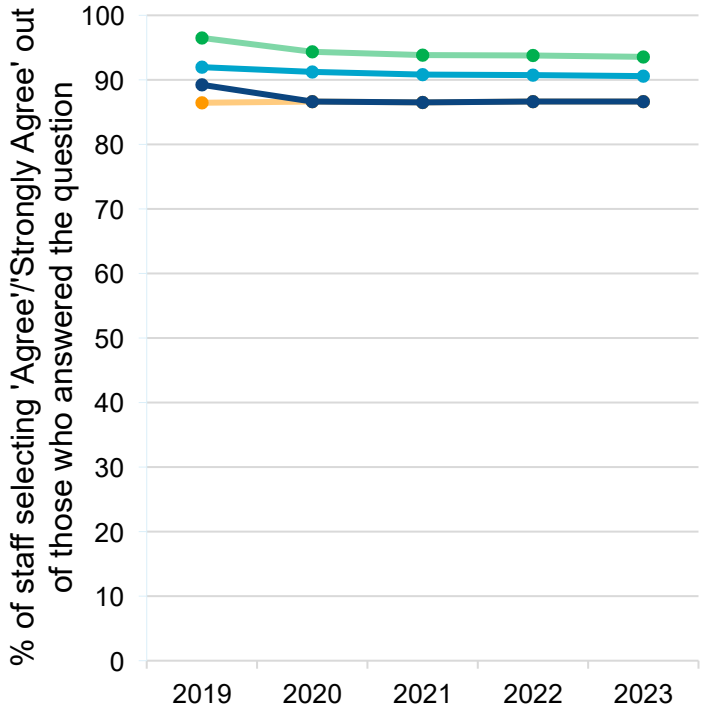
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q3a I always know what my work responsibilities are.



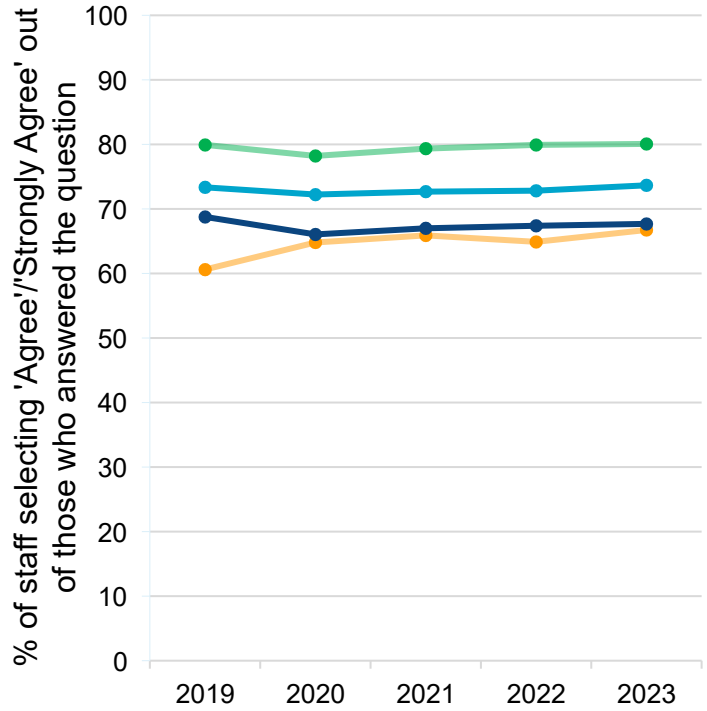
	2019	2020	2021	2022	2023
Your org	84.60%	82.13%	83.36%	84.35%	83.86%
Best result	92.66%	92.10%	92.01%	90.74%	91.10%
Average result	88.24%	86.55%	86.28%	86.30%	86.63%
Worst result	79.44%	81.28%	81.54%	80.62%	82.84%
Responses	4266	3500	4501	3994	4000

Q3b I am trusted to do my job.



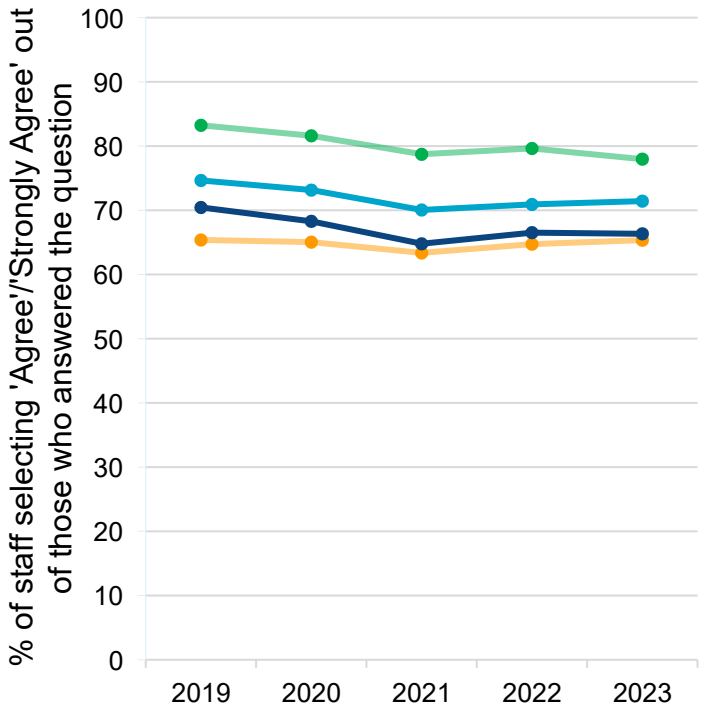
	2019	2020	2021	2022	2023
Your org	89.23%	86.64%	86.51%	86.64%	86.64%
Best result	96.50%	94.35%	93.84%	93.78%	93.56%
Average result	91.97%	91.23%	90.82%	90.74%	90.58%
Worst result	86.45%	86.64%	86.51%	86.64%	86.64%
Responses	4255	3498	4512	4013	3992

Q3c There are frequent opportunities for me to show initiative in my role.



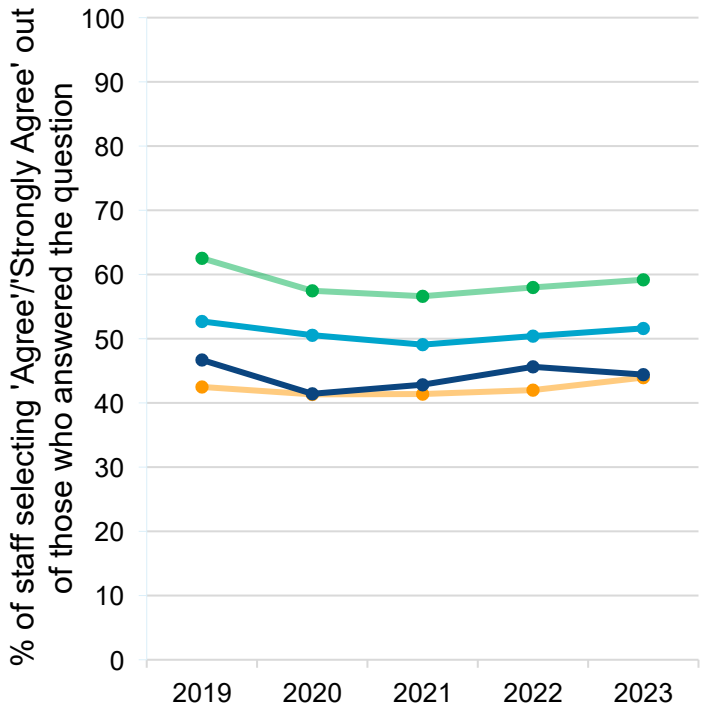
	2019	2020	2021	2022	2023
Your org	68.77%	66.05%	67.00%	67.39%	67.68%
Best result	79.93%	78.22%	79.35%	79.92%	80.07%
Average result	73.35%	72.23%	72.68%	72.83%	73.66%
Worst result	60.61%	64.80%	65.90%	64.90%	66.74%
Responses	4267	3459	4520	4010	3998

Q3d I am able to make suggestions to improve the work of my team / department.



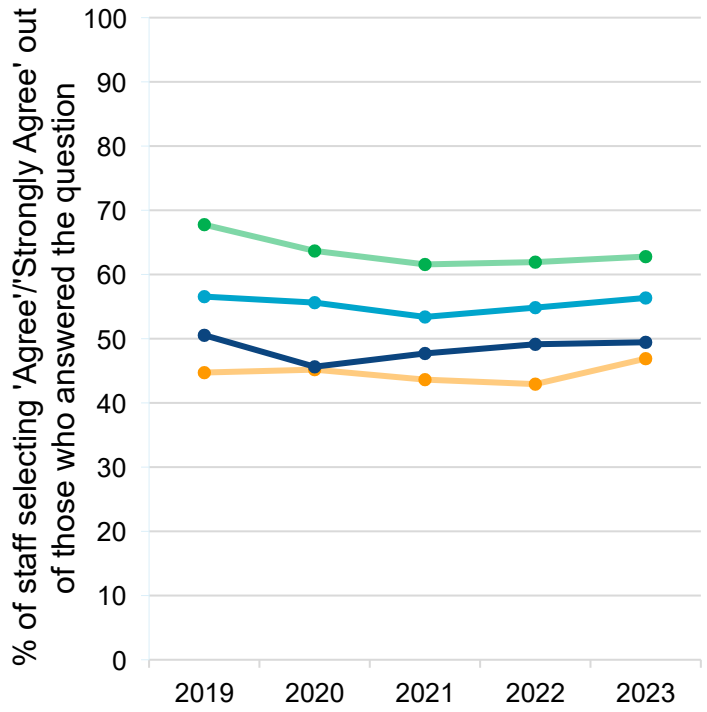
	2019	2020	2021	2022	2023
Your org	70.45%	68.28%	64.79%	66.51%	66.34%
Best result	83.24%	81.60%	78.73%	79.63%	77.96%
Average result	74.65%	73.16%	70.05%	70.92%	71.43%
Worst result	65.38%	65.04%	63.37%	64.73%	65.35%
Responses	4265	3461	4519	4008	3998

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



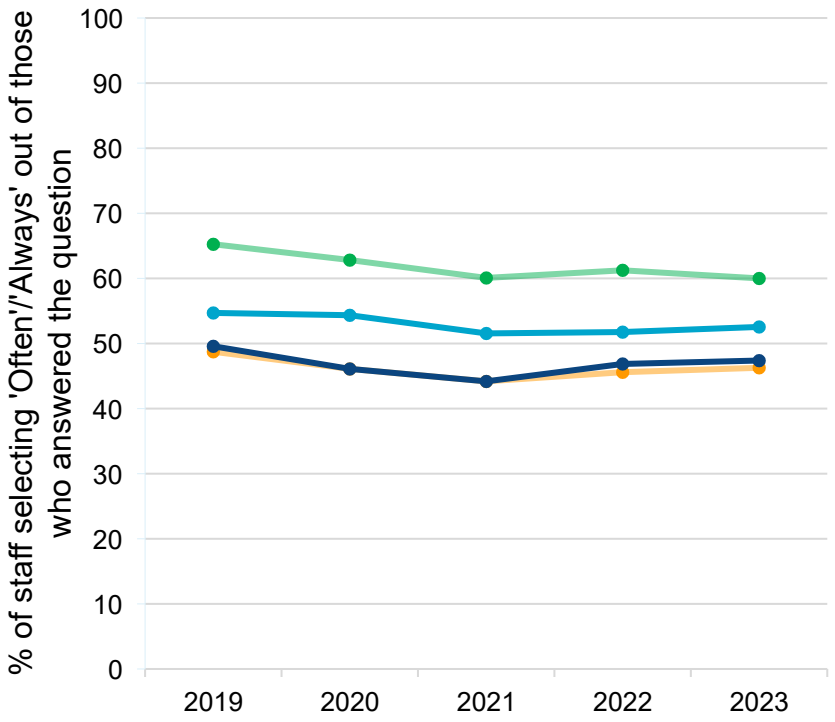
	2019	2020	2021	2022	2023
Your org	46.69%	41.42%	42.84%	45.62%	44.41%
Best result	62.53%	57.46%	56.61%	57.98%	59.18%
Average result	52.69%	50.55%	49.07%	50.41%	51.60%
Worst result	42.49%	41.33%	41.38%	41.99%	43.95%
Responses	4266	3460	4521	4009	3995

Q3f I am able to make improvements happen in my area of work.



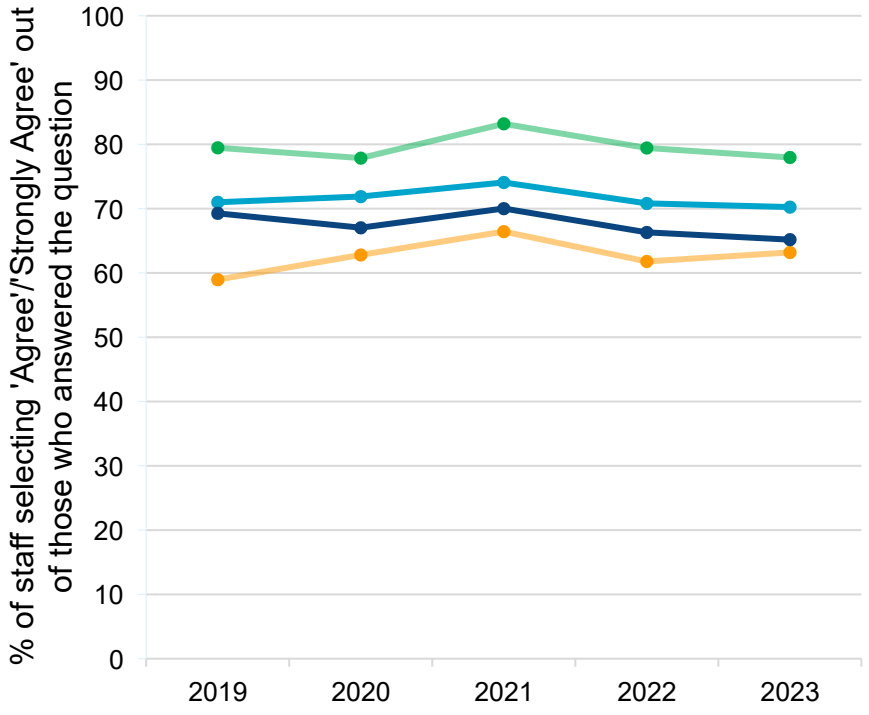
	2019	2020	2021	2022	2023
Your org	50.55%	45.64%	47.70%	49.14%	49.45%
Best result	67.76%	63.68%	61.57%	61.93%	62.79%
Average result	56.56%	55.62%	53.39%	54.84%	56.35%
Worst result	44.73%	45.18%	43.63%	42.93%	46.89%
Responses	4264	3459	4523	4007	3996

Q5b I have a choice in deciding how to do my work.



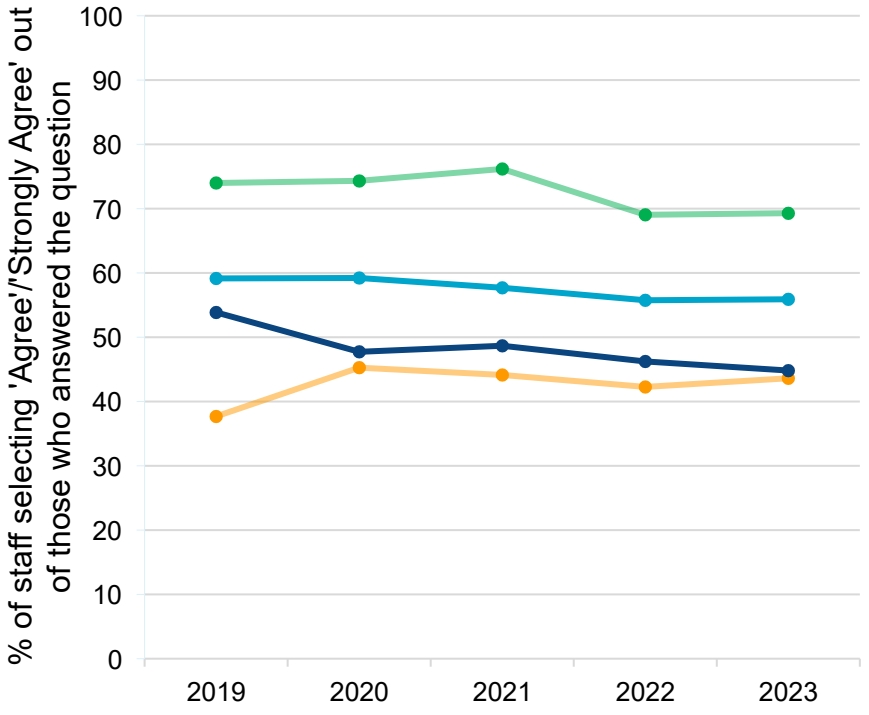
	2019	2020	2021	2022	2023
Your org	49.58%	46.10%	44.18%	46.86%	47.38%
Best result	65.25%	62.83%	60.08%	61.24%	60.00%
Average result	54.70%	54.35%	51.55%	51.76%	52.55%
Worst result	48.73%	46.10%	44.18%	45.59%	46.27%
Responses	4199	3439	4487	4004	3993

Q20a I would feel secure raising concerns about unsafe clinical practice.



	2019	2020	2021	2022	2023
Your org	69.27%	67.04%	70.02%	66.31%	65.18%
Best result	79.47%	77.87%	83.19%	79.44%	77.96%
Average result	71.00%	71.89%	74.07%	70.82%	70.24%
Worst result	58.96%	62.81%	66.44%	61.78%	63.19%
Responses	4121	3354	4386	4006	3991

Q20b I am confident that my organisation would address my concern.

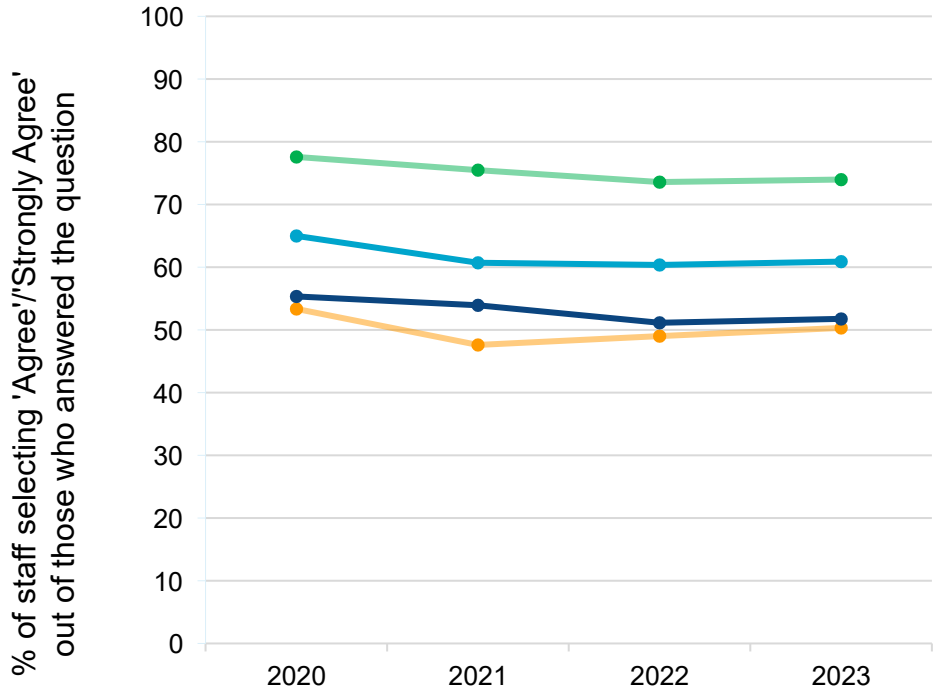


	2019	2020	2021	2022	2023
Your org	53.87%	47.73%	48.67%	46.23%	44.82%
Best result	73.99%	74.33%	76.17%	69.05%	69.29%
Average result	59.15%	59.22%	57.69%	55.75%	55.90%
Worst result	37.69%	45.27%	44.13%	42.27%	43.62%
Responses	4120	3350	4388	4001	3986

Survey Coordination Centre

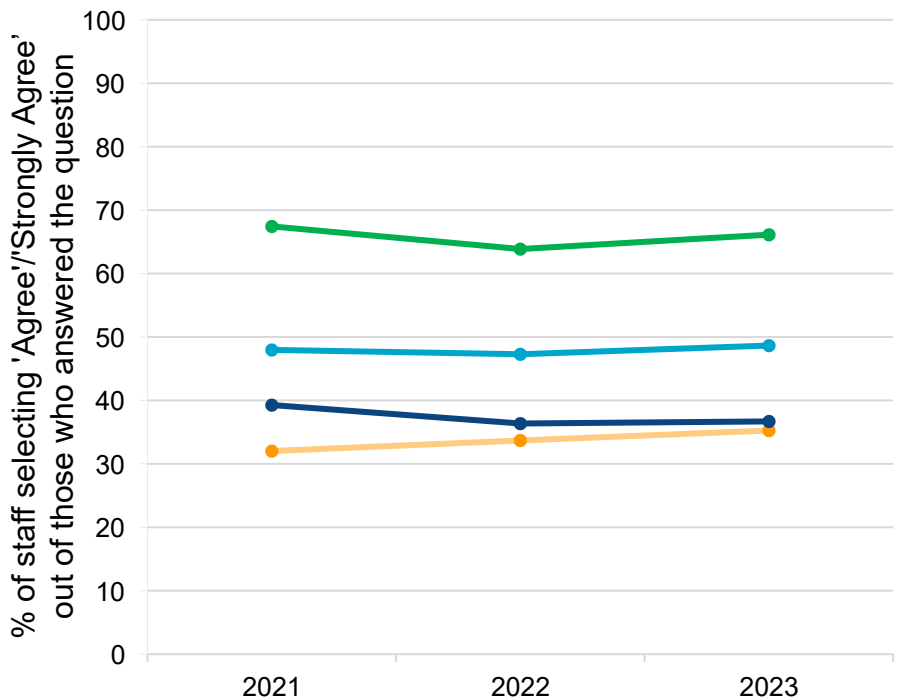
NHS

Q25e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022	2023
Your org	55.34%	53.93%	51.14%	51.76%
Best result	77.58%	75.47%	73.58%	73.98%
Average result	64.99%	60.71%	60.36%	60.89%
Worst result	53.35%	47.60%	49.01%	50.32%
Responses	3334	4329	3996	3984

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022	2023
Your org	39.27%	36.36%	36.69%
Best result	67.43%	63.87%	66.13%
Average result	47.97%	47.28%	48.65%
Worst result	32.02%	33.68%	35.26%
Responses	4327	3993	3985

Survey Coordination Centre

NHS

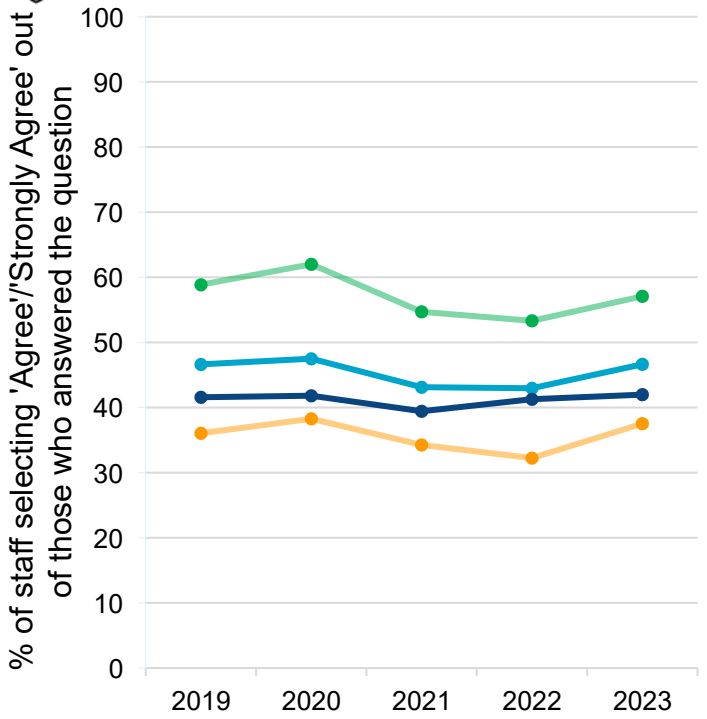
People Promise element – We are safe and healthy

Questions included:
Health and safety climate: Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d
Burnout: Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g
Negative experiences: Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c
Other questions:* Q17a, Q17b, Q22

*Q17a, Q17b and Q22 do not contribute to the calculation of any scores or sub-scores.

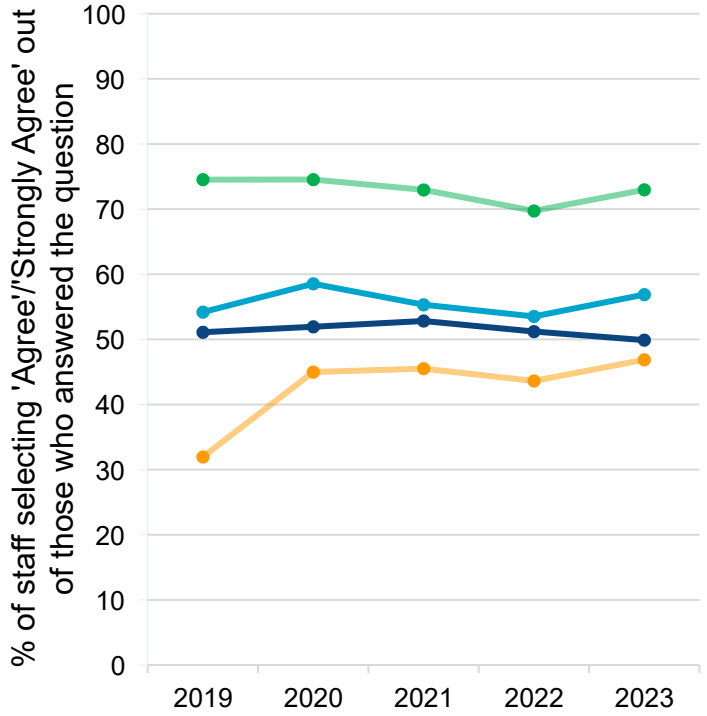
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q3g I am able to meet all the conflicting demands on my time at work.



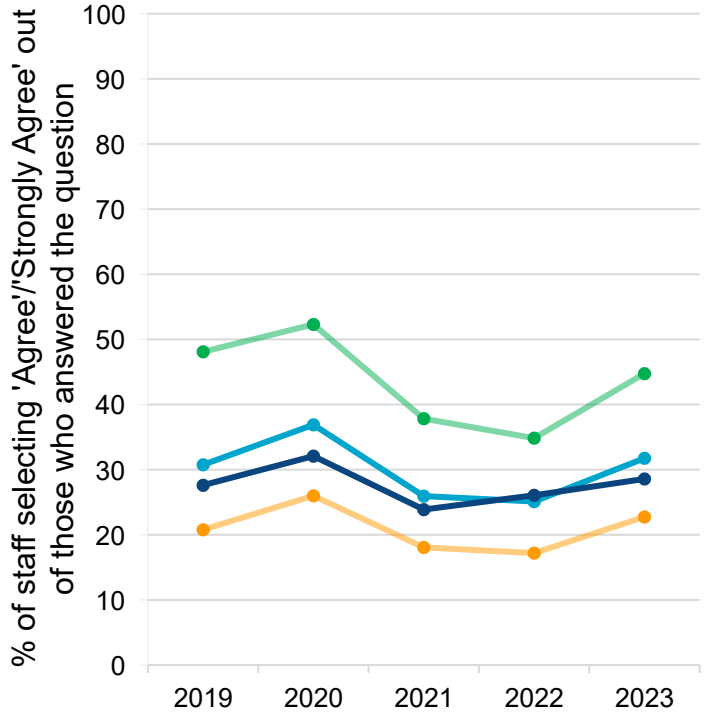
	2019	2020	2021	2022	2023
Your org	41.58%	41.81%	39.43%	41.28%	41.98%
Best result	58.86%	61.99%	54.69%	53.31%	57.08%
Average result	46.63%	47.50%	43.12%	42.96%	46.63%
Worst result	36.05%	38.27%	34.26%	32.24%	37.52%
Responses	4247	3454	4520	4011	3990

Q3h I have adequate materials, supplies and equipment to do my work.



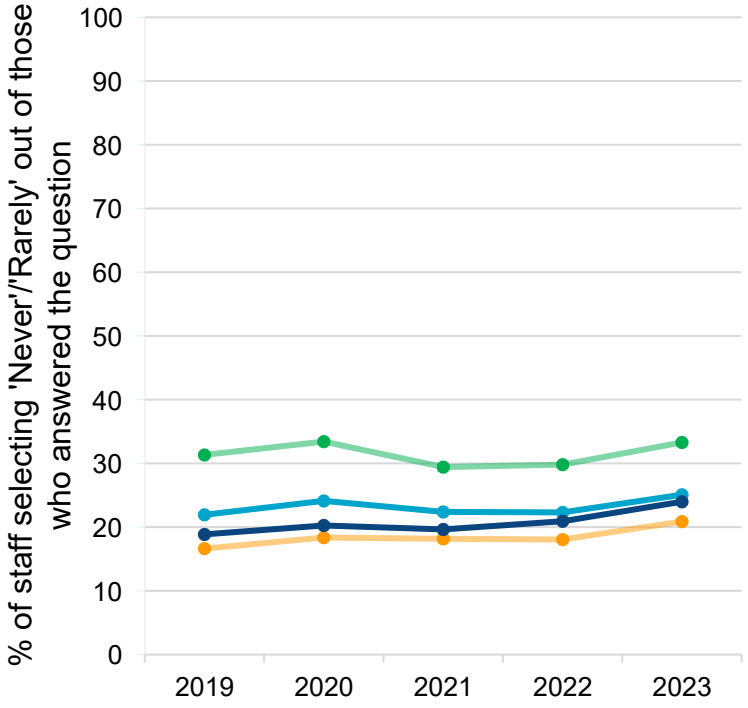
	2019	2020	2021	2022	2023
Your org	51.10%	51.94%	52.82%	51.21%	49.89%
Best result	74.53%	74.54%	72.96%	69.73%	72.97%
Average result	54.19%	58.54%	55.33%	53.52%	56.88%
Worst result	31.96%	44.99%	45.51%	43.63%	46.87%
Responses	4255	3454	4519	4008	3995

Q3i There are enough staff at this organisation for me to do my job properly.



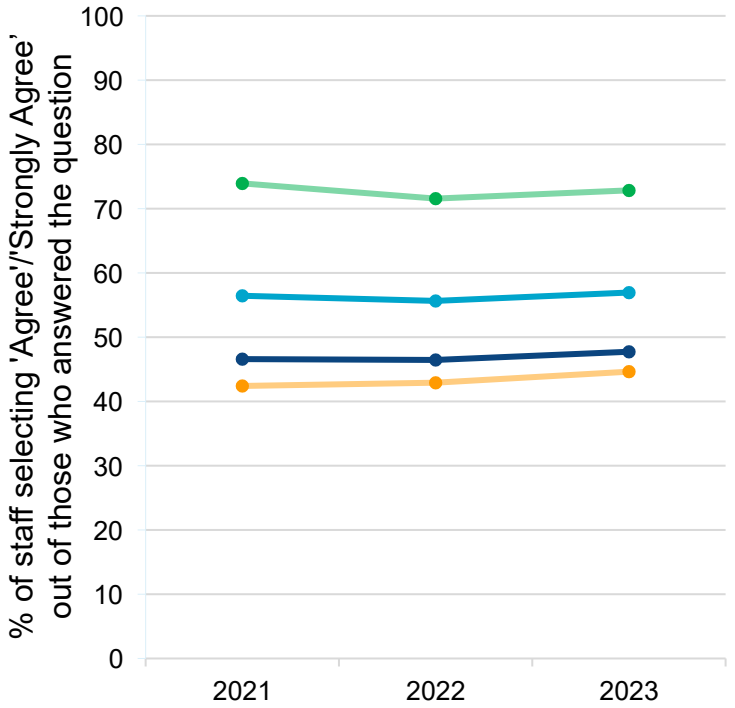
	2019	2020	2021	2022	2023
Your org	27.62%	32.08%	23.88%	26.07%	28.57%
Best result	48.09%	52.30%	37.83%	34.84%	44.76%
Average result	30.74%	36.89%	25.94%	25.11%	31.75%
Worst result	20.78%	25.99%	18.06%	17.19%	22.75%
Responses	4257	3454	4516	4012	3999

Q5a I have unrealistic time pressures.



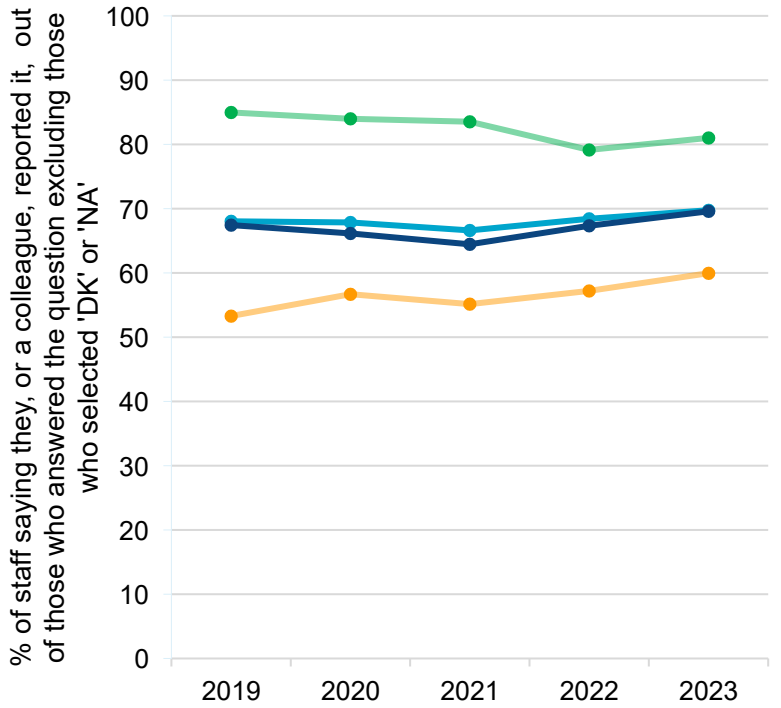
	2019	2020	2021	2022	2023
Your org	18.86%	20.25%	19.64%	20.92%	23.99%
Best result	31.33%	33.42%	29.43%	29.80%	33.29%
Average result	21.94%	24.12%	22.39%	22.31%	25.08%
Worst result	16.62%	18.37%	18.16%	18.05%	20.88%
Responses	4201	3439	4484	4002	3997

Q11a My organisation takes positive action on health and well-being.



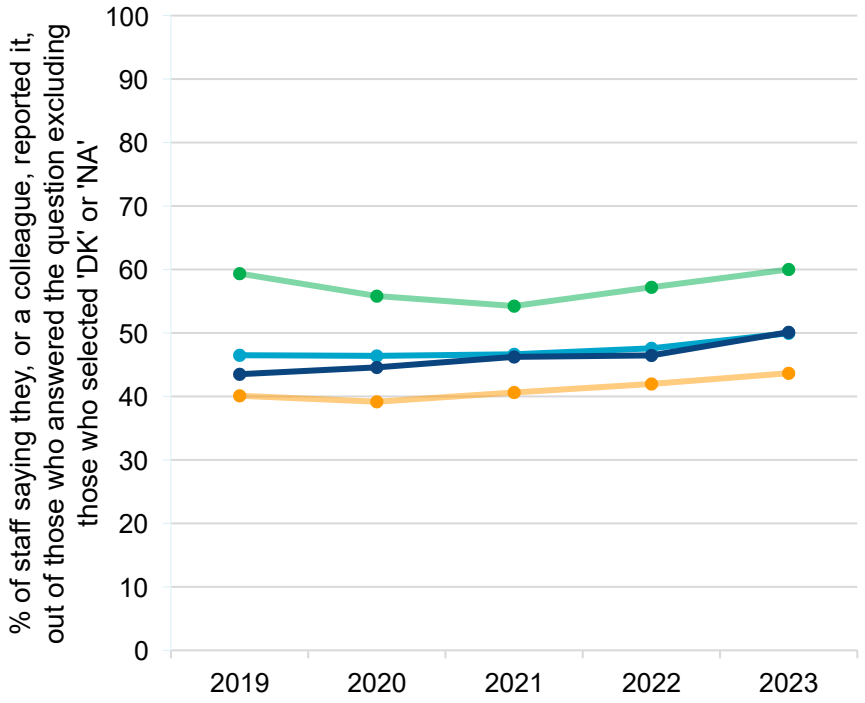
	2021	2022	2023
Your org	46.59%	46.46%	47.73%
Best result	73.93%	71.57%	72.85%
Average result	56.44%	55.65%	56.95%
Worst result	42.41%	42.92%	44.63%
Responses	4353	3937	4001

Q13d The last time you experienced physical violence at work, did you or a colleague report it?



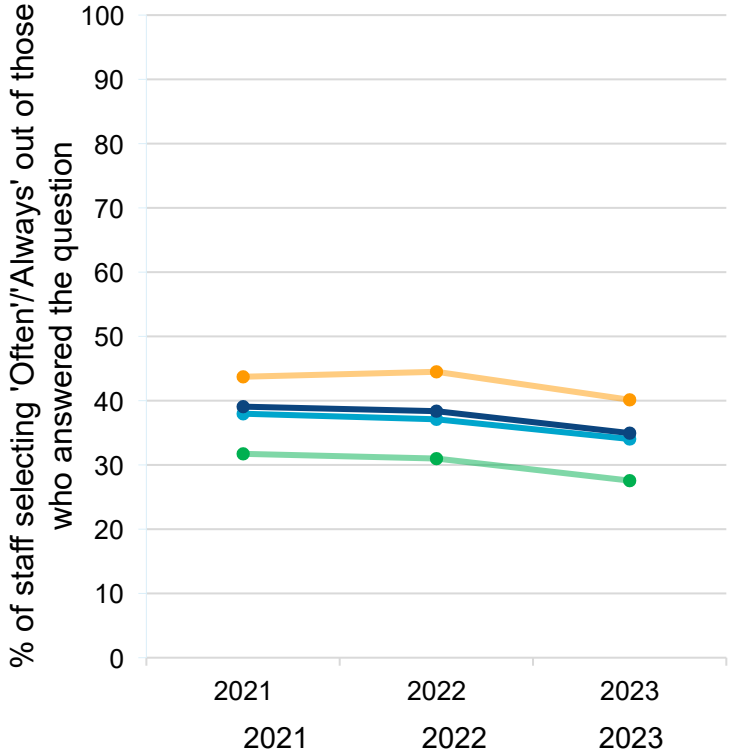
	2019	2020	2021	2022	2023
Your org	67.44%	66.15%	64.45%	67.34%	69.59%
Best result	84.97%	83.98%	83.53%	79.14%	81.01%
Average result	68.03%	67.86%	66.62%	68.43%	69.76%
Worst result	53.29%	56.69%	55.14%	57.21%	59.96%
Responses	503	395	516	470	422

Q14d The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?



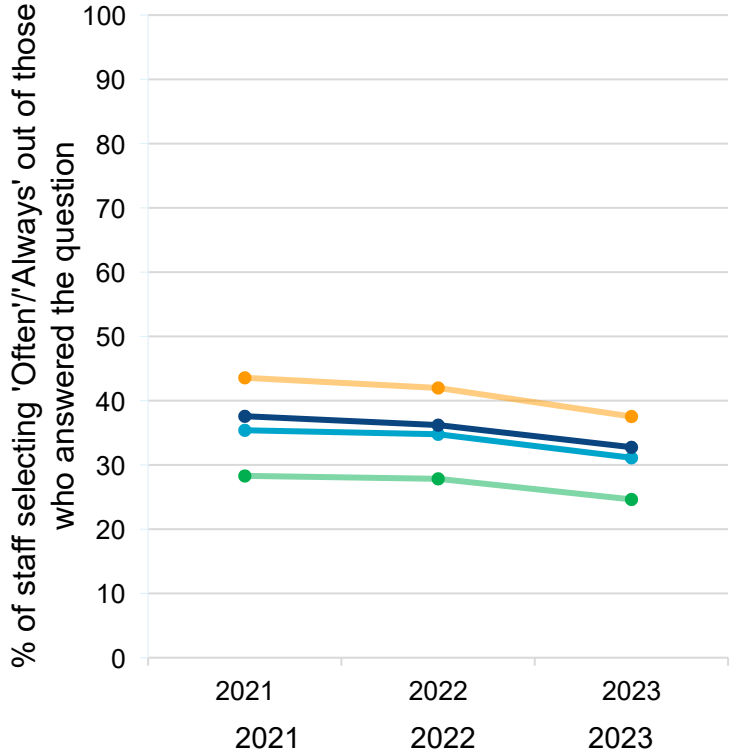
	2019	2020	2021	2022	2023
Your org	43.50%	44.58%	46.23%	46.46%	50.12%
Best result	59.36%	55.82%	54.24%	57.20%	60.00%
Average result	46.49%	46.39%	46.64%	47.58%	49.96%
Worst result	40.11%	39.16%	40.62%	41.97%	43.66%
Responses	1794	1424	1686	1611	1594

Q12a How often, if at all, do you find your work emotionally exhausting?



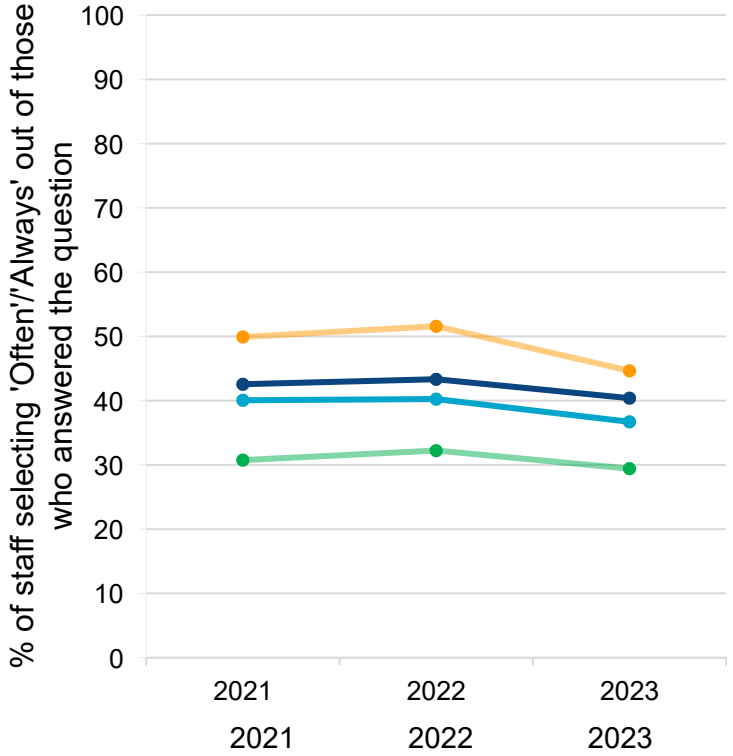
	2021	2022	2023
Your org	39.07%	38.37%	34.95%
Best result	31.73%	30.99%	27.56%
Average result	37.97%	37.10%	34.03%
Worst result	43.72%	44.49%	40.14%
Responses	4410	4005	4003

Q12b How often, if at all, do you feel burnt out because of your work?



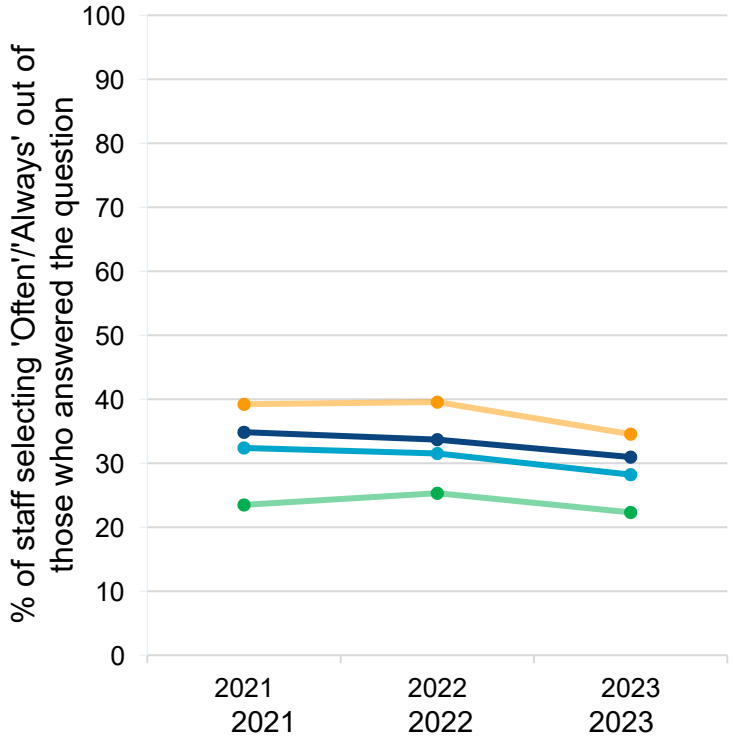
	2021	2022	2023
Your org	37.58%	36.20%	32.76%
Best result	28.30%	27.84%	24.64%
Average result	35.39%	34.77%	31.12%
Worst result	43.56%	41.98%	37.54%
Responses	4413	4009	3998

Q12c How often, if at all, does your work frustrate you?



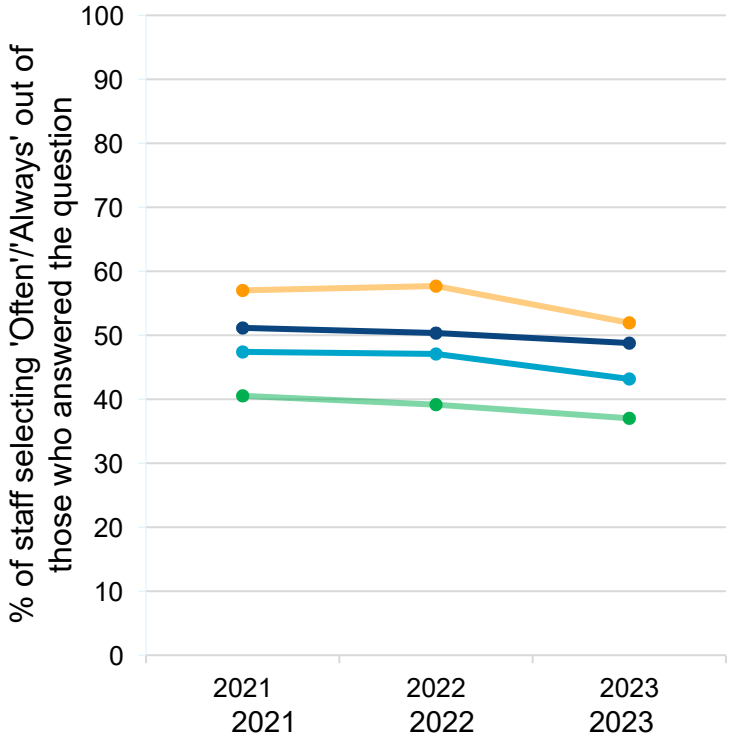
	2021	2022	2023
Your org	42.56%	43.33%	40.39%
Best result	30.75%	32.24%	29.42%
Average result	40.06%	40.25%	36.71%
Worst result	49.91%	51.58%	44.65%
Responses	4406	4009	4004

Q12d How often, if at all, are you exhausted at the thought of another day/shift at work?



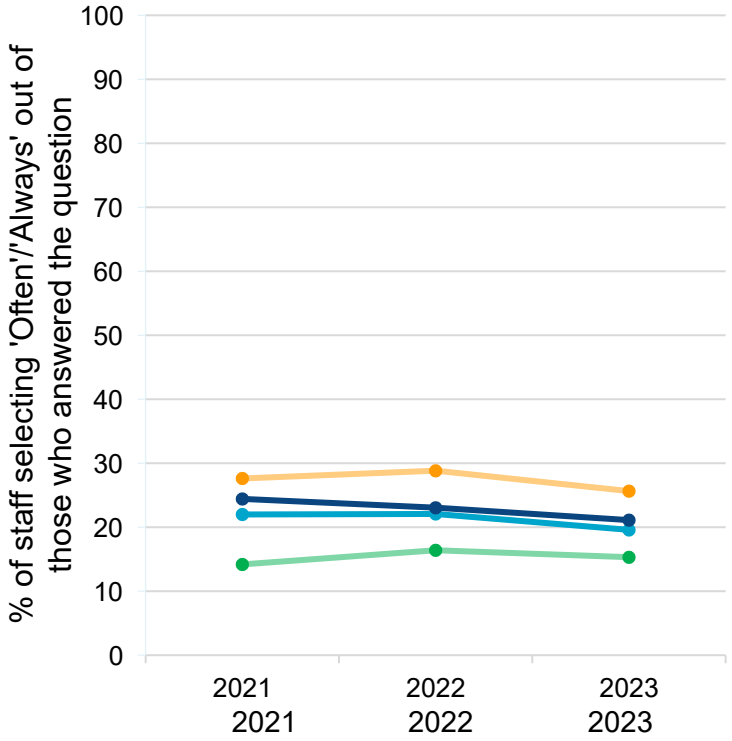
	2021	2022	2023
Your org	34.85%	33.69%	30.97%
Best result	23.50%	25.32%	22.32%
Average result	32.39%	31.53%	28.22%
Worst result	39.23%	39.56%	34.55%
Responses	4405	4007	3998

Q12e How often, if at all, do you feel worn out at the end of your working day/shift?



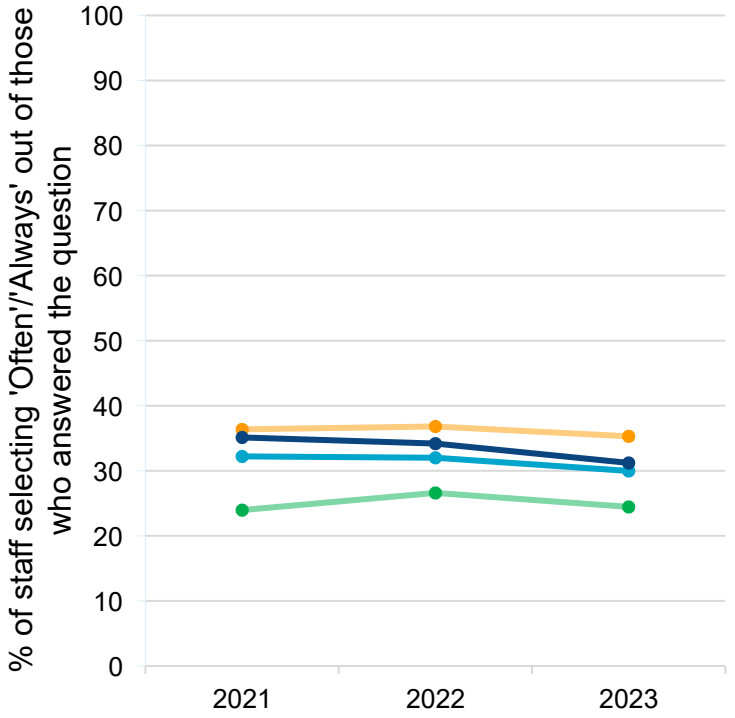
	2021	2022	2023
Your org	51.15%	50.35%	48.78%
Best result	40.53%	39.15%	37.02%
Average result	47.40%	47.08%	43.17%
Worst result	57.02%	57.69%	51.94%
Responses	4407	4004	3997

Q12f How often, if at all, do you feel that every working hour is tiring for you?



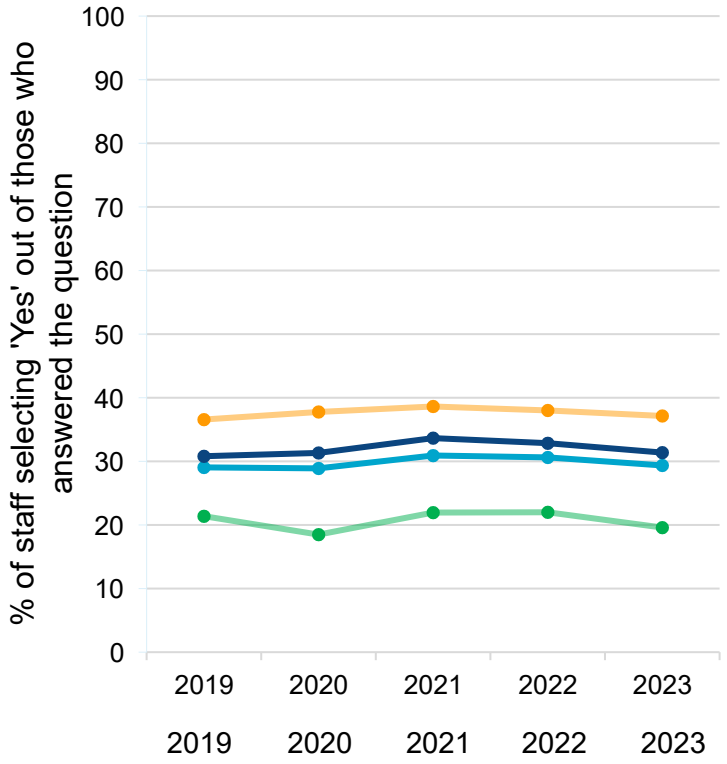
	2021	2022	2023
Your org	24.43%	23.06%	21.11%
Best result	14.19%	16.40%	15.32%
Average result	21.99%	22.07%	19.59%
Worst result	27.62%	28.83%	25.65%
Responses	4406	4004	4000

Q12g How often, if at all, do you not have enough energy for family and friends during leisure time?



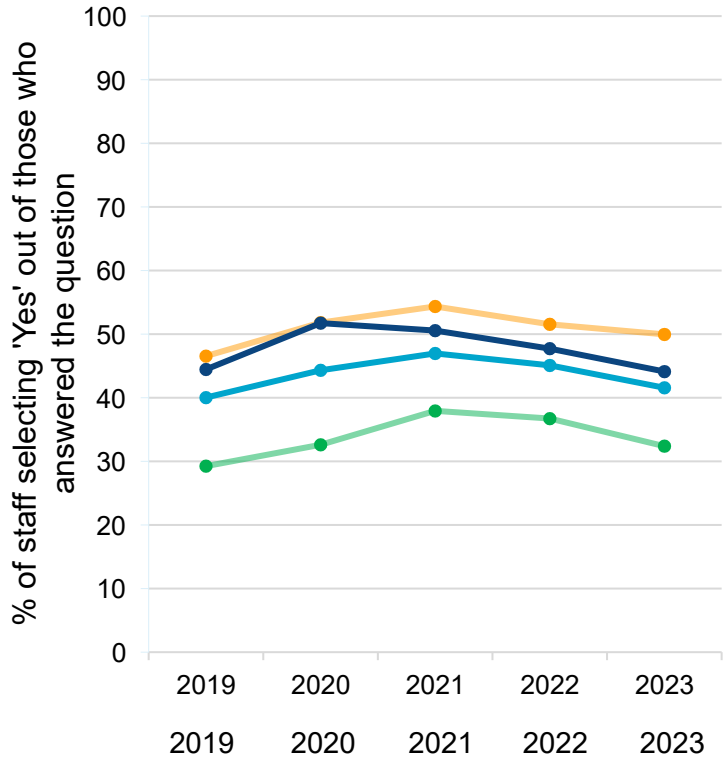
	2021	2022	2023
Your org	35.13%	34.19%	31.21%
Best result	23.96%	26.60%	24.45%
Average result	32.21%	32.01%	29.98%
Worst result	36.37%	36.81%	35.30%
Responses	4405	4005	3994

Q11b In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



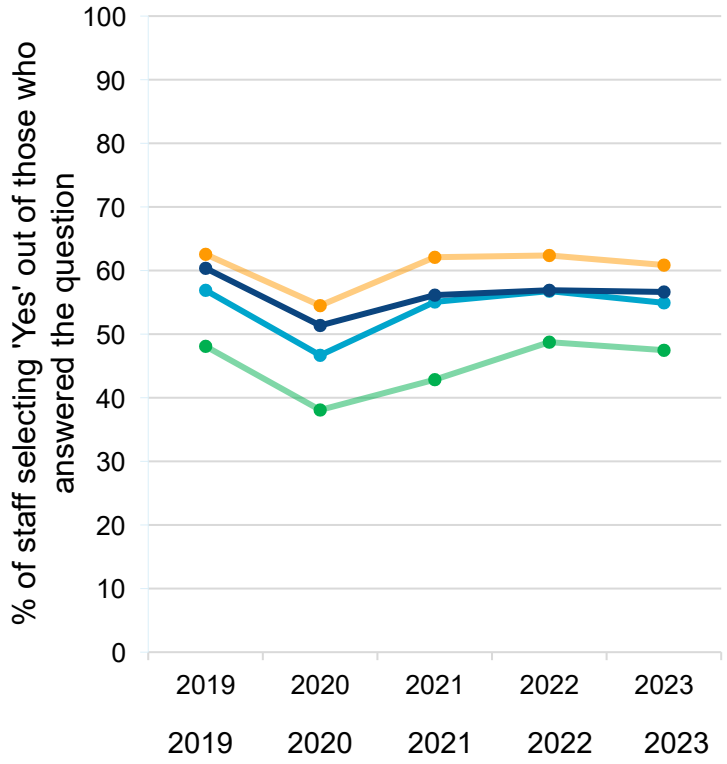
	2019	2020	2021	2022	2023
Your org	30.81%	31.32%	33.65%	32.86%	31.38%
Best result	21.38%	18.49%	21.95%	22.00%	19.59%
Average result	29.05%	28.90%	30.92%	30.62%	29.36%
Worst result	36.57%	37.76%	38.62%	38.01%	37.13%
Responses	4171	3404	4424	4010	4003

Q11c During the last 12 months have you felt unwell as a result of work related stress?



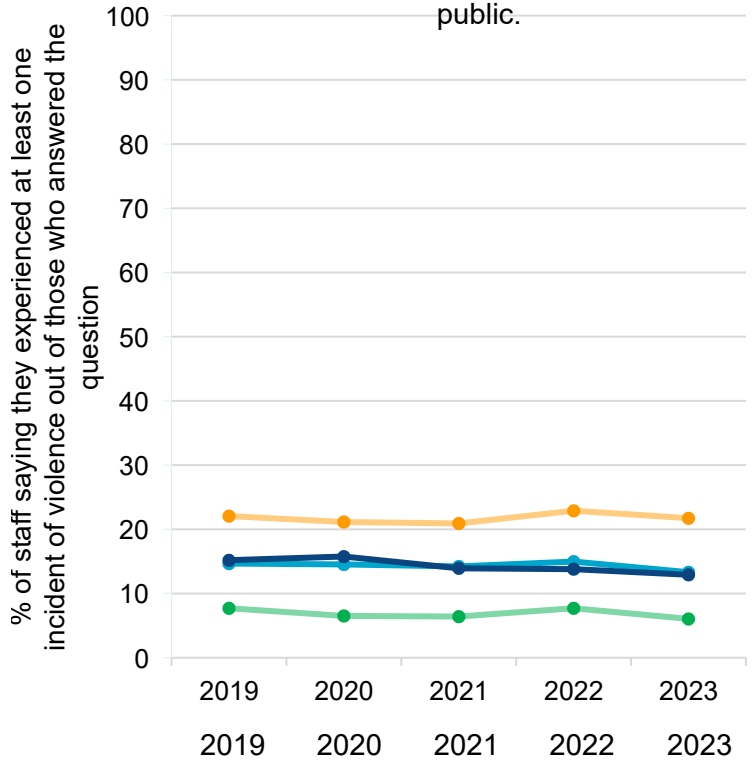
	2019	2020	2021	2022	2023
Your org	44.45%	51.73%	50.56%	47.72%	44.12%
Best result	29.25%	32.61%	37.94%	36.73%	32.39%
Average result	40.03%	44.31%	46.97%	45.09%	41.57%
Worst result	46.55%	51.81%	54.35%	51.55%	49.97%
Responses	4164	3401	4427	4011	3997

Q11d In the last three months have you ever come to work despite not feeling well enough to perform your duties?



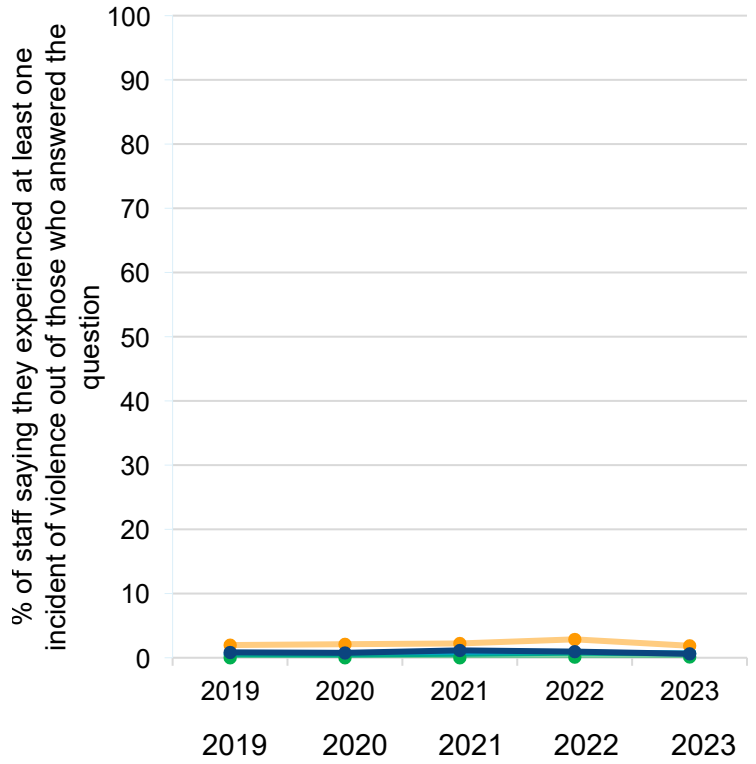
	2019	2020	2021	2022	2023
Your org	60.37%	51.36%	56.13%	56.90%	56.63%
Best result	48.09%	38.07%	42.84%	48.74%	47.48%
Average result	56.90%	46.68%	55.07%	56.76%	54.92%
Worst result	62.56%	54.49%	62.09%	62.37%	60.87%
Responses	4173	3404	4424	4013	4003

Q13a In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives or other members of the public.



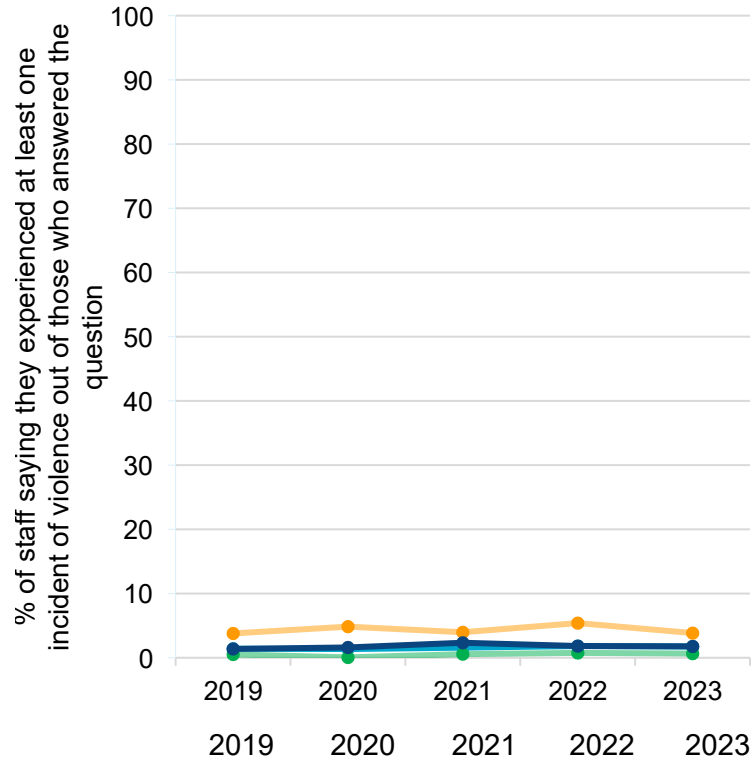
	2019	2020	2021	2022	2023
Your org	15.19%	15.77%	13.93%	13.80%	12.93%
Best result	7.71%	6.51%	6.42%	7.71%	6.06%
Average result	14.67%	14.54%	14.22%	14.98%	13.32%
Worst result	22.06%	21.14%	20.92%	22.90%	21.74%
Responses	4158	3407	4413	3999	3749

Q13b In the last 12 months how many times have you personally experienced physical violence at work from...? Managers.



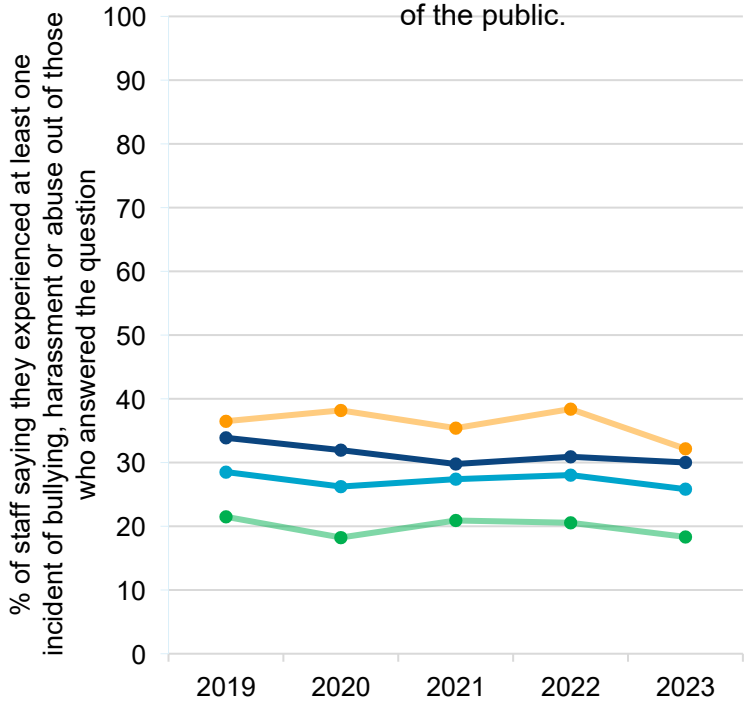
	2019	2020	2021	2022	2023
Your org	0.84%	0.77%	1.15%	0.96%	0.61%
Best result	0.00%	0.00%	0.00%	0.11%	0.14%
Average result	0.54%	0.51%	0.63%	0.79%	0.67%
Worst result	1.98%	2.11%	2.23%	2.87%	1.87%
Responses	4130	3396	4387	3979	3703

Q13c In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues.



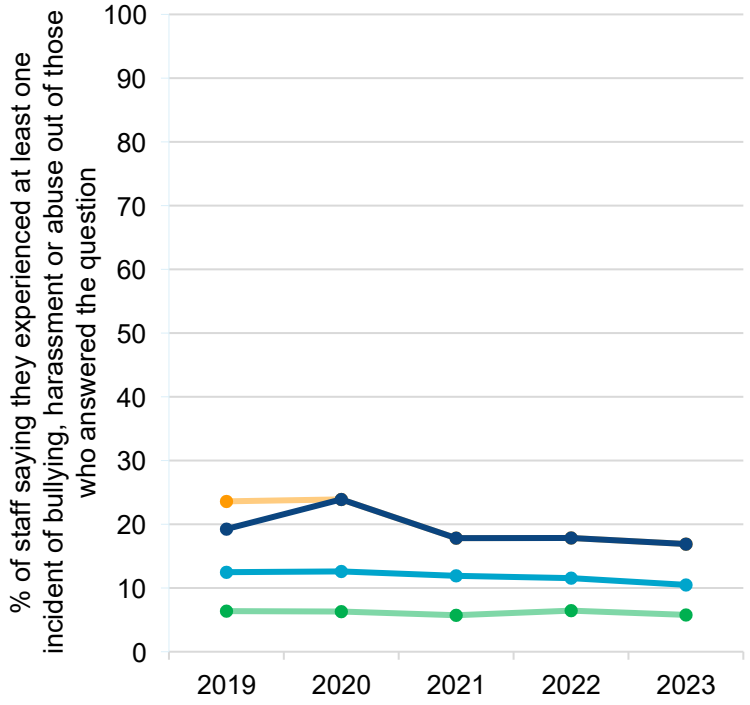
	2019	2020	2021	2022	2023
Your org	1.38%	1.60%	2.34%	1.83%	1.78%
Best result	0.52%	0.06%	0.56%	0.76%	0.66%
Average result	1.41%	1.36%	1.58%	1.82%	1.75%
Worst result	3.79%	4.85%	3.97%	5.40%	3.85%
Responses	4129	3397	4379	3959	3656

Q14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public.



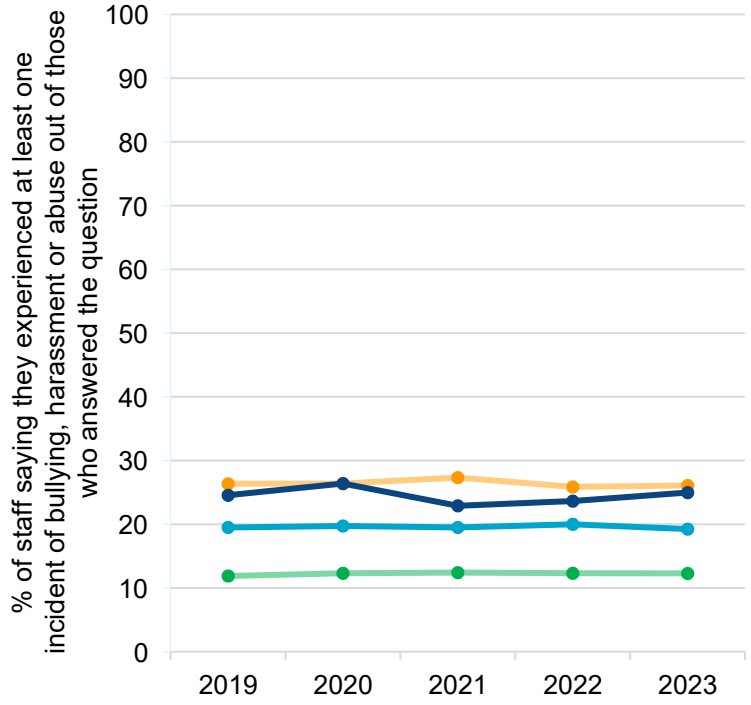
	2019	2020	2021	2022	2023
Your org	33.88%	31.95%	29.77%	30.90%	30.01%
Best result	21.48%	18.24%	20.91%	20.55%	18.33%
Average result	28.51%	26.23%	27.39%	28.03%	25.82%
Worst result	36.49%	38.19%	35.40%	38.39%	32.15%
Responses	4131	3284	4253	3994	3984

Q14b In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Managers.



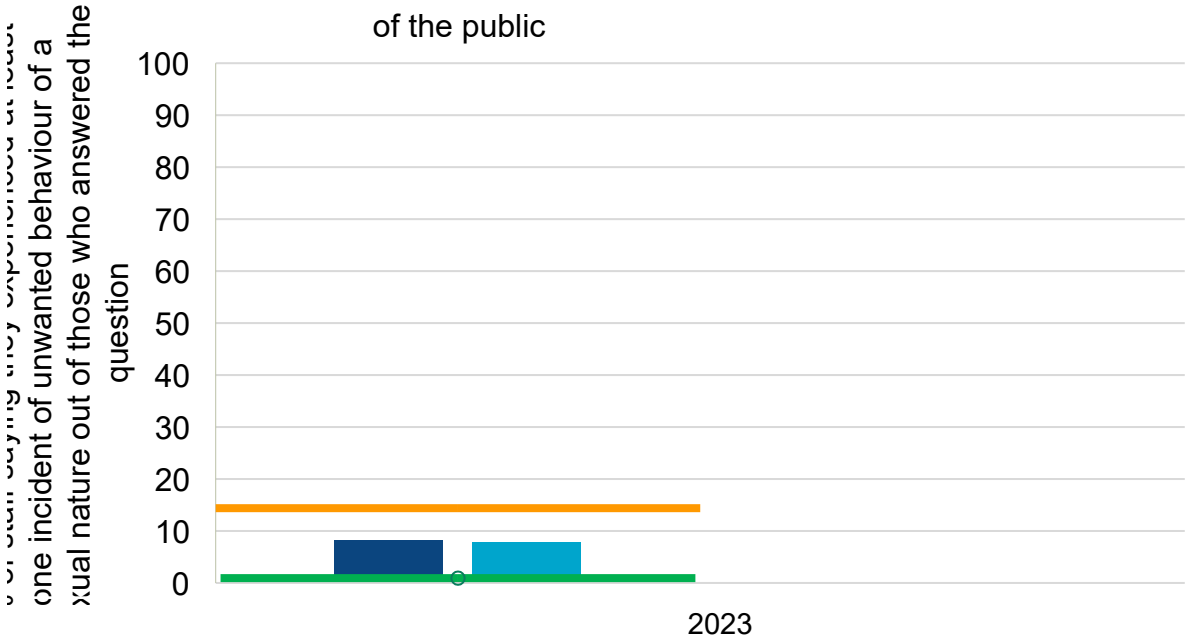
	2019	2020	2021	2022	2023
Your org	19.25%	23.90%	17.82%	17.85%	16.90%
Best result	6.37%	6.31%	5.73%	6.45%	5.78%
Average result	12.48%	12.60%	11.91%	11.55%	10.49%
Worst result	23.60%	23.90%	17.82%	17.85%	16.90%
Responses	4109	3276	4242	3976	3946

Q14c In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues.



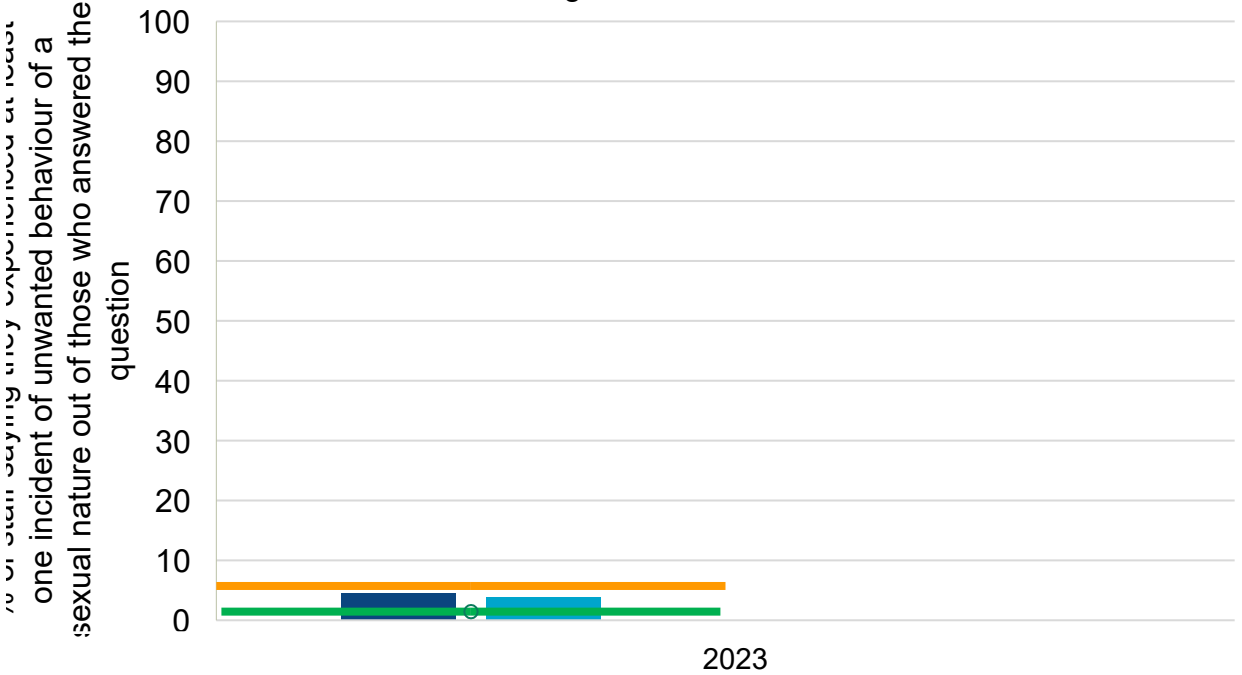
	2019	2020	2021	2022	2023
Your org	24.56%	26.39%	22.90%	23.64%	24.98%
Best result	11.88%	12.31%	12.42%	12.32%	12.30%
Average result	19.50%	19.73%	19.50%	19.99%	19.25%
Worst result	26.36%	26.39%	27.32%	25.87%	26.09%
Responses	4121	3284	4222	3977	3909

Q17a In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From patients / service users, their relatives or other members of the public



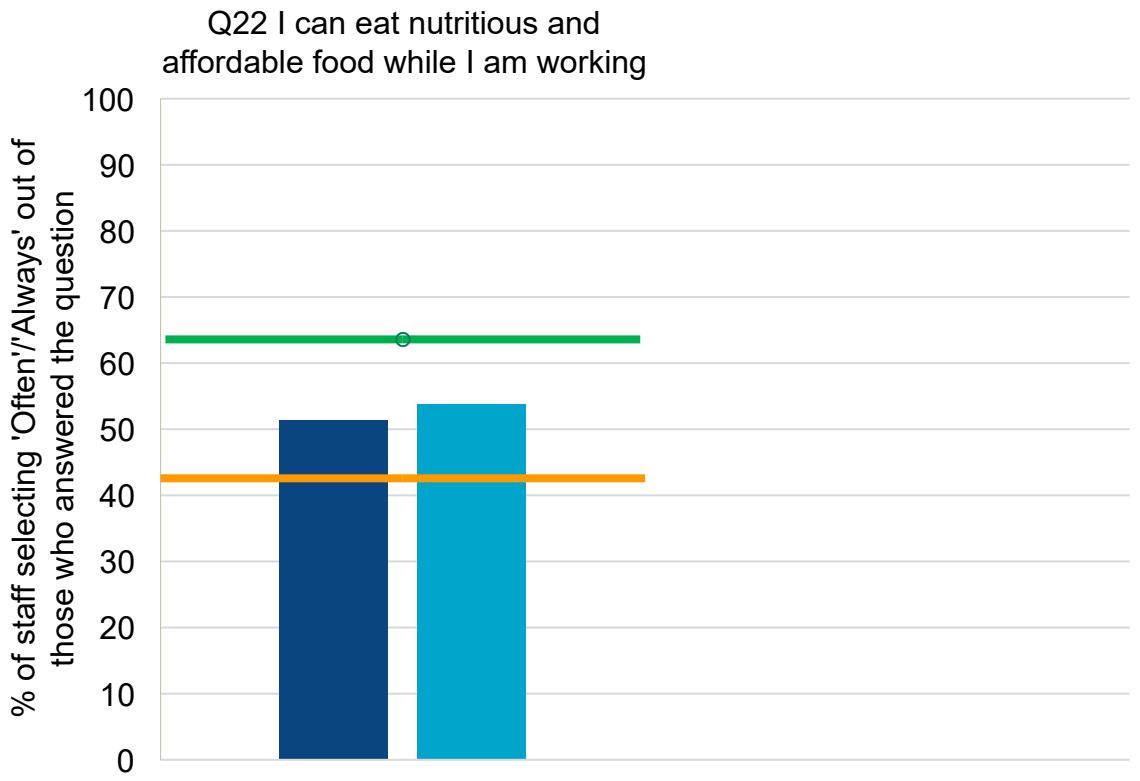
Your org	8.21%
Best result	0.93%
Average result	7.73%
Worst result	14.39%
Responses	3996

Q17b In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From staff / colleagues



Your org	4.45%
Best result	1.44%
Average result	3.82%
Worst result	5.73%
Responses	3985

*These questions do not contribute towards any People Promise element score, theme score or sub-score



	2023
Your org	51.42%
Best result	63.59%
Average result	53.77%
Worst result	42.58%
Responses	3997

*These questions do not contribute towards any People Promise element score, theme score or sub-score

Survey Coordination Centre

NHS

People Promise element – We are always learning

Questions included:

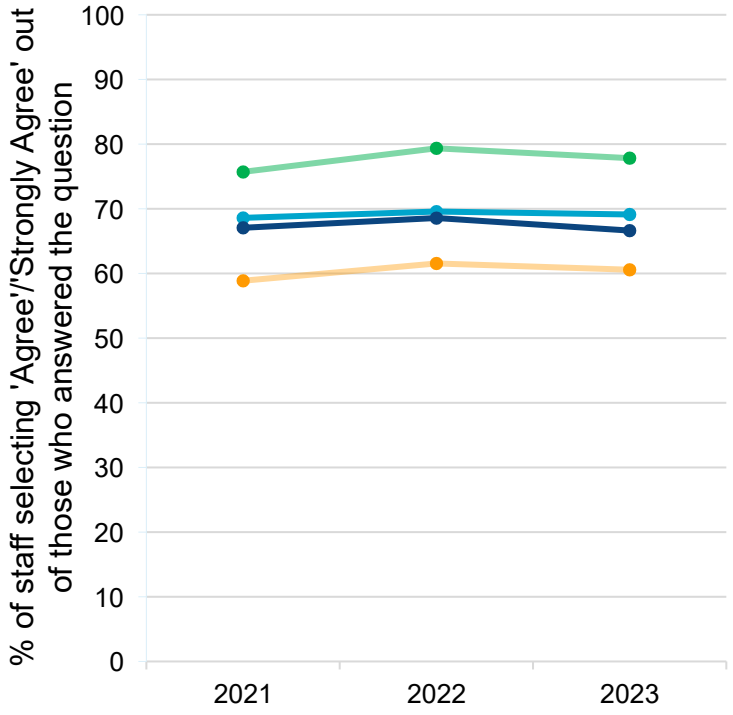
Development – Q24a, Q24b, Q24c, Q24d, Q24e

Appraisals – Q23a*, Q23b, Q23c, Q23d

*Q23a is a filter question and therefore influences the sub-score without being a directly scored question.

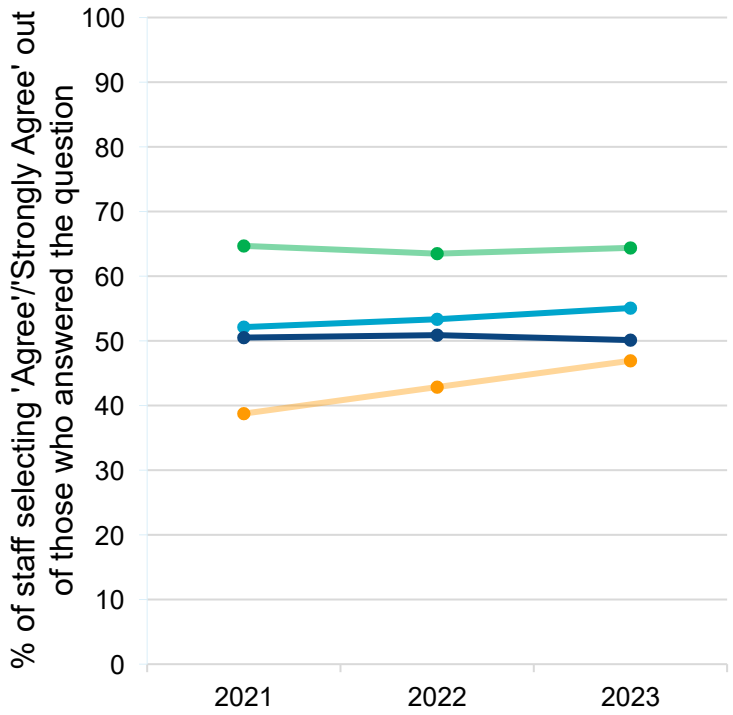
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q24a This organisation offers me challenging work.



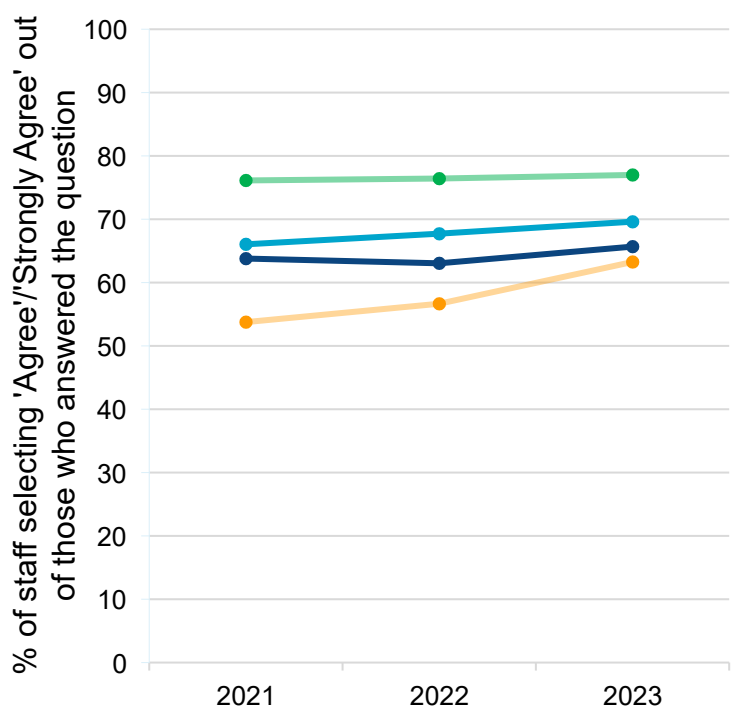
	2021	2022	2023
Your org	67.06%	68.57%	66.63%
Best result	75.71%	79.35%	77.83%
Average result	68.60%	69.57%	69.12%
Worst result	58.88%	61.55%	60.58%
Responses	4356	3992	3984

Q24b There are opportunities for me to develop my career in this organisation.



	2021	2022	2023
Your org	50.50%	50.88%	50.12%
Best result	64.69%	63.48%	64.38%
Average result	52.12%	53.34%	55.07%
Worst result	38.74%	42.85%	46.92%
Responses	4367	3998	3990

Q24c I have opportunities to improve my knowledge and skills.

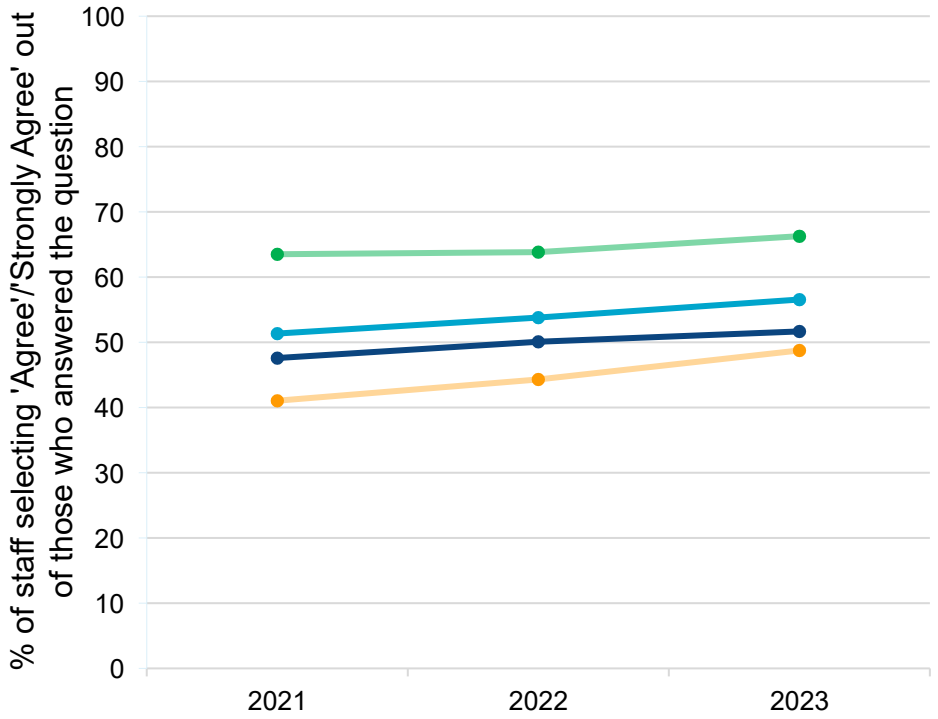


	2021	2022	2023
Your org	63.79%	63.04%	65.68%
Best result	76.13%	76.43%	76.99%
Average result	66.04%	67.72%	69.61%
Worst result	53.76%	56.66%	63.25%
Responses	4364	3995	3993

Survey Coordination Centre

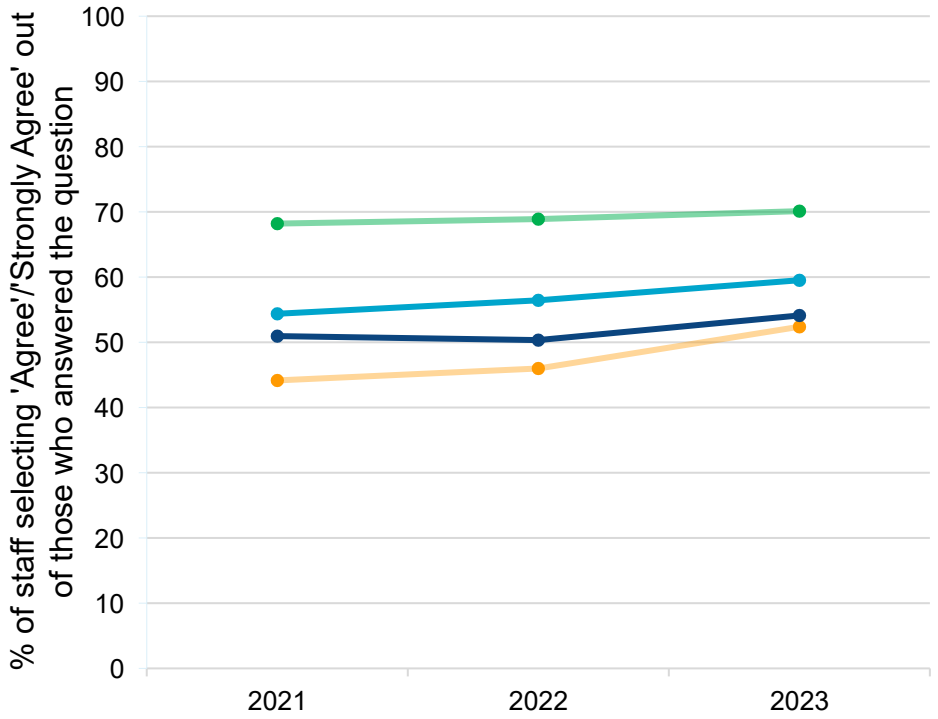
NHS

Q24d I feel supported to develop my potential.



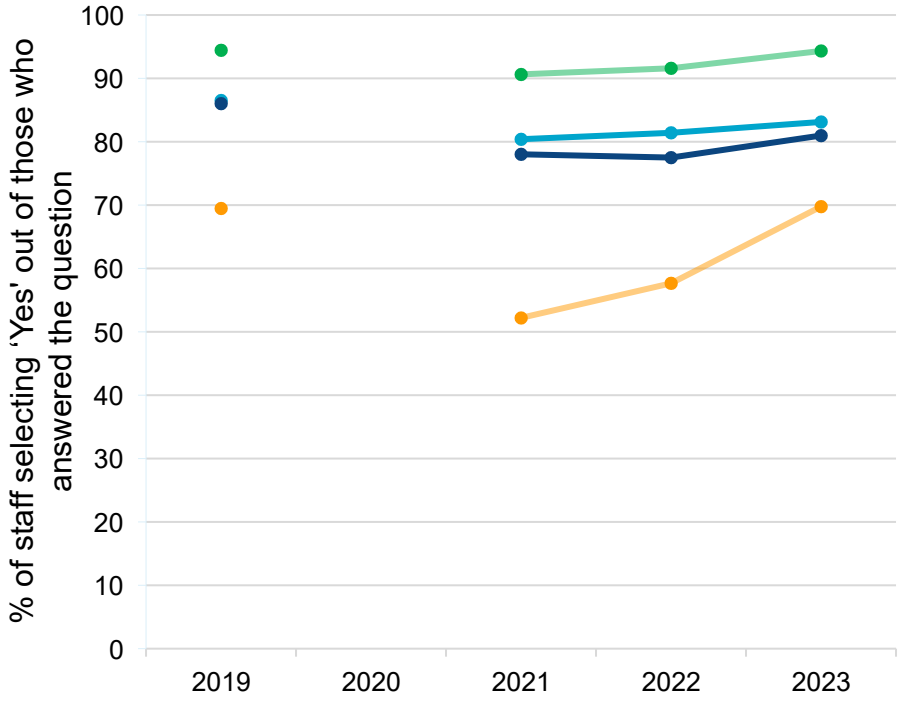
	2021	2022	2023
Your org	47.59%	50.08%	51.67%
Best result	63.51%	63.83%	66.27%
Average result	51.34%	53.79%	56.56%
Worst result	41.04%	44.30%	48.75%
Responses	4361	3995	3983

Q24e I am able to access the right learning and development opportunities when I need to.



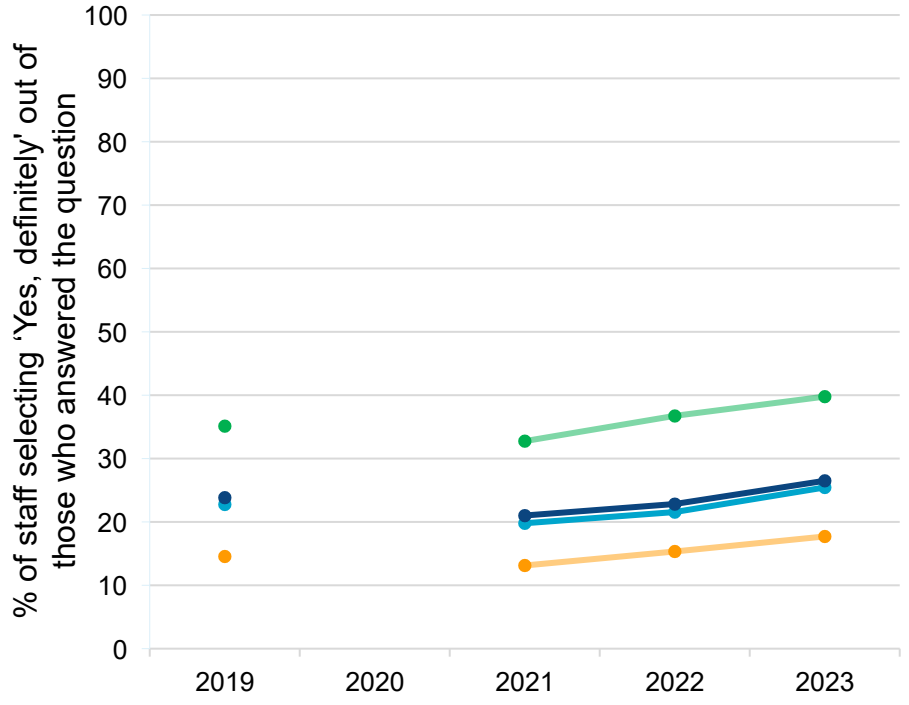
	2021	2022	2023
Your org	50.95%	50.34%	54.12%
Best result	68.20%	68.89%	70.11%
Average result	54.38%	56.44%	59.52%
Worst result	44.16%	45.98%	52.38%
Responses	4359	3995	3987

Q23a* In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?



	2019	2020	2021	2022	2023
Your org	86.02%	-	78.02%	77.50%	80.98%
Best result	94.45%	-	90.63%	91.59%	94.32%
Average result	86.53%	-	80.40%	81.41%	83.12%
Worst result	69.48%	-	52.20%	57.65%	69.76%
Responses	4084	-	4387	3995	3897

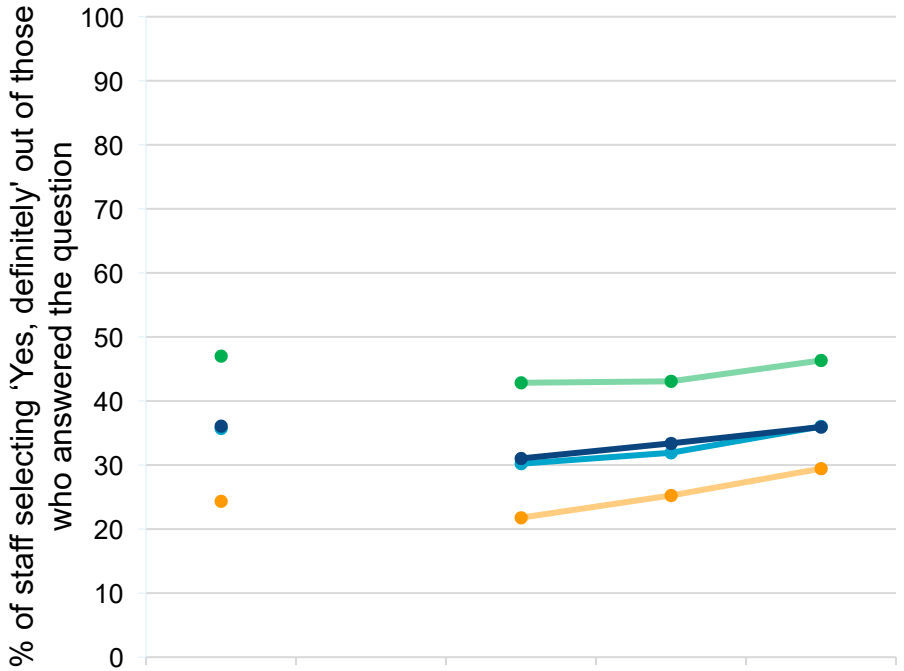
Q23b It helped me to improve how I do my job.



	2019	2020	2021	2022	2023
Your org	23.83%	-	21.01%	22.83%	26.49%
Best result	35.12%	-	32.75%	36.74%	39.78%
Average result	22.76%	-	19.79%	21.56%	25.44%
Worst result	14.56%	-	13.13%	15.33%	17.71%
Responses	3510	-	3408	3103	3152

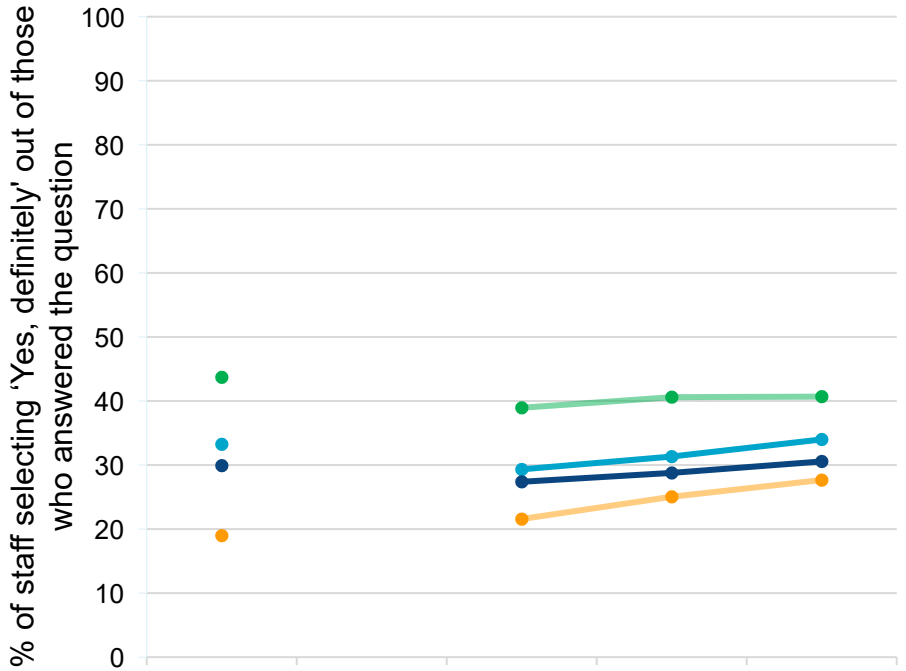
*Q23a is a filter question and therefore influences the sub-score without being a directly scored question.

Q23c It helped me agree clear objectives for my work.



	2019	2020	2021	2022	2023
Your org	36.07%	-	31.03%	33.39%	35.94%
Best result	47.00%	-	42.85%	43.07%	46.33%
Average result	35.71%	-	30.21%	31.92%	36.02%
Worst result	24.35%	-	21.78%	25.24%	29.43%
Responses	3507	-	3411	3105	3149

Q23d It left me feeling that my work is valued by my organisation.



	2019	2020	2021	2022	2023
Your org	29.92%	-	27.39%	28.77%	30.56%
Best result	43.71%	-	38.94%	40.60%	40.68%
Average result	33.25%	-	29.33%	31.33%	34.00%
Worst result	18.99%	-	21.57%	25.05%	27.66%
Responses	3504	-	3406	3104	3146

Survey Coordination Centre

NHS

People Promise element – We work flexibly

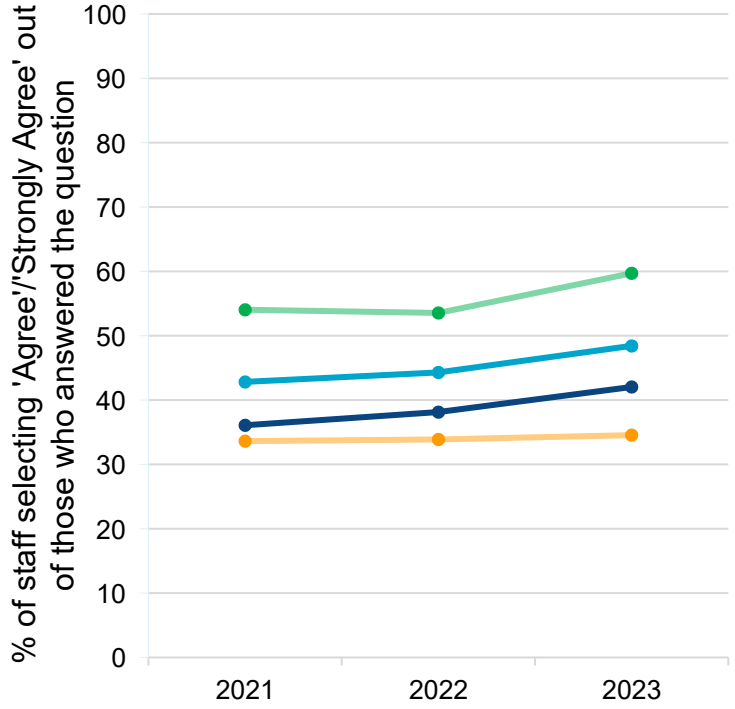
Questions included:

Support for work-life balance – Q6b, Q6c, Q6d

Flexible working – Q4d

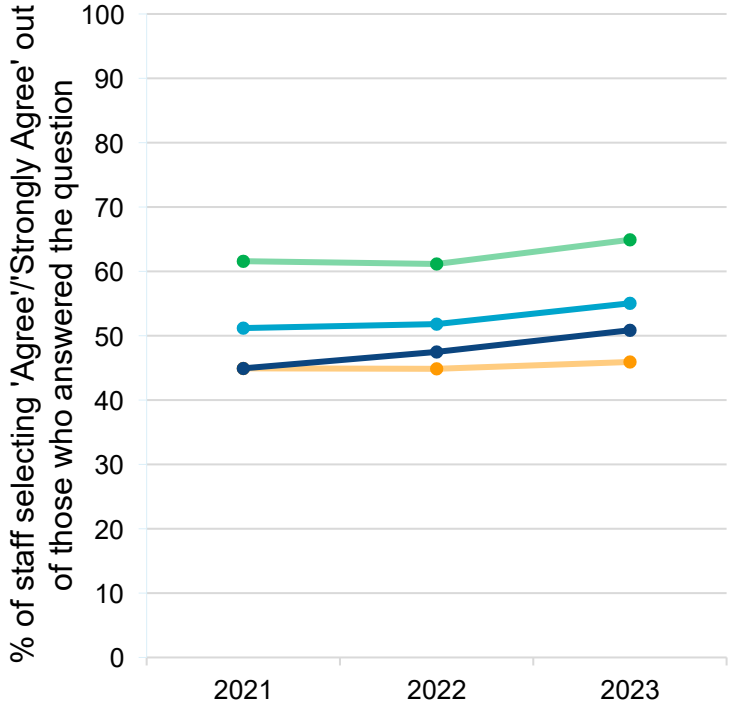
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q6b My organisation is committed to helping me balance my work and home life.



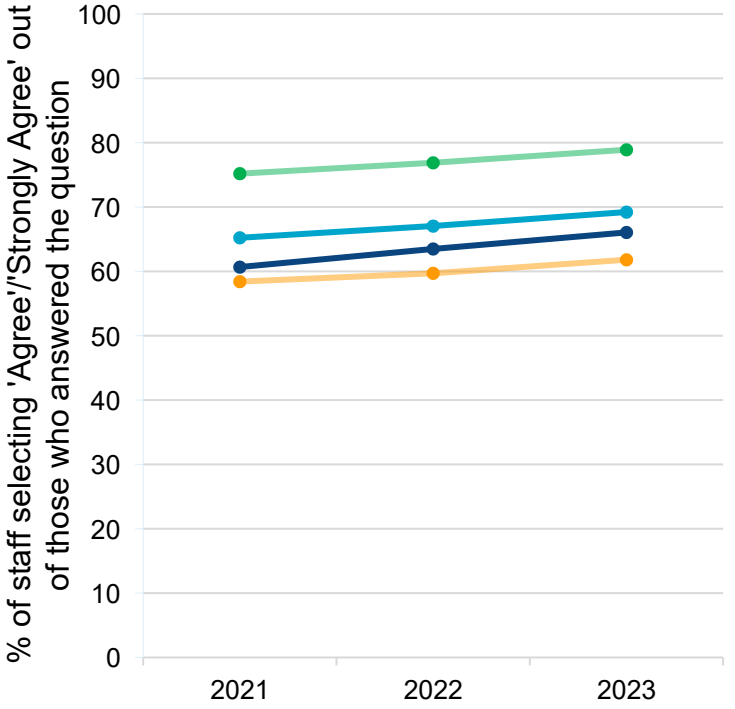
	2021	2022	2023
Your org	36.08%	38.14%	42.04%
Best result	54.04%	53.54%	59.70%
Average result	42.83%	44.29%	48.43%
Worst result	33.62%	33.88%	34.55%
Responses	4491	4015	4001

Q6c I achieve a good balance between my work life and my home life.



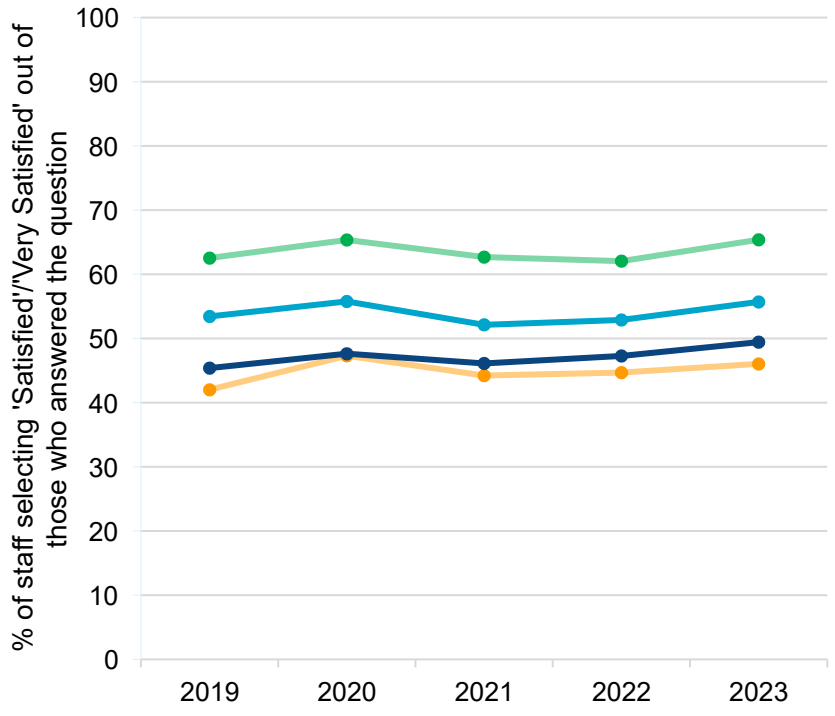
	2021	2022	2023
Your org	44.93%	47.49%	50.85%
Best result	61.58%	61.15%	64.91%
Average result	51.19%	51.81%	55.04%
Worst result	44.93%	44.86%	45.92%
Responses	4490	4016	4001

Q6d I can approach my immediate manager to talk openly about flexible working.



	2021	2022	2023
Your org	60.68%	63.48%	66.06%
Best result	75.18%	76.88%	78.91%
Average result	65.22%	67.05%	69.22%
Worst result	58.41%	59.70%	61.81%
Responses	4492	4016	4001

Q4d How satisfied are you with each of the following aspects of your job? The opportunities for flexible working patterns.

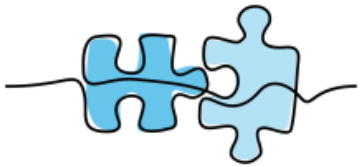


	2019	2020	2021	2022	2023
Your org	45.38%	47.63%	46.11%	47.28%	49.43%
Best result	62.54%	65.35%	62.69%	62.05%	65.39%
Average result	53.43%	55.77%	52.13%	52.89%	55.70%
Worst result	42.02%	47.31%	44.22%	44.69%	46.05%
Responses	4204	3438	4509	4012	3985

Survey Coordination Centre

NHS

People Promise element – We are a team



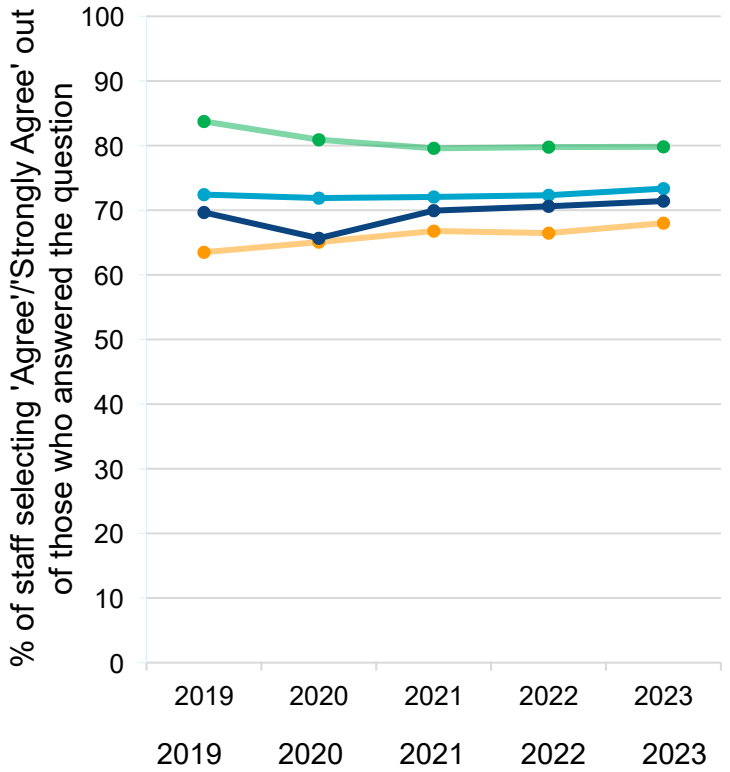
Questions included:

Team working – Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a

Line management – Q9a, Q9b, Q9c, Q9d

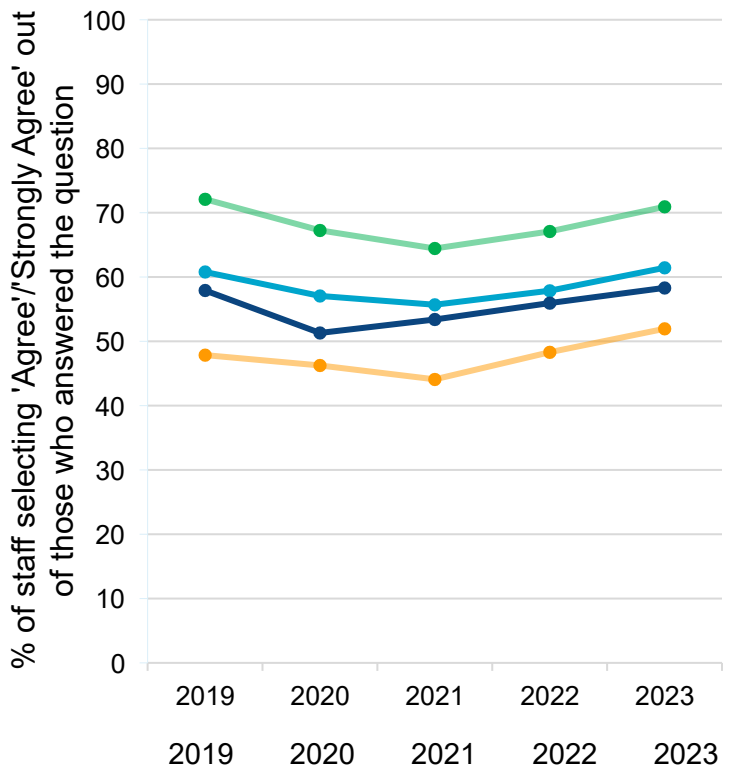
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q7a The team I work in has a set of shared objectives.



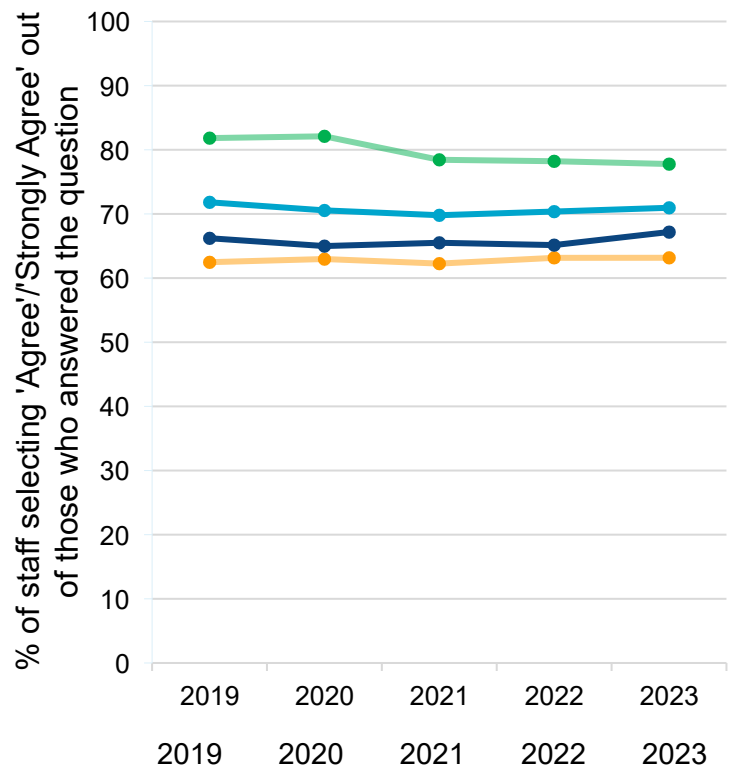
	2019	2020	2021	2022	2023
Your org	69.66%	65.67%	69.94%	70.60%	71.41%
Best result	83.74%	80.91%	79.58%	79.76%	79.81%
Average result	72.42%	71.88%	72.05%	72.32%	73.34%
Worst result	63.51%	65.07%	66.78%	66.46%	68.00%
Responses	4227	3442	4461	4008	3997

Q7b The team I work in often meets to discuss the team's effectiveness.



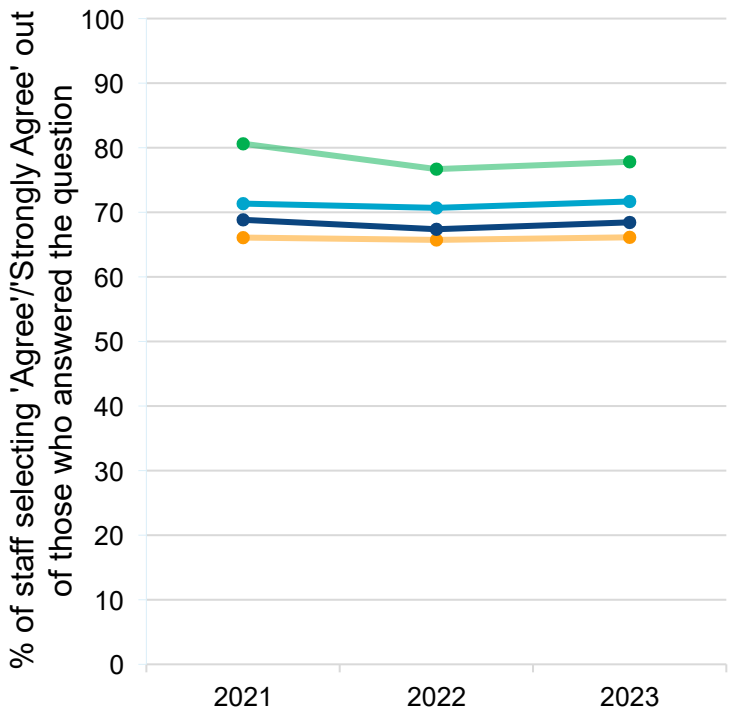
	2019	2020	2021	2022	2023
Your org	57.91%	51.30%	53.39%	55.95%	58.31%
Best result	72.10%	67.26%	64.44%	67.09%	70.92%
Average result	60.78%	57.06%	55.69%	57.87%	61.43%
Worst result	47.86%	46.25%	44.09%	48.30%	51.95%
Responses	4258	3457	4471	4013	3999

Q7c I receive the respect I deserve from my colleagues at work.



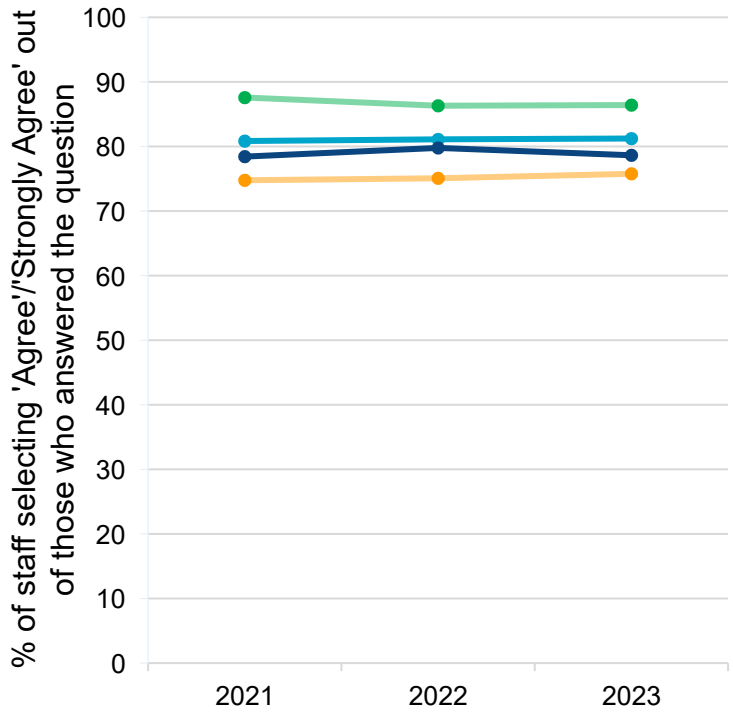
	2019	2020	2021	2022	2023
Your org	66.21%	64.99%	65.50%	65.14%	67.18%
Best result	81.82%	82.10%	78.44%	78.22%	77.78%
Average result	71.82%	70.56%	69.80%	70.37%	70.96%
Worst result	62.48%	62.97%	62.26%	63.16%	63.16%
Responses	4265	3465	4473	4012	4001

Q7d Team members understand each other's roles.



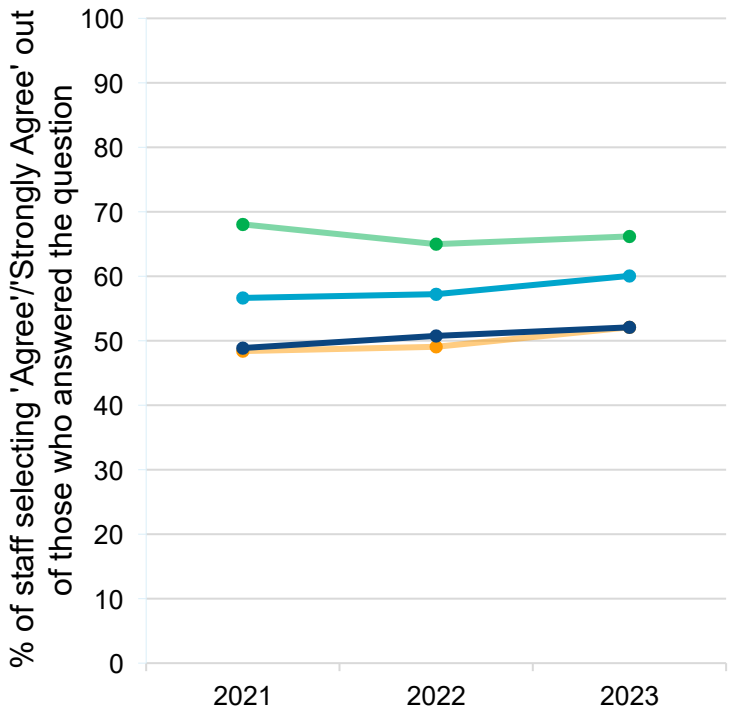
	2021	2022	2023
Your org	68.84%	67.38%	68.44%
Best result	80.62%	76.69%	77.83%
Average result	71.35%	70.69%	71.68%
Worst result	66.09%	65.73%	66.13%
Responses	4473	4014	4001

Q7e I enjoy working with the colleagues in my team.



	2021	2022	2023
Your org	78.43%	79.78%	78.64%
Best result	87.58%	86.31%	86.41%
Average result	80.85%	81.10%	81.23%
Worst result	74.77%	75.07%	75.77%
Responses	4469	4011	3995

Q7f My team has enough freedom in how to do its work.

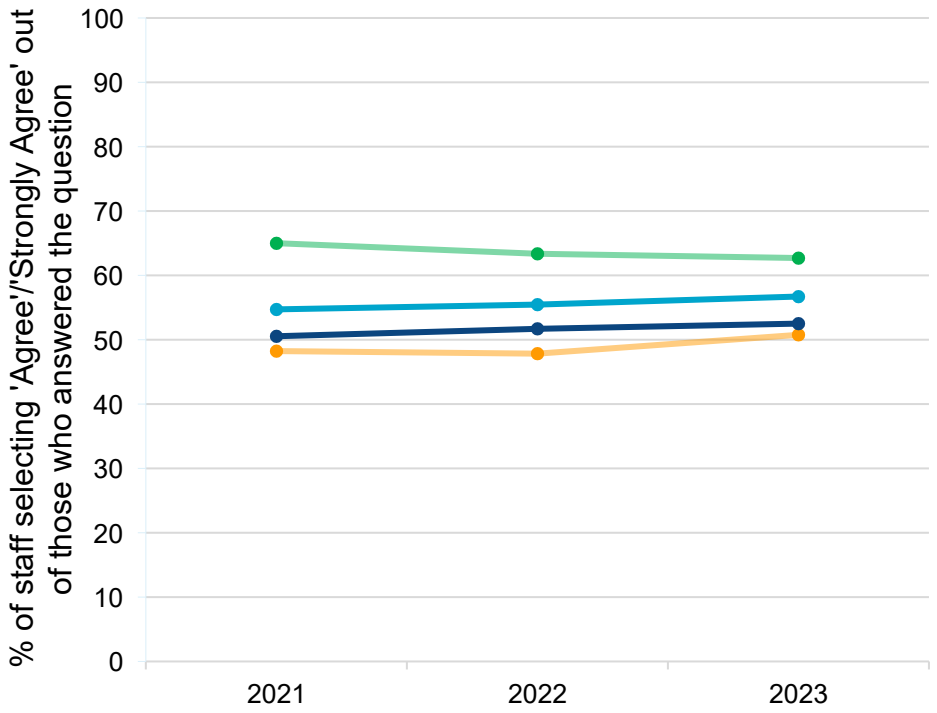


	2021	2022	2023
Your org	48.87%	50.75%	52.08%
Best result	68.05%	64.98%	66.18%
Average result	56.64%	57.22%	60.06%
Worst result	48.40%	49.06%	52.08%
Responses	4470	4009	4002

Survey Coordination Centre

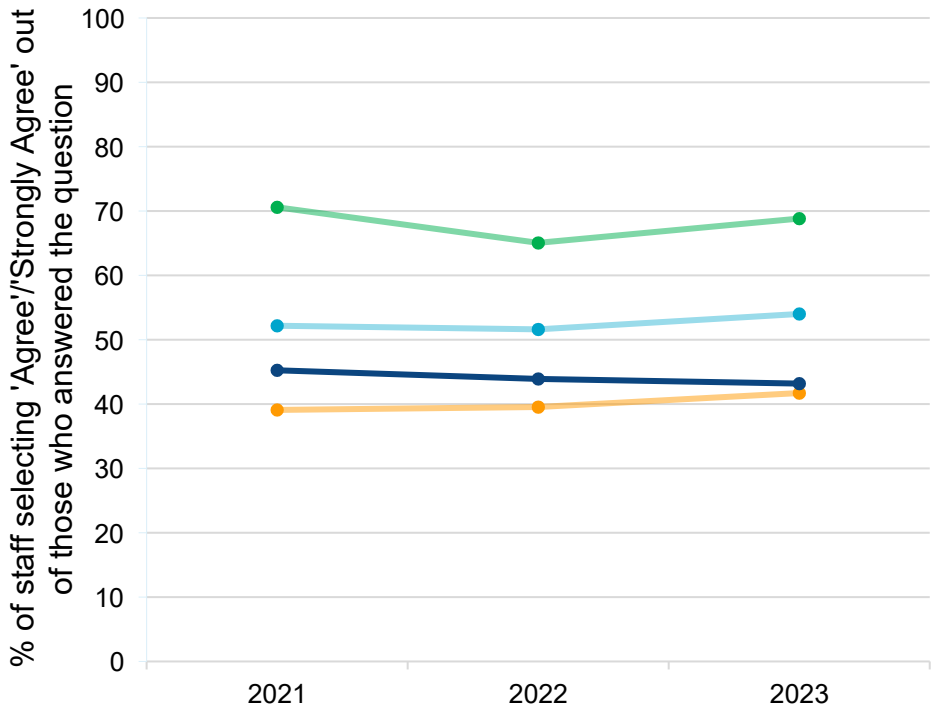
NHS

Q7g In my team disagreements are dealt with constructively.



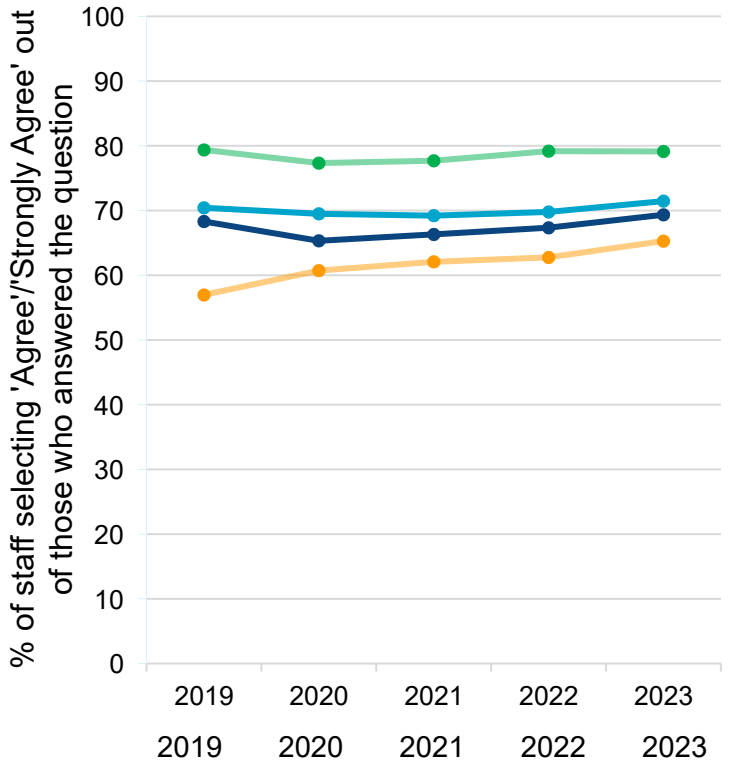
	2021	2022	2023
Your org	50.54%	51.69%	52.50%
Best result	65.00%	63.36%	62.70%
Average result	54.72%	55.46%	56.71%
Worst result	48.24%	47.83%	50.76%
Responses	4460	4010	3997

Q8a Teams within this organisation work well together to achieve their objectives.



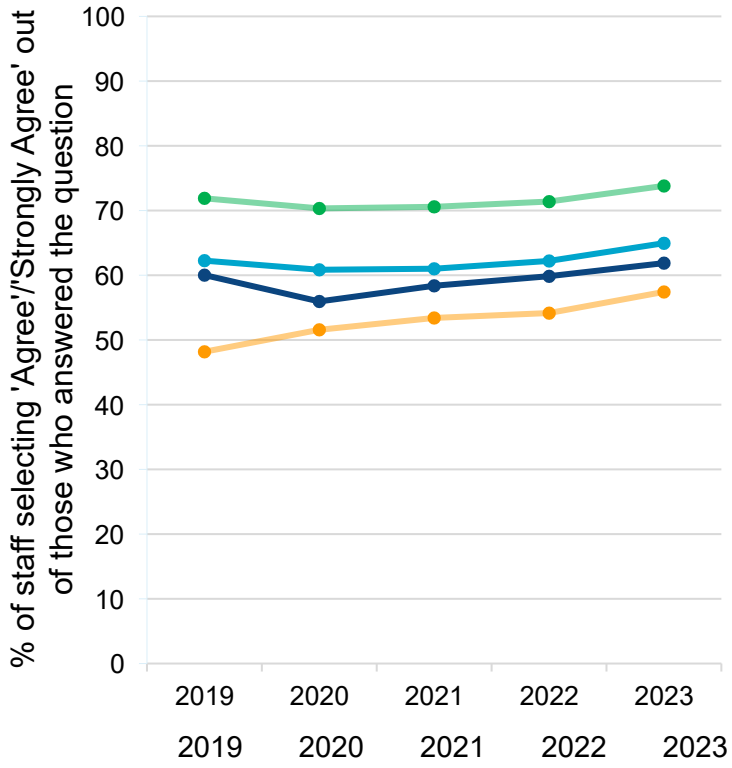
	2021	2022	2023
Your org	45.25%	43.91%	43.18%
Best result	70.58%	65.06%	68.83%
Average result	52.17%	51.61%	54.00%
Worst result	39.09%	39.54%	41.71%
Responses	4451	4009	3998

Q9a My immediate manager encourages me at work.



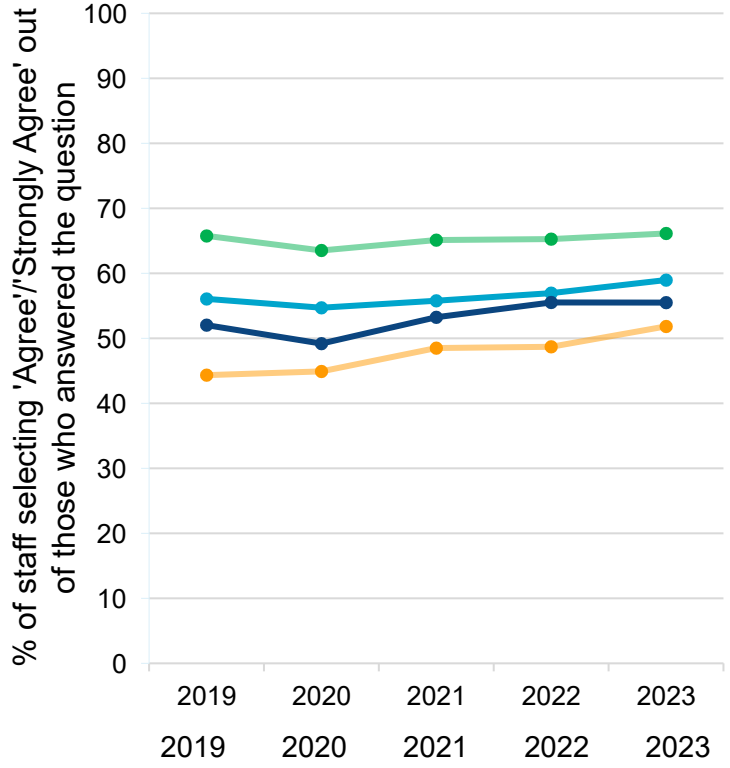
	2019	2020	2021	2022	2023
Your org	68.31%	65.32%	66.32%	67.35%	69.35%
Best result	79.38%	77.33%	77.69%	79.17%	79.13%
Average result	70.43%	69.49%	69.21%	69.78%	71.45%
Worst result	56.97%	60.71%	62.07%	62.76%	65.29%
Responses	4169	3412	4433	4012	4002

Q9b My immediate manager gives me clear feedback on my work.



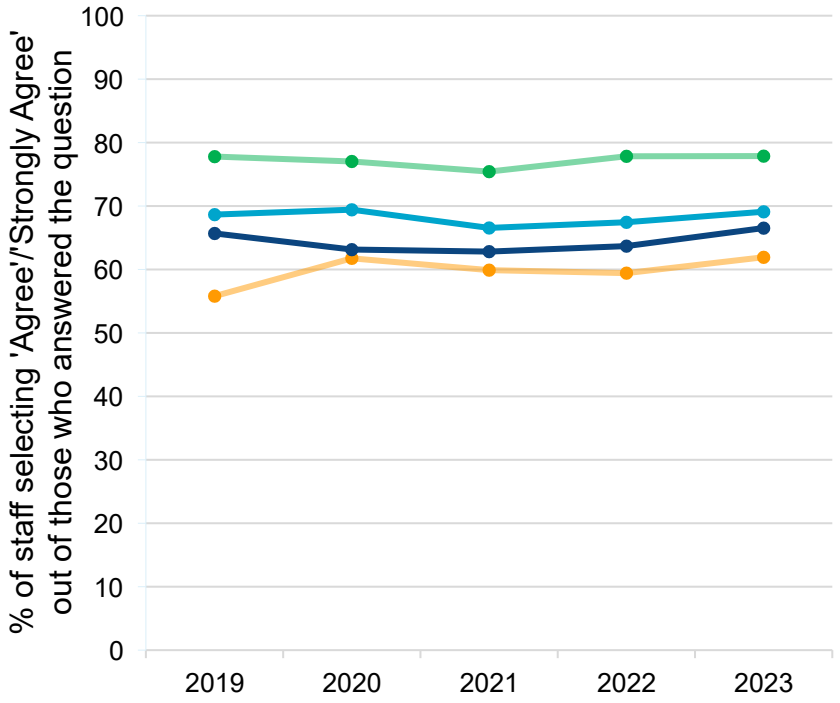
	2019	2020	2021	2022	2023
Your org	60.03%	55.95%	58.37%	59.85%	61.87%
Best result	71.89%	70.33%	70.57%	71.39%	73.81%
Average result	62.26%	60.85%	61.01%	62.21%	64.96%
Worst result	48.18%	51.57%	53.40%	54.16%	57.43%
Responses	4163	3408	4433	4003	3997

Q9c My immediate manager asks for my opinion before making decisions that affect my work.



	2019	2020	2021	2022	2023
Your org	52.03%	49.19%	53.24%	55.52%	55.50%
Best result	65.77%	63.52%	65.12%	65.27%	66.13%
Average result	56.07%	54.71%	55.78%	56.95%	58.97%
Worst result	44.34%	44.91%	48.51%	48.70%	51.84%
Responses	4169	3408	4430	4008	3999

Q9d My immediate manager takes a positive interest in my health and well-being.



	2019	2020	2021	2022	2023
Your org	65.69%	63.14%	62.82%	63.68%	66.53%
Best result	77.80%	77.02%	75.43%	77.84%	77.87%
Average result	68.65%	69.43%	66.55%	67.45%	69.10%
Worst result	55.79%	61.76%	59.90%	59.42%	61.93%
Responses	4167	3412	4432	4011	3998

Survey Coordination Centre

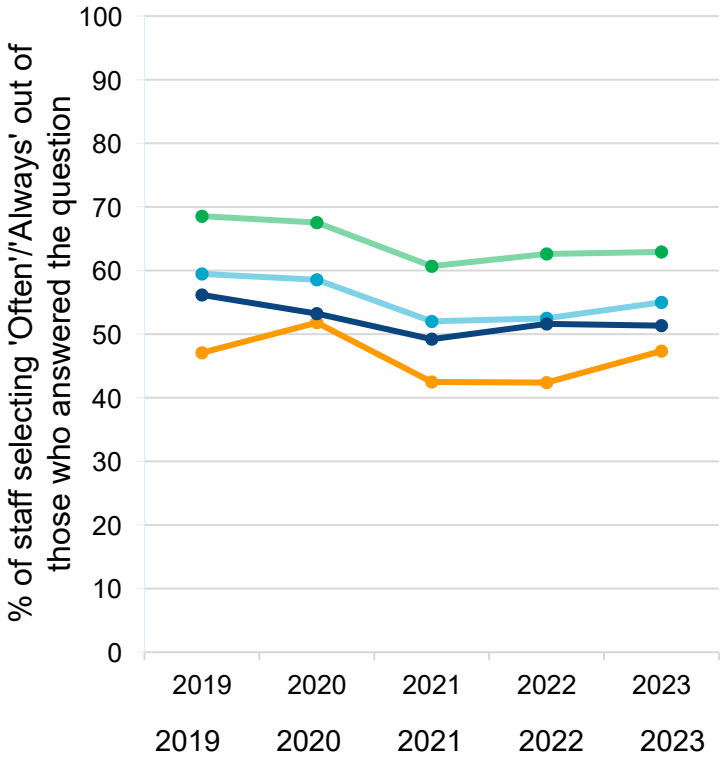
NHS

Theme – Staff engagement

Questions included:
Motivation – Q2a, Q2b, Q2c
Involvement – Q3c, Q3d, Q3f
Advocacy – Q25a, Q25c, Q25d

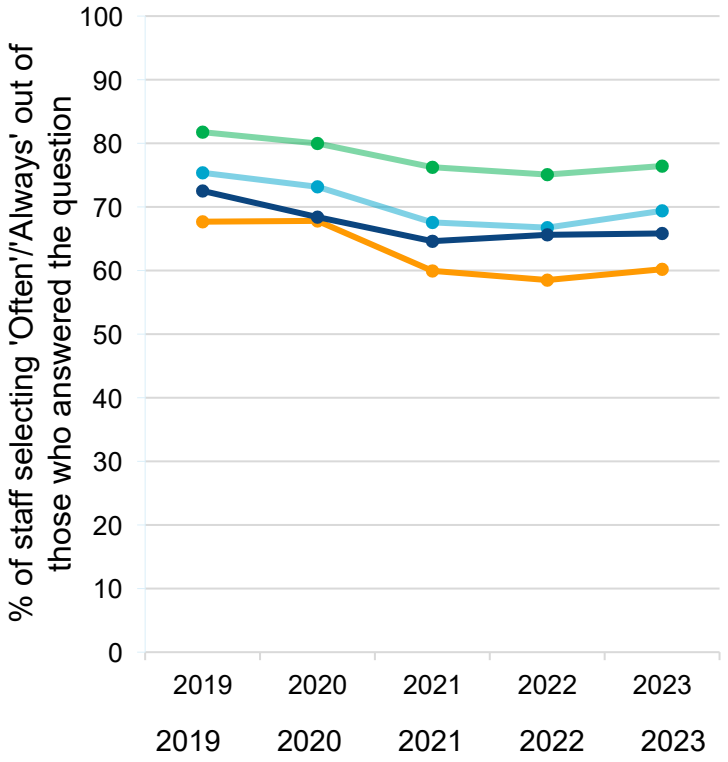
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q2a I look forward to going to work.



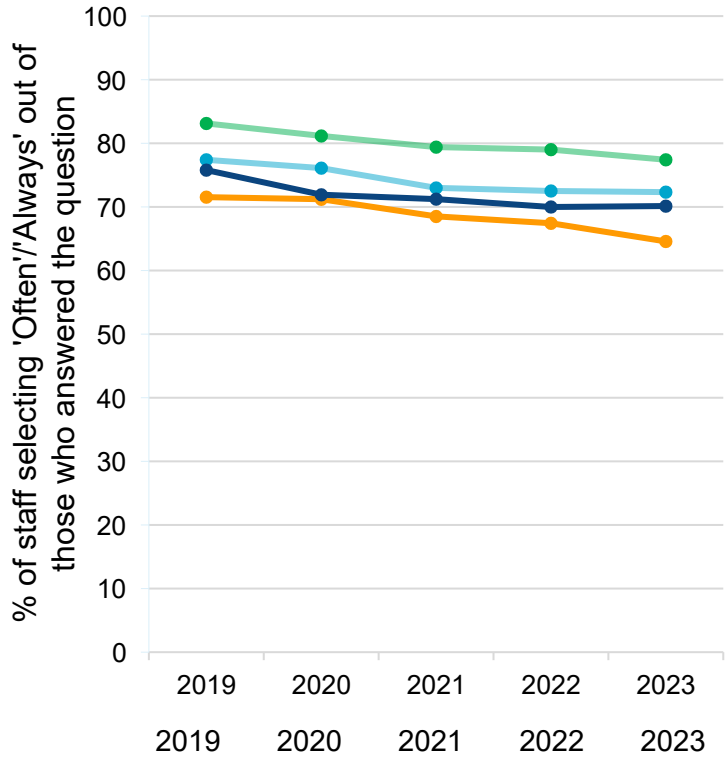
	2019	2020	2021	2022	2023
Your org	56.17%	53.23%	49.21%	51.61%	51.33%
Best result	68.55%	67.55%	60.68%	62.60%	62.92%
Average result	59.47%	58.55%	52.01%	52.49%	55.00%
Worst result	47.07%	51.81%	42.48%	42.39%	47.34%
Responses	4249	3524	4549	4005	3988

Q2b I am enthusiastic about my job.



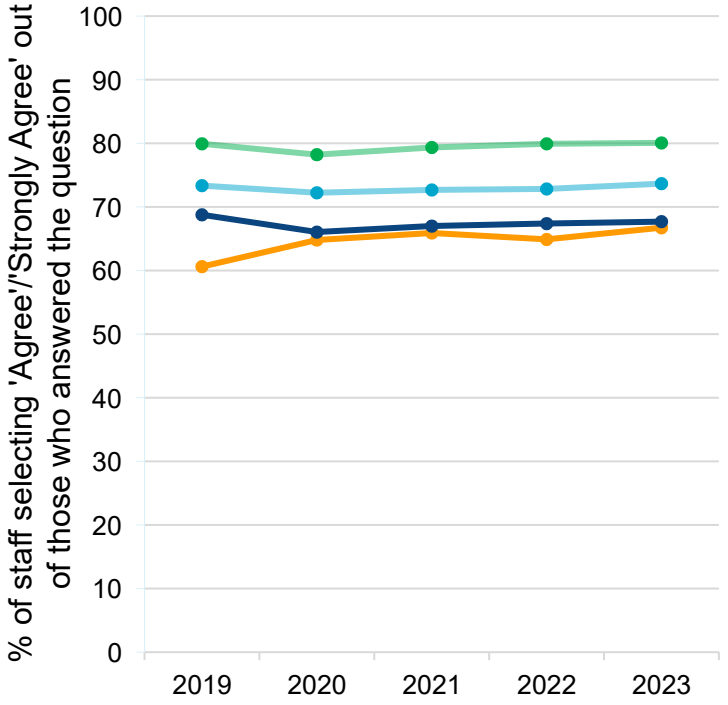
	2019	2020	2021	2022	2023
Your org	72.52%	68.40%	64.62%	65.61%	65.83%
Best result	81.75%	79.97%	76.25%	75.09%	76.43%
Average result	75.37%	73.16%	67.57%	66.74%	69.39%
Worst result	67.68%	67.81%	59.95%	58.50%	60.20%
Responses	4245	3504	4535	3992	3963

Q2c Time passes quickly when I am working.



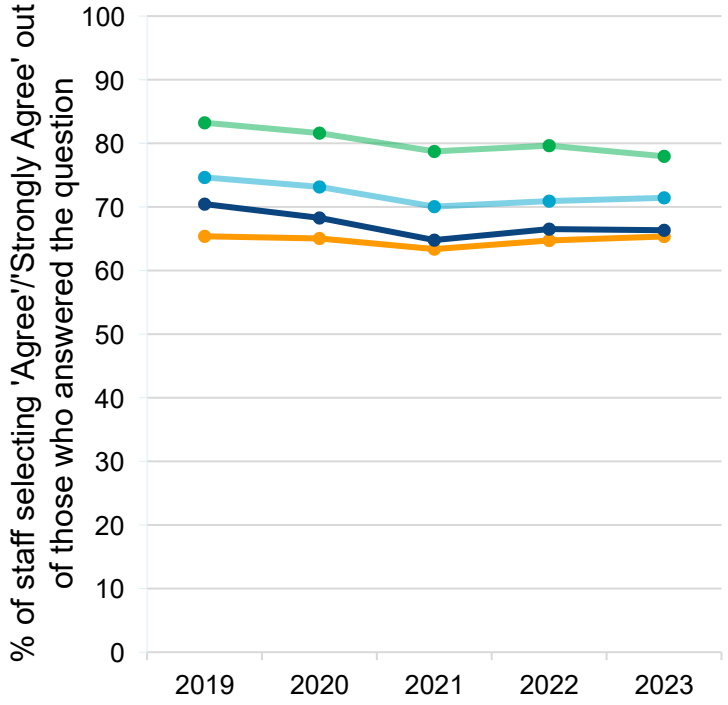
	2019	2020	2021	2022	2023
Your org	75.79%	71.92%	71.23%	69.99%	70.14%
Best result	83.13%	81.17%	79.41%	79.01%	77.42%
Average result	77.41%	76.10%	73.00%	72.50%	72.33%
Worst result	71.54%	71.21%	68.52%	67.44%	64.58%
Responses	4247	3513	4544	3997	3966

Q3c There are frequent opportunities for me to show initiative in my role.



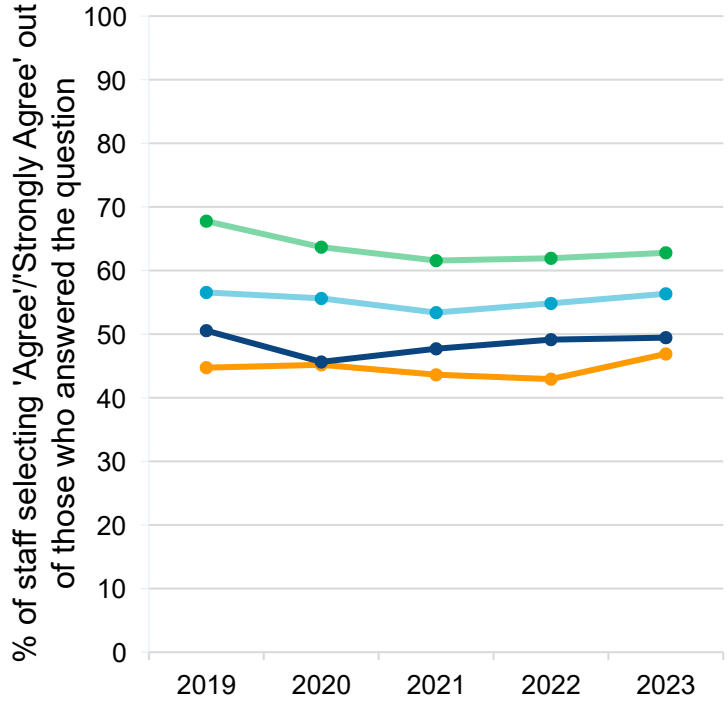
	2019	2020	2021	2022	2023
Your org	68.77%	66.05%	67.00%	67.39%	67.68%
Best result	79.93%	78.22%	79.35%	79.92%	80.07%
Average result	73.35%	72.23%	72.68%	72.83%	73.66%
Worst result	60.61%	64.80%	65.90%	64.90%	66.74%
Responses	4267	3459	4520	4010	3998

Q3d I am able to make suggestions to improve the work of my team / department.



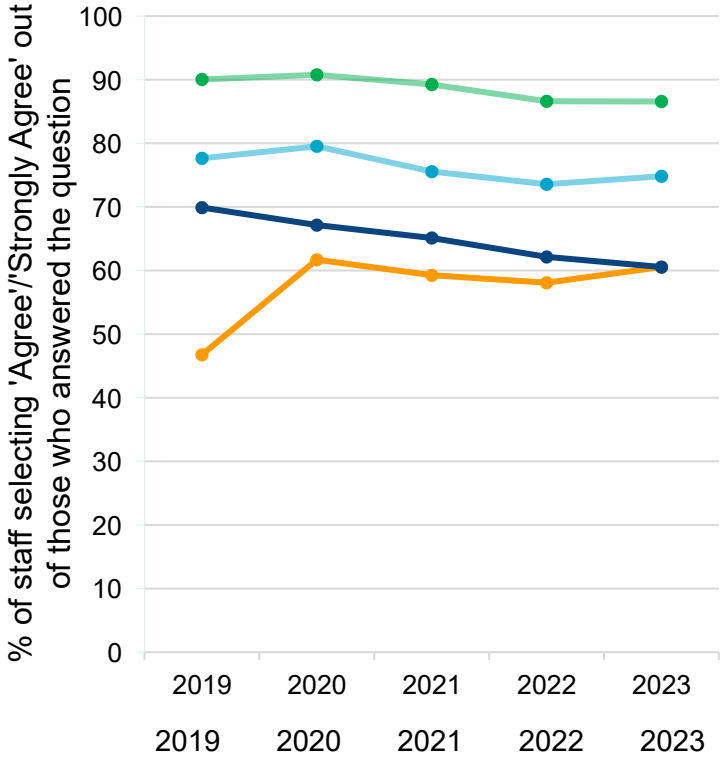
	2019	2020	2021	2022	2023
Your org	70.45%	68.28%	64.79%	66.51%	66.34%
Best result	83.24%	81.60%	78.73%	79.63%	77.96%
Average result	74.65%	73.16%	70.05%	70.92%	71.43%
Worst result	65.38%	65.04%	63.37%	64.73%	65.35%
Responses	4265	3461	4519	4008	3998

Q3f I am able to make improvements happen in my area of work.



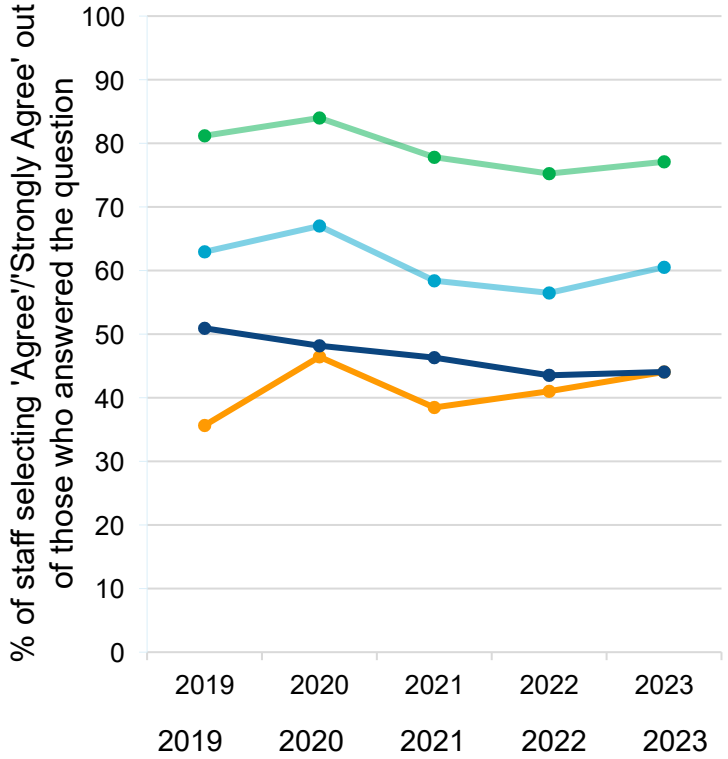
	2019	2020	2021	2022	2023
Your org	50.55%	45.64%	47.70%	49.14%	49.45%
Best result	67.76%	63.68%	61.57%	61.93%	62.79%
Average result	56.56%	55.62%	53.39%	54.84%	56.35%
Worst result	44.73%	45.18%	43.63%	42.93%	46.89%
Responses	4264	3459	4523	4007	3996

Q25a Care of patients / service users is my organisation's top priority.



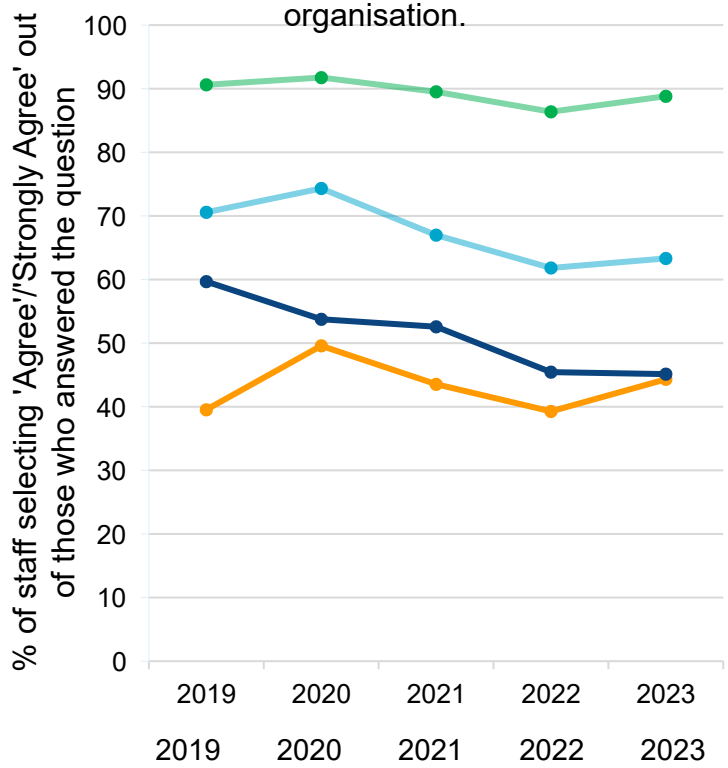
	2019	2020	2021	2022	2023
Your org	69.91%	67.15%	65.11%	62.15%	60.55%
Best result	90.05%	90.77%	89.25%	86.61%	86.57%
Average result	77.64%	79.53%	75.57%	73.56%	74.83%
Worst result	46.76%	61.70%	59.27%	58.09%	60.55%
Responses	4070	3330	4329	3995	3988

Q25c I would recommend my organisation as a place to work.



	2019	2020	2021	2022	2023
Your org	50.92%	48.17%	46.30%	43.53%	44.05%
Best result	81.18%	83.99%	77.82%	75.24%	77.09%
Average result	62.94%	67.00%	58.40%	56.48%	60.52%
Worst result	35.64%	46.44%	38.47%	41.03%	44.05%
Responses	4069	3333	4332	3994	3983

Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



	2019	2020	2021	2022	2023
Your org	59.68%	53.75%	52.58%	45.44%	45.13%
Best result	90.62%	91.76%	89.51%	86.38%	88.82%
Average result	70.57%	74.32%	66.99%	61.82%	63.32%
Worst result	39.54%	49.58%	43.54%	39.27%	44.31%
Responses	4069	3331	4330	3996	3985

Survey Coordination Centre

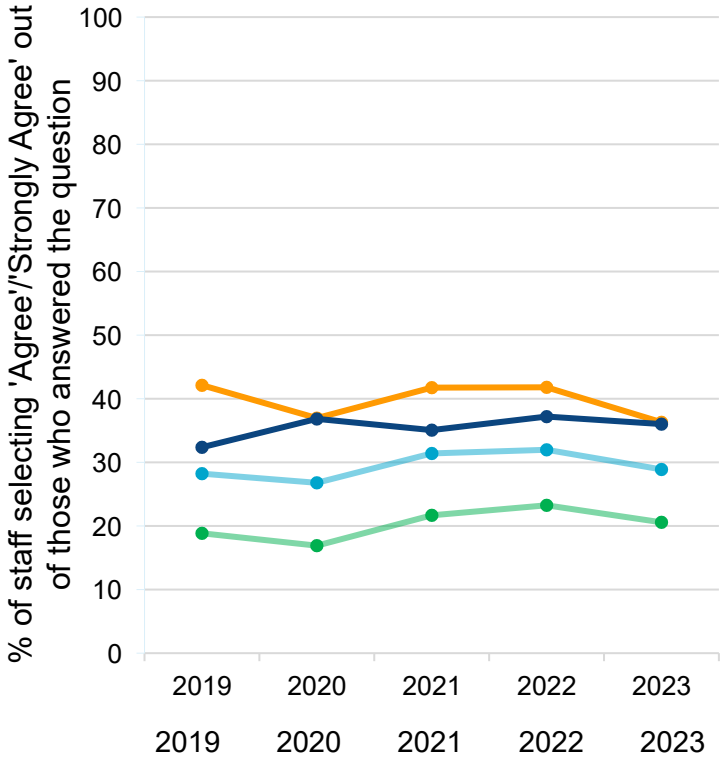
NHS

Theme - Morale

Questions included:
Thinking about leaving – Q26a, Q26b, Q26c
Work pressure – Q3g, Q3h, Q3i
Stressors – Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a

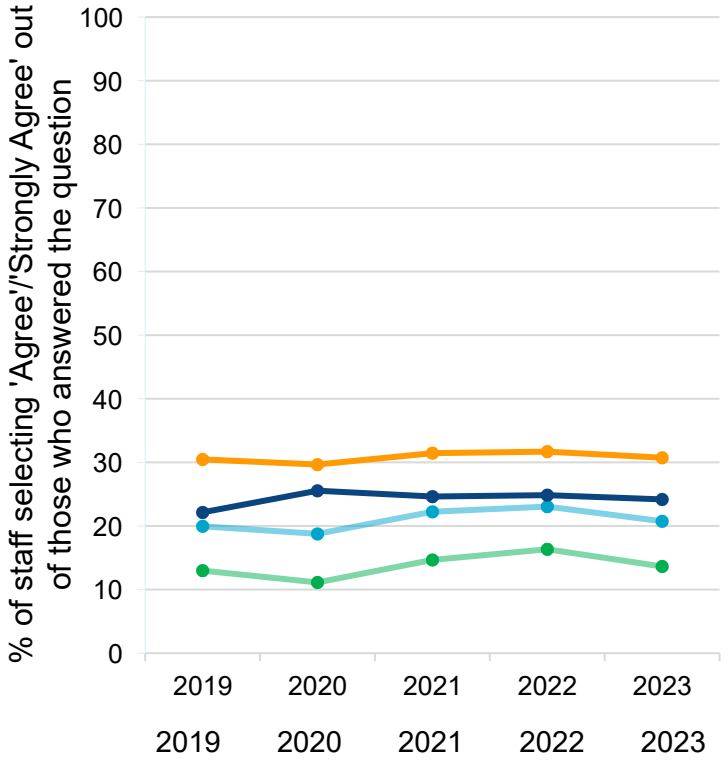
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q26a I often think about leaving this organisation.



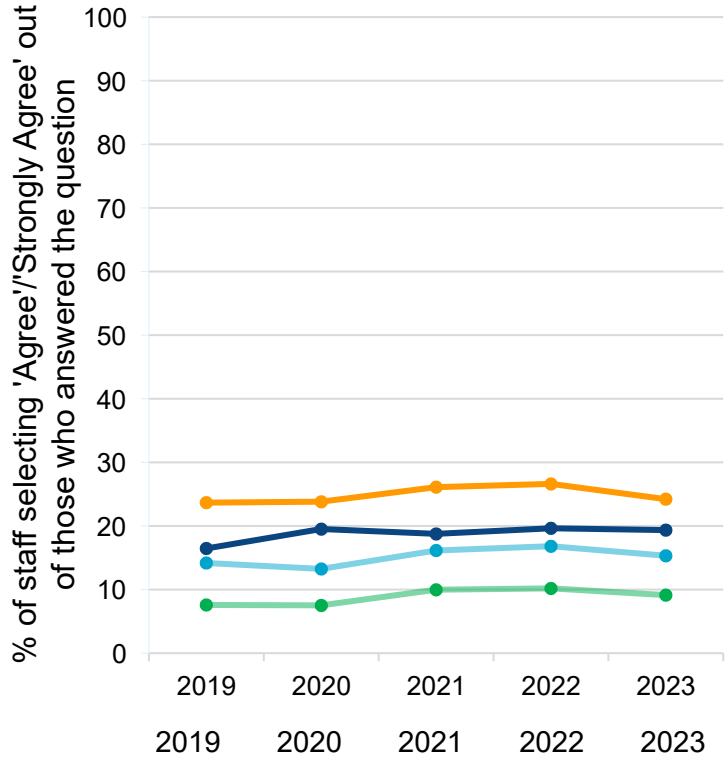
	2019	2020	2021	2022	2023
Your org	32.37%	36.84%	35.07%	37.20%	36.02%
Best result	18.85%	16.90%	21.67%	23.25%	20.57%
Average result	28.22%	26.78%	31.40%	31.98%	28.89%
Worst result	42.13%	36.96%	41.75%	41.80%	36.31%
Responses	4070	3331	4309	3978	3997

Q26b I will probably look for a job at a new organisation in the next 12 months.



	2019	2020	2021	2022	2023
Your org	22.14%	25.54%	24.63%	24.84%	24.18%
Best result	12.98%	11.12%	14.66%	16.34%	13.63%
Average result	19.95%	18.76%	22.23%	23.05%	20.74%
Worst result	30.46%	29.66%	31.44%	31.68%	30.73%
Responses	4063	3335	4304	3978	3996

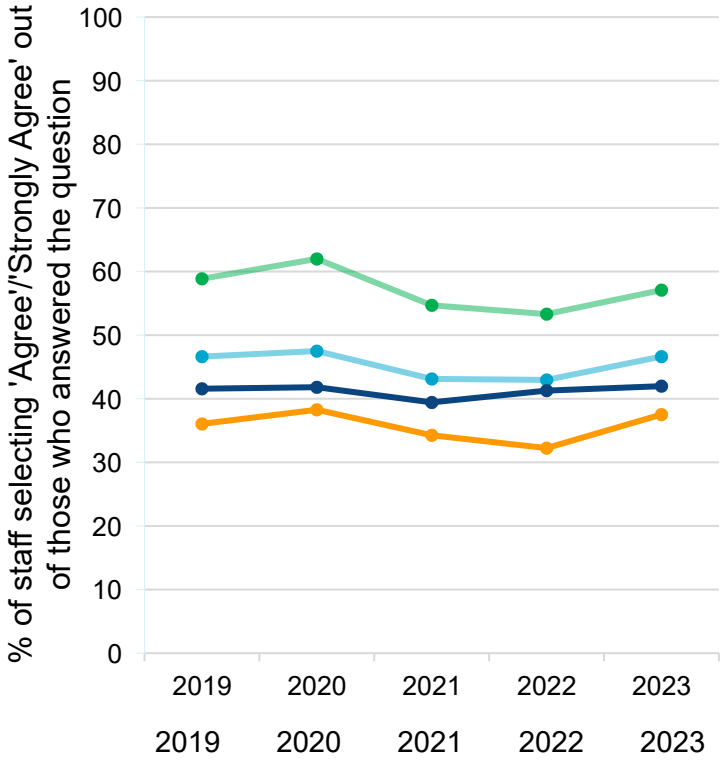
Q26c As soon as I can find another job, I will leave this organisation.



	2019	2020	2021	2022	2023
Your org	16.46%	19.52%	18.76%	19.63%	19.35%
Best result	7.58%	7.52%	9.98%	10.19%	9.13%
Average result	14.18%	13.25%	16.14%	16.82%	15.32%
Worst result	23.67%	23.82%	26.10%	26.61%	24.21%
Responses	4060	3333	4305	3973	3991

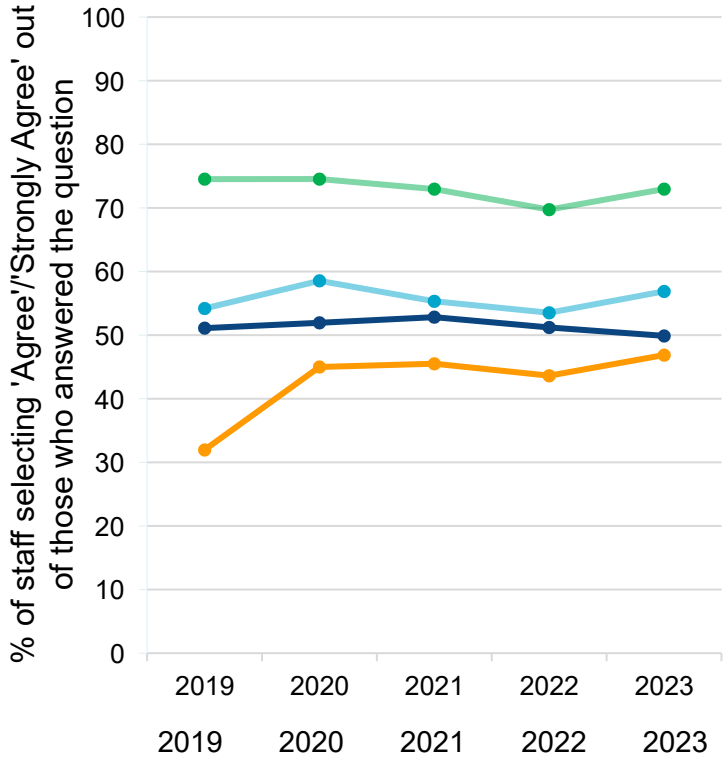
Survey Coordination Centre NHS

Q3g I am able to meet all the conflicting demands on my time at work.



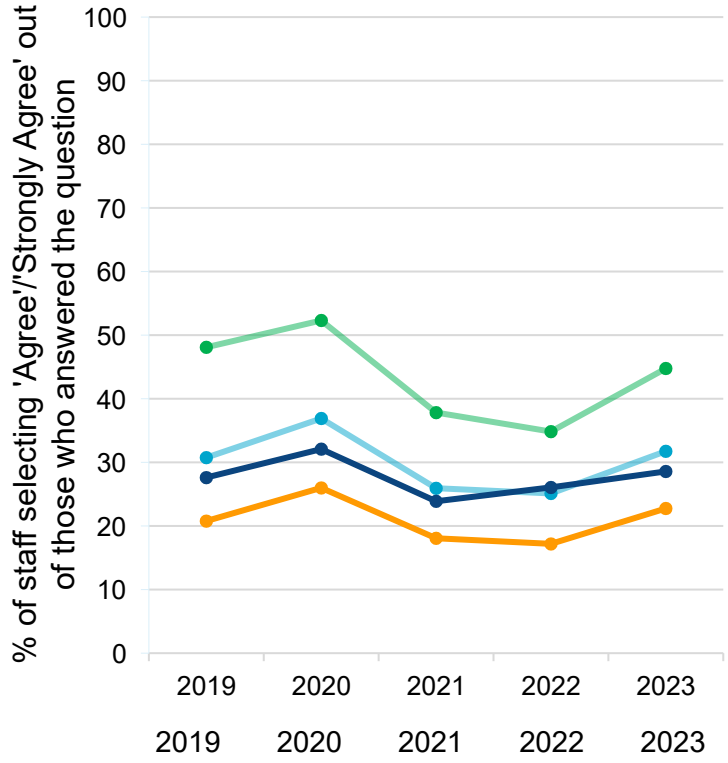
	2019	2020	2021	2022	2023
Your org	41.58%	41.81%	39.43%	41.28%	41.98%
Best result	58.86%	61.99%	54.69%	53.31%	57.08%
Average result	46.63%	47.50%	43.12%	42.96%	46.63%
Worst result	36.05%	38.27%	34.26%	32.24%	37.52%
Responses	4247	3454	4520	4011	3990

Q3h I have adequate materials, supplies and equipment to do my work.



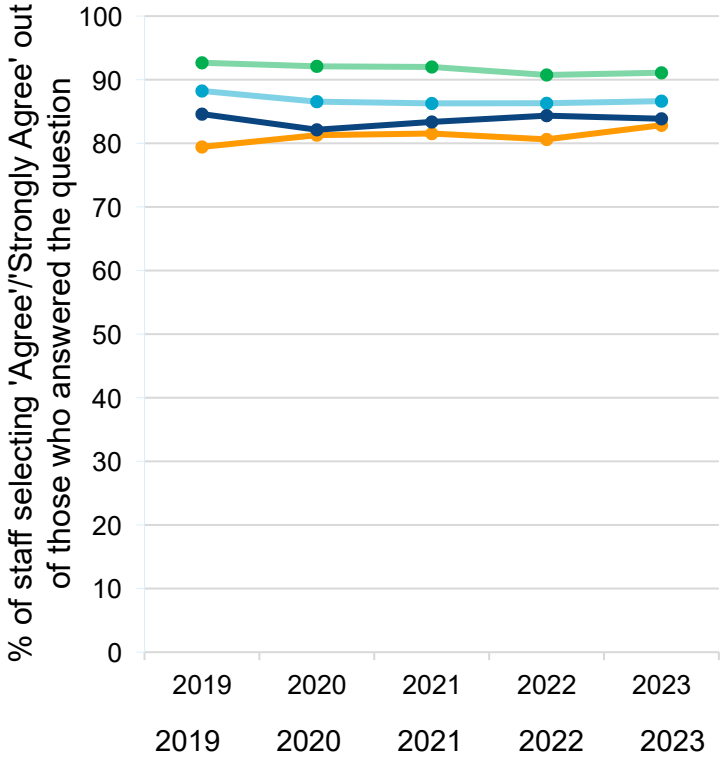
	2019	2020	2021	2022	2023
Your org	51.10%	51.94%	52.82%	51.21%	49.89%
Best result	74.53%	74.54%	72.96%	69.73%	72.97%
Average result	54.19%	58.54%	55.33%	53.52%	56.88%
Worst result	31.96%	44.99%	45.51%	43.63%	46.87%
Responses	4255	3454	4519	4008	3995

Q3i There are enough staff at this organisation for me to do my job properly.



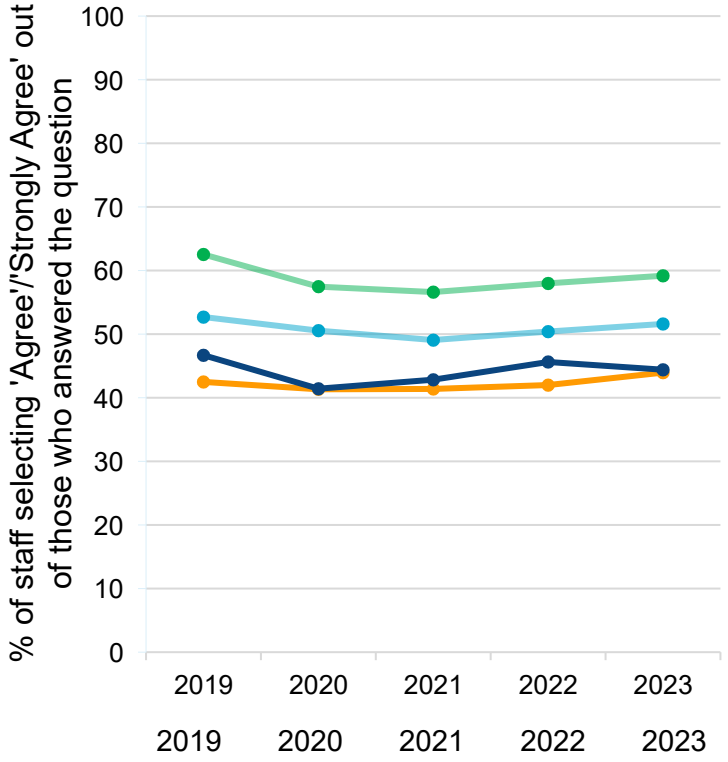
	2019	2020	2021	2022	2023
Your org	27.62%	32.08%	23.88%	26.07%	28.57%
Best result	48.09%	52.30%	37.83%	34.84%	44.76%
Average result	30.74%	36.89%	25.94%	25.11%	31.75%
Worst result	20.78%	25.99%	18.06%	17.19%	22.75%
Responses	4257	3454	4516	4012	3999

Q3a I always know what my work responsibilities are.



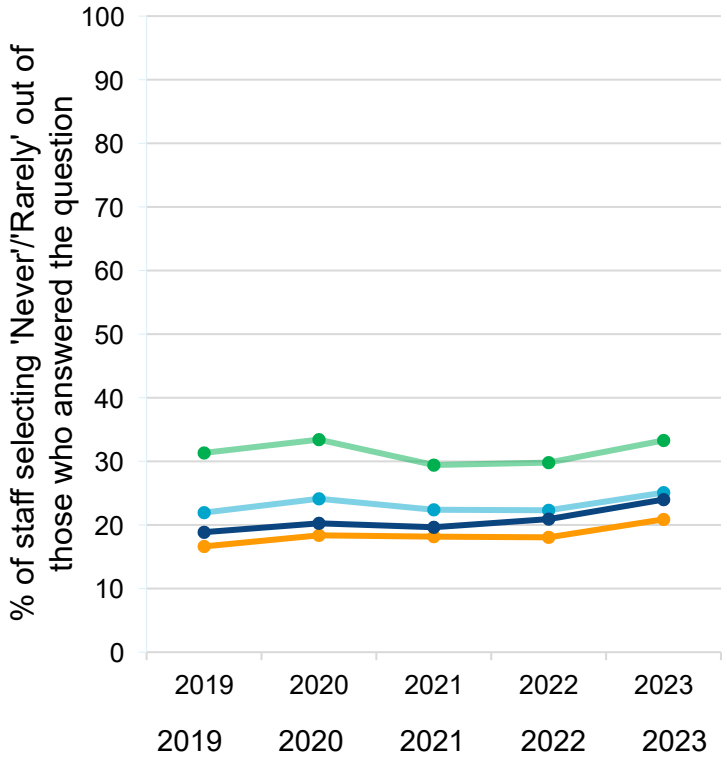
	2019	2020	2021	2022	2023
Your org	84.60%	82.13%	83.36%	84.35%	83.86%
Best result	92.66%	92.10%	92.01%	90.74%	91.10%
Average result	88.24%	86.55%	86.28%	86.30%	86.63%
Worst result	79.44%	81.28%	81.54%	80.62%	82.84%
Responses	4266	3500	4501	3994	4000

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



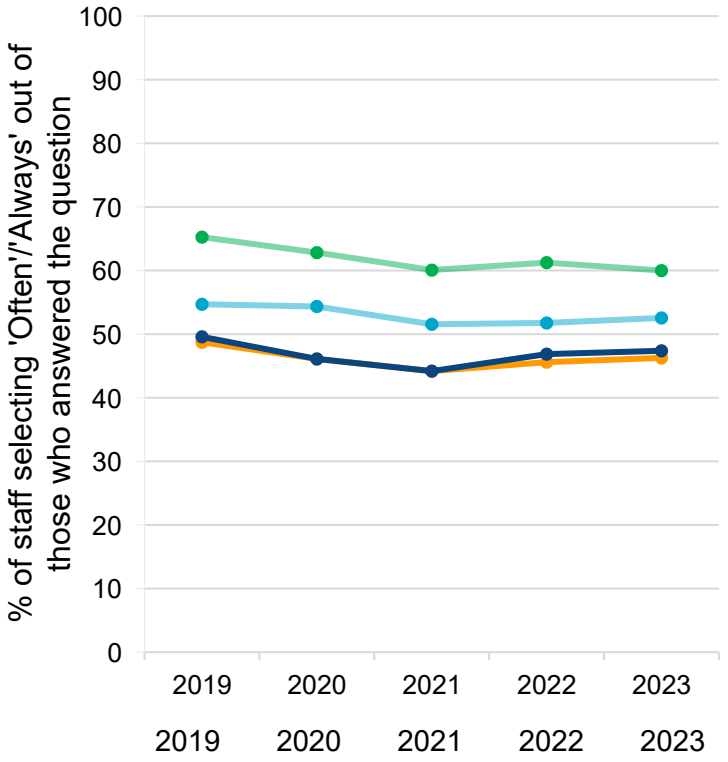
	2019	2020	2021	2022	2023
Your org	46.69%	41.42%	42.84%	45.62%	44.41%
Best result	62.53%	57.46%	56.61%	57.98%	59.18%
Average result	52.69%	50.55%	49.07%	50.41%	51.60%
Worst result	42.49%	41.33%	41.38%	41.99%	43.95%
Responses	4266	3460	4521	4009	3995

Q5a I have unrealistic time pressures.



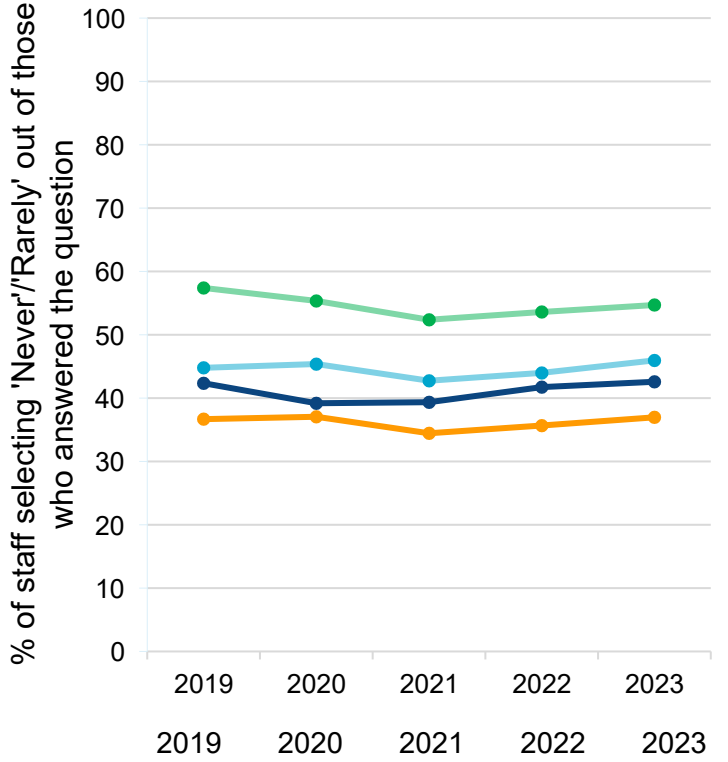
	2019	2020	2021	2022	2023
Your org	18.86%	20.25%	19.64%	20.92%	23.99%
Best result	31.33%	33.42%	29.43%	29.80%	33.29%
Average result	21.94%	24.12%	22.39%	22.31%	25.08%
Worst result	16.62%	18.37%	18.16%	18.05%	20.88%
Responses	4201	3439	4484	4002	3997

Q5b I have a choice in deciding how to do my work.



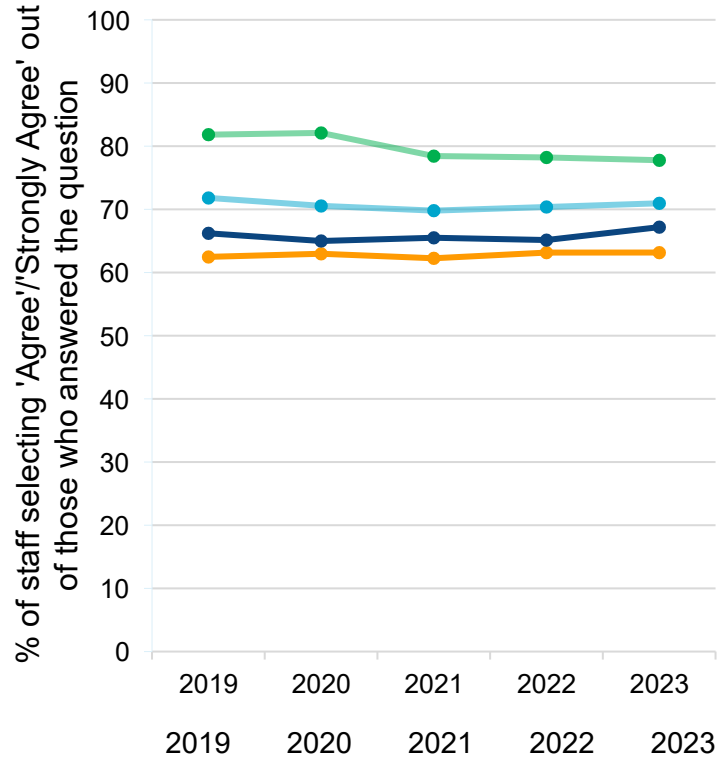
	2019	2020	2021	2022	2023
Your org	49.58%	46.10%	44.18%	46.86%	47.38%
Best result	65.25%	62.83%	60.08%	61.24%	60.00%
Average result	54.70%	54.35%	51.55%	51.76%	52.55%
Worst result	48.73%	46.10%	44.18%	45.59%	46.27%
Responses	4199	3439	4487	4004	3993

Q5c Relationships at work are strained.



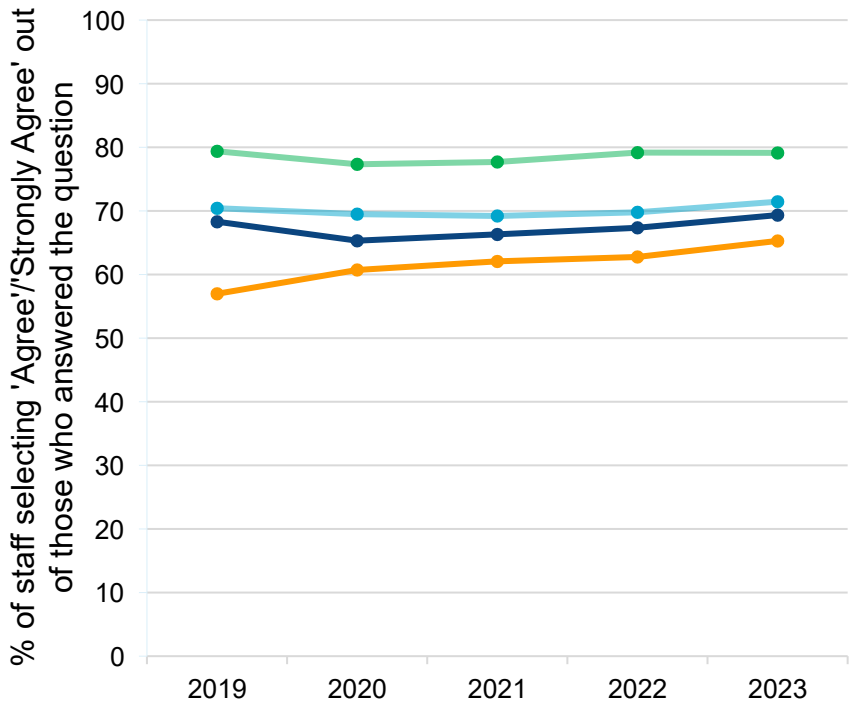
	2019	2020	2021	2022	2023
Your org	42.35%	39.19%	39.36%	41.74%	42.58%
Best result	57.40%	55.35%	52.37%	53.60%	54.70%
Average result	44.78%	45.38%	42.74%	43.99%	45.96%
Worst result	36.68%	37.06%	34.45%	35.67%	36.97%
Responses	4196	3437	4490	4004	3987

Q7c I receive the respect I deserve from my colleagues at work.



	2019	2020	2021	2022	2023
Your org	66.21%	64.99%	65.50%	65.14%	67.18%
Best result	81.82%	82.10%	78.44%	78.22%	77.78%
Average result	71.82%	70.56%	69.80%	70.37%	70.96%
Worst result	62.48%	62.97%	62.26%	63.16%	63.16%
Responses	4265	3465	4473	4012	4001

Q9a My immediate manager encourages me at work.



	2019	2020	2021	2022	2023
Your org	68.31%	65.32%	66.32%	67.35%	69.35%
Best result	79.38%	77.33%	77.69%	79.17%	79.13%
Average result	70.43%	69.49%	69.21%	69.78%	71.45%
Worst result	56.97%	60.71%	62.07%	62.76%	65.29%
Responses	4169	3412	4433	4012	4002

Question not linked to People Promise elements or themes

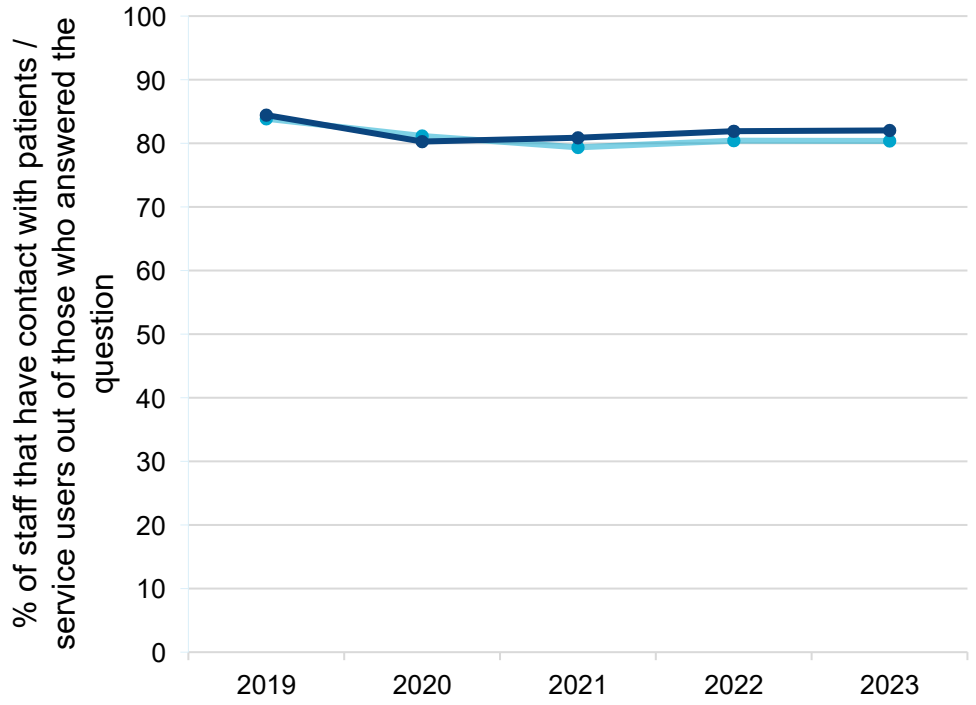
Questions included:*

Q1, Q10a, Q10b, Q10c, Q11e, Q16c, Q18, Q19a, Q19b, Q19c, Q19d, Q31b, Q26d

*The results for Q17a, Q17b and Q22 are reported in the section for People Promise element 4: We are safe and healthy. These questions do not contribute to any score or sub-score calculations.

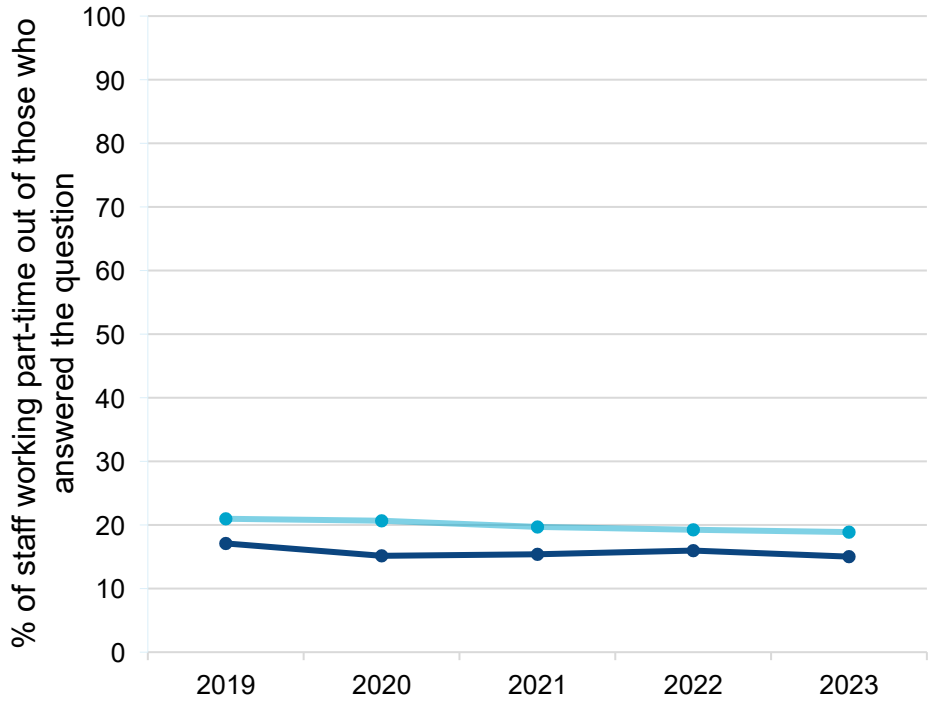
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q1 Do you have face-to-face, video or telephone contact with patients / service users as part of your job?



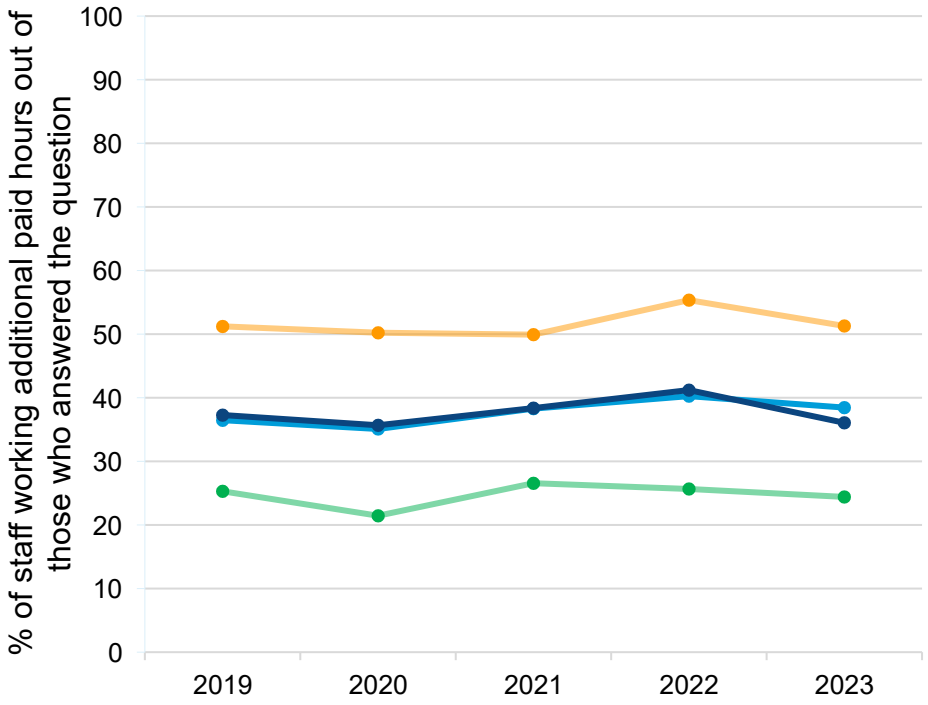
	2019	2020	2021	2022	2023
Your org	84.44%	80.28%	80.88%	81.91%	82.02%
Average	83.86%	81.16%	79.36%	80.42%	80.37%
Responses	4267	3534	4560	3996	3994

Q10a How many hours a week are you contracted to work?



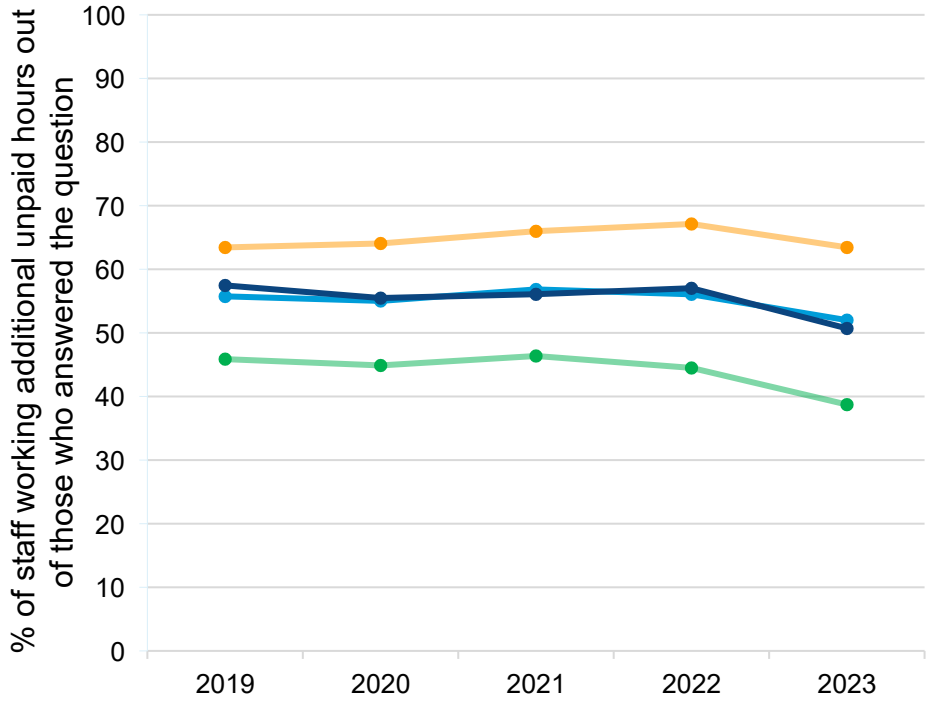
	2019	2020	2021	2022	2023
Your org	17.10%	15.15%	15.39%	15.97%	15.02%
Average	20.97%	20.66%	19.69%	19.24%	18.88%
Responses	4147	3380	4334	3938	3908

Q10b On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?



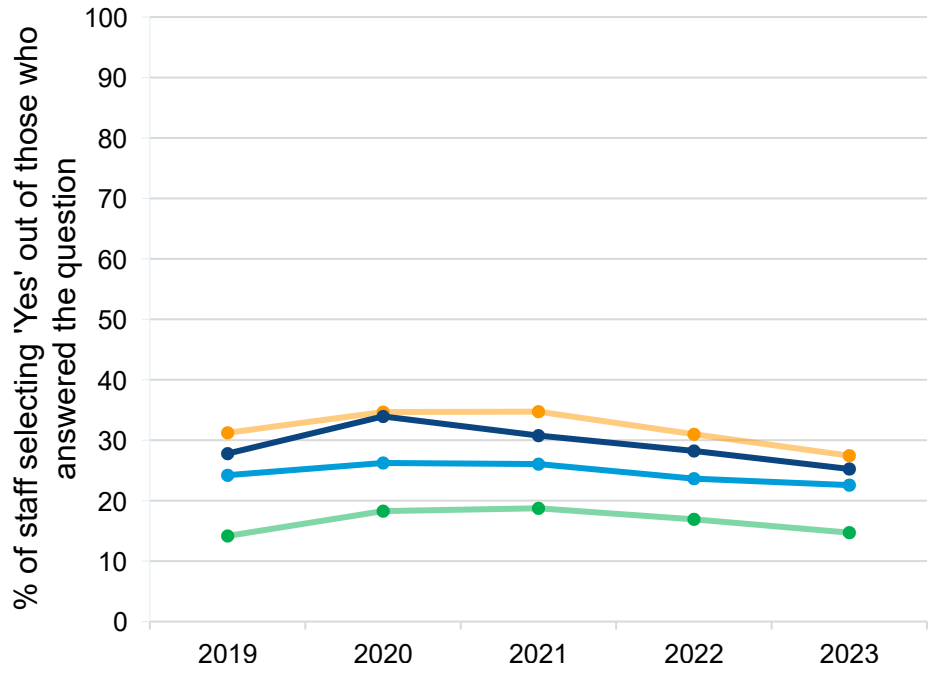
	2019	2020	2021	2022	2023
Your org	37.28%	35.67%	38.37%	41.20%	36.06%
Lowest	25.29%	21.45%	26.56%	25.66%	24.41%
Average	36.47%	35.09%	38.29%	40.25%	38.45%
Highest	51.23%	50.22%	49.92%	55.35%	51.29%
Responses	4150	3406	4406	3992	3975

Q10c On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?



	2019	2020	2021	2022	2023
Your org	57.46%	55.48%	56.08%	57.02%	50.71%
Lowest	45.87%	44.88%	46.37%	44.50%	38.73%
Average	55.74%	55.02%	56.83%	56.06%	52.00%
Highest	63.43%	64.06%	65.99%	67.12%	63.45%
Responses	4140	3402	4404	3998	3971

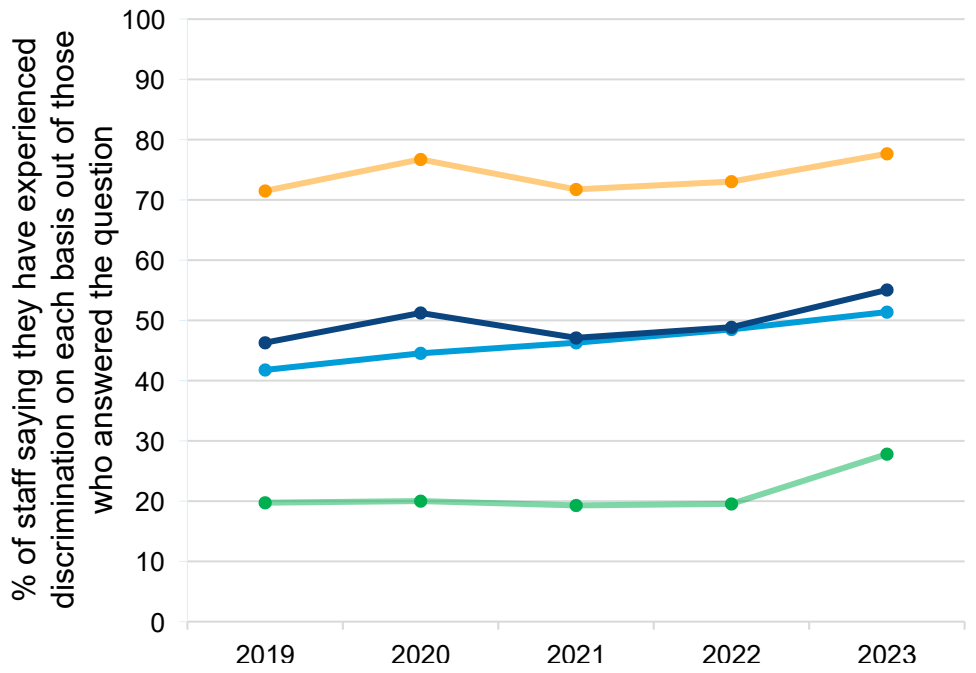
Q11e* Have you felt pressure from your manager to come to work?



	2019	2020	2021	2022	2023
Your org	27.79%	33.93%	30.77%	28.22%	25.23%
Best result	14.16%	18.27%	18.73%	16.91%	14.70%
Average result	24.21%	26.23%	26.05%	23.64%	22.57%
Worst result	31.23%	34.66%	34.72%	30.98%	27.44%
Responses	2501	1728	2458	2274	2214

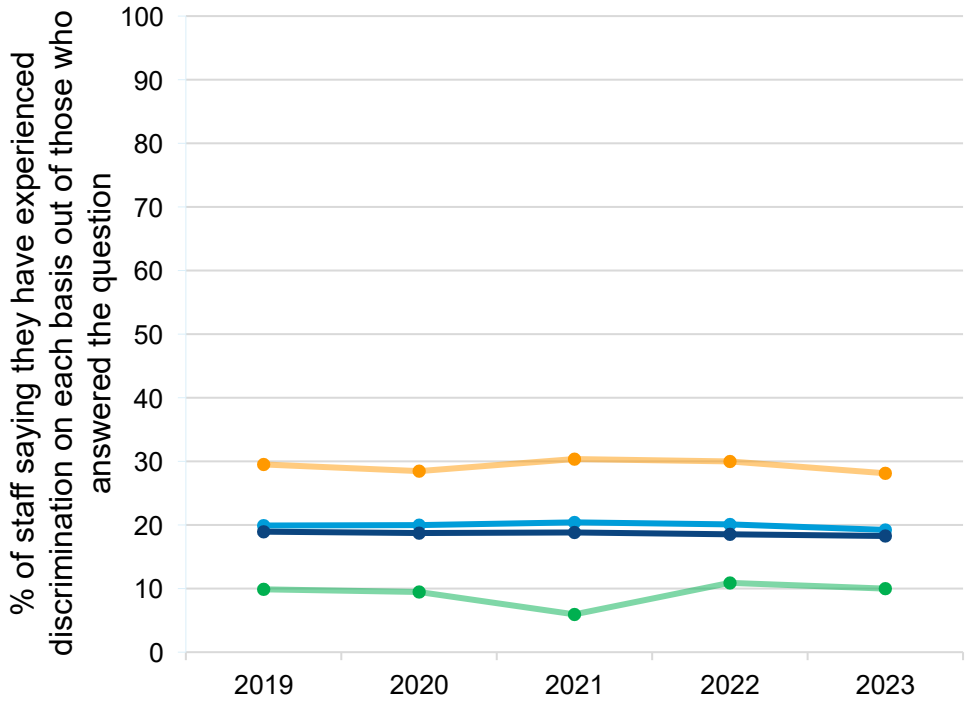
*Q11e is only answered by staff who responded 'Yes' to Q11d.

Q16c.1 On what grounds have you experienced discrimination? - Ethnic background.



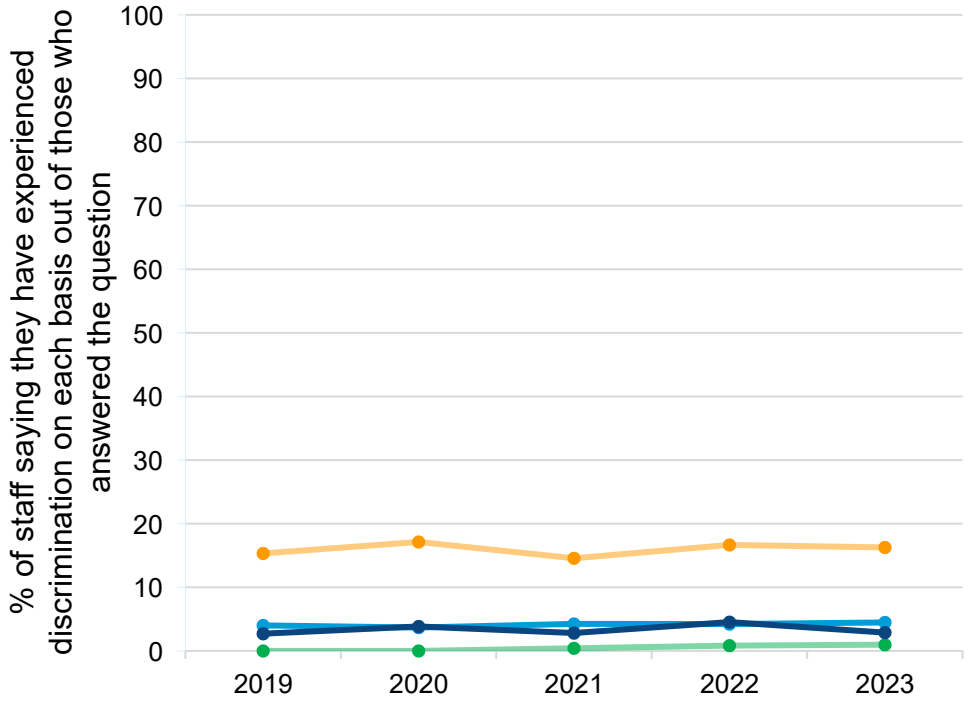
	2019	2020	2021	2022	2023
Your org	46.30%	51.23%	47.10%	48.87%	55.05%
Best result	19.75%	20.01%	19.29%	19.55%	27.81%
Average result	41.77%	44.53%	46.29%	48.50%	51.38%
Worst result	71.50%	76.72%	71.74%	73.03%	77.66%
Responses	552	480	642	642	631

Q16c.2 On what grounds have you experienced discrimination? – Gender.



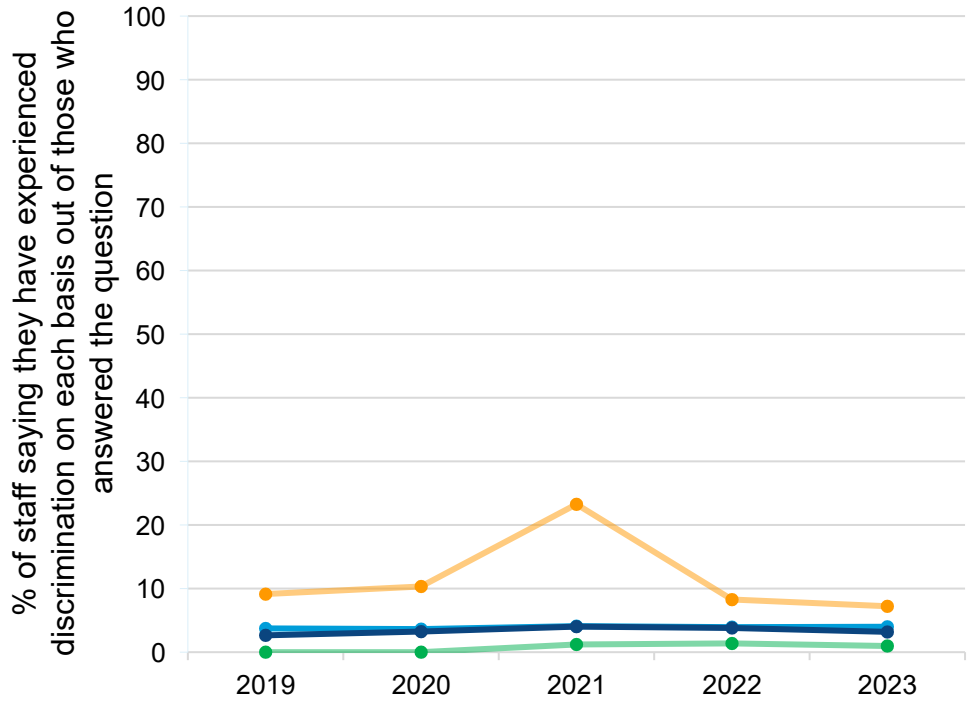
	2019	2020	2021	2022	2023
Your org	18.94%	18.73%	18.82%	18.53%	18.27%
Best result	9.88%	9.46%	5.94%	10.90%	9.99%
Average result	19.91%	19.98%	20.41%	20.09%	19.22%
Worst result	29.51%	28.46%	30.36%	29.99%	28.12%
Responses	552	480	642	642	631

Q16c.3 On what grounds have you experienced discrimination? – Religion.



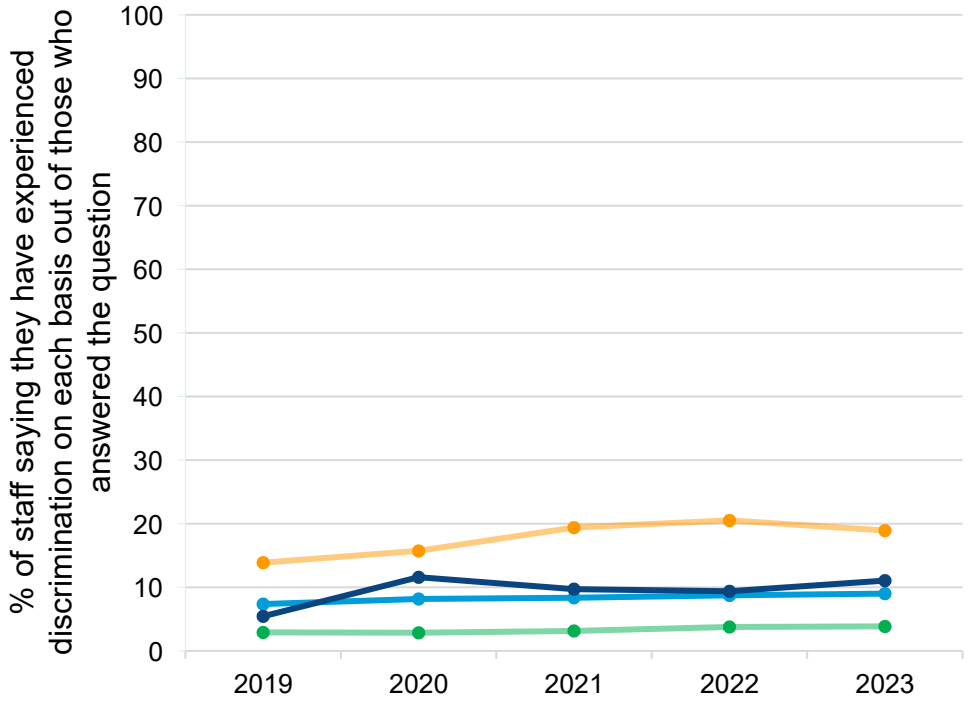
	2019	2020	2021	2022	2023
Your org	2.71%	3.84%	2.81%	4.53%	2.88%
Best result	0.00%	0.00%	0.41%	0.83%	0.98%
Average result	4.01%	3.68%	4.25%	4.23%	4.47%
Worst result	15.33%	17.13%	14.56%	16.66%	16.27%
Responses	552	480	642	642	631

Q16c.4 On what grounds have you experienced discrimination? – Sexual orientation.



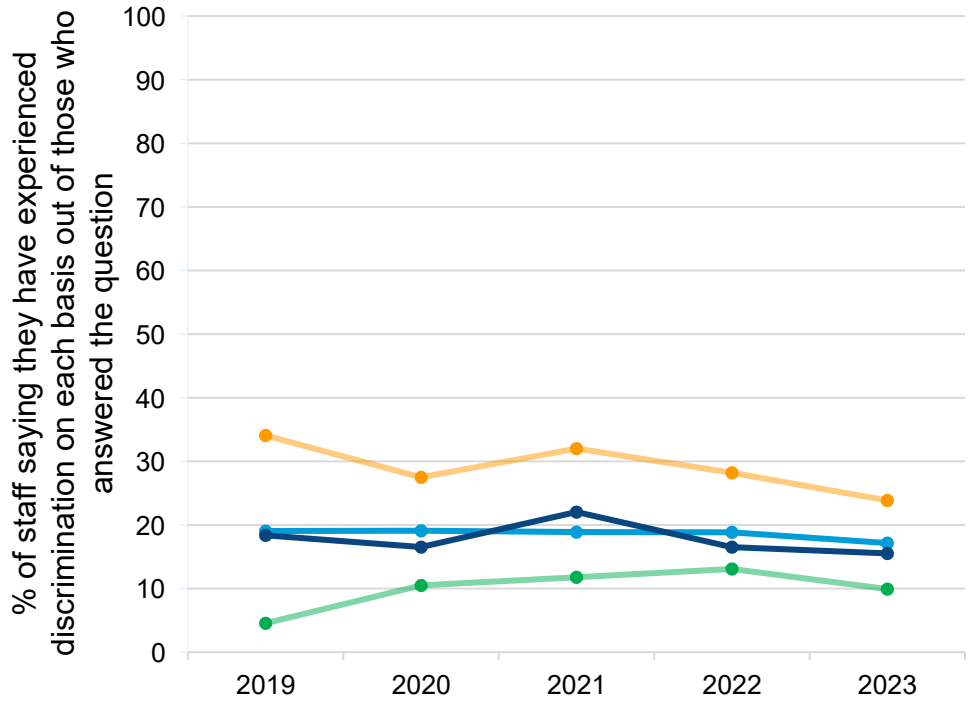
	2019	2020	2021	2022	2023
Your org	2.65%	3.24%	4.02%	3.80%	3.19%
Best result	0.00%	0.00%	1.21%	1.38%	0.97%
Average result	3.74%	3.63%	4.09%	3.93%	4.00%
Worst result	9.14%	10.33%	23.26%	8.28%	7.22%
Responses	552	480	642	642	631

Q16c.5 On what grounds have you experienced discrimination? – Disability.



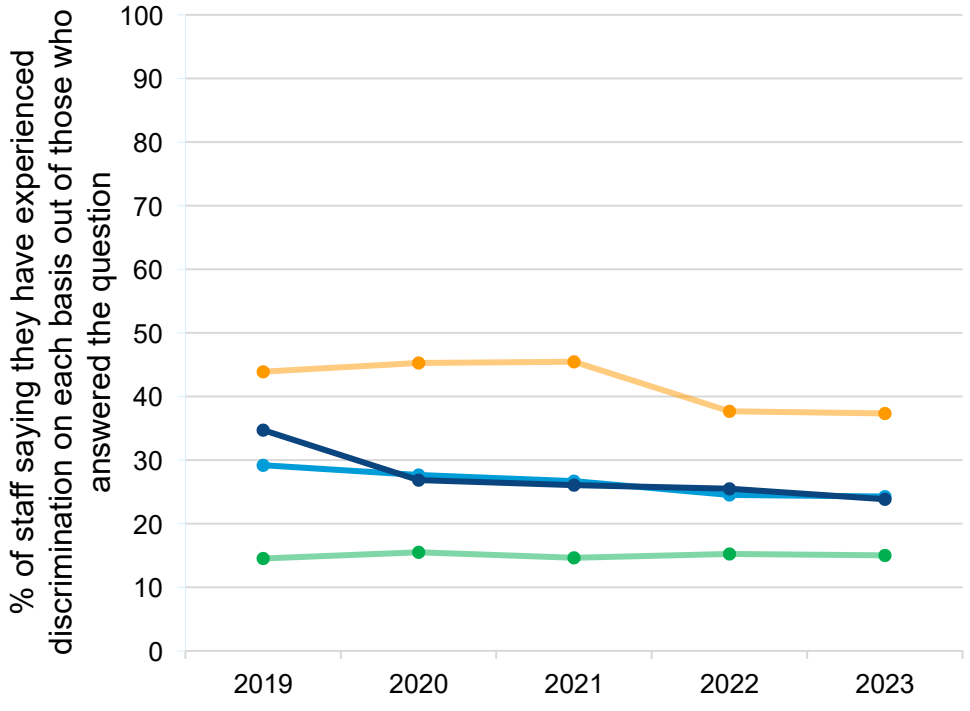
	2019	2020	2021	2022	2023
Your org	5.44%	11.59%	9.71%	9.38%	11.05%
Best result	2.91%	2.86%	3.14%	3.77%	3.86%
Average result	7.37%	8.17%	8.36%	8.74%	9.01%
Worst result	13.87%	15.73%	19.39%	20.53%	18.93%
Responses	552	480	642	642	631

Q16c.6 On what grounds have you experienced discrimination? – Age.



	2019	2020	2021	2022	2023
Your org	18.37%	16.53%	22.04%	16.51%	15.53%
Best result	4.55%	10.50%	11.78%	13.08%	9.92%
Average result	19.05%	19.09%	18.89%	18.84%	17.15%
Worst result	34.06%	27.49%	32.01%	28.20%	23.85%
Responses	552	480	642	642	631

Q16c.7 On what grounds have you experienced discrimination? – Other.

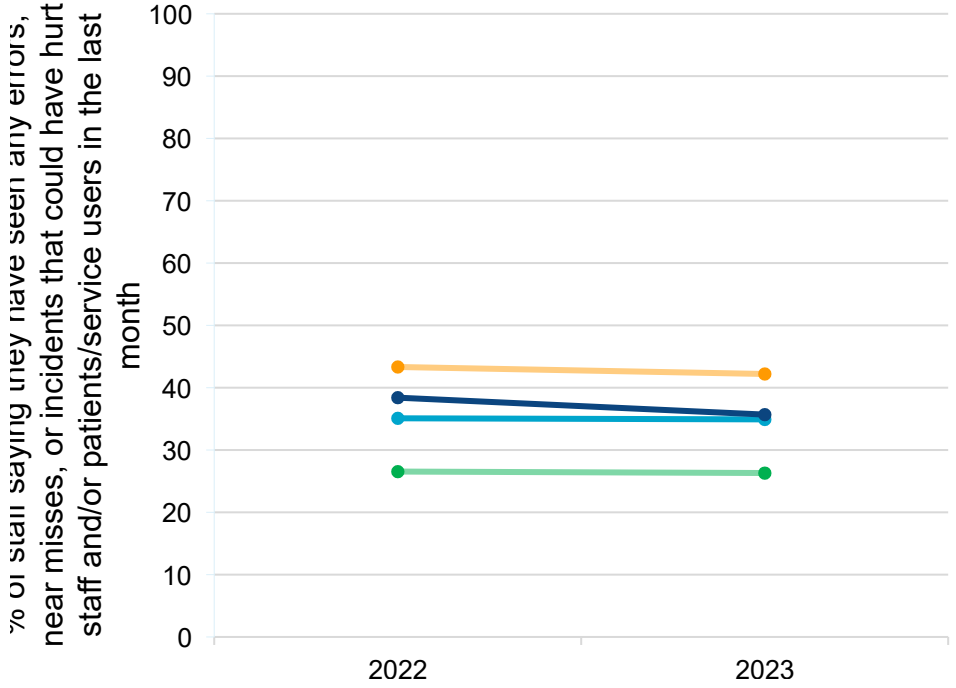


	2019	2020	2021	2022	2023
Your org	34.72%	26.86%	26.06%	25.50%	23.85%
Best result	14.53%	15.51%	14.64%	15.24%	15.03%
Average result	29.20%	27.66%	26.69%	24.52%	24.27%
Worst result	43.90%	45.27%	45.46%	37.68%	37.34%
Responses	552	480	642	642	631

Survey Coordination Centre

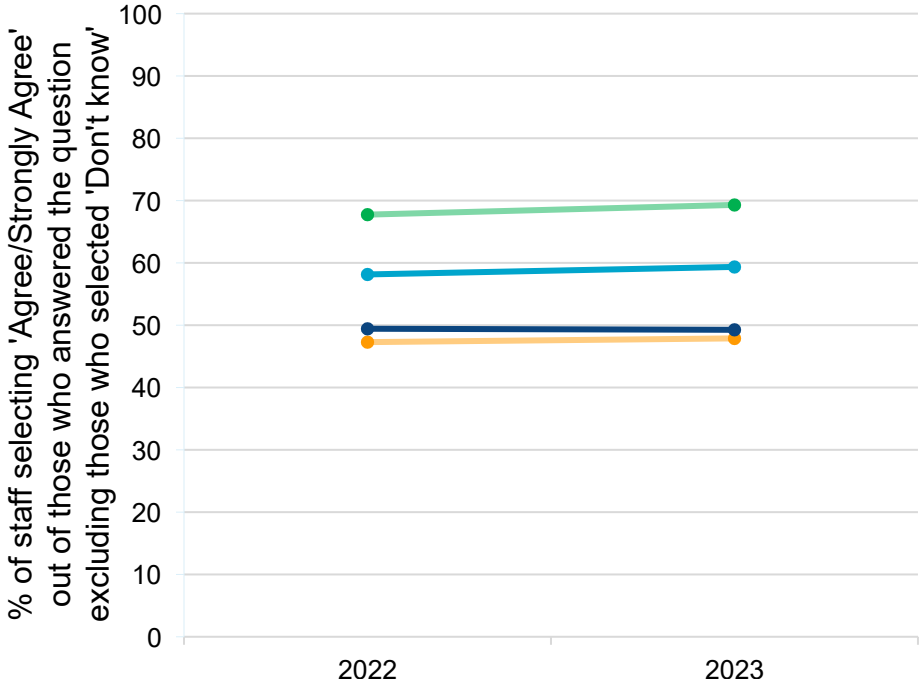
NHS

Q18 In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?



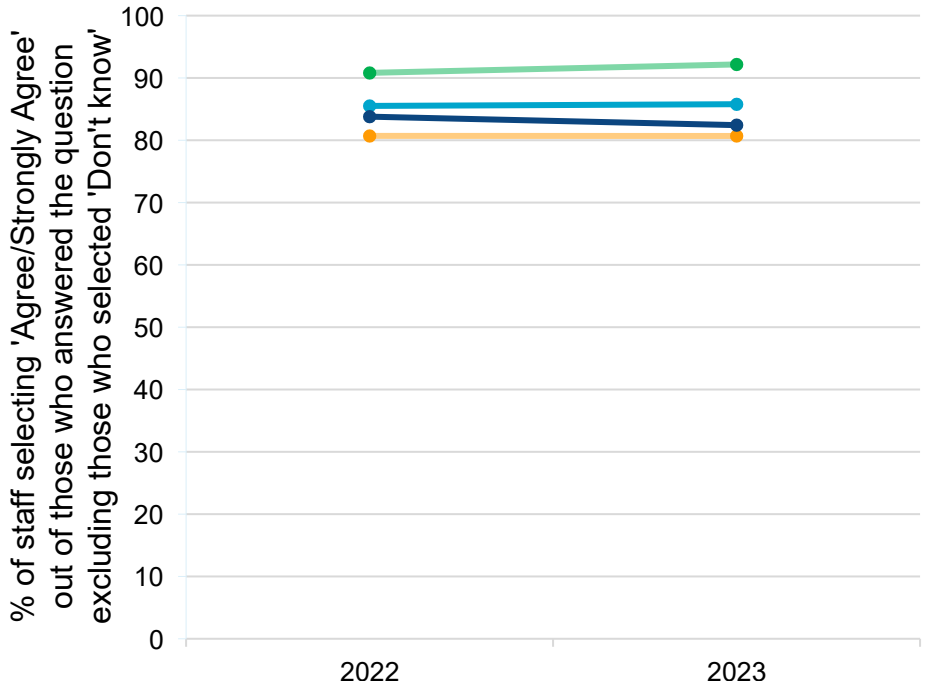
	2022	2023
Your org	38.40%	35.68%
Best result	26.54%	26.31%
Average result	35.09%	34.92%
Worst result	43.33%	42.20%
Responses	3922	3922

Q19a My organisation treats staff who are involved in an error, near miss or incident fairly.



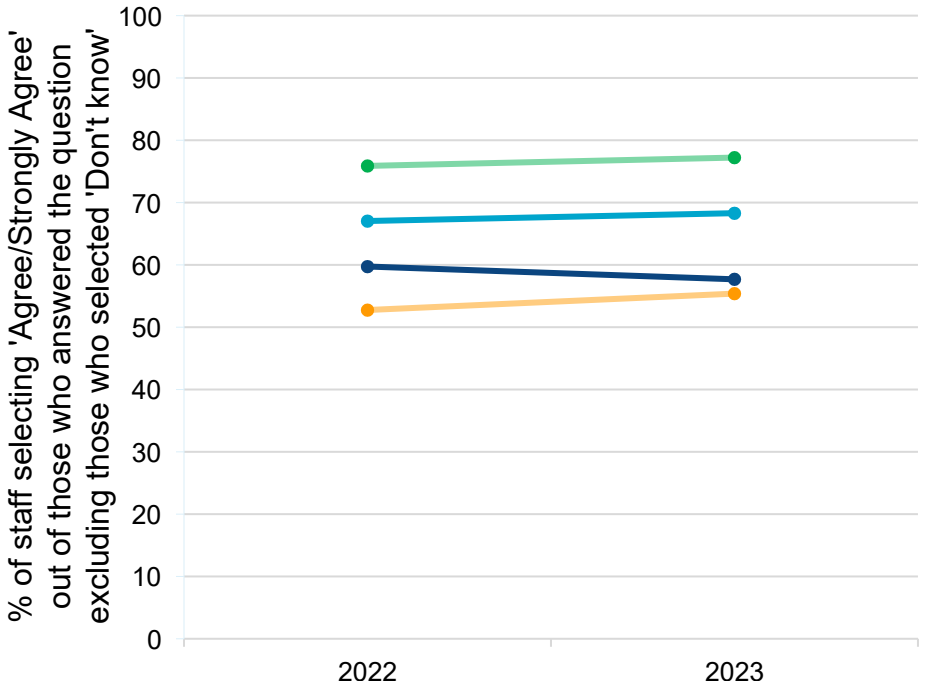
	2022	2023
Your org	49.43%	49.26%
Best result	67.74%	69.31%
Average result	58.15%	59.36%
Worst result	47.28%	47.88%
Responses	3035	2964

Q19b My organisation encourages us to report errors, near misses or incidents.



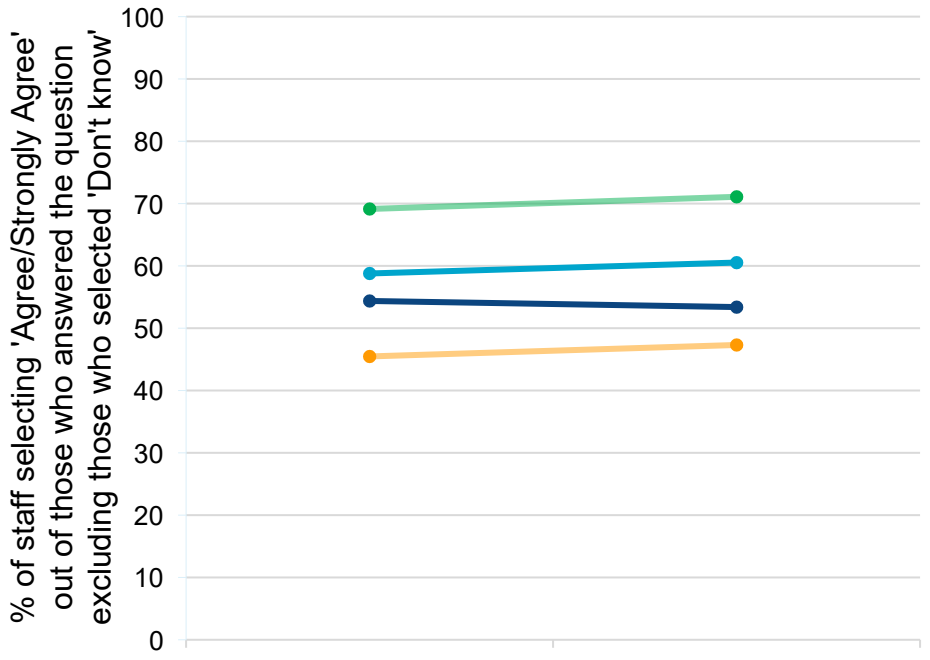
	2022	2023
Your org	83.79%	82.43%
Best result	90.82%	92.17%
Average result	85.51%	85.79%
Worst result	80.70%	80.69%
Responses	3837	3825

Q19c When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.



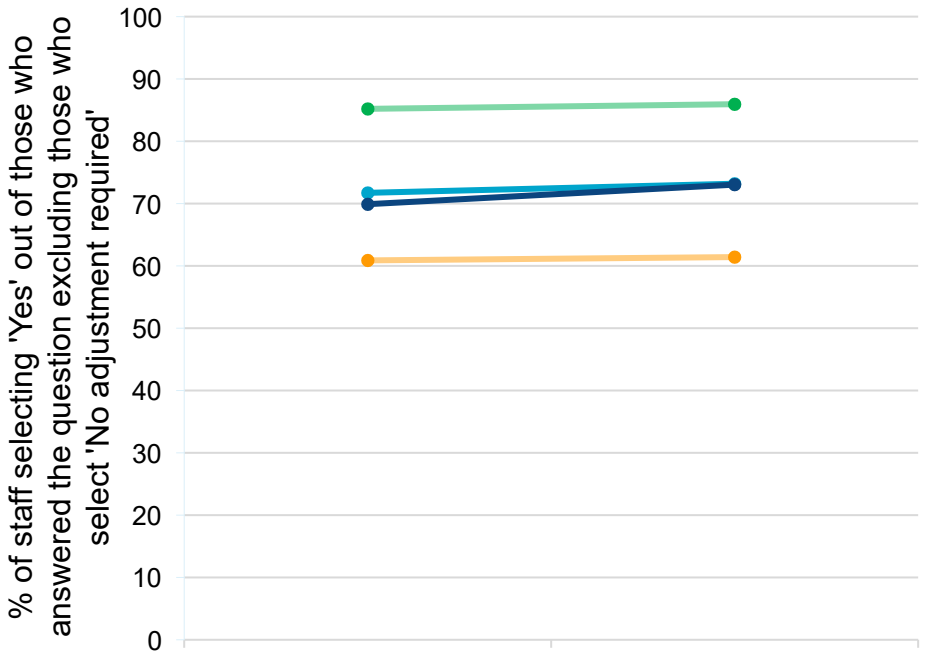
	2022	2023
Your org	59.74%	57.69%
Best result	75.89%	77.22%
Average result	67.04%	68.30%
Worst result	52.76%	55.39%
Responses	3487	3491

Q19d We are given feedback about changes made in response to reported errors, near misses and incidents.



	2022	2023
Your org	54.37%	53.39%
Best result	69.13%	71.09%
Average result	58.78%	60.53%
Worst result	45.47%	47.31%
Responses	3518	3534

Q31b Has your employer made reasonable adjustment(s) to enable you to carry out your work?

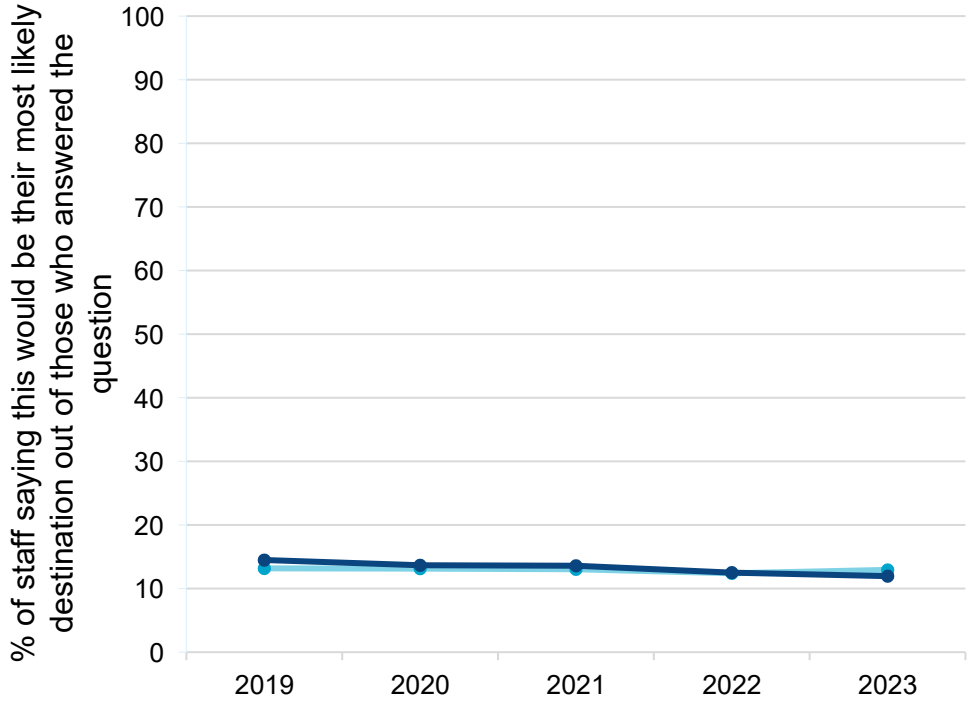


	2022	2023
Your org	69.90%	73.04%
Best result	85.20%	85.95%
Average result	71.72%	73.19%
Worst result	60.88%	61.41%
Responses	513	593

Survey Coordination Centre

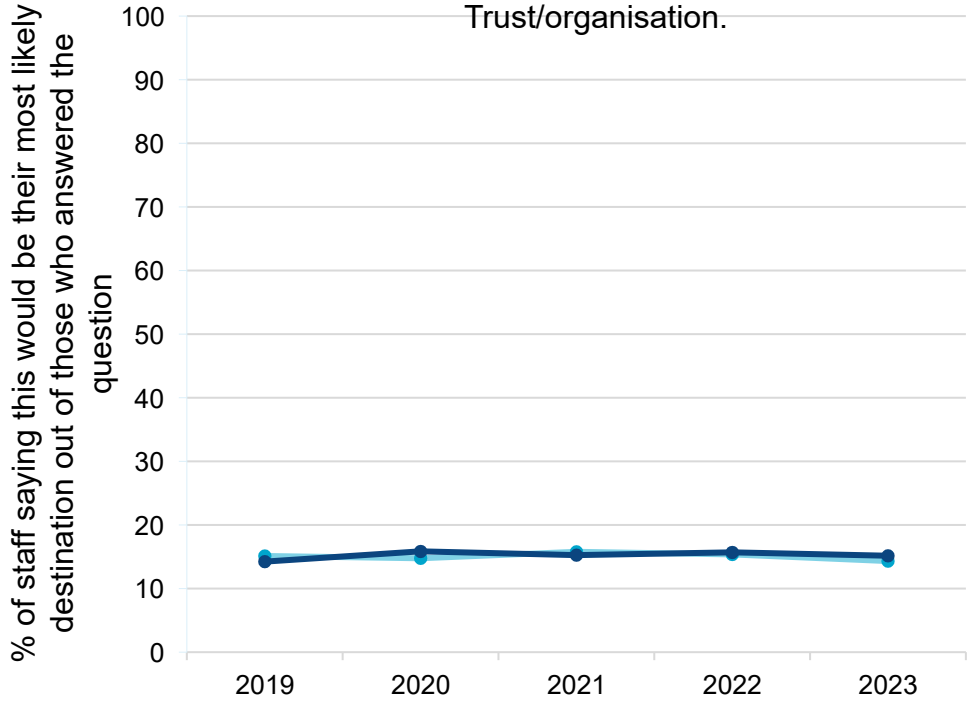
NHS

Q26d.1 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job within this organisation.



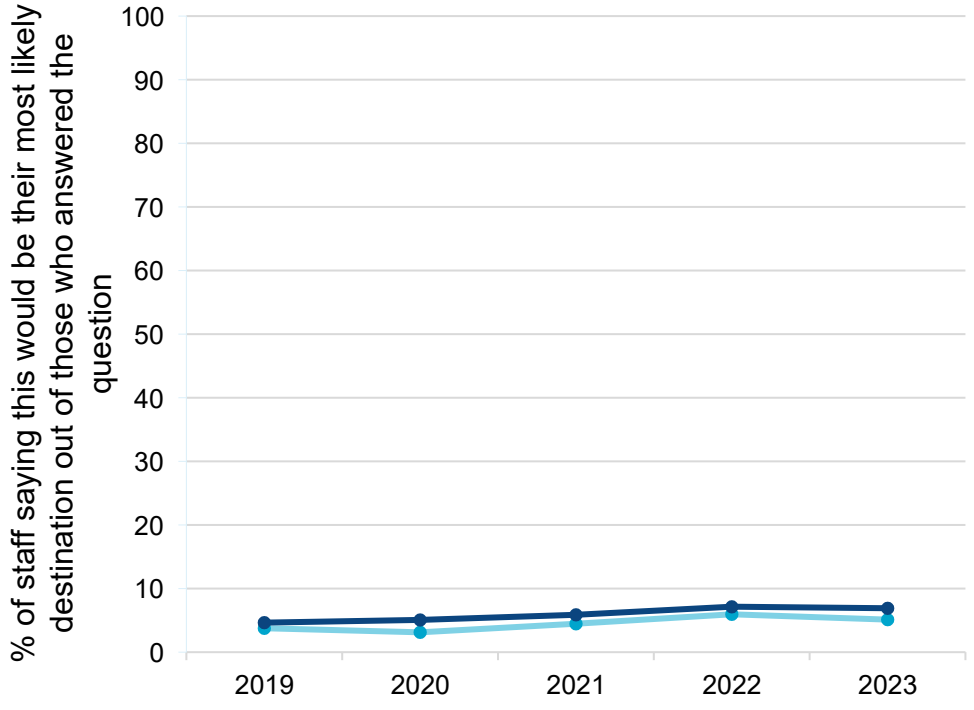
	2019	2020	2021	2022	2023
Your org	14.49%	13.67%	13.59%	12.50%	11.95%
Average	13.18%	13.13%	13.04%	12.40%	12.94%
Responses	3941	3293	4136	3791	3865

Q26d.2 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job in a different NHS Trust/organisation.



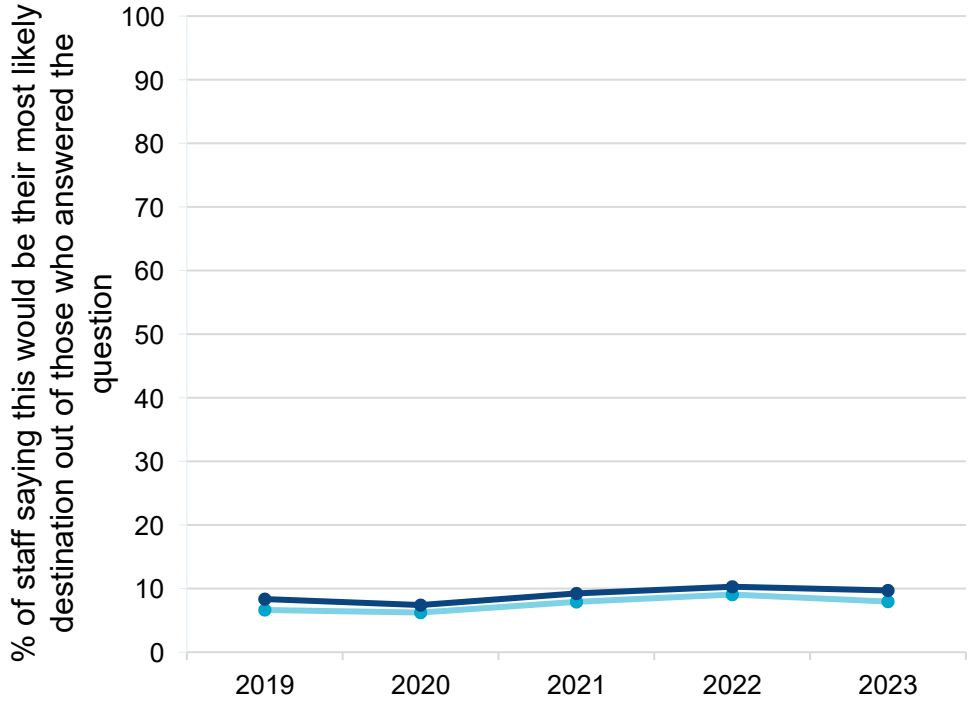
	2019	2020	2021	2022	2023
Your org	14.23%	15.85%	15.26%	15.70%	15.16%
Average	15.12%	14.76%	15.78%	15.37%	14.32%
Responses	3941	3293	4136	3791	3865

Q26d.3 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job in healthcare, but outside the NHS.



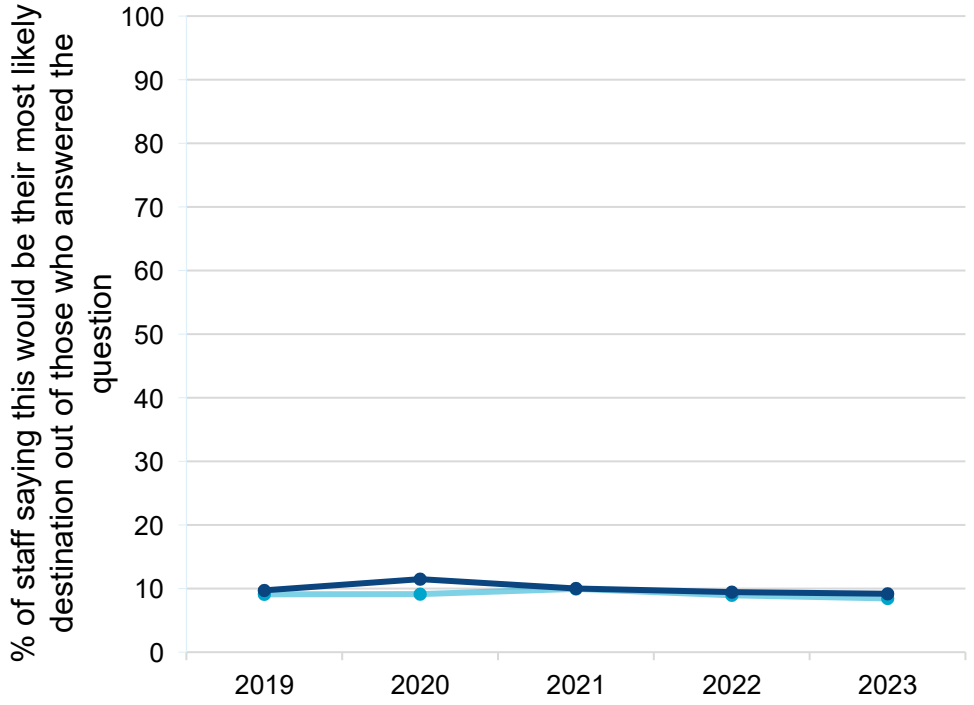
	2019	2020	2021	2022	2023
Your org	4.64%	5.07%	5.88%	7.15%	6.91%
Average	3.76%	3.12%	4.47%	5.95%	5.12%
Responses	3941	3293	4136	3791	3865

Q26d.4 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job outside healthcare.



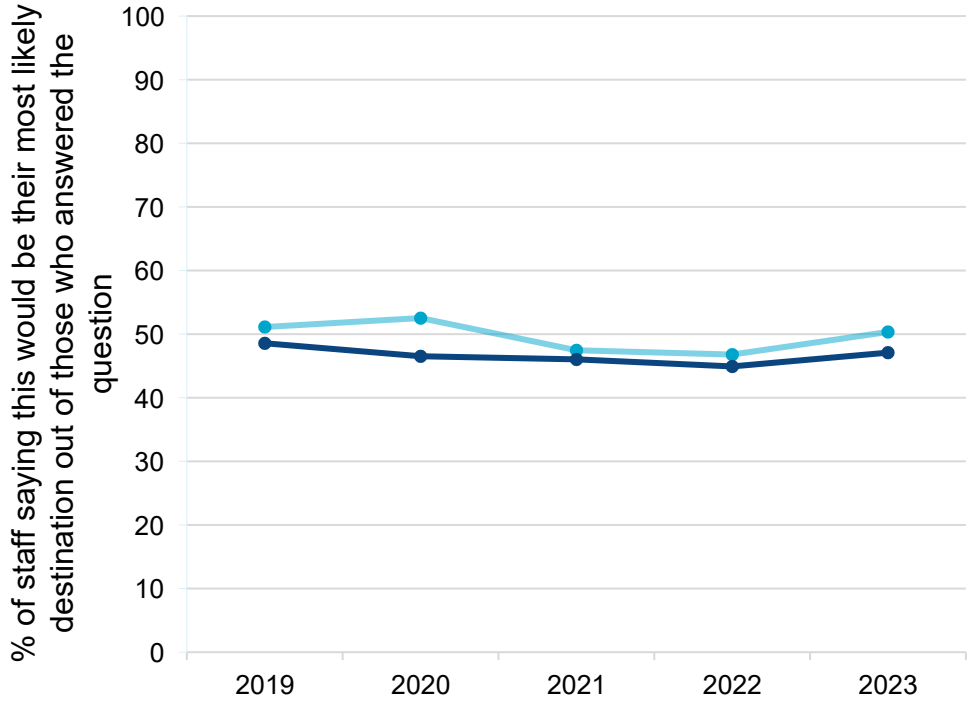
	2019	2020	2021	2022	2023
Your org	8.35%	7.41%	9.24%	10.29%	9.70%
Average	6.63%	6.23%	7.91%	9.06%	7.96%
Responses	3941	3293	4136	3791	3865

Q26d.5 If you are considering leaving your current job, what would be your most likely destination? - I would retire or take a career break.



	2019	2020	2021	2022	2023
Your org	9.72%	11.48%	10.01%	9.44%	9.18%
Average	9.09%	9.13%	9.95%	8.94%	8.45%
Responses	3941	3293	4136	3791	3865

Q26d.9 If you are considering leaving your current job, what would be your most likely destination? - I am not considering leaving my current job.



	2019	2020	2021	2022	2023
Your org	48.57%	46.52%	46.03%	44.92%	47.09%
Average	51.12%	52.53%	47.46%	46.79%	50.34%
Responses	3941	3293	4136	3791	3865

Survey Coordination Centre

NHS

Workforce Equality Standards

Note where there are fewer than 10 responses for a question, results are suppressed to protect staff confidentiality and reliability of data.

Workforce Race Equality Standards (WRES)

This section contains data for the organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES). It includes the 2019-2023 organisation and benchmarking group median results for q13a, q13b&c combined, q15, and q16b split by ethnicity (by white staff / staff from all other ethnic groups combined).

Workforce Disability Equality Standards (WDES)

This section contains data for the organisation required for the NHS Staff Survey indicators used in the Workforce Disability Equality Standard (WDES). It includes the 2019-2023 organisation and benchmarking group median results for q4b, q11e, q14a-d, and q15 split by staff with a long lasting health condition or illness compared to staff without a long lasting health condition or illness. It also shows results for q31b (for staff with a long lasting health condition or illness only), and the staff engagement score for staff with a long lasting health condition or illness, compared to staff without a long lasting health condition or illness and the overall engagement score for the organisation.

In 2022, the text for q31b was updated and the word ‘adequate’ was updated to ‘reasonable’.

The WDES breakdowns are based on the responses to q31a Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?

Workforce Equality Standards

Survey Coordination Centre NHS

This section contains data required for the staff survey indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted.

Workforce Race Equality Standards (WRES)

Indicator	Qu No	Workforce Race Equality Standard
		For each of the following indicators, compare the outcomes of the responses for white staff and staff from all other ethnic groups combined
5	Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	Q14b & Q14c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	Q15	Percentage believing that their organisation provides equal opportunities for career progression or promotion
8	Q16b	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other

Workforce Disability Equality Standards (WDES)

Indicator	Qu No	Workforce Disability Equality Standard
		For each of the following indicators, compare the responses for staff with a LTC* or illness vs staff without a LTC or illness
4a	Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public
4b	Q14b	Percentage of staff experiencing harassment, bullying or abuse from managers
4c	Q14c	Percentage of staff experiencing harassment, bullying or abuse from other colleagues
4d	Q14d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
5	Q15	Percentage believing that their organisation provides equal opportunities for career progression or promotion
6	Q11e	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
7	Q4b	Percentage staff saying that they are satisfied with the extent to which their organisation values their work
8	Q31b	Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work
9a	theme_engagement	The staff engagement score for staff with LTC or illness vs staff without a LTC or illness

*Staff with a long term condition

Survey Coordination Centre

NHS

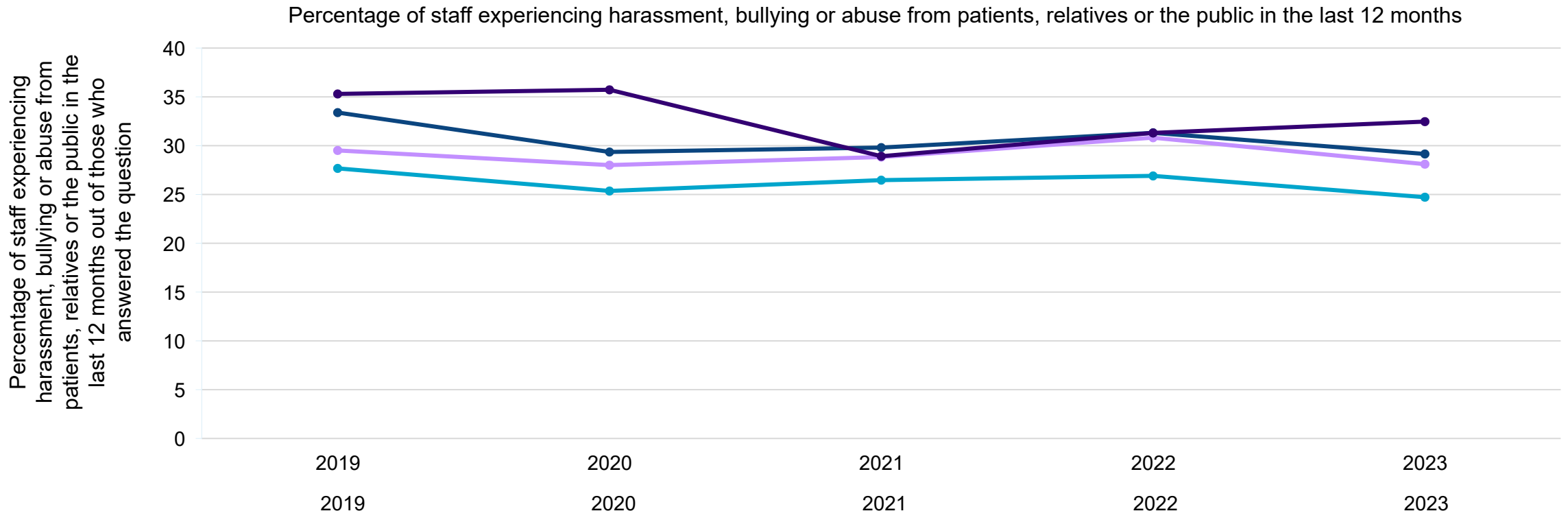
Workforce Race Equality Standards (WRES)

Vertical scales on the following charts vary from slide to slide and this effects how results are displayed. This allows incremental changes and small differences between results for subgroups to be more easily interpreted.
Data shown in the WRES charts are unweighted.
Averages are calculated as the median for the benchmark group.

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

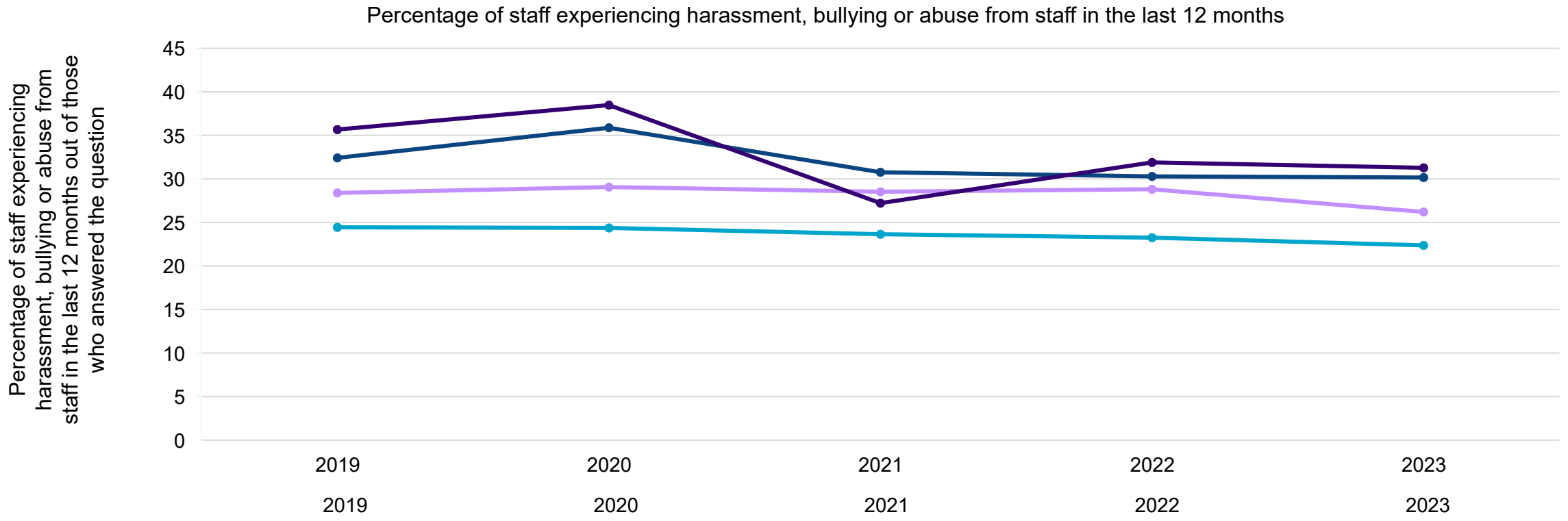


	2019	2020	2021	2022	2023
White staff: Your org	33.39%	29.36%	29.80%	31.31%	29.15%
All other ethnic groups*: Your org	35.30%	35.73%	28.92%	31.31%	32.47%
White staff: Average	27.67%	25.36%	26.47%	26.91%	24.72%
All other ethnic groups*: Average	29.51%	28.01%	28.84%	30.82%	28.11%
White staff: Responses	3306	2606	3258	3088	2974
All other ethnic groups*: Responses	643	473	823	856	961

*Staff from all other ethnic groups combined

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS



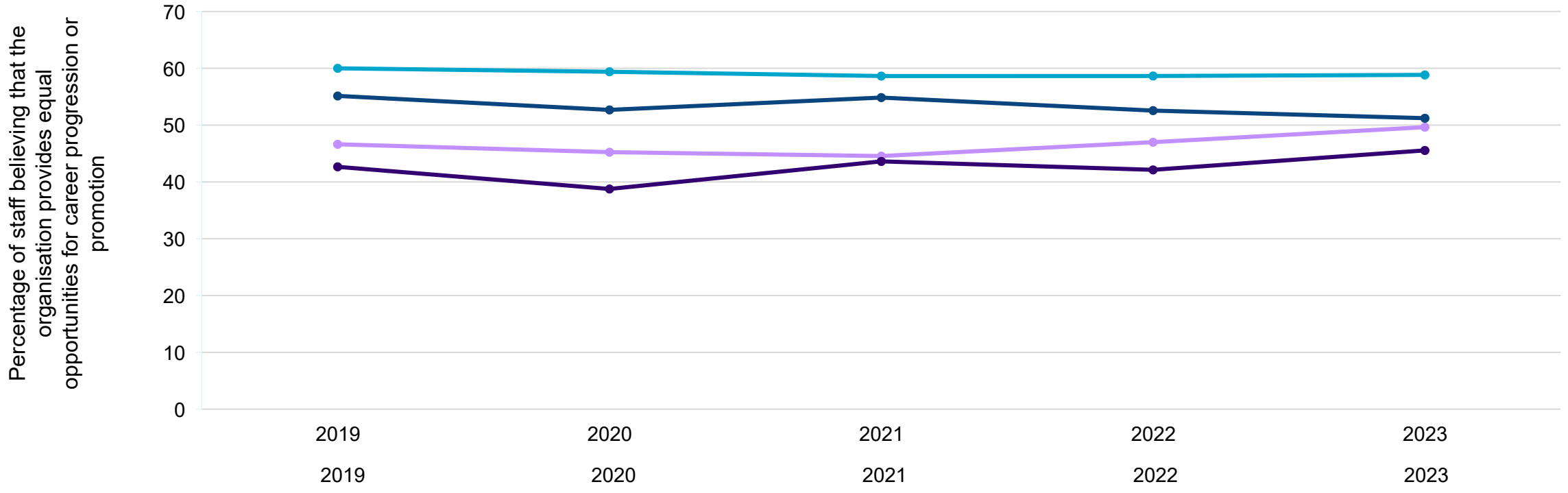
	2019	2020	2021	2022	2023
White staff: Your org	32.42%	35.88%	30.76%	30.29%	30.16%
All other ethnic groups*: Your org	35.67%	38.48%	27.22%	31.89%	31.28%
White staff: Average	24.44%	24.37%	23.65%	23.25%	22.37%
All other ethnic groups*: Average	28.39%	29.07%	28.53%	28.81%	26.20%
White staff: Responses	3310	2609	3267	3090	2971
All other ethnic groups*: Responses	642	473	823	856	956

*Staff from all other ethnic groups combined

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

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



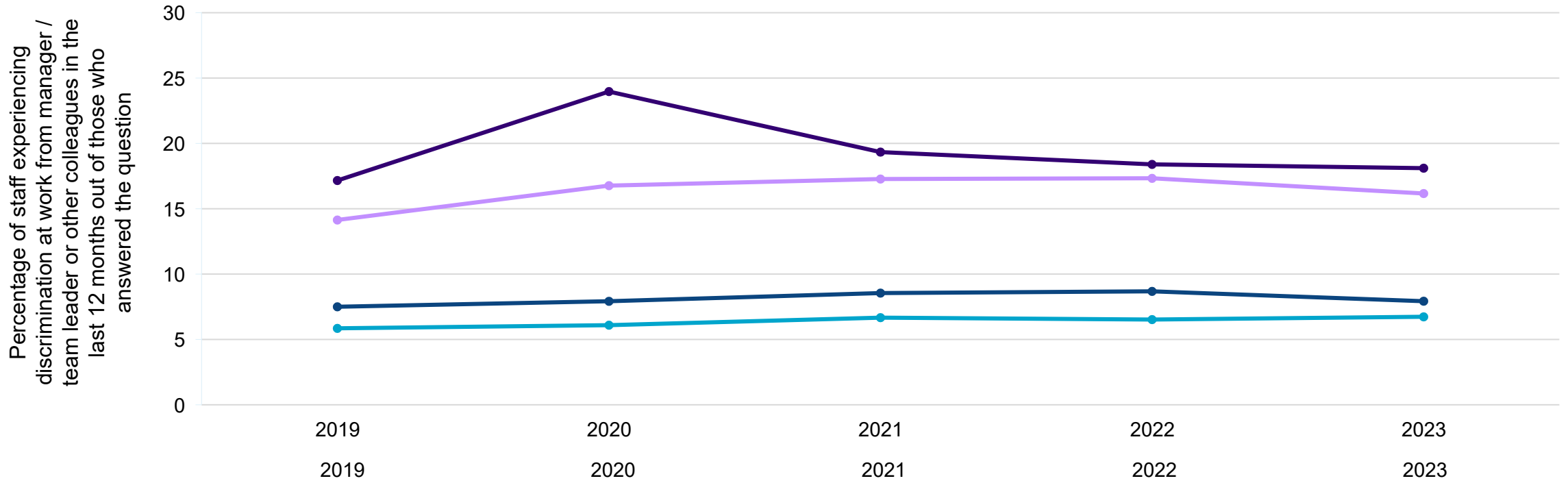
	2019	2020	2021	2022	2023
White staff: Your org	55.14%	52.68%	54.85%	52.55%	51.22%
All other ethnic groups*: Your org	42.66%	38.76%	43.62%	42.13%	45.55%
White staff: Average	60.00%	59.39%	58.64%	58.65%	58.84%
All other ethnic groups*: Average	46.62%	45.24%	44.56%	47.00%	49.64%
White staff: Responses	3306	2667	3353	3073	2948
All other ethnic groups*: Responses	640	485	846	845	966

*Staff from all other ethnic groups combined

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.



	2019	2020	2021	2022	2023
White staff: Your org	7.50%	7.92%	8.55%	8.68%	7.93%
All other ethnic groups*: Your org	17.16%	23.97%	19.34%	18.40%	18.11%
White staff: Average	5.85%	6.09%	6.67%	6.52%	6.73%
All other ethnic groups*: Average	14.14%	16.77%	17.28%	17.33%	16.17%
White staff: Responses	3306	2688	3369	3087	2965
All other ethnic groups*: Responses	641	484	843	848	961

*Staff from all other ethnic groups combined

Survey Coordination Centre

NHS

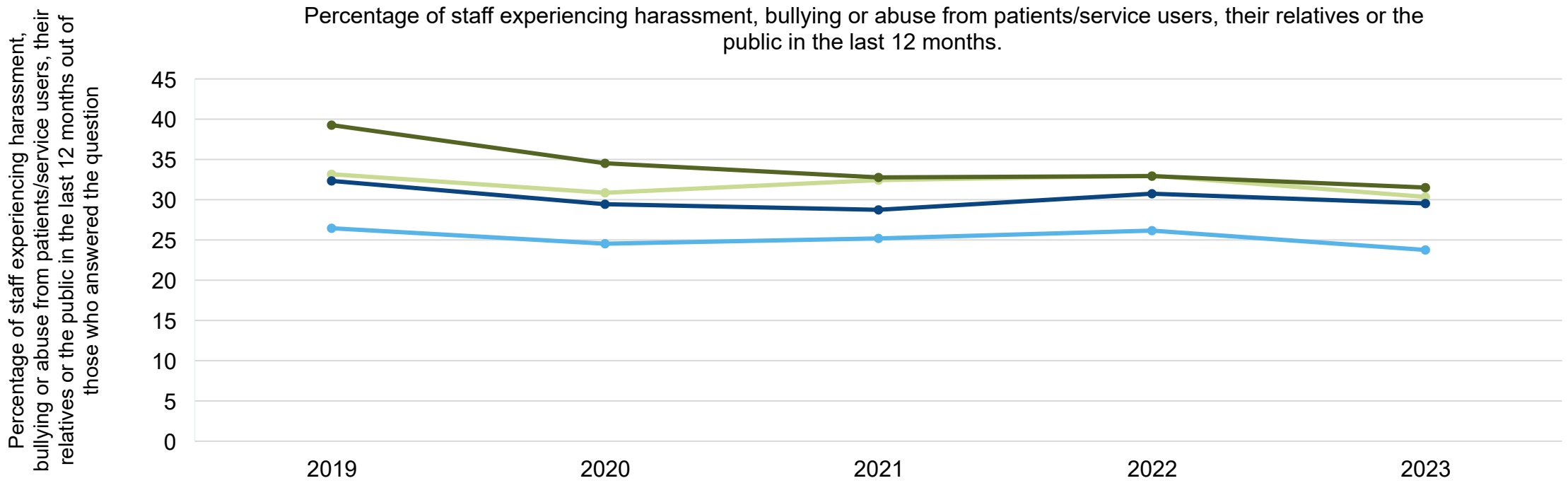
Workforce Disability Equality Standards (WDES)

Vertical scales on the following charts vary from slide to slide and this effects how results are displayed. This allows incremental changes and small differences between results for subgroups to be more easily interpreted.
Data shown in the WDES charts are unweighted.

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Workforce Disability Equality Standards

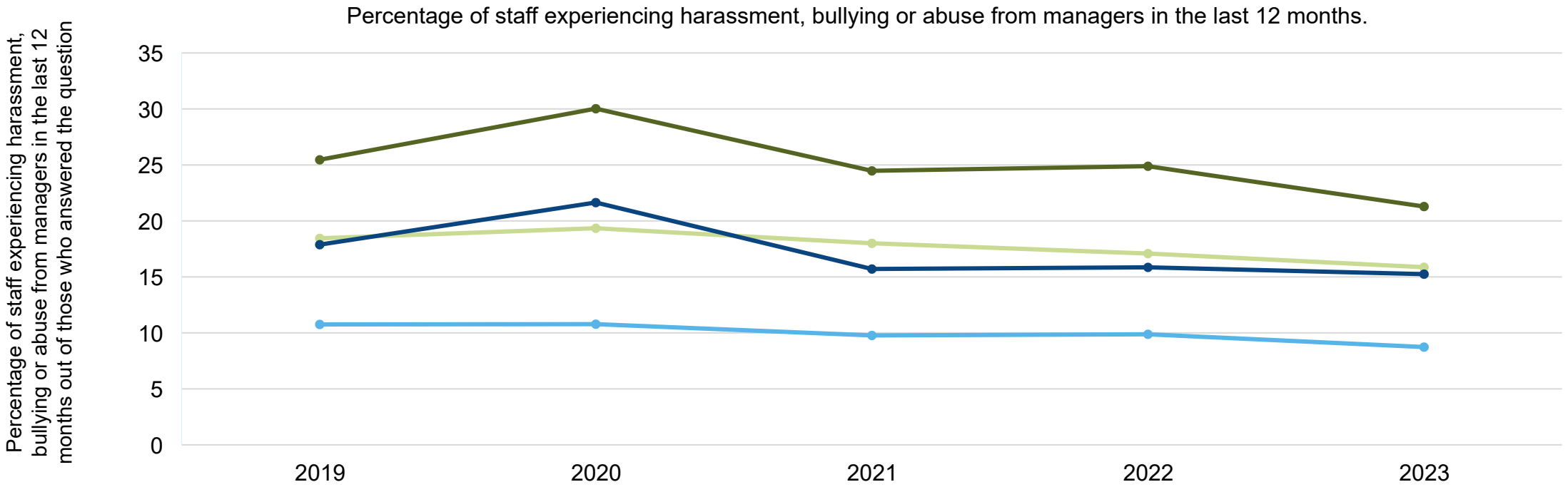
Survey Coordination Centre NHS



	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	39.27%	34.53%	32.77%	32.93%	31.51%
Staff without a LTC or illness: Your org	32.33%	29.44%	28.74%	30.74%	29.54%
Staff with a LTC or illness: Average	33.17%	30.86%	32.43%	32.98%	30.35%
Staff without a LTC or illness: Average	26.45%	24.53%	25.19%	26.16%	23.76%
Staff with a LTC or illness: Responses	764	698	1007	911	1006
Staff without a LTC or illness: Responses	3266	2449	3138	3051	2861

Workforce Disability Equality Standards

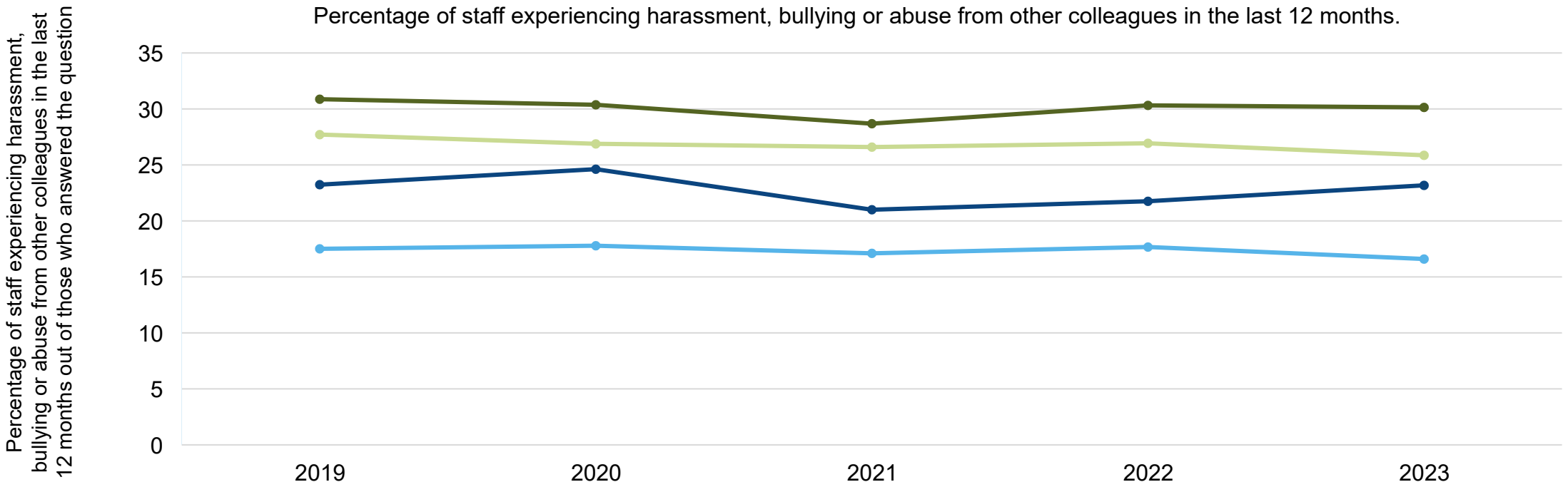
Survey Coordination Centre NHS



	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	25.46%	30.03%	24.48%	24.89%	21.29%
Staff without a LTC or illness: Your org	17.88%	21.64%	15.71%	15.86%	15.25%
Staff with a LTC or illness: Average	18.45%	19.35%	18.00%	17.09%	15.87%
Staff without a LTC or illness: Average	10.76%	10.78%	9.77%	9.88%	8.74%
Staff with a LTC or illness: Responses	758	696	1001	904	996
Staff without a LTC or illness: Responses	3249	2444	3132	3040	2833

Workforce Disability Equality Standards

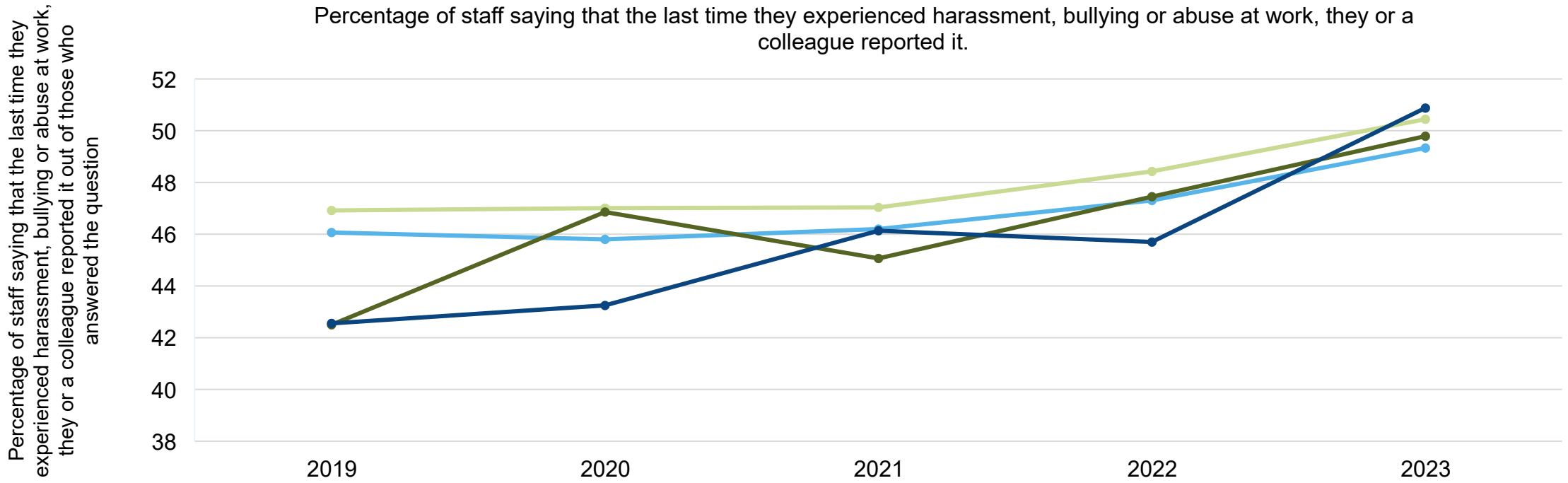
Survey Coordination Centre NHS



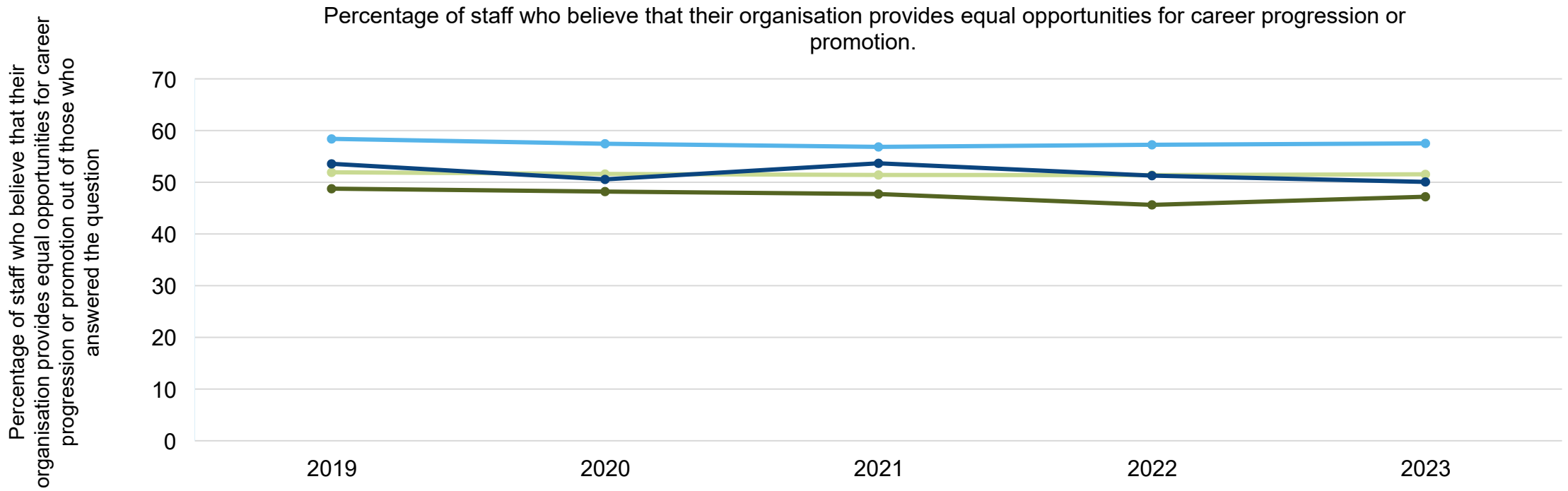
	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	30.87%	30.37%	28.69%	30.32%	30.14%
Staff without a LTC or illness: Your org	23.24%	24.62%	21.00%	21.76%	23.18%
Staff with a LTC or illness: Average	27.71%	26.89%	26.60%	26.93%	25.86%
Staff without a LTC or illness: Average	17.51%	17.79%	17.11%	17.67%	16.60%
Staff with a LTC or illness: Responses	758	698	997	907	992
Staff without a LTC or illness: Responses	3262	2449	3119	3038	2800

Workforce Disability Equality Standards

Survey Coordination Centre NHS



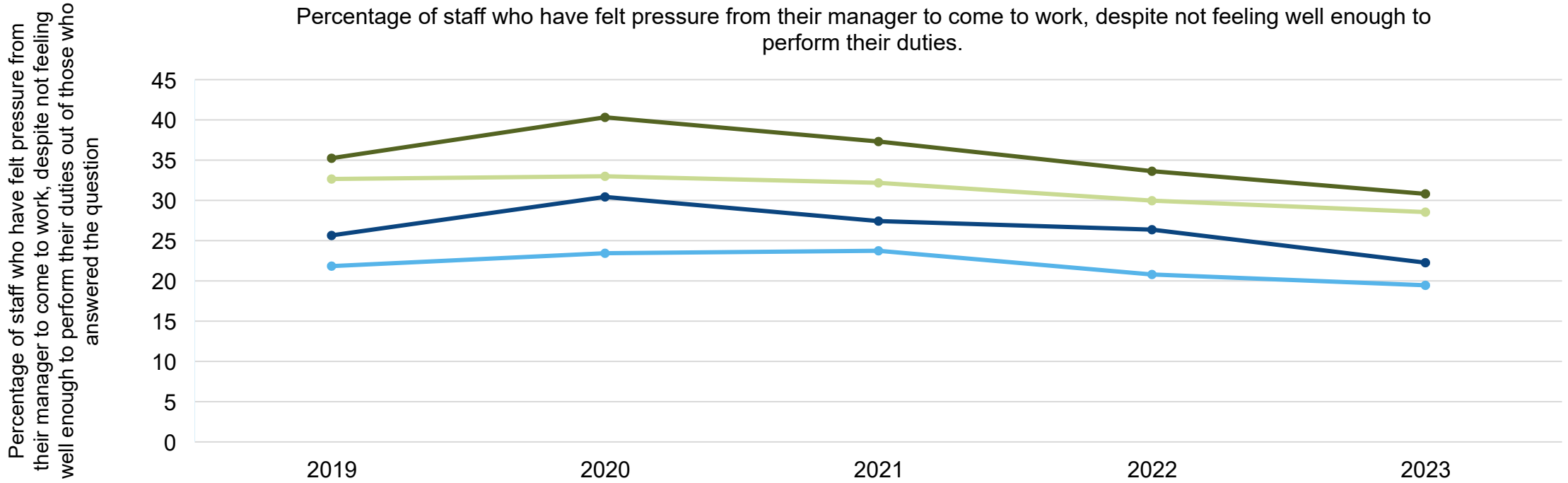
	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	42.50%	46.86%	45.06%	47.45%	49.79%
Staff without a LTC or illness: Your org	42.55%	43.25%	46.13%	45.70%	50.88%
Staff with a LTC or illness: Average	46.92%	47.01%	47.03%	48.43%	50.44%
Staff without a LTC or illness: Average	46.07%	45.80%	46.20%	47.30%	49.33%
Staff with a LTC or illness: Responses	400	350	466	451	470
Staff without a LTC or illness: Responses	1363	1022	1177	1151	1083



	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	48.76%	48.20%	47.73%	45.63%	47.20%
Staff without a LTC or illness: Your org	53.57%	50.56%	53.67%	51.29%	50.07%
Staff with a LTC or illness: Average	51.93%	51.61%	51.41%	51.39%	51.54%
Staff without a LTC or illness: Average	58.39%	57.45%	56.84%	57.25%	57.52%
Staff with a LTC or illness: Responses	767	722	1033	903	1000
Staff without a LTC or illness: Responses	3261	2504	3233	3034	2850

Workforce Disability Equality Standards

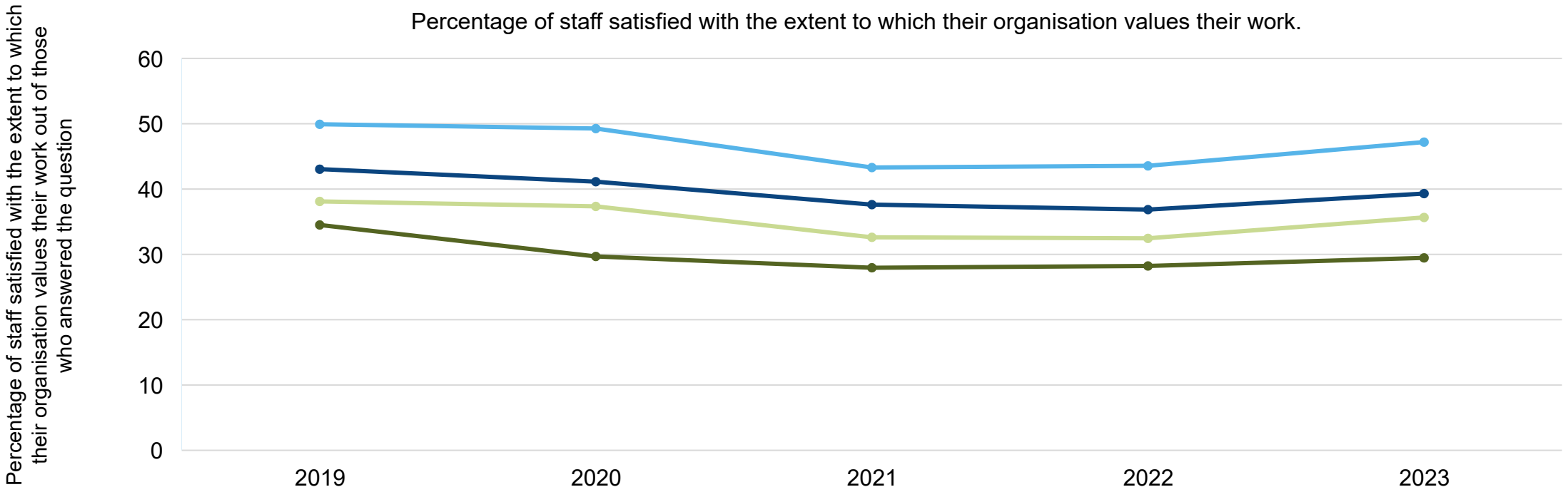
Survey Coordination Centre NHS



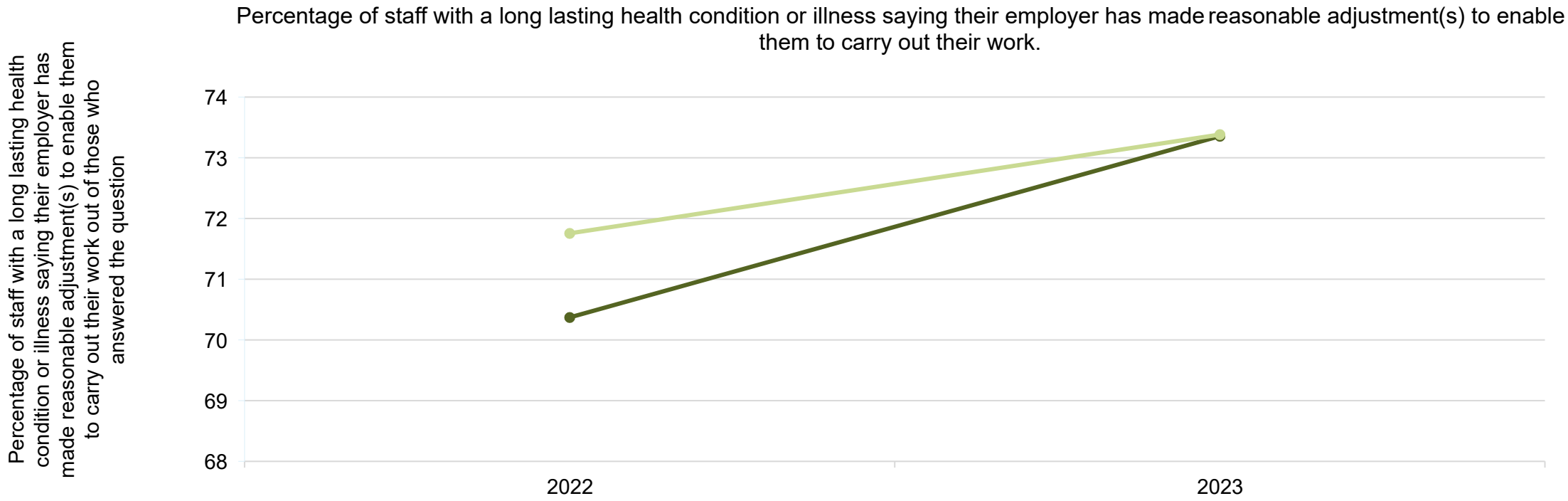
	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	35.24%	40.32%	37.32%	33.63%	30.81%
Staff without a LTC or illness: Your org	25.65%	30.43%	27.43%	26.37%	22.27%
Staff with a LTC or illness: Average	32.66%	33.00%	32.18%	29.97%	28.55%
Staff without a LTC or illness: Average	21.84%	23.44%	23.74%	20.80%	19.46%
Staff with a LTC or illness: Responses	593	496	745	669	727
Staff without a LTC or illness: Responses	1836	1160	1644	1589	1428

Workforce Disability Equality Standards

Survey Coordination Centre NHS



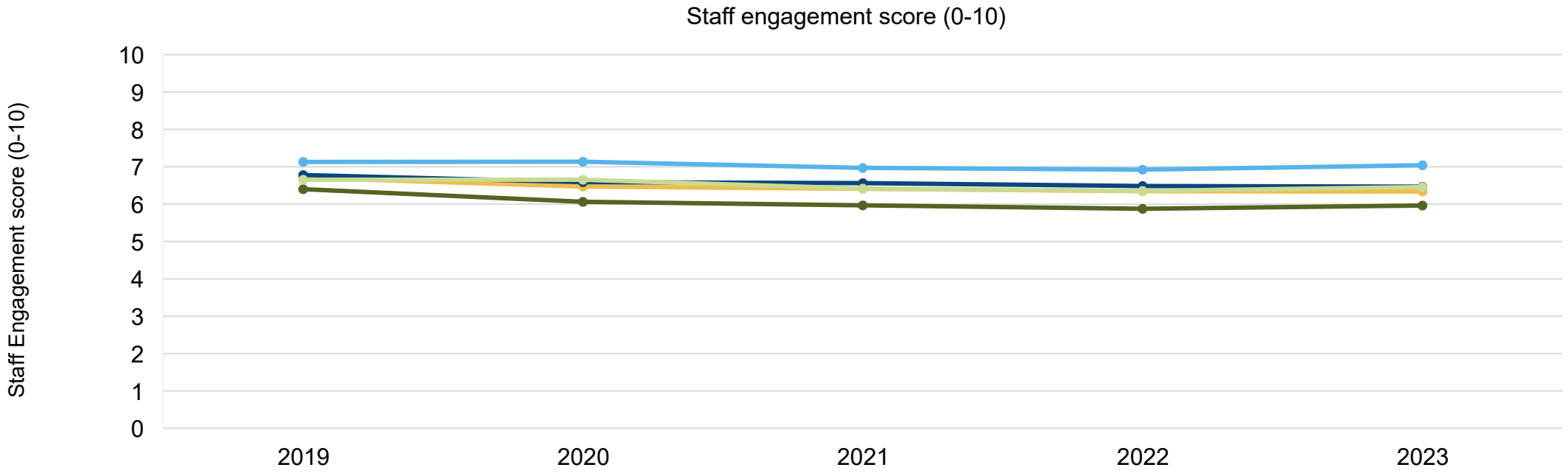
	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	34.51%	29.69%	27.95%	28.23%	29.46%
Staff without a LTC or illness: Your org	43.05%	41.13%	37.62%	36.86%	39.31%
Staff with a LTC or illness: Average	38.11%	37.36%	32.62%	32.46%	35.66%
Staff without a LTC or illness: Average	49.92%	49.27%	43.30%	43.56%	47.19%
Staff with a LTC or illness: Responses	768	731	1041	914	1008
Staff without a LTC or illness: Responses	3282	2521	3251	3063	2862



	2022	2023
Staff with a LTC or illness: Your org	70.37%	73.36%
Staff with a LTC or illness: Average	71.76%	73.38%
Staff with a LTC or illness: Responses	513	593

Workforce Disability Equality Standards

Survey Coordination Centre NHS



	2019	2020	2021	2022	2023
Organisation average	6.71	6.47	6.41	6.35	6.34
Staff with a LTC or illness: Your org	6.40	6.06	5.97	5.88	5.96
Staff without a LTC or illness: Your org	6.78	6.59	6.56	6.49	6.47
Staff with a LTC or illness: Average	6.65	6.65	6.42	6.35	6.46
Staff without a LTC or illness: Average	7.13	7.14	6.97	6.92	7.04
Staff with a LTC or illness: Responses	771	731	1041	913	1011
Staff without a LTC or illness: Responses	3284	2525	3255	3070	2876

Note: Data shown in this chart are unweighted therefore will not match weighted staff engagement scores in other outputs.

Survey Coordination Centre

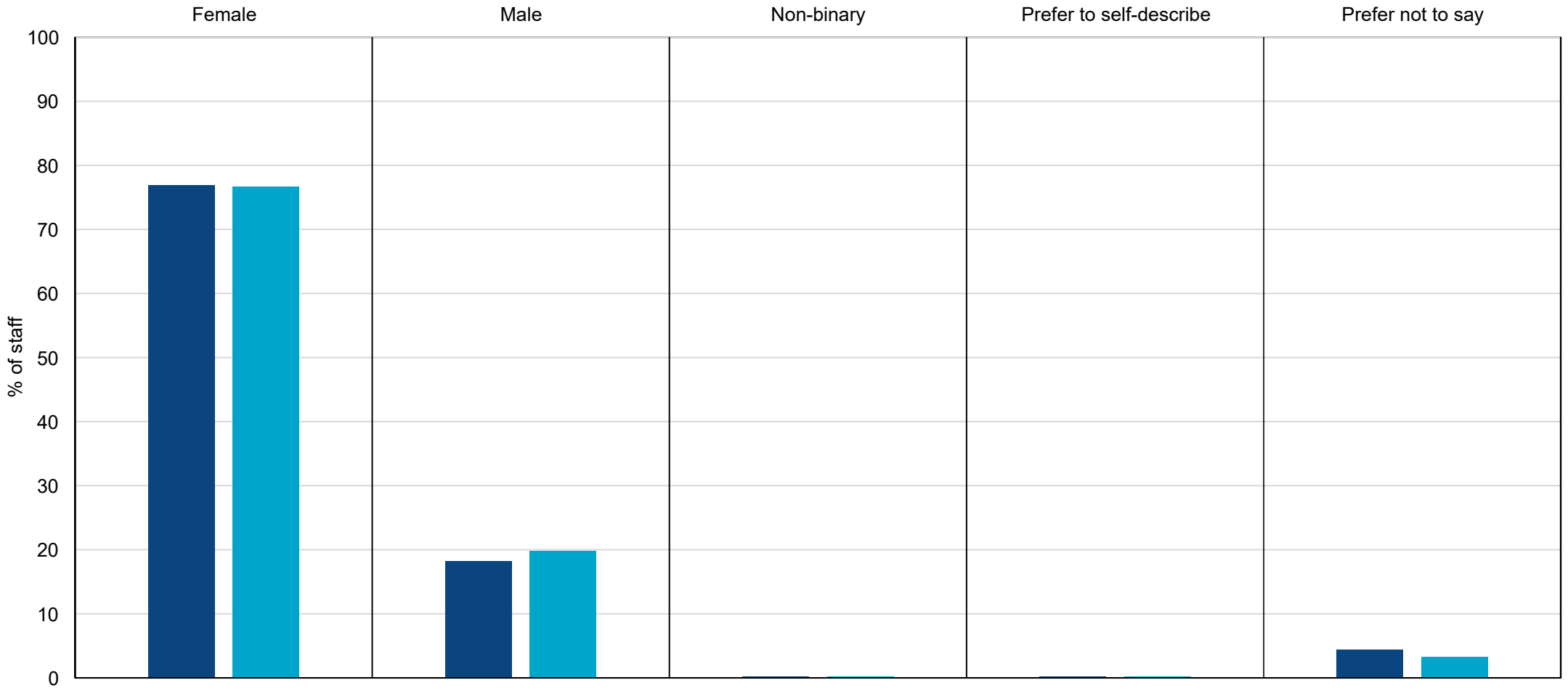
NHS

About your respondents

This section shows demographic and other background information for 2023.

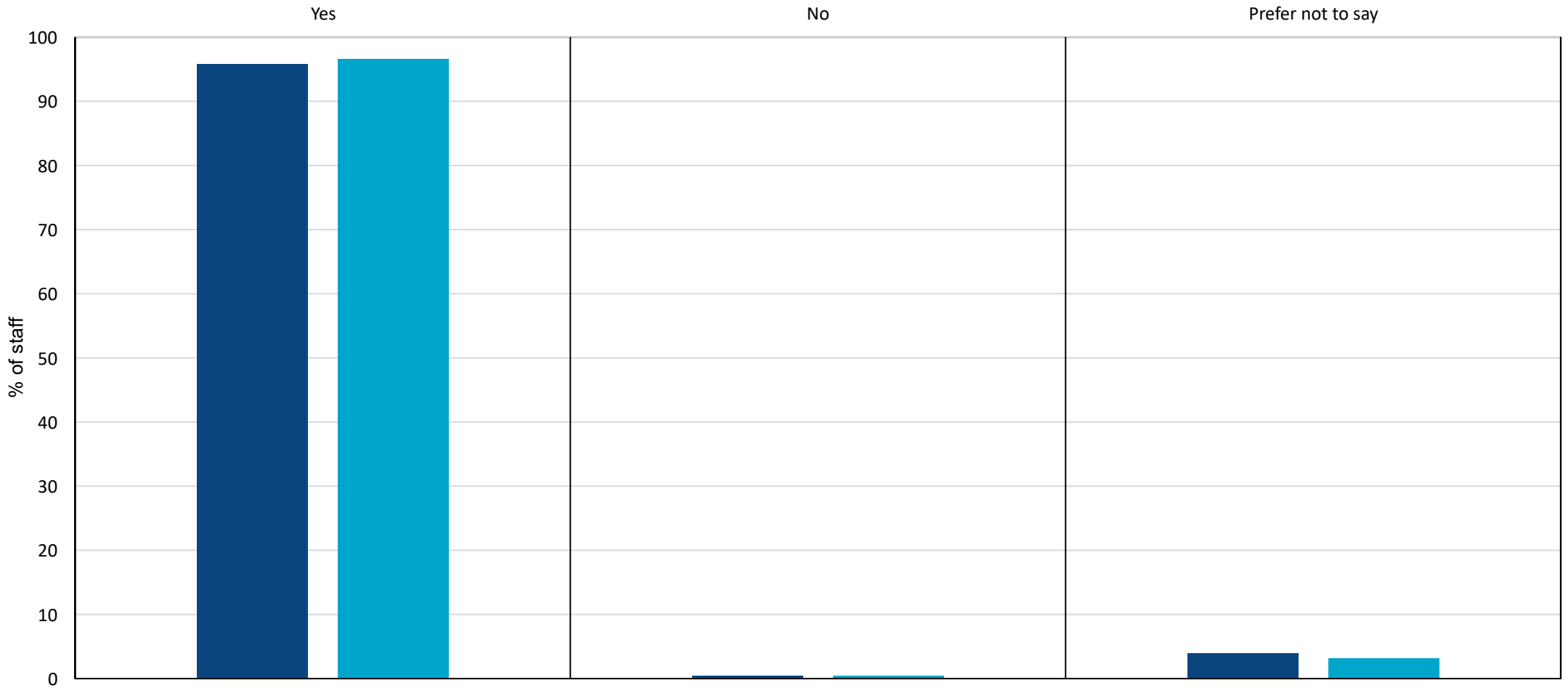
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Background details - Gender



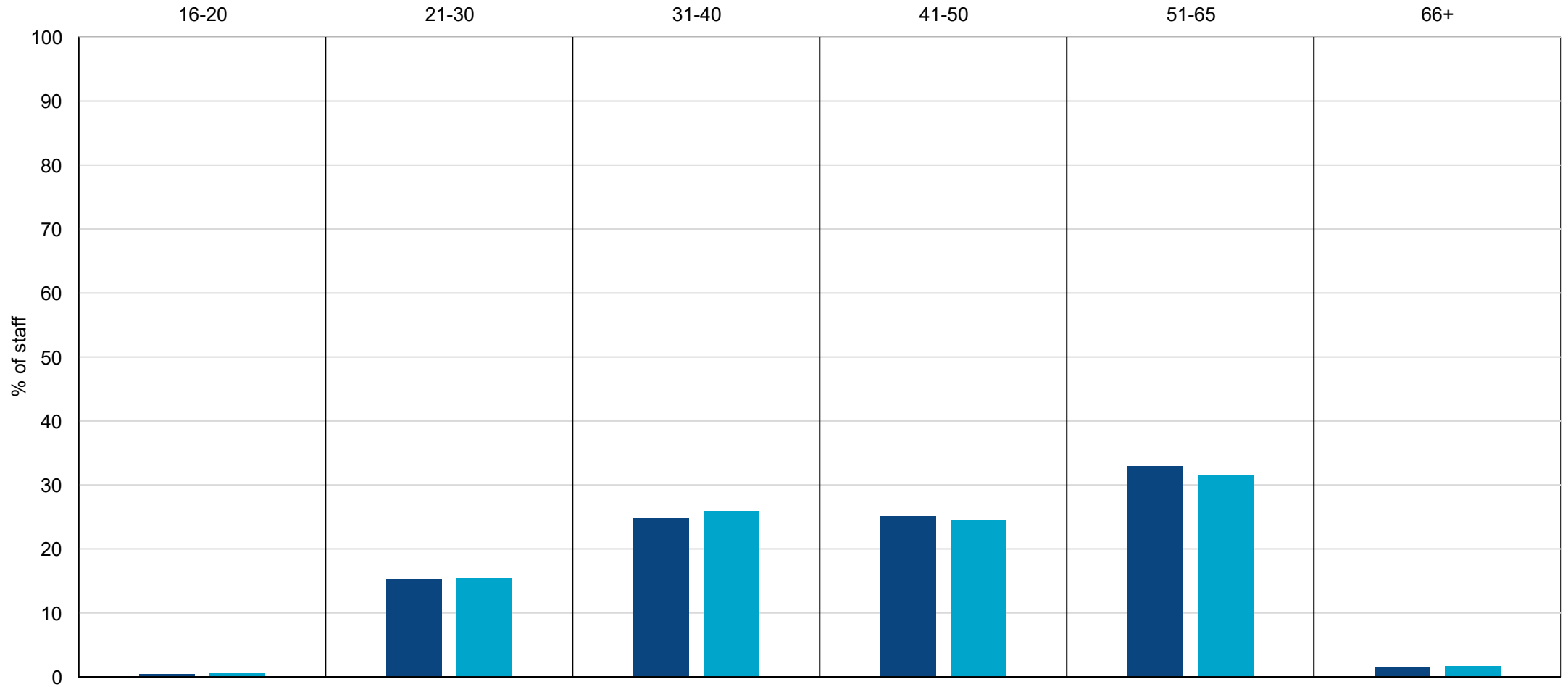
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say
Your org	76.91%	18.24%	0.23%	0.23%	4.40%
Average	76.60%	19.78%	0.24%	0.18%	3.22%
Responses	3959	3959	3959	3959	3959

Background details – Is your gender identity the same as the sex you were registered at birth?



	Yes	No	Prefer not to say
Your org	95.76%	0.36%	3.88%
Average	96.62%	0.37%	3.08%
Responses	3943	3943	3943

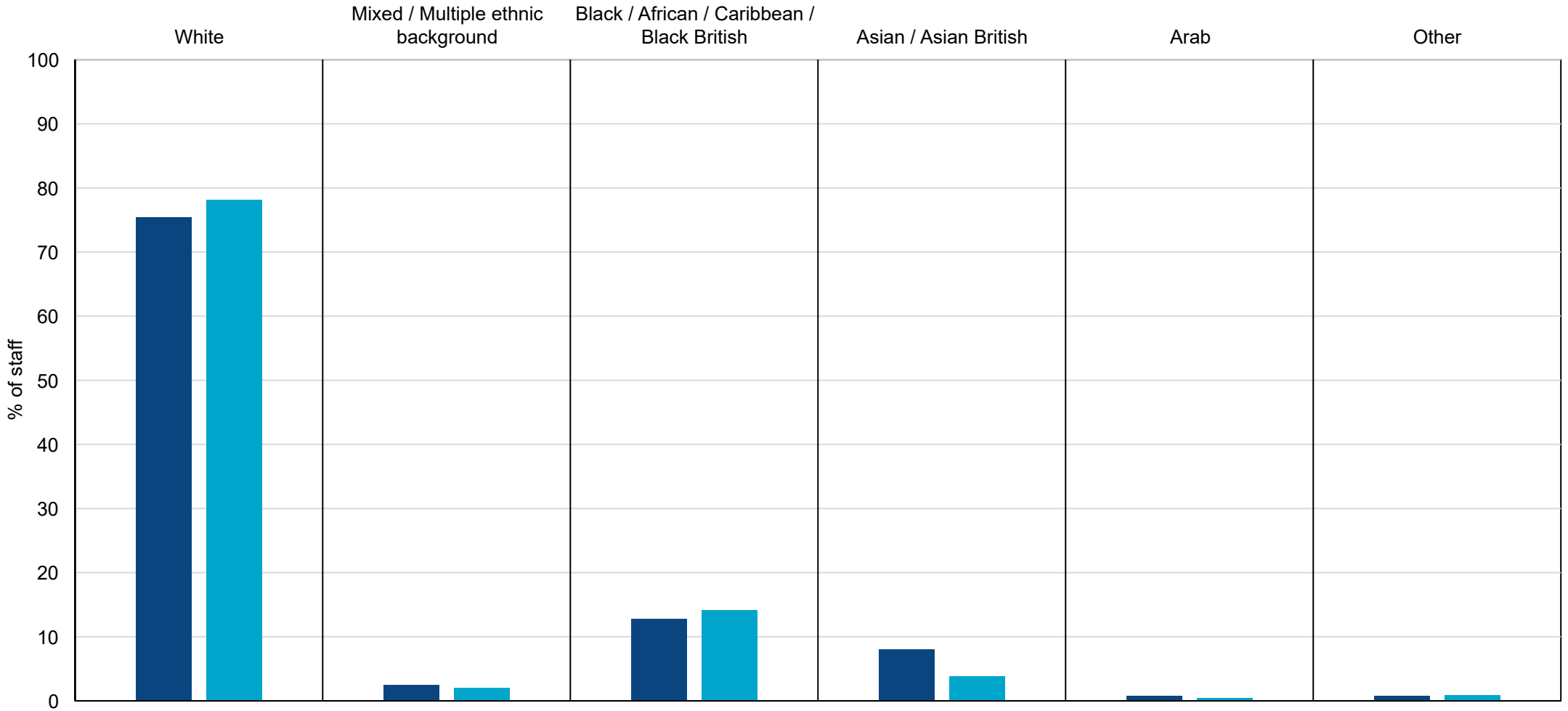
Background details - Age



	16-20	21-30	31-40	41-50	51-65	66+
Your org	0.43%	15.24%	24.80%	25.10%	32.96%	1.48%
Average	0.55%	15.42%	25.91%	24.51%	31.50%	1.70%
Responses	3984	3984	3984	3984	3984	3984

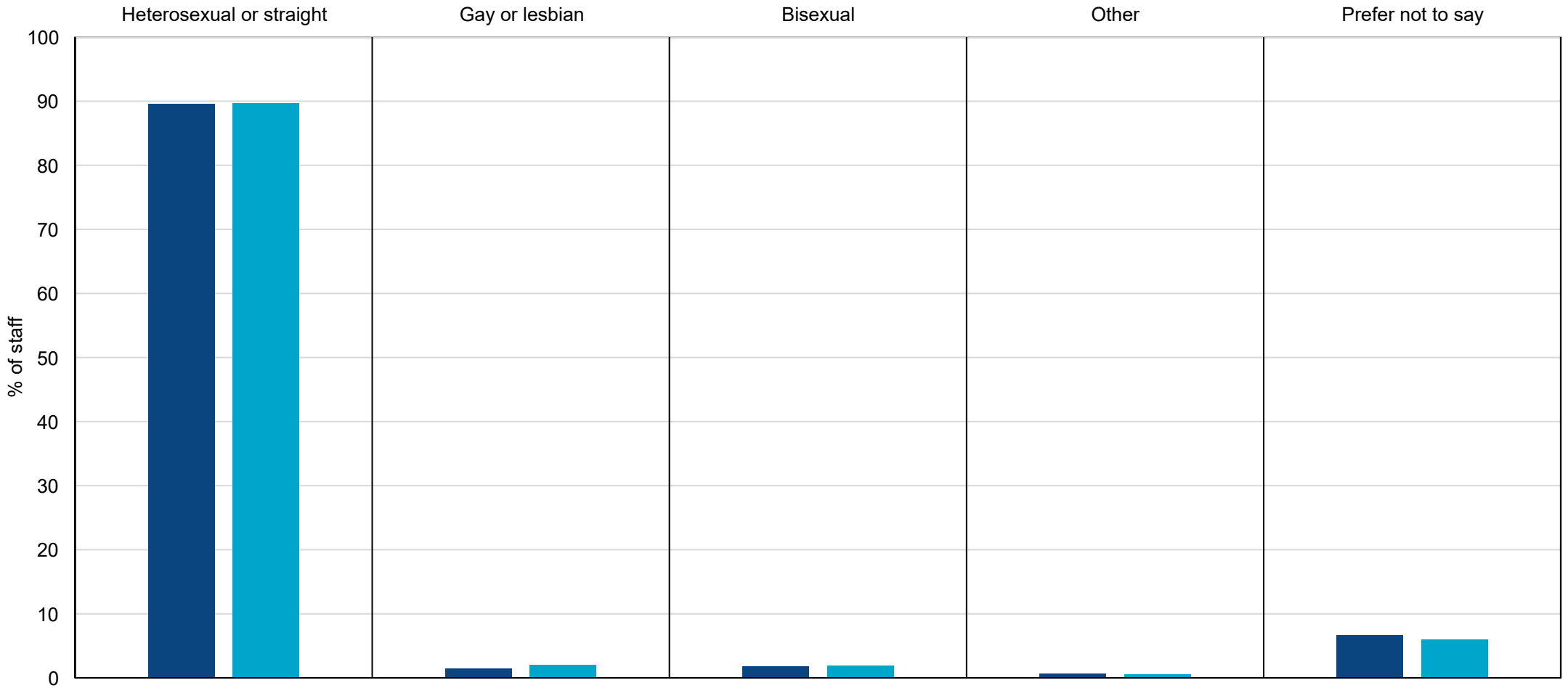
Background details - Ethnicity

Survey Coordination Centre NHS



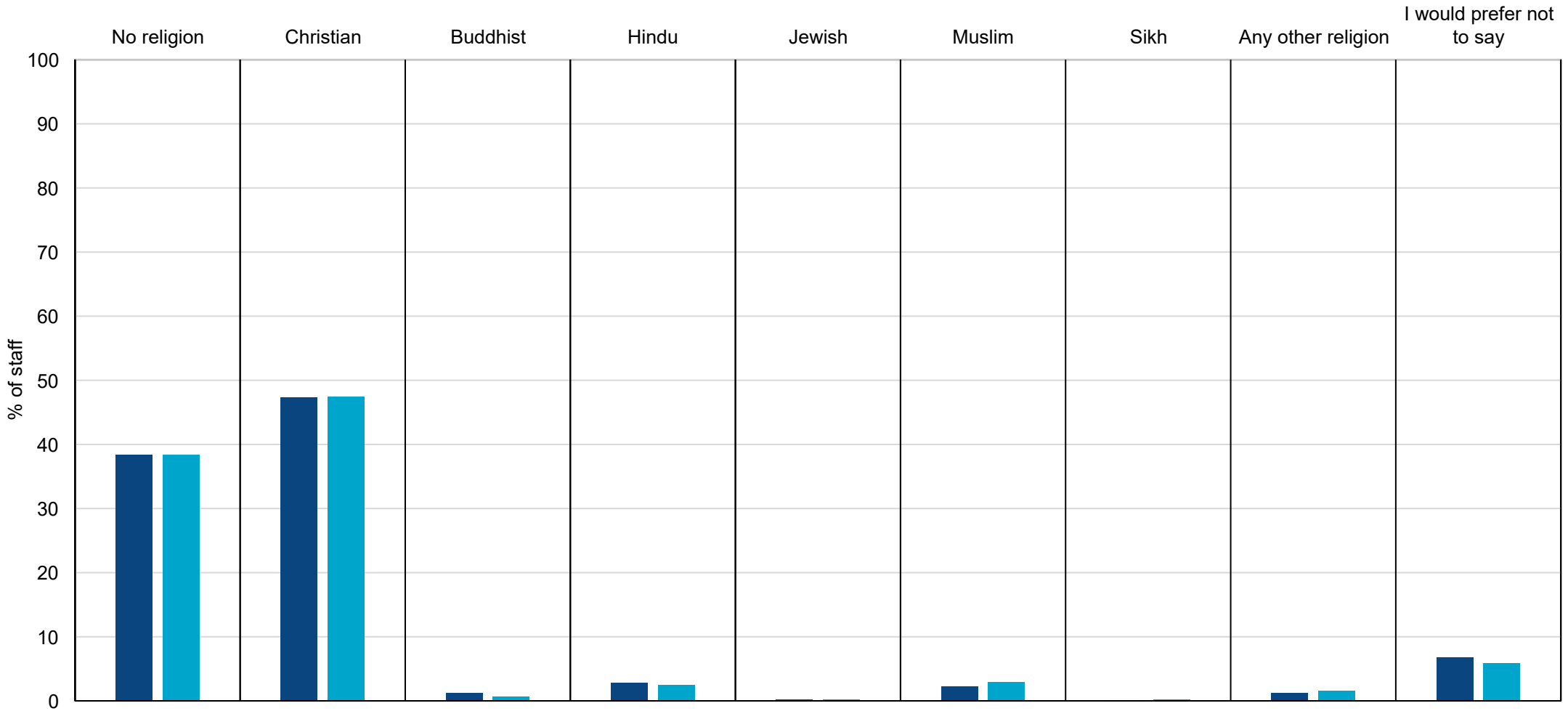
	White	Mixed / Multiple ethnic background	Black / African / Caribbean / Black British	Asian / Asian British	Arab	Other
Your org	75.44%	2.42%	12.72%	7.95%	0.73%	0.73%
Average	78.07%	1.97%	14.15%	3.83%	0.44%	0.84%
Responses	3961	3961	3961	3961	3961	3961

Background details – Sexual orientation



	Heterosexual or straight	Gay or lesbian	Bisexual	Other	Prefer not to say
Your org	89.59%	1.43%	1.79%	0.58%	6.61%
Average	89.71%	2.00%	1.84%	0.52%	5.94%
Responses	3976	3976	3976	3976	3976

Background details - Religion



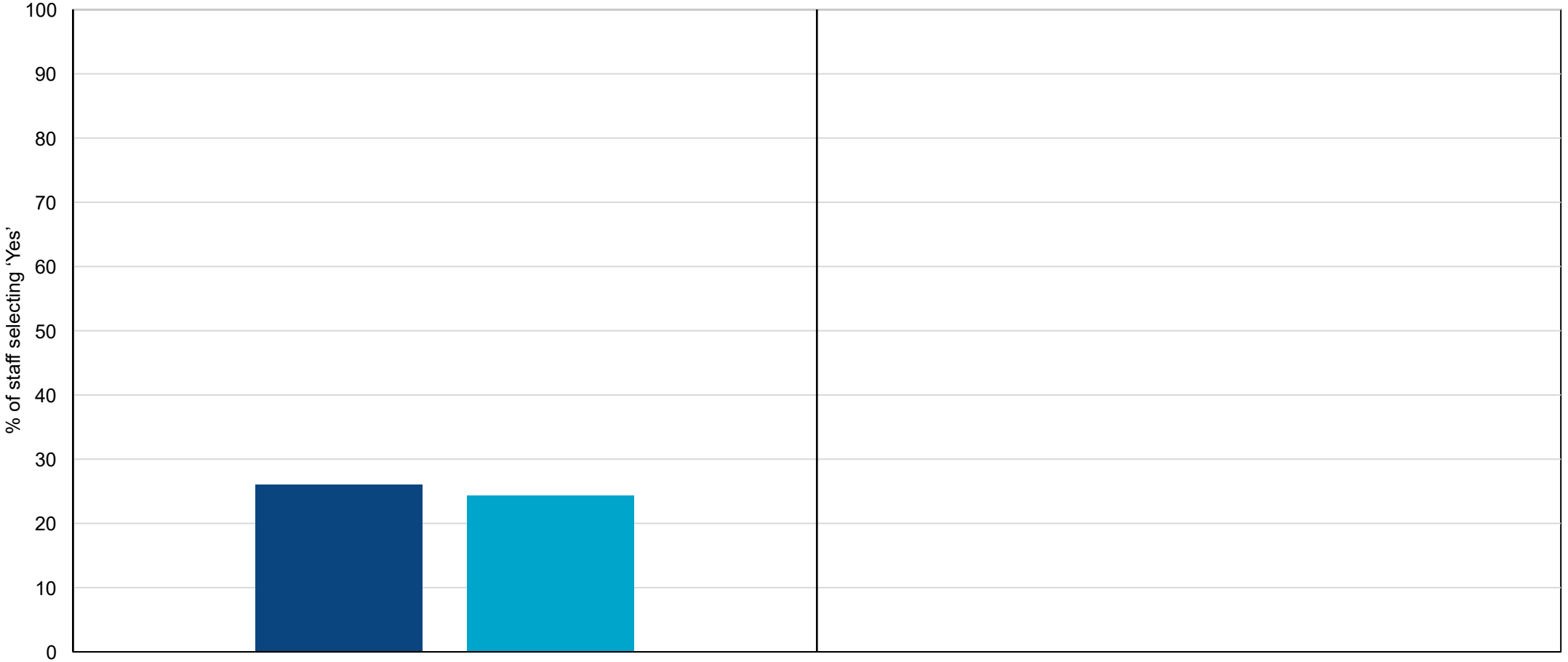
	No religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Any other religion	I would prefer not to say
Your org	38.35%	47.29%	1.23%	2.83%	0.13%	2.23%	0.03%	1.20%	6.72%
Average	38.30%	47.38%	0.65%	2.43%	0.15%	2.93%	0.23%	1.51%	5.80%
Responses	3990	3990	3990	3990	3990	3990	3990	3990	3990

Background details – Long lasting health condition or illness

Survey Coordination Centre

NHS

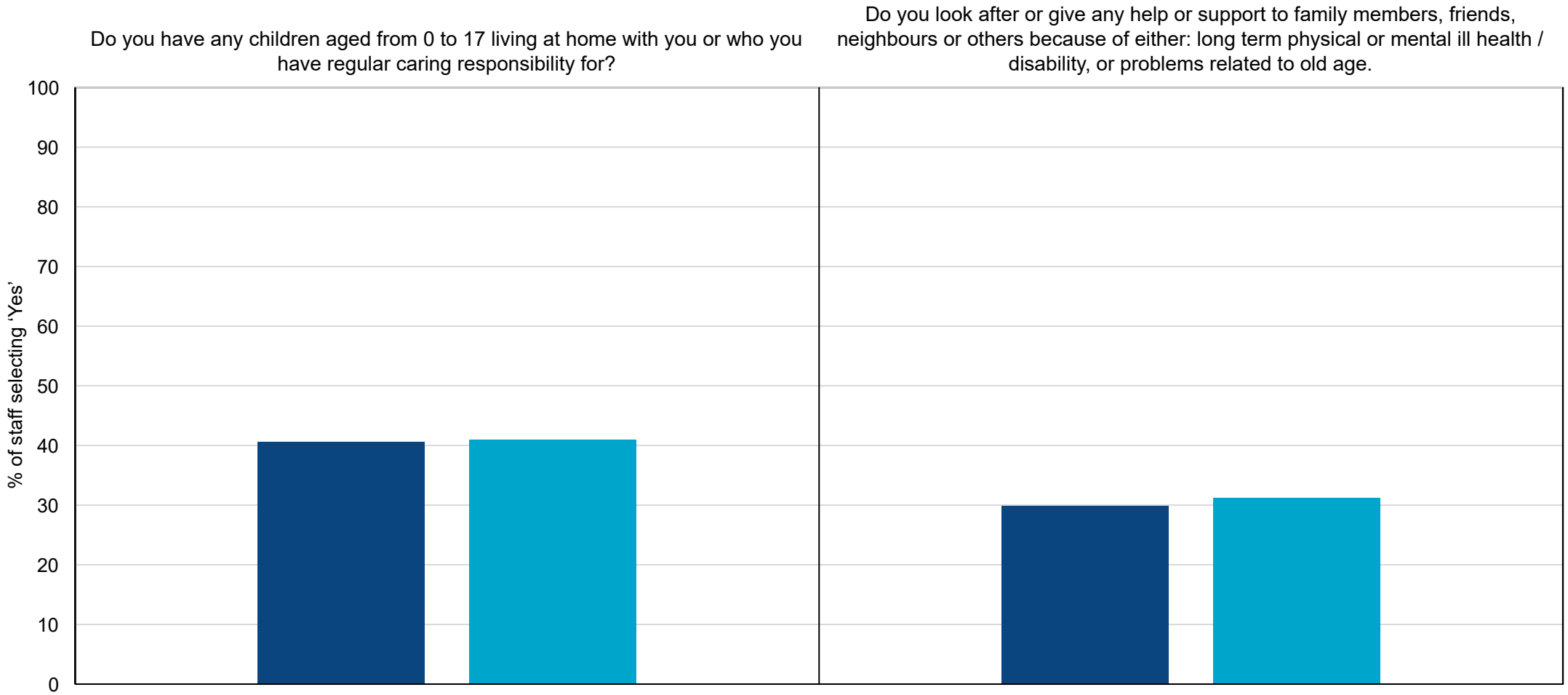
Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?



Your org	25.98%
Average	24.33%
Responses	3892

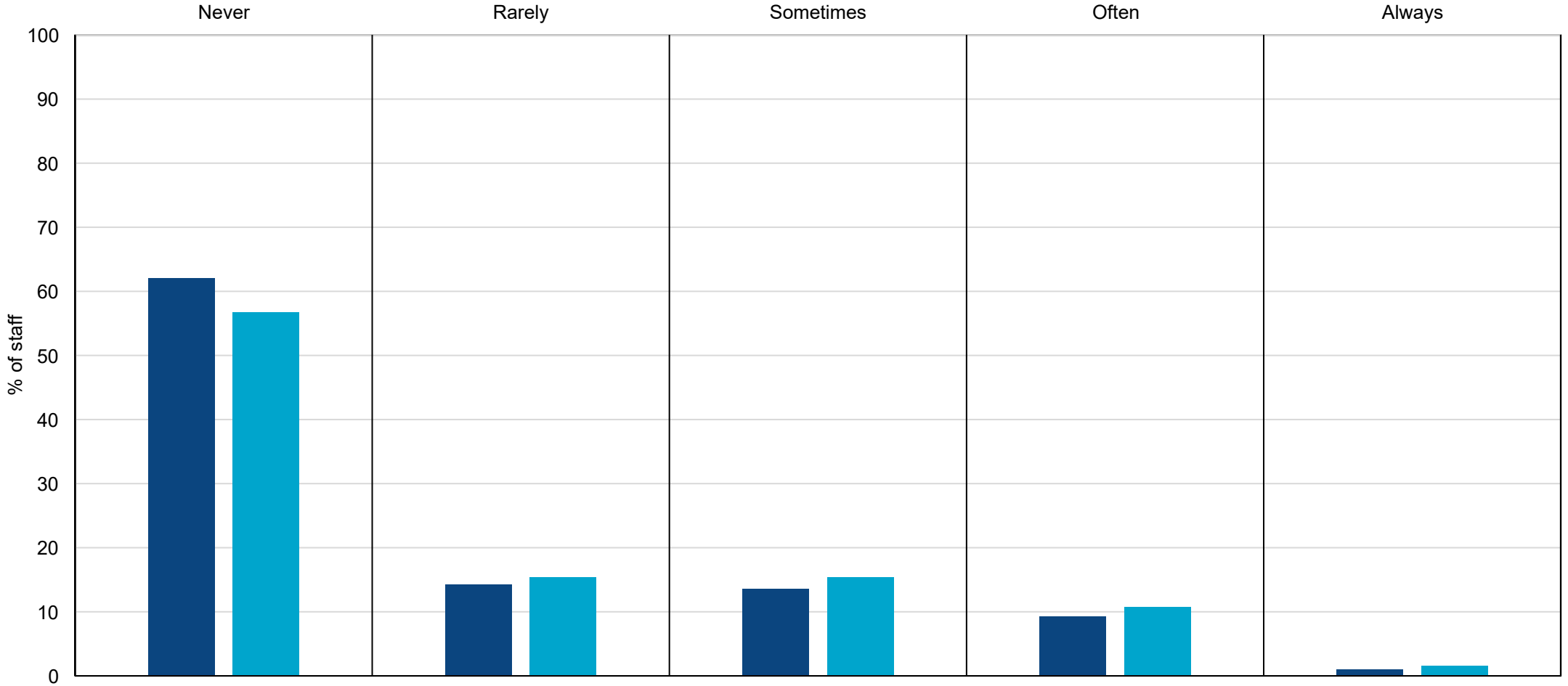
Background details – Parental / caring responsibilities

Survey Coordination Centre NHS



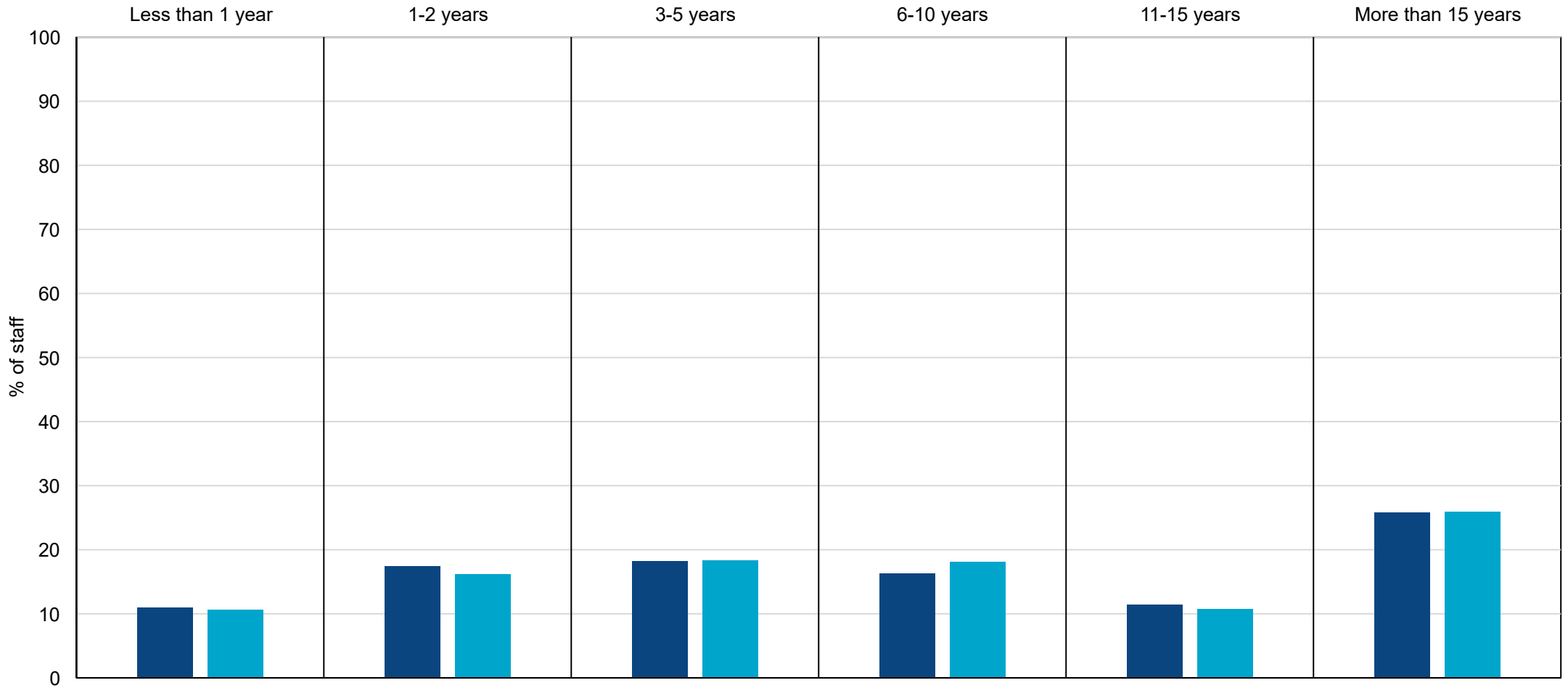
Your org	40.60%	29.88%
Average	40.90%	31.16%
Responses	3980	3973

Background details – How often do you work at/from home?



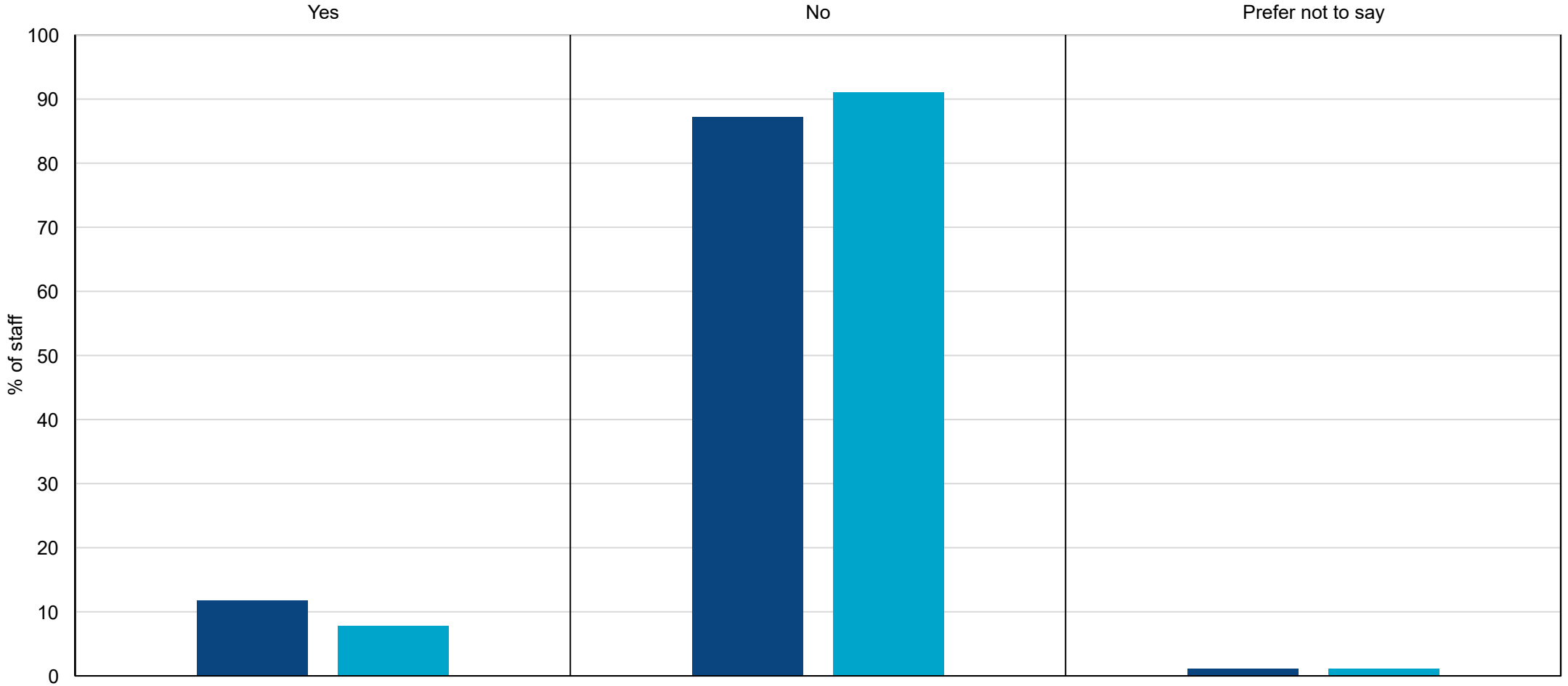
	Never	Rarely	Sometimes	Often	Always
Your org	62.01%	14.19%	13.57%	9.23%	1.00%
Average	56.75%	15.34%	15.41%	10.73%	1.52%
Responses	3988	3988	3988	3988	3988

Background details – Length of service



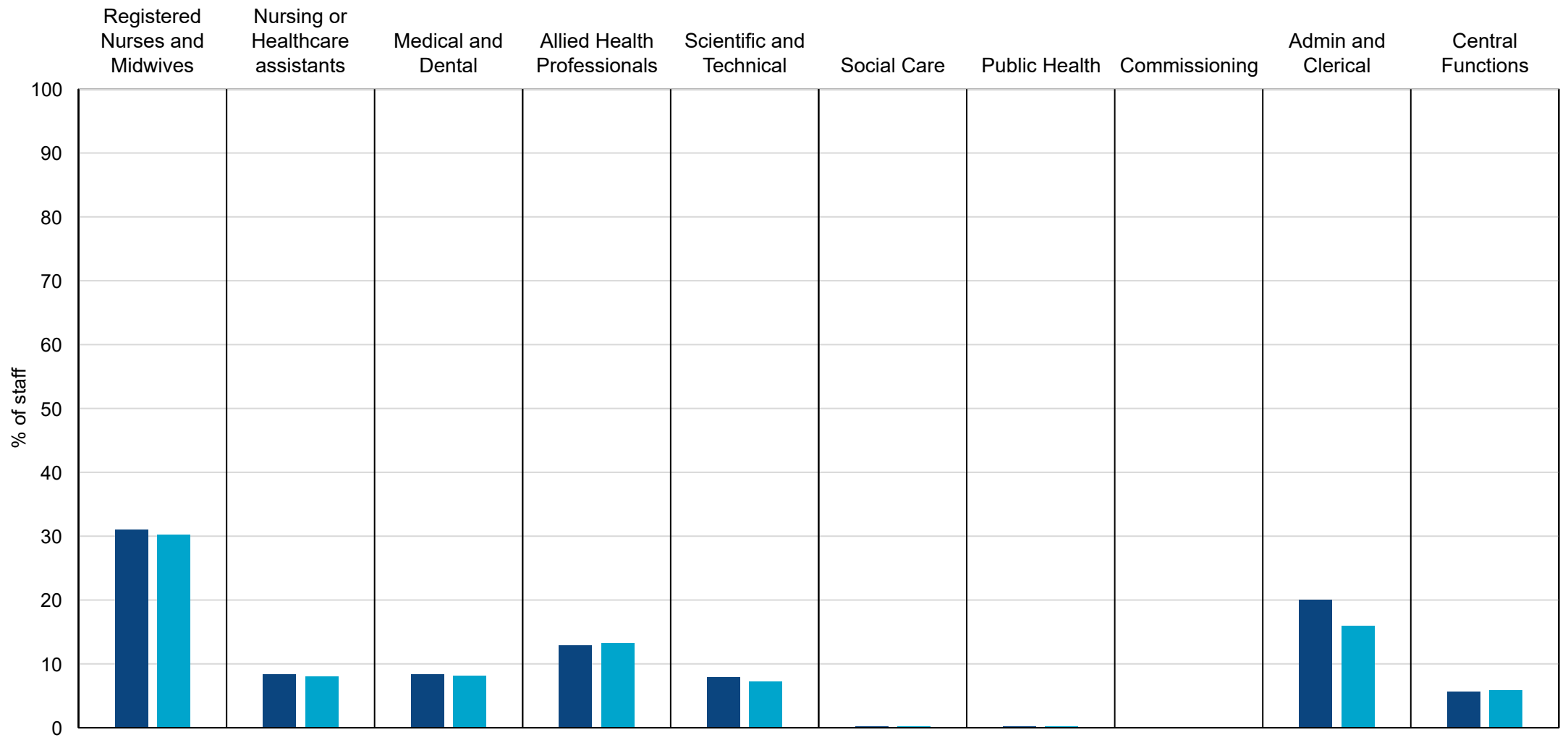
	Less than 1 year	1-2 years	3-5 years	6-10 years	11-15 years	More than 15 years
Your org	10.95%	17.42%	18.17%	16.32%	11.38%	25.76%
Average	10.57%	16.18%	18.32%	18.03%	10.71%	25.95%
Responses	3990	3990	3990	3990	3990	3990

Background details – When you joined this organisation were you recruited from outside of the UK?



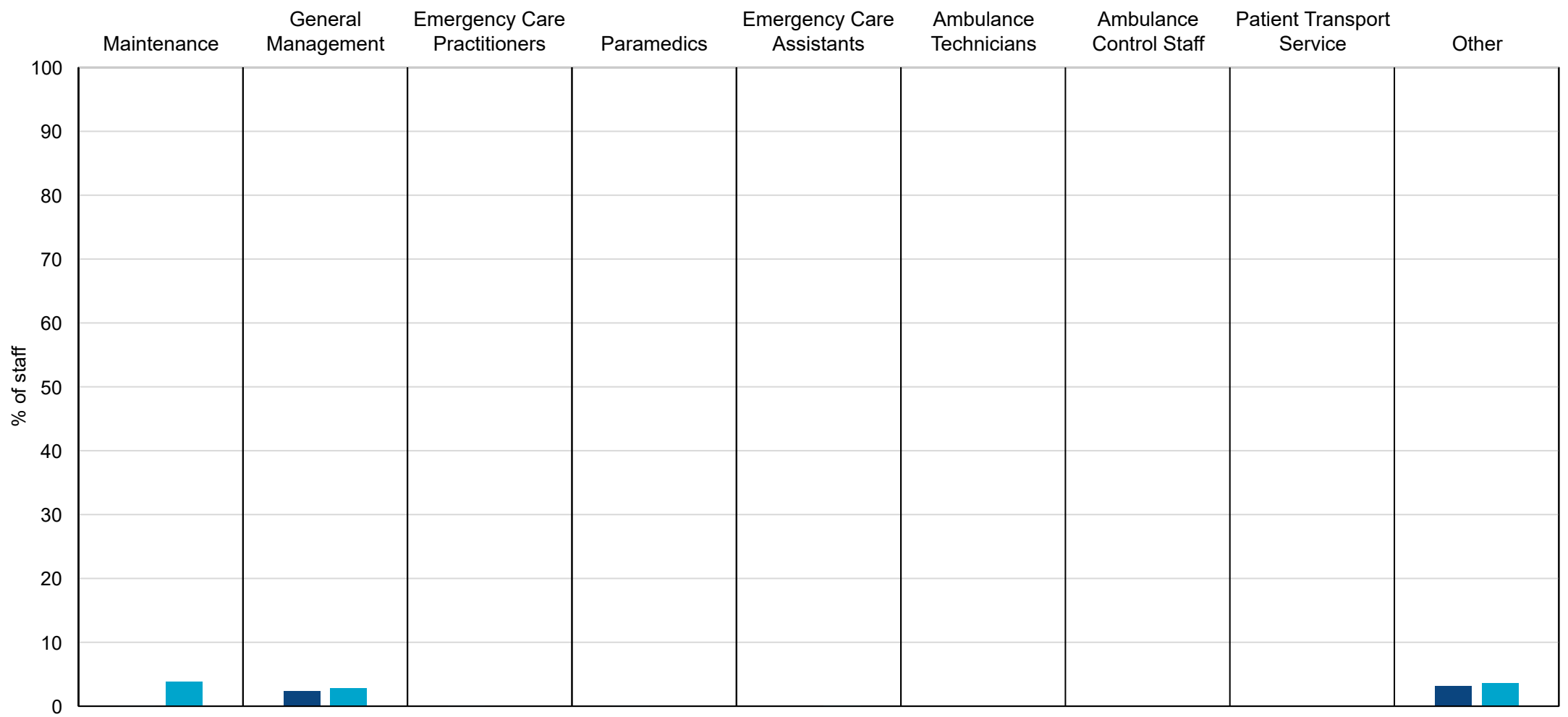
	Yes	No	Prefer not to say
Your org	11.79%	87.18%	1.03%
Average	7.79%	90.98%	1.04%
Responses	3970	3970	3970

Background details – Occupational group



	Registered Nurses and Midwives	Nursing or Healthcare assistants	Medical and Dental	Allied Health Professionals	Scientific and Technical	Social Care	Public Health	Commissioning	Admin and Clerical	Central Functions
Your org	30.97%	8.29%	8.39%	12.87%	7.86%	0.20%	0.15%	0.08%	20.02%	5.64%
Average	30.16%	8.01%	8.16%	13.19%	7.17%	0.15%	0.19%	0.07%	15.88%	5.86%
Responses	3956	3956	3956	3956	3956	3956	3956	3956	3956	3956

Background details – Occupational group



	Maintenance	General Management	Emergency Care Practitioners	Paramedics	Emergency Care Assistants	Ambulance Technicians	Ambulance Control Staff	Patient Transport Service	Other
Your org	0.05%	2.33%	0.03%	0.03%	0.00%	0.00%	0.00%	0.00%	3.11%
Average	3.76%	2.74%	0.02%	0.00%	0.03%	0.00%	0.00%	0.00%	3.63%
Responses	3956	3956	3956	3956	3956	3956	3956	3956	3956

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Appendices

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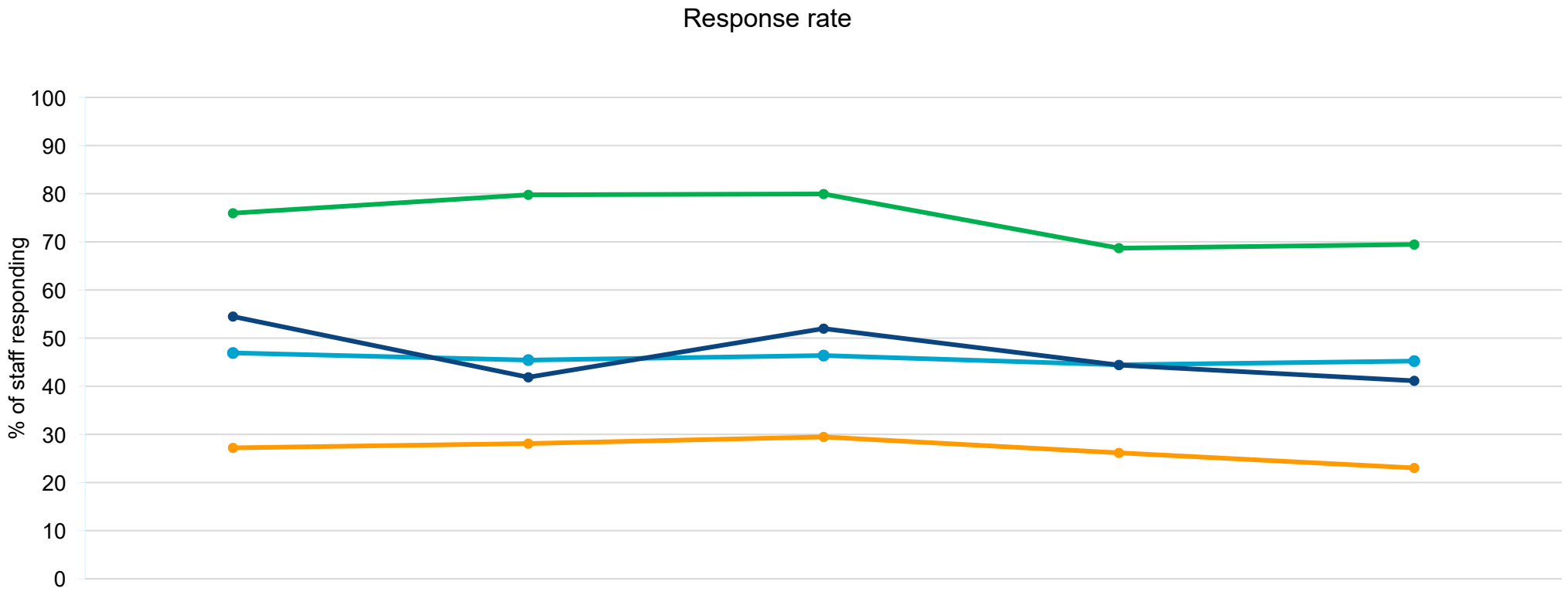
Appendix A: Response rate

Appendix A: Response rate



	2019	2020	2021	2022	2023
Your org	54.49%	41.87%	51.98%	44.39%	41.13%
Highest	75.96%	79.77%	79.95%	68.69%	69.45%
Average	46.93%	45.43%	46.38%	44.46%	45.23%
Lowest	27.20%	28.09%	29.47%	26.17%	23.03%
Responses	4278	3539	4587	4023	4011

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NHS

Appendix B: Significance testing 2022 vs 2023

Appendix B: Significance testing – 2022 vs 2023

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Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2022 and 2023*. For more details please see the technical document.

People Promise elements	2022 score	2022 respondents	2023 score	2023 respondents	Statistically significant change?
We are compassionate and inclusive	6.84	4012	6.85	4003	Not significant
We are recognised and rewarded	5.50	4015	5.62	4000	Significantly higher
We each have a voice that counts	6.24	3988	6.21	3972	Not significant
We are safe and healthy	5.74	3998	5.83	3974	Significantly higher
We are always learning	5.13	3813	5.36	3756	Significantly higher
We work flexibly	5.70	4009	5.88	3983	Significantly higher
We are a team	6.42	4008	6.51	4002	Not significant
Themes					
Staff Engagement	6.37	4018	6.34	4006	Not significant
Morale	5.50	4017	5.59	4007	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

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NHS

Appendix C: Tips on using your benchmark report

Appendix C: Data in the benchmark reports

Survey Coordination Centre NHS

The following pages include tips on how to read, interpret and use the data in this report. The **suggestions are aimed at users who would like some guidance on how to understand the data** in this report. These suggestions are by no means the only way to analyse or use the data, but [illegible]ers.

Key points to note

The seven People Promise elements, the two themes and the sub-scores that feed into them cover key areas of staff experience and present results in these areas in a clear and consistent way. All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher result is more positive than a lower result. These results are created by scoring questions linked to these areas of experience and grouping these results together. Details of how the results are calculated can be found in the technical document available on the Staff Survey website.

A key feature of the reports is that they **provide organisations with up to five years of trend data**. Trend data provides a much more reliable indication of whether the most recent results represent a change from the norm for an organisation than comparing the most recent results only to those from the previous year. Taking a longer term view will help organisations to identify trends over several years that may have been missed when comparisons are drawn solely between the current and previous year.

People Promise elements, themes and sub-scores are benchmarked so that organisations can make comparisons to their peers on specific areas of staff experience. Question results provide organisations with more granular data that will help them to identify particular areas of concern. The trend data are benchmarked so that organisations can identify how results on each question have changed for themselves and their peers over time by looking at a single chart.

Note. Historical benchmarking data for 2019 has been revised for the Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts, and Community Trusts benchmarking groups. This is due to a revision in the occupation group weighting to correctly reflect historical benchmarking group changes. Historical data is reweighted each year according to the latest results and so historical figures change with each new year of data; however it is advised to keep the above in mind when viewing historical results released in 2023.

Appendix C: 1. Reviewing People Promise and theme results

Survey Coordination Centre NHS

When analysing People Promise element and theme results, it is easiest to start with the **overview** page to quickly identify areas of interest which can then be compared to the best, average, and worst result in the benchmarking group.

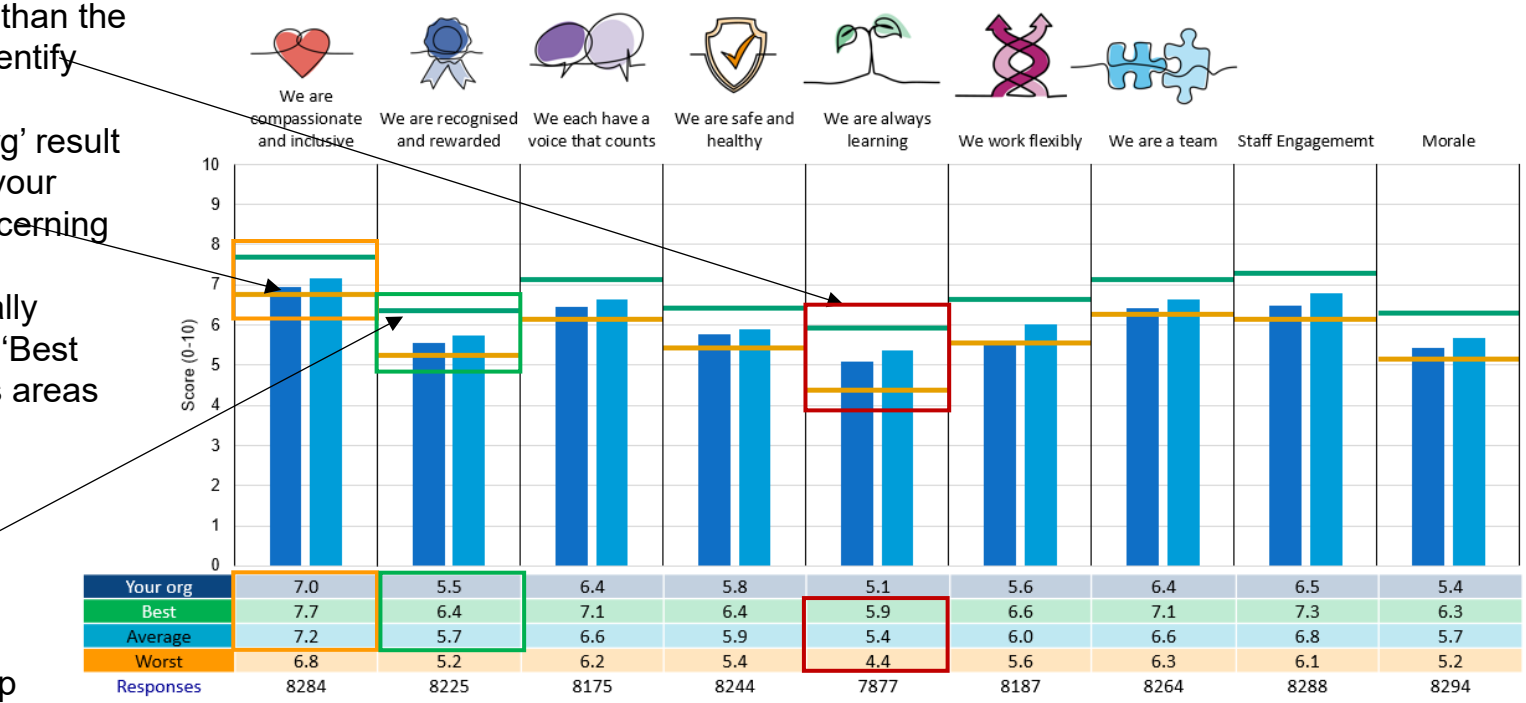
It is important to **consider each result within the range of its benchmarking group 'Best result' and 'Worst result'**, rather than comparing People Promise element and theme results to one another. Comparing organisation results to the benchmarking group average is another important point of reference.

Areas to improve

- By checking where the 'Your org' column/value is lower than the benchmarking group 'Average result' you can quickly identify areas for improvement.
- It is worth looking at the difference between the 'Your org' result and the benchmarking group 'Worst result'. The closer your organisation's result is to the worst result, the more concerning the result.
- Results where your organisation's result is only marginally better than the 'Average result', but still lags behind the 'Best result' by a notable margin, could also be considered as areas for further improvement.

Positive outcomes

- Similarly, using the overview page it is easy to identify People Promise elements and themes which show a positive outcome for your organisation, where 'Your org' results are distinctly higher than the benchmarking group 'Average result'.
- Positive stories to report could be ones where your organisation approaches or matches the benchmarking group's 'Best result'.



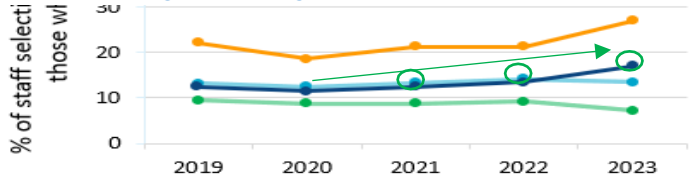
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.0	5.5	6.4	5.8	5.1	5.6	6.4	6.5	5.4
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	8284	8225	8175	8244	7877	8187	8264	8288	8294

Only one example is highlighted for each point

Appendix C: 2. Reviewing results in more detail

Review trend data

Trend data can be used to identify measures which have been consistently improving for your organisation (i.e. showing an upward trend) over the past years and ones which have been declining over time. These charts can **help establish if there is genuine change in the results** (if the results are consistently improving or declining over time), or whether a change between years is just a minor **year-on-year** fluctuation.

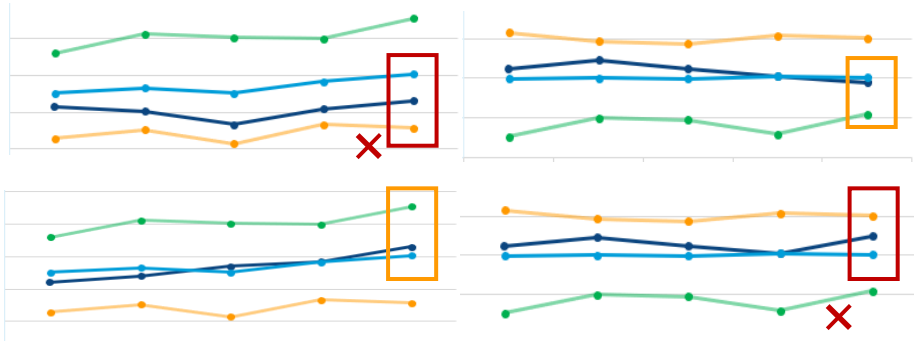


	2019	2020	2021	2022	2023
Your org	12.4%	11.5%	12.5%	13.4%	17.0%
Best result	9.5%	8.7%	8.7%	9.1%	7.3%
Average result	13.2%	12.5%	13.4%	14.1%	13.5%
Worst result	22.2%	18.6%	21.3%	21.4%	27.0%
Responses	1200	1115	1200	1200	592

Benchmarked trend data also allows you to review local changes and benchmark comparisons at the same time, allowing for various types of questions to be considered: e.g. how have the results for my organisation changed over time? Is my organisation improving faster than our peers?

Review the sub-scores and questions feeding into the People Promise elements and themes

In order to understand exactly which factors are driving your organisation's People Promise element and theme results, you should review the sub-scores and questions feeding into these results. The **sub-score results** and the '**Question results**' section contain the sub-scores and questions contributing to each People Promise element and theme, grouped together. By comparing 'Your org' results to the benchmarking group 'Average', 'Best' and 'Worst' results for each question, the **questions which are driving your organisation's People Promise element and theme results can be identified**.
For areas of experience where results need improvement, action plans can be formulated to **focus on the questions where the organisation's results fall between the benchmarking group average and worst results.** Remember to keep an eye out for questions where a lower percentage is a better outcome – such as questions on violence or harassment, bullying and abuse.



✕ = Negative driver, org result falls between average and worst benchmarking group result for question

Appendix C: 3. Reviewing question results

Survey Coordination Centre NHS

This benchmark report displays results for all questions in the questionnaire, including benchmarked trend data wherever available. While this a key feature of the report, at first glance the amount of information contained on more than 140 pages might appear daunting. The below suggestions aim to provide some guidance on how to get started with navigating through this set of data.

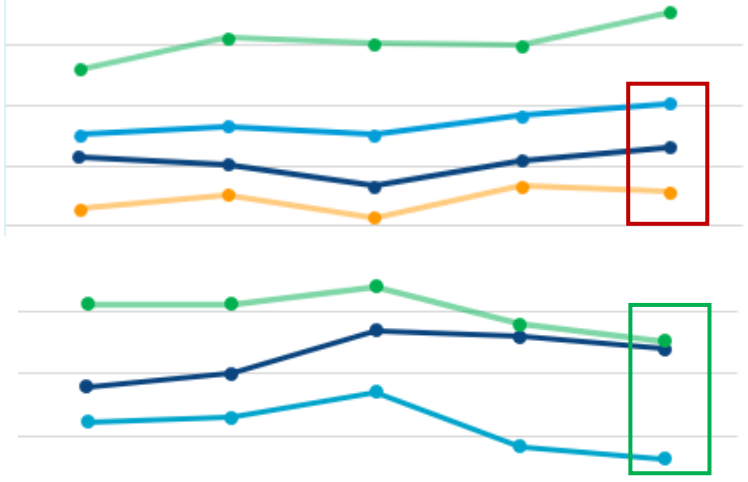
Identifying questions of interest

- **Pre-defined questions of interest – key questions for your organisation**

Most organisations will have questions which have traditionally been a focus for them - questions which have been targeted with internal policies or programmes, or whose results are of heightened importance due to organisation values or because they are considered a proxy for key issues. Outcomes for these questions can be assessed on the backdrop of benchmark and historical trend data.

- **Identifying questions of interest based on the results in this report**

The methods recommended to review your People Promise and theme results can also be applied to pick out question level results of interest. However, **unlike People Promise elements, themes and sub-scores where a higher result always indicates a better result, it is important to keep an eye out for questions where a lower percentage relates to a better outcome** (see details on the 'Using the report' page in the



- **To identify areas of concern:** look for questions where the organisation value falls between the benchmarking group average and the worst result, particularly questions where your organisation result is very close to the worst result. Review changes in the trend data to establish if there has been a decline or stagnation in results across multiple years, but consider the context of how the organisation has performed in comparison to its benchmarking group over this period. A positive trend for a question that is still below the average result can be seen as good progress to build on further in the future.

- **When looking for positive outcomes:** search for results where your organisation is closest to the benchmarking group best result (but remember to consider results for previous years), or ones where there is a clear trend of continued improvement over multiple years.

Survey Coordination Centre

NHS

Appendix D: Additional reporting outputs

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Appendix D: Additional reporting outputs

Survey Coordination Centre NHS

Below are links to other key reporting outputs that complement this report. A full list and more detailed explanation of the reporting outputs is included in the Technical Document.

Supporting documents

Basic Guide: Provides a brief overview of the NHS Staff Survey data and details on what is contained in each of the reporting outputs.

Technical Document: Contains technical details about the NHS Staff Survey data, including: data cleaning, weighting, benchmarking, People Promise, historical comparability of organisations and questions in the survey.

Other reporting outputs

Online Dashboards: Interactive dashboards containing results for all trusts nationally, each participating organisation (local), and for each region and ICS. Results are shown with trend data for up to five years where possible and show the full breakdown of response options for each question.

Breakdown reports: Reports containing People Promise and theme results split by breakdown (locality) for East Kent Hospitals University NHS Foundation Trust.

National Briefing Document: Report containing the national results for the People Promise elements, themes and sub-scores. Results are shown with trend data for up to five years where possible.

Detailed spreadsheets Contain detailed weighted results for all participating organisations, all trusts nationally, and for each region and ICS.

East Kent Hospitals University NHS Foundation Trust

Responding to the NHS Staff Survey

Public Board

4 April 2024

We care

Responding to the NHS Staff Survey

East Kent Hospitals University NHS Foundation Trust

Values, voice & leadership

- Summarising our results & providing overall context
- How we have identified our priorities
- Focusing on values, voice & leadership
- Addressing our challenges at every level of the organisation
- How will this be different, and improvement made & sustained
- Measuring improvement every month.

We care

Summary of 2023 Results

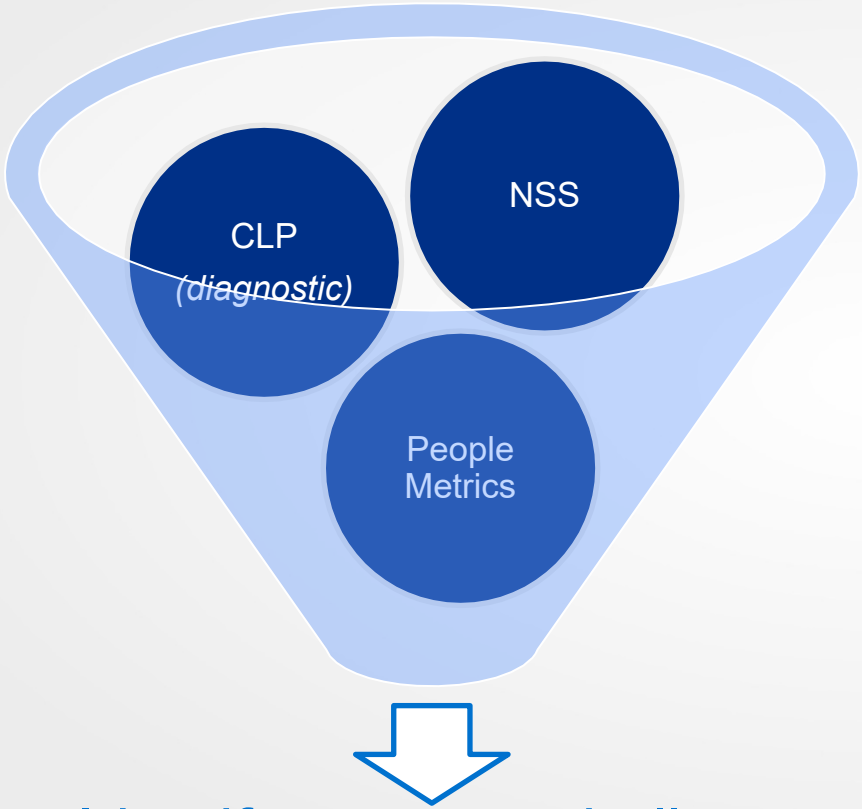
East Kent Hospitals University NHS Foundation Trust

- A minority response rate (41%), below the national average (46%)
- Score significantly **below** the national* average for most questions
- Three of the nine key themes score the lowest of 122 Acute Trusts
- The 3 questions with the biggest gap from the national standards all relate to advocacy (*i.e.* Recommend as a place to work/ be treated & care being our top priority)
- Fewer staff would recommend the Trust as a place to work than at any other Acute Trust
- Our challenges centre around; advocacy, risk and culture
- Compared to the 2022 survey, there were no scores that went down and 26% of scores were marginally higher. However, our scores remain very low compared to other Trusts.

We care

Combining sources of feedback

East Kent Hospitals University NHS Foundation Trust



Identify greatest challenges & action needed

We are using the feedback from the NHS Staff Survey, the Culture and Leadership Programme diagnostic, and other measures such as turnover and sickness absence to understand our greatest challenges and where we need to take action.

We care

Evidence-based priorities

NHS
East Kent Hospitals University
NHS Foundation Trust

Values, voice & leadership

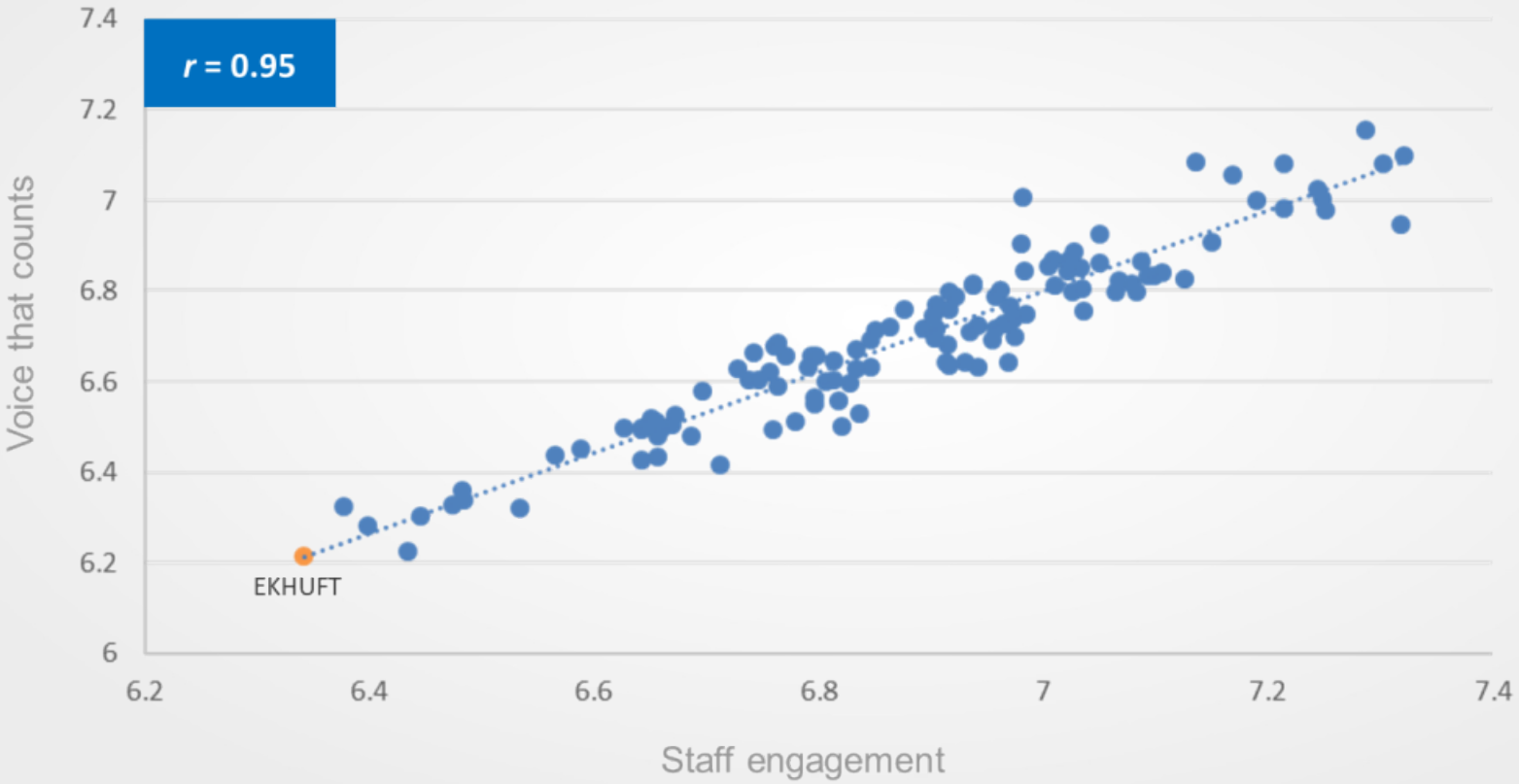
- Feedback from the NHS Staff Survey, Culture & Leadership Programme diagnostic and listening events is that many staff do not feel we are living our values – feeling cared for, safe, respected and making a difference.
- Staff do not feel that care represents our top priority and that the way we behave towards each other does not reflect our values
- Findings from Culture & Leadership Programme diagnostic also reflect that their experience of our values & behaviours varies considerably across teams.

We care

Evidence-based priorities

NHS
East Kent Hospitals University
NHS Foundation Trust

Values, **voice** & leadership



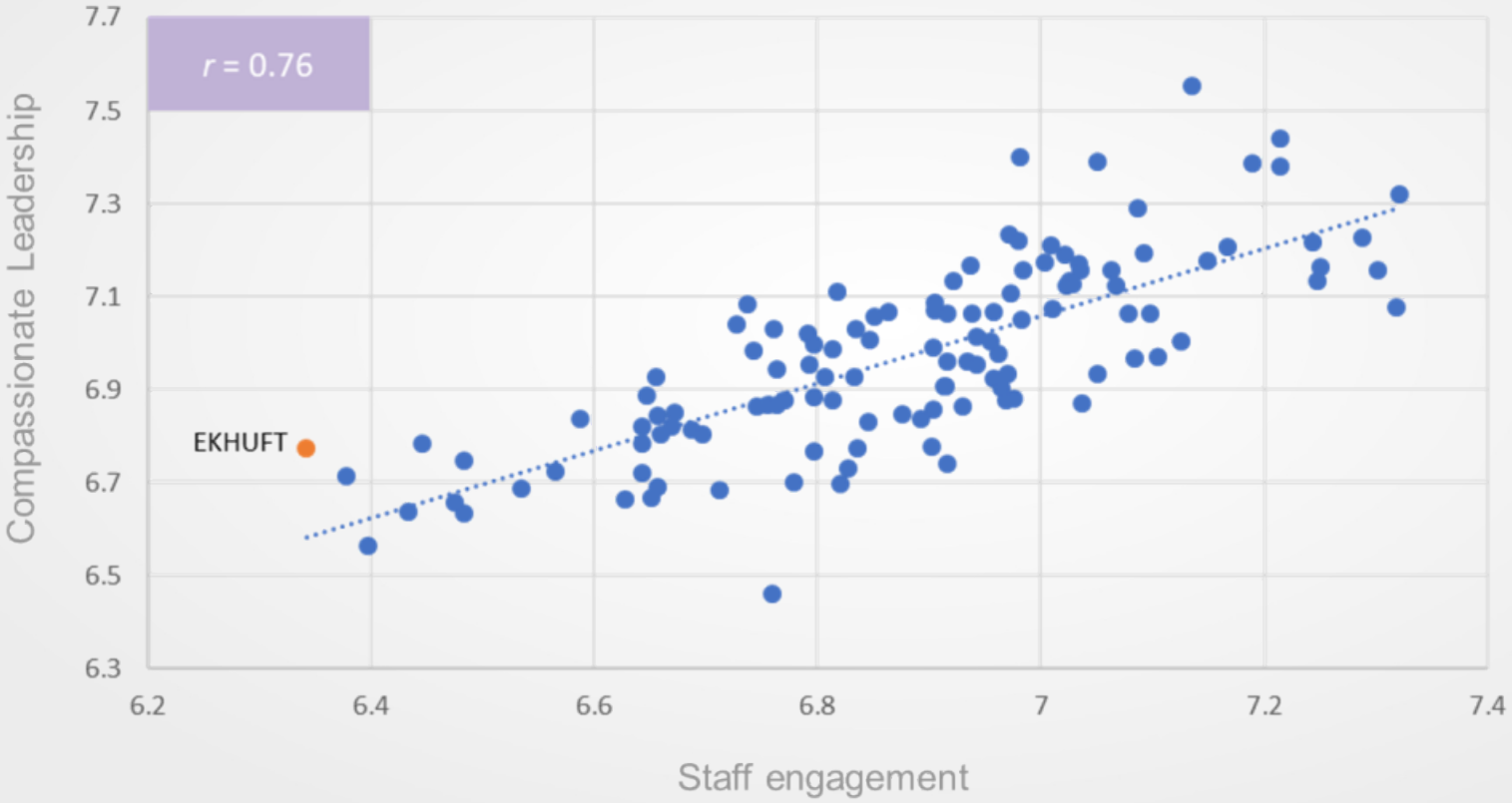
Giving staff a voice and showing that it counts is the single greatest thing we could do to improve staff engagement.

We care

Evidence-based priorities

East Kent Hospitals University NHS Foundation Trust

Values, voice & **leadership**

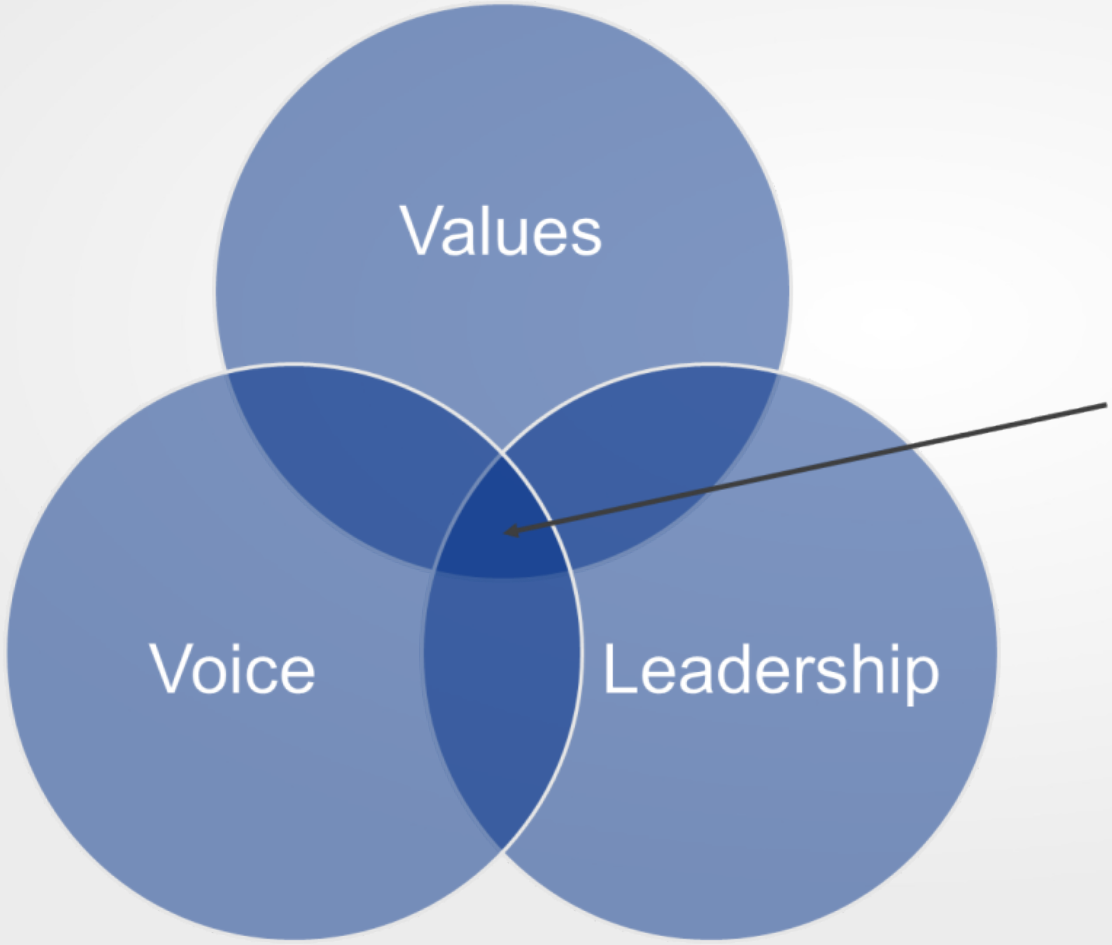


Managers are the single greatest driver of engagement & account for 70% of the variance in team engagement levels

We care

Taking Action: Trust-wide

Programme One: Engagement Programme



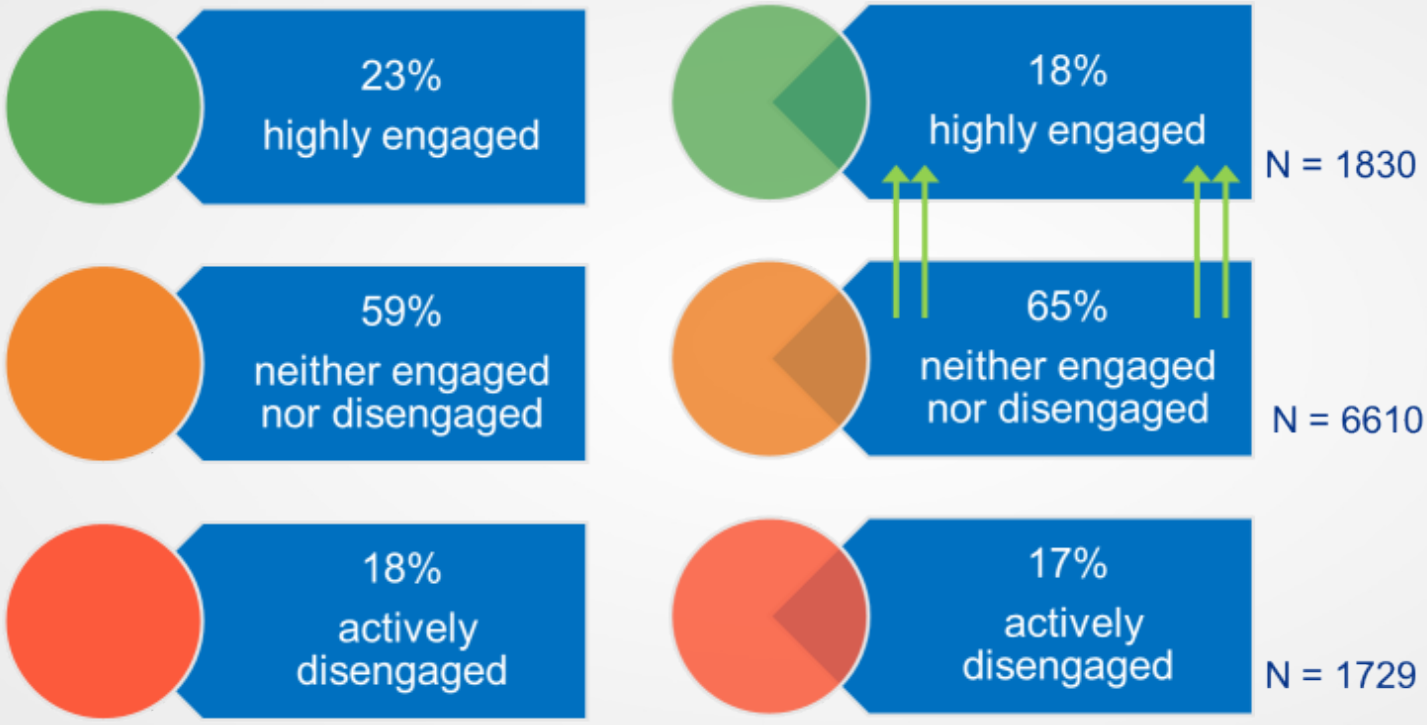
Large-scale engagement programme around living our values and behaviours.

Giving people a **voice**, living our **values** and being compassionate as **leaders** will improve how it feels to work in East Kent.

Taking Action: Targeted Work

East Kent Hospitals University NHS Foundation Trust

Programme Two: Intensive Support



International engagement levels (Gallup*)

EKHUFT engagement levels

- The number of staff (*n*) has been scaled to represent the whole organisation (Headcount: 10,169)

We want to support people to remain highly engaged, to improve engagement in the middle group and understand and address the concerns of those who are actively disengaged.

We care

Taking Action: Reviewing progress

NHS
East Kent Hospitals University
NHS Foundation Trust

Programme Three: Introducing our People Dashboard

- 12 people metrics
- Updated monthly
- All correlated w/ Staff Eng.
- Allow progress tracking
- Feedback – action
- Year-round focus
- Closes loop

People Plans developed at an Organisation & Care Group level will allow for collective focus and action. Critical to their success is them being tracked, monitored and held to **account** against in various forums.

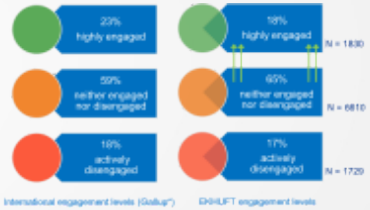
We care

How will this be different?

East Kent Hospitals University NHS Foundation Trust

How will this be different?

- Year-round focus at every level
- Intensive support in specific areas
- Whole organisation approach



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What will be different

East Kent Hospitals University NHS Foundation Trust

- Three clear and simple priorities – values, voice and leadership
- A new, stable leadership team is now in place
- Real-time (monthly) measurement of progress (previously annual)
- Intensive focus / support in specific areas
- Action from Board to Ward – everyone talking about it, all of the time
- Supported by local plans
- Monthly review of progress at Performance Review Meetings, Clinical Executive Management Group and People & Culture Committee
- Regular communication of changes made – 'You said, we did'.

We care

Improving our Response Rate

East Kent Hospitals University NHS Foundation Trust

- Show what we've done as a result of the feedback
- Continually reinforce anonymity & confidentiality
- Encourage take-up with different professional groups
- Highly visible leadership, especially in low-responding areas
- Using a range of communication methods (eg. face-to-face, video)
- Encourage healthy competition.

We care

Improving Staff Engagement

NHS
East Kent
Hospitals University
NHS Foundation Trust

Values, voice & leadership

- Large-scale engagement approach to living our values & behaviours
- Delivered with the support of our Change Ambassadors and Connectors
- Leadership and engagement at every level of the organisation
- Supported by new and existing leadership development programmes and the team engagement and development (TED) tool
- Completing the loop through regular communication of a ‘you said, we did’ feedback loop

We care

Summary

NHS
East Kent
Hospitals University
NHS Foundation Trust

Values, voice & leadership

- The Board recognise the challenges described by our staff
- They can expect to see clear, visible change and compassionate leadership
- We are ambitious for our staff and patients. We need to make quick progress but recognise significant and sustained improvement takes time
- Our first steps centre around listening and improving how it feels to work here
- We want our staff to be proud and confident to recommend the Trust as a place to be treated.

We care

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Staff Experience Story – Freedom to Speak Up (FTSU) Service**

Meeting date: **4 April 2024**

Board sponsor: **Chief People Officer (CPO)**

Paper Author: **Deputy Freedom to Speak Up Guardian**

Appendices:

Appendix 1: Staff Story Checklist
Appendix 2: Case Study

Executive summary:

Action required:	Discussion
Purpose of the Report:	To present to the Board of Directors a colleague's experience of speaking up, with the support of the FTSU Team at EKHUFT.
Summary of key issues:	• A Speciality Doctor in Health Care of Older People (HCOOP) reached out to a FTSU Guardian at Queen Elizabeth the Queen Mother Hospital (QEQM) with issues regarding the behaviour of a colleague. • The impact of their colleague's behaviour was affecting their morale as well as the continuity and quality of care. • The FTSU Guardian worked with the doctor to understand the challenges to speaking up, focusing on locally-led resolutions in line with Trust policies. • The leadership team of HCOOP listened to the concerns, were actively engaged in supporting the doctor to reach a resolution. The actions they took led the doctor to feel that they were committed to making improvements. The matter was concluded satisfactorily and the doctor felt that speaking up had been a worthwhile thing to do.
Key recommendations:	The Board of Directors is asked to **NOTE**: • Speaking up can be a challenging experience for many people. Responsive leaders have a significantly positive impact on the experience of the person speaking up. Psychological safety improves which leads to improvements in patient care and outcomes. • E-learning on speaking up, listening up and following up is mandatory. This training makes clear managers' and leaders' responsibilities when listening up and taking action.

We care

East Kent Hospitals University NHS Foundation Trust

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	N/A
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

Staff Experience Story Checklist

Section A **To be completed by the story sponsor and supplied to the Staff Experience team along with any additional contextual information.**		
Name of person sharing the story: Dr F Yasir (and Freedom To Speak Up (FTSU) Guardian, Queen Elizabeth the Queen Mother Hospital (QEQM)) (contact details to be shared via email to the team: ekhuft.staffexperience@nhs.net) Service the story relates to: Freedom to Speak Up Service Senior sponsor name and email: Head of Staff Experience (robertfordham@nhs.net) Board Sponsor name: Chief People Officer		
Preparation	**Prompt**	**Comments**
Why are we hearing this story?	What sort of story is it?	This is a doctor's experience of speaking up at East Kent Hospitals University Foundation Trust (EKHUFT). Dr Yasir, a doctor in Health Care of Older People (HCOOP) was experiencing challenging behaviour from a colleague. The impact of this behaviour was affecting morale as compromising patient care. The doctor sought support from the FTSU Team and they were then able to raise their concerns to their leadership team. Matters were resolved and the doctor speaking up feels assured that the issues have been addressed.
	Will the story show the organisation or staff negatively?	The story will show the organisation both positively and negatively; negatively because of the impact of poor behaviours on the quality of patient care but positively as the leadership team were responsive and proactively took steps to address and remedy the concerns.
	What actions has the service taken to address the issues raised?	The doctor has been assigned another role to best utilise their skills and experience whilst also protecting their health and wellbeing. The doctor's colleague is being supported to improve their behaviours that have a negative impact on others.
How is this item going to be managed?	Who from the service is going to lead this item and attend the Board meeting?	FTSU Guardian will accompany Dr Yasir.

	What preparation or information will Board members need to ensure their questioning is appropriate?	Dr Yasir is not directly responsible for making the changes and improvements required and they will have limited knowledge of any personnel details or barriers to addressing the concerns. Dr Yasir can speak best to their experience of speaking up and working with the FTSU Team.
What does this story add to our understanding of the quality of our services?	How does this story relate to information in our quality and/or performance reports?	This story relates to information shared in previous FTSU reports to the Board. It provides a recent example of the experience of many staff members who are exposed to poor behaviours. It highlights the impact of poor behaviours on others and the delivery of good quality care. It also reinforces the importance of responsive leaders who can make changes and improvements when they listen and follow up.
	What additional information does the Board require to help put the story in context?	None

Please return completed form to the Staff Experience Team:
ekhuft.staffexperience@nhs.net

24/6.1 – APPENDIX 2

Staff Experience Story – Freedom to Speak Up (FTSU) Service

Case Study

Dr Yasir made contact with her local FTSU Guardian, from the FTSU Team in November 2023 wishing to raise issues regarding one of the consultants that she was directly working with in Health Care Of Older People (HCOOP). Her concerns had been ongoing since prior to the COVID pandemic and all attempts to resolve the issues had not been successful.

Dr Yasir found the behaviour of the consultant to be inappropriate and not in keeping with the Trust values. These behaviours and working practices caused disruption to the continuity and the quality of care given by Dr Yasir and others.

After establishing contact with the FTSU Team, the FTSU Guardian and Dr Yasir created an action plan based on what Dr Yasir wanted to achieve. Regular contact was maintained and the plan was reviewed and adapted as time went on. The FTSU Rox further supported Dr Yasir by recognising what needs she had and signposted her to internal resources such as the Wellbeing and Employee Relations Teams.

Following conversations with the FTSU Guardian, Dr Yasir was able to raise her concerns to the service leadership team. She was able to explain what her concerns were, seek support as well as make suggestions for improvement.

The FTSU Guardian also spent time with the service leadership team, offering insight in to the support available where needed.

Dr Yasir requested an opportunity to work in a different area, which was arranged by the service leadership team. So as not to lose sight of the original concern, some work is being done with the consultant to address any behaviours that are considered counterproductive to the delivery of good care.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **4 April 2024**

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 Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	N/A
Resource:	No
Legal and regulatory:	No

East Kent Hospitals University NHS Foundation Trust

Subsidiary:	No

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

ACTING 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. Chairman's Report

As we move forward into the next financial year, the Trust continues to face considerable pressures. I am pleased, however, to announce that our Trust financial position has sustained positive improvement. As of Month 11, our agency and bank expenditure has continued to fall, alongside our substantive staffing expenditure back to the forecasted amount. As a result, the Trust has delivered on our forecast position, in line with the £117.4m year-end deficit position. This work would not have been possible without the considerable work happening Trust-wide to deliver on our Cost Improvement Programmes (CIPs) which has resulted in £13.1m worth of savings across the Trust. Our target for next year is to deliver a minimum of £49m CIPs and I am pleased to report the Trust is making good progress planning these initiatives.

All of the Board, not least myself, are aware that although this position is a positive improvement, and shows a large enhancement in our grip and control processes, the work ahead of us as we move into 2024/25 continues to be a challenge. A pivotal part of the Trust's work will require close working with partners across the system to deliver a significantly improved financial position in 2024/25. Based on the recent three-month performance, there is cause for optimism that a significant decrease in the trust's deficit could be accomplished in the next financial year.

Alongside our improved financial position, we also have seen a positive improvement in operational performance across the Trust. Firstly, the three-year £30 million expansion project for the emergency departments in Margate and Ashford has successfully finished. I would personally like to thank all of our teams who have worked tirelessly on the works, and our clinical teams who have continued to provide the best care for our patients whilst work was underway. The new expansion provides additional patient bays to both sites, alongside additional features to ensure dignity, privacy and the best environment to receive care for patients.

Although our services continue to receive high utilisation, the length of time patients are waiting to be seen has seen an improvement, although we still have significant progress to make. Our Accident & Emergency (A&E) and Urgent Treatment Centres attended to 24,515 patients in February alone, with 70.8% receiving care within four hours. This is an improved position from 68.5% in January. In March, we are aiming to achieve the national standard of 76%.

Alongside our emergency services, our planned cancer treatment has also seen reductions in waiting times. The Trust had 554 patients awaiting cancer treatment for over 62 days in February. At the time of writing, that number has reduced to 187. Additionally, the number of patients waiting over 104 days has dropped from 105 to 47, which is a significant achievement. Once again, this has not been possible without huge efforts from our onsite clinical teams. Although there is still work to be done, this improvement clearly shows a positive direction for the Trust.

For our wider elective waiting lists, we again are making progress, with a clear focus to clear our 78 week breaches.

Furthermore, I have been fortunate to visit both of our maternity sites at Ashford and Margate this month, which provided me an opportunity to meet the teams on site. The improvements within our maternity services are substantial, with higher patient satisfaction, and the Trust on target to meet all targets as part of the National Maternity and Neonatal Improvement Programme. As a result, we are keen that the hard work into our maternity services does not go unrecognised, and we will be utilising this area of success as a way to show learning across the Trust.

As a clear showcase of the work taking place, I would like to congratulate the Trust's Maternity Bereavement team who received national recognition for the incredibly hard work they undertake across the organisation. Specifically, Dr Jen Essex, who received 'Outstanding Contribution' accolade in the OBGYN of the Year category. Furthermore, Emma Barritt and Amy Barnes, who both work for the Small Steps bereavement team, picked up a 'Special Recognition' and 'Outstanding Contribution' in the Bereavement Midwife of the Year at the at the fifth National Mariposa Bereavement Awards. This is a clear example of how far our maternity services have transformed, and I am glad the team has received recognition for their unbelievably hard work.

Finally, as many would have seen, the national NHS Staff Survey results were published which showed that the Trust still requires a considerable improvement to engage and support our staff. As we all know, staff which are happy at work result in better patient outcomes, and safer care. We know that the number of staff who responded to the survey only accounted for 41% of our workforce, which is a concerning number and one we must actively address to ensure our staff feel that their views should be heard, and importantly, that we are acting on what is said. Unfortunately, the Trust scored below the national average in most of the questions, including staff engagement and advocacy for patients to be treated at the Trust, or recommending somebody to work at East Kent.

In response to the staff survey results, the Executive Team have already begun to undertake a series of regular open-forum listening events across all of our acute sites. There will also be targeted interventions for areas which had specific low uptake. It is clear that change is required for us to improve our staff wellbeing, and the Board is committed to do this.

In addition, a key feature of the Staff Survey results were how our leaders supported staff across the organisation. As a result, we have focused on providing dedicated support and intervention to our managers, which has included the delivery of an externally led full-day masterclass to 250 leaders across all divisions which aimed to understand how a kinder culture leads to safer care, and better outcomes, for our patients. Further in-house leadership development programmes have begun to roll out to all leaders.

Furthermore, we understand that it is important for our staff to feel listened to, and have multiple avenues to speak up should they wish. Our internal Freedom to Speak Up Team (FTSU) have continued to provide additional opportunities for staff to reach out, with additional outreach work including in-person visits to all teams and listening events, with an ever-growing list of connectors across the Trust to support staff in speaking up.

We understand that this is just the first step to support our work force, and there is a significant further way to go to support our staff.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **4 April 2024**

Board sponsor: **Chief Executive**

Paper Author: **Chief Executive**

Appendices:

None

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 Trust Risk Register:	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

East Kent Hospitals University NHS Foundation Trust

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

At meetings of the Clinical Executive Management Group (CEMG) in February and March 2024, the group approved a cost neutral Business Case to re-configure ward arrangements at the Queen Elizabeth the Queen Mother Hospital (QEQM), co-locating specialty services (specifically Gastroenterology, Colorectal and General Surgery), whilst delivering a dedicated discharge lounge, therapy gym and creating an enhanced frailty assessment unit.

The group also approved a proposal to review the Trust's on-call accommodation arrangements and supported the continued role out of Palliative and End of Life Care (PEoLC) beds at the William Harvey Hospital (WHH), whilst approving a Social Finance project that would support the long-term sustainability of the PEoLC beds project and the development of ambulatory care to meet unscheduled care needs and reduce Emergency Department (ED) attendance.

4. Operations update

4.1. Reduced Waiting Times

The length of time patients are waiting to be seen is reducing. As a Trust we have a long way to go, but there has been significant progress.

In February, the Trust had 554 patients awaiting cancer treatment for over 62 days. At the time of writing, that number has reduced to 187. Additionally, the number of patients waiting over 104 days has dropped from 105 to 47, marking a significant achievement.

Since the beginning of January, a huge effort has been made to address the number of patients waiting for an endoscopy across our surveillance, urgent and routine waiting lists. During the last three months the waiting list has reduced by over 2,000 patients with clear plans in place to further reduce the remaining backlog in the coming months. A special thank you is extended to the team for managing additional appointments, including weekends, resulting in the highest patient throughput for the month of March compared to any other month in this financial year. Further improvements are also acknowledged for our patients on the routine colonoscopy

pathway; by the end of March 2024, all 2,037 patients will have undergone a Q-fit test for cancer.

Efforts to mitigate long waiting times for planned treatments have also seen marked improvements. In January, over 2,000 patients were at risk of exceeding the 78-week wait threshold by the end of March 2024; however, collective efforts have substantially reduced this number. The Trust now estimates that by year-end, the number of patients waiting over 78 weeks for planned treatment will be 468. Whilst recognising the progress that has been made, the Trust acknowledges that these long waits for planned treatment fall below the standard of care expected by our patients. Detailed capacity planning and efficiency improvements are underway to ensure that these advancements continue throughout 2024/25 and into future years.

In February, our Accident & Emergency (A&E) and Urgent Treatment Centres (UTCs) attended to 24,515 patients, with 70.8% receiving care within four hours. In March, we are aiming to achieve the national standard of 76%.

As we continue striving for excellence, we remain committed to providing timely, high-quality care to our community. A huge thank you to the teams across the Trust for their ongoing support and dedication.

4.2. Emergency pathway reset - Right patient, right bed, first time

As we approach spring and the new operating year, the Trust has the opportunity to review what we are currently doing and how we work together to manage patient flow throughout our hospitals. At this time, we need a particular focus on reducing the length of time patients need to wait in ED for admission and on reducing corridor care within ED.

To address these challenges, a Trust wide ‘re-set’ of our emergency pathways will commence in late March, working differently to ensure the right patient is in the right bed first time. This will build on the work done so far, and also allow us to start making the most of the opportunities our newly-configured emergency departments can give us.

The re-set will start at QEQM between Monday 25 March and Friday 5 April, and then will roll-out to WHH and Kent & Canterbury Hospital (K&C) throughout April.

As part of the re-set, we will re-launch and embed our professional standards and adopt an agreed approach to board rounds across the Trust, to ensure there is a consistent approach to decision-making for every patient.

4.3. Emergency Departments builds complete

The three-year, £30m expansion of the emergency departments at Margate and Ashford has been completed with the final area, two new resuscitation bays at QEQM, handed over to clinical teams. These additions bring the number of resus bays at QEQM to seven, each equipped with sliding doors to ensure privacy, dignity, and to reduce the risk of infections spreading. Additionally, there is a new rapid assessment and treatment unit, dedicated mental health facilities, a new children’s

emergency department, a new entrance and waiting area, a treatment area for adults, and a relatives' room.

At the William Harvey Hospital, there is a large new ambulance entrance, nine resuscitation bays, dedicated areas for patients with mental health needs, and 12 rapid assessment and treatment bays. The expansion has also led to the creation of a new children's area and a new treatment area for adults.

5. Financial performance and 2024/ 2025 Business Planning/ outlook

Further improvement of the Trust's financial position was seen in Month 11, with agency expenditure continuing to fall, whilst substantive staffing spend also fell back in month (following the non-recurrent impact of January's industrial action falling away). As a result, we have delivered our forecast position, in line with the £117.4m year-end deficit agreed with the national team at the meeting on 19 January 2024.

Income continues to be ahead of forecast, reflecting improved operational performance and allowing more patients to receive care at our hospitals. Inevitably this additional activity has incurred more cost, and so the non-pay position compared to forecast is overspent.

The in-month position also saw the recognition at a group level of the back-pay agreement 2gether Support Solutions has reached with its staff. Whilst this was recognised in the month 11 financial position, our forecast expected this cost to be incurred in March (month 12). The fact that the group remained on track despite the earlier recognition, talks to the underlying improvement that has been seen across the Trust.

Looking forward and into 2024/25, we continue to work with partners across the system to deliver a significantly improved financial position. Given the performance over the last three months, there is reason to be hopeful that a material reduction in the size of the Trust's deficit can be realised in the new financial year.

6. Workforce Savings Scheme consultation – Admin and Clerical Review

A 30-day collective consultation process to review the Trust's Administration and Clerical Support Structure was launched on 22 February 2024 and ended on 22 March 2024, with the aim to redeploy as many staff into suitable alternative roles as possible and avoid redundancies.

This review follows the consultation held last year to realign and reorganise services into six new Care Groups and will provide uniformity in structure, consistency in roles, a holistic view across teams of the Trust's administrative functions and will support the work that is being done to improve the Trust's financial position by ensuing the best use of our people and resources.

7. Annual Staff Survey

The 2023 NHS Staff Survey took place between 18 September - 24 November 2023. A total of 9,751 eligible employees were invited to complete this and over 4,000 people responded, which represents a response rate of 41% which has fallen for a second consecutive year, from 44% in 2022 and 51% in 2021. This is indicative of a level of staff engagement.

A summary of the headlines emerging from the 2023 NHS Staff Survey are provided below:

- The Trust currently scores below the national average in 87% of questions
- The Trust scores the lowest of all 122 Acute Trusts in three of the nine key domains, this includes staff engagement, where the Trust scored 6.34 / 10
- The three questions with the biggest gap from the national standard all relate to advocacy (i.e. recommend as a place to work/ be treated & care being our top priority)
- Challenges centre around; advocacy, risk and culture with fewer staff who would recommend the organisation as a place to work/ be treated than at any other Acute Trust.

These results will be taken alongside the findings from the discovery phase of the Culture and Leadership Programme (CLP) and our wider people metrics (i.e. turnover, sickness absence) allowing us to identify our greatest challenges and where we need to act.

It is necessary for a materially different approach to be taken to that of previous years given the stark reality of these results and the current experience of our staff. This has begun with the launch of a series of Executive led listening events that have been held across the Trust.

This must however be a year-round focus at every level of the organisation to improve the experience and wellbeing of staff across the Trust and to start intensively immediately.

8. Asceptic Unit for pharmacy

On 12 March 2024 an inspection of the Trust's sterile unit for chemotherapy synthesis, within Pharmacy, was undertaken by the London and South East regional Quality Assurance for Specialist Pharmacy services team.

The inspection found three critical and eight major concerns and made a number of recommendations in relation to these. As a consequence, work has been undertaken on the roof of the unit, and internal work to make good the damage that was highlights by the inspection has also been complete, however the unit itself is old and increasingly unfit for purpose.

Refurbishment would require significant downtime (12 - 18 months) and come at significant cost with estimates between £2m - 3m and would only extend the unit two – three years. Outsourcing chemotherapy during that time, or as a long-term solution is costly and the medications have short use by times, meaning many preparations are wasted. A new build would be more expensive, but would support delivery to the revised national standards.

Audit has suggested that the increase in demand for chemotherapy is being met by the unit at EKHUFT regularly working above maximum capacity.

A detailed response to the London and South East Regional Quality Assurance for Specialist Pharmacy services inspectors and an options paper for the Board are being produced by the Care Group and the Chief Medical Officer to meet the inspector's timelines.

9. Association for Perioperative Practice (AfPP) Peer Review

Following the identification of an increased incidence of Surgical Site Infections (SSI) within the Orthopaedic Services and the occurrence of four Never Events between quarter 2 and quarter 3 of 2023, the Trust commissioned the Association for Perioperative Practice (AfPP) to undertake a peer review of the Operating Departments at the QEQM, William Harvey and Kent and Canterbury Hospitals.

These reviews were held between 9 – 26 January 2024 to provide the team with a framework to examine service performance and to identify potential improvements in line with AfPP standards and recommendations.

A detailed report of this review, including immediate recommendations was received on 16 February 2024, with good practice including excellent leadership, the use of five steps and a clear/ concise team brief noted.

The relevant Care Groups have begun to develop their improvement plans which will include the identification of surgical safety checklist champions and the development of an operational policy reflective of theatre practices and processes.

10. National Clinical Impact Award - Consultant Gastroenterologist Dr Zach Tsiamoulos

Congratulations to consultant gastroenterologist Dr Zach Tsiamoulos, who has been granted one of only 600 National Clinical Impact Awards across England and Wales, that are designed to recognise clinicians who lead the way in the provision and improvement of patient care, demonstrating national impact by going above and beyond their roles.

11. Recovery Support Programme (RSP) and support from NHSE

Mark Blakeman has joined the Trust as part of the national RSP team from NHS England and will continue the work started by Moira Durbridge and support the delivery of the Integrated Improvement Plan (IIP).

12. Executive Team update

I am delighted to announce the appointment of Rob Hodgkiss as the Trust's substantive Chief Operating Officer; Rob has more than 30 years' experience in the NHS, starting his career working as a healthcare assistant before moving on to various junior, middle and senior management roles across London and the Midlands, before taking up his most recent role as Chief Operating Officer and Deputy Chief Executive at the Chelsea and Westminster Hospital in 2016.

I would also like to take this opportunity to advise the Board of the appointment of Khaleel Desai as the Trust's Director of Corporate Governance. Khaleel will join the Trust on Monday 29 April 2024.

13. 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: **4 April 2024**

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

Paper Author: **Chief Strategy & Partnerships Officer**

Appendices:

APPENDIX 1: February 2024 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 and a revised format with a wider view of metrics is presented for the September board meeting. 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 (February Reported Month): **Patients** • All type Emergency Department (ED) performance is improved at 70.8%. • Type 1 ED performance also improved on previous months at 45.1%. • Cancer 28 Faster Diagnosis Standard (FDS) recovered its position to achieve 68.4% in month. • Diagnostics performance increased significantly to 61.6% due to improved waiting times in diagnostic imaging. **Quality & Safety** • 11 Serious Incidents (SIs) declared in the month. • Zero never event reported in February. • The number of overdue incidents reduced further by 1,323. • Hospital Standardised Mortality Ratio (HSMR) remains below 100 and appears to have plateaued at an index figure of around 90. **People** • Sickness absence has reduced back under the 5% threshold in month at 4.8%. • Vacancy rate remains below the 10% threshold at 8.4%. • Staff turnover remains in line with the previous month at 9.2% and has now sat below the national standard (10%) for over a year. • Staff engagement score has dropped to 6.13. • Completed medical job plans remains below the target at 70.5% but continues on its improving trajectory. • Appraisal rates remain around 73%. **Sustainability** • The financial position Year to Date (YTD) is £38.8m away from a plan of £66.5m, with a total deficit YTD of £105.2m. • The Trust recognised recurrent savings of £0.1m in February, and £3.2m on a YTD basis. • Schemes relating to income are delivering, with £0.6m in month, and forecast £5.4m (Clinical £2.2m Non-clinical £3.2) for Financial Year (FY) 2023/24. The current value of the pipeline is £13.1m • Premium pay remains below the mean of the 24 month period for the sixth consecutive month. **Maternity** • Zero SIs declared in the month of February 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 93.2% for the month.
Key recommendations:	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the metrics reported in the Integrated Performance Report

East Kent Hospitals University NHS Foundation Trust

Implications:

Links to Strategic Theme:	• Patients • People • Sustainability • Quality and Safety
Link to the Trust Risk Register:	**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

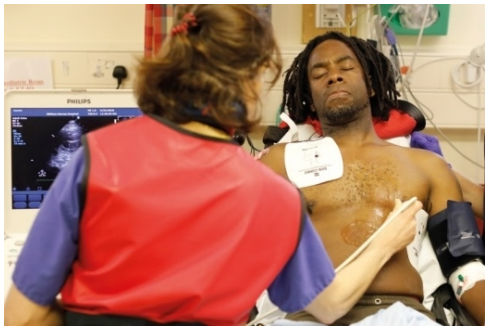
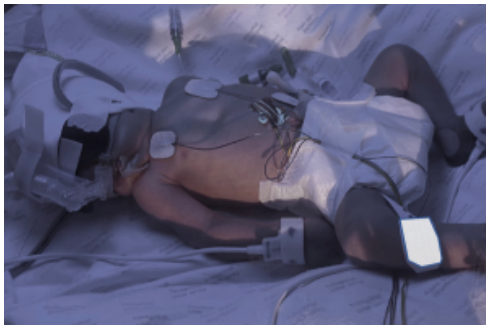
Integrated Performance Report

February 2024







Patients

Operational Performance

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Operational Performance	IIP		ED Compliance		73.0%	67.1%	70.7%	71.7%	73.2%	74.3%	71.9%	70.7%	70.6%	70.3%	69.0%	68.8%	70.8%
	IIP		Type 1 Compliance 4hrs		55.0%	39.1%	44.0%	45.1%	48.1%	51.6%	46.5%	45.5%	45.8%	45.2%	43.5%	42.9%	45.1%
	IIP		12 Hr Total Time in Department		7.0%	12.4%	10.4%	10.5%	9.6%	8.7%	9.7%	10.2%	10.7%	10.4%	11.4%	11.1%	10.2%
	IIP		12Hr Trolley Waits (MTD unvalidated)		0	1,189	989	1,136	929	769	908	867	1,079	1,168	1,260	1,368	1,111
	IIP		Ambulance Handovers within 30m		95.0%	80.5%	86.0%	86.2%	90.4%	91.8%	89.7%	90.0%	90.3%	88.7%	89.4%	89.4%	88.2%
	IIP		Super Stranded >21D		107	296	280	272	260	246	241	245	235	260	244	243	229
	IIP		Not Fit to Reside (pats/day)		100.0	232.8	226.1	213.4	218.5	192.3	193.0	199.8	193.5	207.0	176.7	184.6	166.5
	IIP		Cancer 28d Combined Performance		75.0%	65.6%	62.3%	61.8%	64.7%	63.2%	60.5%	59.5%	63.6%	62.3%	68.6%	57.7%	68.4%
	IIP		Cancer Over 62d on PTL		67	182	324	308	325	313	327	403	366	308	404	415	243
	IIP		Cancer Over 104d on PTL		0	45	41	61	59	63	67	77	83	67	65	82	62
	IIP		RTT 78w Breaches		Traj.	2,997	3,027	3,608	3,907	4,575	4,767	5,113	5,966	6,194	6,459	6,912	6,691
	IIP		RTT 65w Breaches		0	707	766	984	1,023	1,148	1,292	1,499	1,900	1,942	2,360	2,698	2,695
	IIP		RTT 78w Breaches		0	86	91	156	135	127	145	233	325	435	643	752	653
	IIP		DM01 Compliance		75.0%	60.3%	56.3%	58.6%	59.0%	55.9%	53.6%	54.1%	60.7%	59.1%	55.8%	54.2%	61.6%

February Performance Summary

Emergency Department: February saw an improvement in compliance against the key ED access targets. The number of patients waiting in the department for a DTA within 1 hour has improved month on month, as well as a reduction in time in the department >12 hours. An improvement in flow through the hospital supported by a reduction in the number of patients not meeting the criteria to reside and a reduction in super stranded patients has supported this improvement. Further work continues to reduce delays through a focused reset programme during March/April across the sites and relaunch of the reducing length of stay programme.

Cancer: FDS performance showing a significant improvement to 68.4% in February due to a targeted focus within Skin, Gynae, H&N and Urology. The number of patients waiting over 62 has seen a significant reduction to 243 from 415 in January and those waiting over 104 has decreased to 62 from 82. The highest contributing factors remain within Urology where a targeted support structure has been put into place to complete a full review of pathway management. Monthly Cancer Boards are now in place & Trust wide weekly assurance is now well embedded with a clear remedial action plans agreed for Urology.

Diagnostics: February has seen a strong improvement in the DMO1 performance due to a significant reduction in CT vetting backlog (CT compliance at 84.5%), an overall reduction of 521 Endoscopies from the backlog over February. Some further highlights are the Cardiac CT performance (33 to 52%) due to the continued focus and DEXA up to 47% from 36% as the second scanner has come online at CDC. Targeted work on validation & use of internal capacity within Endoscopy continues so further improvements are expected in March.

Referral to Treatment Waiting Times: The trust is forecasting a maximum of 651 78+ week breaches at end of March and is currently ahead of trajectory but noting March includes a bank holiday period and teams are continuing to manage the capacity lost at QEQM due to essential theatre works. There is a clear trust-wide focus on the clearance of this backlog through the weekly access meeting chaired by the COO. The remaining risks relate to Otology and a specific tubing shortage for FESS procedures (ENT) to which remedial action plans are in place.

Type 1 Emergency Department 4h Compliance

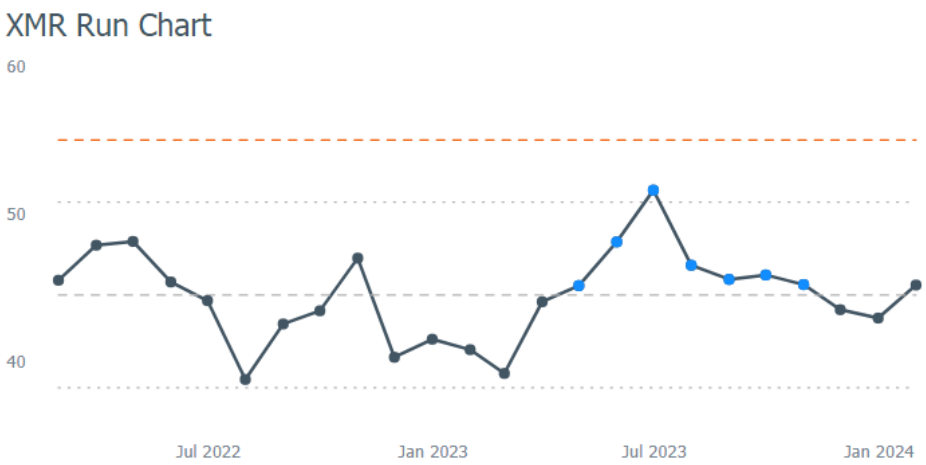
Integrated Improvement Plan

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
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%	
Jan-24	42.9%	
Feb-24	45.1%	



Understanding the most recent data point

Performance

45.1% — 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
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	• April 24 • April 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 in place • ED Internal professional standards drafted and to be tested through Trust wide roll out
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	• April 24 • Jan 24 • Feb 24	• Draft IPS reviewed for roll out as part of reset week. 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

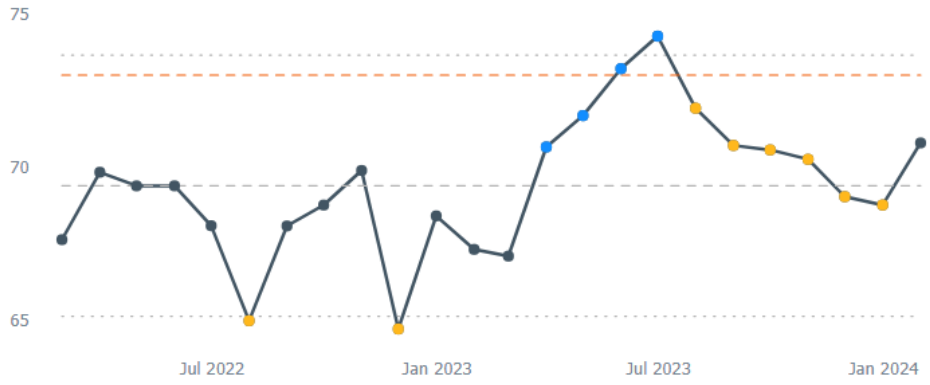
East Kent Hospitals University NHS Foundation Trust

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
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%	
Jan-24	68.8%	
Feb-24	70.8%	

XMR Run Chart



Understanding the most recent data point

Performance

70.8%

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
Lack of timely access to UTC pathways and direct access from the front door. Requirement for direct access pathways for 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 completed • 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 & 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	• SDEC review to maximise opportunities supported by NHSE/I delivered 21st March 2024 • CAU pathway development to be progressed at QEQM and pilot completed September with a improvement plan in place across WHH/QEQM to enhance pathway & utilisation of CAU
Safety of the ED when in overcapacity | Review new models in place with external guidance on plans to improve ambulance 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

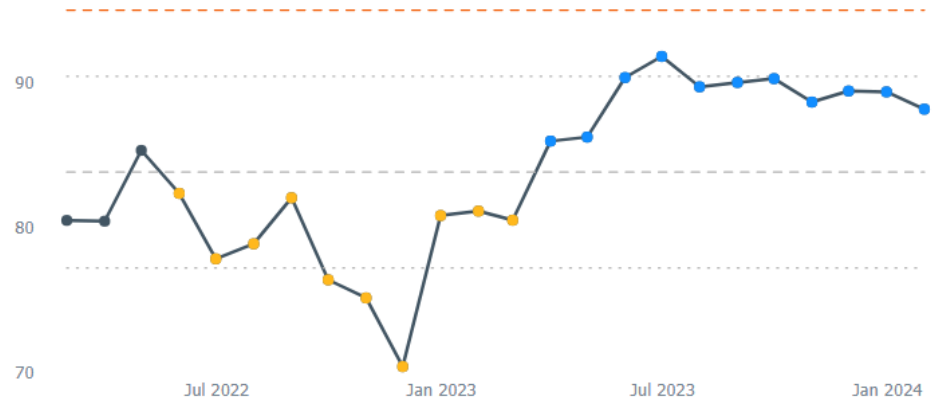
East Kent Hospitals University NHS Foundation Trust

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
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%	
Dec-23	89.4%	
Jan-24	89.4%	
Feb-24	88.2%	

XMR Run Chart



Understanding the most recent data point

Performance

88.2% — 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

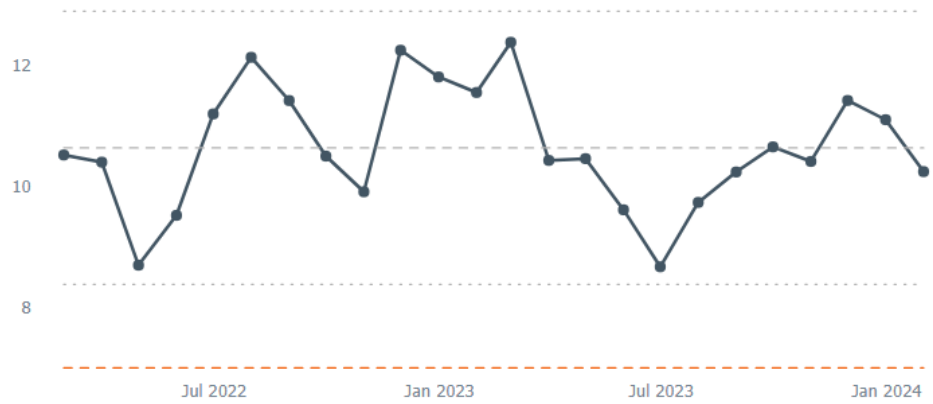
East Kent Hospitals University NHS Foundation Trust

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
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%	
Jan-24	11.1%	
Feb-24	10.2%	

XMR Run Chart



Understanding the most recent data point

Performance

10.2%

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; commenced Jan 24 • Setting up of a UEC weekly forum chaired by COO – Feb 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 on 5 medical wards – with focus at QEQM by Prism • Trustwide discharge Task Forces to focus on internal delays • From February 2024 and refocus of Trust wide Reducing LOS programme
Use of corridor to manage high numbers of pts in ED	• Implement SAFER Bundles • Protection of the DAP pathways & assessment units • Increase UTC/SDEC activity • Increase capacity – bed head service review • Review internal triggers aligned to OPEL Framework, work with HCP on system response	• COO/CNO • Clinical lead/MDs /Head of Ops	• On going • Nov 23 • Sep 2023 for 3 mth	• 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 • 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/QEQM	• 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

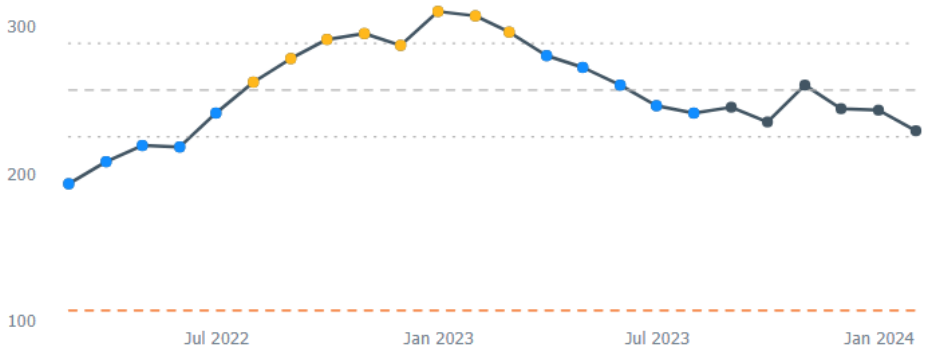
East Kent Hospitals University NHS Foundation Trust

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
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	
Jan-24	243	
Feb-24	229	

XMR Run Chart



Understanding the most recent data point

Performance

229 — 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	• March 24	• SAFER Board Round Bundle – phased roll out across 2 sites – K&C requires refocus and relaunch • Stranded reviews – weekly to be established across all sites with clear escalation plans internally and externally to remove all barriers
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

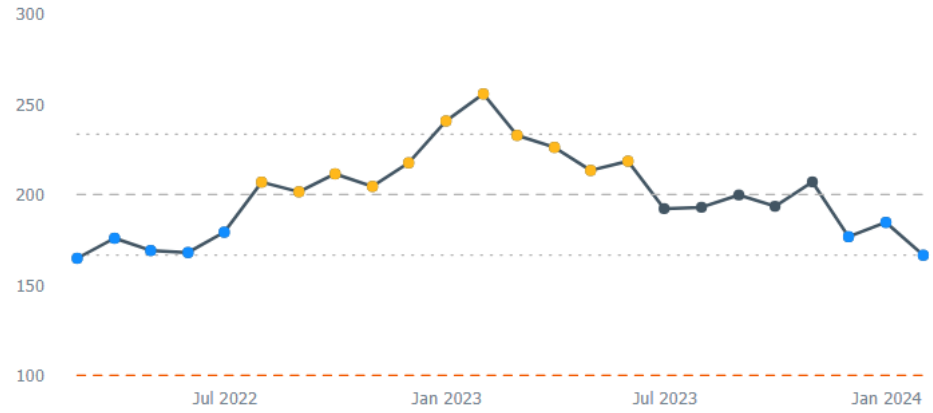
East Kent Hospitals University NHS Foundation Trust

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
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	
Jan-24	184.6	
Feb-24	166.5	

XMR Run Chart



Understanding the most recent data point

Performance

166.5 — Variation indicates consistently falling short of the target

Variation

Variation	Special cause of improving nature or lower 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
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	• April 24	• SAFER Board Round Bundle roll out across the Trust - programme of roll in place- QEQM complete through Prism, WHH 5 medical wards, K&C – tbc • Focus on weekly stranded reviews and escalation across all sites in development – tests of change commenced in Feb at WHH and QEQM
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

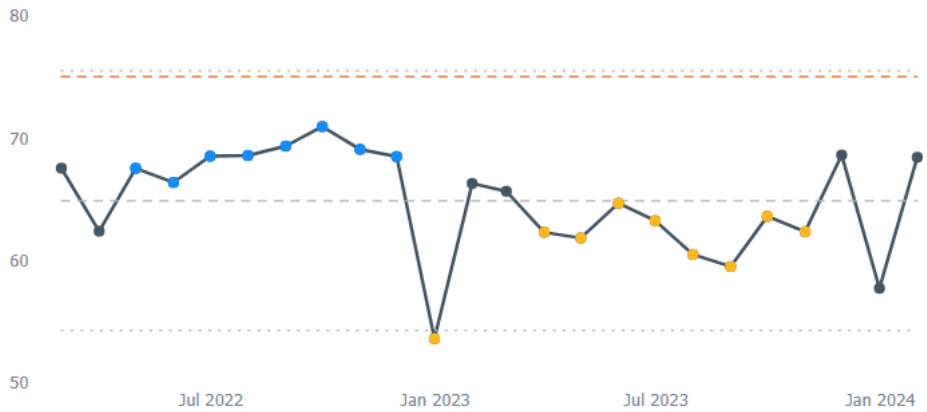
Integrated Improvement Plan

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
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	68.6%	
Jan-24	57.7%	
Feb-24	68.4%	



Understanding the most recent data point

Performance

68.4% — 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
Diagnostic reporting for CT's & MRI's	Reduce referral to reporting to 10 days for CT and MRI Pilot of protected MRI slots for Urology	• Head of Imaging	• Ongoing • Apr 2024	• Improved escalation process now in place and formal escalations also made at weekly Access meeting. • Programme Manager for Urology working with Imaging teams to trial weekly blocks of MRI slots to review impact on 28 day performance.
Endoscopy demand challenges affecting ability to treat cancer patients within 10 days of referral.	qFIT process to be consistently applied and sustained to reduce demand. To reduce waiting time to Scope to 10 days for 2ww patients via enhanced capacity	• Endoscopy Recovery Lead • Endoscopy Recovery Lead	• Apr 2024 • Mar 2024	• Task and finish group well established that includes actions for Endoscopy recovery. • Revised protocol for Lower GI referrals with alternative pathways to Colonoscopy in draft to be implemented in April with clinician engagement. This includes the referral form to include qFIT result. • Full root and branch review of existing booking processes underway and to include consolidation of waiting list codes, review of booking utilisation rates and overall structure of administrative teams to support service delivery.
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	• Ongoing	• Updates on progress circulated to teams 3 times a week to support improvement • Significant improvement within all tumour groups seen with targeted work still required within Lower GI.

Cancer Patients >62d on PTL

Integrated Improvement Plan

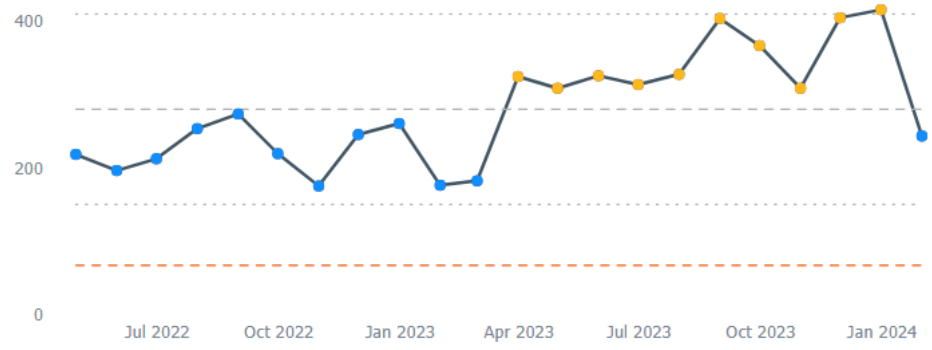
East Kent Hospitals University NHS Foundation Trust

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
Mar-23	182	
Apr-23	324	
May-23	308	
Jun-23	325	
Jul-23	313	
Aug-23	327	
Sep-23	403	
Oct-23	366	
Nov-23	308	
Dec-23	404	
Jan-24	415	
Feb-24	243	

XMR Run Chart



Understanding the most recent data point

Performance

243 — Variation indicates consistently falling short of the target

Variation

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

Flags — Outside Moving Range Limit; 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	• Feb 2024	• Radiology Improvement plan in place awaiting new interventionalists to start • Ultrasound guided biopsy waiting times decreased significantly
Delays with radiology vetting, booking and reporting adding weeks to suspected cancer patient pathway	• Targeted waiting lists and prioritisation	• Head of Imaging	• Feb 2024	• Backlog included in weekly feeder pack, for update and discussion at Performance meetings and Access meetings to ensure weekly improvement • Additional improvement funding of £345K secured from NHSE to support improvement • Dramatic improvements seen in vetting backlogs, to ensure this oversight becomes BAU.
Challenges with access to Histopathology within 10 day turnaround time.	• Review of unnecessary referrals into Histopath. • Streamlining of MDT's to enhance Histopath capacity. • Active recruitment drive – albeit national shortages recognised.	• FDS Lead Clinician • Associate MD • Associate MD	• Q1 2024 • Q1 2024 • Ongoing	• 2ww Transformation Group established • ICB supporting with the development of this service • Ongoing support in place.

Cancer Patients >104d on PTL

Integrated Improvement Plan

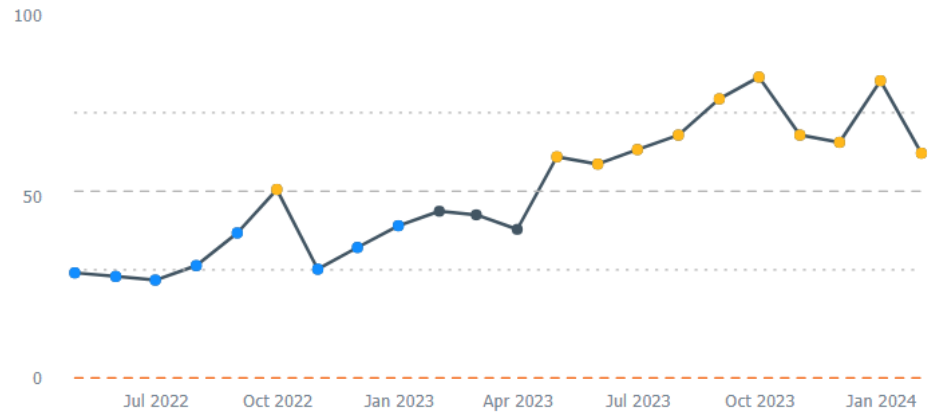
East Kent Hospitals University NHS Foundation Trust

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
Mar-23	45	
Apr-23	41	
May-23	61	
Jun-23	59	
Jul-23	63	
Aug-23	67	
Sep-23	77	
Oct-23	83	
Nov-23	67	
Dec-23	65	
Jan-24	82	
Feb-24	62	

XMR Run Chart



Understanding the most recent data point

Performance

62 — 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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Urology Surgical capacity and high levels of breaches	Increase surgical capacity by better utilisation of mutual aid with MFT for RALP and Cystectomy.	• MD • AMD and MD K&C • Programme Support	• Immediate	• Pathways reviewed with Medway. • Reviewing options for out of area referrals and nurse led triage prior to issuing for mutual aid. • Additional weekend capacity in place to support longer waiting patients.
Urology backlog of Outpatient Clinics	STT nurses to be recruited and to support review of patients overdue ASAP	• Cancer Manager	• Immediate	• STT nurses in post and working to support existing backlogs.
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 Team	• Feb 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 • Early escalation to Cancer CNS's to support patients • Additional patient oversight and support being offered by Cancer support workers

Diagnostic Waiting Times: DM01

Integrated Improvement Plan

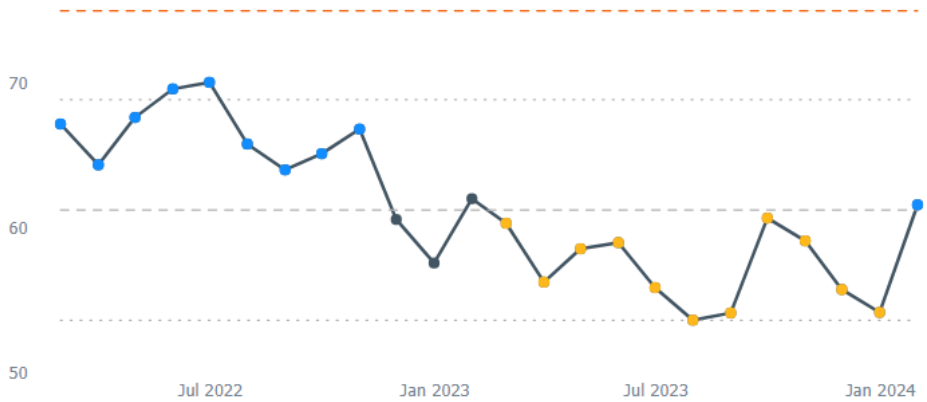
East Kent Hospitals University NHS Foundation Trust

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
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%	
Jan-24	54.2%	
Feb-24	61.6%	

XMR Run Chart



Understanding the most recent data point

Performance

61.6% — Variation indicates consistently falling short of the target

Variation

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

Flags — Two Out Of Three Beyond Two Sigma Group

KEY ISSUE(S)	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
CT issues; • CT Cardiac • CT Vetting	• Cardiac | Clearance of backlog • Vetting | Clearance of backlog	• Head of Imaging • Head of Imaging	• Q2 2024 • Ongoing	• CT Cardiac beaches much improved once more - reduced again now to 130 breaches and 52% compliance with clear trajectory to compliance by Q2 2024. • Vetting numbers continue to be a challenge but have seen a big improvement now down to 643 breaches from a peak of 3,599.
MRI scanning capacity	• Development of improvement plan for MRI	• Business Manager	• April 2024 • Oct 2024	• MRI compliance up to 66.14% but impacted by prolonged scanner downtime. Extended capacity now in place at Estuary View until the end of March. • ICB funded additional scanner for installation in Autumn 2024.
Dexa Backlog	• Increase Scanner activity to reduce backlog	• Head of Imaging	• April 24	• New Dexa scanner now operational at CDC • Overall compliance up to 47.4% from 35.8% last month.

Referral to Treatment Waiting Times: 78w Waits

Integrated Improvement Plan

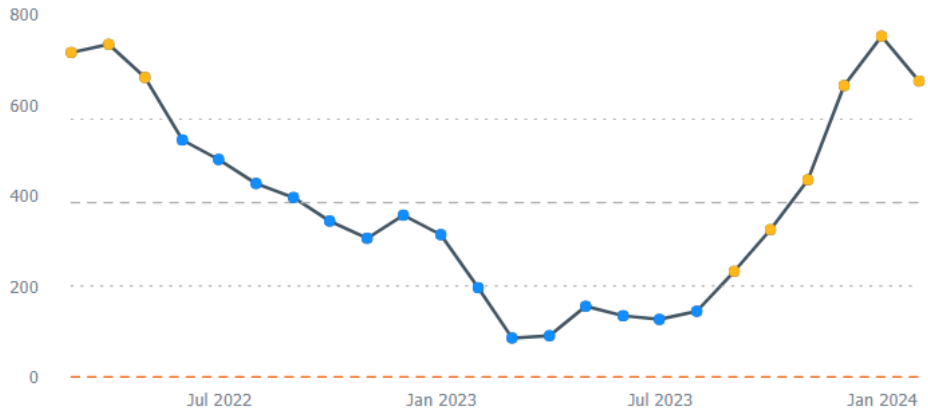
East Kent Hospitals University NHS Foundation Trust

This metric measures the number of RTT reportable patients waiting in excess of 78 weeks to start treatment.

RTT 78w Breaches

Timescale	Value	SPC
Mar-23	86	
Apr-23	91	
May-23	156	
Jun-23	135	
Jul-23	127	
Aug-23	145	
Sep-23	233	
Oct-23	325	
Nov-23	435	
Dec-23	643	
Jan-24	752	
Feb-24	653	

XMR Run Chart



Understanding the most recent data point

Performance

653

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; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
78 week clearance by year-end	• Targeted funds to clear all 78 week risks managed through weekly access meeting	• MD's	• Mar 2024	• Recognised challenges within Otology & FESS. 176 breaches to continue into Q1 for clearance once FESS equipment arrives.
	• Significant workstreams in place across all Care Groups to focus on clearance to include WLI's, insourcing & validation.	• DCOO	• Mar 2024	• IS capacity in place with 41 patients sent to KIMs to date. • Forecast position of 651 by year end from current position achievable.
Outstanding patients to be validated.	• MBI brought in to validate 13,446 DM01 patients > 6 weeks and 12,441 RTT validations targeted to longer waiters in all specialities.	• DCOO	• Feb 2024	• Team commenced onsite from 19th February and all patients > 52 weeks fully validated by end of March so ahead of plans.
	• Specialities and IS team to validate all long waiters.	• Care Groups	• Mar 2024	• All patients > 78 weeks fully validated.

Referral to Treatment Waiting Times: 65w Waits

Integrated Improvement Plan

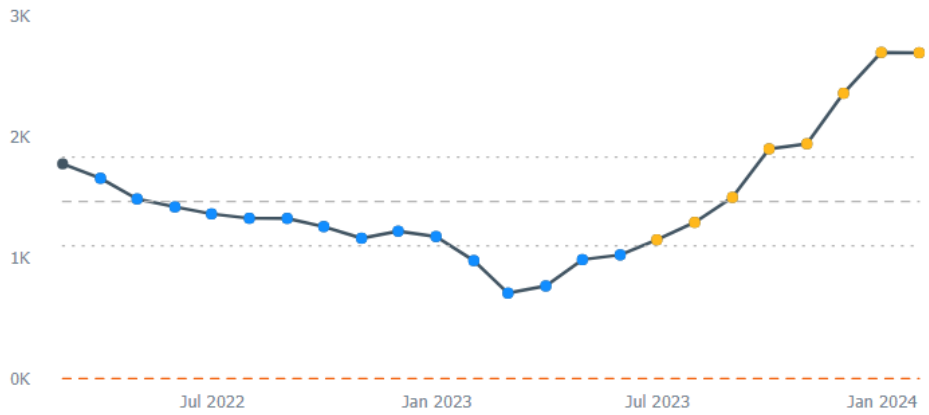
East Kent Hospitals University NHS Foundation Trust

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
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	
Jan-24	2,698	
Feb-24	2,695	

XMR Run Chart



Understanding the most recent data point

Performance

2,695

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 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 Care Groups focussed on recovery actions (65 week risk cohort & specialities with long 1st apt waits)	• COO	• Ongoing	• Focus on 65 week cohort patients • Key focus to include FESS backlog, Otology & Gastro 1st OPA.
Endoscopy delays – impacting ability to scope routine (longer waiting RTT patients) creating significant increase in 65 week breaches	• Endoscopy Insourcing in place. • Endoscopy Lead in place to enhance booking utilisation.	• Care Groups • Lead	• Ongoing • Q1 2024	• Weekly oversight in place via Endoscopy Recovery Group.
Business Planning to be completed to identify how 65 week position will be cleared in 2024/25	• First draft business plans completed and IS capacity to be confirmed to support agreed clearance plan for 2024/25.	• COO	• Apr 2024	• In hand and on track for delivery.

Cancer Performance

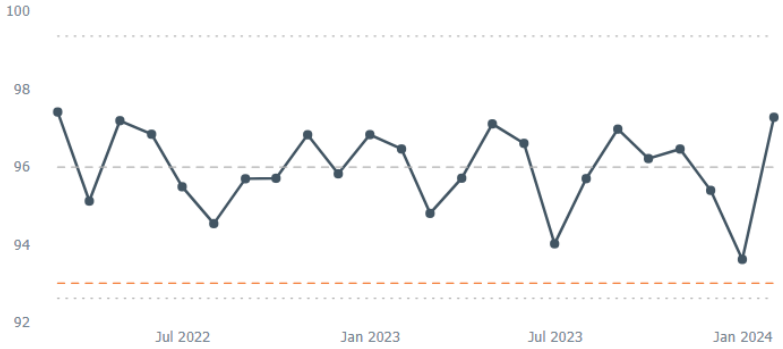
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Cancer 2ww Performance

Timescale	Value	SPC
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%	
Jan-24	93.6%	
Feb-24	97.3%	

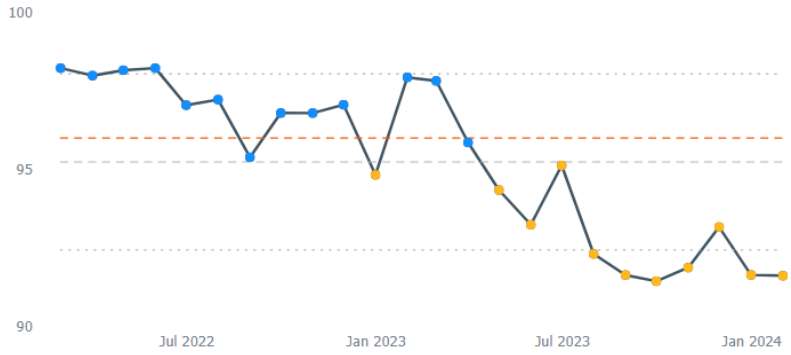
XMR Run Chart



Cancer 31d Combined Performance

Timescale	Value	SPC
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	93.2%	
Jan-24	91.6%	
Feb-24	91.6%	

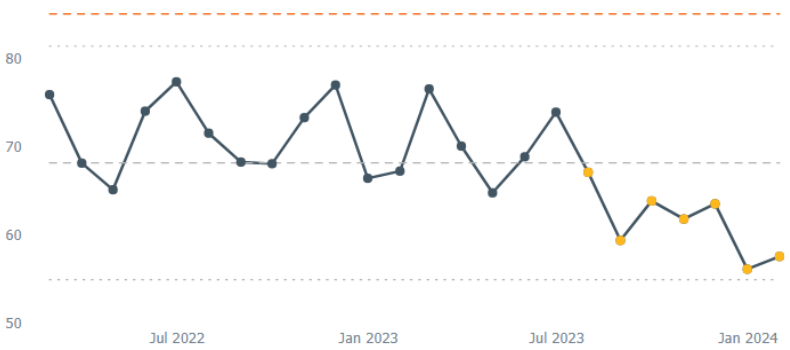
XMR Run Chart



Cancer 62d Combined Performance

Timescale	Value	SPC
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	63.5%	
Jan-24	56.1%	
Feb-24	57.5%	

XMR Run Chart



PERFORMANCE UPDATE

2ww performance has improved in month remaining compliant with the national standard. 2WW working group and weekly capacity meetings in place, but industrial action did affect performance.

31 Day Performance stabilised in month. The actions needed to improve are highlighted weekly within Cancer Performance Feeder pack, daily escalation and Friday PTL meetings to influence improvement. Insourcing has been arrange to support improvement in high risk areas through supported cancer alliance funding.

62d performance improved in month – main delays within the backlog remain within endoscopy and urology albeit improved position.

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
- Targeted programme support for Urology to deep dive into service provision to support enhanced patient care.
- Imaging recovery plan now in place and monitored through weekly access meetings
- Review of MDM's to streamline process and hence ensure patients are treated more quickly against the timed pathways.
- Cancer Board now in place and MDT's meet monthly to focus on performance improvement.

RTT Performance

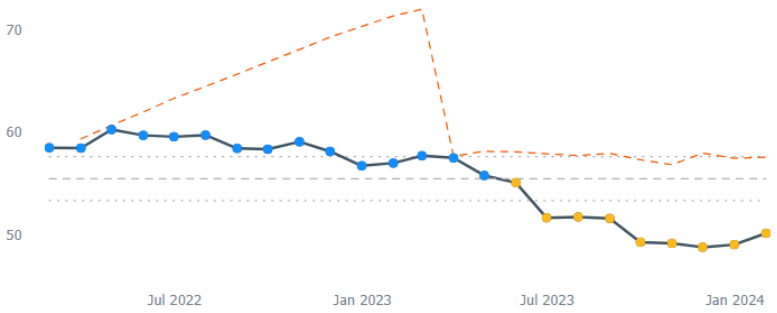
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

RTT Incomplete Performance

Timescale	Value	SPC
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%	
Jan-24	49.0%	
Feb-24	50.1%	

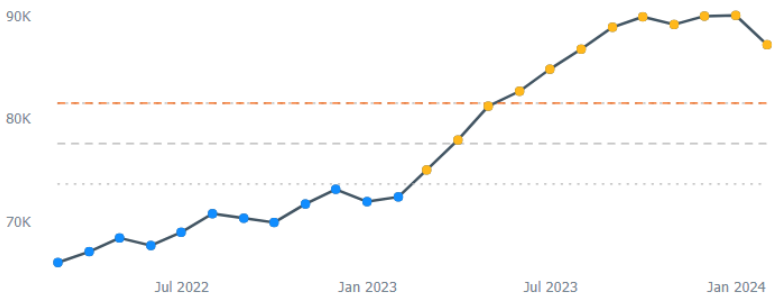
XMR Run Chart



RTT Total Incomplete Pathways

Timescale	Value	SPC
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	
Jan-24	90.0K	
Feb-24	87.2K	

XMR Run Chart



PERFORMANCE UPDATE

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

- Validation strategy agreed to include sustainable training plan.
- 12 week validation programme to be developed.
- Access Policy awaiting review.

External organisation (MBI) commenced from 20th February to validate all of DM01 backlog and 25,441 RTT patients over Feb/Mar.

To date on track to complete works and all 52 week risks will be validated by end of March.

Access Policy to be updated and training programme to commence in April to support the enhanced management of PTL's.

DQ reporting to be developed to target improvements and training needs analysis.

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 and will be rolled out from April 2024.

IS Team supporting targeted validation of long waiters within Endoscopy has been completed with a focus on Gastro in April 2024.

Efficiency Metrics

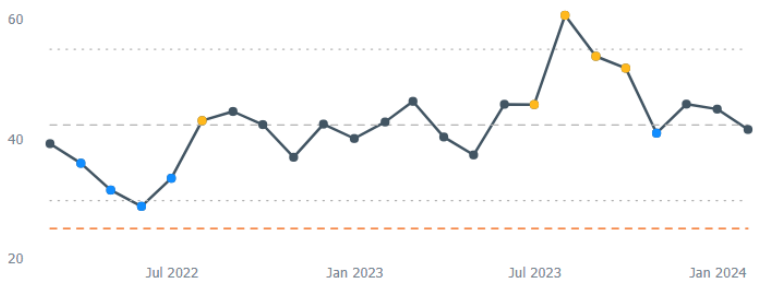
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Theatre Session Opp.

Timescale	Value	SPC
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	
Jan-24	45	
Feb-24	42	

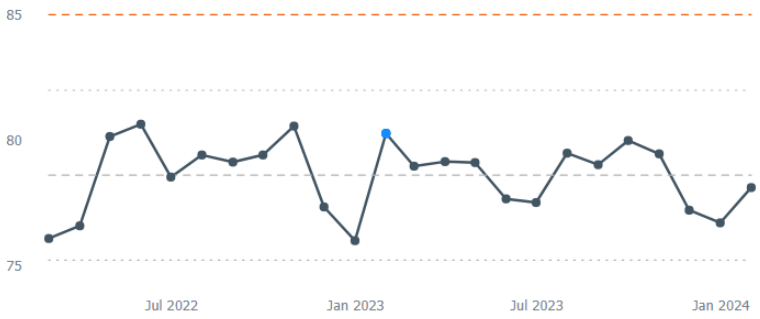
XMR Run Chart



Theatre Uncapped Utilisation

Timescale	Value	SPC
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%	
Jan-24	76.7%	
Feb-24	78.1%	

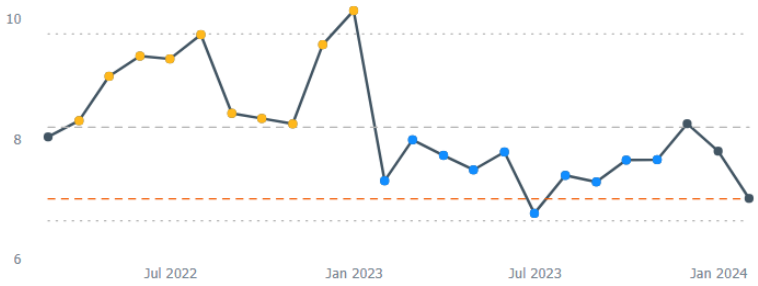
XMR Run Chart



DNA Rate OP New

Timescale	Value	SPC
Mar-23	8.0%	
Apr-23	7.7%	
May-23	7.5%	
Jun-23	7.8%	
Jul-23	6.8%	
Aug-23	7.4%	
Sep-23	7.3%	
Oct-23	7.6%	
Nov-23	7.7%	
Dec-23	8.3%	
Jan-24	7.8%	
Feb-24	7.0%	

XMR Run Chart



PERFORMANCE UPDATE

Doctor strike action continues to be a contributing factor to the high session opportunity and has continued with cases cancelled due to strike action.

Right sizing theatres work programme underway to then confirm clear plan on how to reduce lost sessions with engagement with Spencer and/or insourcing providers.

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 now meets monthly with clear improvement trajectories agreed to commence from the start of January.

Improvements are being seen around the implementation of strong 6-4-2 processes and in session utilisation.

Prism to continue for 12 weeks to support embedding of programme.

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 commenced and to review in Q1 2024.

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.

Quality & Safety

Quality & Safety

Integrated Improvement Plan

NHS
East Kent
Hospitals University
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Domain	Nat	Flag	KPI	SPC	Thres.	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Quality	IIP		Serious Incidents		Sigma	33	9	5	13	11	12	13	13	14	7	16	11
	IIP		Incidents - Moderate / Severe		Sigma	49	29	35	34	36	23	33	44	30	32	41	29
	IIP		Patient Incidents - Moderate / Severe		Sigma	0	0	0	0	0	0	0	0	0	0	0	23
	IIP		Overdue Incidents		0	4,755	3,897	3,340	2,938	2,395	2,669	2,980	3,353	3,293	3,614	2,986	1,663
	IIP		Serious Incidents Breached exceed 60...		0	6	10	13	6	6	2	3	1	2	3	4	1
	IIP		HSMR		96.0	96.1	95.0	94.9	94.4	92.7	92.3	90.9	88.6	90.3			
	IIP		Pressure Ulcers		Sigma	78	75	85	92	78	76	62	103	82	83	114	90

February Performance Summary

Incident Reporting: There were 2,055 patient incidents reported in February, of which 11 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 2,337 in January and 2,062 in December 2023. 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.

Due the implementation of LfPSE on 19/02/2024, moderate/severe harm incidents for February are reported on two lines. Prior to LfPSE on 19/02/2024 moderate/severe harms are recorded on line 2 of the above data (Incidents-Moderate/severe) after 19/02/2024 they are recorded on line 3 (Patient Incidents-moderate/severe) which is why there is a new spike of 23. Adding the two lines together gives a total of Moderate/Severe harms of 52. 7 of these incidents have since been downgraded bringing the number to 45. Under LfPSE, incidents are no longer categorised as clinical or non-clinical incidents, therefore the increase in moderate/severe harm level is attributed to 7 staff related harm incidents which would previously have been excluded from the figures.

Mortality: Results from the November reporting period shows an increase in HSMR (90.3) but overall continues to demonstrating a statistically lower than expected mortality. The full mortality report was shared with the Trust on 15 January and was discussed in the Mortality Surveillance Steering Group in March.

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

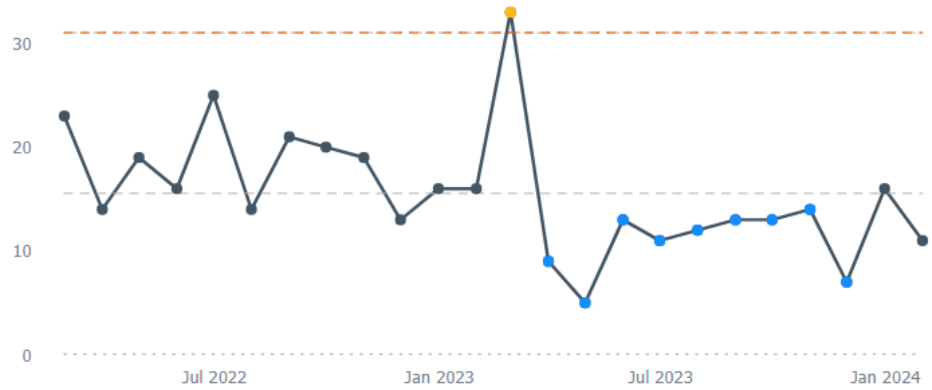
East Kent Hospitals University NHS Foundation Trust

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
Mar-23	33	
Apr-23	9	
May-23	5	
Jun-23	13	
Jul-23	11	
Aug-23	12	
Sep-23	13	
Oct-23	13	
Nov-23	14	
Dec-23	7	
Jan-24	16	
Feb-24	11	

XMR Run Chart



Understanding the most recent data point

Performance

11 — 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	Progress Update
• Four diagnostic delay incidents	• Missed lung lesion on chest x-ray • Delay in follow up of blood test result indicative of myeloma • Two delays in endoscopy surveillance leading to cancer diagnosis	• Care Group Leadership Team	• Within 60 days of each incident being reported on StEIS.	• This investigation is in progress.
• Three surgical/invasive procedure incident	• Delay in escalation of complication from surgery • Cardiac arrest post surgery, deemed unsuitable for surgical treatment on review • Misplaced nasogastric tube	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• This investigations is in progress.

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
One safeguarding incident	• Use of excessive restraint on patient	• Care Group Leadership Team	• Within 60 days of each incident being reported on StEIS.	• This investigation is in progress.
One pressure ulcer incidents	• Pressure ulcer damage	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• These investigations are in progress.
One medication incident	• Patient self overdosed on IV drugs whilst off ward	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• These investigations are in in progress.
One treatment delay incident	• Delay in transfer of patient to appropriate site for treatment	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS	• These investigations are in progress.

Overdue Incidents

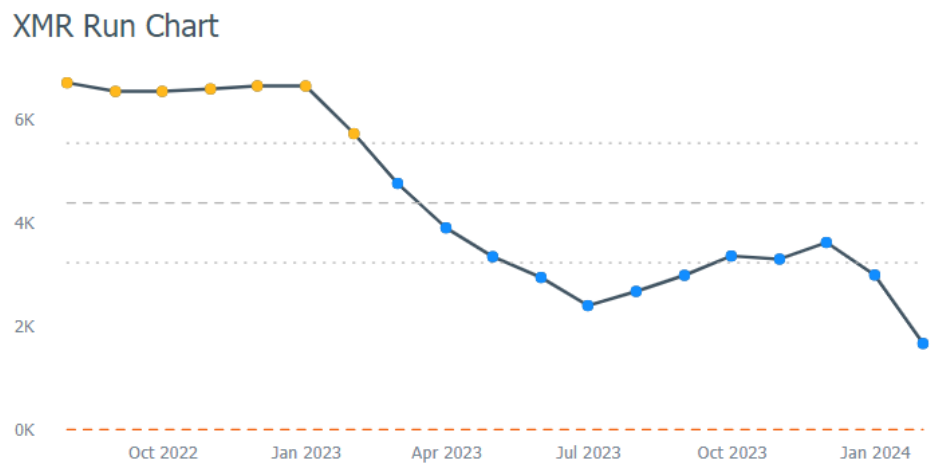
Integrated Improvement Plan

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
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	
Jan-24	2,986	
Feb-24	1,663	



Understanding the most recent data point

Performance

1,663

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
The backlog of overdue incidents being investigated impacts on the timely learning from incidents report to prevent future harm.	• Additional support in place to address the backlog. • The aim is to fully resolve the overdue incidents by 31/03/2023	• Director of Quality Governance	31/03/2024	The progress with clearing overdue incidents that are open for longer than 6 weeks, is hampered by new incidents becoming overdue every day. 618 new overdue incidents in January and 192 in February. The responsibility for managing incidents in a timely manner sits with the Care Groups, further system work required to manage this risk effectively.

Incidents Causing Harm

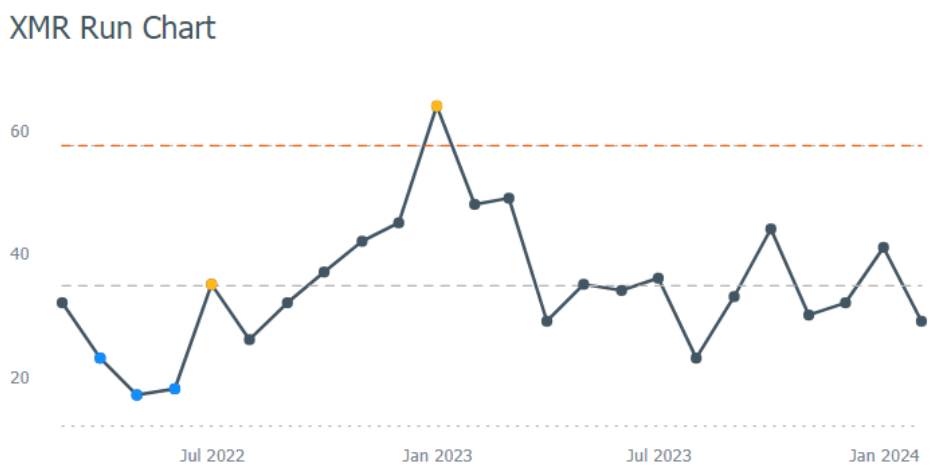
Integrated Improvement Plan

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
Mar-23	49	
Apr-23	29	
May-23	35	
Jun-23	34	
Jul-23	36	
Aug-23	23	
Sep-23	33	
Oct-23	44	
Nov-23	30	
Dec-23	32	
Jan-24	41	
Feb-24	29	



Understanding the most recent data point

Performance

29

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 with known Barrett's oesophagus referred by GP. Gastroscopy surveillance was requested for patient in February 2019. GP surgery has no documentation to advise that this has occurred. Patient now on a 2WW referral pathway.	• Patient scheduled for urgent OGD but unable to be completed due to significant narrowing of oesophagus • Barium swallow scheduled and PET scan. • Duty of Candour completed with patient • Incident discussed at SIDP, not declared as an SI but to be included in thematic review of endoscopy delays	Gastroenterology Consultant	30/04/2024	Results of investigations being followed up by ENT consultant for further investigation
Patient had an unwitnessed fall in the bathroom, sustained head injury.	• Emergency assistance call put out • Flojac used to move patient onto bed • Urgent CT head completed which showed acute subarachnoid haemorrhage • Bleed managed conservatively • Incident discussed at Tissue Viability and Falls Panel (TiVFP) • Falls assessment found no omissions in care that contributed to fall, Unanimously agreed good practice identified. • Does not meet SI criteria however to remain moderate harm as per national guidance	Falls Lead	28/03/2024	

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.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patient was last seen in bed however found at 04.45 found on the floor next to the bed. Medical assessment post fall CT requested 2.5 hours later completed 5 hours 45 minutes later. CT requested due to unwitnessed fall patient with confusion. CT showed right sided subdural haematoma.	• Falls team review of incident completed • Discussed at Tissue Viability and Falls MDT Panel, TiVFaP • No 1:1 in place • unwitnessed fall • No harm prevention measures identified on MFRACP	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 and ward mangers meeting.
Patient death, patient was walking to use the toilet and fell, patient independent, deemed to have full mental capacity. Fall resulted in large bilateral acute subdural haematomas Fall reported on Datix as witnessed fall. Presented at the Tissue Viability and falls MDT Panel TiVaP. Returned to panel with further information due to inconsistencies with presented case and injury sustained. Delay in Duty of Candour.	• Case referred to coroner for inquest. • Patient Safety Lead and Governance Lead to address duty of candour. • Ward manger to liaise with ward staff to obtain factual account of events.	Lead Nurse for Falls Patient safety Lead Governance Lead	May 2024	Coroners request for statement date 8th march. Liaised with patient safety and Governance Leads to address Duty of candour.

Hospital Standardised Mortality Ratio (HSMR)

Integrated Improvement Plan

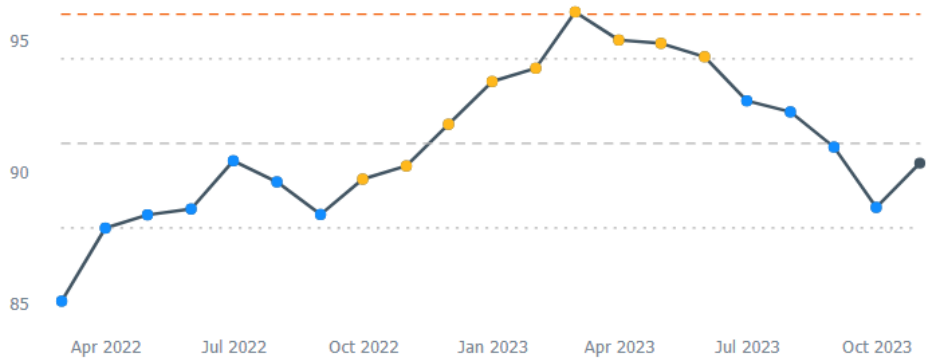
East Kent Hospitals University NHS Foundation Trust

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
Dec-22	91.8	
Jan-23	93.4	
Feb-23	93.9	
Mar-23	96.1	
Apr-23	95.0	
May-23	94.9	
Jun-23	94.4	
Jul-23	92.7	
Aug-23	92.3	
Sep-23	90.9	
Oct-23	88.6	
Nov-23	90.3	

XMR Run Chart



Understanding the most recent data point

Performance

90.3 — Variation indicates consistently passing the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

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	• Work to understand and mitigate risks of recent rise in mortality and identification of surgical site infection is complete. No definitive links identified. .
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 March MSSG but not able to finalise analysis at present. Further data requested.

VTE Assessment Compliance

Integrated Improvement Plan

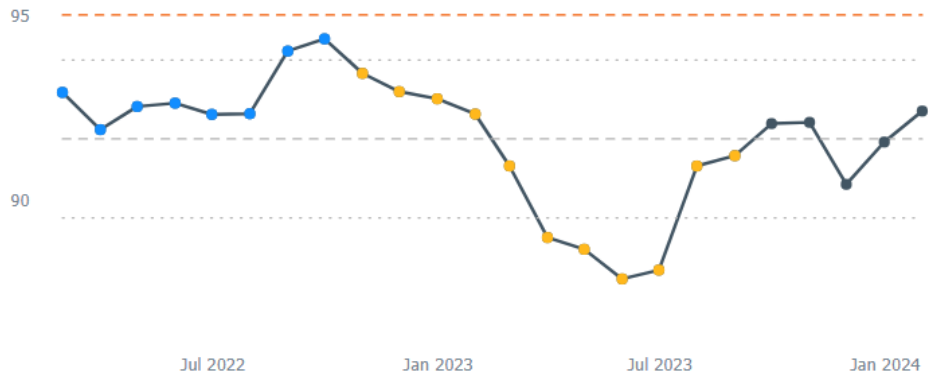
East Kent Hospitals University NHS Foundation Trust

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
Mar-23	90.9%	
Apr-23	89.0%	
May-23	88.7%	
Jun-23	87.8%	
Jul-23	88.1%	
Aug-23	90.9%	
Sep-23	91.2%	
Oct-23	92.1%	
Nov-23	92.1%	
Dec-23	90.4%	
Jan-24	91.6%	
Feb-24	92.4%	

XMR Run Chart



Understanding the most recent data point

Performance

92.4%

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
There is a concern that the compliance data is not accurate.	• Thrombosis group has raised the issue with IT to interrogate the data • Thrombosis group has presented this concern to Clinical Audit and Effectiveness Committee • Issue to be discussed by the Clinical Design Authority	• Michael Jackson	• March 2024	• Awaiting feedback from IT • Awaiting feedback from CDA
VTE is not currently a mandatory form on Sunrise	• Thrombosis group liaising with the CDA to consider this change	• Michael Jackson	• April 2024	• Awaiting decision regarding mandatory form for Sunrise
Awareness and training needs have been identified that will influence this metric. Training on this issue is not currently mandatory.	• Thrombosis group work with learning and development to deliver a VTE mandatory training session. • Multiple routes for education and awareness delivered through Thrombosis group	• Michael Jackson	• March 2024	• Awaiting update at next Thrombosis meeting in March

Pressure Ulcers

Integrated Improvement Plan

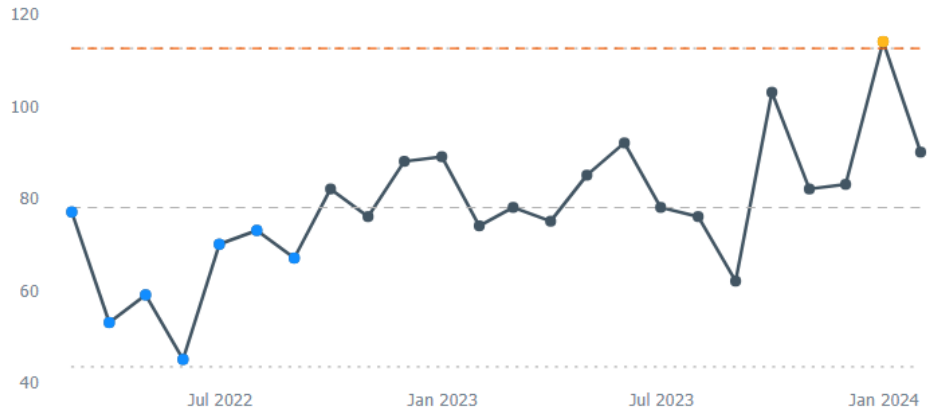
NHS
East Kent Hospitals University
NHS Foundation Trust

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
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	82	
Dec-23	83	
Jan-24	114	
Feb-24	90	

XMR Run Chart



Understanding the most recent data point

Performance

90

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
Increase of damage from medical device related pressure damage particularly on the toes from TED stockings	• PURPOSE T risk assessment has been added which includes descriptive care plan for each level of pressure ulcer risk. • Medical device guidance available on Sunrise • To discuss with ITU audit lead to share their good practice trust wide to help reduce incidents.	• Lead TVN Specialist	• June 2024	• TNA form submitted to Statutory and Mandatory steering group to be discussed at next meeting. • Email sent to liaise with ITU audit lead
Increased pressure damage noted due to gaps in repositioning	• PURPOSE T risk assessment, will provide specific plan of care to specify level of repositioning. • All repositioning regime to be added to Sunrise to avoid terminology such as 'checked and changed' • Continue to work with manual handling team to improve repositioning techniques	• Tissue Viability Team	• May 2024	• Monthly ward walks on each site taking place with Tissue and Moving and Handling • All documentation has been rolled out onto Sunrise. Met with Sunrise team to discuss ways of allowing staff to track when repositioning is due.
Increased length of stay in ED contributing to increased pressure damage.	• Meeting to be set with ED and procurement to approve the trolley tender prior to trial. • Seating specification to be updated prior to trial. • TV team presence in ED to support/monitor equipment. • ED leads and nurse educators to encourage the use of repose trolley companions.	• Lead TVN Specialist	• June 2024	• PURPOSE T rollout concluded in Feb '24 • Trolley tender approved trial to commence Mar '24 • Working with Procurement to secure funding for active seat cushions and T&F Group reviewing appropriate seating to trial. Seating specification complete.

Falls (with harm)

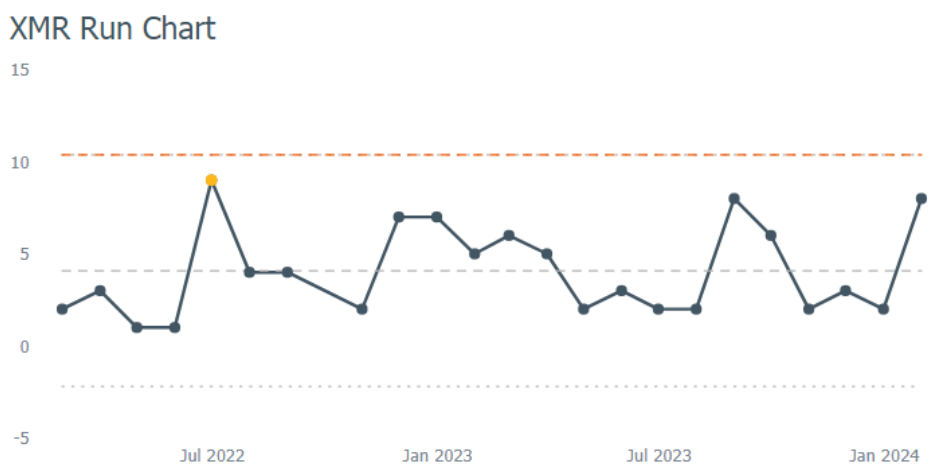
Integrated Improvement Plan

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
Mar-23	6	
Apr-23	5	
May-23	2	
Jun-23	3	
Jul-23	2	
Aug-23	2	
Sep-23	8	
Oct-23	6	
Nov-23	2	
Dec-23	3	
Jan-24	2	
Feb-24	8	



Understanding the most recent data point

Performance

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
FallStop face to face training discontinued June 2023.	• Liaise with RCP to introduce a national falls prevention training package. • Edits to package to include lying and standing BP. • Liaise with Learning and Development team to make mandatory on ESR	• Lead Nurse for Falls • CNS	• April 2024	• Agreed falls training package at SMET • Online training package to go live March 2024
Unwitnessed falls continue to remain high in the most vulnerable patients.	• Falls team promote the use of Enhanced Observations Tool. • Falls team are part of EKHUFT working group for Enhanced Care.	• HON GSM QEQMH • Associate Director FOC	• September 2024	• The EKHUFT Enhanced Care Tool is now on Sunrise and is being piloted on a ward at QEQM. The proposal is to be rolled out across the Trust. • Roll out plan to be agreed. • EKHUFT working group with other trust and community ICB led by Associate Director of Fundamentals of Care.
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	• Lead nurse and CNS cross site support where able.

Incident Reporting

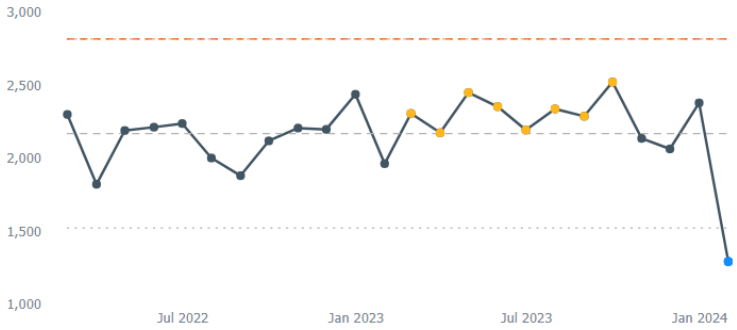
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Clinical Incidents

Timescale	Value	SPC
Mar-23	2,305	
Apr-23	2,173	
May-23	2,448	
Jun-23	2,352	
Jul-23	2,192	
Aug-23	2,336	
Sep-23	2,286	
Oct-23	2,520	
Nov-23	2,134	
Dec-23	2,062	
Jan-24	2,377	
Feb-24	1,291	

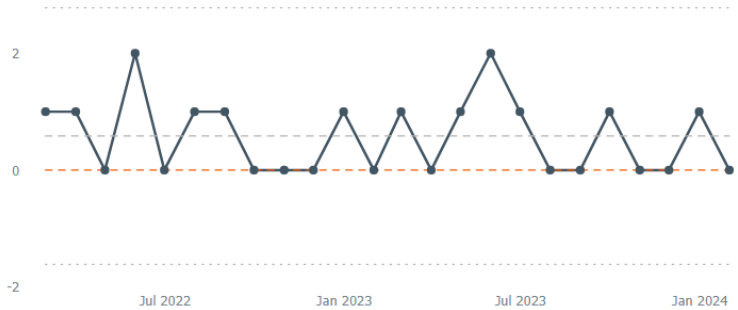
XMR Run Chart



Never Events

Timescale	Value	SPC
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	
Jan-24	1	
Feb-24	0	

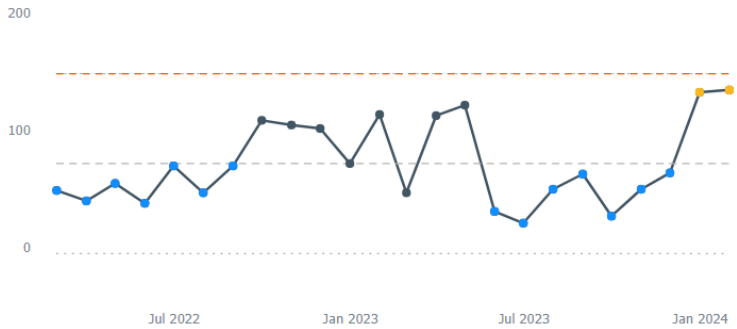
XMR Run Chart



Mixed Sex Breaches

Timescale	Value	SPC
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	
Jan-24	132	
Feb-24	134	

XMR Run Chart



PERFORMANCE UPDATE

Clinical Incident reporting appears to show significant drop in reporting levels however this is due to the change to LfPSE on 19th February 2024, therefore this graph only shows data collected from 01/02/2024 to 19/02/2024.

The number of clinical incidents after 19/02/2024 comes under different category of Patient Incidents. There were 764 clinical incidents reported after 19/02/2024 which are not included in this graph. The corrected total of incidents reported is **2,055** which falls only just below the lower limit for reporting and within normal variation for the Trust.

Due to the significant changes in the way incidents are reported this number is reassuring that incident reporting rates have not significantly fallen following the implementation of LfPSE

There were no never events reported in February 2024.

Duty of Candour

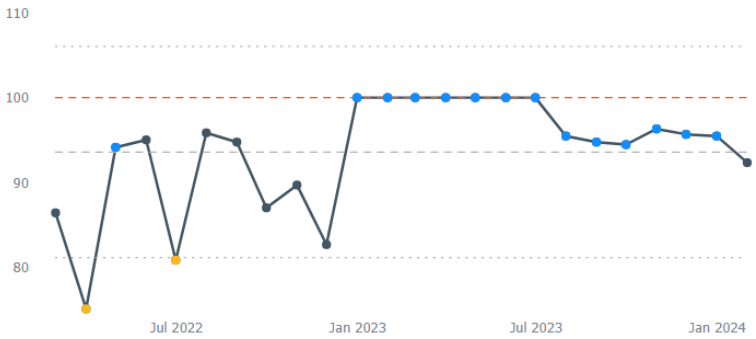
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Duty of Candour - Verbal

Timescale	Value	SPC
Mar-23	100%	
Apr-23	100%	
May-23	100%	
Jun-23	100%	
Jul-23	100%	
Aug-23	95.5%	
Sep-23	94.7%	
Oct-23	94.4%	
Nov-23	96.3%	
Dec-23	95.7%	
Jan-24	95.5%	
Feb-24	92.3%	

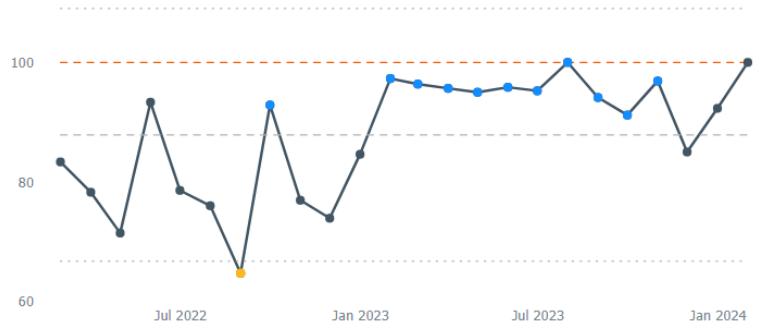
XMR Run Chart



Duty of Candour - Written 15wd

Timescale	Value	SPC
Mar-23	96.4%	
Apr-23	95.7%	
May-23	95.0%	
Jun-23	95.8%	
Jul-23	95.2%	
Aug-23	100%	
Sep-23	94.1%	
Oct-23	91.2%	
Nov-23	96.9%	
Dec-23	85.0%	
Jan-24	92.3%	
Feb-24	100%	

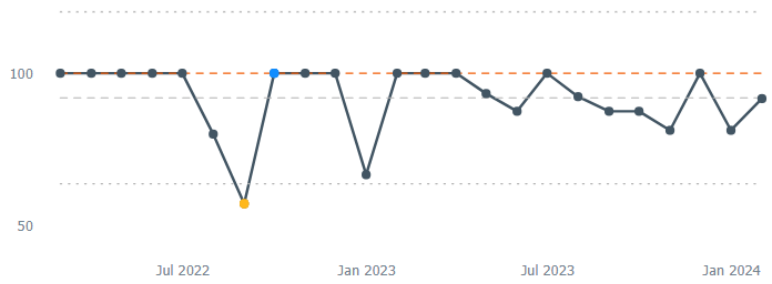
XMR Run Chart



Duty of Candour - Findings

Timescale	Value	SPC
Mar-23	100%	
Apr-23	100%	
May-23	93.3%	
Jun-23	87.5%	
Jul-23	100%	
Aug-23	92.3%	
Sep-23	87.5%	
Oct-23	87.5%	
Nov-23	81.3%	
Dec-23	100%	
Jan-24	81.3%	
Feb-24	91.7%	

XMR Run Chart



PERFORMANCE UPDATE

Verbal Duty of Candour 92.3% compliant. Two cases breached the timeframe but both have been completed since.

Written DoC within 15 working days was 100% compliant in February 2024.

The final DoC letter which accompanies the completion of the investigation report was 91.7% compliant, with 1 letter outstanding at the end of February, however this has since been completed.

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

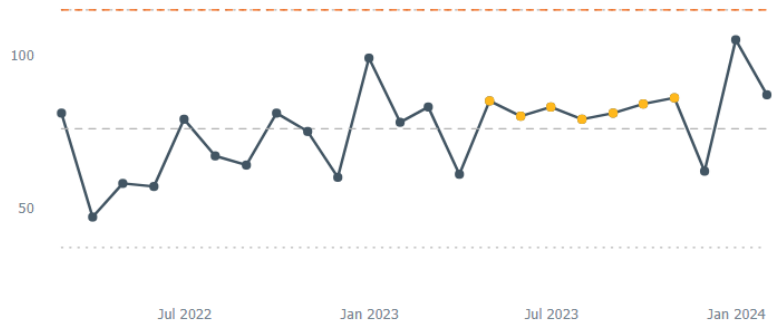
Complaints
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Complaints Number

Timescale	Value	SPC
Mar-23	83	
Apr-23	61	
May-23	85	
Jun-23	80	
Jul-23	83	
Aug-23	79	
Sep-23	81	
Oct-23	84	
Nov-23	86	
Dec-23	62	
Jan-24	105	
Feb-24	87	

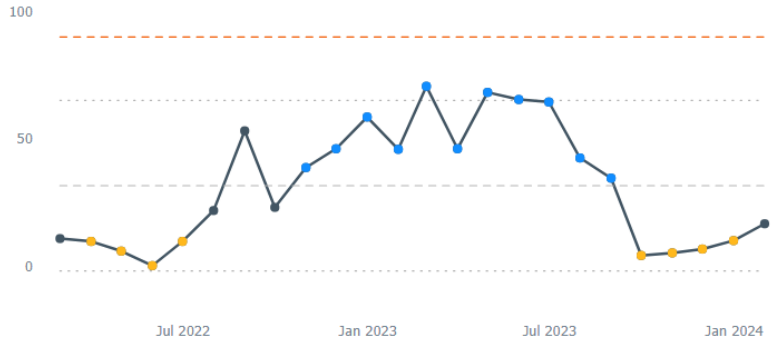
XMR Run Chart



Complaint Response

Timescale	Value	SPC
Mar-23	70.6%	
Apr-23	46.0%	
May-23	68.2%	
Jun-23	65.4%	
Jul-23	64.4%	
Aug-23	42.4%	
Sep-23	34.4%	
Oct-23	4.0%	
Nov-23	5.0%	
Dec-23	6.5%	
Jan-24	9.8%	
Feb-24	16.5%	

XMR Run Chart



PERFORMANCE UPDATE

February 2024 saw 1034 contacts to the department resulting in 87 new formal complaints and 503 new PALS contacts being taken forward. 8% of contacts in February 2024 were taken forward as new formal complaints. 94% of the new complaints were acknowledged within three working days, this is above the target of 90%.

As a seasonal comparison, in February 2023 there was 82 complaints and 506 PALS; a 6.1% increase in complaints. This equates to a 0.6% 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, the service was closed April 2023. During November to April the Waiting Patient contacts were recorded as PALS and reflects the increased number of PALS recorded during February 2023.

February 2024 saw a slight increase in performance of responses within timescales to 15% from 8% in January 2024. There continues to be an increase in the number of new complaints. There also is a continuing increased complexity for both PALS and complaints. The increase and complexity continues to impact on response performance.

CNMO is continuing to ensure the quality of complaints responses is improved. The care groups are being supported by the central complaints team and an interim to improve the quality of responses. The staff working on complaints, within the care group governance teams moved to the central team on 04 March 2024. There is work being carried out on mapping a new complaints process, along with support and training for complaints staff.

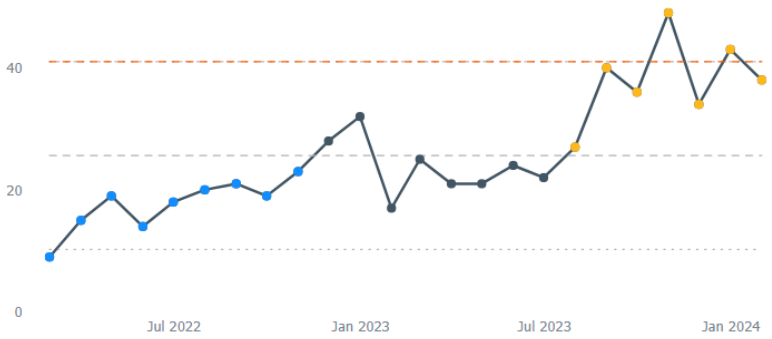
Safeguarding
Statutory Metrics

NHS
East Kent Hospitals University
NHS Foundation Trust

Safeguarding Incidents

Timescale	Value	SPC
Mar-23	25	
Apr-23	21	
May-23	21	
Jun-23	24	
Jul-23	22	
Aug-23	27	
Sep-23	40	
Oct-23	36	
Nov-23	49	
Dec-23	34	
Jan-24	43	
Feb-24	38	

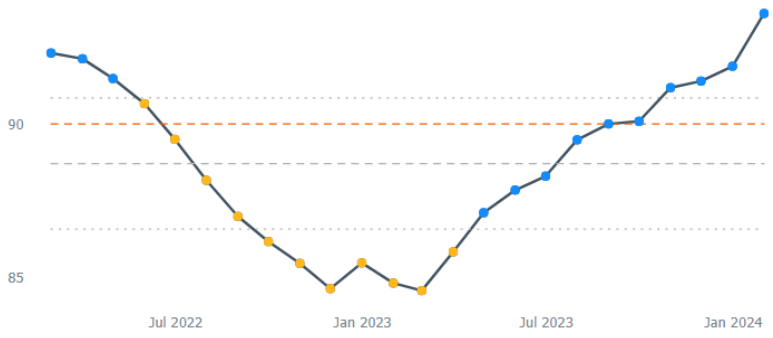
XMR Run Chart



Safeguarding Children Training

Timescale	Value	SPC
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%	
Jan-24	91.9%	
Feb-24	93.6%	

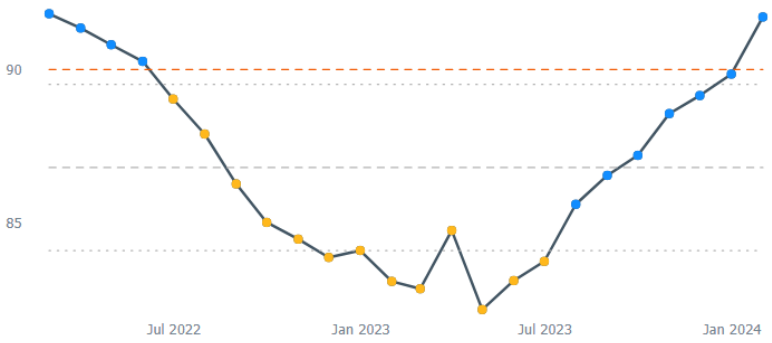
XMR Run Chart



Safeguarding Adults Training

Timescale	Value	SPC
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%	
Jan-24	89.8%	
Feb-24	91.7%	

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 January in line with seasonal variants. The highest category of incidents related to pressure sores and poor discharge .

Following the last report, the outstanding S42s have reduced and additional staffing hours used to commence investigations once we have terms of reference . Meetings are in place with the Local authority although there is a plan to change their delivery model which could impact this in a positive way.

Care groups alongside the Safeguarding team are now completing safeguarding investigations the next stage will be to delivering supervision including reflections actions and embedding learning.

Safeguarding supervision for case holder's remains an area for improvement

Training is over the required 85% for children's Level 1,2,3,4 and adults level 1,2,4 and level 3 training is now at 84%

Progress against the safeguarding recovery plan is presented monthly at the ICB oversight meetings

IPC - Infections

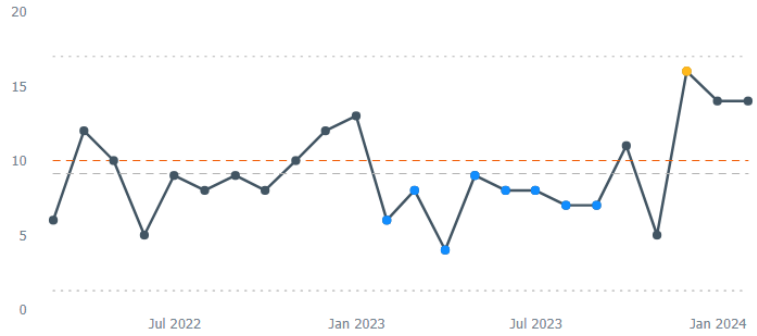
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

IPC: EColi Infections

Timescale	Value	SPC
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	
Jan-24	14	
Feb-24	14	

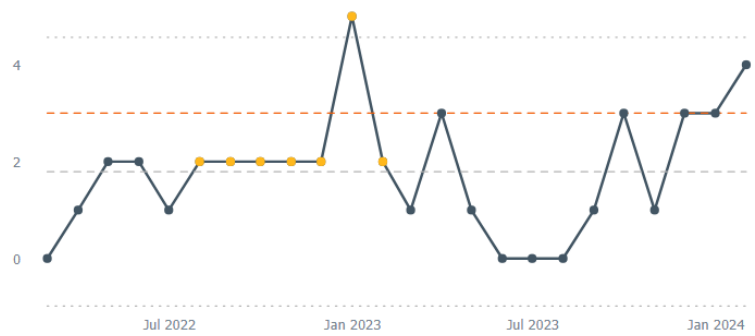
XMR Run Chart



IPC: Pseudomonas Infections

Timescale	Value	SPC
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	
Jan-24	3	
Feb-24	4	

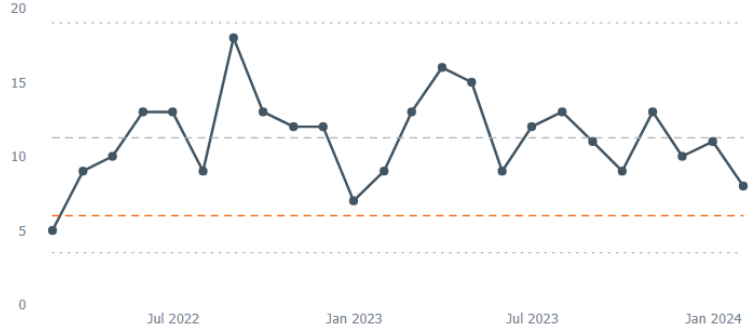
XMR Run Chart



IPC: CDiff Infections

Timescale	Value	SPC
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	
Jan-24	11	
Feb-24	8	

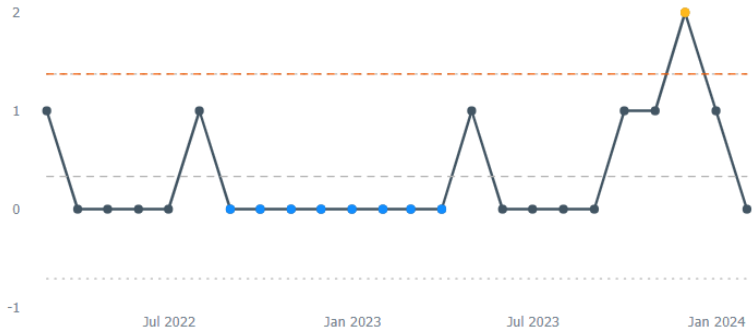
XMR Run Chart



IPC: MRSA Infections

Timescale	Value	SPC
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	
Jan-24	1	
Feb-24	0	

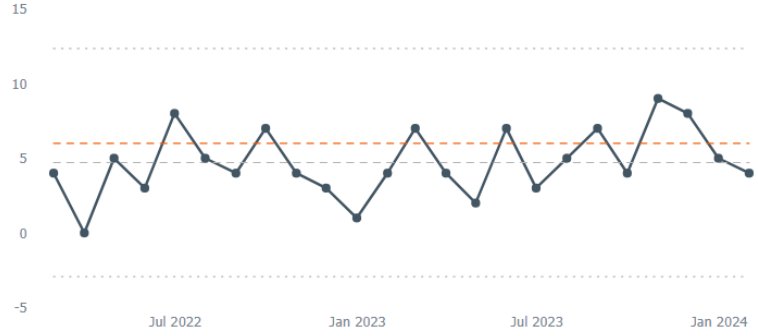
XMR Run Chart



IPC: Klebsiella Infections

Timescale	Value	SPC
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	
Jan-24	5	
Feb-24	4	

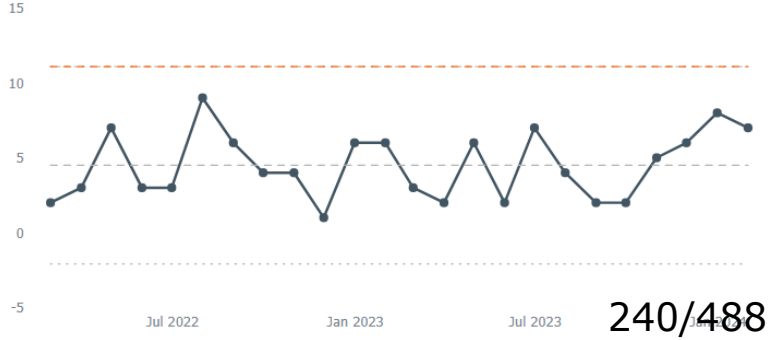
XMR Run Chart



IPC: MSSA Infections

Timescale	Value	SPC
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	
Jan-24	8	
Feb-24	7	

XMR Run Chart



IPC - Infections

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

PERFORMANCE UPDATE

Performance against trajectories for e-coli and Klebsiella remain over 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.

Pseudomonas infections are significantly below threshold, E-coli is 14% lower than the previous year, however Klebsiella is 20% higher this is a decrease from last month there is no clear cause for the differences in these infection rates

The Trust has now breached the threshold for C-dif this year by 46 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. In February the Trust reported it's lowest c-dif rates for over a year

MSSA bacteraemias continue to be within parameters, and we are still seeing a reduction compared to the previous year. The ongoing increase in reported MRSA bacteraemias continues to be driven by community onset cases, thus far, with limited learning identified for EKHUFT, but continued focus on MRSA screening and eradication protocols continues. The Trust reported no MRSA bacteraemia's in February

The IPC team have launched a focussed campaign to improve compliance to good infection prevention and control practice – commencing with hand hygiene

IPC – Training Compliance

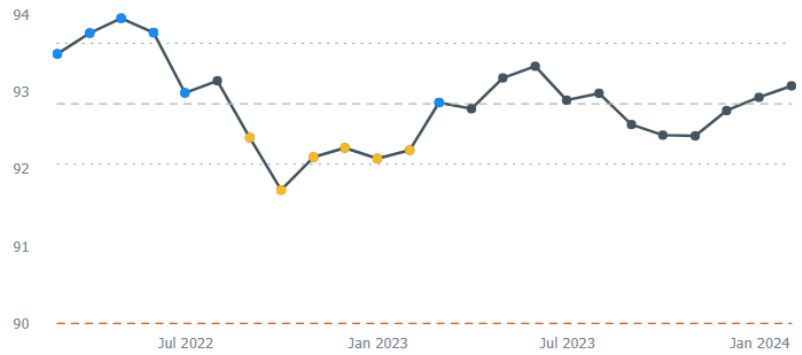
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Infection Control Training

Timescale	Value	SPC
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%	
Jan-24	92.9%	
Feb-24	93.1%	

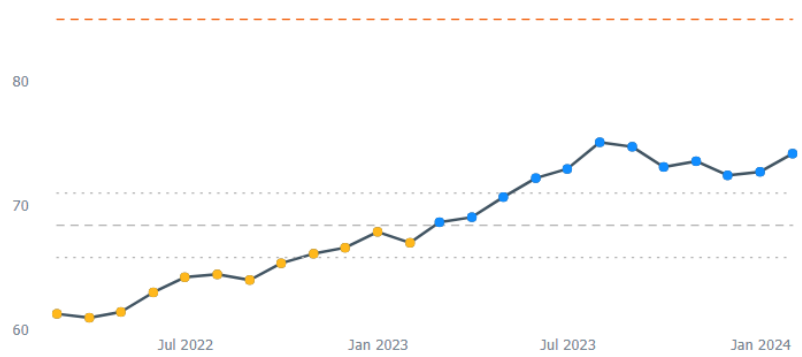
XMR Run Chart



Hand Hygiene Training

Timescale	Value	SPC
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%	
Jan-24	72.7%	
Feb-24	74.2%	

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 have embarked on a hand hygiene campaign. Focus continues on ensuring link workers are able to training staff, and upload compliance directly to ESR.

Friends & Family Test

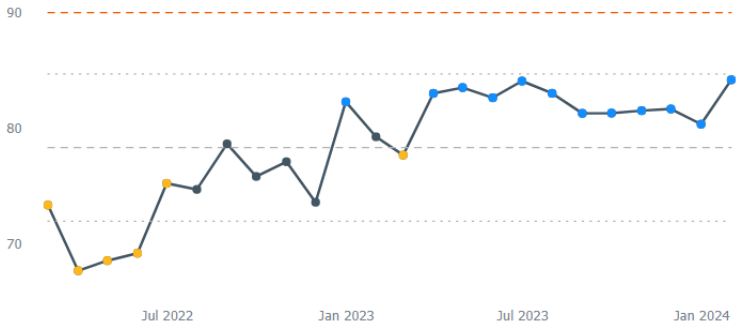
Statutory Metrics

NHS
East Kent
Hospitals University
NHS Foundation Trust

FFT Satisfaction Level - ED

Timescale	Value	SPC
Mar-23	77.7%	
Apr-23	83.0%	
May-23	83.5%	
Jun-23	82.6%	
Jul-23	84.1%	
Aug-23	83.0%	
Sep-23	81.3%	
Oct-23	81.3%	
Nov-23	81.5%	
Dec-23	81.7%	
Jan-24	80.4%	
Feb-24	84.2%	

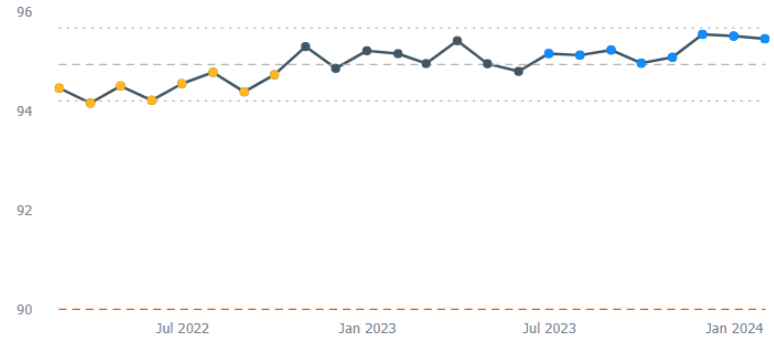
XMR Run Chart



FFT Satisfaction Level - Outpatient

Timescale	Value	SPC
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	95.5%	
Jan-24	95.5%	
Feb-24	95.5%	

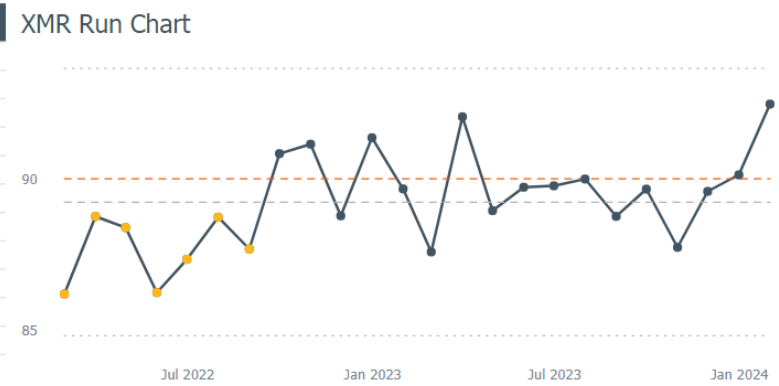
XMR Run Chart



FFT Satisfaction Level - Inpatient

Timescale	Value	SPC
Mar-23	87.6%	
Apr-23	92.1%	
May-23	88.9%	
Jun-23	89.7%	
Jul-23	89.8%	
Aug-23	90.0%	
Sep-23	88.8%	
Oct-23	89.7%	
Nov-23	87.7%	
Dec-23	89.6%	
Jan-24	90.1%	
Feb-24	92.5%	

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 February 2024 it was 93.8%.** Looking at overall satisfaction by hospital Care Groups, it varied from 92.3% for WHH Care Group, 92.9% at QEQM Care Group and 94.9% for K&CH Care Group.

For out-patients the satisfaction level was 95.4% overall, a very slight decrease. This is based on **19,049 responses** – 20% of people sent the FFT survey. The highest satisfaction level was at Buckland Hospital – 97.2% and lowest at William Harvey 94.7%. QEQM was 96.1%, Kent and Canterbury was 95% and Royal Victoria was 97.1%. 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. All sites OPD scores rose except at Kent and Canterbury.

For in-patients the overall satisfaction score across the three sites was 92.4%, a 2% increase compared to January. This is based on 1,000 responses, which is 18.2% of those sent the FFT survey. The highest satisfaction level for in-patients was 94.7% at Kent and Canterbury, followed by 91.4% at QEQM and 90.9% at William Harvey. Triangulation of theming from FFT, the national in-patient survey and our Trust in-patient survey shows that patients are satisfied with care given by staff but dissatisfied with the discharge process and information given when leaving hospital.

For Urgent and Emergency Care our FFT satisfaction level in February 2024 was 84.1% overall, which is an increase of 3.5% overall. This is based on 2,468 responses. When breaking this down by site, QEQM ED scored 80.4%, William Harvey ED scored 82.8% , KCH Urgent Treatment Centre scored 89.6%, and Buckland UTC scored 91.2%. Both the UTCs scored lower than the previous month.

How we compare with national data:

The most recent national data available is for January 2024. For Emergency Departments, Urgent Treatment Centres and Minor Injury Units the overall satisfaction level nationally is 78%. **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 February of **92.4% overall is lower but improving** and for outpatients at **95.4% 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 February 2024, the top positive themes were care given by staff, staff attitude, communication and quality of treatment. The most common negative themes were waiting time to be seen on site, poor communication and information, and staff attitude, but these were in the minority compared to overall feedback.

People

People, Leadership & Culture

Integrated Improvement Plan

NHS
East Kent Hospitals University
NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
People	IIP		Sickness		5.0%	5.1%	4.3%	4.0%	4.1%	4.6%	4.7%	4.9%	5.2%	5.2%	5.5%	5.4%	4.8%
	IIP		Vacancy Rate		10.0%	8.4%	8.2%	8.2%	7.9%	7.2%	7.9%	7.4%	6.7%	7.5%	7.7%	7.9%	8.4%
	IIP		Staff Turnover Rate		10.0%	10.0%	9.8%	9.7%	9.6%	9.5%	9.2%	9.0%	9.1%	9.1%	9.3%	9.2%	9.2%
	IIP		Premature Turnover Rate		25.0%	15.0%	15.0%	14.1%	14.0%	13.8%	13.7%	13.3%	13.6%	13.9%	14.7%	14.1%	14.5%
	KEY		Appraisals Compliance		80.0%	70.5%	70.1%	67.4%	66.8%	72.4%	73.0%	73.3%	72.6%	72.9%	72.4%	73.9%	73.6%
	IIP		Staff Engagement Score		6.80	6.17	6.20	6.20	6.20	6.27	6.27	6.27	6.34	6.34	6.34	6.13	6.13
	IIP		Statutory Training		91.0%	91.0%	91.4%	91.9%	91.9%	91.7%	92.1%	91.9%	90.1%	90.6%	90.8%	91.4%	91.9%
	IIP		Infection Control Training		90.0%	92.9%	92.8%	93.2%	93.3%	92.9%	93.0%	92.6%	92.4%	92.4%	92.8%	92.9%	93.1%
	IIP		Hand Hygiene Training		85.0%	68.7%	69.1%	70.7%	72.2%	73.0%	75.1%	74.7%	73.1%	73.6%	72.4%	72.7%	74.2%
	IIP		Medical Job Planning Rate		90.0%	38.3%	46.4%	50.4%	50.5%	58.7%	52.3%	58.1%	60.3%	58.3%	58.8%	61.1%	70.5%

February Performance Summary

People Metrics: Sickness absence has fallen significantly following the introduction of on-site clinical psychology. There have been 105 referrals into the service within the first month and sickness absence has already reduced back under the alerting threshold (to 4.83%). Stress, anxiety & depression continues to represent the primary reason for sickness, although the number of staff absent for this reason has fallen by 27 WTE month-on-month. Vacancy rate has risen to 8.4%, although this increase has been largely due to a deliberate holding of vacancies as part of the review of Admin & Clerical establishments. Staff turnover remains stable (9.2%) and continues to achieve a desired performance standard (≤10%). Given the wider landscape across Kent and Medway this is a strong position. Premature turnover has risen slightly but remains within the desired parameters (15%). Statutory training rates have improved again and by 2% across the last 4 months. They now exceed the desired threshold of 90%. Compliance for medical staff is below the expected threshold, but has been on an upward trajectory and is the highest it has been (77%) in 9 months. Infection control training remains stable at 93%. Hand hygiene training, however, is below the desired threshold and is not yet showing signs of longer-term improvement. Medical job planning has improved considerably (by almost 10%) and is now tracking in the right direction.

Engagement Metrics: The NHS Staff Survey results are now available and show that the Trust scores the lowest for staff engagement (6.34) against all 122 other Acute Trusts in the country. This appears largely related to a continued fall in advocacy – indeed, less staff would recommend the organisation as a place to work/ for treatment than in any other Trust in the country. There have been statistically significant improvements in 26% of questions, but this progress is largely offset by our national position, with the Trust scoring below the national average against 87% of questions. Our main challenges centre around; reputation, risk and culture and a proposal responding to these in a materially different way to previous years is going to Board for approval in April.

Leadership Metrics: Our three biggest gaps from the national standard relate to staff advocacy. Recommending as a place for treatment, for example, is 18% away from the national average. This continues to deteriorate in the latest NQPS (from 5.73 to 5.70). Advocacy, in fact, represents the only domain of staff engagement that isn't improving or stabilising – and is anchoring any improvement in our overall staff engagement score. Responding to the NHS Staff Survey results ought to represent a key organisational priority, with our leaders pivotal to delivering the required change in experience.

Staff Sickness

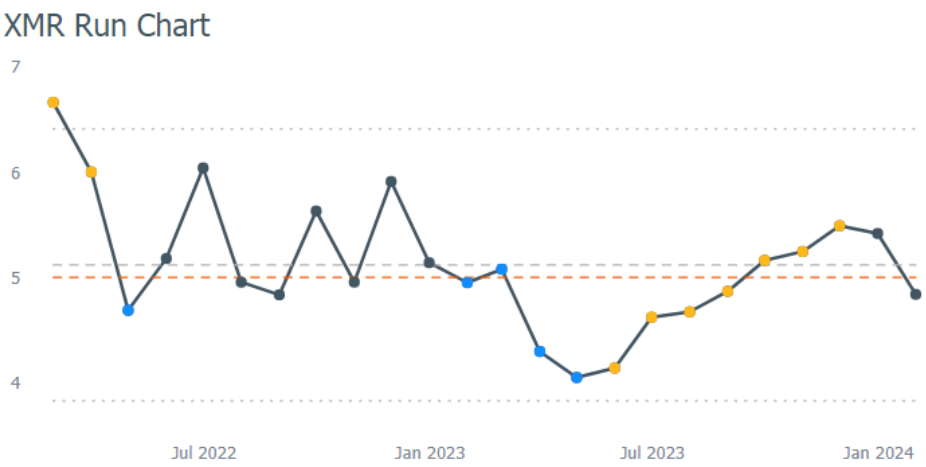
Integrated Improvement Plan

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
Mar-23	5.1%	
Apr-23	4.3%	
May-23	4.0%	
Jun-23	4.1%	
Jul-23	4.6%	
Aug-23	4.7%	
Sep-23	4.9%	
Oct-23	5.2%	
Nov-23	5.2%	
Dec-23	5.5%	
Jan-24	5.4%	
Feb-24	4.8%	



Understanding the most recent data point

Performance

4.8%

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
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 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. Two key areas of focus (ED WHH and Maternity WHH) have supported a drop in sickness absence compared to the rest of the Trust.

Staff Vacancy Rate

Integrated Improvement Plan

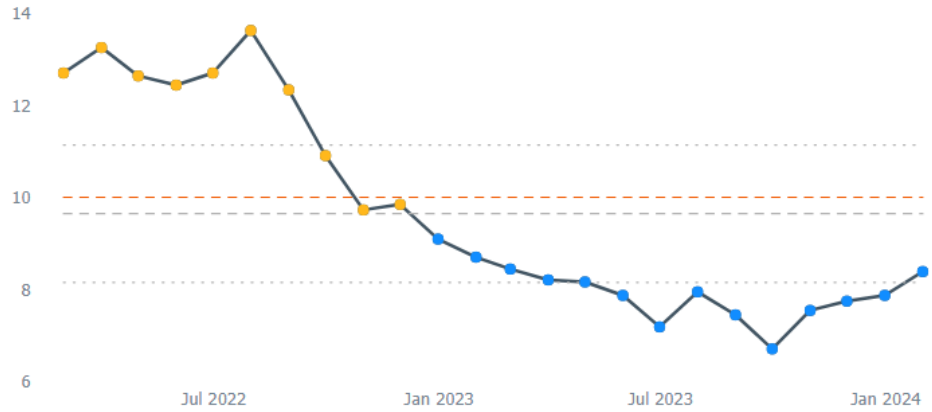
East Kent Hospitals University NHS Foundation Trust

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

Vacancy Rate

Timescale	Value	SPC
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%	
Jan-24	7.9%	
Feb-24	8.4%	

XMR Run Chart



Understanding the most recent data point

Performance

8.4% — 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; 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. • Overall Nursing & Midwifery vacancy rate down to 5.2% • A&C vacancy rate increased as roles are held for pending review.

Staff Turnover Rate

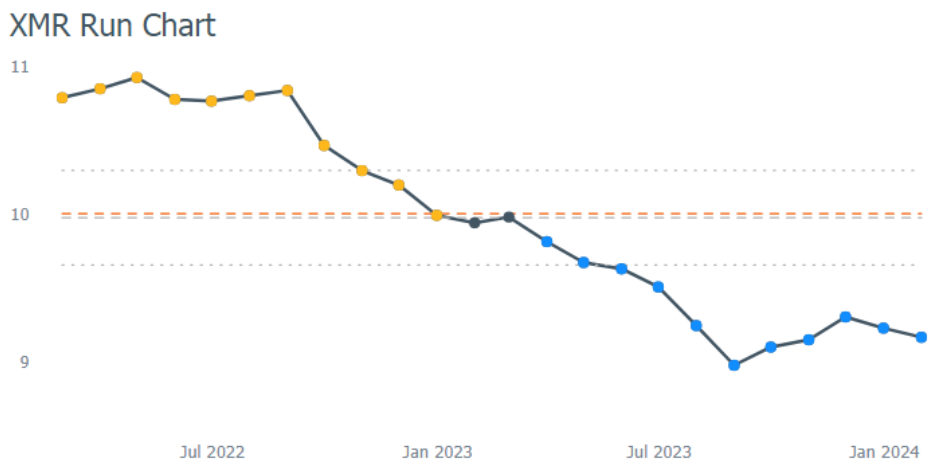
Integrated Improvement Plan

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
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%	
Jan-24	9.2%	
Feb-24	9.2%	



Understanding the most recent data point

Performance

9.2%

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 **9.2%**.
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 **8.1%.**
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 is on an improving trajectory. At **13.1**%, it is >6% better than the same time last year and >10% better than nine months ago.

Premature Staff Turnover Rate

Integrated Improvement Plan

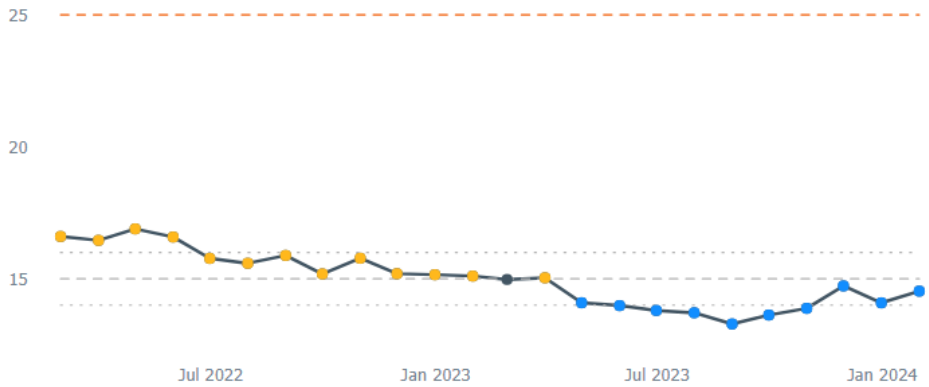
East Kent Hospitals University NHS Foundation Trust

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
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%	
Jan-24	14.1%	
Feb-24	14.5%	

XMR Run Chart



Understanding the most recent data point

Performance

14.5% — 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

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 risen slightly but remains within the desired parameters (≤15%).
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 Mar 24	• System-level managers guide to onboarding published by EKHUFT and animation to support being finalised with Plus R and the ICB.
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 Mar 24	• NSES developed internally to reduce cost. Publication of results will follow once desired threshold of respondents is met.

Staff Engagement Score

Integrated Improvement Plan

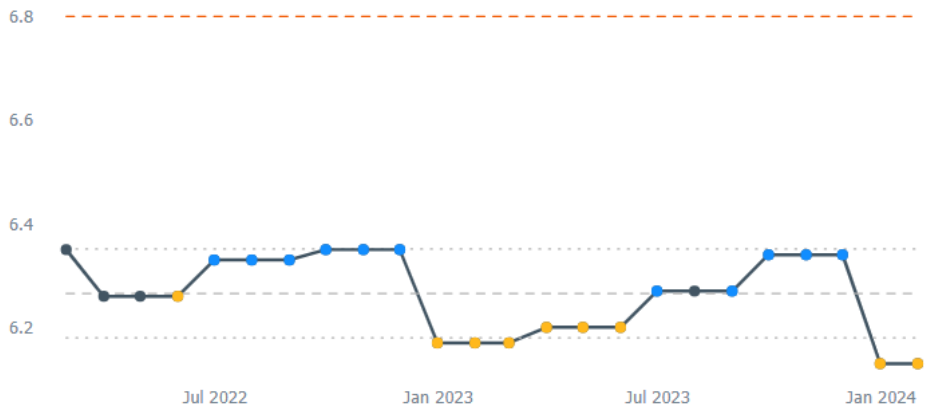
East Kent Hospitals University NHS Foundation Trust

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
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	
Oct-23	6.34	
Nov-23	6.34	
Dec-23	6.34	
Jan-24	6.13	
Feb-24	6.13	

XMR Run Chart



Understanding the most recent data point

Performance

6.13

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
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	• End Apr 24	• NSS 23 results indicate lowest SE score across all Acute Trusts. Proposal going to Board in April to respond to.
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 Apr 24	• A Trust-wide focus on listening, understanding and responding to staff voice is being proposed to Board, alongside a dual organisation and CG-level People Plan to ensure remedial action is taken.
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 Apr 24	• An advanced People Dashboard has been developed to visualise results and enable clarity around priorities and necessary actions for improvement.

Statutory Training

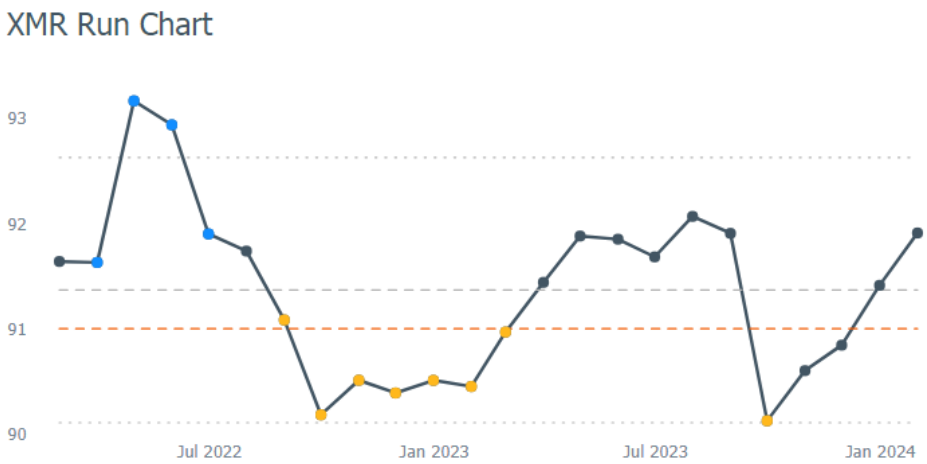
Integrated Improvement Plan

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
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%	
Jan-24	91.4%	
Feb-24	91.9%	



Understanding the most recent data point

Performance

91.9%

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	• Apr 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. Medical staff compliance at 77.4%, and has increased for five months running.
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

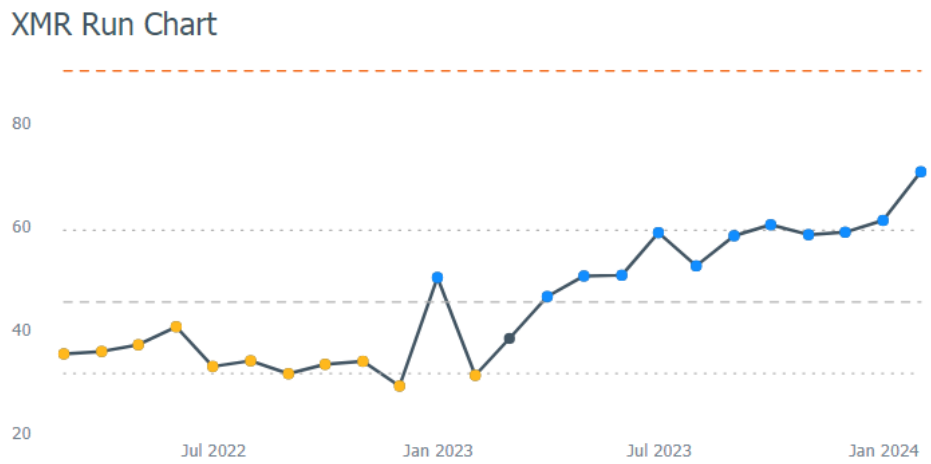
Integrated Improvement Plan

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
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%	
Jan-24	61.1%	
Feb-24	70.5%	



Understanding the most recent data point

Performance

70.5%

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 70% (Feb 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

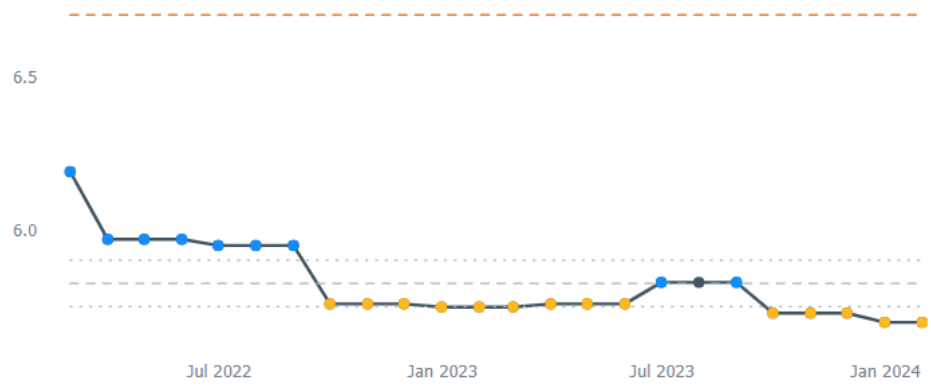
East Kent Hospitals University NHS Foundation Trust

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
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	
Oct-23	5.73	
Nov-23	5.73	
Dec-23	5.73	
Jan-24	5.70	
Feb-24	5.70	

XMR Run Chart



Understanding the most recent data point

Performance

5.70

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
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 are the lowest in the country and have fallen further in the latest NQPS. 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	• Proposal around responding to the NHS Staff Survey to be presented to Board in April – focusing on what would enable staff to recommend the Trust.

Appraisal Rates

Statutory Metrics

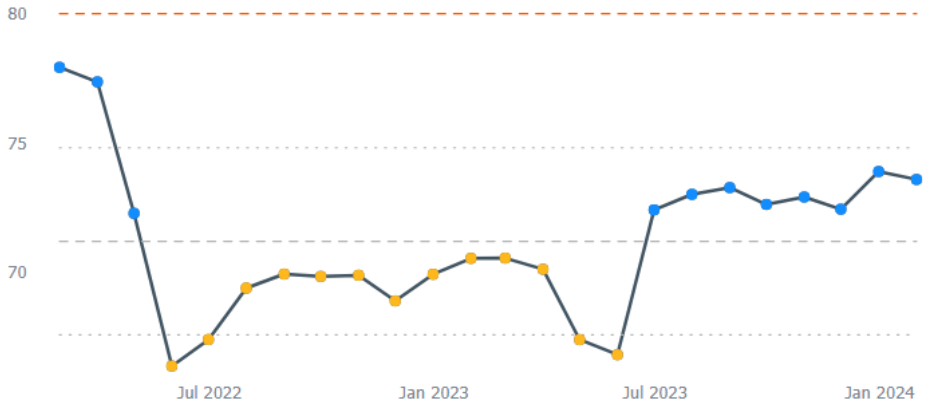
East Kent Hospitals University NHS Foundation Trust

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
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%	
Jan-24	73.9%	
Feb-24	73.6%	

XMR Run Chart



Understanding the most recent data point

Performance

73.6%

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

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 Mar 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. Additional issue with current A&C Consultation.
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.

Sustainability

Financial Sustainability

Integrated Improvement Plan

NHS
East Kent Hospitals University
NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Finance	IIP		I&E Monthly Variance Group (£M)		Traj.	4.264	-9.826	-9.826	-9.244	-10.0...	-11.314	-9.030	-8.929	-6.461	-9.326	-10.995	-10.215
	IIP		Efficiencies Green Schemes (£M)		40	20	0	1	4	3	10	9	9	11	11	13	13
	IIP		Efficiencies YTD Variance (£M)		0.0	-10.4	-1.5	-2.9	-4.8	-8.0	-6.3	-9.5	-11.8	-14.8	-17.2	-20.5	-23.7
	IIP		Premium Pay		Traj.	9,058	8,839	10.2K	9,666	9,687	10.7K	8,847	8,179	8,404	8,258	8,671	8,391

February Performance Summary

Financial Position: The financial position YTD is £38.8m away from a plan of £66.5m, with a total deficit YTD of £105.2m. The key drivers behind the deficit variance are non-delivery of efficiency savings, shortfall in funding for AfC & Medical and Dental pay award and unfunded impact of the Strike action by the Junior doctors and Consultants (above ERF guidance and IA System funding). The agency spend YTD is £40.6m which is £15.2m away from the agency cap. Year end forecast approved by NHS England of £117.4m Deficit. £0.2m under forecast YTD to Month 11.

Efficiencies: The agreed Efficiencies FOT plan for 2023/24 is £13.1m. The Trust recognised recurrent savings of £0.1m in February, and £3.2m on a YTD basis. Schemes relating to income are delivering, with £0.6m in month, and forecast £5.4m (Clinical £2.2m Non-clinical £3.2) for FY 23/24. The current value of the pipeline is £13.1m.

There are various theme based workstreams including vacancy and non-pay panels to support the reduction in Run Rate.
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.

Theme Executive Owners Theme leads have been agreed to carry this work forward with support from the PMO and have developed a refined list of quantified schemes for milestone 2 at the end of February. Schemes identified amount to £63.8m, and RAG adjusted £30.0m. PIDs and QIAs are planned to be completed and signed off by the end of March. This will put the trust in a strong position for action and commence delivery in FY24/25.

I&E YTD Actual Group (£m)

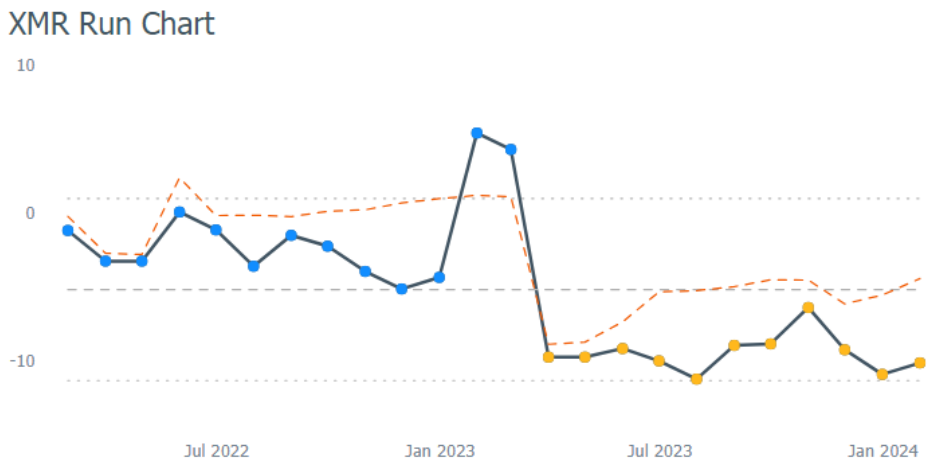
Integrated Improvement Plan

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
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	-9.326	
Jan-24	-10.995	
Feb-24	-10.215	



Understanding the most recent data point

Performance

-10.215

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 embedded led by CPO. • Nursing workforce review led by CNMO. • Investment panel implemented led by CFO • Fortnightly Finance Improvement Programme Board (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 • Year end forecast approved by NHS England. £117.4m deficit. £0.2m under forecast YTD to Month 11.
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 commissioned 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. Fortnightly Financial Improvement Programme Board in place.

Financial Efficiencies: Green Rated Schemes

Integrated Improvement Plan

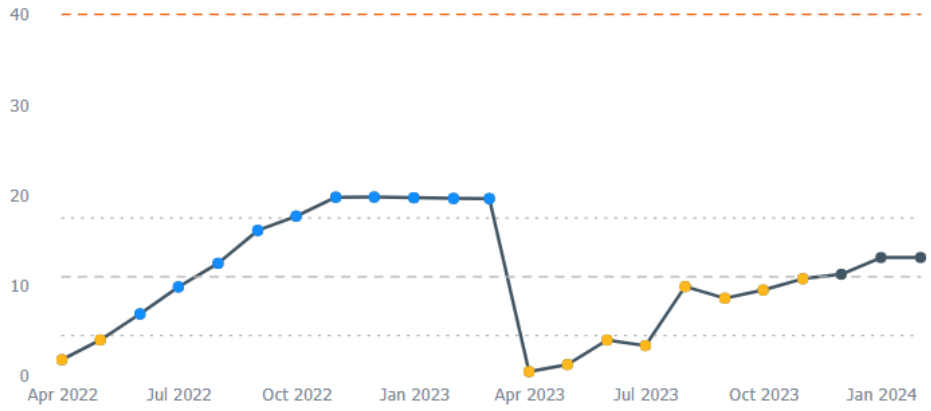
NHS East Kent Hospitals University NHS Foundation Trust

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
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	
Jan-24	13	
Feb-24	13	

XMR Run Chart



Understanding the most recent data point

Performance

13

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 & 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 for 2024-25	Finance/ PMO	Underway	• 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 • Focus now on development of FY24/25 • FOT expected to deliver £13.1m in year
Pace of scheme development	• Engagement with PWC to work with the Trust to delivery CIP's • Refined Long list for 24/25 produced on time at the end of February • PIDs and QIAs are planned to be completed and signed off by the end of March. Schemes identified £63.8m and RAG adjusted £30.0m. • Target of 80% achievement of CIP identification for 24/25 by 31st of March 24	CFO	Underway	• PWC Support to PMO and Theme leads continuing development of PIDs & QIAs to achieve sign-off. • Focus on moving schemes through the gateways from Red to Amber then to Green.
Identification of opportunities sufficient to reach the required £49m FY24/25	• 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/AD FI TD/PMO	Ongoing	• Theme scheme values being firmed up. • FRD/ADFI meeting weekly with PMO • Regular engagement with PMO / PWC

Financial Efficiencies YTD Variance

Integrated Improvement Plan

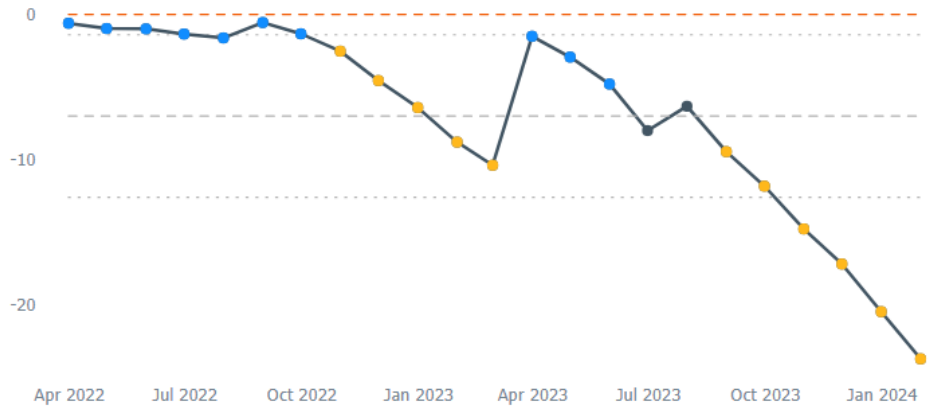
East Kent Hospitals University NHS Foundation Trust

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
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	
Jan-24	-20.5	
Feb-24	-23.7	

XMR Run Chart



Understanding the most recent data point

Performance

-23.7

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 Descending Run Group 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). Focus on Run Rate reductions is having the desired effect. • Focus is now on CIPs for 2024-25 and phasing of identified schemes and budget setting.	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

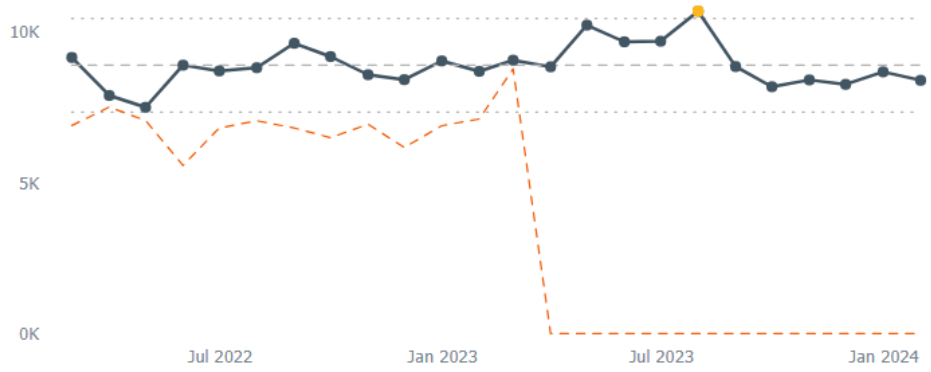
East Kent Hospitals University NHS Foundation Trust

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
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	
Jan-24	8,671	
Feb-24	8,391	

XMR Run Chart



Understanding the most recent data point

Performance

8,391

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 – Issue been identified and dashboard is being adapted.
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. • ID Medical Managed Service, working with Deputy CMO identifying high cost agency to swap for a cheaper alternative.
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	• Implemented on 31/01/24, with Nursing that followed on 01/03/24

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.	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Maternity	IIP		Serious Incidents Maternity		Sigma	4	4	1	3	2	0	2	2	1	2	2	0
	IIP		Maternity Incidents Moderate / Severe		Sigma	6	0	3	2	0	1	1	4	0	2	1	3
	IIP		Maternity Complaints		Sigma	8	12	8	4	6	2	17	5	7	6	13	7
	IIP		Maternity Complaint Response		90.0%	75.0%	25.0%	16.7%	38.9%	50.0%	60.0%	60.0%	0.0%		33.3%	0.0%	21.1%
	IIP		Extended Perinatal Mortality		5.87	4.44	4.62	4.47	3.87	3.40	3.58	3.11	2.62	2.29	2.81	2.99	2.45
	IIP		FFT Maternity Response Rate		15.0%	12.9%	12.8%	14.9%	14.4%	15.4%	13.4%	11.5%	13.7%	16.1%	15.2%	14.1%	13.0%
	IIP		FFT Maternity Recommended		90.0%	92.2%	93.7%	92.1%	92.3%	91.6%	88.3%	90.7%	96.3%	93.0%	88.9%	93.5%	93.2%
	IIP		FFT Maternity (IP) Recommended		90.0%	96.2%	95.1%	92.6%	94.3%	94.3%	88.8%	90.6%	96.8%	93.8%	90.4%	94.1%	92.9%
	IIP		WH Engagement Score		6.90	5.45	5.87	5.87	5.87	6.15	6.15	6.15	6.38	6.38	6.38	6.35	6.35

February Performance Summary

Incidents: There were 0 serious incidents reported in February in Women's Health for Maternity.

Complaints: 8 Stage 1 complaints were received in February for Maternity. This is a decrease on the previous month.

Patient Involvement: FFT Response rate 13% - 93.2% extremely likely or likely to recommend

Staff Engagement: Score 6.35

Maternity Serious Incidents

Integrated Improvement Plan

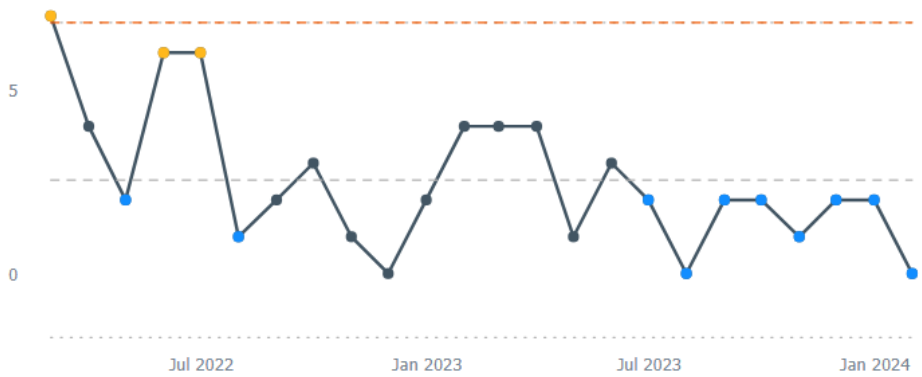
East Kent Hospitals University NHS Foundation Trust

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
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	
Jan-24	2	
Feb-24	0	

XMR Run Chart



Understanding the most recent data point

Performance

0	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
There were 0 serious incidents reported in February for Maternity.				
At month end there were 8 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
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 6 at 01/03/24. The overall current overdue actions has decreased to 94. There is additional agency resource focussing on open actions from October-February and further sprint days with NHSE Maternity Improvement Advisor were held in December and January. Patient Safety Matron vacancy is backout to advert. Substantive Head of Governance appointed commencing 28.3.24

Maternity Incidents Causing Harm

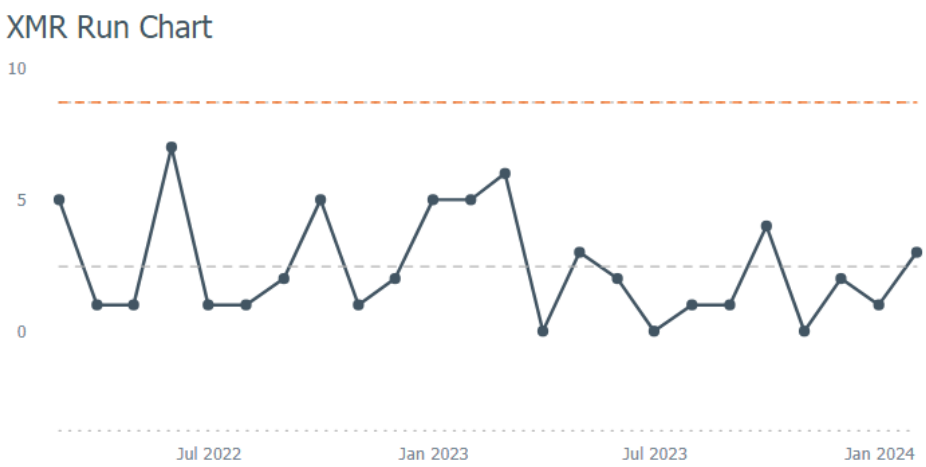
Integrated Improvement Plan

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
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	
Jan-24	1	
Feb-24	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
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	• Rapid Review SOP updated and now live on Policy Centre • Themes and learning identified from rapid reviews disseminated via Message of the Week and Safety Threads. • Team Brief introduced for Ward Managers and Matrons to summarise key messages for the week with teams
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	31/03/2024	The number of open datix from the original June backlog for Maternity has reduced from 686 to 16 at 01/03/2024. The overall current overdue datix is 196 within Maternity which is a slight increase from the previous month. 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

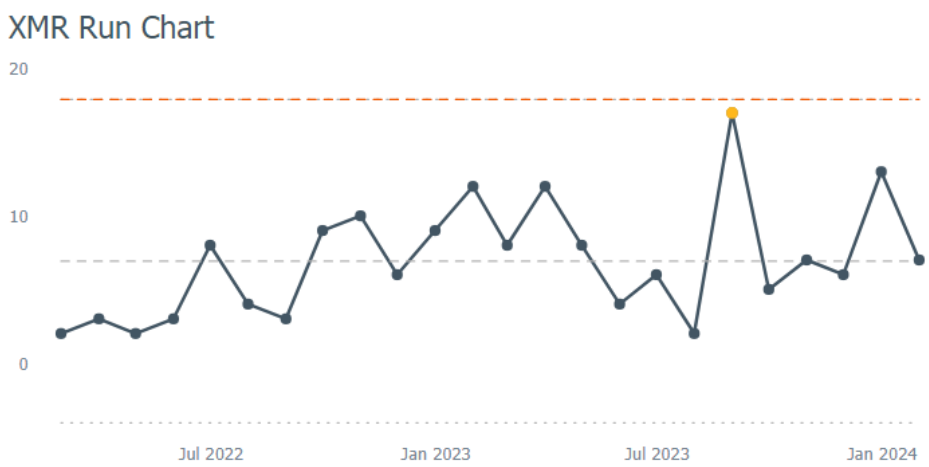
Integrated Improvement Plan

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
Mar-23	8	
Apr-23	12	
May-23	8	
Jun-23	4	
Jul-23	6	
Aug-23	2	
Sep-23	17	
Oct-23	5	
Nov-23	7	
Dec-23	6	
Jan-24	13	
Feb-24	7	



Understanding the most recent data point

Performance

7

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
8 Stage 1 complaints received in February 2024 for Maternity	Decrease from the number of complaints received in previous month.	Patient Experience and Complaints Coordinator	Monthly reporting	• Submitted a total of 9 DDoM approved drafts to CPBS in Feb • A total of 27 cases were closed in February by sending the final Exec letters to patients. • At the end of February there are 32 open complaints in Maternity
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	Themes arising from complaints have been included in the MNVP strategy and QI projects being co=produced. For example the team are currently developing a postnatal booklet . The MNVP have been surveying women in relation to antenatal education. The service is working with the region in relation to embedding PSCPs. There is a workstream dedicated to addressing culture and behaviours.

Maternity Complaints Response Rate

Integrated Improvement Plan

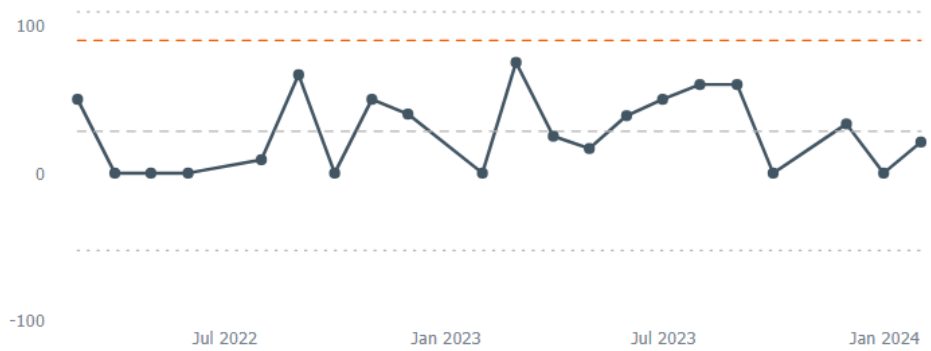
East Kent Hospitals University NHS Foundation Trust

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
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	60.0%	
Sep-23	60.0%	
Oct-23	0.0%	
Dec-23	33.3%	
Jan-24	0.0%	
Feb-24	21.1%	

XMR Run Chart



Understanding the most recent data point

Performance

21.1% — 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
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 05/03/2024 there were 43 open first complaints of which only 1 breached complaint responses all with CPBS.

Extended Perinatal Mortality

Integrated Improvement Plan

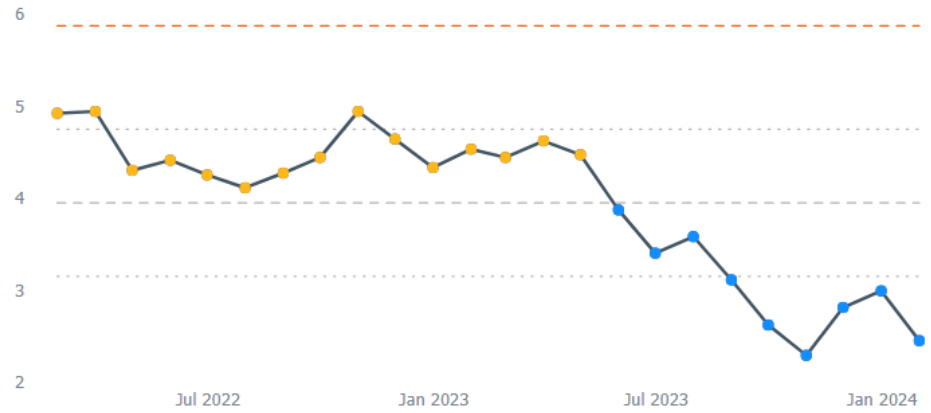
East Kent Hospitals University NHS Foundation Trust

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
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	2.81	
Jan-24	2.99	
Feb-24	2.45	

XMR Run Chart



Understanding the most recent data point

Performance

2.45 — 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 February there was 1 neonatal death reportable to MBRRACE: – 22/02/2024 NND at 3 days old on NICU	As of February the 12m rate is 1.23. 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. To be reviewed through the Rapid Review Process.
In February there were no stillbirths reportable to MBRRACE.	The rolling 12 month rate for stillbirths is 1.23 which remains lower than both the threshold.	DDoM	Monthly	The team are meeting on 28.3.24 to explore the existing SBs and understand any existing disparities
Perinatal Mortality Review Tool	All neonatal deaths and stillbirths are reviewed through the Perinatal Mortality Review Tool by a multidisciplinary panel and external attendees (If over 22weeks gestation)	PMRT Lead Midwife	Monthly	100% of perinatal mortality reviews include an external reviewer

Maternity Friends & Family Test: Response Rate

Integrated Improvement Plan

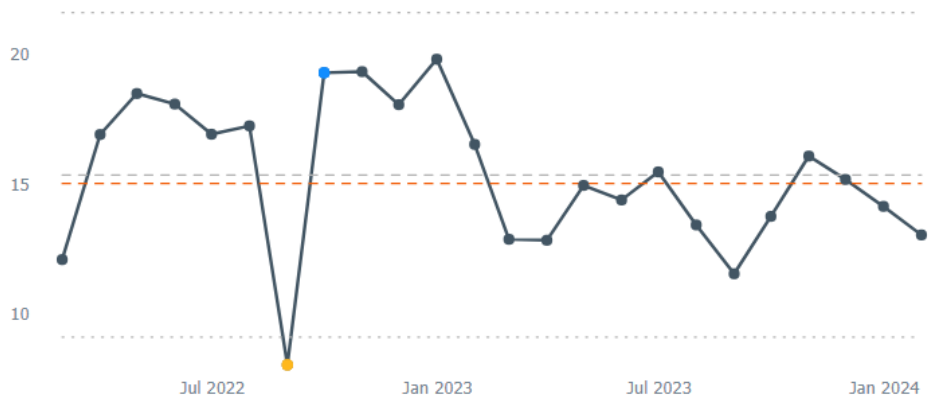
East Kent Hospitals University NHS Foundation Trust

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
Mar-23	12.9%	
Apr-23	12.8%	
May-23	14.9%	
Jun-23	14.4%	
Jul-23	15.4%	
Aug-23	13.4%	
Sep-23	11.5%	
Oct-23	13.7%	
Nov-23	16.1%	
Dec-23	15.2%	
Jan-24	14.1%	
Feb-24	13.0%	

XMR Run Chart



Understanding the most recent data point

Performance

13.0%

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
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

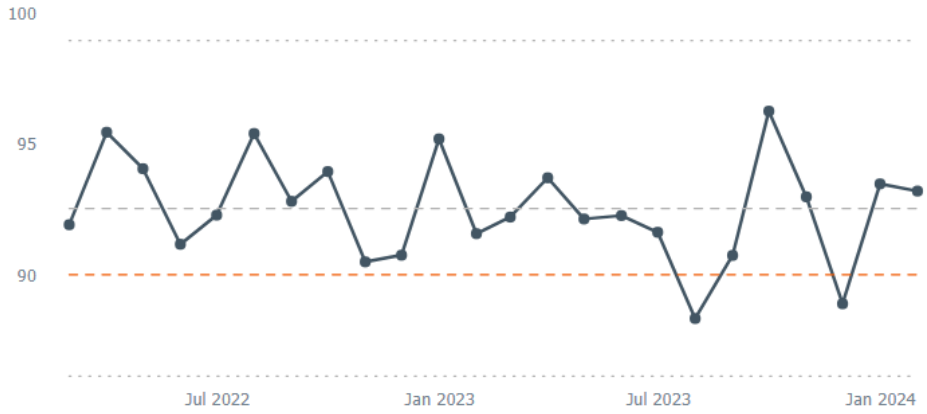
NHS East Kent Hospitals University NHS Foundation Trust

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
Mar-23	92.2%	
Apr-23	93.7%	
May-23	92.1%	
Jun-23	92.3%	
Jul-23	91.6%	
Aug-23	88.3%	
Sep-23	90.7%	
Oct-23	96.3%	
Nov-23	93.0%	
Dec-23	88.9%	
Jan-24	93.5%	
Feb-24	93.2%	

XMR Run Chart



Understanding the most recent data point

Performance

93.2%

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
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

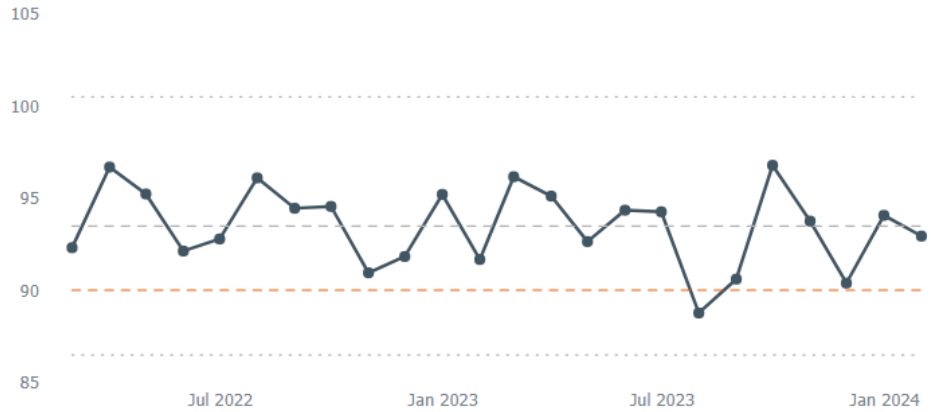
East Kent Hospitals University NHS Foundation Trust

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
Mar-23	96.2%	
Apr-23	95.1%	
May-23	92.6%	
Jun-23	94.3%	
Jul-23	94.3%	
Aug-23	88.8%	
Sep-23	90.6%	
Oct-23	96.8%	
Nov-23	93.8%	
Dec-23	90.4%	
Jan-24	94.1%	
Feb-24	92.9%	

XMR Run Chart



Understanding the most recent data point

Performance

92.9%

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 94.1% 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 LMNS undertaking further exploration of national data and opportunities to improve response rates

Women's Health Staff Engagement Score

Integrated Improvement Plan

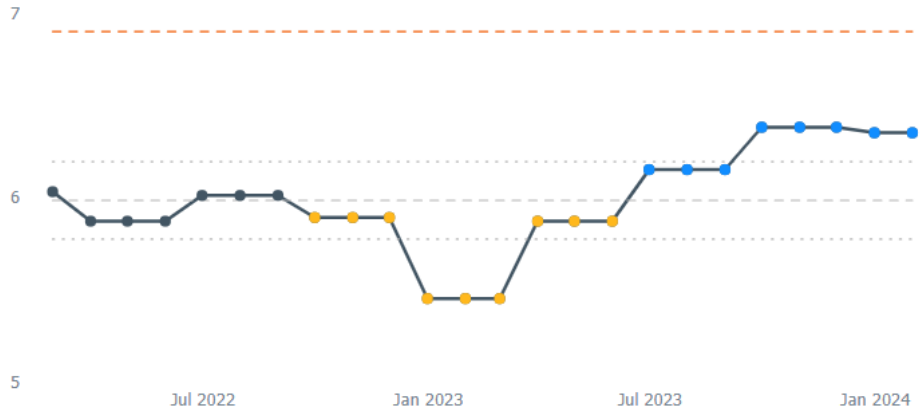
East Kent Hospitals University NHS Foundation Trust

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
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	
Oct-23	6.38	
Nov-23	6.38	
Dec-23	6.38	
Jan-24	6.35	
Feb-24	6.35	

XMR Run Chart



Understanding the most recent data point

Performance

6.35

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
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 received . 8 sessions have been facilitated by Korn Ferry with good attendance from local teams.. Work is being planned in response to staff feedback

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Month 11 Finance Report**

Meeting date: **4 April 2024**

Board sponsor: **Interim Chief Finance Officer (CFO)**

Paper Author: **Director of Finance**

Appendices:

Appendix 1: Finance Report

Executive summary:

Action required:	Information
Purpose of the Report:	The report is to update the Board on the current financial performance and actions being taken to address issues of concern.
Summary of key issues:	**Context:** Month 11 shows further improvement in the group's financial position. Agency employee expenditure continues to fall, and substantive staffing spend also fell back in month (following the non-recurrent impact of January's industrial action falling away). As a result, we have delivered our forecast position for month 11, in line with the £117.4m year-end deficit agreed with the national team. Income continues to perform ahead of forecast, reflecting improved operational performance allowing more patients to receive care at our hospitals. Inevitably this additional activity has incurred more cost, and so the non-pay position compared to forecast is overspent. The in-month position also saw the recognition at a group level of the back-pay agreement 2gether Support Solutions (2gether) reached with its staff. Whilst this was recognised in the month 11 financial position, our forecast expected this cost to be incurred in March. The fact that the group remained on track despite this earlier recognition talks to the underlying improvement being seen at the Trust. Looking forward we continue to work with partners across the system to deliver a significantly improved financial position in 2024/25. Given the performance over the last three months, there is reason to be hopeful that a material reduction in the size of the Trust's deficit can be achieved in 2024/25. **The Finance Report:** Our Board and NHS England have agreed a year-end forecast outturn for the Group of £117.4m deficit. The Group reported an in-month deficit position of £10.2m against a forecast deficit of £10.3m, resulting in a £0.1m improvement to forecast in month. The Year to Date (YTD) position is a £105.2m deficit against a forecast deficit of £105.4m, a YTD variance to forecast of £0.2m.

East Kent Hospitals University NHS Foundation Trust

	Trust Income is £3.6m favourable to forecast, as a result of higher than forecast Elective Recovery Fund (ERF) income and an increase in rechargeable drugs and devices (Homecare drugs, Haemophilia blood products, other drugs and High Cost Devices). These increases are offset by additional expenditure. Trust Employee Expenses is favourable to forecast by £1.5m YTD. Use of temporary staff is favourable to forecast by £2m YTD (Bank £0.5m and Agency £1.5m), mainly driven by better than expected winter impact. Trust Non-Pay is £4.6m adverse to forecast. There are fluctuations in the non-pay categories, however the adverse variance is predominantly due to increased levels of non-pay to deliver the additional patient care activity in month, together with an increase in high cost drugs and devices (which is offset by a corresponding increase in income). The Group cash balance (including subsidiaries) at the end of February was £37.9m. The Trust drew £2.6m of working capital (Public Dividend Capital (PDC)) in the month, making a YTD total of £87.8m. Total capital expenditure at the end of February was £22.4m spend against a plan of £24.8m; this represents a £2.4m net underspend YTD. The Trust is forecasting capital spend of £32.6m in 2023/24.
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 Trust Risk Register:	**CRR 137**: There is a risk that the Trust will not be able to meet its 23/24 efficiencies target equating to £40m.
Resource:	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 & Performance Committee

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2023/24

February 2024

Chief Finance Officer
Tim Glenn

Contents

CFO Message

Month 11 (February) 2023/24

Month 11 shows further improvement in the group's financial position. Agency employee expenditure continues to fall, and substantive staffing spend also fell back in month (following the non recurrent impact of January's industrial action falling away). As a result, we have delivered our forecast position for month 11, in line with the £117.4m year-end deficit agreed with the national team.

Income continues to perform ahead of forecast, reflecting improved operational performance allowing more patients to receive care at our hospitals. Inevitably this additional activity has incurred more cost, and so the non-pay position compared to forecast is overspent.

The in-month position also saw the recognition at a group level of the back-pay agreement 2gether reached with its staff. Whilst this was recognised in the month 11 financial position, our forecast expected this cost to be incurred in March. The fact that the group remained on track despite this earlier recognition talks to the underlying improvement being seen at the trust.

Looking forward, we continue to work with partners across the system to deliver a significantly improved financial position in 2024/25. Given the performance over the last three months, there is reason to be hopeful that a material reduction in the size of the trust's deficit can be achieved in 2024/25.

Trust Summary
Month 11 (February) 2023/24

	Trust			Trust		
	This Month			Year to Date		
(£'m)	**Forecast**	**Actual**	**Variance**	**Forecast**	**Actual**	**Variance**
NHS Income From Commissioners - exc. D&D	64.336	63.829	(0.507)	700.621	702.135	1.514
NHS Income From Commissioners - Drugs	4.577	5.154	0.578	50.343	51.960	1.617
NHS Income From Commissioners - Devices	0.554	0.371	(0.184)	6.098	6.304	0.206
Other Income	6.612	6.982	0.371	57.750	57.986	0.235
Total Income	**76.079**	**76.337**	**0.258**	**814.813**	**818.385**	**3.572**
Substantive Staff (inc. Apprenticeship Levy)	(44.684)	(44.301)	0.383	(483.581)	(484.092)	(0.511)
Bank Staff	(4.091)	(3.919)	0.172	(41.725)	(41.204)	0.521
Agency/Contract	(3.323)	(2.469)	0.854	(38.474)	(36.998)	1.476
Total Employee Expenses	**(52.098)**	**(50.689)**	**1.409**	**(563.780)**	**(562.293)**	**1.487**
Drugs	(3.633)	(3.920)	(0.287)	(38.759)	(39.966)	(1.208)
Rechargeable Drugs	(4.017)	(4.778)	(0.761)	(44.188)	(46.212)	(2.023)
Rechargeable Devices	(0.554)	(0.371)	0.184	(6.098)	(6.304)	(0.206)
Supplies and Services - Clinical	(4.700)	(3.868)	0.832	(43.650)	(41.893)	1.757
Supplies and Services - General	(12.039)	(11.814)	0.225	(130.459)	(130.601)	(0.142)
Clinical negligence	(2.550)	(2.550)	0.000	(28.047)	(28.047)	0.000
Depreciation and Amortisation	(2.003)	(1.857)	0.146	(21.086)	(21.187)	(0.100)
Other non pay	(3.744)	(4.253)	(0.509)	(36.702)	(39.428)	(2.726)
Total Other Operating Expenses	**(33.240)**	**(33.411)**	**(0.170)**	**(348.990)**	**(353.639)**	**(4.648)**
Non Operating Expenses	(1.082)	(0.715)	0.368	(9.142)	(9.011)	0.131
Profit/(Loss)	**(10.342)**	**(8.478)**	**1.863**	**(107.100)**	**(106.558)**	**0.542**
Less Technical Adjustments	0.073	(0.067)	0.140	0.692	1.001	(0.309)
Technically Adjusted Profit/(Loss)	**(10.415)**	**(8.411)**	**2.004**	**(106.408)**	**(105.557)**	**0.851**

The Trust YTD deficit is £105.6m against a forecast deficit of £106.4m; a £0.9m favourable variance to forecast.

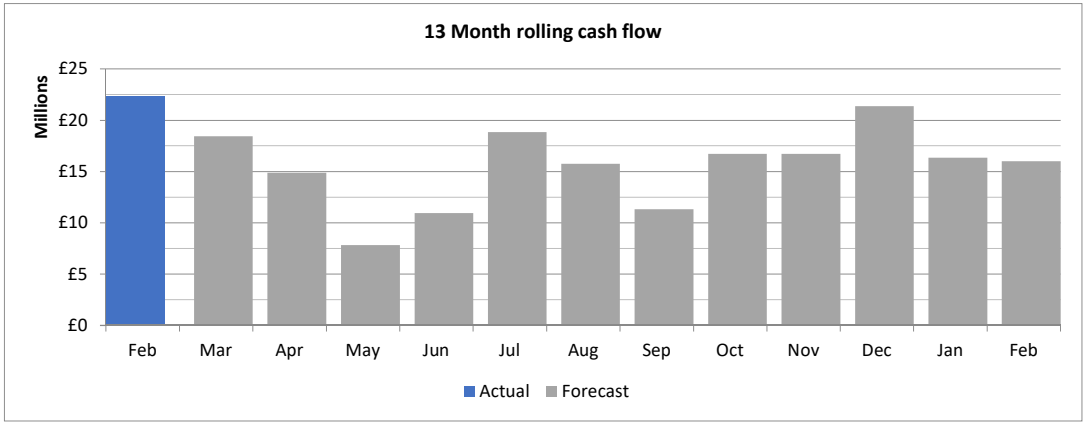
The key drivers are noted below.

Income:
Total income for the Trust is £3.6m above forecast YTD. The increase is predominantly as a result of higher than forecast Elective Recovery Fund (ERF) income and an increase in rechargeable drugs and devices (Homecare drugs, Haemophilia blood products, other drugs and High Cost Devices). These increases are offset by additional expenditure.

Employee expenses:
Employee Expenses is favourable to forecast by £1.5m YTD. Use of temporary staff is favourable to forecast by £2m YTD (Bank £0.5m and Agency £1.5m), mainly driven by better than expected winter impact.

Other operating expenses:
Other operating expenses is adverse to forecast by £4.6m YTD. There are fluctuations in the non pay categories, however the adverse variance is predominantly due to increased levels of non pay to deliver the additional patient care activity, together with an increase in high cost drugs and devices (which is offset by a corresponding increase in income).

Cash Flow
Month 11 (February) 2023/24



Unconsolidated Cash balance was £22.3m at the end of February 2024, £12.4m above plan.

Cash receipts in month totalled £87.6m (£6.9m above plan):

- K&M ICB paid £59.7m in February (£8.2m above plan)
- NHS England paid £18.7m in February (£1.1m above plan)
- Other NHS receipts totalled £1.1m (£0.1m below plan)
- Non NHS Receipts totalled £5.5m (£0.9m above plan)
- Revenue Support received in month was £2.6m (£3.1m below plan)

Cash payments in month totalled £87.9m (£4.5m above plan)
Creditor payment runs including Capital payments were £29.0m (£3.2m above plan). £14.7m payments to 2gether were £1.1m below plan. Payroll was £2.4m above plan primarily due to an increase in PAYE and NI Contributions in year.

YTD cash receipts total £975.3m (£81.0m above plan) largely driven by receipts from NHS England above plan (£32.3m, of which £17.2m was unconsolidated pay award in June) and revenue support above plan by £23.4m.

YTD cash payments total £971.5m (£68.7m above the plan) driven by payments to 2gether below plan (£14.5m), Payroll over plan (£42.5m, predominantly due to the unconsolidated pay award) and creditor payments over plan (£41.5m, due to increase in bank and agency spend).

2023/24 Forecast

The Group submitted a revised forecast at month 10 for a deficit of £117.4m.

Creditor Management

The Trust stayed at 30 day creditor terms in Month 11.

In prior months, payments to one key supplier were being held and invoices cleared only if the funds were available.

At the end of February 2024, the Trust was recording 53 creditor days (Calculated as invoiced creditors at 29th February/ Forecast non-pay expenditure x 365).

Statement of Financial Position

Month 11 (February) 2023/24

	Trust			2gether Support Solutions			Spencer Private Hospitals			Consolidation Adjustments			Group		
(£'m)	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**
Non Current Assets	**402.006**	**401.409**	**(0.597)**	**73.453**	**68.293**	**(5.160)**	**3.456**	**3.270**	**(0.186)**	**(153.387)**	**(147.138)**	**6.249**	**325.528**	**325.834**	**0.306**
Inventories	6.749	8.523	1.774	5.582	5.582	0.000	0.140	(0.003)	(0.143)	0.000	0.000	0.000	12.471	14.102	1.631
Trade Receivables	41.658	26.963	(14.695)	16.153	17.075	0.922	3.956	4.735	0.779	(17.264)	(23.764)	(6.500)	44.503	25.009	(19.494)
Accrued Income and Other Receivables	0.000	(2.078)	(2.078)	0.000	(0.053)	(0.053)	0.000	(0.059)	(0.059)	0.000	0.000	0.000	0.000	(2.190)	(2.190)
Assets Held For Sale	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Cash and Cash Equivalents	18.618	22.339	3.721	9.074	13.238	4.164	1.839	2.290	0.451	0.000	0.000	0.000	29.531	37.867	8.336
Current Assets	**67.025**	**55.747**	**(11.278)**	**30.809**	**35.842**	**5.033**	**5.935**	**6.963**	**1.028**	**(17.264)**	**(23.764)**	**(6.500)**	**86.505**	**74.788**	**(11.717)**
Payables and Accruals	84.178	91.776	7.598	16.398	18.466	2.068	4.010	4.813	0.803	(13.471)	(19.917)	(6.446)	91.115	95.138	4.023
Deferred Income and Other Liabilities	3.902	6.119	2.217	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(0.010)	(0.010)	3.902	6.109	2.207
Provisions	2.528	5.779	3.251	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	2.528	5.779	3.251
Borrowing	4.850	4.237	(0.613)	2.389	2.423	0.034	0.110	0.107	(0.003)	(4.822)	(4.321)	0.501	2.527	2.446	(0.081)
Current Liabilities	**95.458**	**107.911**	**12.453**	**18.787**	**20.889**	**2.102**	**4.120**	**4.920**	**0.800**	**(18.293)**	**(24.248)**	**(5.955)**	**100.072**	**109.472**	**9.400**
Provisions	3.764	3.282	(0.482)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	3.764	3.282	(0.482)
Borrowing	77.371	71.868	(5.503)	52.833	50.610	(2.223)	2.150	2.859	0.709	(121.872)	(116.171)	5.701	10.482	9.166	(1.316)
Non Current Liabilities	**81.135**	**75.150**	**(5.985)**	**52.833**	**50.610**	**(2.223)**	**2.150**	**2.859**	**0.709**	**(121.872)**	**(116.171)**	**5.701**	**14.246**	**12.448**	**(1.798)**
Net Assets	**292.438**	**274.095**	**(18.343)**	**32.642**	**32.636**	**(0.006)**	**3.121**	**2.454**	**(0.667)**	**(30.486)**	**(30.483)**	**0.003**	**297.715**	**278.700**	**(19.013)**
Public Dividend Capital	454.994	543.207	88.213	30.267	30.267	0.000	0.048	0.048	0.000	(30.315)	(30.315)	0.000	454.994	543.207	88.213
Retained Earnings	(217.591)	(331.010)	(113.419)	2.375	2.366	(0.009)	1.432	0.764	(0.668)	0.364	0.368	0.004	(213.420)	(327.512)	(114.092)
Revaluation Reserve	55.035	61.899	6.864	0.000	0.000	0.000	1.641	1.641	0.000	(0.535)	(0.535)	0.000	56.141	63.005	6.864
Taxpayers Equity	**292.438**	**274.096**	**(18.342) 1**	**32.642**	**32.633**	**(0.009) 2**	**3.121**	**2.453**	**(0.668) 3**	**(30.486)**	**(30.482)**	**0.004 4**	**297.715**	**278.700**	**(19.015)**

1. Trust

Non-Current Assets 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.

Current Assets - Accrued Income and receivables have decreased from the 2023/24 opening position by £16.8m (£10.7m in January). See Working Capital page for additional detail.

Current Liabilities - Payables have increased by £7.6m (£3.4m increase in January). See Working Capital sheet for more detail.

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

PDC increased in month by deficit support (total £2.6m).

2. 2gether Support Solutions

Non-current assets underspend due to limited capital spend, this is expected to be rectified in m12.

Borrowing value will reduce during the year as inter-company loans are repaid.

Cash value increased against a low opening position. No material increases in creditors which could be a consequence.

3. Spencer Private Hospitals

Current Assets increases in accrued income due to slow recovery of cash from ICB, this is also impacting on the reduced cash balance.

Current Liabilities balance increase due to increased costs for agency staff.

4. Consolidation Adjustments - Removal of inter-company transactions and loans.

Capital Expenditure
Month 11 (February) 2023/24

Capital Programme	Annual	Annual	Year to Date		
£000	Plan	Forecast	Plan	Actual	Variance
Emergency Department Expansions	4,271	7,355	4,271	7,139	(2,868)
Community Diagnostics Centre	2,845	1,725	2,436	1,675	761
Mechanical Thrombectomy	2,608	1,270	2,258	322	1,936
Diagnostics Clinical Equipment	2,550	3,210	2,125	1,123	1,002
Information Development Group	2,000	4,000	1,995	3,060	(1,065)
Medical Devices Group	1,666	2,772	1,518	1,242	276
Electronic Medical Records	1,545	1,826	1,505	1,683	(178)
Stroke HASU	1,463	825	1,192	708	484
Diagnostics Imaging Capacity	1,433	139	1,433	(0)	1,433
Patient Environment Investment Committee	3,771	3,067	3,771	1,057	2,714
Charity Donations	900	556	818	411	407
Other Build	736	1,748	736	1,345	(609)
Subsidiaries	519	837	450	253	197
Other IT	375	2,346	0	2,061	(2,061)
Other Medical Equipment	259	729	259	287	(28)
Trust IFRS16 Acquisitions	0	174	0	174	(174)
Lease Cars	0	36	0	36	(36)
All Other	0	9	0	(191)	191
	26,941	**32,624**	**24,767**	**22,385**	**2,382**

Funded By:	Plan	Forecast	Change
Operational Capital utilisation limit	18,665	22,530	3,865
System Capital PDC	1,463	754	(709)
Donations	900	556	(344)
Disposals	250	250	0
PDC	5,663	8,025	2,362
New Lease Loans	0	509	509
	26,941	**32,624**	**5,683**

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

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

The year-end forecast **at M11 is £32.6m** which is **a £5.7m net increase** from the original plan. This net impact is comprised of:

Increases against plan totalling £6.8m, of which:

• **£3.9m additional Operational Capital** (CDEL uplift only and not contingent upon being repaid in 2024/25), made up from:

£1.11m granted by NHSE in December 2023 to cover emergent Fire Safety risks; £2.04m agreed with the ICB in February 2024 as a means of mitigating system slippage and reducing the Trust's cost pressure in 2024/25 (funding allocated entirely to brought forward spend from 2024/25); £0.71m of Operational Capital, previously classified as System PDC (of the £1.46m System PDC to fund the Stroke HASU, only £0.75m was cash-backed by the DHSC, so the remaining £0.71m had to be re-classified as Operational Capital).

• **£2.4m of additional PDC funding**: £1.7m for Digital Histopathology (ICB Business Case); £0.4m for Paediatric Scopes/ Guides; £0.3m of capital reimbursement from other K&M Trusts to EKHUFT, as we are the main contract holder for iRefer.

• **£0.5m CDEL Uplift relating to IFRS16 items**, confirmed by NHSE in March 2024, to fund the IFRS16 items at the level of the 2023/24 forecast outturn position reported in M10 (which has not changed).

Reductions against plan totalling £1.1m, of which:

£0.71m relates to a re-classification of System PDC capital as Operational Capital in M11, following the outcome of the Trust's System PDC Cash Application to NHSE and DHSC (as detailed above); £0.34m forecast reduction on Charity Donations expenditure and £0.05m was due to a reduction in the Diagnostic Imaging Capacity PDC to align it to the final funding figure provided by NHSE in the MOU (matched to spend).

YTD Capital Spend

The Group's gross capital spend YTD to the end of Month 11 was £22.4m, against a revised year-end forecast outturn (FOT) of £32.6m. Capital expenditure of £10.2m is required in the next month to the end of March 2024, for the Trust to deliver on its capital commitments in 2023/24.

The regional NHSE colleagues have now confirmed that the IFRS16 impact (based on the M10 reported FOT) in 2023/24 will be fully funded for the South-East Region. The funding is not inclusive of any subsequent increases incurred after the M10, however, the Trust's forecast in respect of IFRS16 items (totalling £0.5m) has not changed.

Risks and Mitigations

The delivery of the £36.2m forecast outturn includes an inherent degree of risk associated with the scale of capital expenditure planned in M12, totalling £10.2m. To support this delivery, weekly review meetings chaired by the Director of Strategy are being held (implemented in February) with all key scheme leads to ensure any logistical issues are picked up early and mitigating actions are agreed so that the Trust will deliver it's capital FOT.

A potential additional risk of underspend against the current FOT has been flagged at M11 (circa £0.2m), relating to levels of VAT recovery and Prior Year Schemes. This will also be managed as part of the above process.

Cost Improvement Summary

Month 11 (February) 2023/24

Delivery Summary	This Month		Year to Date		Forecast
Programme Themes £000	Forecast	Actual	Forecast	Actual	Outturn
Agency	-	-	550	550	550
Bank	3	-	9	6	6
Workforce	45	48	468	471	516
Outpatients	-	-	43	43	43
Procurement	30	32	573	576	594
Medicines Value	37	51	540	554	591
Theatres	-	-	-	-	-
Care Group Schemes *	633	635	3,373	3,376	4,004
Sub-total	**748**	**767**	**5,557**	**5,576**	**6,304**
Central	-	-	6,795	6,795	6,795
Grand Total	**748**	**767**	**12,352**	**12,371**	**13,099**

* Smaller divisional schemes not allocated to a work stream

Delivered £000		
Month	Target	Actual
April	58	58
May	149	149
June	290	290
July	311	311
August	5,422	5,422
September	842	842
October	1,379	1,379
November	940	940
December	1,577	1,577
January	635	635
February	748	767
March	748	
	13,099	**12,371**

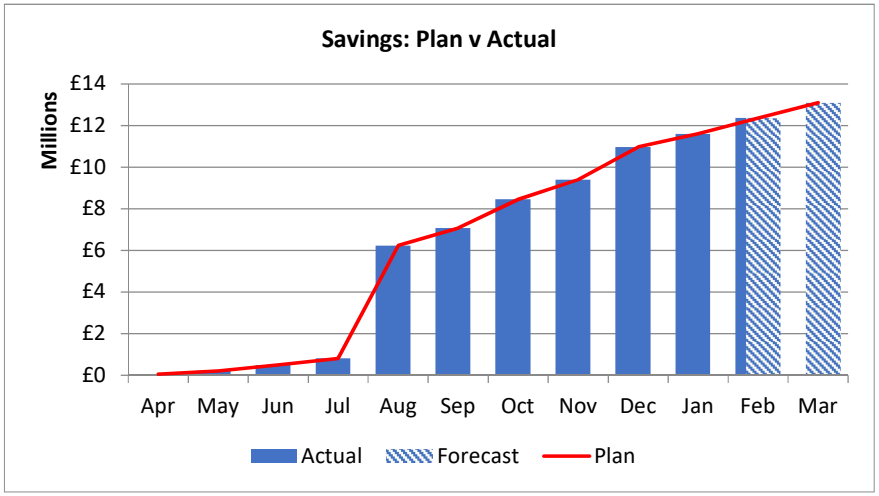
Efficiencies

The agreed Efficiencies FOT plan for 2023/24 is £13.1m. The Trust recognised recurrent savings of £0.1m in February, and £3.2m on a YTD basis. Schemes relating to income are delivering, with £0.6m in month, and forecast £5.4m (Clinical £2.2m Non-clinical £3.2) for FY 23/24.

There are various theme based workstreams including vacancy and non-pay panels to support the reduction in Run Rate.

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.

Theme Executive Owners Theme leads have been agreed to carry this work forward, with support from the PMO, and have developed a refined list of quantified schemes for milestone 2 at the end of February. PIDs and QIAs are planned to be completed and signed off by the end of March. This will put the trust in a strong position to commence delivery in FY24/25.



East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

Report title: **Report on Journey to Exit NHS Oversight Framework 4 (NOF4) and Integrated Improvement Plan (IIP)**

Meeting date: **4 April 2024**

Board sponsor: **Chief Executive**

Paper Author: **Chief Strategy and Partnerships Officer**

Appendices:

Appendix 1: IIP Update – March 2024 Summary
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 at EKHUFT on delivery progress of the IIP during February 2024 and offers assurance based on evidence gathered for how this is influencing the exit criteria set within the NHS England Recovery Support Programme (RSP) National Oversight Framework Segment 4 (NOF4) as at Q3. 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. The Leadership & Governance, Maternity, and People & Culture programmes continue to be rated as green this month. Progress continues to be made in Quality & Safety which remains amber. Operational Performance and Finance programmes continue to be rated as red in this period which are the biggest risk to delivery and exit from NOF4. There has been a significant focus on reviewing the risks associated with the IIP risks in this reporting period. The Strategic Improvement Committee (SIC) agreed that there should no longer be an independent risk register associated with the IIP following the work that has been undertaken throughout the organisation on the management of risk. The IIP risks have now been reviewed and aligned with the overarching Trust risk register with any duplications closed. Moving forward any risks associated with the IIP will be monitored both at the SIC and through the revised and strengthened organisations risk governance process. Detail of the remaining risks associated with the IIP can be found on Appendix 2.

East Kent Hospitals University NHS Foundation Trust

	Evidence continues to be gathered against the IIP and the SIC continue to self-assess against the NOF4 exit criteria which is shared in the IIP Board report based on current evidence gathered as at the Q3 position. Evidence now continues to be gathered to support the Q4 closing position of the 2023/24 RSP programme and will be shared in a future report to the Board of Directors.
Key recommendations:	The Board of Directors is invited to **DISCUSS** the report on Journey to Exit NOF4 and IIP.

Implications:

Links to Strategic Theme:	This report aims to support: • Quality and Safety • Patients • People • Partnerships • Sustainability
Link to Trust Risk Register:	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:

Oversight and Assurance is provided through the Strategic Improvement Committee (SIC).

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

East Kent Hospitals University NHS Foundation Trust

Journey to Exit NHS Oversight Framework 4 (NOF4) – IIP Update

March 2024 Summary

Purpose of Report

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 with a programme RAG self-assessment. 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**	Key appointments have been made by Chief Medical Officer (CMO) to strengthen structure. Plan is in progress to recruit a substantive Chief Finance Officer (CFO). 2023 Staff Survey results published and response from Exec Team is in progress.
	Governance	Governance model roll out continues and full implementation remains on target for the end of March ’24. Board Assurance Framework (BAF) has now been finalised and is at the 'sign off' phase at sub-committees before being presented to Trust Board.
	Comms & Engagement	This project RAG 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).
	Transformation Programme	Development of Trust strategy was discussed at the board Development Day and outline plan is being developed. Training and engagement plan produced for 'We Care' Improvement Methodology refresh.
People and Culture	**Attract and Retain**	This project remains RAG rated as green. The overarching Whole Time Equivalent (WTE) plan for the Trust is in its final stages and remains on track. Workforce plans for each specialty have not been completed and although the deadline is end of March, with current priorities this is unlikely to be achieved. Following the evidence review panel and thorough self assessment, the evidence provided for recruitment trajectories and delivery of these have moved the programme evidence to blue indicating embedded and fully assured
	Culture Leadership & Development	This project remains RAG rated at green with continued progress against milestones. The Culture and Leadership Programme (CLP) is reaching is final stages of discovery, with board papers being prepared to share. NSS results embargoed until March 24. New organisational dashboard has been written and will replace the 2023 version.
	Medical Workforce	This programme RAG remains amber, with the team remaining confident that the right mitigating milestones have been put in place for the completion of Phase 2. The rostering business case has been signed off and work is commence with the early adopter areas. Continued sharing of the evidence of KPIs available for medical, outside of a unique dashboard along with summaries of social media progress and analysis.

High-level Assurance on Programme/Project Delivery

Programme	Project	Summary
Quality & Safety	Quality Governance	The following actions have been taken to improve 72hour report provision to the Integrated Care Board (ICB): Coaching the Care Group Governance teams to streamline the investigation prior to 72hr report submission. Meetings held between the Director of Quality Governance and members of all Care Group Triumvirates to better inform them of the process and the associated timeline requirements. Pre-populating the 72hr report with Terms of reference to make this easier for the Care Groups to complete. Actions taken to comply with meeting the 60 day due date for SI reports: Have significantly improved in the past 12 months, however continued work has been required to prevent breaches from occurring (1 in February): Weekly meetings between Patient Safety Leads and Care Group governance leads to monitor progress and to identify potential barriers to completion Escalation to Director of Quality Governance of any investigations not on track for completion Weekly Quality Governance update to executives identifying overdue serious incident's (SIs) and actions taken to progress Monthly SI report to Clinical Executive Management Group (CEMG) and board with updates on overdue SI's and progress. The PSIRF Plan and Policy Board approval routes and sign off dates have been agreed. Intention to submit for ICB approval w/c 25 March 2024.
	Safeguarding	As part of the induction programme the new head of safeguarding has met with the ICB designated professionals , clear communication was a theme of this discussion and monthly oversight meetings communicate progress in line with the safeguarding accountability and assurance framework. Process and dataset are being reviewed to monitor sustained change this will continue to be presented to the safeguarding operational group and feed into the safeguarding assurance committee through to the board . This will give sight of any emerging risks and maintenance of achieved standards. Continued improvement has been achieved in training compliance With all safeguarding children's levels above 85% and level 1 & 2 Adults above 85% Level 3 Adults now 79%. The yearly review of training needs analysis is in progress. Additional training has been delivered to hard to reach staffing groups . The interim Head of safeguarding met prior to the Agency and subcontracted services task and finish group gaining further assurance from providers around safeguarding training in place and escalation measures when we have a safeguarding concern regard a member of staff they provide . The policy is drafted for restraint and key stakeholder feedback is currently being sort. Safeguarding supervision is ongoing and their is work take place in the maternity space to improve levels . The role of section 42s is being received positively by the care groups and supervision is part of the support offer with this . The Safeguarding adult self assessment framework has been completed and peer reviewed the Safeguarding adults board remarked on significant and sustained progress with EKHUFT prioritising safeguarding
	Fundamentals of Care	Significant progress continues to be made in the completion and evidencing of the Fundamentals of Care milestones. Currently, just 2 of the original 17 milestones remain open, this project remains RAG green and is on track to close within the next 8 weeks.
	Deteriorating Patient	The Focus on recognising, responding and escalating the deteriorating patient continues. The Q3 National Early Warning Score (NEWS2) Commissioning for Quality and Innovation (CQUIN) report evidenced compliance greater than national target set for NEWS2 recording identification, escalation and response to the clinical deterioration of patients. To learn from incidents relating to the deteriorating patient, additional data is collected, which is beyond the scope of the CQUIN and presented at the deteriorating patient steering group (DPSG) monthly. This information identifies progress in CQUIN compliance, clinical areas where unplanned emergency admissions to critical care units have been identified in order to monitor trends. Clinical reasons for critical care admissions are monitored from the patient demographic within the CQUIN to identify themes to facilitate planning of further education in relation to the deteriorating patient. This report is generated and discussed monthly to learn from recurrent themes if identified. The CQUIN reports are also shared to the senior nursing team to monitor and disseminate information for learning. Engagement in this scope of practice has been evidenced with the NEWS2 e-learning compliance trajectory. A dashboard of Critical Care Outreach Team (CCOT) activity has been created and will be available for reporting subsequent to the completion of the CQUIN (March 2024) to ensure monitoring, reporting and learning continue within this scope of practice. Due to assurance from governance of the DPSG reporting to Patient Safety Committee (PSC) and with the support of the deteriorating patient lead nurse, learning from SIs relating to patient deterioration has a streamlined process to ensure improvement in practice can be delivered.

High-level Assurance on Programme/Project Delivery

Programme	Project	Summary
Operational Performance Continued…	Urgent & Emergency Care (UEC) and Whole System Interface	Performance for February improved for all types (70.4% v 68.5% Jan) with type 1 at 44.8% v 42.7% January. The % of patients staying over 12 hours in the department also improved from the previous month(10.6% v11.3%). The Emergency Care Delivery Group (ECDG) is focussed on reducing the 12 hour waits in Emergency Department (ED), for both adults and paediatrics. Paediatric performance for February was 70.9% v 71.7% in Jan. Both sites continue to focus on delivering the Length of stay, improving patient flow programme with the Internal Professional Standards being reviewed for launch March 24. Ambulance conveyances to the sites report a circa 10% reduction following the implementation of the single point of contact with Queen Elizabeth the Queen Mother Hospital (QEQM) in place from February. Patients staying over 14 days and 21 days continue to show month on month improvement (229 v 249 in Jan). Getting it Right First Time (GIRFT) review of the recommendations is planned for March with support to further develop the Acute Frailty pathways.
	Elective Recovery (including Diagnostics)	The Elective position remains red as the current revised trajectories are forecasting 651 78wk breaches as of the end of March 24 against the original expectation of zero. The trust is on target to meet the 651 target. The trust has created a clear targeted plan of improvement, driven through the weekly Access meetings which commenced on the 25 January. Remaining risks relate to Otology (52), Functional Endoscopic Sinus Surgery (FESS) (131) and largely the Endoscopy backlogs. The Endoscopy backlog has reduced from 13,350 at the start of January to 11,917 at the end of February. The programme of Quantitative Faecal Immunochemical Test (QFIT) testing the routine backlog (2,037 patients) commenced on 29 January as planned and will be completed by the end of March. To date of the 182 QFIT tests returned 76% have a score of <10 so fit to be discharged which highlights the importance of QFIT testing forming part of initial referrals into the Trust. An internal secondment to the role of Endoscopy Lead has been appointed starting on 13 March to focus on effective booking utilisation, consolidation of waiting lists and creation of a clear recovery plan for the organisation. DM01 compliance has improved from 55.8% in December to 61.26% at the end of February. The particular improvement has been seen in MRI and CT which has been due to the drastic reduction in CT vetting now at below 500 patients. A detailed recovery plan for Imaging is now in place and reviewed at the weekly Access Meeting. Emergency Care Improvement Support Team (ECIST) support commenced on 5th February to develop a clear Patient Tracking List (PTL) training programme to improve validation (to commence in April), update the Trust Access policy & design of key DQ reporting to aid training and to progress the 12 week validation programme for the Trust. MBI have commenced on 19 February to complete targeted validation of Referral to Treatment (RTT) (12,490) and full review of DM01 (13,446) above 7 weeks. This is going well with 3,576 pathways reviewed and on plan for completion.
	Cancer	Weekly trajectory's are being delivered. Dedicated senior project manager has been released to focus on our Urology our greatest risk, adding to the learning and the weekly Faster Diagnosis Standard (FDS) Straight to Test (STT) prostrate pathway work. Additional radiology support being provided for Virtual colonoscopy capacity, vetting, booking and reporting. We have also been working on a new Business Intelligence (BI) process that helps support the highest priorities within radiology re: longest waiters and FDS, to reduce escalation, improve team working and the celebration of the talents. Additional week-end lists for Dermatology have started and treated over 50 patients which is supporting the improvement. The new Cancer Deliver Board chaired by the Chief Operating Officer (COO) met on the 21 February with really good attendance and a presentation from the Managing Director (MD) of the Kent and Medway Cancer Alliance re Streamlining Multi-Disciplinary Meetings (MDM's) going forward. FDS performance for Feb 68.3% against the trajectory of 65%. D104 back log for the week commencing 4th 55 patients against a trajectory of 64 and 62D 221 patients against the trajectory of 256. National League table shows an improving position from 34th to 73rd.
Maternity	Team Working	This project RAG moves from green to blue due to the demonstrable sustainability in the milestones. The obstetric rotas that went live in January have been recognised as good practice by the Regional Obstetric lead during the regional and Maternity Safety Support Programme (MSSP) review on 8 Feb 24. Team working events and leadership/culture sessions continue to be held across the service as BAU.
	Clinical Escalation & Handover	To support the embedding of quarterly escalation audits, a number of task and finish groups have been re-established to highlight areas for improvement that will see improved compliance against the auditable standards e.g Venous Thromboembolism (VTE). A new 'Pregnant People in Hospital' PTL has been developed and implemented across maternity with ways of working being refined with the clinical team to ensure the safety of outliers across the hospital (cross site).

High-level Assurance on Programme/Project Delivery

Programme	Project	
Maternity Continued…..	**Clinical Assessment & Care Pathways**	Centralised telephone triage is in the final stage of completion; office relocation complete, triage PTL is live cross site, training is underway pending finalisation of the call system model. Once live, the telephony system will have call recording available to record and listen back for quality and training purposes. Medical devices for the new Enhanced Maternity Care (EMC) (previously referred to as High Dependency Unit (HDU)) service are in the procurement process and essential to the go live date of EMC. Discharge trends continue to be monitored at stop the clocks
	Governance & Patient Safety	The Quality Standards Framework (QSF) was approved by the women's health clinical governance group on 8 Feb. Patient safety backlogs continue to be progressed and will have future oversight for sustainability by the new Head of Governance due to start in April 24 Weekly learning forum established for sharing learning from incidents and complaints which reports through into the women's health perinatal mortality and morbidity (MnM) group and upwards through the care group governance structure to Trust Board
	Engagement, Listening & Leadership	Coproduction event with Maternity and Neonatal Voices Partnership (MNVP) booked for 12 March to develop a post natal booklet for pregnant people. Score result has been shared with the QUAD and are now being shared with the wider workforce through 8 feedback sessions from which themes for learning will be shared back with the QUAD to identify areas and ideas for improvement.
Finance	**Financial Governance**	During the Q3 Evidence Review and Assurance panel, discussions were held on the considerable change in landscape with financial grip and controls and the significant change in the way that this programme is now being managed, resulting in a change to the reporting against the current Exit Criteria. It was recognised that Finance remains a significant challenge for the Organisation and will remain in NOF4 going into 24/25. The revised financial recovery plan does not align to the original IIP agreed in May 23 and in acknowledging this, the panel agreed that this would be the closing position for the 23/24 IIP, on what is deemed historical, out of date exit criteria and suggested evidence
	Financial Improvement	
	Financial Consciousness	

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/NHS England (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 Healthcare Partnership (HCP) for East Kent, the provider collaboratives and the Integrated Care System (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, Freedom to Speak Up (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 and never events (SIs and Never Events (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 - Maternity

NHS 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 Health Education England (HEE) & Nursing & Midwifery Council (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 – Care Quality Commission (CQC), NHSE (Ockenden), National Institute for Health and Care Excellence (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 – 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 - 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

Significant risks to IIP delivery in this period:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Risk Control	Date of Last Review	Residual Risk Score	Risk Trend
1891	14.01.24	Operational Performance	Rob Hodgkiss	Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway	20	a) Daily board rounds at ward level to release beds b) Daily sitrep calls with EK HCP and Kent and Medway OCC c) Kent and Medway UEC Delivery Board provides system wide strategic direction attended by the COO d) Trust Access Standards monitored 'ED 12 Hour Total Time in Department'		20	⬌
3528	04.10.23	Operational Performance	Rob Hodgkiss	Patients are at risk of breaching the national cancer standards. This could result in patients waiting longer for treatment with associated poor patient outcomes and patient experience.	20	a) 104 day process developed and being followed. Low volume TSSG less of a concern than High volume e.g Lower GI b) Daily report of patients over 62 days sent to all the Care Group Ops Managers which is followed up by a daily phone call for an update and decision. Out Patient booking managers and General Managers to monitor and resolve any capacity issues. Daily email sent to Pathway Manager at Maidstone and Tunbridge Well NHS Trust to escalate patients to book for Oncology. Director of Operations will liaise with Ops Directors in other Care Groups to expedite patient's treatment c) Daily report of patients over 62 days sent to all the Care Group Ops Managers which is followed up by a daily phone call for an update and decision. Out Patient booking managers and General Managers to monitor and resolve any capacity issues. Daily email sent to Pathway Manager at Maidstone and Tunbridge Well NHS Trust to escalate patients to book for Oncology. Director of Operations will liaise with Ops Directors in other Care Groups to expedite patient's treatment d) Implementation of UGI and Lung STT service in 2021 followed by the LGI STT service in 2023 Weekly cancer tumour site PTL meetings to monitor all cancer standards. Track patients through their pathway . Optimise pathway if can. e) Weekly KPI meeting led by COO, Deputy COO for Elective Services and Director of Performance with Operations Directors and General Managers f) Weekly tertiary centre PTL to escalate any patients of concern externally		16	⬌

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

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Significant risks to IIP delivery in this period continued:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Actions Required	Date of Last Review	Residual Risk Score	Risk Trend
2038	09.04.20	Operational Performance	Rob Hodgkiss	Misalignment between Demand and Capacity across the Trust's RTT, non-RTT and Cancer pathways	16	a) All 52 week breaches will be added to datix closely monitored by clinical and operational teams. Patients are monitored on a 3 monthly basis by post. Patients continue to be treated in clinical priority order. b) Consultants risk stratifying their outpatient and surgery waiting lists to identify any urgent cases that need to be seen or treated. c) Daily elective PTL meetings to maximise capacity and maintain flow in conjunction with weekly access meetings at COO level to ensure grip and control. d) External validation team (MBI) commissioned to complete validation of all DM01 > 7 weeks (13,446) and 50% of the existing unvalidated RTT (13,000 commissioned). e) NHSEI focus to have dates for all patients waiting over 65 weeks by the end of March 2024. Additional activity added to the business plan to enable delivery. f) To maintain an equipment register that will proactively highlight any pending risks g) Trust under Tier 1 oversight with fortnightly reviews of performance within Elective Recovery and also Cancer. h) Trust validation teams regularly review longer waiting patients to ensure harm is minimised wherever possible.		16	⇔
3536	10.10.23	Operational Performance	Rob Hodgkiss	Delayed diagnostics for patients awaiting Endoscopy	16	a) Additional 1000 scopes per month sourced through ID medical from November 2023 b) Administrative validation c) Task and finish recovery group established with COO, Deputy COO and Executive Director of Communications and Engagement membership		16	⇔
1679	10.06.19	People & Culture	Andrea Ashman	There is a risk of failure to address poor organisational culture	16	a) Agreed HR KPIs (Inc. vacancy rate, turnover and engagement scores) b) Alignment of leadership framework with the behavioural framework and competencies within We Care c) Clinical and non-clinical leadership programmes in place d) EDI strategy in place e) Freedom to Speak Up policy and dedicated Freedom to Speak Up guardians meet monthly with Chief People Officer f) Leadership diagnostics g) Revised Disciplinary Policy to include Just and learning culture practices h) Staff Survey action plan progress reports standing agenda item for PCC i) Trust-wide leadership competency framework		16	⇔

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

Significant risks to IIP delivery in this period continued:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Actions Required	Date of Last Review	Residual Risk Score	Risk Trend
2565	21.09.21	Maternity	Sarah Hayes	There is a risk of inadequate midwifery staffing levels and skills to meet the needs of women and there families	20	a) 10 am service SITREP staffing reviews undertaken to identify gaps and put in place actions eg: re location of staff to address b) Active utilisation of escalation policy to manage activity vs staffing. Including divert escalation between sites. c) All shifts to be released to NHSP as soon as possible. Where possible agency lines booking in place d) Daily review of staffing by operational lead and senior team. Out of hours the manager on call will facilitate this. Long line of agency set up where there are on going gaps e) International recruitment of 18 wte midwives. f) NHSP offered through community g) Recruitment approach modernised to maximise the opportunities by working with HR and use of social media h) Specialist midwives redeployed in times of increased acuity and escalation i) Suspension of continuity of carer j) Utilisation of managers on call and community midwives to support.		16	⇔
3084	31.01.23	Maternity	Sarah Hayes	QEQM - Regulatory action - Section 31 notice due to risk to safety during fire due to maintenance of fire routes primary and secondary and adherence to fire protocols	15	a) 2gether and estates have completed a review of all areas and decluttered b) Additional notices deployed to remind staff to keep fire doors closed c) Closing mechanisms (automatic closing) for fire doors has been reviewed and repaired where necessary d) Daily environmental checking in place to ensure fire exits are clear and door closed		9	⇔
3133	09.03.23	Finance	Tim Glenn	Non delivery of the agreed CIP programme that contributes to the Trust deficit position	20	a) A new Financial Improvement Board, chaired by the CEO, meets every two weeks to focus on the progress of implementation against agreed milestone and to track financial benefits. b) A Non-Pay Panel, chaired by Executive Directors in rotation, has been created which initially meets weekly to review all requisitions and purchase orders above £500 c) Model Hospital benchmarking to identify areas d) New Vacancy Control Panels for each Care Group meet to approve recruitment. Agency, bank, interim, FTC and locum usage. Also approves grade and pay changes.		20	⇔

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	Actions Required	Date of Last Review	Residual Risk Score	Risk Trend
3574	07.11.23	Quality	Sarah Hayes	There are a significant number of risks at Care Group and Specialty level currently scored at 15 or above which could compromise the delivery of high quality, safe and patient-centred care.	16	a) A comprehensive review and refresh of the current Corporate, Care Group and Specialty level risk registers is underway b) Risk Review Group in place chaired by Chief Nursing & Midwifery Officer (CNMO) c) The Board and its' sub-Committees receive monthly progress reports on the progress of this review.		16	⬌
3495	18.09.23	Quality Safeguarding	Sarah Hayes	The Trust is to ensure that the purpose of the S42 investigation is understood, the recommendations and actions are embedded in the Trust		a) Completed a paper which was presented to the August Safeguarding Assurance Committee on 10/08 /2023, and outlined the number of external assurance meetings and duplications in place relating to safeguarding and the potential impact this was having on safeguarding activities b) Interface between mental health and mental capacity being rolled out across the Trust starting with ED c) New Complex Discharge and Transfer SOP completed d) New Complex discharge group commenced to mitigate risks within the Trust e) New Service Level Agreement with KMPT now in place f) NHSE national recovery support team g) Paper on how lessons learnt from SARs and DHRs presented to Safeguarding Assurance Committee on 10/08/2023 and Fundamentals of Care Committee 17/08/2023 to mitigate the risks h) Raised concerns with Chief Nursing and Midwifery Officer and Non-Executive Director for Safeguarding with regards to the impact on the safeguarding activities 11/09/2023 outlining the risk i) Scoping on people with mental health against CQC Inspection into acute Trust completed in March 2023 j) Thematic reviews undertaken and action plans completed and incorporated into business as usual activities k) Training ,examples of high standard work and 1;1 support of care groups supporting S$" investigations since Jan 24. Safeguarding team will review prior to final submission for quality control		9	⬌
3559	02.11.23	Quality	Sarah Hayes			a) Budget and ESR review to ensure staff list is accurate b) Current trajectories have shown continual rise in compliance, medical compliance and paediatric nursing compliance area of focus currently. Training is available but currently not booked c) Successful recruited Business and Quality Manager who is supporting the improvement programme for mandatory and statutory training d) Training records being maintained and staff attendance monitored manually by line managers. Performance reviews are taking place monthly and training compliance is a standing item at our care groups quality and business meetings e) Where possible, staffing gaps are covered by moving staff who are on clinical shifts rather than moving staff from or cancelling training.			⬌

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 IIP delivery in this period continued:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Actions Required	Date of Last Review	Residual Risk Score	Risk Trend
2115	29.06.20	Quality & Safety	Sarah Hayes	Lack of timely recognition and response to the deteriorating patient	16	a) Clinical Induction contains management of deteriorating patients including the septic patient b) Deteriorating Patient Report to Nursing, Midwifery and Allied Health Professional Board bi-monthly c) Deteriorating Patient Steering Group and resus council committee Trust-wide feeding in to Patient Safety Committee d) ED dashboard in place with triggers for NEWS e) Education and Training - ILS, PILS, ALERT, NEWS2, ALS, BEACH, acute respiratory study day and tracheostomy emergency training continues. f) Management of the Deteriorating Adult Patient policy g) Management of the Deteriorating Child and Young Person Policy h) NEWS2 CQUIN for patients admitted to ICU reported to ICB and locally to the deteriorating patient steering group monthly. i) Resus Committee to amalgamate with Deteriorating Patient Steering Group as of March 24 j) Sepsis clinical documents included on Sunrise		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	Mitigating Actions	Date of Last Review	Residual Risk Score	Risk Trend

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
3.7.01	12.12.23	Operational Performance	Jane Dickson	Junior Drs strike in January 24 will affect UEC and whole system pathway performance.	16	No longer considered a risk, request to close	14.03.24	9	⟺
2.101	29.06.2023	Maternity	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.	8	QSF Signed off and communicated 23rd Feb 24 . Risk to close		2	⟺

Summary

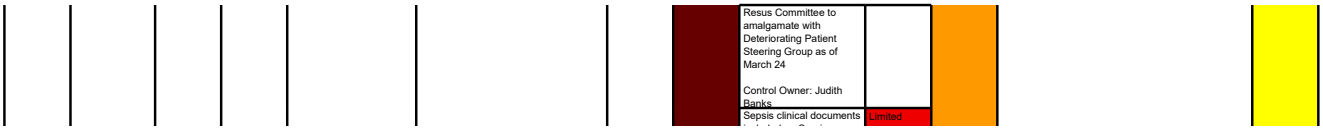
- At the beginning of this reporting period 26 risks were recorded on the original stand alone IIP risk register.
- In line with the work that has been completed by the Quality Governance team, reviewing and reassessing the corporate risk register, all IIP risks have now been aligned to the Trusts overarching risk register. This replaces the IIP register.
- No new risks have been added during this reporting period and 2 risks have closed relating to Junior Drs strikes and the completion of the QSF in Maternity.
- In total 28 key areas of risk were discussed in this period relating to delivery against the IIP and the closing position after the amalgamations are 12 risks on the Trust risk register that relate to the IIP
- 12 risks open on the Trust risk register and relate to the IIP, summary per programme is as follows; 1 Finance (reduced from 5), 0 Leadership & Governance (reduced from 1), 3 Maternity, 4 Operational Performance (reduced from 9), 2 People & Culture (reducing from 3), 4 Quality & Safety risks.
- All 12 of these risks are classed as significant, with a score over 15, and are reported within this report
- Please see Appendix A for a full detailed IIP Risk Register.

Open Risks on Trust Risk Register Linked to IIP (as at 14th March 2024)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
1891	14/01/2020	Corporate - Operations		Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway Risk Owner: Robert Hodgkiss Delegated Risk Owner: Last Updated: 13 Mar 2024 Latest Review Date: 09 Feb 2024 Latest Review By: Rhiannon Adey Latest Review Comments: Risk reviewed by Business Manager to the COO. Controls and actions revised.	Cause: The increasing demand for healthcare services within the Trust has surpassed the existing capacity, leading to strain on resources, longer waiting times, and compromised patient care. Effect: Elevated patient dissatisfaction due to prolonged waiting times. Possible decline in the quality of the services provided. Increased risk of adverse patient outcomes. Strain on staff leading to burnout and decreased morale.	Quality	I = 4 L = 5 Extreme (20)	Daily board rounds at ward level to release beds Daily sitrep calls with EK Kent and Medway UEC Trust Access Standards monitored 'ED 12 Hour Total Time in Department' Control Owner: Robert Hodgkiss	Limited Adequate Adequate Limited	I = 4 L = 5 Extreme (20)	Expand trial of SPoA to QEQM Person Responsible: Sandra Cotter To be implemented by: 29 Feb 2024 Further enhance Further enhance collaboration with community healthcare providers to alleviate ED burden with measure attendance avoidance Person Responsible: Sandra Cotter Further enhance Utilise investment from the	**09 Feb 2024** **Rhiannon Adey** **09 Feb 2024** **Rhiannon Adey** From March 24 the further embedding of SAFER will be supported by the site based discharge taskforce.	I = 3 L = 2 Low (6)
3528	04/10/2023	Corporate - Operations		Patients are at risk of breaching the national cancer standards. This could result in patients waiting longer for treatment with associated poor patient outcomes and patient experience. Risk Owner: Robert Hodgkiss Delegated Risk Owner: Sunny Chada Last Updated: 15 Feb 2024 Latest Review Date: 15 Feb 2024 Latest Review By: Janet Murat Latest Review Comments: Risk title revised in discussion with COO.	Cause: Delays with diagnostic capacity and earlier in cancer pathway cause later delays Surgical capacity issues in Urology & Colorectal Staffing issues due vacancy & recruitment of specialist trained clinician specific to certain tumour groups e.g Urology. Limited EMR availability , limited GA & Heavy sedation availability for colonoscopy. EPIC introduction in GSTT & KCH with limited notice TP biopsy process in Urology Patient choice Effect: Patients are waiting longer for diagnostics and treatment plan Emotional harm to patients Staff at risk of 'burn out' and stress due attempting to provide quality care to patients affected by delays Risk of Trust reputational damage due to delays, poor outcomes and poor performance. Now patients are breaching daily. This has raised by 500 in a month	Quality	I = 5 L = 4 Extreme (20)	104 day process developed and being followed. Low volume TSSG less of a concern than High volume e..g Lower GI Control Owner: Chiara Hendry Availability of high tech interventions locally, this includes work done by transformation lead e.g. Carbogen Nicotinamide in the Oncology Department at K&C a new treatment for prostate tumors which is already being used at MTW and east Kent patients previously Daily report of patients over 62 days sent to all the Care Group Ops Managers which is followed up by a daily phone call for an update and decision. Out Patient booking managers and General Managers to monitor and resolve any capacity issues. Daily email sent to Pathway Manager at Maidstone and Tunbridge Well NHS Trust to Implementation of UGI and Lung STT service in 2021 followed by the LGI The tumour site specific nurses provide a weekly update on the support provided and required for patients who are experiencing pathway delays to improve patient experience and outcome. This includes escalation regarding any Weekly cancer tumour site PTL meetings to monitor all cancer standards. Track patients through their pathway . Optomise pathway if can. Control Owner: Karen Weekly KPI meeting led by COO, Deputy COO for Elective Services and Director of Performance with Weekly tertiary centre PTL to escalate any patients of	Limited Limited Adequate Adequate Adequate Adequate Adequate	I = 4 L = 4 High (16)	28 Day Performance Manager to work with all the tumour sites to improve engagement with 28 day patient letter turn around times. Person Responsible: Ashley Wilson To be implemented by: 01 Nov 2023 Lead to support joint working with 2ww team to improve booking turn around times and capacity. Staffing has been highlighted on risk reference 2850 Person Responsible: Ashley Wilson To be implemented by: 30 Nov 2023 Faster Diagnosis Nursing Lead to support the implementation of straight to test (STT) and a standardised and consistent approach to achieve compliance Person Responsible: Vicki Hatcher To be implemented by: 30 Dec 2023 To monitor trust wide compliance with the completion of clinical harm Each TSSG to have identified patient information (and where High Risk Qfit facilitator, to support community implementation at pace and help reduce interventional diagnostics for patients within the Trust. Person Responsible: Danielle Mackenzie To be implemented by: 31 Dec 2023 Weekly PTL meeting with GSST/KCH to be established to ensure patients are followed up by tertiary centers. Work with lead GP to ensure patient fully informed of process - quarterly meetings with lead GP to be initiated Criteria for patients who fit the 104 CHR process to be applied. Currently biggest issue for Lower GI as high numbers of patients without a diagnosis at 104 plus. Person Responsible: Chiara Hendry Annual review of 104 day process and completed for 2022 -2023. Content includes - data from Breech Reports (BR), benign audit and thematic review of CHR. Findings to be disseminated with clinical leads and CWG. Person Responsible: Chiara Hendry Each TSSG to identify area to focus on. Currently Lung and H&N have identified areas for 2023-2024 Person Responsible:	**09 Feb 2024** **Rhiannon Adey** Update by Vicki Hatcher 13.10.2023 FD manager and Clinical nursing lead have engaged with operational teams for 28 day support. FD manager is supporting the performance feeder pack with data for 28 day and back log. Early engagement has **09 Feb 2024** **Rhiannon Adey** Update by Vicky Hatcher 13.10.2023 FD manager and FD clinical nursing lead are working with our trust improvement facilitator and 2ww colleagues to support ongoing work and engagement regarding **09 Feb 2024** **Rhiannon Adey** Update by Vicky Hatcher 13.10.2023 Upper GI, LGI and Lung STT pathways in place. Lower GI CNS lead is working with Consultant surgeon to review LGI STT patient criteria. FDS nursing lead is working with Lead Prostate CNS towards STT pathway **09 Feb 2024** **Rhiannon Adey** Update provided by Danielle Mackenzie 08.11.2023 - Continuing to request qFIT as referral received if no accompanying qFIT. To discuss with surgery how qFIT SOP compliance is being monitored and impact this is having on **04 Dec 2023** **Pippa Enticknap** 04/12 - Due to the post holder we were liaising with to set up weekly PTL **15 Jan 2024** **Vicki Hatcher** 15.01.2024 Quarterly **09 Feb 2024** **Rhiannon Adey** Update provided by action owner 15.12.2023 - Process with admin now being trialled to review no diagnosis patients with CH **09 Feb 2024** **Rhiannon Adey** Update provided by action owner 15.12.2023 - Clinical leads informally advised of process via PSC to check if CWG issue at this stage. **09 Feb 2024** **Rhiannon Adey** Update provided by action owner 15.12.2023 - A Further TSSG area identified for Breast and Skin	I = 3 L = 2 Low (6)
2038	09/04/2020	Corporate - Operations		Misalignment between Demand and Capacity across the Trust's RTT, non-RTT and Cancer pathways Risk Owner: Robert Hodgkiss Delegated Risk Owner: Sunny Chada Last Updated: 13 Mar 2024 Latest Review Date: 04 Mar 2024 Latest Review By: Sunny Chada Latest Review Comments: Update of IS records and	Cause: The increasing demand for healthcare services within the Trust has surpassed the existing capacity, leading to strain on resources, longer waiting times, and compromised patient care. 1. Competing pressures from non elective flow for bed capacity and staff. 2. Lack of diagnostic capacity. 3. Specialty specific consultant vacancies within ENT (Otology), Dermatology, Urology, Endoscopy & Radiology. 4. Lack of clear validation oversight and training for specialities means patients on non-RTT pathways return to core waiting lists.	Quality	I = 4 L = 4	All 52 week breaches will be added to datix closely Consultants risk stratifying their outpatient and Daily elective PTL meetings to maximise Early reporting of any External validation team (MBI) commissioned to Independent Sector (IS) NHSEI focus to have To maintain an equipment Trust under Tier 1	Adequate Limited Adequate Limited Adequate Adequate	I = 4 L = 4	To work with the theatres ICB to agree IS levels of commissioning for Development of a clear trust-wide improvement ECIST Team supporting via the creation of the Data Quality Improvement Group to develop the Creation of an Insourcing strategy for the Trust for		I = 3 L = 2

				addition of existing	5. Endoscopy capacity and utilisation			Trust validation teams				
3536	10/10/2023	Corporate - Operations		Delayed diagnostics for patients awaiting Endoscopy Risk Owner: Robert Hodgkiss Delegated Risk Owner: Susan Travis Last Updated: 13 Mar 2024 Latest Review Date: Latest Review By: Latest Review Comments:	Cause: Inability to undertake surveillance due to capacity and demand for endoscopy service Effect: Potential severe harm and death to patients if growths have not been monitored and malignancies have not being identified and treated.	Quality	I = 4 L = 4	Additional 1000 scopes		I = 4 L = 4	To develop trajectory for		I = 4 L = 2
								Administrative validation Control Owner: Susan Travis	Substantial		To source additional capacity for endoscopy patients on a surveillance pathway Person Responsible: Tammy-Ann Sharp To be implemented by: 31 Mar 2024	**08 Feb 2024** **Susan Travis** Additional capacity from 5th Feb at whh using theatre 12 and staffed by ID medical Room 3 in Endoscopy utilized from 10th feb using ID medical
								Clinical validation Control Owner: Susan Travis	Adequate			
								Task and finish recovery group established with COO, Deputy COO and Executive Director of Communications and Engagement membership Control Owner: Benjamin Stevens	Adequate		To undertake administrative validation of patients on a surveillance pathway Person Responsible: Susan Travis To be implemented by: 31 Mar 2024	**10 Oct 2023** **Rhiannon Adey** Area identified for administrative team to undertake this work. Currently in the process of identifying capacity within admin team.
											To undertake clinical	
1679	10.06.2019	People Culture		There is a risk of failure to address poor organisational culture Risk Owner: Andrea Ashman Delegated Risk Owner: Last Updated: 16 Feb 2024 Latest Review Date: 18 Dec 2023 Latest Review By: Rhiannon Adey Latest Review Comments: Working through diagnostic phase of Culture and Leadership Programme. Frequent communication to staff on progress through Staff Zone and Trust News around the Culture and Leadership Programme. Change agents recruited.			I = 4 L = 4 High (16)	Agreed HR KPIs (Inc. vacancy rate, turnover and engagement scores) Control Owner: Andrea Ashman		I = 3 L = 3 Moderate (9)	Deliver countermeasures identified on A3 for Developing a positive culture Person Responsible: Andrea Ashman	**15 Jan 2024** **Rhiannon Adey** Continuing to pursue interventions at a local level.	I = 2 L = 2 Low (4)
								Alignment of leadership framework with the behavioural framework and competencies within We Care Control Owner: Andrea			NHSE culture and leadership programme roll out across the Trust Person Responsible: Andrea Ashman To be implemented by: 29 Mar 2024	**15 Jan 2024** **Rhiannon Adey** CLP is on track and is being progressed with Programme Director for CLP and two OD
								Clinical and non-clinical leadership programmes in				
								EDI strategy in place				
								Freedom to Speak Up	Adequate			
								Guidance and toolkits for managers	Adequate			
								Leadership Development	Adequate			
								Leadership diagnostics Control Owner: Andrea Ashman	Adequate			
								Revised Disciplinary				
								Staff Survey action plan	Adequate			
								Staff webinars monthly				
								Trust-wide leadership				
2565	21.09.2021	People		There is a risk of inadequate midwifery staffing levels and skills to meet the needs of women and there families Risk Owner: Sarah Hayes Delegated Risk Owner: Michelle Cudjoe Last Updated: 29 Feb 2024 Latest Review Date: 29 Feb 2024 Latest Review By: Janet Murat Latest Review Comments: Exec risk owner added due to risk rating >15, agreed with CN-SH			I = 4 L = 5 Extreme (20)	10 am service SITREP staffing reviews undertaken to identify gaps and put in place	Adequate	I = 4 L = 4 High (16)	Centralise triage phone to QEQM to release midwifery staffing at WHH	**26 Jan 2024** **Rhiannon Adey** Note added by Cherrie	I = 4 L = 2 Moderate (8)
								Active utilisation of escalation policy to manage activity vs staffing. Including divert escalation between sites. Control Owner: Michelle Cudjoe	Adequate		Recruitment of internationally educated midwives Person Responsible: Joanne Shayler To be implemented by: 31 Jan 2024	**26 Jan 2024** **Rhiannon Adey** 18 internationally educated midwives recruited	
								All shifts to be released to NHSP as soon as possible. Where possible agency lines booking in place Control Owner: Joanne	Adequate		Full review of Birthrate plus Person Responsible: Hannah Horne	**26 Jan 2024** **Rhiannon Adey** Full workforce review using birthrate+ tool is in progress.
								Daily review of staffing by operational lead and senior team. Out of hours the manager on call will facilitate this. Long line of agency set up where there are on going gaps	Adequate		Explore further the use on non Midwife roles (Registered Nurses/Nursery Nurses/ MSW's) to release	**26 Jan 2024** **Rhiannon Adey** Nurse recruitment has
								International recruitment of 18 wte midwives. Control Owner: Michelle	Adequate		To improve open communication with staff and women around the improvements made within the service. Person Responsible: Adaline Smith	**26 Jan 2024** **Rhiannon Adey** Six month away day held in January 2024, slides have been shared and continue to be discussed
								NHSP offered through community Control Owner: Angela	Adequate		Developing a coproduced plan with staff and RCM members around how the on-call system is fairly applied and to explore improved retention strategies. Person Responsible: Adaline Smith To be implemented by: 31 Mar 2024	**26 Jan 2024** **Rhiannon Adey** RCM are reviewing systemwide. 52 students in the local pipeline for January 2025. Recruitment has been impacted by withdrawal of NMC approval for the midwifery programme at
								Recruitment approach				
								Specialist midwives redeployed in times of increased acuity and escalation Control Owner: Adaline Smith	Adequate			
								Suspension of continuity				
								Utilisation of managers on	Adequate			
3084	30/01/2023	Maternity		QEQM - Regulatory action - Section 31 notice due to risk to safety during fire due to maintenance of fire routes primary and secondary and adherence to fire protocols Risk Owner: Cherrie Knight			I = 5 L = 3	2gether and estates have	Adequate	I = 3 L = 3	mandatory to be above 90% for fire and fire wardens to be on each	I = 2 L = 2
								Additional notices deployed to remind staff to keep fire doors closed	Adequate		annual H&S audit to be above 90% Person Responsible:	**27 Nov 2023** **Cherrie Knight** previous audit at 65%
								Closing mechanisms (automatic closing) for fire doors has been reviewed	Adequate		Implement the relocation of the kitchen as part of estates strategy - phase 1	
								daily environmental	Substantial			
3133	09/03/2023	Finance		Non delivery of the agreed CIP programme that contributes to the Trust deficit position Risk Owner: Benjamin Stevens Delegated Risk Owner: Last Updated: 08 Feb 2024 Latest Review Date: 08 Feb 2024			I = 4 L = 5	A new Financial Improvement Board, chaired by the CEO		I = 4 L = 5	Care Groups to identify		I = 3 L = 3
								A Non-Pay Panel, chaired by Executive Directors in relation, has been created			Align CIP development with business planning timetable for 2024/25	
								Model Hospital benchmarking to identify areas			Develop a series of larger transformational savings schemes	
								New Vacancy Control			PMO to work with PWC to appropriately resource the efficiencies programme	
								Programme Management	Limited			
3574	07/11/2023	Quality		There are a significant number of risks at Care Group and Specialty level currently scored at 15 or above which could compromise the delivery of high quality, safe and patient-centred care. Risk Owner: Katy White Delegated Risk Owner: Rhiannon Adey			I = 4 L = 4 High (16)	A comprehensive review and refresh of the current Corporate, Care Group and Specialty level risk	Limited	I = 3 L = 3 Moderate (9)	To align risks to the revised risk appetite approved at the Board of Directors to ensure the correct significant risks are	**26 Jan 2024** **Rhiannon Adey** Action date extended due	I = 3 L = 2 Low (6)
								Risk Review Group in				
								The Board and its' sub-Committees receive monthly progress reports on the progress of this review.				
3495	18/09/2023	Quality Safeguarding		The Trust is to ensure that the purpose of the S42 investigation is understood, the recommendations and actions are embedded in the Trust Risk Owner: Salli Alihodzic Delegated Risk Owner: Last Updated: 12 Feb 2024 Latest Review Date: 26 Feb 2024 Latest Review By: Salli			I = 4 L = 5	Completed a paper which was presented to the August Safeguarding	Adequate	I = 3 L = 4	Liaise with interim mental		I = 3 L = 2
								Concerns raised on 24/08/2023 with the NHSE National team, as part of SIIP pre-meeting	Adequate		Meeting arranged with ED to triangulate themes within safeguarding and Care Group and agree mitigations	**25 Jan 2024** **Janet Murat** Partially implement.
								Interface between mental health and mental capacity being rolled out across the Trust starting with ED Control Owner: Salli	Substantial			

				Latest Review By: Salli Alihodzic Latest Review Comments: To Consider if mental health risks should be held separately explore this with mental heath lead				Mental Health Strategy and policy completed and out for consultation Control Owner: Salli Alihodzic	Adequate				
								New Complex Discharge	Substantial				
								New Complex discharge	Adequate				
								New Service Level	Substantial				
								NHSE and ICB safeguarding oversight meetings which commenced in April 2023 and are held every four weeks Control Owner: Salli Alihodzic	Substantial				
								NHSE national recovery support team Control Owner: Salli Alihodzic	Substantial				
								Paper on how lessons learnt from SARs and DHRs presented to Safeguarding Assurance Committee on 10/08/2023 and Fundamentals of Care Committee 17/08/2023 to mitigate the risks Control Owner: Salli	Adequate				
								Raised concerns with Chief Nursing and Midwifery Officer and Non-Executive Director for Safeguarding with regards to the impact on the safeguarding activities 11/09/2023 outlining the risk Control Owner: Salli	Adequate				
								Raised concerns with Deputy Chief Nurse on 05/09/2023 to escalate to the Strategic Improvement Committee at the meeting of 05/09/2023 Control Owner: Salli	Adequate				
								Scoping on people with mental health against CQC Inspection into acute Trust completed in March 2023 Control Owner: Salli Alihodzic	Adequate				
								Thematic reviews undertaken and action plans completed and incorporated into business as usual activities Control Owner: Salli Alihodzic	Substantial				
								Training ,examples of	Substantial				
3559	02/11/2023	Patients		Risk that staff are not fully up to date with mandatory and statutory training Risk Owner: Benjamin Hearnden Delegated Risk Owner: Last Updated: 05 Jan 2024 Latest Review Date: 08 Feb 2024 Latest Review By: Nicola Brooker Latest Review Comments: Reviewed with BH and RP			I = 3 L = 5	Budget and ESR review		I = 3 L = 3	To review and identify sufficient training spaces to ensure that compliance		I = 2 L = 2
								Current trajectories have shown continual rise in compliance, medical					
								Operational safeguarding meetings attended monthly by Head of Nursing. Safeguarding papers are submitted, inclusive of training compliance. Control Owner: Benjamin Hearnden	Limited		Data regarding previous safeguarding training needs to be captured in our validation processes. G&SM are assisting with gaining hard to gain information in relation to doctors who work within their care group but are on our records due to rostering November 2022 remains ongoing, and work		
								Successful recruited Business and Quality Manager who is	Adequate				
								Training records being maintained and staff attendance monitored manually by line managers. Performance reviews are taking place monthly and training compliance is a standing item at our care groups quality and business meetings. Control Owner: Tomislav Canzek	Limited		The care Group are seeking quotes for external trainers to come in and provide necessary updates and training with money from ICB Person Responsible: Benjamin Hearnden To be implemented by: 28 Jun 2024		
								Where possible, staffing	Limited		Compliance with mandatory and safeguarding training and appraisal should be prioritised and monitored by line managers. Alternatives to face to face	**08 Feb 2024** **Nicola Brooker** Staff who are able are encouraged to complete training online	
2115	29.06.2020			Lack of timely recognition and response to the deteriorating patient Risk Owner: Desmond Holden Delegated Risk Owner: Eibhlin Moore Last Updated: 07 Mar 2024 Latest Review Date: 07 Mar 2024 Latest Review By: Eibhlin Moore Latest Review Comments: NIV policy completed and sent to DPSG members for comment. PAG contacted for ratification, currently discussing if this is policy or guidelines. This is the delay for completion. Will update register when outcome identified.			I = 4 L = 4 High (16)	Clinical Induction contains management of deteriorating patients including the septic patient	Limited	I = 4 L = 3 Moderate (12)	To develop a policy for Acute NIV/CPAP Person Responsible: Eibhlin Moore	**15 Mar 2024** **Eibhlin Moore** This has been sent to	I = 2 L = 2 Low (4)
								Deteriorating Patient Report to Nursing, Midwifery and Allied Health Professional Board bi-monthly Control Owner: Eibhlin Moore			To integrate NEWS2 into Sunrise by time of termination of VitalPac. Person Responsible: Elisa Steele To be implemented by: 31 Mar 2024	**27 Feb 2024** **Elisa Steele** Vitals transition to Sunrise from VitalPac roll out during February and beginning of March	
								Deteriorating Patient Steering Group and resus council committee Trust-wide feeding in to Patient Safety Committee			To reestablish deteriorating patient/sepsis compliance audit. Person Responsible: Eibhlin Moore To be implemented by: 01	**06 Feb 2024** **Rhiannon Adey** Update provided by Eibhlin Moore - 2/2/24 - HEE money has paid for dashboards for the CCOT	
								ED dashboard in place					
								Education and Training -	Adequate				
								Management of the	Limited				
								Management of the Deteriorating Child and Young Person Policy Control Owner: Natalie Oliver Hendy	Adequate				
								NEWS2 CQUIN for	Adequate				


Resus Committee to amalgamate with Deteriorating Patient Steering Group as of March 24
Control Owner: Judith Banks
Sepsis clinical documents
Limited

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Risk Register Report**

Meeting date: **4 April 2024**

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

Paper Author: **Associate Director Quality Governance (DQG) (on behalf of DQG)**

Appendices:

Appendix 1: Significant Risk Report 25.03.24

Executive summary:

Action required:	Assurance
Purpose of the Report:	This paper to the Board provides assurances on the completion of the Trust Risk Review and recommendations approved that will ensure the work is embedded in operational business as usual processes with appropriate local governance and oversight. This paper also presents the current Significant Risk Report to ensure Board oversight of those risks rated as high and above (15>). Lastly a number of escalations were made at the Risk Review Group on 22 March 2023. These escalations, largely related to emerging risks, have been made to Clinical Executive Management Group (CEMG) on 3 April 2024 but are also contained here for completeness.
Summary of key issues:	Phase 1 of the Risk Review is near completion at the time of writing of this report (due end of March 2024). The CNMO, Chair of the Risk Review Group, acknowledged and thanked the Care Group, Corporate Leads and Risk Manager/Interim Risk Consultant for the focused work which has led to a much-improved position. There are several outstanding actions outlined in the main body of the paper (section 6) however, which require urgent attention which are being taken forward by Care Group, Corporate and Accountable Executive Leads. Phase 2 of the Risk Review involves embedding the improvements made into business as usual with appropriate oversight and governance. The recommendations within the paper (section 7) were agreed at the Risk Review Group on 22 March 2024. All of the risks contained in the significant risk report have had a 'review' within the last 4 weeks but it should be noted that not all risk records are complete (i.e. not all actions agreed in meetings with the Risk

We care

	Manager/Interim Risk Management Consultant have been completed and there are overdue actions and risk controls that need updating). These are under review urgently by the risk owners. Other escalations from the Risk Review meeting to CEMG are noted below for the information of the Board. • An external visit of the aseptic unit at Kent & Canterbury Hospital (K&C) took place on 12 March 2024 by the NHS Specialist Pharmacy Service Quality Assurance (QA) team (London & South East (SE) England). The unit's operation was deemed 'high risk' – with three deficiencies rated as 'critical'. Two are related to facilities and one to product approval. The facilities risk has been upgraded from 15 (high) to 20 (extreme) (ref 679). • A quality review of the Renal Dialysis service by the Specialist Commissioners will take place on 17 April 2024. The K&C care group confirmed that the renal risks on the risk register had been updated and were up to date. • There are 2 emerging risks that need to be urgently quantified on the Risk Register for the K&C site. The first relates to lack of 24-hour Critical Care Outreach (CCOT). This risk will be owned by the Critical Care, Anaesthetics & Specialist Surgery (CCAS) Care Group. The second risk relates to medical cover on the K&C site. The K&C Associate Medical Director and Chief Medical Officer (CMO) have discussed and a new risk proforma is to be approved through the K&C Care Group governance meeting. • A meeting has been held with the Managing Director (MD) for 2gether Support Solutions (2gether) regarding 2gether risks. 2gether share a risk report as part of the monthly contractual meeting. It was agreed at the Risk Review Group on 22 March that relevant risks should be duplicated on the Trust Risk Register and escalation of emerging and joint risks should happen via the Risk Review Group with reporting also into CEMG. • Interim Consultant, has been reviewing Spencer Wing, and will make recommendations in relation to risk management. • There is a business case drafted relating to the need for a Quality Management System (to support many of the Quality Governance workstreams – patient safety, risk, regulatory compliance, policy, audit etc.) There is a particular risk around the current version of 4Risk, which is currently unsupported. This will be articulated as an emerging risk on the risk register and a proforma completed. A decision will need to be made about procurement of an alternative system or migrating to Version 2 (Cloud based so requires administrative investment to maintain).
Key recommendations:	The Board is asked to: • **SUPPORT** the recommendations above made within the paper.

	• Receive and **NOTE** the Significant Risk Report for assurance purposes and for visibility of key risks facing the organisation.

Implications:

Links to Strategic Theme:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Trust Risk Register:	This paper provides an update on the significant risks (to be known as the 'significant risk report') to the Trust which replaces the Corporate Risk Register (CRR).
Resource:	Yes. Additional resource will be required to mitigate some of the significant risks identified. Short term reduction in corporate risk team due to sickness absence. Current risk management system is unsupported from the supplier. Business case developed for consideration later in the month and mitigations to be worked through (migration of system to new Cloud based module).
Legal and regulatory:	Yes. The Trust is required to comply with the requirements of a number of legal and regulatory bodies including but not limited to: • NHS England • Care Quality Commission • Health and Safety Executive
Subsidiary:	2gether Support Solutions Spencer

Assurance route:

Previously considered by: Risk Review Group 22 March 2024 and CEMG on 3 April 2024. People and Culture Committee and Quality and Safety Committee have also received reports on the Significant Risk Register in March 2024.

East Kent Hospitals University NHS Foundation Trust

SIGNIFICANT RISK REPORT

1. Purpose of the report

1.2 This paper is presented to the Board to provide assurance on the outcome of the Trust Risk Review and to support the recommendations to ensure improved risk management is embedded at all levels of the organisation.

1.3 The Significant Risk Report is presented for assurance and oversight.

1.4 Escalations are presented as discussed and agreed at the Risk Review Group on 22 March 2024. These have previously been escalated to CEMG on 3 April 2024 but are contained for completeness.

2. Background

2.1 A comprehensive review and refresh of the Corporate, Care Group and Specialty level risk registers was launched in November 2023. This followed an initial review and recommendations made by the Interim Consultant in October 2023.

2.2 The review has been supported corporately by the Trust Risk Manager and an Interim Risk Consultant (two days per week). Phase 1 of this work is to be concluded by the end of March 2024.

2.3 One of the outputs of the Trust Risk Review was the creation of a Significant Risk Report. The latest is attached (Appendix 1) and summarised with priority actions noted.

2.4 The Risk Review Group was established in early February 2024. The third meeting was held on 23 March 2024. Escalations are noted for the attention of CEMG.

3. Risk Review – Streamlining the Risk Register

3.1 There were previously multiple risk registers in place. These included the Corporate risk register, Care Group risk registers, Specialty level risk registers and risk registers for each of the corporate functions. There is now one Trust risk register.

3.2 In September 2023 the total number of risks open within the Trust was 824. As of 18 March 2024 this is now 550.

3.3 When the risk review exercise was initially undertaken in September 2023 there were 82 'significant' risks scored 15 or above. This reduced to 60 by the 1 December 2023. As of the 20 March 2024 there are 47 'significant' risks, 12 which are Corporate and the remaining 35 sit within the Care Groups.

4. Risk register and risk management review process

The table below (updated from the December 2023 CEMG report for CEMG on 3 April 2024) provides an overview of key activities that have been undertaken as part of the Risk Review and status.

East Kent Hospitals University NHS Foundation Trust

Activity	Due date	Progress	Status
Refresh risk appetite and risk tolerance	August 2023	Complete. Risk appetite and tolerance refreshed at Board Development Day August 2023. Approved at Board of Directors September 2023.	Closed
Refresh risk management policy	December 2023	Risk management policy approved at CEMG and Integrated Audit and Governance Committee (IAGC) on 7 November, policy to be submitted for final approval at Board of Directors 7 December.	Closed
Revised Board Assurance Framework (BAF) aligned with strategic objectives	December 2023	In progress. Session delivered by Governance Management Consultant at the Board of Directors development session on 2 November 2023 to determine risks and seek agreement on controls/actions. Redesign of the BAF has been undertaken with quality risks identified and others in development. Revised BAF to be presented to the Board of Directors on 7 November with committee specific reviews being undertaken by the Board sub-Committees in January. Final approval of the BAF will be at the closed Board of Directors 1 February 2023. Approved BAF transferred to Group Company Secretary thereafter.	Closed
Risk register review	December 2023	Initial review of all risks on the 4risk system undertaken by Catherine Pelley with recommendations made and theming of risks to align with Care Quality Commission (CQC) domains, reporting in October 2023. Completed. In progress: A Risk Management Consultant has joined the team to support a	On track

		central cleanse of the Corporate, Care Group and specialty level risks during November and December 2023 and create one single Trust-wide risk register. Risk descriptions, scores and mitigations to be revised and historic risks closed. The cleansed Trust risk register will be shared with Care Group triumvirates for agreement during November 2023. Risk review meetings to validate the 15+ scores have been held with all Care Groups.	
Significant risk register developed	December 2023	A significant risk register will be developed from the Trust risk register and a draft presented to the CEMG on 6 December following the cleanse and rationalisation of risk scoring with a final version presented to the CEMG on 7 February. All risks scoring 15 and above will have an Executive owner and will be included in the significant risk register. Agreement of closure of the corporate risk register at CEMG with onward reporting to Board sub-Committees and quarterly to the Trust Board.	Closed
Risk review group	December 2023	Specialty level and Care Groups to approve any new risks through their Quality Governance meetings using a standardised proforma. Terms of reference for an operational risk review group, led by the CNMO, to be agreed at CEMG on 6 December 2023, which will focus on deep dives of care group and speciality level risks on a rotating basis. Risk proforma to be submitted to trust Risk Manager with any risks scoring over 15 to be presented by Care Group triumvirates for inclusion on	Closed

		significant risk register, approved by CEMG from January 2024.	
Risk maturity assessment	January 2024	Internal Audit undertook a questionnaire for Board members and Care Group Leaders to gauge the perception of risk management processes and extent to which risk management is embedded across the Trust. The annual risk maturity assessment will be postponed until the outcome of the Internal Audit is known to prevent duplication. Date to be confirmed.	Awaiting report
Risk management internal audit	March 2024	The Trust's internal auditors will undertake their annual internal audit to determine whether the Trust has an appropriate risk management framework in place that is used for managing risks.	On track

5. Risk Review (Phase 1) Progress

5.1 In addition to the high-level milestones provided above the following work has been undertaken;

5.2 Regular risk review meetings have taken place with the executive, care groups and corporate teams;

5.3 Significant risks have been allocated an executive risk owner and there is now one risk register in entirety (closure of the corporate risk register);

5.4 Access has been reduced to the 4Risk system and there is a risk assessment proforma in place for new risks. This has been amended in month to ensure risks related to the Integrated Improvement Plan (IIP) and medical devices risks can be easily identified. It was agreed at the Risk Review Group (RRG) on 22 March 2024 that whilst all risks should be considered at care group governance meetings using the proforma only new risks with a score of 15 or above would be submitted to the RRG before being added on 4Risk. The proforma will be amended and recirculated to reflect this. A weekly report is being run to identify any exceptions.

5.5 Aged risks >2 years with a 'low' residual risk score which have reached the Trust risk appetite have been closed.

5.6 Deep dives for care group and corporate areas commenced in February 2024 reporting via the RRG.

5.7 The Significant Risk Register (SRR) is received monthly by CEMG, Board Sub-Committees and the Board.

6. Risk Review (Phase 1) Priorities (to end of March 24)

6.1 Risk Consultant and Managing Director for 2gether met on the 20 March 2024 to review the 2gether Risk Register and ensure appropriate risks are visible on the Trust Risk Register. Recommendations are made in Section 10 of this paper.

6.2 Finalise a review of cross site overarching risks. Considerable progress has been made with Emergency Department (ED) risks, Referral to Treatment (RTT), cancer and endoscopy risks being linked and merged with some closures where appropriate. Where risks do need to be duplicated across site consideration to be given to risk rating to ensure parity.

6.3 Work is underway to link the IIP workstreams to the risk register. As above any new risks that may be related to the IIP programme will be identified at the outset on the new risk application proforma.

6.4 There are a number of overdue actions relating to entries on the SRR as well as actions with a due date of the end of March 2024. These must be reviewed by Accountable Executives and delegated risk owners as a priority with a process established for monthly reviews going forward (see Section 7 below).

7. Risk Review (Phase 2) – Sustaining the improvements (April - June 2024)

7.1 The Risk Review needs to transition into sustainable business as usual processes. Recommendations are set out below.

7.2 Risk needs to be standing agenda item for Care Group and Speciality level governance meetings. At a minimum the following items should be discussed – new risk applications, changes to risk scores (in particular escalations), proposed closures and outstanding actions.

7.3 The Risk Register will be discussed at every PRM and is now part of the slide pack.

7.4 It is recommended that risk meetings should be ‘live’ and ‘action focused’ (supported by Governance Lead or similar) with updates made in real time on the 4Risk system.

7.5 All Executive leads to have a monthly ‘live’ SRR review with the Trust Risk Manager (or member of corporate team). The SRR would be sent to the lead ahead of the meeting to ensure that action updates were requested from delegated owners as appropriate.

7.6 Embed a ‘hub and spoke’ model in terms of 4Risk systems access. At present anyone can have ‘read’ access on request. Owners and delegated owners are accountable for updating their own risks. In addition, ‘editor’ access can be set. Editor rights can be at specialty or care group level and enable any aspect of the risk record to be amended. It is recommended that the Governance Lead for each Care Group have this access in addition to the Director of Nursing (or delegate).

East Kent Hospitals University NHS Foundation Trust

7.7 Develop a Training Needs Analysis in relation to Risk Management. At present there is a Risk Management e-learning module on Electronic Staff Record (ESR) (to be reviewed) and bespoke training is available on request.

8. Risk Review (Phase 3) – Evidence of continuous improvement

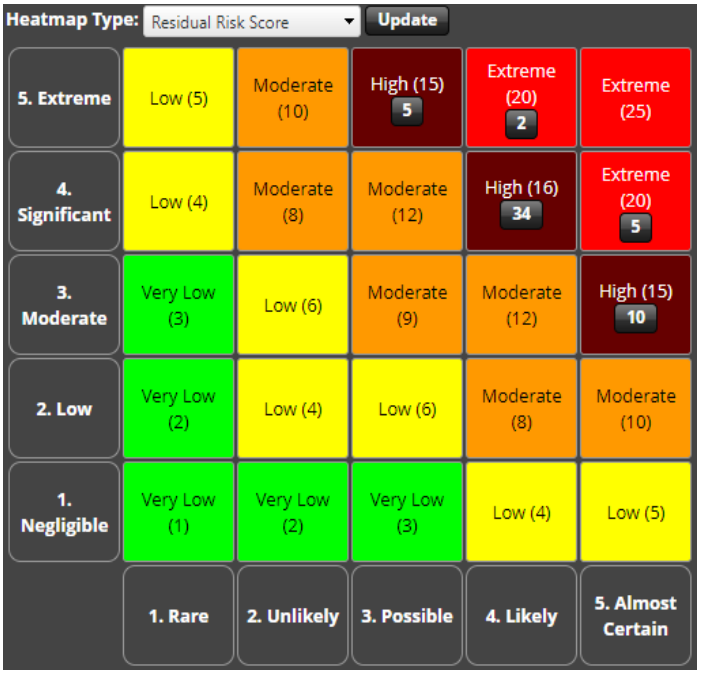
8.1 The Risk Review Group will receive a monthly report of overall status of the Trust Risk Register and will continue to undertake deep dive reviews.

8.2 The next internal audit will happen in February/March 2025. It is recommended that an in-house review audit takes place in the interim (September 2024) to ensure that progress continues to be made.

9. Current Significant Risk Register

9.1 There are currently 47 risks in total on the SRR (down from 49 in the last report and 82 at the start of the review). These are show by care group and residual risk rating below.

	Residual Risk Score				
Care Group	**15**	**16**	**20**	**25**	**Total**
CCASS CG	3	2	1		6
DCB CG	3	8			11
K&C CG	1				1
QEQM CG	1	6			7
WHH CG	3	3			6
WCYP CG		3	1		4
Corp Finance				1	1
Corp Medical	2				2
Corp Nursing	1				1
Corp Operations	1	3	2		6
Corp SD			2		2
TOTAL	**15**	**25**	**6**	**1**	**47**
CHANGE SINCE LAST MONTH REPORT	**0**	**-2**	**+2**	**+1**	**-3**



9.2 The Risk Review Group has now met three times. Deep dives have been undertaken for Corporate Nursing, the William Harvey Hospital (WHH) Care Group, Corporate Operations, Queen Elizabeth the Queen Mother Hospital (QEQM) Care Group and Corporate Medical. There has been considerable work to cleanse the risk registers, remove aged risks and ensure risks are well described, risk scores, controls and actions are updated, appropriate risk owners are assigned and control targets are in line with the risk tolerances set by the Board. There is, however, further work to be undertaken. The SRR is presented at Appendix 1.

10. Escalations from Risk Review Group (22 March 2024)

10.1 An external visit of the aseptic unit at Kent & Canterbury Hospital (K&C) took place on 12 March 2024 by the NHS Specialist Pharmacy Service QA team (London & SE England). The unit's operation was deemed 'high risk' – with three deficiencies rated as 'critical'. Two are related to facilities and one to product approval. The facilities risk has been upgraded from 15 (high) to 20 (extreme) (ref 679).

10.2 A quality review of the Renal Dialysis service by the Specialist Commissioners will take place on 17 April 2024. The K&C care group confirmed that the renal risks on the risk register had been updated and were up to date.

10.3 There are two emerging risks that need to be urgently quantified on the Risk Register for the K&C site. The first relates to lack of 24-hour Critical Care Outreach (CCOT). This risk would be owned by the CCAS Care Group. The second risk relates to medical cover on the K&C site. The K&C Associate Medical Director and CMO have discussed and a new risk proforma is to be approved through the K&C Care Group governance meeting.

10.4 A meeting has been held with the MD for 2gether regarding 2gether risks. 2gether share a risk report as part of the monthly contractual meeting. It was agreed at the Risk Review Group on 22 March that relevant risks should be duplicated on the Trust Risk Register and escalation of emerging and joint risks should happen via the Risk Review Group with reporting also into CEMG.

10.5 The Interim Consultant, has been reviewing Spencer Wing, and will **m**ake recommendations in relation to risk management.

10.6 There is a business case drafted relating to the need for a Quality Management System (to support many of the Quality Governance workstreams – patient safety, risk, Regulatory compliance, policy, audit etc.) There is a particular risk around the current version of 4Risk, which is currently unsupported, that will be articulated as an emerging risk on the risk register. A decision will need to be made about procurement of an alternative system or migrating to Version 2 (Cloud based so requires administrative investment to maintain).

11. Conclusion

11.1 The Board is asked to support the recommendations above made within the paper.

11.2 The Board is asked to receive the Significant Risk Report for assurance purposes and for visibility of the key risks facing the organisation.

Risk Register Report (By Residual Risk Ranking)

Report Date	27 Mar 2024
Comparison Date	In the past 30 Day(s)

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3133	09 Mar 2023	Corporate - Strategic Development & Capital Planning		Non delivery of the agreed CIP programme that contributes to the Trust deficit position **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** **Last Updated:** 08 Feb 2024 **Latest Review Date:** 08 Feb 2024 **Latest Review By:** Benjamin Stevens **Latest Review Comments:** The risk has been reviewed and revised to better reflect the risk and current status	**Cause** Insufficient schemes identified to deliver the agreed efficiency target **Effect** The trust will not meet its financial plan increasing the likelihood of increased oversight and external control. Failing to meet the exit criteria to exit	Financial	I = 4 L = 5 Extreme (20)	A new Financial Improvement Board, chaired by the CEO, meets every two weeks to focus on the progress of implementation against agreed milestone and to track financial benefits. **Control Owner:** Tracey Fletcher		I = 4 L = 5 Extreme (20)	Care Groups to identify gaps in efficiencies targets and turn identified efficiencies to green **Person Responsible:** Bernard Pope **To be implemented by:** 31 Oct 2023		I = 3 L = 3 Moderate (9)
								A Non-Pay Panel, chaired by Executive Directors in rotation, has been created which initially meets weekly to review all requisitions and purchase orders above £500 **Control Owner:** Tracey Fletcher			Align CIP development with business planning timetable for 2024/25 **Person Responsible:** Benjamin Stevens **To be implemented by:** 29 Mar 2024		
								Model Hospital benchmarking to identify areas **Control Owner:** Michelle Stevens			Develop a series of larger transformational savings schemes **Person Responsible:** Benjamin Stevens **To be implemented by:** 29 Mar 2024		
								New Vacancy Control Panels for each Care Group meet to approve recruitment. Agency, bank, interim, FTC and locum usage. Also approves grade and pay changes. **Control Owner:** Tracey Fletcher			PMO to work with PWC to appropriately resource the efficiencies programme **Person Responsible:** Benjamin Stevens **To be implemented by:** 29 Mar 2024		
								Programme Management Office in place **Control Owner:** Benjamin Stevens	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
1891	14 Jan 2020	Corporate - Operations		Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** **Last Updated:** 13 Mar 2024 **Latest Review Date:** 09 Feb 2024 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed by Business Manager to the COO. Controls and actions revised.	**Cause** The increasing demand for healthcare services within the Trust has surpassed the existing capacity, leading to strain on resources, longer waiting times, and compromised patient care. **Effect** Elevated patient dissatisfaction due to prolonged waiting times. Possible decline in the quality of the services provided. Increased risk of adverse patient outcomes. Strain on staff leading to burnout and decreased morale.	Quality	I = 4 L = 5 Extreme (20)	Daily board rounds at ward level to release beds **Control Owner:** Robert Hodgkiss	Limited	I = 4 L = 5 Extreme (20)	Expand trial of SPoA to QEQM **Person Responsible:** Sandra Cotter **To be implemented by:** 29 Feb 2024	**09 Feb 2024** **Rhiannon Adey** A single point of access (SPoA) coordinates care more effectively by maximising the use of non-ED pathways. Appropriate patients are identified by clinicians/navigators who can utilise a dedicated team to direct a patient to services outside of an acute ED therefore reducing ambulance conveyances. A trial was put in place at the WHH in November 2023 with evidence of impact on the volume and ambulance conveyance and the trial is being rolled out to QEQM at end of January 2024.	I = 3 L = 2 Low (6)
								Daily sitrep calls with EK HCP and Kent and Medway OCC **Control Owner:** Robert Hodgkiss	Adequate				
								Kent and Medway UEC Delivery Board provides system wide strategic direction attended by the **Control Owner:** Robert Hodgkiss	Adequate				
								Trust Access Standards monitored 'ED 12 Hour Total Time in Department' **Control Owner:** Robert Hodgkiss	Limited				
											Further enhance collaboration with community healthcare providers to alleviate ED burden with measure attendance avoidance **Person Responsible:** Sandra Cotter **To be implemented by:** 31 Mar 2024		
											Conduct a comprehensive review of current ED processes and identify areas for improvement - focussing initially on the opportunity to reduce the number of patients spending 12+ hour in ED **Person Responsible:** Sandra Cotter **To be implemented by:** 31 Mar 2024		
											SAFER roll-out supported by consultancy led programmes from PRISM and KPMG. **Person Responsible:** Sandra Cotter **To be implemented by:** 31 Mar 2024	**09 Feb 2024** **Rhiannon Adey** From March 24 the further embedding of SAFER will be supported by the site based discharge taskforce.	
											Utilise investment from the NHSE Bed Capacity Management System to invest in technology solutions, to more accurately manage the placement of admitted patients resource allocation **Person Responsible:** Sandra Cotter **To be implemented by:** 31 Mar 2024		

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3333	23 Jun 2023	Care Group - Critical Care, Anaesthetics and Specialist Surgery		Patients do not receive timely and specialist medical input due to a lack of ITU consultants at weekends on K&CH site **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Pradeep Basnyat **Last Updated:** 29 Feb 2024 **Latest Review Date:** 29 Feb 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Exec risk owner added due to risk rating >15 , agreed with CN-SH & DoG- KW.	**Cause** The consultant on for ITU at weekends is also responsible for the anaesthetic service at K&CH The additional specialties treated at the K&CH site has increased the likelihood of anaesthetic cover required, particularly vascular The acuity of patients post-Covid also increases the anaesthetic requirement **Effect** The risk is that the ITU patients do not always get timely and thorough medical input. This can lead to to increased morbidity and longer patient stays	Quality	I = 4 L = 5 Extreme (20)	The on call consultants attempt to run both services. There is a resident middle grade but they have to cover ITU, HDU, theatres and deteriorating patients on the ward and vascular and urology emergencies. **Control Owner:** Martin	Limited	I = 4 L = 5 Extreme (20)	Explore an on-call arrangement for additional mitigation whilst business case is progressed **Person Responsible:** Anthony Adams **To be implemented by:** 29 Feb 2024	**31 Jan 2024** **Rhiannon Adey** Risk reviewed with CCASS Senior Leadership Team. New action added.	I = 2 L = 3 Low (6)
											Business case to be written to support additional anaesthetic cover **Person Responsible:** Anthony Adams **To be implemented by:** 29 Feb 2024	**31 Jan 2024** **Rhiannon Adey** Risk reviewed with CCASS Senior Leadership Team. New action added.	
											Ensure that all incidents of delay due to a lack of ITU consultants are reported on the Datix system **Person Responsible:** Pradeep Basnyat **To be implemented by:** 29 Mar 2024	**31 Jan 2024** **Rhiannon Adey** Risk reviewed with CCASS Senior Leadership Team. New action added.	

Risk Register Report (By Residual Risk Ranking)

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
679	31 Aug 2016	Care Group - Diagnostics, Cancer and Buckland		Failure to supply, from Pharmacy, scheduled chemotherapy treatments to patients **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Emily Hunnisett **Last Updated:** 20 Mar 2024 **Latest Review Date:** 20 Mar 2024 **Latest Review By:** Emily Hunnisett **Latest Review Comments:** Added 'deficiencies'	**Cause** Aseptic unit failure Air handling unit failure Regional QA audit review (12.3.24) highlight 3 critical deficiencies which move the unit from medium to high risk unit Inability to recruit and retain staffs year on year increase in demand for chemotherapy Capacity issues in commercial sector for supply of ready to use chemotherapy Isolator failure within the Aseptic unit Failure to obtain consumables due to non payment of invoices Unsuitable storage conditions of consumables and starting materials **Effect** 1. Failure to supply scheduled chemotherapy (as at 23.10.23 2500 treatments dispensed per month) 2. Cancellation of patients treatments 3. Rescheduling of patients treatments 4. Outsourcing of chemotherapy from a commercial market - substantial increase in costs (c.£50M pa (Sep-23))that may not be met by NHS Specialised commissioning 5. Commercial market may not have capacity to support volume of work from EKHUFT especially at short notice 6. Risk of waste from outsourcing 7. Some treatments cannot be outsourced due to short expiries impacting on patient care 8. Increased risk of error as the unit is not designed as a 'dispensing' facility 9. Support for clinical trials would stop 10. Adverse publicity for the Trust 11. The effect of the unsuitable storage conditions of consumables and starting materials would affect the production process and ultimately the quality of the medicinal products 12. If Trust does not rectify the 3 critical deficiencies highlighted in regional QA report (12.3.24), the unit is extremely likely to be shut down, causing all of the above effects to occur.	Quality	I = 5 L = 5 Extreme (25)	APU now has 5 working isolators which can be alternated between in case of a shut down for 2 isolators in a room **Control Owner:** Jenny Clements	Adequate	I = 5 L = 4 Extreme (20)	Detailed time line of progress to rectify facility issues listed in report provided following regional QA audit on 12.3.24. Evidence that progress has been made by next audit in August 2024. Initial report in **Person Responsible:** Albert Karugaba **To be implemented by:** 10 Apr 2024		I = 5 L = 2 Moderate (10)
								Business continuity plan in place **Control Owner:** Jenny Clements	Limited		Risk assessment to be conducted and mitigations in place to account for leak in ceiling (even if fixed). Mitigations to include reduction in preparation activity. The level of this is dependent on plans to rectify other facility issues. See attachment for report **Person Responsible:** Desmond Holden **To be implemented by:** 10 Apr 2024		
								Capacity plan in place, monitored and reviewed on a daily basis, (takes into account activity demand, staffing and isolator capacity). Breaches of capacity risk assessed. Activity demand reviewed monthly and reported through Governance **Control Owner:** Jenny Clements	Limited		Risk assessment for manufactured items which have visible particulate within. Update of processes to ensure medical staff aware when situation arises. **Person Responsible:** Jenny Clements **To be implemented by:** 10 Apr 2024		
								Chief Pharmacist acts as accountable pharmacist supported by Authorised pharmacists from the clinical pharmacy (haem/Onc team) **Control Owner:** Will Willson	Limited		Replacement of the unit with off site licensed facility as part of the ICS strategy and linked to the national aseptic review. **Person Responsible:** Will Willson **To be implemented by:** 30 Sep 2029	**04 Jul 2022** **Will Willson** National Aseptic review has allocated the £75M of capital, none has gone to London or the SE so therefore the case will not be reviewed until 2026. Action date to be updated	
								Control of consumable stock management and ordering - highlight supplier list in order of priority **Control Owner:** Jenny Clements	Adequate				
								Daily review and inspection of clean rooms **Control Owner:** Jenny Clements	Adequate				
								Embedded Quality Management System inclusive of: Weekly quality meetings Internal and External Inspections Error reporting and review Risk assessment on days where capacity exceeded Pharmacy QA resource to refer to **Control Owner:** Will Willson	Adequate				
								Estates PPM of building, AHU and clean room **Control Owner:** Jenny Clements	Limited				

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								for the unsuitable storage conditions of stock and starting materials , storage boxes and and plastic pallets are being used to store starting materials and stock to minimize the transfer of microbiological organisms into the production unit **Control Owner:** Jenny Clements					
								Patient tracking list to support allocation of treatments to appts scheduled - **Control Owner:** Jenny Clements	Adequate				
								Quarterly PPM reports for all five isolators with supplier **Control Owner:** Jenny Clements	Adequate				
								SLA in place with all suppliers for servicing and support **Control Owner:** Jenny Clements	Adequate				
								SLA with commercial companies supported by SOP for outsourcing **Control Owner:** Jade Winthrop	Limited				
								Use of pharmacy technicians as accredited product approvers in the aseptic unit, except for clinical trials & paediatric chemotherapy to maintain unit capacity and utilize staffs skills. **Control Owner:** Will Willson					
3386	17 Jul 2023	Care Group - Women's Health	Maternity	Potential risk of inaccurate records due to Euroking backcopying **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Adaline Smith **Last Updated:** 07 Mar 2024 **Latest Review Date:** 29 Feb 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added due to >15 risk rating. Agreed with CN- SH & DoG-KW.	**Cause** Notified by digital midwife from another trust about some of their records showing inaccurate information. Known issue to us from 2020 when this was reported to E3. E3 backcopying information awaiting full breakdown but examples and how many records affected. Potential safeguarding risks declared at 28 weeks appearing as though reported at booking but not actioned or sweep given at term backcopying to appear it was given at 18 weeks. Parity uploading incorrectly has been raised in other trusts **Effect** Information logging incorrectly, data and reporting on inaccurate records	Quality	I = 4 L = 5 Extreme (20)	Have requested that CIS team log ticket for all patient and pregnancy level questions to be immediately changed to contact only by **Control Owner:** Sharon Gough		I = 4 L = 5 Extreme (20)	Full breakdown of records/questions affected **Person Responsible:** Joanne Petcher **To be implemented by:** 24 Nov 2023		I = 2 L = 2 Low (4)
								Issue is known and being investigated by the LMNS and the regional digital group. **Control Owner:** Claire Bayat	Adequate		Update to be obtained monthly from E3 and trust IT **Person Responsible:** Claire Bayat **To be implemented by:** 31 Jan 2024		
								Trust IT and Magnetus aware 18/07/23. IT unaware if this has directly affected any of our records. Magnetus advised that evidence and trail of records will be available so not a risk for us. Will look to fix these issues affecting any user of any **Control Owner:** Joanne Petcher	Adequate				

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1895	16 Jan 2020	Care Group - Diagnostics, Cancer and Buckland		Current CT and MRI reporting backlog presents a clinical risk due to potential delays in diagnosis and treatment **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Gemma Matthews **Last Updated:** 12 Feb 2024 **Latest Review Date:** 19 Mar 2024 **Latest Review By:** Deborah Thornton **Latest Review Comments:** 4 CDC recruits' arrival, one in April, June, August and October. Additional 4 General Consultant Radiologist posts going through VCP process. "Breast Radiology consultants out to advert.	**Cause** The reporting position has been under pressure since April 2019 due to severe operational difficulties resulting from significant unit failures. In order to recover access times and waiting list stability, additional capacity was engaged. Due to the current the demand on the service, the demand is exceeding the capacity due to the growth of ED imaging, requests, growth in inpatient requests, Increase staff sickness and reporting radiographers requiring to be clinical due to service shortfalls. New pathways being embedded within the Trust such as SDEC has caused additional service pressures. Limited knowledge of pathways or clinicians referring on inappropriate pathways. **Effect** Patient safety Radiologist well being This has increased the 2WW backlog reporting which is a clinical and patient risk affecting the Cancer PTL. Increase in urgent backlog reporting, delaying patient treatment. Increase in complaints being received	Quality	I = 4 L = 5 Extreme (20)	Ad hoc sessions by internal radiographers **Control Owner:** Gemma Matthews	Limited	I = 4 L = 4 High (16)	Approval for international recruitment given under the CDC business case with NHSE. International recruitment of 12 radiographers and 4 **Person Responsible:** Gemma Matthews **To be implemented by:** 31 Dec 2023		I = 4 L = 3 Moderate (12)
								Backlog demand is being monitored by Head of Radiological Sciences **Control Owner:** Gemma Matthews	Limited				
								Five routine backlog cases identified for reporting each week **Control Owner:** Gemma Matthews	Adequate				
								Outsourced reporting **Control Owner:** Gemma Matthews	Limited				
								Two additional locum radiologists recruited **Control Owner:** Gemma Matthews	Adequate				
3384	13 Jul 2023	Corporate - Strategic Development & Capital Planning		The ability to deliver safe and effective services & implement improvements across Trust estate is compromised due to financial constraints for capital funding and assets replacement **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** **Last Updated:** 12 Feb 2024 **Latest Review Date:** 08 Feb 2024 **Latest Review By:** Benjamin Stevens **Latest Review Comments:** The action has been reviewed and updated. No change to risk scoring	**Cause** **Effect** - Resulting in poor patient and staff experience - Adverse effects during extreme weather conditions (e.g. leaking roofs; burst pipes leading to water supply shortage; injury to staff/patients) - Potential breaches to health & safety standards and legislation - Inefficiencies and difficulties in moving forward with providing services of the future such as the Clinical Strategy - Difficulty in controlling the spread of infection	Regulatory	I = 4 L = 5 Extreme (20)	A 6 facet estates survey has been undertaken which will be used as a benchmark to prioritise backlog maintenance requirements. **Control Owner:** Benjamin Stevens		I = 4 L = 4 High (16)	Approach the Kent and Medway Integrated Care Board for capital slippage across the county to focus on infrastructure compliance **Person Responsible:** Benjamin Stevens **To be implemented by:** 29 Mar 2024		I = 4 L = 3 Moderate (12)
								Prioritisation exercise for capital spend has been completed to ensure resources are used in the most effective / efficient way **Control Owner:** Benjamin Stevens			Full plan agreed for capital funding in 23/24. Programme of replacement agreed and to be delivered by year end **Person Responsible:** Benjamin Stevens **To be implemented by:** 29 Mar 2024		
								Prioritised Patients Environment Investment Committee (PEIC) action plan in place for 2023/24. **Control Owner:** Benjamin Stevens			Implement annual investment plan for statutory compliance and monitor in year improvements against the agreed trajectory for 23/24 **Person Responsible:** Benjamin Stevens **To be implemented by:** 31 Mar 2024		
											Prioritise through CIG the investments for backlog maintenance as part of the PEIC capital investment programme. This will be informed by the Six Facet Survey, the work undertaken by NHSE on reducing the backlog position and the ARUP report. Investment will be monitored **Person Responsible:** Benjamin Stevens **To be implemented by:** 31 Mar 2024		

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2406	04 May 2021	Care Group - Diagnostics, Cancer and Buckland		Delay to patient diagnosis from potential loss of Nuclear Medicine service at WHH **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** Gemma Matthews **Last Updated:** 29 Feb 2024 **Latest Review Date:** 29 Feb 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Exec risk owner added due to risk rating >15, agreed with CN-SH & DoG-KW	**Cause** The Skylight Gamma Camera located in Nuclear Medicine at WHH is 18 years old. • Unavailability of spare parts • Un-validated and out dated software for image processing • Potential for unintended radiation exposures to patients • Only one maintenance provider currently available (single tender SLA) • This single provider has recently given written notification that they plan to end support in March 2024. There is no alternative as the manufacturer (Philips) have confirmed that they no longer provide any support for this system (Document available). • The most recent service carried out on the camera indicated imaging artefacts developing which cannot be corrected for. These are currently outside the required field of view, however these have the potential to deteriorate which could end in the critical failure of the equipment. (Service report available). The current infrastructure of the department is tired and requires updating to fully comply with current infection control and EA guidance. Equipment No: 109293 **Effect**	Quality	I = 4 L = 5 Extreme (20)	Current SLA in place with gamma camera service engineer for routine servicing, 3 times per year and robust breakdown cover. **Control Owner:** Mark Dwyer	Adequate	I = 4 L = 4 High (16)	create a working group to discuss the return tender documents and works required prior to installation **Person Responsible:** Cassie Croft **To be implemented by:** 31 Mar 2024		I = 3 L = 2 Low (6)
								Routine gamma camera QC carried out by NM Physics. Quarterly testing. **Control Owner:** Lois Collins	Limited		To go out to tender to procure a replacement gamma camera for the WHH. **Person Responsible:** Colin Fell **To be implemented by:** 31 Mar 2024	**23 Feb 2023** **Deborah Thornton** awaiting capital plan for 2023/2024 to be able to proceed with business case	

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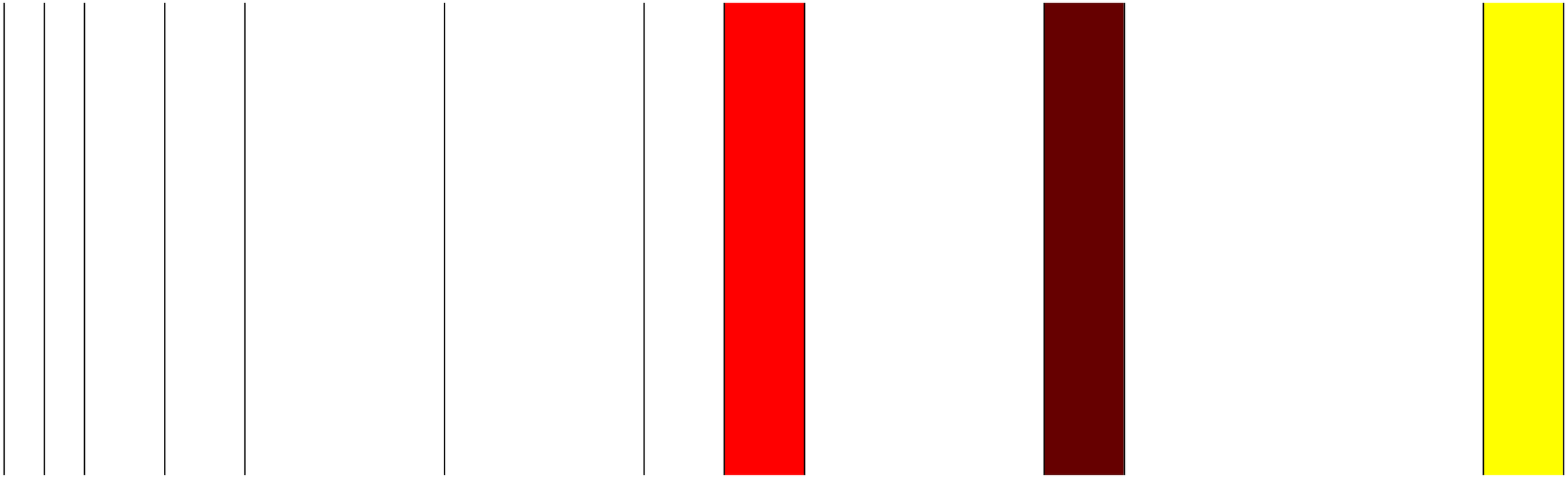

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					Complete loss of Nuclear Medicine service at WHH.This gamma camera supports a wide range of patients who have been referred for diagnostic Nuclear Medicine investigations and contributes to about one-third of the imaging capacity for nuclear medicine. This includes, for instance, parathyroid imaging for endocrinology, paediatric renal imaging, as well as the WACU pathway's VQ lung service. If the equipment malfunctioned, these investigations would have to be imaged at Kent & Canterbury, which would affect the present wait times for 2WW and Urgent patients. Loss of service at WHH would reduce our current imaging capacity by a third, impacting heavily on the already huge backlog of patients waiting for a nuclear medicine study. A datix (WEB229525) was raised on the 13th October due to an equipment failure of the skylight. At the point of system failing two patients had been administered radioactive tracers that could not then be imaged. This falls within the criteria notification of a radiation incident notifiable to the CQC. The full report/investigation can be found on the Datix entry. The CQC were informed within 24 hours of the incident. A full report will be submitted to the CQC at the end of November 2022. With no plan for replacement and the skylight a similar incident occurring is very likely. Two datix investigations were raised in November 2022 for the same currently unresolved camera fault (as of 28/11/2022 WEB231686 & WEB228801). The camera will not be used clinically until this fault is resolved. This is impacting on clinical capacity during a period when Nuclear Medicine is already experiencing a large patient backlog. This includes delay to urgent investigations such as VQ Lung scans from SDEC that can currently only be offered at KCH until the camera at WHH is back in service. Update 19/12/2022 MD: The camera has been returned to service following further investigations and work by the service engineers as well as subsequent testing by NM Physics.							

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2934	11 Aug 2022	Care Group - Women's Health	Maternity	Inadequate theatre capacity at QEQM for maternity services **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Cherrie Knight **Last Updated:** 29 Feb 2024 **Latest Review Date:** 29 Feb 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Exec risk owner added due to risk rating >15, agreed with CN-SH & DoG- KW	**Cause** Currently within maternity services at QEQM there is only one theatre within the maternity setting. There is only one obstetric theatre at QEQM, meaning potential for delays in emergency C/S and if this theatre has issues, the main theatre is some distance from the main obstetric unit. **Effect** - impact on theatre capacity - elective surgery being done in maternity theatres due to limited main theatre capacity causing an impact on emergency surgery - Delays in surgery being undertaken which can impact on patient safety and outcome -Overall the impact is that staff are not able to work as effectively as they might and this has a detrimental impact on their ability to ensure high standards of care. Inefficient working and diminished team communication.	Quality	I = 4 L = 5 Extreme (20)	Appropriate assessment of complexity of elective caesareans booked with RAG rating. A C-section SOP has been implemented to support this process.(effective controls for planned **Control Owner:** Clare Redfearn	Adequate	I = 4 L = 4 High (16)	centralized booking process for caesarean sections against an updated RAG rated clinical proforma **Person Responsible:** Zena Jacobs **To be implemented by:** 30 Nov 2023	**22 Sep 2023** **Cherrie Knight** phased approach starting at WHH and then to QEQM	I = 2 L = 2 Low (4)
								risk assessment completed by MDT with mitigations to follow if a 2nd for any 2nd emergency C section requirements when the obs theatre and main theatre are already in use. **Control Owner:** Natasha Curtiss	Adequate				
								The number of ELCS is monitored daily with the clinical operational and theatre teams and adjustment made accordingly **Control Owner:** Zena Jacobs	Adequate				
2808	06 May 2022	Care Group - Queen Elizabeth, The Queen Mother	QEQM Urgent and Emergency and Acute Medicine	There is a risk of patient harm occurring due to delays in recognising and escalating deteriorating patients in ED due to capacity **Risk Owner:** Sarah Hayes **Delegated Risk Owner:** Joanna Williams **Last Updated:** 12 Mar 2024 **Latest Review Date:** 12 Mar 2024 **Latest Review By:** Janet Webber **Latest Review Comments:** Risk reviewed	**Cause** The increase in patient attendances and in corridor care mean that monitoring of patient's and that the recognition of patient deterioration is not always identified in a timely manner. Staffing levels are impacted on by acuity and overcrowding and do not always support documentation and timely sepsis screening Recruitment of large volumes of new nurses without ED experience has diluted the skill mix and proven to have impacted on recognition of deteriorating patients. **Effect** *Patient deterioration is not always promptly identified and escalated, potentially resulting in a poor patient outcome. *Observations not always taken in a timely manner or repeated within recommended timeframe. *Delay in critical medications being administered.	Quality	I = 5 L = 4 Extreme (20)	Adverse incidents resulting from lack of timely recognition and deterioration are recorded on Datix and investigated. Findings and identified actions are implemented and shared with staff at team and governance **Control Owner:** Janet Webber	Limited	I = 4 L = 4 High (16)	System work being undertaken to improve flow **Person Responsible:** Susan Brassington **To be implemented by:** 03 May 2024	**09 Feb 2024** **Rhiannon Adey** Updated by Director of Nursing, QEQM. Co-located Safe Haven in place and Thanet SPOA	I = 3 L = 2 Low (6)
								Dedicated education teams to support the junior workforce and upskill the ED and AMU teams. **Control Owner:** Joanna Williams	Limited		Participation in relevant audits relating to deteriorating patients and development and implementation or robust actions to address gaps and identified areas where improvement is needed. **Person Responsible:** Joanna Williams **To be implemented by:** 31 May 2024	**05 Apr 2023** **Janet Webber** April 2023 - risk score increased due to data and increase in incidents and SIs relating to deteriorating patients	
								Improving access to resuscitation training **Control Owner:** Joanna Williams	Limited				
								Launch of quality strategy with deteriorating patient being a dedicated workstream. Actions from workstream include NEWS2 nurse that has positively impacted on time to treatment, escalation and recognition of deteriorating patients, proving better **Control Owner:** Joanna Williams	Limited				
								Recruited into all band 5 vacancies across the ED and AMU's, providing safer staffing numbers	Adequate				

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1628	15 Apr 2019	Care Group - William Harvey		Staffing mix and experience impact on the ability of the Care Group to provide services to paediatric patients in line with the RCPH standards **Risk Owner:** Sarah Hayes **Delegated Risk Owner:** Benjamin Hearnden **Last Updated:** 07 Mar 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Exec risk owner added due to > 15 risk , agreed with CN- SH	**Cause** Nurse staffing establishment lacks resilience ED nursing and medical staff may treat paediatric patients without the relevant competencies Paediatric patients are cared for in a separate area in ED and it is not always possible for a doctor to be present in the area at all times Issues with delays in specialist services reviewing children following referral which leads to increased ED stay. There are not always EPALS trained staff on duty **Effect** May not be able to provide a safe and sustainable service as not fully compliant with RCPCH standards.	People	I = 4 L = 5 Extreme (20)	Agreed dedicated Matron for WHH is going out to advert This position was advertised but we were unable to appoint. Adult Matron to step into seconded role for a six month period with an role advertised to backfill the adult matron position. **Control Owner:** Tomislav Canzek	Adequate	I = 4 L = 4 High (16)	Interviews are to take place for an interim Matron as the post was not recruited in to. Whilst this is being advertised CNO HON and Dir ON to support wider advertisement and knowledge of vacancy **Person Responsible:** Benjamin Hearnden **To be implemented by:** 31 May 2024		I = 2 L = 2 Low (4)
								Assistance/support from paediatric services are available when required **Control Owner:** Thomas Boon	Adequate		Medical staff to attend advanced training (PILS then APLS) Paediatric ED Consultant Leads in place for WHH and QEQMH All new doctors are booked for PILS and Registrars are expected to undertake APLs but this has been impacted due to Covid-19 April 2023 PILS training impacted by training staff shortages and lack of spaces to book This is still work in prgress due date ammended **Person Responsible:** Thomas Boon **To be implemented by:** 30 Jun 2024	**29 Sep 2023** **Nicola Brooker** Due to staff absence this is now overdue with no other staff able to action this.	
								Daily huddles and escalation to Director of Nursing for UEC **Control Owner:** Joanna Williams	Adequate				
								Liaison across sites for cross cover **Control Owner:** Catherine Miller	Adequate				
								Long lines of agency staff are booked for continuity and to ensure gaps are filled. A doctor is allocated to oversee Paediatrics. **Control Owner:** Joanna Williams	Limited		Ensure staff are trained in resus and safeguarding training. Safeguarding training is monitored and reported monthly. Training is role specific. All nurses are PILS trained and Band 6 and above APOLS trained - training has been impacted by Covid restrictions. Ongoing monitoring. April 2023 PILS training impacted by training staff shortages and lack of spaces to book This is still a concern due date amended **Person Responsible:** Catherine Miller **To be implemented by:** 30 Jun 2024	**23 Dec 2020** **Janet Webber** 23/12/2020 RCN competencies in place for nursing and staff are working through them Expectations and programme in place to ensure EPLS and APLS training for medical and nursing staff. A doctor is available for Paediatric ED 24 hours a day. There is a building programme to address issues with space and isolation	
								QEQM ED adult nurses have received training competencies to be able to support the Paediatric team and deemed clinically competent. **Control Owner:** Joanna Williams	Adequate				
								Review of current establishments/booking of temporary staffing to bridge gap As of December, this is necessary for unexpected sickness absences as establishment of staff in place **Control Owner:** Joanna Williams	Adequate				
								Training and competency for existing medical and nursing staff to increase skills and knowledge safeguarding and resus training **Control Owner:** Rachel Perry	Limited				
								Use of Paediatric doctors within ED to support the Paediatric service. **Control Owner:** Hitendra Tanwar	Limited				

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								WHH Five Registered nurses have been have been seconded into positions in the paediatric ED. They have all within first month of secondment signed off all of their paediatric competencies. This will be used to mitigate vacancies. **Control Owner:** Tomislav Canzek						
								Whilst a doctor may not always be present in the Paediatric area in ED, nursing staff are present to monitor and observe the children there and they will escalate any concerns to medical staff and take any necessary urgent actions **Control Owner:** Hitendra Tanwar	Limited				

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2038	09 Apr 2020	Corporate - Operations		Misalignment between Demand and Capacity across the Trust's RTT, non-RTT and Cancer pathways **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Sunny Chada **Last Updated:** 13 Mar 2024 **Latest Review Date:** 04 Mar 2024 **Latest Review By:** Sunny Chada **Latest Review Comments:** Update of IS records and addition of existing controls.	**Cause** The increasing demand for healthcare services within the Trust has surpassed the existing capacity, leading to strain on resources, longer waiting times, and compromised patient care. 1. Competing pressures from non elective flow for bed capacity and staff. 2. Lack of diagnostic capacity. 3. Specialty specific consultant vacancies within ENT (Otology), Dermatology, Urology, Endoscopy & Radiology. 4. Lack of clear validation oversight and training for specialities means patients on non-RTT pathways return to core waiting lists. 5. Endoscopy capacity and utilisation affecting performance **Effect** Elevated patient dissatisfaction due to prolonged waiting times. Possible decline in the quality of the services provided. Increased risk of adverse patient outcomes. Strain on staff leading to burnout and decreased morale. The non clinically urgent elective cancellations and delays are leading to patients on the RTT pathway delays	Quality	I = 4 L = 4 High (16)	All 52 week breaches will be added to datix closely monitored by clinical and operational teams. Patients are monitored on a 3 monthly basis by post. Patients continue to be treated in clinical priority order. **Control Owner:** Desmond Holden	Adequate	I = 4 L = 4 High (16)	To work with the theatres to secure additional sessions required to deliver the activity **Person Responsible:** Juliet Apps **To be implemented by:** 31 Mar 2024		I = 3 L = 2 Low (6)
								Consultants risk stratifying their outpatient and surgery waiting lists to identify any urgent cases that need to be seen or treated. **Control Owner:** Juliet Apps	Limited		ICB to agree IS levels of commissioning for 2024/25. **Person Responsible:** Sunny Chada **To be implemented by:** 10 Apr 2024		
								Daily elective PTL meetings to maximise capacity and maintain flow in conjunction with weekly access meetings at COO level to ensure grip and control. **Control Owner:** Sunny	Adequate		Development of a clear trust-wide improvement programme for 2024/25 via the following improvement groups: - 1. Outpatient Transformation. 2. Theatre Improvement. 3. Diagnostics Delivery Group. **Person Responsible:** Sunny Chada **To be implemented by:** 06 May 2024		
								Early reporting of any equipment shortages or issues to ensure timely repair or procurement **Control Owner:** Juliet Apps	Limited		ECIST Team supporting via the creation of the Data Quality Improvement Group to develop the following: - 1. Update of Access Policy. 2. Development of a clear Trust-wide 12 week validation programme. 3. Development of a PTL management training programme combined with a clear competency **Person Responsible:** Sunny Chada **To be implemented by:** 03 Jun 2024		
								External validation team (MBI) commissioned to complete validation of all DM01 > 7 weeks (13,446) and 50% of the existing unvalidated RTT (13,000 **Control Owner:** Louise					
								Independent Sector (IS) Capacity formally commissioned by the ICB to support the Trust in the specialities in most need. Weekly utilisation of IS capacity provided to Access meeting and ICB hold monthly contract monitoring meetings to ensure patients are not returned to the Trust post referral. **Control Owner:** Sara			Creation of an Insourcing strategy for the Trust for 2024/25 to utilise any unmet capacity, whilst also generating income for the Trust. Full tendering programme and care group engagement required ahead of a clear plan for approval in Q2. **Person Responsible:** Sunny Chada **To be implemented by:** 01 Jul 2024		
								NHSEI focus to have dates for all patients waiting over 65 weeks by the end of March 2024. Additional activity added to the business plan to enable delivery. **Control Owner:** Sunny	Adequate				
								To maintain an equipment register that will proactively highlight any pending risks **Control Owner:** Juliet Apps	Adequate				

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								Trust under Tier 1 oversight with fortnightly reviews of performance within Elective Recovery and also Cancer. **Control Owner:** Sunny					
								Trust validation teams regularly review longer waiting patients to ensure harm is minimised wherever **Control Owner:** Louise					

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3528	04 Oct 2023	Corporate - Operations		Patients are at risk of breaching the national cancer standards. This could result in patients waiting longer for treatment with associated poor patient outcomes and patient experience. **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Sunny Chada **Last Updated:** 15 Feb 2024 **Latest Review Date:** 15 Feb 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Risk title revised in discussion with COO.	**Cause** Delays with diagnostic capacity and earlier in cancer pathway cause later delays Surgical capacity issues in Urology & Colorectal Staffing issues due vacancy & recruitment of specialist trained clinician specific to certain tumour groups e.g Urology. Limited EMR availability , limited GA & Heavy sedation availability for colonoscopy. EPIC introduction in GSTT & KCH with limited notice TP biopsy process in Urology Patient choice **Effect** Patients are waiting longer for diagnostics and treatment plan Emotional harm to patients Staff at risk of 'burn out' and stress due attempting to provide quality care to patients affected by delays Risk of Trust reputational damage due to delays, poor outcomes and poor performance. Now patients are breaching daily. This has raised by 500 in a month	Quality	I = 5 L = 4 Extreme (20)	104 day process developed and being followed. Low volume TSSG less of a concern than High volume e..g Lower GI **Control Owner:** Chiara Hendry	Limited	I = 4 L = 4 High (16)	28 Day Performance Manager to work with all the tumour sites to improve engagement with 28 day patient letter turn around times. **Person Responsible:** Ashley Wilson **To be implemented by:** 01 Nov 2023	**09 Feb 2024** **Rhiannon Adey** Update by Vicki Hatcher 13.10.2023 FD manager and Clinical nursing lead have engaged with operational teams for 28 day support. FD manager is supporting the performance feeder pack with data for 28 day and back log. Early engagement has improved the 28 day PTL from over 1000 patients to 774 and a further reduction at the end of this week to 599.	I = 3 L = 2 Low (6)
								Availability of high tech interventions locally, this includes work done by transformation lead e.g. Carbogen Nicotinamide in the Oncology Department at K&C a new treatment for prostate tumors which is already being used at MTW and east Kent patients previously had to travel to receive the **Control Owner:** Mark	Limited		Lead to support joint working with 2ww team to improve booking turn around times and capacity. Staffing has been highlighted on risk reference **Person Responsible:** Ashley Wilson **To be implemented by:** 30 Nov 2023	**09 Feb 2024** **Rhiannon Adey** Update by Vicky Hatcher 13.10.2023 FD manager and FD clinical nursing lead are working with our trust improvement facilitator and 2ww colleagues to support ongoing work and engagement regarding booing process and capacity.	
								Daily report of patients over 62 days sent to all the Care Group Ops Managers which is followed up by a daily phone call for an update and decision. Out Patient booking managers and General Managers to monitor and resolve any capacity issues. Daily email sent to Pathway Manager at Maidstone and Tunbridge Well NHS Trust to escalate patients to book for Oncology. Director of Operations will liaise with Ops Directors in other Care Groups to **Control Owner:** Sarah	Adequate		Faster Diagnosis Nursing Lead to support the implementation of straight to test (STT) and a standardised and consistent approach to achieve compliance **Person Responsible:** Vicki Hatcher **To be implemented by:** 30 Dec 2023	**09 Feb 2024** **Rhiannon Adey** Update by Vicky Hatcher 13.10.2023 Upper GI, LGI and Lung STT pathways in place. Lower GI CNS lead is working with Consultant surgeon to review LGI STT patient criteria. FDS nursing lead is working with Lead Prostate CNS towards STT pathway implementation.	
								Implementation of UGI and Lung STT service in 2021 followed by the LGI STT service in 2023 **Control Owner:** Carolyn Maynard	Adequate		Each TSSG to have identified patient information (and where located) relating to likely diagnostic procedures on Cancer pathway . H&N completed. **Person Responsible:** Chiara Hendry **To be implemented by:** 31 Dec 2023		
								The tumour site specific nurses provide a weekly update on the support provided and required for patients who are experiencing pathway delays to improve patient experience and outcome. This includes escalation regarding any concerns. Documenting all care on infoflex. Providing an overview of how this is done by each team-opportunity for shared learning and developing best practice. **Control Owner:** Carolyn Maynard	Adequate		To monitor trust wide compliance with the completion of clinical harm reviews (CHR). A clinical harm review is completed for all patients who have a cancer diagnosis or RIP and wait more than 104-days on a cancer **Person Responsible:** Chiara Hendry **To be implemented by:** 31 Dec 2023		

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
								Weekly cancer tumour site PTL meetings to monitor all cancer standards. Track patients through their pathway . Optomise pathway if can. **Control Owner:** Karen Rowland	Adequate		High Risk Qfit facilitator, to support community implementation at pace and help reduce interventional diagnostics for patients within the Trust. **Person Responsible:** Danielle Mackenzie **To be implemented by:** 31 Dec 2023	**09 Feb 2024** **Rhiannon Adey** Update provided by Danielle Mackenzie 08.11.2023 - Continuing to request qFIT as referral received if no accompanying qFIT. To discuss with surgery how qFIT SOP compliance is being monitored and impact this is having on LGI pathway. Due to increased workload, data submission for NHSE has fallen behind, qFIT nav and qFIT project facilitator attempting to catch up with this.	
								Weekly KPI meeting led by COO, Deputy COO for Elective Services and Director of Performance with Operations Directors and General Managers **Control Owner:** Karen Rowland	Adequate				
								Weekly tertiary centre PTL to escalate any patients of concern externally **Control Owner:** Sarah	Adequate		Weekly PTL meeting with GSST/KCH to be established to ensure patients are followed up by tertiary centers. Current discussions around suitable day for the meetings to ensure correct people attend. **Person Responsible:** Anna Lamb **To be implemented by:** 30 Jan 2024	**04 Dec 2023** **Pippa Enticknap** 04/12 - Due to the post holder we were liaising with to set up weekly PTL meetings leaving, we have had to start up new conversations with SE London Cancer Alliance. Currently trying to find a mutual day in the week that the relevant staff can attend.	
											Work with lead GP to ensure patient fully informed of process - quarterly meetings with lead GP to be initiated **Person Responsible:** Vicki Hatcher **To be implemented by:** 30 Jan 2024	**15 Jan 2024** **Vicki Hatcher** 15.01.2024 Quarterly meetings in place for 2024 with Dr Jonathan Bryant. First Primary/secondary care engagement meeting took place 08.01.2024	
											Criteria for patients who fit the 104 CHR process to be applied. Currently biggest issue for Lower GI as high numbers of patients without a diagnosis at 104 plus. **Person Responsible:** Chiara Hendry **To be implemented by:** 31 Jan 2024	**09 Feb 2024** **Rhiannon Adey** Update provided by action owner 15.12.2023 - Process with admin now being trialled to review no diagnosis patients with CH	
											Annual review of 104 day process and completed for 2022 -2023. Content includes - data from Breech Reports (BR), benign audit and thematic review of CHR. Findings to be disseminated with clinical leads and CWG. **Person Responsible:** Chiara Hendry **To be implemented by:** 31 Jan 2024	**09 Feb 2024** **Rhiannon Adey** Update provided by action owner 15.12.2023 - Clinical leads informally advised of process via PSC to check if CWG issue at this stage.	
											Each TSSG to identify area to focus on. Currently Lung and H&N have identified areas for 2023-2024 **Person Responsible:** Chiara Hendry **To be implemented by:** 31 Jan 2024	**09 Feb 2024** **Rhiannon Adey** Update provided by action owner 15.12.2023 - A Further TSSG area identified for Breast and Skin	

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2696	15 Dec 2021	Care Group - Critical Care, Anaesthetics and Specialist Surgery	Resus	There is a risk that staff will not be sufficiently trained in resuscitation due to the size of the resuscitation team **Risk Owner:** Peter Samworth **Delegated Risk Owner:** Judith Banks **Last Updated:** 07 Mar 2024 **Latest Review Date:** 01 Feb 2024 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed with CCASS Senior Leadership team. Additional posts to be advertised imminently. Agency currently undertaking additional training, however, we remain non-compliant therefore the risk rating remains a high risk. Additional actions undertaken to be included within the risk.	**Cause** The ratio of resuscitation officers to clinical staff is below the Resuscitation Council UK requirements Skill mix of the team does not meet the needs of the service Maternity leave and sickness absence Inadequate capacity within K&CH training room to deliver the amount of training required within the Trust Staff within the team are asked to provide clinical support to the front line High DNA rate due to ward pressures **Effect** Increased risk of harm to patients as clinical practitioners will not be able to recognise a deteriorating patient Breach of resuscitation training targets Increased risk of financial settlements to patients or relatives following legal proceedings Reputational damage due to failure in care for EKHUFT patients Difficulty in recruiting clinical practitioners due to reputational damage	Quality	I = 4 L = 4 High (16)	Ad-hoc NHSP/overtime if team are required to work **Control Owner:** Peter Samworth	Limited	I = 4 L = 4 High (16)	**Person Responsible:** **To be implemented by:**		I = 4 L = 2 Moderate (8)
								Ad-hoc training undertaken for high risk areas e.g. ED, **Control Owner:** Peter Samworth	Adequate				
								Audits undertaken of resuscitations that take place in the Trust **Control Owner:** Peter Samworth					
								Diary management undertaken to fit as many sessions in as possible **Control Owner:** Peter Samworth	Limited				
								Dickon Weir-Hughes review undertaken in to workforce and training **Control Owner:** Michelle Rose	Limited				
								DNA rate sent to ward managers **Control Owner:** Peter Samworth	Limited				
								Encourage staff to contact the Resus team for ad-hoc training where there are a number of people that are **Control Owner:** Peter Samworth	Limited				
								Funding received from ICB to source external company to deliver resuscitation training **Control Owner:** Gemma Oliver					
								Move capacity away from K&CH to other sites **Control Owner:** Peter Samworth	Adequate				
								Reduced face-to-face training time to encourage staff to attend **Control Owner:** Peter Samworth	Limited				
								Regular meetings at WHH to discuss CPR figures and the importance of attending training **Control Owner:** Peter Samworth					

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3354	27 Jun 2023	Care Group - Queen Elizabeth, The Queen Mother		Clinical environment not fit for purpose in many areas **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** Susan Brassington **Last Updated:** 18 Mar 2024 **Latest Review Date:** 08 Mar 2024 **Latest Review By:** Janet Webber **Latest Review Comments:** Ris reviewed	**Cause** Old estate poorly maitained means many areas are not fit for purpose. Examples include: Lack of space for staff to work effectively - office/access to quiet area staff toilets/rest rooms etc. Floors not able to take patients above a certain weight Storage limited resulting in clutter/falls risk/fire risk Repairs are not addressed in a timely manner once reported to the Estates Team **Effect** Impact on patient pathways and access to care IPT risk health & safety issues Staff morale staff conflict due to having to work in space limited areas Infection risk due to storage of kit Fire risk due to access/clutter staff unhappy/low morale	Quality	I = 4 L = 4 High (16)	Staff are aware of the need to report estates issues promptly having taken appropriate remedial action and to record and follow up on requests to estates, escalating as necessary **Control Owner:** Susan Brassington	Limited	I = 4 L = 4 High (16)	Estates issues for all ward areas to be addressed with the Estates team to ensure an ongoing programme of maintenance and repair. List of estates issues from closed ward risks **Person Responsible:** Susan Brassington **To be implemented by:** 30 Nov 2024	**08 Mar 2024** **Janet Webber** Ward estates issue closed and added to this overarching	I = 2 L = 2 Low (4)

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
1511	29 Nov 2018	Care Group - Queen Elizabeth, The Queen Mother		Increased length of stay for mental health patients awaiting inpatient community beds **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** David Bogard **Last Updated:** 12 Mar 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added- COO, RH, due to risk > 15, agreed with CN- SH	**Cause** *Lack of acute inpatient mental health beds external to the Trust causing long waits in ED, and need for patients to remain in ED or be admitted to ward areas which are not secure mental health environments. *Knowledge gap of general nursing and medical staff to manage significant mental health appropriately *There is a lack of assessment space and therapeutic intervention. *Length of stay has doubled since this time last year **Effect** *Potential poor service to and environment for patients with a stay over 12 hours *Potential unsafe service to patients * Patient behaviour can escalate/ deteriorate and become challenging whilst waiting for mental health assessment which is a risk to staff and patients *Increased violence and aggression with assaults on staff attributed to increased LoS	Quality	I = 4 L = 5 Extreme (20)	*Direct referral pathways to psychiatry and single point of access team at both WHH and QEQM. *Review of frequent attendees, meetings monthly with good representation from external partners. *Enhanced observation support worked employed by the Emergency Department to support the care for patients experiencing mental health illness. *Head of Nursing meets to review patients being brought into ED under 136 *Supportive visits from ICB - welcomed. *Length of stay of mental health patients is reported by the Fundamentals of Care Committee. **Control Owner:** Joanna Williams	Limited	I = 4 L = 4 High (16)	Ensure safeguarding vulnerable adults and paediatric training compliance in place for all relevant staff. Compliance is monitored on an ongoing basis and also reinforced at Team Days **Person Responsible:** Joanna Williams **To be implemented by:** 31 May 2024	**29 Jun 2021** **Rhiannon Adey** Not far off 90% compliance	I = 3 L = 3 Moderate (9)
											Work with external partners/commissioners to ensure provision of service meets the needs of mental health patients in a timely way. Ongoing meetings with KMPT November 2022 KMPT provide LP team to ED streaming at QEQMH This continues with a steering group in place Ongoing consultation and recent ICB visit and actions u=identified. SLA still not in place between EKHUFT & KMPT **Person Responsible:** Joanna Williams **To be implemented by:** 31 Jul 2024	**06 May 2022** **Janet Webber** LP service is now available 24 hours. HoN is meeting with KMPT Coo to plan services and input	
								A Frequent Attender review process is embedded with regular meetings and development of care plans and strategies to support patients to help them reduce attendance. **Control Owner:** Joanna Williams	Limited				
								Agency Registered Mental Health nurses utilised to support staff when delays in psychiatric assessment occur and delays are reported on DATIX and escalated to Site Triumvirate. **Control Owner:** Joanna Williams	Limited				
								An increase in DATIX incident reports relating to issues with MH patients exhibiting aggressive behaviour has resulted in Security staff being in place in the Observation bay at QEQMH. In addition, 4 EOSW have been appointed. Weekly Security meetings are utilised **Control Owner:** Joanna Williams	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
								Immediate work is being undertaken on the relatives room at WH which is currently being used as a Mental Health Assessment Room (relocated here due to Covid streams) is being undertaken to make it compliant with requirements for mental **Control Owner:** Joanna Williams	Limited				
								QEQM Daily shift logs of mental health patients within the department escalated to Hospital Triumvirate daily. **Control Owner:** Joe Keefe	Adequate				
								The risk relating to the Trust not having a Ligature Policy in place has been raised at the Risk and CQC Assurance meetings. Ligature Risk Assessments have been undertaken for all areas and are reported and reviewed weekly by the Care Group Triumvirate **Control Owner:** Joanna Williams	Adequate				
								There are delays in mental health assessments being undertaken and, where appropriate, patients with mental health conditions are cared for in the Observation Bays to ensure their comfort and safety. Both EDs now have 24 hour MH Liaison contact teams **Control Owner:** David	Limited				
								We have an enhanced observation support worker 24/7 and use agency registered mental health nurses to match the demands, alongside agency **Control Owner:** Joanna Williams	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3264	24 May 2023	Care Group - Critical Care, Anaesthetics and Specialist Surgery	Maxillofacial	There is a risk that patients will breach the 52 week wait standard for a maxillofacial first outpatient appointment due to an inability to recruit specialty doctors **Risk Owner:** Juliet Apps **Delegated Risk Owner:** Abbie Rogers **Last Updated:** 12 Feb 2024 **Latest Review Date:** 01 Feb 2024 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed with CCASS Senior Leadership Team. Locum in place which is an effective control, new action added to move locum to short term contract. Specialty doctor recruited who commences in April, it is expected that the risk will then reduce.	**Cause** Two full-time speciality doctor vacancies - been unable to recruit since August 2022. **Effect** Increased wait time for first outpatient appointment. Delayed start to treatment and increase risk of 52 & 75-week breaches.	Quality	I = 4 L = 5 Extreme (20)	Additional clinics to see longest waiters and clinical staff engagement to support (new patient clinics arranged at WLI in SPH in addition to additional clinics in dept) **Control Owner:** Abbie		I = 4 L = 4 High (16)	Work to move locum doctor to short term contract **Person Responsible:** Juliet Apps **To be implemented by:** 29 Mar 2024		I = 4 L = 2 Moderate (8)
								Limited nursing staff. Increase use of agency but there is limited agency available due to speciality requirement - Dental Nurse. **Control Owner:** Donna Parker			Recruitment into vacancies and reduce outpatient first appointment wait time. **Person Responsible:** Juliet Apps **To be implemented by:** 29 Mar 2024	**01 Feb 2024** **Rhiannon Adey** Specialty doctor recruited, starting in April.	
								Locum Speciality Doctor starts 31/05/23 - clinics to commence from 05/06/23, following local induction and e-learning to access systems. Locum Dr commenced in post and first OPA time reducing 1/9 - Locum released due to poor performance. Substantive staff to give additional capacity **Control Owner:** Abbie					

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3557	02 Nov 2023	Care Group - William Harvey		Increased length of stay for mental health patients awaiting inpatient community beds **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Rachel Perry **Last Updated:** 07 Mar 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added- COO as >15 risk, agreed with CN- SH	**Cause** *Lack of acute inpatient mental health beds external to the Trust causing long waits in ED, as the ED is not a mental health environment or secure area. *Knowledge gap of general nursing and medical staff to manage significant mental health appropriately *There is a lack of assessment space and therapeutic intervention. *At QEQMH a temporary MH room due to building works and there is insufficient assessment space *Length of stay has doubled since this **Effect** *Potential poor service to and environment for patients *Potential unsafe service to patients * Patient behaviour can escalate/ deteriorate and become challenging whilst waiting for mental health assessment which is a risk to staff and patients *Increased violence and aggression with assaults on staff	Quality	I = 4 L = 5 Extreme (20)	*Direct referral pathways to psychiatry and single point of access team at both WHH and QEQM. *Review of frequent attendees, meetings monthly with good representation from external partners. *Enhanced observation support worked employed by the Emergency Department to support the care for patients experiencing mental health illness. *Head of Nursing meets to review patients being brought into ED under 136 *Supportive visits from ICB - welcomed. *Length of stay of mental health patients is reported by the Fundamentals of Care **Control Owner:** Benjamin Hearnden	Limited	I = 4 L = 4 High (16)	UEAM team to ensure all patients awaiting an inpatient mental health bed are reported on the incident reporting system **Person Responsible:** Nicola Brooker **To be implemented by:** 30 Apr 2024		I = 3 L = 3 Moderate (9)
											Work with external partners/commissioners to ensure provision of service meets the needs of mental health patients in a timely way. Ongoing meetings with KMPT November 2022 KMPT provide LP team to ED streaming at QEQMH This continues with a steering group in place Ongoing consultation and recent ICB visit and actions unidentified. **Person Responsible:** Benjamin Hearnden **To be implemented by:** 31 May 2024		
								A Frequent Attender review process is embedded with regular meetings and development of care plans and strategies to support patients to help them reduce attendance. **Control Owner:** Benjamin Hearnden	Limited		The UEAM team are working to identify and provide assessment facilities for patients awaiting inpatient beds This is still under review due date amended **Person Responsible:** Benjamin Hearnden **To be implemented by:** 30 Jun 2024		
								Agency Registered Mental Health nurses utilised to support staff when delays in psychiatric assessment occur and delays are reported on DATIX and escalated to Site Triumvirate. **Control Owner:** Benjamin Hearnden	Limited		Recruit mental health nurses. This is still in progress due date amended **Person Responsible:** Tomislav Canzek **To be implemented by:** 31 Jul 2024		
								An increase in DATIX incident reports relating to issues with MH patients exhibiting aggressive behaviour has resulted in Security staff being in place in the Observation bay at QEQMH. In addition, 4 EOSW have been appointed. Weekly Security meetings are utilised **Control Owner:** Benjamin Hearnden	Limited		Ensure safeguarding vulnerable adults and paediatric training compliance in place for all relevant staff. Compliance is monitored on an ongoing basis and also reinforced at Team Days November 2022 training is booked and planned in to 2023 **Person Responsible:** Benjamin Hearnden **To be implemented by:** 31 Aug 2024		
								Immediate work is being undertaken on the relatives room at WH which is currently being used as a Mental Health Assessment Room (relocated here due to Covid streams) is being undertaken to make it compliant with requirements for mental **Control Owner:** Benjamin Hearnden	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
								The risk relating to the Trust not having a Ligature Policy in place has been raised at the Risk and CQC Assurance meetings. Ligature Risk Assessments have been undertaken for all areas and are reported and reviewed weekly by the Care Group Triumvirate **Control Owner:** Benjamin Hearnden	Adequate				
								There are delays in mental health assessments being undertaken and, where appropriate, patients with mental health conditions are cared for in the Observation Bays to ensure their comfort and safety. Both EDs now have 24 hour MH Liaison contact teams **Control Owner:** Hitendra Tanwar	Limited				
								We have an enhanced observation support worker 24/7 and use agency registered mental health nurses to match the demands, alongside agency **Control Owner:** Benjamin Hearnden	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3553	31 Oct 2023	Care Group - William Harvey	Cardiology	Failure of Cardiac Catheter Suite equipment (Lab 1, 2 & 3) WHH **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** Alexandra Mcvey **Last Updated:** 07 Mar 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added as risk >15, agreed with CN-SH	**Cause** All 3 cardiac catheter labs at WHH require replacement due to the fact they are over 10 years old. This has led to an increasing frequency of breakdowns and also deterioration in image quality. **Effect** Potential inability to provide the regional PPCI service - divert to other sites may be required. Cancellation of electives leading to long wait time for cardiac angiography/PCI (approx 48 weeks). Potential harm to patients Loss of clinical income. QE inpatients have lengthy transfer times to the WHH waiting an average of 3 days longer than patients at WHH for NSTEMI Delays to patient flow Under utilisation of lab 3 due to poor image quality. Detrimental effect on reputation Deterioration in RTT position. Impact on staff morale Impact on recruitment and retention of clinical staff.	Quality	I = 4 L = 5 Extreme (20)	All procedures conducted in lab 3 to use LOW DOSE setting on the C-arm **Control Owner:** Merrill Schofield	Limited	I = 4 L = 4 High (16)	Discuss capital replacement programme Sarah Charman at next capital meeting. **Person Responsible:** Nicky Bentley **To be implemented by:** 06 Nov 2023		I = 3 L = 2 Low (6)
								Cardiology matron now in post and actively monitoring lab PTL and pulling/swapping patients across sites/ensuring better flow through the cath labs. **Control Owner:** Rebecca Enright	Adequate		Engineering assessment of lab equipment in labs 1 & 2 to be undertaken. Lab 3 assessment complete - high priority for replacement. **Person Responsible:** Andrew **To be implemented by:** 29 Feb 2024		
								Datix completed for electives cancelled due to lack of capacity/lab break down etc **Control Owner:** Shirley Wilson	Adequate		Explore outsourcing options for elective work - KIMS negotiations underway and liaison with consultant colleagues to best utilise KIMS capacity. To proceed through sign off process. **Person Responsible:** Alexandra Mcvey **To be implemented by:** 29 Feb 2024		
								electives booked as agreed with lab lead around the PPCI's to try and minimise cancellations and avoid delays with PPCI **Control Owner:** Shirley Wilson	Adequate		Development of COPEL levels. **Person Responsible:** Alexandra Mcvey **To be implemented by:** 29 Mar 2024		
								Equipment moved between labs and between sites where possible. **Control Owner:** Alexandra Mcvey	Limited		Exploration of running of weekend lists. Discussion re rates to be had with physiologists **Person Responsible:** Alexandra Mcvey **To be implemented by:** 29 Mar 2024		
								Issues fixed as they occur in the labs. Electives cancelled as necessary to allow the PPCI service to run as priority **Control Owner:** Alexandra Mcvey	Limited		BCP to be updated following September 23 failure of both PCI labs at WHH **Person Responsible:** Alexandra Mcvey **To be implemented by:** 29 Mar 2024		
								maintenance carried out as per specification for **Control Owner:** Alexandra Mcvey	Adequate				
								Monitoring will be on-going re radiation levels via medical physics **Control Owner:** Merrill Schofield	Adequate				
								Staff members are monitored by their dose badges for occupational exposure **Control Owner:** Merrill Schofield	Adequate				
								Utilisation of the second lab through job planning has increased use of both labs **Control Owner:** Alexandra Mcvey	Adequate				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
								Vacant lab sessions offered out as additional shifts to consultants on admin/SPA to increase capacity. **Control Owner:** Alexandra Mcvey	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2620	03 Nov 2021	Care Group - Diagnostics, Cancer and Buckland		Reduced Consultant Medical Microbiologist (CMM) workforce **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Samuel Moses **Last Updated:** 26 Mar 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added as >15 risk, agreed with CN-SH	**Cause** The current CMM workforce for East Kent is 3.5 as opposed to the required total number of 4.5. This in itself is an underestimate of current need. The maximum establishment ceiling of 5 WTE's existed for approximately 30 years and has not been assessed recently. Regionally (Kent & Medway) as well as nationally there are deficits in CMM workforce. The clinical service related to microbiology has changed over the past 10 years where the focus is more towards an integrated clinical infection service with infectious diseases physicians. This should have been reflected by an increase in CMM head count but perhaps not a practical possibility considering the existing challenges in recruitment. This is made evident in how postgraduate medical training has changed with most of the doctors coming out as dual accredited in microbiology as well as infectious disease/internal medicine. This is reflected in the recent RCPath/BIA/RCP guidance on Best Practise for delivering NHS Infection Services in UK https://www.rcpath.org/uploads/assets/6bf59929-d2e5-44d7-8fe9862bdb0fa787/BIA-Infection-Services-Standards-Doc-for-consultation-April-2021.pdf . The consensus trend is more towards Consultant in Infection with sub-specialisms such as Microbiology, Virology. In other words, most of the medical specialists are coming out trained as infection specialists and the numbers of sole microbiology trainees is dwindling with no sole microbiology training programmes. **Effect**	People	I = 4 L = 5 Extreme (20)	Current clinical establishment re-aligned to two Senior Clinical Fellows (ST6-8), 1 Junior Clinical Fellow (ST3-5) and 4.5 WTE CMM. Senior Clinical Fellows will be functioning at a higher level including 1 in 5 weekend on-calls under supervision from a second on-call CMM. **Control Owner:** Samuel Moses	Adequate	I = 4 L = 4 High (16)	To continue seeking locum or substantive recruitment for the vacant 1.0 wte CMM posts **Person Responsible:** Samuel Moses **To be implemented by:** 05 Jul 2024	**01 Jan 2024** **Samuel Moses** 1) Current locum CMM post extended for 26 weeks up to 19th of July 2024; to cover 1:5 site rotas, oncall evenings and weekend 2) 5th CMM post still in advert: closing date 14th of January 2024: Applications = 0	I = 4 L = 2 Moderate (8)
								We have recruited 3 clinical fellows and 1 Consultant Clinical Scientist in the recent past to help with pressures relating to service. Diagnostics is being predominantly managed by the Clinical scientist workforce. We have changed the duty desk services such that inpatient service burden is dealt with mostly via Careflow referrals, whilst the telephone duty desk service is reserved for external/GP referrals with initial reviews conducted by clinical fellows. On-call pack is available for Clinical Fellows for out-of-hours on-call service under CMM supervision who will be available as 2nd on-call **Control Owner:** Samuel Moses	Adequate		Reprofile roles at EKHUFT to consider recruiting Consultants in Infection who are dual accredited in Infectious Diseases/GIM as well as **Person Responsible:** Samuel Moses **To be implemented by:** 31 Jan 2025	**03 Jan 2023** **Samuel Moses** Email received from Richard Kingston, CD for General and Specialist Medicine regarding co-funding for 4xWTE ID/GIM Consultants. Initial response from Micro is that we cannot give up 2 CMM (Consultant Medical Microbiologist) WTE funding as we have a succession plan in place envisaging Senior Clinical Fellows and CESR path. Furthermore there is an existing interest in 0.5 WTE from a returning CMM who previously worked in EKHUFT	
											To draft an integrated model of infection services in collaboration with acute medicine and acute specialities to deliver both direct patient care and diagnostic aspects of infectious services for the Trust with support of the CMO and workforce development team. **Person Responsible:** Samuel Moses **To be implemented by:** 31 Jan 2025	**11 Sep 2023** **Naomi Rogers** Dr Moses is liaising with Deputy Chief People Officer and team and has contacted senior medical executive regarding progressing the Infectious diseases/GIM workforce.	

Risk Register Report (By Residual Risk Ranking)

					The resulting effect of changes in microbiology practices is that it is more of a clinical infection service and less laboratory-based microbiology service. There is an increasing need for medically qualified infection doctors to deal with more ward based direct infection service, antimicrobial stewardship initiatives directly delivered for inpatient services as well as outpatient administered services where possible. The long-standing underfilling of microbiology workforce in the background of increasing complex patient services has led us to alternative ways of engaging of providing clinical microbiology advice using electronic consultation services such as careflow referral services. The careflow services to begin with were only 20 referrals a day but received				

Risk Register Report (By Residual Risk Ranking)

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					rapid responses from microbiology which has led to clinicians relying more on the the team for rapid decision making on patient discharges and parts of patient care pathways. This has led to the daily careflow referrals increasing from 20 to approximately 60 per day, including weekends which are only covered by one consultant on-call. Unless the Trust is able to fill its significant vacancies in acute medicine specialities, this trend on relying on microbiology services will continue to grow. The ensuing increased demand and pressure on CMM's needs to be addressed by either expanding the CMM workforce or the Trust employing infectious diseases/internal medicine consultants to take care of the burden that is increasingly placed on CMM's, in fact the recommendation of creating an infections diseases/GIM is one of the actions required. In the absence of the above there is a serious risk of work related stress and burnout of the CMM's as the current arrangement is not sustainable. Furthermore if the current situation continues, there is a risk to the quality and safety of patient care which could lead to an increased risk of adverse incidents, infection control lapses and sub-optimal monitoring of antimicrobial practice due to the lack of resources. The direct impact of trying to reconcile high quality and safe patient care with the limited resources could lead to the following: 1. Readjustment of clinical services: - absence of infection control doctor from within CMM's since 2020 - absence of CMM involvement in the sepsis pathway - reducing daily ITU ward rounds to 2/3 times a week - reduced CMM input into Trust IPC meetings (already occurring) - reduce periods for receiving calls from GP's (currently we are providing 9-5 service but likely to reduce to am only) - inability to provide regular antimicrobial stewardship rounds - inability for regular CMM sessions in other MDT's e.g. renal MDT, haematology MDT, ortho MDT, TB MDT 2. Adverse impact on patient outcomes - reduced CMM input e.g. IPC, AMS has had a negative impact on efforts to reduce C.difficle rates; inability to look into gram-negative bacteraemia which has been requested by IPC from CMM's for last couple of years. - inability to have a true picture of sepsis management outcomes in the							

Risk Register Report (By Residual Risk Ranking)

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					Trust. - by not addressing the points above; this impacts the CQC audit outcomes. 3. Risk of maintaining current CMM's - continued service pressure has led to long-term sickness leave absence within the CMM workforce with a high chance of reoccurrence. - the increasingly busy clinical on-call service could lead to CMM's thinking of a better work life balance moving to a less intense workplace, and this has already happened twice already. Our current locum confirms that EKHUFT is one of the busiest places they have worked. 4. Risk of unprofessional workplace behaviour due to impact on mental health and workplace stress e.g complaints, bullying and harassment.								

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2850	13 Jun 2022	Care Group - Diagnostics, Cancer and Buckland		Risk to service delivery as a result of difficulty recruiting to Patient Service Centre **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Angharad Lum **Last Updated:** 07 Mar 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added as >15 risk, agreed with CN-SH	**Cause** Recruitment is an issue within PSC this is due to natural career progression within the trust and relocation out of area. Struggling to get any applicants for vacancies despite using all resources. Vacancy and Control Panel rejecting job vacancies, which is causing difficulty to recruit to vacant posts. **Effect** Staffing levels; high turnover, sickness, competencies and lack of suitable candidates within recent recruitment into Band 2 Assistant Administrator positions. Failure in retaining staff leaving for promotional roles, resulting in lose of knowledge. Staff working below pay band to support, lack of supervisory support. Supervisors currently bolstering band 2 and band 3 work. VCP rejection of Senior Administrator roles, resulting in not being able to recruit into 4 WTE Band 3 positions. Lack of promotional structure within departments results in Band 2's being headhunted. Wellbeing - Low morale, lack of staff to cover essential roles within department - answering phones, booking appointments, registering referrals. High levels of sickness. Risk of staff burnout. Risk of error in process with staff covering too much. Pressure on staff/panic. KPIS - Failure to maintain KPIs. Delay to patient care. Failure to deliver service. 2WW - Potential breach of 2WW pathways. Lack of staff to process referrals. Delayed cancer diagnosis. Failure of 28-Day faster diagnosis targets. Un-utillised capacity - waste of clinical time due to empty slots. Strike action - Failure to provide care groups with action to support strike impact. Patient Delay/Harm - potential increase in inpatients admissions. Impacting pathways and failure to achieve RTT. Potential SIs. Increased risk to service. Delay in registering referrals - potential to miss urgent referrals. Reputation - Failure to support services with their capacity and demand work and building clinics routinely or short notice. Care group relationship breakdown and dissatisfaction of services not being provided. Potential for care groups	People	I = 4 L = 5 Extreme (20)	Reception superiors to discharge PIFU patients from PTL who have reached their target date and PSC would be responsible for booking. Training complete, monitoring regularly. **Control Owner:** Angharad Lum Rejected letters from synertec to be sent to new email account so they are not lost in the referral email account. Reception to be given access and training to look at. New email account set up, Reception have access. Monitoring and actioning **Control Owner:** Angharad Lum Staff working overtime and NHSP to cover vacancies to ensure service covered. **Control Owner:** Angharad Lum	Limited Limited Limited	I = 4 L = 4 High (16)	7 WTE Band 2 positions. 4 WTE Band 3's positions. Job vacancies are out to advert currently. **Person Responsible:** Angharad Lum **To be implemented by:** 30 Apr 2024		I = 3 L = 2 Low (6)

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
					withdrawing funding from PSC to be managed internally. Un-utillised capacity - waste of clinical time due to empty slots. Increased DNA rates due to lack of ability to follow OPD process. Complaints - Increased complaints. Loss of trust in healthcare at start of pathways. Poor FFT feedback. NHSP/OT - High cost to service (although offset with vacancy). Staff internally to PSC undertaking however concerns about burnout. Datix/Risk - Increased datix numbers for patient delay.								

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2234	11 Nov 2020	Care Group - Diagnostics, Cancer and Buckland		Failure to meet national histopathology TAT's to support **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Stuart Turner **Last Updated:** 14 Mar 2024 **Latest Review Date:** 14 Mar 2024 **Latest Review By:** Naomi Rogers **Latest Review Comments:** Histology performance – Overall turnaround time KPI in February for histology cases reported in 10 days has increased to 64% compared to last month 53%. Overall backlog position at the end of month shows worsened position 1214 cases compared to <800 cases last month (<500 cases). This adverse position is a direct result of locum and consultant unavailability and admin staff unavailability supporting the manual entry of results from LDPath.	**Cause** Consultant substantive workforce is now 10.8 WTE's (budgeted 16.6 WTE) and supported by 1.2 WTE bank locums and 1.5 WTE agency locums, together with costly outsourcing of low risk cases at a rate of 40 cases a day (£35 per case). 80% reporting capacity required to maintain a good performance and safe backlog; currently maintaining 50%. Modelling performed by EKHUFT as part of K&M Pathology Network 'post pandemic' indicates additional 4.4 WTE's required (i.e. 21.0 WTEs') necessary to meet RCPath target 90% and 98% by April 25. Vacancy gap currently mitigated by using a combination of locums and fixed term NHS pay rate recruitment; • 1.2 WTE NHSP (60% of all skin reporting) • 1.5 WTE premium pay locums • 2.0 WTE full time, fixed term specialist doctors into consultant positions, with a view to creating 2.0 WTE consultants at the end of FT contract • 3.0 WTE specialty doctors with FRCPath Part 2 examinations with the view to create specialist doctors, ultimately creating 3.0 WTE consultants (NB: 1.0 WTE funded by deanery so can be replaced once in consultant position; 1.0 WTE funded by trust grade position; 1.0 WTE occupies a consultant position already) • Out to advert for 1.0 WTE consultant – other vacancies mapped against locum hire • K&M Pathology Network to support bid for additional medical staff recruitment at MTW and EKHUFT • Digital referral through outsourcing agency Source-LDPath of low clinical risk cases that would otherwise be 'de-prioritised' In addition department has continued to see a significant increase in workload volume and workload complexity comparative to previous pre-covid years. In September the average number of specimens per case was 3.1, compared to 1.6 in 2019. The number of cases seen in 2022-23 was 10% higher than 2019-20, with 20- 30 % increases in certain subspecialties, notably breast and	People	I = 4 L = 5 Extreme (20)	Cancer pathway patients prioritised from within the workload. **Control Owner:** Marcus Coales Locum support when available and position numbers available and outsourcing non-complex histology cases to LD Path **Control Owner:** Stuart The short term mitigation is to put in place additional NHSP. **Control Owner:** Stuart We have recruited x3 FT proto-consultants in addition to the x1 FT consultant. In a year at least x2 of them will be consultant level. These are x2 specialist and x1 specialty grade doctors. **Control Owner:** Marcus Coales	Limited Adequate Limited Limited	I = 4 L = 4 High (16)	1.0 WTE histopathologist vacancies are being advertised on a rolling basis but currently unsuccessful in recruitment. **Person Responsible:** Stuart Turner **To be implemented by:** 30 Jun 2024 Review a workforce/workload points based manager system to manage workload in line with RC Path Guidance **Person Responsible:** Sophie Coales **To be implemented by:** 31 Mar 2025	**14 Mar 2024** **Naomi Rogers** 1 x WTE was used to recruit to a 1 year FT position. We have x3 WTE positions mapped against bank and locum hire, which we cannot be without, even if we managed to recruit. Locums cannot be hired without position numbers. More establishment needed **14 Mar 2024** **Naomi Rogers** Implementation date extended as digital pathology tech will be used to instigate	I = 4 L = 2 Moderate (8)

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
					prostate. In 2023-24 this increase has been a further 10%, with yet more increases in breast, prostate and GI biopsies. Greater than 40 histology cases are being referred to LDPath each day (15% of daily workload and equivalent to 2.0 WTE consultants daily reporting workload). Once the reports are received back from LDPath they require manual transcription back into APEX by under established histopathology admin staff, creating a secondary backlog whenever there is any staff absence from the admin team. Additional admin staff above establishment are being recruited at risk with the approval of the People and Culture team. Breast Histopathologist availability less than 50% capacity due to unplanned sick leave, together with further 15% increase in workload relative to 2022-23, has led to delays in reporting breast pathology specimens. This results in a delay of treatment plans for some breast patients **Effect** Histopathology is not achieving 90% compliance against nationally required 10 day turnaround time Further increase in backlog due to lack of admin staff reporting LDPath cases. Lack of Breast Histopathologists results in a delay of treatment plans								
3309	15 Jun 2023	Care Group - Queen Elizabeth, The Queen Mother	QEQM Urgent and Emergency and Acute Medicine	Inability to recruit Emergency Department Consultants and Acute Consultants at QEQM **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Wayne Kissoon **Last Updated:** 15 Mar 2024 **Latest Review Date:** 08 Mar 2024 **Latest Review By:** Janet Webber **Latest Review Comments:** Risk reviewed	**Cause** Geographical location of hospital makes it hard to recruit suitably qualified ED and Acute consultants and lack of a Paediatric Emergency Medicine Consultant . Organisational reputation of minimal consultants in post **Effect** *Lack of senior oversight and support *Increased of use of locum consultants and financial impact on organisation *Education and training, not always available on the QEQM site and junior doctors are required to travel to WHH for consultant education. *Availability of locums * Limitations to SDEC service at the weekend as not always possible to provide consistent medical cover resulting in patients being seen in ED rather than SDEC contributing to	Quality	I = 5 L = 5 Extreme (25)	CESER programme in place to develop middle grade doctors to consultant level **Control Owner:** David — Limited Daily staffing reviews which are esclaated and reported to Executive Team **Control Owner:** David — Limited Liaison with WH to devise a cross site plan and ensure cross site cover **Control Owner:** David — Limited Use of locum consultants **Control Owner:** David — Limited	I = 4 L = 4 High (16)	*Active recruitment with dedicated HR support to the Care Group *Digital and social media campaign *Awaiting commencement of recruited Consultant **Person Responsible:** David Bogard **To be implemented by:** 30 Jun 2024	**08 Mar 2024** **Janet Webber** Riks 2939 and 2688 merged with this risk	I = 2 L = 2 Low (4)

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2419	14 May 2021	Corporate - Operations	Information Management	Data Quality issues created by administrative staff **Risk Owner:** Marc Farr **Delegated Risk Owner:** Sunny Chada **Last Updated:** 12 Feb 2024 **Latest Review Date:** 23 May 2023 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Paper on Data Quality being presented to CEMG.	**Cause** Administrative and clinical staff too often do not use the electronic systems properly meaning that we have poor data quality; not discharging in a timely manner, discharge and readmission rather than transfer, merging patient's details mistakenly, allowing men to be recorded as having babies, admin staff admitting patients all under the same/wrong consultant (in breach of clinical guidelines) and so on. **Effect** It creates a lot of wasted time for the IT and Information teams in correcting the data held against patients and reduces the Trust's ability to present correctly the costs incurred in treating patients and to plan in particular our elective plans for recovery as so many patients are recorded on the wrong type of pathway or waiting list. There is also a patient safety risk that we simply do not know which patient is where and could not safely evacuate the hospital for example. More likely we are not able to monitor and audit the care of a patient if we do not know which doctor a patient is under at any one time.	Quality	I = 4 L = 4 High (16)	DQ issues are overseen by the Information Assurance Committee which reports into the CEMG. A DQ dashboard is presented monthly and available live and a programme of work to address DQ issues is updated each month **Control Owner:** Marc Farr		I = 4 L = 4 High (16)	A comprehensive training program is in development for Waiting List Data Quality Improvement aims to enhance confidence in the trust's waiting list information by establishing an efficient feedback loop. This program specifically targets priority pathway cohorts, monitors error and correction rates, and draws insights from validation outcomes, thereby contributing to overall improvements in data quality. Establish working group, to include DQ Assurance, BI, Ops, with IST lead pending identification of trust lead **Person Responsible:** Sunny Chada **To be implemented by:** 31 Mar 2024 Insourcing support being provided by MBI to administratively validate a proportion of the DM01 and RTT waitlist reviewing and updating the patient status and requirements **Person Responsible:** Sunny Chada **To be implemented by:** 31 Mar 2024		I = 3 L = 2 Low (6)

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2158	20 Aug 2020	Care Group - Diagnostics, Cancer and Buckland		Risk of Patient harm and treatment due to unreported A&E chest xrays - **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Gemma Matthews **Last Updated:** 07 Mar 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added as >15risk, agreed with CN-SH	**Cause** Since the introduction of the "failsafe reporting" for all 40,000 ED CXR's, Radiology have been unable to keep up with the demand of meeting the expected and agreed 10 day reporting TAT. for ED CXR's. This is in addition to the 40,000 plain film GP CXR referrals we also report on a yearly basis. That are within the expected TAT. Due to the increase expectation this can lead to delayed reporting for other modalities and subsequently delays with patient's being referred for further investigations for incidental findings. There is now 8 vacancies with the reporting workforce. **Effect** Unreported chest x-rays result in delay of patient diagnosis and treatment. One pathway prioritised over the other. Creating a backlog in chest xray reports	Quality	I = 4 L = 4 High (16)	All backlog reports are captured on a weekly run and escalated. Harm review can be ascertained **Control Owner:** Gemma Matthews	Adequate	I = 4 L = 4 High (16)	Backlog targeting plan has been agreed **Person Responsible:** Beverley Saunders **To be implemented by:** 30 Nov 2023		I = 3 L = 2 Low (6)
								Clinical Lead has assigned weekly designated workstream to ensure the reporting of examinations are completed within the local **Control Owner:** Beverley Saunders	Adequate		Recruitment to four Consultant posts to support capacity and demand **Person Responsible:** Gemma Matthews **To be implemented by:** 31 Dec 2023		
								To reduce uneccessary reporting, the CEMG has agreed that CXR's on deceased patients can be auto-reported with Trust **Control Owner:** Beverley Saunders			the trainee Radiology Registrars are bein g supported and encouraged to report on A&E Chest X-Rays as part of there annual Radiographer reporting numbers. These will be reviewed and authorised by the named daily Consultant **Person Responsible:** Beverley Saunders **To be implemented by:** 31 Dec 2023	**13 Nov 2023** **Deborah Thornton** work is ongoing to support this action	
								Weekly incidental finding of a probable cancer report, is generated by the Governance Team to highlight patient's who require review under MDM. This is to ensure appropriate follow up can take place and reduce clinical harm due to delays. **Control Owner:** Deborah Thornton	Substantial				
								Weekly PTL meeting in place to monitor backlog and escalate where appropriate **Control Owner:** Gemma Matthews	Substantial				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2565	21 Sep 2021	Care Group - Women's Health		There is a risk of inadequate midwifery staffing levels and skills to meet the needs of women and there **Risk Owner:** Sarah Hayes **Delegated Risk Owner:** Michelle Cudjoe **Last Updated:** 29 Feb 2024 **Latest Review Date:** 29 Feb 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Exec risk owner added due to risk rating >15, agreed with CN-SH	**Cause** Sub-optimal staffing levels and inability to cover shifts on a daily basis across hospital and community services. Whilst the funded establishment has been increased , recruitment has been slow resulting in insufficient establishment that supports a labour ward coordinator to be supernumerary on every shift supported by a band 7 operational role Vacancy, maternity leave and sickness impact on staffing NHSP and agency midwifery cover to fill gaps in rotas has been in consistent with poor uptake, coupled with unreliable agency compliance Lack of Maternity Support Workers at WHH to release Midwifery time **Effect** Non compliance with fundamentals of care impacting on the clinical outcomes for women and babies Poor staff morale leading to sickness and poor professional behaviour Dilution of skill mix due to recruitment of newly qualified band 5s Non compliance with national recommendations. Inability to provide 1:1 care in labour and supernumary band 7 labour ward coordinator status Inability to sustain a homebirth service 24/7 Inability to sustain Midwifery Led Units on both sites 24/7 (WHH closed) Difficulty in re establishing appropriate postnatal care at home Concerns raised by the women during feedback sessions over staffing numbers	People	I = 4 L = 5 Extreme (20)	10 am service SITREP staffing reviews undertaken to identify gaps and put in place actions eg: re location of staff to address **Control Owner:** Michelle Cudjoe	Adequate	I = 4 L = 4 High (16)	Centralise triage phone to QEQM to release midwifery staffing at WHH **Person Responsible:** Cherrie Knight **To be implemented by:** 15 Dec 2023	**26 Jan 2024** **Rhiannon Adey** Note added by Cherrie Knight 29 Nov 2023 - Works on offices taking place w/c 27th November 23	I = 4 L = 2 Moderate (8)
								Active utilisation of escalation policy to manage activity vs staffing. Including divert escalation between sites. **Control Owner:** Michelle Cudjoe	Adequate		Full review of Birthrate plus **Person Responsible:** Hannah Horne **To be implemented by:** 31 Jan 2024	**26 Jan 2024** **Rhiannon Adey** Full workforce review using birthrate+ tool is in progress	
								All shifts to be released to NHSP as soon as possible. Where possible agency lines booking in place **Control Owner:** Joanne Shayler	Adequate		Recruitment of internationally educated midwives **Person Responsible:** Joanne Shayler **To be implemented by:** 31 Jan 2024	**26 Jan 2024** **Rhiannon Adey** 18 internationally educated midwives recruited	
								Daily review of staffing by operational lead and senior team. Out of hours the manager on call will facilitate this. Long line of agency set up where there are on going gaps **Control Owner:** Joanne Shayler	Adequate		Explore further the use on non Midwife roles (Registered Nurses/Nursery Nurses/ MSW's) to release Midwifery time **Person Responsible:** Adaline Smith **To be implemented by:** 29 Mar 2024	**26 Jan 2024** **Rhiannon Adey** Nurse recruitment has gone back out to advert	
								International recruitment of 18 wte midwives. **Control Owner:** Michelle Cudjoe	Adequate		Developing a coproduced plan with staff and RCM members around how the on-call system is fairly applied and to explore improved retention strategies. **Person Responsible:** Adaline Smith **To be implemented by:** 31 Mar 2024	**26 Jan 2024** **Rhiannon Adey** RCM are reviewing systemwide. 52 students in the local pipeline for January 2025. Recruitment has been impacted by withdrawal of NMC approval for the midwifery programme at Canterbury Christ Church University.	
								NHSP offered through community **Control Owner:** Angela Kelly	Adequate		To improve open communication with staff and women around the improvements made within the service. **Person Responsible:** Adaline Smith **To be implemented by:** 31 Mar 2024	**26 Jan 2024** **Rhiannon Adey** Six month away day held in January 2024, slides have been shared and continue to be discussed during the appraisal process	
								Recruitment approach modernised to maximise the opportunities by working with HR and use of social media **Control Owner:** Michelle Cudjoe					
								Specialist midwives redeployed in times of increased acuity and escalation **Control Owner:** Adaline Smith	Adequate				
								Suspension of continuity of carer **Control Owner:** Sarah Hayes					
								Utilisation of managers on call and community midwives to support. **Control Owner:** Michelle Cudjoe	Adequate				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2899	15 Jul 2022	Care Group - Women's Health		consultant obstetric vacancies at QEQM may result in an inability to deliver the service **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Zoe Woodward **Last Updated:** 07 Mar 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added as >15 risk, agreed with CN-SH	**Cause** Number of consultant vacancies at QEQM have been out to advert for considerable periods of time (rolling adverts) without successful recruitment. In addition there are currently 4 substantive consultants not doing full on call duties due to OH recommendations. 2 substantive consultants not delivering full on call duties due to job plan changes (leadership and post retirement This puts significant pressure on the remaining consultant body to cover the on call rota. There are 10 consultants doing on calls (it is a 16 person rota) and these same consultants are then being asked to step down to cover gaps in the registrar and SHO rotas as well as trying to keep elective work going. Agency locums is heavily used to help cover activity. Disparity in the rate of pay for consultants working additional shifts compared to other departments. Middle grade vacancies are a challenge in terms of recruitment due to the inability to provide housing for overseas doctors coming to the UK. **Effect** It is becoming increasingly difficult to cover the on call rota: - this is at the expense of benign gynae activity being cancelled to which will an adverse effect on our waiting lists. - financial impact on the care group with the use of high premium cost agency staff. Increased pressure on the current consultant workforce leading to burnout - increased sickness and occupational health referrals. Impact on training due to using locums. Possible closure of the unit due to unsafe staffing. Negative impact on restore and recovery work. Consultants less likely to cover additional shifts if paid less than other departments. Ongoing shortages accross the pbstetric workforce is impacting on the compliance with PROMPT training in terms of delivery as well as participation.	People	I = 4 L = 5 Extreme (20)	Consultants working additional shifts to cover workload and acting down to cover junior gaps where **Control Owner:** Natasha Curtiss	Limited	I = 4 L = 4 High (16)	**Person Responsible:** **To be implemented by:**		I = 3 L = 3 Moderate (9)
								Job plan review has been undertaken to aligned current activity and ways of working to ensure current establishment are working as efficiently as possible. **Control Owner:** Zoe Woodward	Limited				
								recruitment incentive has been applied to all QEQM consultant vacancies **Control Owner:** Cherrie Knight					
								Risk escalated to Trust Board in October 2022 and Monthly at PRM. **Control Owner:** Cherrie Knight	Limited				
								use of high cost agency staff to cover activity of vacant positions **Control Owner:** Zena Jacobs	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3617	12 Dec 2023	Care Group - Diagnostics, Cancer and Buckland	Audiology	Insufficient Tympanometers - Risk to service delivery **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** Karen Dyer **Last Updated:** 25 Mar 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added as > 15 risk, agreed with CN- SH.	**Cause** Urgent replacement of irreparable Tympanometers: Annual Tympanometer (Middle Ear Analyser) calibration between the 27.11.23 & 29.11.23 4 old Tympanometers were condemned as unrepairable 1 at K&C, 1 at RVHF and 1 at WHH **Effect** if not replaced as a matter of urgency this will severely affect service activity/provision/CIP targets across the main sites for these mandatory tests. On an ENT Clinic every patient needs tympanometry so approximately 12 patients a day per Tympanometer = 48 day = 240 a week = 960 > 1000 a month With the new coding this would be the loss: If all Adults = £115 per test If between 5 and 18 years = £122 per test If 4 years and under = £143 per test	Quality	I = 4 L = 4 High (16)	K&C currently 'sharing' 3 x tympanometers between 5 clinical rooms RVHF currently 'sharing' 1 tympanometer between 2 clinical rooms WHH currently 'sharing' 1 tympanometer between 2 clinical rooms. This is results in delays in clinic due to having to clean equipment between transfer and resulting in delays to patient wait times. Now affecting service delivery for all diagnostics and patient satisfaction **Control Owner:** Karen Dyer		I = 4 L = 4 High (16)	need to purchase 4 x replacement tympanometers. Condemned equipment was not trust standard as old equipment. Business case would be for 4 x path Medical tympanometers which is the trust standard 09.03.2024 - Is now with MDG for costing and funding - KD met with BT in MDG 24.01.2024 - business case done and on portal - awaiting to secure funding **Person Responsible:** Karen Dyer **To be implemented by:** 31 Mar 2024		I = 4 L = 2 Moderate (8)

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3383	13 Jul 2023	Corporate - Finance & Performance Management		Failure to deliver the financial plan of the Trust as requested by NHSE for 2023/24 **Risk Owner:** Tim Glenn **Delegated Risk Owner:** Michelle Stevens **Last Updated:** 12 Feb 2024 **Latest Review Date:** 08 Feb 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** CFO added as risk owner & Director of Finance delegated risk owner	**Cause** Efficiencies delivery Elective recovery fund delivery Corporate memory/changing leadership **Effect** not having adequate cash to continue adequate operations of the organisation, potentially make poor financial decisions which will result in reputational damage and non-compliance with regulators.	Financial	I = 5 L = 5 Extreme (25)	Financial improvement specialist in place for six months **Control Owner:** Michelle Stevens		I = 4 L = 4 High (16)	Activity and quality oversight group and workforce and finance oversight groups commencing in September **Person Responsible:** Michelle Stevens **To be implemented by:** 02 Oct 2023		I = 4 L = 3 Moderate (12)
								Individual finance reports go to Care Groups on a monthly basis. Finance is monitored through the monthly IPR plus Finance report which goes to Finance and Performance Committee and Trust Board on a monthly basis **Control Owner:** Michelle Stevens			Establish a refreshed Financial Improvement Programme Board **Person Responsible:** Michelle Stevens **To be implemented by:** 30 Nov 2023		
								Interim Chief Finance Officer appointed for twelve months **Control Owner:** Tracey Fletcher			Develop medium-term and long-term financial plans in conjunction with NHSE and Kent and Medway ICB **Person Responsible:** Michelle Stevens **To be implemented by:** 31 Jan 2024		
								Other controls in place; annual business planning process, annual cost improvement programme developed, fortnightly financial control meeting in **Control Owner:** Michelle Stevens			Medical workforce review to be undertaken **Person Responsible:** Desmond Holden **To be implemented by:** 31 Mar 2024		
								The Chief Finance Officer is the lead for this risk, and it is managed through the Finance and Performance Committee, Clinical Executive Management Group, Finance Improvement Programme Board, Performance Meetings with Care Groups and Directors **Control Owner:** Michelle Stevens			Nursing workforce review to be undertaken **Person Responsible:** Sarah Hayes **To be implemented by:** 31 Mar 2024		
											Administrative workforce review to be undertaken **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Mar 2024	**15 Nov 2023** **Rhiannon Adey** Financial Improvement Director and Chief People Officer undertaking administrative workforce review.	

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2682	29 Nov 2021	Care Group - Diagnostics, Cancer and Buckland	Medical Physics	Increased likelihood of potential radiation incidents and regulatory breaches leading to patient, staff and public harm, due to repeated postponement of TRAC meetings **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Julie Childs **Last Updated:** 07 Mar 2024 **Latest Review Date:** 12 Mar 2024 **Latest Review By:** Julie Childs **Latest Review Comments:** Controls updated	**Cause** Repeated postponement of Trust Radiation Advisory Committee meetings due to attendance and quoracy issues. **Effect** Lack of engagement of Trust in radiation safety and governance, resulting in increased likelihood of incidents and potential for regulatory breaches	Quality	I = 4 L = 4 High (16)	15-01-24 Associate Medical Director, (Nic Goodger) has identified an executive chair; Chief Medical Officer- Des Holden **Control Owner:** Julie Childs		I = 4 L = 4 High (16)	Regular, quorate local radiation safety meetings and modality meetings to be re-established and maintained. **Person Responsible:** Beverley Saunders **To be implemented by:** 12 Oct 2023		I = 2 L = 2 Low (4)
								An executive chair has now been identified, (Chief Medical Officer- Des Holden). Terms of reference and attendance reviewed. Representation and information will be requested with templates provided by Medical Physics. Roles and responsibilities will be clarified by Medical Physics. CH has had follow-up meetings with DH. Rebranded meeting to be scheduled in June. In the meantime, radiation protection matters will continue to be escalated outside of the TRAC meeting **Control Owner:** Claire Hooker			Schedule quarterly meetings and ensure required staff are invited. **Person Responsible:** Beverley Saunders **To be implemented by:** 12 Oct 2023		
								An executive sponsor for radiation protection has been identified, (Dylan Jones, COO). **Control Owner:** Ladan Najafi			TOR templates for local radiation safety and modality meetings to be created. **Person Responsible:** Claire Hooker **To be implemented by:** 12 Oct 2023		
								In-house RPS courses booked and advertised, (08-12-23, 09-01-24, 12-03-24) Trained RPSs should be more aware of their roles and responsibilities. **Control Owner:** Claire Hooker			Attendance at TRAC meetings to be ensured and supported by care groups. **Person Responsible:** Benjamin Stevens **To be implemented by:** 12 Oct 2023		
								New scoring as this risk is ongoing and as such poses corporate risks in terms of potential for regulatory enforcement, resulting in service, financial and reputational impacts **Control Owner:** Julie Childs			Radiation safety to be agenda item for all care group governance meetings and quarterly report to be submitted to TRAC. **Person Responsible:** Benjamin Stevens **To be implemented by:** 29 Dec 2023		
								Quarterly meetings are scheduled. A non-quorate meeting took place on 13-04-23 **Control Owner:** Beverley Saunders					
								Radiation safety issues are progressed outside of TRAC meetings if necessary. **Control Owner:** Julie Childs					

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								Terms of reference and attendance reviewed. Representation and information will be requested with templates provided by Medical Physics. Roles and responsibilities will be clarified by Medical Physics. TRAC will be “relaunched / rebranded” with a meeting expected to be scheduled in **Control Owner:** Claire Hooker					
								There is a appointed chair for TRAC, (Dr Bev Saunders, Radiology Clinical Lead) **Control Owner:** Beverley Saunders					
								Upward reporting to Strategic Health and Safety Committee and Patient Safety Committee has been re-established and quarterly meetings attended by Head of Clinical Physics. **Control Owner:** Julie Childs					

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2195	01 Oct 2020	Care Group - Queen Elizabeth, The Queen Mother		Due to large volumes of recruitment, risk of poor skill mix, junior nursing workforce **Risk Owner:** Sarah Hayes **Delegated Risk Owner:** Susan Brassington **Last Updated:** 12 Mar 2024 **Latest Review Date:** 12 Mar 2024 **Latest Review By:** Janet Webber **Latest Review Comments:** Risk reviewed	**Cause** Successful recruitment campaign has resulted in a large number of internally educated nurses being appointed without experience of working within the NHS. In addition, junior nurse educated in the UK have been recruited. Due to overcrowding additional escalation areas have been opened, along with boarding on ward, requiring staffing and nursing oversight. There are high numbers of patients who require enhanced supervision such as 1:1 care to maintain their safety Geographical location makes it a difficult to recruit to site. **Effect** *Managing the rosters to provide senior support to junior team is often challenging due to the number of senior vacancies. Education and support to our internally educated nurses. *Reduced skill mix on shift impacting on patient care *Senior nurses time taken away from clinical working due to volume of education needing to be provided. *Large volumes of flexible working requests from internal nursing team due to lack of family support	People	I = 4 L = 5 Extreme (20)	*Head of Nursing oversight of daily shift log *All staffing for the week is discussed at the weekly matrons meetings (Monday) *Weekend planning meetings each week within the Care Group to identify, discuss and mitigate risks. *Deputy and Head of Nursing sign off for use of 'hot shifts' weekly. *Acute Medical Units support ED staffing when needed. **Control Owner:** Joanna Williams	Limited	I = 4 L = 4 High (16)	Staffing levels to be reviewed and active recruitment, in line with the Care Group Recruitment Strategy **Person Responsible:** Susan Brassington **To be implemented by:** 31 Aug 2024	**02 Jun 2023** **Janet Webber** May 2023 - staffing levels have improved but skill mix is an issue due to a junior workforce being in place and need to staff escalation	I = 3 L = 2 Low (6)
								Daily staffing reviews to look at numbers and skill mix to allow for staff to be reallocated to areas where staffing levels/skill mix pose a **Control Owner:** Susan Brassington	Adequate				
								Fulltime PDN's and clinical skills facilitators in place to support and develop clinical staff **Control Owner:** Susan Brassington	Limited				
								In ED an establishment review has been undertaken by the HoN and shift times changed to match activity - more staff are present in the afternoon to meet peek demand. Safe Staffing RAG score has been amended to reflect this and reported to effective nursing team and **Control Owner:** Joanna Williams	Limited				
								In high long lines of temporary shifts are booked and enhanced rates of pay for agency and NHSP are in place for high risk areas such **Control Owner:** Susan Brassington	Limited				
								Quality Strategy at QEQM has an education workstream to further map education requirements for both doctors and nurses. **Control Owner:** Joanna Williams	Limited				

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Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3566	02 Nov 2023	Care Group - Queen Elizabeth, The Queen Mother	QEQM General Surgery and Gastroenterology	Delayed diagnoses for patients awaiting endoscopy **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Sarah Hyett **Last Updated:** 07 Mar 2024 **Latest Review Date:** 25 Mar 2024 **Latest Review By:** Janet Webber **Latest Review Comments:** Reviewed an updates on action progress to be requested	**Cause** 1. Covid pandemic resulted in long delays for routine patients 2. Governance structure around waiting lists lapsed during covid 3. Recruitment to hard to recruit areas **Effect** 1. Delayed diagnosis and therefore treatment for our patients 2. Potential harm to patients 3. Potential psychological damage to patients 4. Challenge of managing long waiting lists with defined capacity 5. Failure to meet the DM01 target 6. Cancellation of patients at short notice - estimated to equate to approx. 20 lists pcm.	Quality	I = 4 L = 4 High (16)	Business planning linked in with recovery plans for specialties monitored at weekly recovery meetings **Control Owner:** Sarah Hyett	Adequate	I = 4 L = 4 High (16)	Endoval process to be revisited to check whether patients on waiting lists still wish to proceed with the procedure they are awaiting **Person Responsible:** Rebecca Clark **To be implemented by:** 02 Oct 2023		I = 4 L = 2 Moderate (8)
								Extra lists undertaken for specialty interventions **Control Owner:** Sarah Hyett	Adequate		Review of insourcing opportunities through framework of Consultant only provision. This is linked to agreement of standardised rates for Consultants **Person Responsible:** Sarah Hyett **To be implemented by:** 02 Oct 2023		
								Recovery/trajectory plans in place for Endoscopy **Control Owner:** Sarah Hyett	Adequate		Clinical performance manager to track untracked cancers and lead on DoC for any delayed diagnosis **Person Responsible:** Judith King **To be implemented by:** 02 Oct 2023		
								Support from NHSE **Control Owner:** Sarah Hyett	Adequate				
								Weekly KPI meetings at specialty level and Care Group level to review patients **Control Owner:** Sarah Hyett	Adequate				
								Weekly recovery meetings to monitor **Control Owner:** Sarah Hyett					
3536	10 Oct 2023	Corporate - Operations		Delayed diagnostics for patients awaiting Endoscopy **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Susan Travis **Last Updated:** 13 Mar 2024 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** Inability to undertake surveillance due to capacity and demand for endoscopy service **Effect** Potential severe harm and death to patients if growths have not been monitored and malignancies have not being identified and treated.	Quality	I = 4 L = 4 High (16)	Additional 1000 scopes per month sourced through ID medical from November 2023 **Control Owner:** Susan		I = 4 L = 4 High (16)	To develop trajectory for endoscopy surveillance patients **Person Responsible:** Louise Pallas **To be implemented by:** 31 Mar 2024		I = 4 L = 2 Moderate (8)
								Administrative validation **Control Owner:** Susan	Substantial		To source additional capacity for endoscopy patients on a surveillance pathway **Person Responsible:** Tammy-Ann Sharp **To be implemented by:** 31 Mar 2024	**08 Feb 2024** **Susan Travis** Additional capacity from 5th Feb at whh using theatre 12 and staffed by ID medical Room 3 in Endoscopy utilized from 10th feb using ID	
								Clinical validation **Control Owner:** Susan	Adequate		To undertake administrative validation of patients on a surveillance pathway **Person Responsible:** Susan Travis **To be implemented by:** 31 Mar 2024	**10 Oct 2023** **Rhiannon Adey** Area identified for administrative team to undertake this work. Currently in the process of identifying capacity within admin team.	
								Task and finish recovery group established with COO, Deputy COO and Executive Director of Communications and Engagement **Control Owner:** Benjamin Stevens	Adequate		To undertake clinical validation of patients on a surveillance pathway **Person Responsible:** Susan Travis **To be implemented by:** 31 Mar 2024		

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3556	02 Nov 2023	Care Group - William Harvey		Delays in delivery and personal care are resulting in an increased risk of pressure ulcers and falls occurring **Risk Owner:** Sarah Hayes **Delegated Risk Owner:** Benjamin Hearnden **Last Updated:** 29 Feb 2024 **Latest Review Date:** 29 Feb 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Exec risk owner added due to risk rating >15, agreed with CN-SH.	**Cause** Inability to provide appropriate care spaces for the number of patients in the department. Inability to provide beds with pressure relieving mattresses in designated escalation areas. Occupancy within ED for patients with a Decision to Admit is extended. Staffing ratios not optimal for nurse to patient due to additional escalation areas being utilised. **Effect** *Overcrowding in ED Departments *Patients being cared for and treated outside of a designated area within the department *Inability to safely observe, monitor and care for patients due to excessive demand and /or low staffing *Reduced flow through the ED departments, and hot floor due to low numbers of discharges in wards In addition there are times when patients remain in ambulance queues as there is no space for them to be moved into the ED.	Quality	I = 5 L = 5 Extreme (25)	Board patients in wards to decongest departmets **Control Owner:** Rachel Perry	Limited	I = 3 L = 5 High (15)	Implementation of the 6 month Emergency Floor Improvement plan which includes direct pathways such as SDEC **Person Responsible:** Rachel Perry **To be implemented by:** 31 Aug 2023		I = 3 L = 2 Low (6)
								Funded GP service running out of ED **Control Owner:** Hitendra Tanwar	Adequate				
								Patient pathway review/retraining of triage and ENP staff Urgent Treatment Centre being planned **Control Owner:** Benjamin Hearnden	Adequate		Regular audits of the ED care plan to ensure that the actions that are prompted by this are delivered **Person Responsible:** Tomislav Canzek **To be implemented by:** 29 Mar 2024		
								Working with external partners to explore alternative pathways and provision of services **Control Owner:** Hitendra Tanwar	Limited				
								Working with patients to improve knowledge/health education and use of alternative pathways **Control Owner:** Benjamin Hearnden	Limited				
								Working with SECAmb to reduce conveyances to ED **Control Owner:** Benjamin Hearnden	Limited				
3465	30 Aug 2023	Care Group - Diagnostics, Cancer and Buckland	Radiology	Risk of patient harm and to staff mental health as a result of mental health patients accessing QEQM Radiology to attempt self harm **Risk Owner:** Lara Green **Delegated Risk Owner:** Gemma Matthews **Last Updated:** 12 Feb 2024 **Latest Review Date:** 15 Mar 2024 **Latest Review By:** Lara Green **Latest Review Comments:** Awaiting sign of from HoS for Works form	**Cause** Several occasions of patients attempting to use ligatures to harm themselves. Risk to patients due to Radiology being unaware patients are in this area Risk to staff having to experience patients in distressing situations Patient 1 – there are 3 DATIX's over the weekend where they have attempted to hang themselves (WEB254738 / WEB254594 / WEB254684) Patient 2 – This patient has attempted to use X-ray before to harm themselves within the department (February twice – WEB239136 / WEB240716) and then most recently on the 24/08 (WEB254371) 26/08 (WEB254516. **Effect** Potential loss of life Trust reputation Loss of service Staff mental health risk	Quality	I = 5 L = 3 High (15)	CCTV in department No CCTV in CT (awaiting MW to quote and install) Faulty CCTV in General (condemnation notice from 2SS - MW form to be submitted Ligature Risk Assessment - awaiting quote for replacement of all incorrect ligatures in radiology ED staff should not allow patients to walk through or use Radiology Toilets OOH even with a security guard escourting. **Control Owner:** Lara Green		I = 5 L = 3 High (15)	Replacement CCTV for General Viewing areas New CCTV for CT department Replacement of all ligatures escalated **Person Responsible:** Gemma Matthews **To be implemented by:** 31 Dec 2023		I = 4 L = 1 Low (4)

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Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2979	07 Oct 2022	Care Group - Critical Care, Anaesthetics and Specialist Surgery	Ophthalmology	Delays to patient care and poor patient experience due fragile YAG Laser machine at QEQM Eye Clinic **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** Lynne Hadley **Last Updated:** 07 Mar 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added as >15 risk, agreed with CN-SH	**Cause** Laser machine was 1st commissioned in 2005 -now 17 years old Poor performance due to age of machine These may impact on both patient and staff safety. Poor focusing of laser beams reported. Laser beam focus deteriorates during the clinic High power sometimes required **Effect** Increased risk of macular oedema to patient. Risks of damage to intra ocular lens. Patients are needing subsequent visits to the clinic to check for any residual effects. Patients required to travel to other sites for treatment Laser sometimes taking longer to perform Stress for staff performing yag laser. Cancellation of clinics due to a defective machine is not good for Trust's reputation	Quality	I = 5 L = 4 Extreme (20)	Machine to be regularly maintained and checked **Control Owner:** Stella Adegoke	Limited	I = 5 L = 3 High (15)	Replacement YAG Laser to be funded and purchased **Person Responsible:** Stella Adegoke **To be implemented by:** 29 Mar 2024	**01 Mar 2024** **Stella Adegoke** Issue is being dealt with by Howard Ford regarding the replacement machine. The current machine is still being used after repairs. The current machine is due for a service on 8/3/24.	I = 3 L = 1 Very Low (3)

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2796	26 Apr 2022	Care Group - Kent and Canterbury and Royal Victoria		There is a risk of delay in dialysis treatment due to high number of Renal Dialysis machines that are over 15 years old **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** Helen Swanborough **Last Updated:** 07 Mar 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added as >15 risk, agreed with CN-SH	**Cause** Currently have 175 HD machines in use across the dialysis service . This includes machines for the six dialysis units , Home Haemodialysis Service and Acute Dialysis Service on Marlowe Ward We have 19 out of the 175 machines which are > 17 years old. This is 10% of our total fleet which increase the risk of machines having a fault either before or during patient's treatment which has meant some patients have had an incomplete dialysis session due to this impact. Therefore patients are receiving suboptimal treatment due to the reduction in dialysis treatment time Replacements for the dialysis machines (medical equipment) should be 10 years. Medical devices request submitted by renal technical manager via the procurement portal in 2020. We previously had rolling replacement programme of 19 new machines a year which is no longer in place. We had 26 machines replaced in 2020, 8 in 2021 and 1 in 2022- none in 2023. (Only 20% replaced in the last 3 years) We have asked for 6 new machines from Phase 1 of the renal business case 2021/2022 to help with the increased dialysis activity which was agreed at SIG to be funded by MDG but has not happened **Effect** There has been a significant increase in frequent breakdowns across the service which is being managed by the renal technical service on a daily basis. Due to poor reliability of these machines we unable to sustain effective dialysis service. The increase in dialysis activity has meant that machines are doing more hours (On average 12 hours per patient which is 384 hours for 32 new patients from the additional twilight shifts) We have spent 250K spend on machine repairs in 24 months. A dialysis machine costs around £11-14K depending on specification of machine.	Quality	I = 4 L = 5 Extreme (20)	All breakdowns of machines are referred on a daily basis to renal technical team either via designated email or phone call in and out of hours . **Control Owner:** David Topham	Adequate	I = 3 L = 5 High (15)	Medical Devices Request to be reviewed by the Medical Devices Group in their meetings to see what potential funding can be agreed this financial year to replace any of existing 17 machines **Person Responsible:** Ladan Najafi **To be implemented by:** 31 Mar 2024		I = 2 L = 3 Low (6)
								Monthly report being completed by Lead Renal technical manager which is presented at the Medical Devices Operational Group **Control Owner:** David Topham	Adequate		Discussion to be held with procurement at Care Group Procurement Meeting regarding a way forward for a rolling replacement programme of equipment (dialysis machines) **Person Responsible:** Karen **To be implemented by:** 31 Mar 2024		

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3134	09 Mar 2023	Corporate - Operations		Failure to secure planned income due to underperformance against the Elective Recovery Fund baseline **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** **Last Updated:** 12 Feb 2024 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** **Effect**	Financial	I = 5 L = 3 High (15)	Monthly Finance Board report and the month end finance report to the Trust Finance and Performance Committee **Control Owner:** Michelle Stevens		I = 5 L = 3 High (15)	Care Groups to deliver 5% of follow ups via a PIFU (patient initiated follow up) process **Person Responsible:** Robert Hodgkiss **To be implemented by:** 29 Mar 2024		I = 5 L = 2 Moderate (10)
								Monthly pack provided to the ICB. Review at the ICB monthly Elective Care Board. **Control Owner:** Michelle Stevens			Produce timely monthly actuals against plan for each specialty and working with Care Groups a year forecast. Care Groups to identify how they will deliver their plans including remedial action plans if underperforming at their monthly PRMs and weekly Planned Care Oversight meetings **Person Responsible:** Robert Hodgkiss **To be implemented by:** 29 Mar 2024		
								Quarterly feedback provided to Care Groups via the Planned Care Improvement Group. Initial 23/24 feedback due at the end of Q1 23/24 **Control Owner:** Robert Hodgkiss			The Trust is only funded for 85% of follow up activity against the 2019-20 baseline. Care Groups to work with the outpatient transformation group to reduce follow up attendances and use the resource to increase inpatient, day case and outpatient first/procedure activity in order to reduce performance gap **Person Responsible:** Robert Hodgkiss **To be implemented by:** 29 Mar 2024		

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678	31 Aug 2016	Care Group - Diagnostics, Cancer and Buckland	Pharmacy	Insufficient Pharmacy support for the safe (and secure) use of medicines on wards **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Will Willson **Last Updated:** 19 Mar 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added as >15 risk, agreed with CN-SH	**Cause** Must do from CQC in Dec 2023 states clinical pharmacy must be present on each medical ward at WHH / QEQM which reduces the impact of the risk assessed clinical service New national standards release which state pharmacist / bed ratios which are not met at EKHUFT e.g. NICU (2023, ITU at QEQM and K&C (longstanding GPIC) Paediatrics (2023) Trust practice Increased activity for pharmacy generated by care groups ; Wards expanded or services developed within the Trust without consultation with pharmacy. This includes escalation areas and changes in pathway including from one site to another. Pharmacy then expected to provide an operational / Clinical service to these areas without additional funding. Extra, multiple escalation areas opened up with current issues with demand/flow has created a context in which many of the standard approaches to pharmaceutical care a less effective as well as increasing the bed to pharmacist ratio New EPMA system introduced in April 2023 has added to the pressure by increasing processes time by up to 50% and reduced the impact of the team to monitor performance Fully established would provide cover to 60% of clinical areas but delays due to VCP is impacting R&R and therefore reducing this further Clinical Pharmacy Operational and workforce lead Pharmacist on long term sickness Trust Vacancy panel delays in recruitment Resignation of Lead Clinical services Pharmacy technician High vacancy rate of foundation (band 6) pharmacists (38%) and specialist clinical (band 7) pharmacists (20%) impacted by the VCP process **Effect**	Quality	I = 3 L = 5 High (15)	Health Building Note 14-02 – Medicines storage in clinical areas **Control Owner:** Elizabeth Shutler		I = 3 L = 5 High (15)	Full 7 day service from Pharmacy **Person Responsible:** Will Willson **To be implemented by:** 30 Oct 2023		I = 3 L = 3 Moderate (9)
								Risk assessment for clinical service and prioritisation of services delivered to high risk clinical areas first mitigates some of this risk but CQC have reduced the impact on this control. **Control Owner:** Rebecca Morgan	Adequate		Document / Case to highlight the gap on each site and submitted to care organisation **Person Responsible:** Rebecca Morgan **To be implemented by:** 01 Jan 2024		
								Staff have been recruited into new posts and trained to increase the number of staff available to cover. This lessens the impact but does not reduce the likelihood of this occurring again. **Control Owner:** Rebecca Morgan	Adequate		Review of clinical workforce model to medicine wards at QEQM/WHH with gap in workforce submitted to organisation to meet the CQC Must **Person Responsible:** Kamaldeep Sahota **To be implemented by:** 29 Mar 2024		
											Review clinical pharmacy service with ePMA to identify if any actions can be taken to release clinical pharmacy time with an action plan. Identifying how much time can be released **Person Responsible:** Rebecca Morgan **To be implemented by:** 29 Mar 2024		

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					Patient Safety Wards only covered on a risk associated basis Medicines reconciliation rate low eDN screening rate is low screening focused on supply only rather than regular review of patients delayed discharges missed doses of medicines Support for audit limited Support for training/education of staff limited including medical and nursing staff patient harm through poor prescribing reduced monitoring of CD use Morale of staff is low due to not feeling effective in their role Inability to provide a weekend, late night and on-call pharmacy service which will lead to harm and delays in patient flow. This includes ITU, AMU 7 day services. Senior staff covering gaps on clinical rosters e.g. weekends and late nights and the inability to plan and mitigate these gaps. Inability to plan the service for the next few years e.g. trainees and NMPs Poor reputation regarding pharmacy workforce and development opportunities impacting recruitment. Reduction in appraisal & mandatory training rate within team Reduction in ability to provide medical education training Inability to support clinical pharmacy team training & supervision Inadequate induction of new staffs. Wellbeing of staff is significantly impacted Increased sickness levels Increase costs from overtime for senior staff on NHSP Regulatory Failure to meet CQC Must do							

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3210	11 Apr 2023	Corporate - Nursing	Infection Prevention and Control	Failure to comply with the NHS standard contract for infection prevention and control **Risk Owner:** Sarah Hayes **Delegated Risk Owner:** Lisa White **Last Updated:** 12 Feb 2024 **Latest Review Date:** 18 Jan 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Reviewed risk with delegated risk owner , Deputy DIPC, LW, assurance	**Cause** Inconsistent application of IPC, hygiene and Antimicrobial Stewardship (AMS) practices and protocols **Effect** Potential harm to patients Breaches of externally set objectives Possible regulatory action Prosecution Litigation Reputational damage	Quality	I = 3 L = 5 High (15)	Collaboration and agreement with 2gether Support Solutions (2SS) on priorities for investment to address gaps in infrastructure compliance, based on clinical (infection prevention) risk and included in business planning **Control Owner:** Lisa White	Limited	I = 3 L = 5 High (15)	Collaborative working with the system on C. difficile **Person Responsible:** Lisa White **To be implemented by:** 29 Mar 2024		I = 3 L = 2 Low (6)
								Compliance with requirements of the Hygiene Code with a plan to address **Control Owner:** Lisa White	Adequate		Delivery of the IPC workplan **Person Responsible:** Lisa White **To be implemented by:** 29 Mar 2024		
								Surveillance and reporting of HCAI via Public Health England (PHE) Data Capture System (DCS) **Control Owner:** Lisa White	Adequate		Deliver antimicrobial stewardship strategy **Person Responsible:** Veronica Chorro-Mari **To be implemented by:** 31 Mar 2025		
3625	05 Jan 2024	Care Group - William Harvey		Capacity and demand for ED care resulting in corridor care **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Rachel Perry **Last Updated:** 07 Mar 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added as >15 risk, agreed by CN-SH	**Cause** Due to the ongoing challenges with LOS and in patient ward capacity patients with DTA's are held in the ED - on average 30 pts per day. This adversely affects the departments ability to safely and effectively manage ED patients, and give a good patient experience to those awaiting beds **Effect** Inability to offload ambulances into a recognised clinical area. Continuous 'corridor care' ie care given outside of a recognized clinical area (ref NHSE). Patient safety potentially compromised. Staff welfare impact. Poor patient experience. Increase complaints	Quality	I = 4 L = 5 Extreme (20)	Review of ED Corridor Care SOP and review of ED escalation flow chart (within SOP) **Control Owner:** Rachel Perry		I = 3 L = 5 High (15)	Send CQC action plan - must and should do's as this will have signed off documents listed as controls This has still not been achieved date amended **Person Responsible:** Rachel Perry **To be implemented by:** 28 Jun 2024		I = 3 L = 5 High (15)
								Updated trust full capacity protocol **Control Owner:** Rachel Perry					

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
1831	13 Nov 2019	Care Group - Queen Elizabeth, The Queen Mother	QEQM Urgent and Emergency and Acute Medicine	Privacy and dignity will be adversely affected when patients are treated in non-care spaces **Risk Owner:** Sarah Hayes **Delegated Risk Owner:** Joanna Williams **Last Updated:** 12 Mar 2024 **Latest Review Date:** 12 Mar 2024 **Latest Review By:** Janet Webber **Latest Review Comments:** Risk reviewed	**Cause** Due to overcrowding and demand not all patients are able to be cared for in an identified designated care space. Corridor care standing operating procedure is audited and shows patient groups often fall outside of this category, negatively impacting privacy and dignity due to overcrowding. **Effect** Patients are being cared for in identified non-clinical areas such as corridors when this is not appropriate. This is resulting in incidents occurring and complaints being received. In addition, it causes potential obstruction of corridor pathways	Quality	I = 4 L = 5 Extreme (20)	2 hourly board rounds in place within the Emergency Department. To help with flow, at these board rounds patients are identified for alternative pathways to reduce the overcrowding. **Control Owner:** Joanna Williams	Limited	I = 3 L = 5 High (15)	Monitoring of use of corridor areas as patient areas using DATIX reports and harm reviews as necessary as an ongoing process **Person Responsible:** Joanna Williams **To be implemented by:** 31 Jul 2024	**12 Mar 2024** **Janet Webber** Request for Risk to move to Urgent, Emergency and Acute Medicine Risk Register	I = 3 L = 2 Low (6)
								A corridor dashboard has been put in place to faciliitate monitoring and DATIX reporting **Control Owner:** Janet Webber	Adequate				
								All use of non care spaces is reported via fundamentals of care and to the board **Control Owner:** Joanna Williams	Limited				
								Audits on the use of non-designated areas for clinical care are carried out and reported to the Fundamentals of Care committee. **Control Owner:** Joanna Williams	Limited				
								DATIX reports are completed for each patient cared for in a non-clinical area and escalated to the COO, with senior staff walking the floor and offering apologies to patients and monitoring the situation **Control Owner:** Joanna Williams	Adequate				
								The Site Management Team produce a daily report on the use of the corridors and length of time patients are there (for both EDs). This data will also be input onto Datix for monitoring purposes. **Control Owner:** David	Adequate				
								The Site team report on a shift basis any use of the corridors within the EDs. **Control Owner:** Joanna Williams	Adequate				
								There are exclusion criteria in place for corridor care and corridor boxes, care plans and buzzers have been initiated. The corridor SOP has been **Control Owner:** Joanna Williams	Adequate				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2599	13 Oct 2021	Corporate - Medical		There is a risk of inadequate medical staffing levels and skills mix to meet patients needs **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Helen Mackie **Last Updated:** 12 Feb 2024 **Latest Review Date:** 09 Feb 2024 **Latest Review By:** Helen Mackie **Latest Review Comments:** Review the medical recruitment process. included as theme in CIP program. 1'st meeting 8,02,24 e-mail to DV re the task and finish group	**Cause** An inability to recruit in key specialties and to key grades. Insufficient substantive consultant staff requiring long term locums to cover vacancies Lack of central medical function **Effect** Patient outcomes Experience and safety Financial impact due to cover with high cost locums	People	I = 3 L = 5 High (15)	Associate Medical Director in post to innovate in medical recruitment **Control Owner:** Desmond Holden		I = 3 L = 5 High (15)	Establish task and finish group to target consultant recruitment in high risk specialities **Person Responsible:** Deborah Viner **To be implemented by:** 29 Mar 2024		I = 3 L = 2 Low (6)
								Locum policy describing induction for locum doctors **Control Owner:** Fiona O'Neill			Review of provision of medical workforce function **Person Responsible:** Andrea Ashman **To be implemented by:** 29 Mar 2024		
								Medical recruitment team have process in place to check and challenge requests to extend locums beyond two **Control Owner:** Twyla Mart	Adequate		Review the medical recruitment process **Person Responsible:** Jason Watson **To be implemented by:** 29 Mar 2024	**12 Mar 2024** **Jason Watson** Draft SOP for managing the recruitment and selection of consultants presented to the people and culture team. Awaiting confirmation of approval for use and the operational support required to deliver it.	
								Task and finish group established around medical recruitment including consultants **Control Owner:** Desmond Holden	Limited		Deliver a fit for purpose medical appraisal platform **Person Responsible:** Jason Watson **To be implemented by:** 30 Aug 2024	**12 Mar 2024** **Jason Watson** Competitive procurement process complete with revised specification document aligned to this risk. New provider transition expected to be complete in	
2766	01 Apr 2022	Care Group - Critical Care, Anaesthetics and Specialist Surgery		There is a risk that patients are cancelled and theatres starts are delayed due to a lack of surgical admissions lounge at WHH, this impacts on patient's experience and dignity **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Michelle Rose **Last Updated:** 07 Mar 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added as risk >15, agreed with CN-SH	**Cause** Higher volume of elective admissions in CDSU due to closure of SAU and A&E expansion building work. This risk was previously mitigated by using the post-op area to admit patients, however, due to Channel Day change of use to an escalation area, this is blocking beds and impacting flow of elective surgery from Recovery to the ward for 2nd stage recovery and discharge. **Effect** Increased activity and not enough space in pre-op area, only 6 cubicles to admit all elective patients. Post op area currently being used to admit CDSU theatre lists but flow of patients is impacted by delays transferring to the ward from Recovery caused by volume of patients and pm admissions. Delayed theatre starts Poor patient experience and increased complaints. Inability to meet statutory requirements of delivering same-sex accommodation Cancellation of patients due to running	Quality	I = 3 L = 5 High (15)	Day surgery use lounge chairs to keep trolley spaces **Control Owner:** Christine Boswell	Adequate	I = 3 L = 5 High (15)	Work with Prism around theatre utilisation to improve productivity **Person Responsible:** Anthony Adams **To be implemented by:** 29 Mar 2024		I = 3 L = 3 Moderate (9)
								Incident completed each time a list is delayed due to staff being unable to complete admission paperwork **Control Owner:** Lynda Marshall	Adequate		Create a surgical admissions unit at WH **Person Responsible:** Anthony Adams **To be implemented by:** 29 Mar 2024		
								Quality Impact Assessment completed **Control Owner:** Gemma Oliver	Adequate				
								Reducing theatre lists to accommodate patients being admitted to Channel Day Surgery Unit **Control Owner:** Anthony Adams	Limited				
								Review daily and work with day surgery to cohort patients together where appropriate **Control Owner:** Christine Boswell	Adequate				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2480	25 Jun 2021	Care Group - Critical Care, Anaesthetics and Specialist Surgery		Lack of skilled trained ITU nurses **Risk Owner:** Sarah Hayes **Delegated Risk Owner:** Gemma Oliver **Last Updated:** 04 Mar 2024 **Latest Review Date:** 29 Feb 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Exec risk owner added due to risk rating >15, agreed with CN-SH	**Cause** Staff and trauma of working during Covid-19 has led to higher amounts of people moving to a different type of nursing Significant vacancy on WHH and K&CH sites at band 5 For WHH the expansion of the critical care unit from 16 beds to 24 beds has diluted the skill mix further, although the number of people on shift meets the GPICS standard the skill mix of staff does not meet the high level needs of all of the patients. The usual mechanisms for supporting staff are also diluted due to the number of new starters with no ITU experience **Effect** Reduction in the amount of ITU experienced nurses on shift Delivery of timely intensive care nursing is sometimes compromised due to this There may be a delay in patients receiving the necessary equipment due to the staff available not having the knowledge to commence the treatment or continue the treatment once attached to the patient Lack of support to staff means that we have an increase in leavers due to anxiety and stress caused by working in a high intensity area with insufficient support A reduction in morale for the remaining staff as they see people start and leave ITU in quick succession ITU consultants have too been affected by the lack of nursing skill mix leading to the nurse at the bedside not always being able to carry out the requests from the consultants without senior support which they have to wait for	People	I = 3 L = 5 High (15)	Increased the practice development team by two band 6's. Increased the amount of people going on the ITU course to 9 a year. Introduced a different shift leadership by having bravo nurses in each area and an alpha nurse in charge **Control Owner:** Julia Cristall	Limited	I = 3 L = 5 High (15)	Ongoing recruitment of band 5 nurses **Person Responsible:** Julia Cristall **To be implemented by:** 31 May 2024		I = 3 L = 2 Low (6)
								Offered experienced staff to coach and mentor junior staff **Control Owner:** Julia Cristall	Adequate		To run two ITU courses per year for WHH and QEQM to increase the percentage of staff with ITU endorsement **Person Responsible:** Julia Cristall **To be implemented by:** 28 Mar 2025	**01 Feb 2024** **Rhiannon Adey** GPICS standards require a minimum 50% of nursing staff to have ITU endorsement. This is currently 34%.	
								Raising skill mix at daily site huddle with triumvirate **Control Owner:** Julia Cristall	Adequate				
								Staging band 6 recruitment to enable the existing new staff and the new pending staff to have a good experience and be supported which will lead to them staying as was the culture pre-covid **Control Owner:** Julia Cristall	Adequate				
								We Care Driver metric - reducing premium pay **Control Owner:** Michelle Rose	Limited				
								WHH ICU - Stopped general nursing students having placements within critical care until such time they can be fully supported **Control Owner:** Jane Kirk-Smith	Adequate				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3367	03 Jul 2023	Corporate - Medical		Lack of timely review of diagnostic test results **Risk Owner:** Desmond Holden **Delegated Risk Owner:** **Last Updated:** 12 Feb 2024 **Latest Review Date:** 01 Feb 2024 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Target score updated in line with Trust risk appetite for quality.	**Cause** Sunrise system does not have a functionality whereby a consultant is able to review on one page all test results that sit under them for all patients. What they are required to do is to review the test results within each patients records. The challenge is that as a result of difficulty within the Sunrise system or PACS system staff are not always able select the correct consultants because of the way the system is designed therefore regularly they have to select an incorrect consultant **Effect** Consultants are overwhelmed with test results that do not relate to the patients that are under them and that these test results are then sent on to another consultant providing they are reviewed in a timely manner Patients will have a delay in medical and nursing response to abnormal test results. We are aware that these issues relate to radiology, pathology including histology and haemotology.	Quality	I = 3 L = 5 High (15)	Radiology have implemented a number of fail safe processes. including spreadsheets of all query cancer results to the Cancer Nurse Specialists weekly. **Control Owner:** Gemma Matthews	Limited	I = 3 L = 5 High (15)	To understand the issues and Trust processes across the specialties to identify the causes of this risk **Person Responsible:** Samantha Gradwell **To be implemented by:** 30 Nov 2023 Developing a page on Sunrise for consultants to review all results that are allocated to them **Person Responsible:** Michael Bedford **To be implemented by:** 31 Jul 2024		I = 3 L = 2 Low (6)

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
526	08 Aug 2016	Care Group - William Harvey		Insufficient capacity in Endoscopy **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Ruth DeBerry **Last Updated:** 07 Mar 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Risk linked to 3536	**Cause** Lack of capacity versus demand. High Gastroenterology consultant vacancy Lost capacity due to equipment failure WLI payments reduced Insourcing was stopped which was part of capacity recovery plan **Effect** Failure to provide sufficient capacity will impact on patient's outcome, particularly if on a cancer pathway Financial penalties to the Trust due to a failure to meet the RTT standard Risk of overspend due to the high cost of premium rate lists and placing of agency locums Delayed diagnosis Out of hours GI bleed on-call rota becoming non-compliant at 1 in 5	People	I = 3 L = 5 High (15)	Insourcing in place with ID Medical up to 1000 scopes per month **Control Owner:** Stella Grey		I = 3 L = 5 High (15)	Exploration of other external capacity **Person Responsible:** Tammy-Ann Sharp **To be implemented by:** 29 Feb 2024		I = 3 L = 2 Low (6)
								Locums identified to cover lists. **Control Owner:** Sarah Hyett	Adequate		Discuss a trust-wide on-call rota to temporarily mitigate the non-compliant GI bleed on-call rota **Person Responsible:** Omar Yanni **To be implemented by:** 31 Mar 2024		
								New agreement on WLI rates - internal locums being put in place **Control Owner:** Sarah Hyett			Business case to be completed for funding for 1 x additional clinical endoscopists. Looking at funding for additional endoscopy activity funding. Insourcing to be reduced once this is in place. (draft completed). **Person Responsible:** Susan Travis **To be implemented by:** 31 Mar 2024	**08 Feb 2024** **Susan Travis** Funding agreed for 1 endoscopist Business case to be completed	
								Training of nurse specialists to perform endoscopy **Control Owner:** Paula Morgan	Substantial		Recruitment of gastroenterologists to WHH **Person Responsible:** Stella Grey **To be implemented by:** 31 May 2024	**08 Nov 2023** **Rhiannon Adey** One vacancy has been recruited to	
											Recruitment of gastroenterologists to QEQM **Person Responsible:** Sarah Hyett **To be implemented by:** 31 May 2024		
											Complete review of surveillance backlog against new guidelines to be able to potentially remove patients who no longer meet criteria. **Person Responsible:** Katherine Hills **To be implemented by:** 31 May 2024		
											Training of nurse endoscopists utilising HEE training scheme. **Person Responsible:** Paula Morgan **To be implemented by:** 05 Jun 2024	**07 Feb 2023** **Kathryn Rogers** 3 nurses currently in training 1 nurse fully trained	

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

Committee: Nominations and Remuneration Committee (NRC)

Meeting date: 12 March 2024

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

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
Executive Appointments • **Chief Operating Officer (COO)** • **Director of Corporate Governance (DCG)**	• The Committee received assurance of the recruitment, interview and stakeholder process to appoint substantively to the roles of COO and DCG. • The Committee approved the appointment of Rob Hodgkiss as COO, noting Rob has been working with the Trust since the beginning of January 2024 as Interim COO. Rob has extensive COO and operational performance experience, and has already successfully implemented improvements since he has been with the Trust. His most recent role was COO and Deputy Chief Executive at Chelsea and Westminster NHS Foundation Trust. • The Committee approved the appointment of Khaleel Desai as DCG. Khaleel has extensive governance and legal experience and the skills to fulfil the scale and scope of this challenging role. He currently works for Mencap as Executive Director of Governance.
Annual Pay Award Very Senior Managers (VSMs)/Executives	• The Committee considered and approved to apply the national pay award of 5% to eligible Executive/VSM roles, backdated to 1 April 2023, noting the total full year effect. • The Committee noted this uplift payment against annual cost of living award was in alignment with the agenda for change pay recommendations for 2023/24. This payment has been awarded nationally by Trusts and Integrated Care Boards. • The Committee recognised the need for payment award uplifts to be recommended and considered as early as feasible, and this

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	process needed to be much more streamlined for earlier consideration the next financial year.
Any Other Business (AOB)	• The Committee discussed the key role of Chief Finance Officer (CFO), currently being covered on an Interim basis. It was emphasised the need for early planning to recruit substantively to this role to ensure there is no gap in cover at the end of the interim period, term of secondment ends towards the end of this year.

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 4 April 2024

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

Committee: **People and Culture Committee (P&CC)**

Meeting date: **20 February 2024**

In-the-Chair: **Claudia Sykes, Non-Executive Director (NED)**

Paper Author: **Interim Director of Corporate Governance**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

No

Assurances received at the Committee meeting:

Agenda item	Assurance
February 2024 Integrated Performance Report (IPR) 'We Care' and 'True North' Objectives	Significant key points for the Board to **note:** • **PARTIALLY ASSURED**: **Staff Engagement and Staff Involvement** Staff Engagement has improved subtly quarter-on-quarter. Further overall improvement is blunted by a significant reduction in advocacy, the extent to which people would recommend the Trust. • **ASSURED: Premium Pay** In December premium pay spend decreased. This is the third month in which a steady decline in usage has been recorded. • **ASSURED: Sickness absence** Sickness absence increased to 5.6% in January from 5.5% in December. The majority of all sickness was due to short term coughs, colds and chest infections (including COVID). Stress, anxiety and depression now accounts for just 6% of all sickness, down from a peak of 33% in March 2021. • **NOT ASSURED: Appraisals** Overall appraisal compliance has increased (by 1.5%) to 73.9% following a three-month plateau. This metric remains below the reviewed alerting threshold of 80%. • **ASSURED: Staff Turnover**

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	December saw the lowest number of total leavers in over a year, falling by 40% since September 2022. In-month turnover has been below 10% for four consecutive months, and fell further to 9.2% in January 2024.
Integrated Performance Report (IPR) – Appraisals Deep Dive	The Committee was **NOT ASSURED** in respect of appraisals. Additional work is being completed around the support of appraisals and their importance, including the development of a more comprehensive behavioural framework which has been piloted with a number of teams. The Committee have asked for a further item on Appraisals, once this work has been completed.
Cultural Development & HR Programme	The Committee was **ASSURED** in respect of the Cultural Development & HR Programme. The Committee noted that the final analysis is on 8 March 2024. After this the design phase will commence, which will include the engagement of Change Ambassadors.
'Hot Items'	The Committee **NOTED** the following developments: • Agenda for Change Staff – open consultations around separate/distinct pay. • Workforce Realignment – the consultation period begins on 22 February. This includes the removal of circa 200 roles as a cost saving exercise. The Trust is looking at redeployment rather than redundancies.
Industrial Action	The Committee **NOTED** that a Junior Doctors strike was due to happen in the following week and that the Care Groups were making plans around cover and rotas.
Vacancy and Recruitment update – Pipeline against establishment to include vacancies review	The Committee **NOTED** that the topic has been discussed in detail at different forums. Recruitment is going well in relation to International Nursing but recruitment is not in place for Domestic. They are considering ad hoc recruitment as part of a formal programme of cohorts.
Vacancy Review Panel	The Committee **NOTED** that Vacancy Panels have been extended to clinical roles. The Executives attend the panels weekly on a Friday, and are all very active in scrutinising posts and rejecting roles that do not meet the criteria.
Survey Results	The Committee **NOTED** that there are current indications that there is a significant gap from the national standard. EKHUFT are below average scores for approx. 90% of the survey questions. Progress is being made against involvement, management, wellbeing, and appraisal.
Equality Delivery System (EDS)	The Committee formally **NOTED** the paper.

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Freedom to Speak Up Guardians (FTSUG) report	The Committee **NOTED** that the number of issues and concerns shared with the FTSU team continued to rise. However, there has been a decrease in the number of issues raised in Q3 2023/24 due to long term absence in the team.
Doctor's Voice Group (DVG)	The Committee **NOTED** that the DVG has been set up to provide the Trust with a vehicle of communication to all junior doctors and to enable them to contribute to ongoing improvement in all areas in the Trust.
Board Assurance Framework (BAF)	The Committee was provided with a refreshed version of the BAF and **NOTED** that additional work was needed on the Committee assurance process.
Medical Education	The Committee **NOTED** an update on the Kent and Medway Medical School Feedback Report. Concerns were noted in regards to budget lines. There is uncertainty around whether the full allocation of tariff is reaching the Medical Education department. The Committee was **NOT ASSURED** in respect of the NHS Whole Time Equivalent (WTE) Financial return submission. The submission is currently being worked on, however, is overdue by two months from the national timeline. The Committee requested this item be referred to the Integrated Audit and Governance Committee (IAGC) as an area of non-compliance.
Statutory and Mandatory Training	The Committee was **ASSURED** in respect of Statutory and Mandatory Training. Both statutory and mandatory training compliance figures have been relatively stable or improved over the past 12 months, although both have been impacted by the introduction of new subjects.
Committee Annual Workplan	The Committee **NOTED** the P&CC Annual Work Programme, 2023/24.
Feedback from Integrated Education, Training and Leadership Development Group (IETLDG)	The Committee **NOTED** the Feedback from IETLDG.
Feedback from Equality, Diversity & Inclusion (EDI) Steering Group	The Committee **NOTED** Feedback from the EDI Steering Group.

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Other Items of Business

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

The Committee asks the **BoD** to discuss and **NOTE** this P&CC Chair Assurance Report.	Assurance	4 April 2024
The Committee asks the **IAGC** to **REVIEW** the work undertaken for the national NHS WTE Financial Return Submission, and areas for learning.	Action	26 April 2024

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

Committee: Quality and Safety Committee (Q&SC)

Meeting date: 26 March 2024

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

Paper Author: Executive Assistant

Quorate: No

Appendices:

Appendix 1: Patient Safety Incident Response (PSIP) Policy and Plan for 2024/2025

Declarations of interest made:

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

Assurances received at the Committee meeting:

Agenda item	Summary
Focussed Review of Serious Incidents (SIs) pre-Patient Safety Incident Response Framework (PSIRF) Implementation	The Committee received the report and **NOTED** that the number of SIs had reduced over the past 12 months as the Trust is moving towards PSIRF. The Committee was made aware that the SIs closure rate by the Integrated Care Board (ICB) Panel and the 72-hour report compliance had improved.
Care Quality Commission (CQC) Update Report	The Committee received the report and **NOTED** the acceleration of closures of the outstanding CQC must-do and should-do actions. The Committee expressed concern that following the recent CQC restructure it had become challenging for the Trust to communicate with the CQC colleagues promptly and effectively. The Committee received assurance that with collaboration with the ICB team appropriate levels of communication would be restored.
Significant Risk Register Update	The Committee received the report and **NOTED** that out of 47 risks on the Significant Risk Register 33 risks were quality related risks. The Committee were assured that all significant risks had been assigned Executive Director and would be updated monthly and reported through Clinical Executive Management Group (CEMG) and appropriate Board subcommittees to the Trust Board.

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Patient Safety Committee Chair's Report	The Committee received the report on the activities of the Patient Safety Committee and had a focussed discussion around radiation safety and the use of controlled drugs.
Maternity & Neonatal Assurance Group (MNAG) Chair's Report	The Committee received the report on the activities of the Maternity and Neonatal Assurance Group and agreed that significant assurance continued to be provided. The Committee **NOTED** that whilst there had been significant improvements in the estates' facilities, some larger projects were awaiting decisions on funding including the second theatre at Queen Elizabeth the Queen Mother Hospital (QEQM). The Committee received an update on the National Patient Safety Alert around the Maternity Information System used by EKHUFT and all other Maternity Services in the Local Maternity and Neonatal System (LMNS) and the risks in relation to the accuracy of clinical information. The Committee was assured that the team was working with the LMNS on a system-wide procurement of an alternative system.
Safeguarding Committee Assurance Report	The Committee received the report and **NOTED** that the Safeguarding Assurance Committee was now chaired by the Chief Nursing & Midwifery Officer (CNMO). The Committee acknowledged the significant amount of work the Safeguarding team was continuing to undertake.
Infection Prevention and Control Report	The Committee were provided with an update and **NOTED** that in February 2024 the Trust had reported the lowest number of C-difficile cases in 14 months. The Committee had a robust discussion around effectiveness of the antimicrobial stewardship processes and surgical site infections surveillance.
Clinical Audit and Effectiveness Committee (CAEC) Chair's report	The Committee received the report and **NOTED** good compliance with the national audits. The Committee sought clarity as to the reasons for poor compliance with implementing the National Institute for Health and Care Excellence (NICE) Guidelines and asked to receive an improvement trajectory.
Patient Safety Incident Response (PSIR) Policy and Plan	The Committee were made aware that preparations for Patient Safety Incident Response Framework (PSIRF) implementation were on schedule and the Trust Board were required to approve the PSIR Plan and Policy (attached Appendix 1 for Board approval).

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Fundamentals of Care Chair's report	The Committee were provided with an update and **NOTED** that the Ward Accreditation Programme had been revised to ensure enhanced quality standards were met before wards were accredited.
Patient Experience Committee Assurance Report	The Committee received and **NOTED** the report on the activities of the newly established Patient Experience Committee.

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	4 April 2024
The Committee asks the BoD to **APPROVE** the PSIRF Policy and Plan.	Approval	4 April 2024

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Report title: **Patient Safety Incident Response (PSIP) Policy and Plan for 2024/2025**

Meeting date: **4 April 2024**

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

Paper Author: **Deputy Director of Quality Governance (DQG)**

Appendices:

Appendix 1: Patient Safety Incident Response Policy April 2024 and Patient Safety Incident Response Plan for 2024/2025

Executive summary:

Action required:	**Approval**
Purpose of the Report:	1. The Board is asked to approve both the Policy and Plan for the coming year in readiness for the Trusts transition to Patient Safety Incident Response Framework (PSIRF) in April 2024.
Summary of key issues:	1. The plan and the policy should be read together. They will be updated after the first six months and then every year thereafter. 2. The policy explains how we will respond to incidents and the plan details what we will be responding to over the next year. 3. We are planning to go live in April 2024, however, we will also need Integrated Care Board (ICB) approval as well. 4. There are significant changes in relation to how the Trust will respond to our incidents in particular serious incidents from April 2024. 5. Serious Incidents (SIs) will no longer be a part of our response, instead the Trust will be required to undertake Patient Safety Incident Investigations (PSIIs) using a different methodology. 6. The Trust experienced 240 serious incidents last year. There will be an expectation that we will try and keep our PSII figures to less than 20 over the coming year. The aim is to use the time to focus on improvement rather than repeat investigations. 7. The Trust is in a fortuitous position as we are also in the process of transferring the Care Group Governance teams to the Corporate Governance team. This has provided the Trust with an opportunity to rethink how we will deliver PSIRF by creating one team, aligned to be able to deliver on PSIRF over the coming year.
Key recommendations:	The Board of Directors is asked to **APPROVE** the PSIRF Policy and Plan, essential documents that need to be signed off by the ICB so that we are able to go live in April 2024. The Board of Directors is asked to consider the new approach as detailed in both documents, which is required by the new PSIRF guidance.

East Kent Hospitals University NHS Foundation Trust

Implications:

Links to Strategic Theme:	• Quality and Safety • Our Patients
Link to the Trust Risk Register:	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. This has been created within the transfer of the Care Group Governance Teams to the corporate team. • 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. A training plan is now in place. Much of this training is on line and free. • We have created a deputy role for the Head of Clinical Safety and Improvement which will release the Head of Clinical Safety and Improvement to lead on PSIRF over the coming year.
Legal and regulatory:	No
Subsidiary:	No

Assurance route:

Previously considered by: No

East Kent Hospitals University NHS Foundation Trust

Awaiting Comms input

Patient safety incident response policy

Effective date: April 2024

Interim Review and Update: October 2024

Estimated refresh date: March 2024

	NAME	TITLE	SIGNATURE	DATE
Author	**Samantha Gradwell**	**Deputy Director of Quality Governance**		
Reviewer	**Melinda Brewer**	**Head of Clinical Safety & Improvement**		
Authoriser	**Sarah Hayes**	**Chief Nursing Officer**		
Authoriser	**Des Holden**	**Chief Medical Officer**		

Contents

Foreword

I am delighted to introduce our new Patient Safety Incident Response Plan (PSIRP) for East Kent Hospitals Foundation Trust (EKHUFT).

I am very thankful for the input from all staff, for their dedication and commitment to the new Patient Safety Incident Framework planning and implementation in our Trust. Particularly our clinical staff and their commitment to delivering high quality patient safety for our patients, their families, and carers.

We aspire to deliver compassionate, safe, effective and high-quality care to all our patient's families and carers, this will remain our highest priority. We strive to provide excellent care to ensure that any harm to patients is minimised, we aim to achieve this in all areas of our Trust.

This plan aligns with the National Patient Safety Incident Response Framework and will continue to develop as we work together to provide the best outcome and experience for every patient.

It is our hope that as the implementation progresses and becomes embedded over the coming years, the value of this transformation will be visible not only to our staff but all our stakeholders.

Signature

Sarah Hayes

Chief Nursing and Midwifery Officer

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out East Kent Hospitals Foundation Trusts approach to developing and maintaining effective systems and processes for responding to patient safety incidents. The purpose of which is to ensure learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all areas of this organisation.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Learning responses do not take a ‘person-focused’ approach where the actions or inactions of people, or ‘human error,’ are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Our patient safety culture

The Trust has implemented a Trust wide workstream focused on improving the culture, including safety culture, which spans two years. This workstream will identify key areas of focus as well as the most appropriate range of responses with measured improvement. The first six months included data collection and analysis to identify the underlying contributory factors.

Within our People and Culture team the principles of the Just culture guide has been applied to both clinical and non-clinical cases that are considered by them. The aim of this work has been to drive down the number of disciplinary investigations for clinical staff who have made a mistake as well as reducing fear for staff and the sense of blame when they make a mistake.

Further work is planned to review the current approach and build upon the work already completed to fully embed the use of the Just Culture Guide across the organisation. This will be achieved by raising awareness of the tool to all staff, ensuring that it is accessible and providing on line training on how and when to apply it. The training will be monitored centrally as well as data from both the Culture Workstream and the Staff Survey results to demonstrate progress.

The implementation of the systems approach using a range of tools include the SEIP model, which will also encourage a different approach to understanding how to move away from focusing on individuals who have made an error, to understanding the system within which they work.

During transition the Trust will move away from simple action plans, as a result of investigations, to Trust wide improvement plans to drive up quality and safety for our staff and patients. This will further embed our Improvement methodology to include the PSIRF and support this transition. The Trust will also cease to request statements for learning responses as this does not provide the information that will be required for a system learning response.

Patient safety partners

It is recognised that both patients and carers can provide valuable insights based on their experience, in the development and improvement of safety responses.

The recruitment of six Patient Safety Partners (PSPs) across the Trust will support this work. There will be two PSPs based at each of the main hospital sites: Queen Elizabeth the Queen Mother Hospital (QEQM), William Harvey Hospital (WHH) and Kent and Canterbury Hospital (K&CH).

The aim is to appoint one PSP who will lead on working within our Maternity Services and up to two that will be attending the Quality and Safety Committee as well as the Patient Safety Committee. A key aspect of their work will be to support the implementation of compassionate engagement with our patients and families.

These staff will be managed by the Patient Safety Leads or the Deputy Head of Clinical Safety & Improvement, within the Corporate Patient Safety Team. Our PSP will be appointed by June 2024.

Addressing health inequalities

There is a requirement under PSIRF to evidence the that health inequalities have been taken into consideration when responding to incident reviews. The identification of those patients who may be at a disadvantage in accessing the care they need must be identified as part of our responses as well as consideration in the development of solutions.

The Trust will apply a more flexible approach and intelligent use of data to help identify any disproportionate risk to patients with specific characteristics and this information will inform our patient safety incident responses.

Further work is needed to address the lack of data within our Incident Management System to identify such cases which will enable the Trust to analyse the data to a meaningful depth.

The Trust will develop a small working group which will explore how we will respond to issues related to health inequalities as part of the development and maintenance of the Trusts patient safety incident response policy and plan. As part of the review of our incident responses and the development of our associated templates consideration of health inequalities, including when developing safety actions will be included and appropriate fields and prompts will be included on the revised templates.

As part of our response to incidents the way in which we engage our patients is important to us. Appropriate consideration must be given to the needs of each patient, members of staff or carer when planning to communicate with them.

The Trust will be providing training to all staff who will be responsible for undertaking an investigation to ensure that the system-based approach is consistently applied across the Trust. In addition to this the Patient Safety Incident Investigation (PSII) leads will also be provided with coaching and direct support until they have been signed off as competent.

Having fully trained investigators will ensure that not only will the focus be appropriately on the systems within which our staff work rather than their behaviour, it will further promote the development of a Just Culture and reduce the ethnicity disparity in rates of disciplinary action across the NHS.

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents this includes patients, families, and staff.

This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

The principles of Engagement

- The Trust requires all staff, who are leading an investigation, to apply compassionate engagement with all those affected by the patient safety incident unless they decline contact. This must include staff involved or otherwise affected by the incident.
- Our approach should be open, kind and sensitive to the needs of those individuals.
- Engagement should be focused on their needs as a priority not the Trust.
- The Trust supports openness and transparency in sharing information throughout the investigation with staff, patients and families. This includes sharing information from the investigation at an early stage. This may be both written or verbal.
- Staff should be confident that by sharing information they will be supported by the Trust.
- The investigative process should be collaborative; with the patient, staff and investigators working together to achieve learning that will ensure improvements are made.
- The approach towards our staff who have been involved in an incident must be without judgement or blame. After each contact with the investigation team they should leave feeling that they have been treated fairly and not blamed or punished.
- Statements should **NEVER** be requested following the initiation of a patient safety Incident response. Statements are unhelpful and will not promote the new ways of thinking within the principles of PSIRF.

- There is an informal agreement between the investigator and staff involved. This agreement is based on the principle that staff share information openly with the investigator and they will not be blamed or punished for making an honest mistake. *(An Honest Mistake is where there was no intention to cause harm and the individual came to work and did their best).*
- Identification of specific communication needs or other needs in relation to Health Inequalities should be considered early in the process.
- The Duty of Candour (Professional and Statutory) is a requirement by professional bodies as well as a legal requirement and therefore must always be applied for those incidents where there is moderate and above harm. This requirement is not changed by the principles of compassionate engagement.
- There will be training for all staff who will be engaging with our patients and staff in response to a patient safety incident. The Training will cover: Duty of Candour, how to engage with our patients, families and staff, understanding the process of compassionate engagement, recommended points of contact, how to share information and sign posting.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

Resources and training to support patient safety incident response

The Trust has recently agreed to transfer all Care Group Governance staff to the Corporate Quality Governance Team. This has provided the Trust with an opportunity to create and tailored workforce that, with the appropriate training and support, will be able to deliver on the PSIRF requirements as well as the wider quality governance agenda.

Resource

Within the new structure which includes the resource from the care group governance teams, there will be six full time Band 8a posts which will become the business partners for each of the six Care Groups. These posts will be known as the Quality Governance Business Partners (QGBP). Their roles will be 60% working on Patient Safety and 40% supporting the embedding of Quality Governance within their Care Group. As part of the role they will also be the main resource for undertaking the PSIIs. It is estimated that they will not need to complete more than three investigations each in a year.

In addition to the business partner roles the existing corporate team include two Band 7, Patient Safety Leads and 1.4 WTE Band 8a roles, Deputy Head of Clinical Safety and Improvement. The corporate staff will manage the day to day running of the corporate team and provide the coaching for the QGBP as well as undertaking PSIIs themselves that relate to the key themes that we are leading on this year. The Band 8b role, Head of Clinical Safety and Improvement will lead on PSIRF alongside the Deputy Director of Quality Governance. The Head of Clinical Safety and Improvement role will also manage the 8a QGBP as well as the remaining care group staff who will provide the business-as-usual function for patient safety and governance.

An important aspect of the corporate teams' role is also to support the development of robust solutions as well as supporting the dissemination and embedding the learning across the Trust for the PSIIs undertaken by the QGBPs.

Table 1: shows the numbers of investigations the Trust has completed in the previous five years as well as the resource demand.

	18/19	19/20	20/21	21/22	22/23	Total
Total SIs declared	**139**	**210**	**232**	**307**	**240**	**1128**
Total Never Events (sub set of total SIs)	7	4	4	3	7	25
HSIB maternity investigations (sub set of total SIs)	4	4	4	10	6	28
RCAs and AARs (not SI's)	**80**	**134**	**140**	**124**	**129**	**607**
Total RCA/AAR investigations	**215**	**340**	**368**	**421**	**363**	**1707**
RCA/AAR Investigation hours (55 hrs each)	11825	18700	20240	23155	19965	93885
Total SJRs completed	**16**	**54**	**52**	**29**	**39**	**190**
SJR Investigation hours (1 hour each)	16	54	52	29	39	190
Total Investigation hours (all types)	11841	18754	20292	23184	20004	94075
Investigation time spent in weeks per annum.	**316**	**500**	**541**	**618**	**533**	**2509**

The table above shows the increasing number of serious incidents the Trust has undertaken over the past five years as well as the sustained number of other types of investigations responses over the same period. The Trust has calculated the number of hours spent on each investigation, irrespective of the staff members grade or profession, and estimated that there is an average of approximately 55 hours spent per investigation. This figure is averaged out between SI investigations and After-Action Reviews (AAR). There are approximately 553 weeks spent on completing investigations over the previous year and this equates to 12.7 WTE staff.

Table 2. Shows the high-level training requirement for key staff across the Trust.

Role	Training Required
Chief Nursing and Midwifery Officer: (Executive Director Responsible for PSIRF)	Level 1 Essentials of Patient Safety Syllabus. (Online) Level 2 Access to Practice of the Patient Safety Syllabus (Patient Engagement) (Online) Level 1 Essentials of PS for Boards and Senior Leadership Teams. (Online) CPD in Incident Response Skills and Knowledge.
Chief Medical Director	Level 1 Essentials of Patient Safety Syllabus. Level 2 Access to Practice of the Patient Safety Syllabus (Patient Engagement) (Online) Level 1 Essentials of PS for Boards and Senior Leadership Teams. CPD in Incident Response Skills and Knowledge.
Patient Safety Specialists (5 individuals)	Level 1, 2, 3 & 4. Specific Investigation Training either HISB or other relevant training
The Trust Board	Level 1 Essentials of PS for Boards and Senior Leadership Teams. (Online) Level 2 Patient Safety Syllabus
Investigators (All)	Level 1, 2 Patient Safety Syllabus (Online) 2 days learning from Patient Safety Incident Training. (Online) Undertake a minimum of two investigations per year. Be provided with in house coaching and support when completing PSIIs or other responses.
All Staff	Level 1 (Mandatory Training) Level 2 Essential but not mandatory.
The Trust has developed a comprehensive training plan which is available separately.	

All staff that undertake PSIIs will have an identified coach from the corporate patient safety team. The role of the coach is to support their development and expertise in undertaking a high-level investigation. Although they may have completed many serious incident investigations previously, the new approach is completely different to Root Cause Analysis as are the tools and templates.

The coach will provide intensive support initially and gradually withdraw as the investigator gains confidence. The coach will need to sign the investigator off as competent to undertake an investigation on their own. A competency assessment tool is being developed.

In addition to the coaching provided the investigator will present the investigation to date, to a small audience, so that there can be gentle challenge as a critical friend. This ensures that investigation is robust and addresses the Terms of Reference.

These sessions are invaluable at ensuring that all relevant investigation lines have been identified. With training and coaching provision, the Trust will develop a robust and expert investigation team over the first year. This knowledge and understanding are essential for leaders in patient safety as the skills and knowledge gained in this process can be used in all other aspects of safety.

Regular peer review sessions will also take place once the Trust has transitioned. This is to ensure consistency in approach with the lead investigators and the central team.

Our patient safety incident response plan

Our plan sets out how East Kent Hospitals Foundation Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

Add link to the PSIR Plan here

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan after the initial 6 months and thereafter every 12 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident

profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement

Responding to patient safety incidents

Patient safety incident reporting arrangements

All incidents will be reported onto the incident management system, Datix. Where there is a requirement to report externally this will be completed by the appropriate speciality with oversight from QGBP and the corporate patient safety team.

For extremely serious incidents the Trust will continue to verbally report to both the ICB and the CQC in line with current practice. This will be completed by the Director of Quality Governance or the Chief Nursing and Midwifery Officer.

Where there is a system issue identified the ICB should be informed and the Trust would be required to respond appropriately.

Patient safety incident response decision-making

One of the requirements of PSIRF is to ensure that we stop undertaking large quantities of investigations when the contributory factors are known and focus on making the necessary improvements. It is recognised that for the Trust to move away from reporting 240 serious incidents last year, there will need to be a clearly defined and structured approach to incident response decision making, particularly in the first year of transition.

The aim of the Trusts plan has been to provide as much guidance on the potential response, in relation to specific incident types and themes, which we hope will remove the need and desire to respond with an investigation. The Trust will transition to the Incident Response Panel from the Serious Incident Declaration Panel where all appropriate incidents will be discussed and responses agreed. There is an expectation that the incidents would have been reviewed and the appropriate response will be recommended to the Chair by the local team supported by the QGBP and corporate patient safety team. This decision-making process is supported by a flow chart found in Appendix 2.

Four Key Themes

The Trust will identify four key themes each year that the corporate patient safety team will focus on. As per the guidance, they will apply the systems methodology to the PSII and identify the contributory factors. These will then have an improvement plan developed and the focus of the work will then move away from the investigation to improvement work. It may be necessary to undertake between 1 – 3 investigations to identify the main contributory factors for each theme.

Continuous Improvement Approach using the Safety Improvement Plans.

As part of the PSIRF preparation and data review, the Trust identified large numbers of repeat incidents for seven areas that would benefit from the implementation of Safety Improvement Plans. Across these seven areas there is an opportunity to significantly increase the level of improvement over the coming year. Having identified the seven areas, once the contributory factors have been identified with support from the Improvement team, a Trust wide improvement plan will be created. For each new case that occurs there will be a desk top review completed and providing there are no new issues identified, the incident will be closed, the review template saved on the system and the time that would have been spend on the investigation will now be spent working on the improvements to be made.

If there are areas that are new and not identified on the improvement plan, then the investigation would focus on only those issues and the improvement plan would be updated with the contributory factors and associated improvements to be made. The levels of improvement will be monitored and for those areas that have met the targets the plan would move to business as usual and those that continue to require improvement will be considered to remain part of the PSIR Plan the following year. There will also be consideration for new themes that have arisen during the previous year to be included in this approach. All improvement plans will be shared with the ICB as well as the Trusts progress against them.

Individual specialty response table

There are two areas across the Trust this year 2024/2025, that we are in the process of creating a table for responses; this includes Maternity Services and Infection Prevention and Control. These will be added to the plan when they have been completed. Each year the Trust will review each of these response plans and update them accordingly. There will also be consideration for the development of new response table for other specialties which high reporting rates.

Responding to cross-system incidents/issues

Should the Trust be involved in a patient safety incident which has been identified by a system partner or the agency, the Trust will ensure that this is also recorded on the local incident management system indicating clearly the lead organisation for the investigation. The Trust will contribute to the response which is led by the partner organisation and ensure that recommendations for the Trust are clearly defined and communicated across the organisation.

Similarly, should the Trust become aware of an incident that involves a system partner the Patient Safety Lead, in the partner organisation, would be contacted via their generic email and asked for their collaboration with the learning response. Many of these relationships have been forged over several years and are known to the Trust. Should there be a significant incident, one which either affects many patients or is a very serious nature, the ICB should be notified as well as the CQC.

Timeframes for learning responses

The response timescales will start on the day the incident has been reported.

Table 3. Shows the learning response selected with approximate timescales as guidance.

Learning Response	Timescales
PSII	3 - 6 months

After Action Review	1 – 5 weeks
Multidisciplinary Team Meeting	4 weeks
SWARM	To be agreed at the time with the inclusion of QGBP. It should take no longer than 4 weeks.
All other responses for significant incidents will be agreed at the time depending on the communication with the patient and/or family.	

1. These timescales are not rigid and will be determined in collaboration with the patient, family and staff.
2. Proposed timescales will be discussed and agreed at the Incident Response Panel (IRP) should the incident be reviewed at this meeting.
3. Guidance and support can be obtained by the Care Groups from the QGBP in relation to timescales.
4. Consideration also needs to be given to the staff who may also be affected by the incident. It can be extremely stressful for staff as well as patients when investigations are prolonged.
5. The time needed to conduct the response must be balanced between the impact of long timescales on those affected and the risk that the opportunity for optimum learning and improvement may diminish.
6. Where there is delay because of external organisations providing information within a reasonable timescale, the Trust will complete the investigation with the information they have.

Safety action development and monitoring improvement

Safety actions will be monitored using the electronic incident management system actions module. All actions will be entered onto the system which will allow monitoring of those that are due and those that have been completed. This data will be reported monthly as part of the Quality Governance Report to the Corporate Executive Management Group (CEMG) and the Quality and Safety Committee.

For PSIIs the corporate patient safety team will take the lead and support the QGBP in the development of local actions in collaboration with the relevant local teams. The QGBP will be responsible for monitoring the completion of actions for their care group.

The patient safety team will be working with the quality improvement team in relation to improvement work. There will now be a unified register of all improvement plans that will sit with the improvement team. For the seven themes that will be using an overarching improvement plan rather than reinvestigating, it has been agreed that the improvement team will work with patient safety and key leads to support this work.

During the first year of PSIRF we will be scoping how patient safety and the improvement team will work more closely as the improvement work starts to increase through the implementation of PSIRF.

Oversight roles and responsibilities

Quality Review

During the transition of both the care group quality governance teams merging with the corporate quality governance team as well as the transition to PSIRF, there will be a peer review process implemented at all levels to ensure consistency in approach and style in relation to undertaking and reviewing all incident learning responses.

Responsibilities and Oversight.

The Board has a responsibility to assure themselves that the PSIR Policy and Plan is being implemented, that lessons have been learnt and areas of weakness are being addressed. Part of this responsibility includes the assurance regarding the Trusts safety culture relating to blame and openness so that learning can be achieved and patient engagement is meaningful. Once a quarter the board should have the opportunity to review an investigation report as part of the assurance process and monitor the improvements.

The Chief Executive is responsible for the provision of appropriate policies and procedures to ensure the safety of patients, staff and visitors. They are ultimately responsible for ensuring that all investigations are dealt with effectively and appropriately.

The Chief Nursing and Midwifery Officer (CNMO) has delegated responsibly by the Board for the implementation of PSIRF. The CNMO will be supported by the Director and Deputy Director of Quality Governance as well as the Patient Safety Specialists in the strategic oversight of the implementation of PSIRF. The CNMO is responsible for the approval of all PSIIs. If the CNMO is not available the Chief Medical Officer (CMO) will provide temporary oversight and approval of PSIIs supported by the Director of Quality Governance.

The oversight of PSIRF transition will currently be monitored and reviewed at the CEMG, Patient Safety Committee as well as the Quality and Safety Committee and the Board.

Complaints and appeals

PSIRF provides a very different approach to how we will manage patient safety incidents in the future. If you would like more information or to offer suggestions or feedback on this policy, please email the Patient Safety Team at ekhuft.serious-incidents@nhs.net

If you have a concern and you would like to make a complaint, please can you use the Trusts complaints process.

To make a complaint you can:

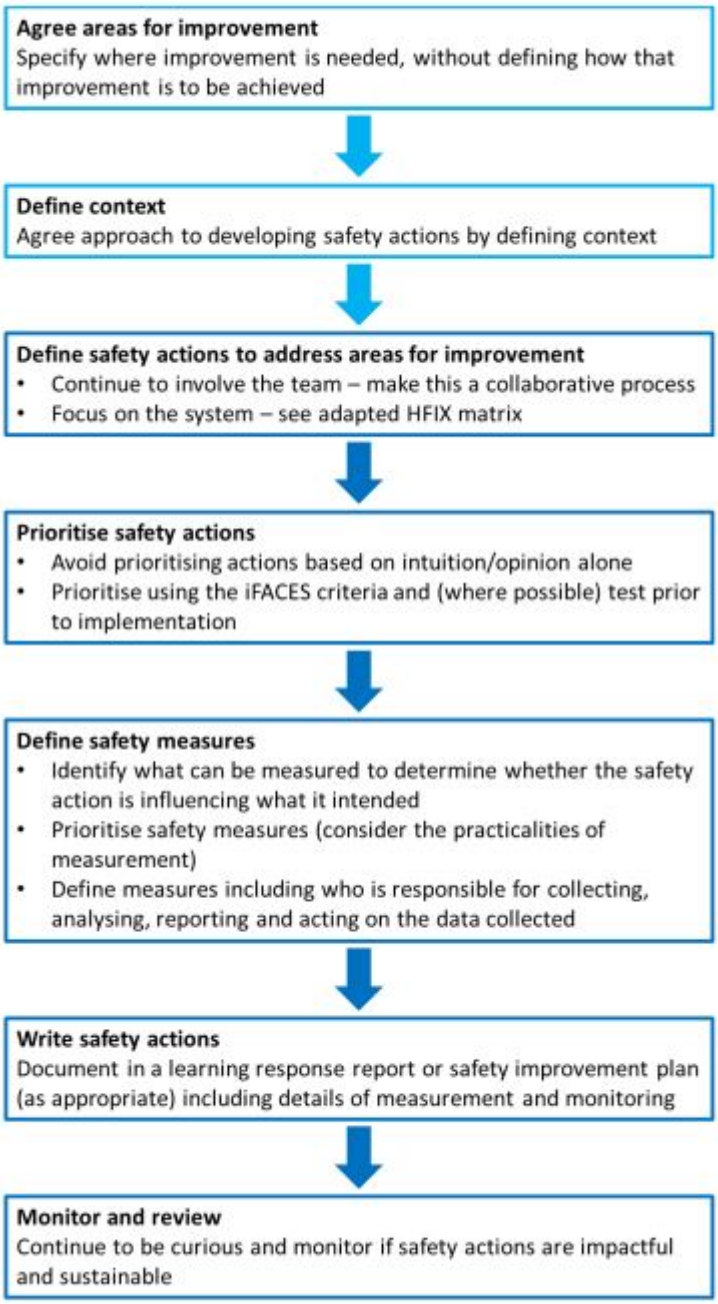
- Call us: 01227 783145
- Email us: ekh-tr.pals@nhs.net
- Write to us at:

The Complaints Team
East Kent Hospitals University NHS Foundation Trust
Trust Offices
Kent and Canterbury Hospital
Ethelbert Road
Canterbury
CT1 3NG

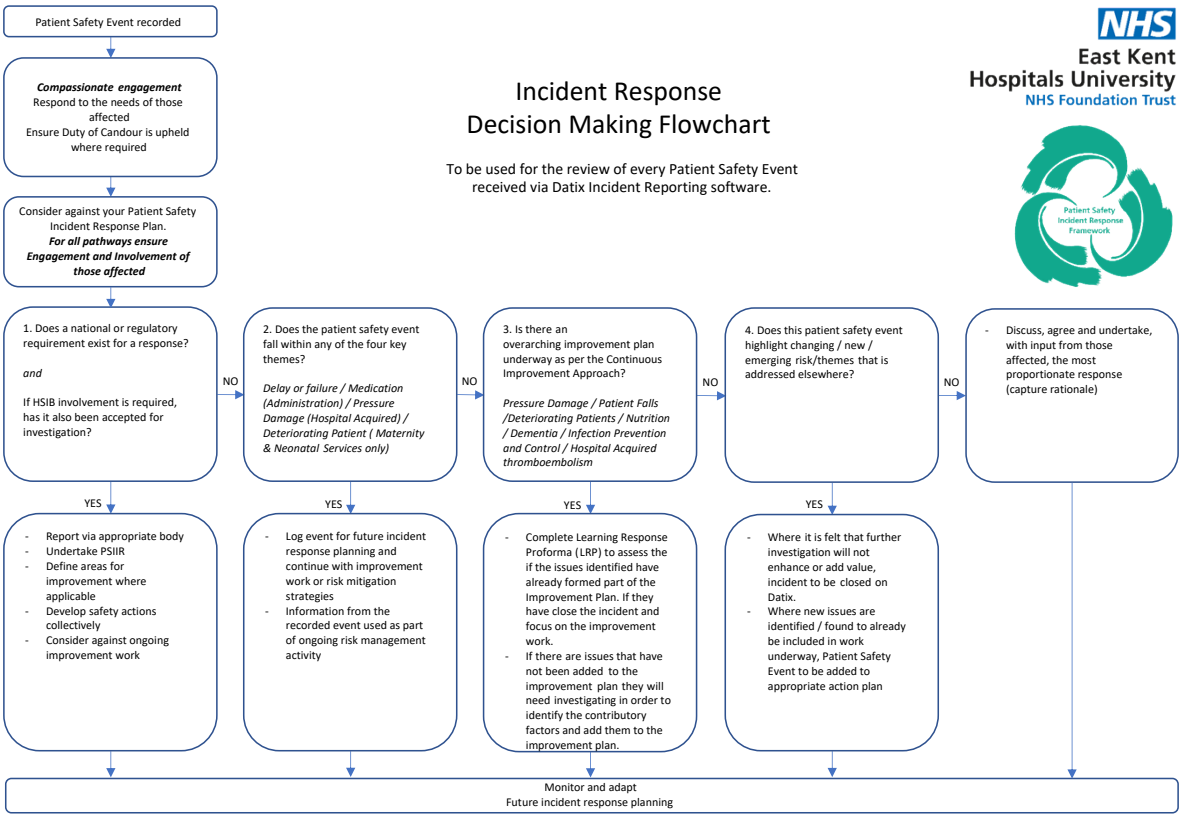
(appropriate links to be added here to complaints policy & PSIR Plan)

Appendix 1 Safety Action Development Process. (Safety Action Development Guide. *NHSE August 2022*)

Figure 1: Overview of safety action development process



Appendix 2. Incident Response Decision Making Flowchart.



This needs to be changed to landscape

East Kent Hospitals University NHS Foundation Trust

Patient safety incident response plan

Effective date: April 2024

Interim Review and Update: October 2024

Estimated refresh date: March 2025

	NAME	TITLE	SIGNATURE	DATE
Author	**Samantha Gradwell**	**Deputy Director of Quality Governance**		
Reviewer	**Melinda Brewer**	**Head of Clinical Safety & Improvement**		
Authoriser	**Sarah Hayes**	**Chief Nursing Officer**		
Authoriser	**Des Holden**	**Chief Medical Officer**		

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Forward

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I am very thankful for the input from all staff, for their dedication and commitment to the new Patient Safety Incident Framework planning and implementation in our Trust. Particularly our clinical staff and their commitment to delivering high quality patient safety for our patients, their families and carers.

We aspire to deliver compassionate, safe, effective and high-quality care to all our patient's families and carers, this will remain our highest priority. We strive to provide excellent care to ensure that any harm to patients is minimised, we aim to achieve this in all areas of our Trust.

This plan aligns with the National Patient Safety Incident Response Framework and will continue to develop as we work together to provide the best outcome and experience for every patient.

It is our hope that as the implementation progresses and becomes embedded over the coming years, the value of this transformation will be visible not only to our staff but all of our stakeholders.

Signature

Sarah Hayes

Chief Nursing and Midwifery Officer

Photo to be added

Introduction

This Patient Safety Incident Response Plan (PSIRP) sets out how East Kent Hospitals NHS Foundation Trust (EKHUFT) intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule and we can adapt the PSIRP accordingly with any learning during this period. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. Prior to further updates to this plan, we will conduct staff and Patient forums/surveys to seek views and assurance on those updates and on the effectiveness of our proposed plan. We will also use patient feedback and data sources, to inform those updates.

With the inception of the Serious Incident Framework from 2007 NHS Trusts were required to report to their commissioners and investigate many more serious incidents that met the threshold. Over the past seventeen years the NHS has matured and developed its understanding and the application of patient safety and risk in the delivery of patient care and minimising harm. During this time the types of incidents that have been investigated has also evolved with a significant increase in numbers of serious incident investigations. This has resulted in the NHS creating the need for a significant resource required to complete these investigations rather than focusing on continuous improvement. This emphasis is about to undergo a dramatic change with the introduction of the PSIRF. The new framework will transform how patient safety is understood and practiced across the NHS at all levels.

The aim of our plan is to minimise the resource dependency for investigations and redirect it to undertaking continuous improvement work, as a result of fewer, higher quality investigations that delve deeper into the contributory factors. The aim is that we develop specific and targeted solutions which result in demonstrable improvements in care. We now have the opportunity and freedom to respond in a proportionate way to all of our incidents by utilising both current and new responses in order to establish and implement learning. EKHUFT is in a unique position as we are also in the process of centralising our Care Group governance support, which will allow us the opportunity to re-design whilst standardising and ensuring consistency of approach to all aspects of the new framework.

Defining our Patient Safety Incident Profile

Our Approach

Two complete years, 2021/2022 and 2022/2023, of patient safety incidents were reviewed. This included all incidents including near misses and low and no harm. As our Trust experiences high reporting numbers we were assured that there would be an adequate number of incidents to review for the purposes of identifying our main themes. The Trust reports approximately 20 - 25 thousand incidents per year.

An analysis of our incident data within our Datix incident management system revealed where our highest number were reported. The table below shows the incident types in relation to our higher reporting rates.

Table 1. Shows the Incident Type with greater reporting rates over the previous two years.

Patient Safety Incident Type	2021/2022	2022/2023	Total
Delay / Failure	7699	4109	11808
Tissue viability (including Pressure Damage)	4624	5184	9808
Care and Treatment	2556	2496	5052
Medication	1897	2115	4012
Patient Falls	1818	2066	3884
Infection Control	1387	596	1983

Our Four Key Quality and Safety Themes for Improvement

These four themes will be the focus of the patient safety workstreams over the coming year. All four themes will also include our Maternity Services however the fourth theme ‘Deteriorating Patient (Maternal and Neonatal)’ is specifically for our Maternity Services.

Delay/Failure

One of our highest reported incident types was Delay/Failure. Further analysis showed that within this incident type a variety of issues were identified. These included the deteriorating patient, delays in diagnosis, delays in treatment, delays or failure in follow up (all of these included cancer patients), inappropriate or delayed transfer. Also work that had been scoped earlier in 2023 showed that there were issues within our electronic patient systems which created risks in terms of follow up, test results (including radiology results) going to the appropriate doctor and many more issues. These all feed into the

category of Delay/Failure. As this affects almost every specialty across the organisation the potential improvement in patient safety is significant. Complaints and the Patient Advice and Liaison Services (PALS) data confirmed this is a common theme across the Trust. Legal data showed that there have been claims that have included allegations around delays.

Further scoping is being undertaken to identify the specific areas to be selected for focus prior to undertaken the Patient Safety Incident Investigations (PSII).

Medication Safety

The data shows that there have been a total of 1679 administering incidents over the two years as well as1135 prescribing incidents. Medication incidents remain within the top 5 highest reported incidents over the previous two years. Although the levels of harm are mostly low or no harm the Trust has experienced 23 incidents where our patients have experienced moderate harm and above including 3 deaths. In April 2023 a new electronic prescribing software programme was introduced which was hoped to have an impact on incident rates for both prescribing and administering errors however the data does not demonstrate this.

Medication Safety, in particular medication administration, has been selected as our second key theme where there is a need for focused work, informed by PSII to identify what the Trust needs to achieve in order to improve patient safety in relation to medication administration.

Pressure Damage (Internal & External)

With 9808 Tissue Viability incidents reported over a two-year period this theme features consistently in the top 5 categories. Within this theme there are other tissue viability issues. Focusing solely on both ‘hospital acquired’ and ‘admitted with’ pressure damage the figures are as follows:

Table 2. Shows Hospital Acquired Pressure Damage rates for the previous two years.

Pressure Damage	2021-2022	2022-2023	Totals
Category 1	122	187	309
Category 2	305	323	628
Category 3	7	10	17
Category 4	4	2	6
Unstageable	80	104	184
Total category 3 and above	91	116	207
Total	518	626	1144

Table 3. Shows Admitted With Pressure Damage rates for the previous two years.

Pressure Damage	2021-2022	2022-2023	Totals
Category 1	326	359	685
Category 2	1538	1687	3225
Category 3	224	222	446
Category 4	116	74	190
Unstageable	254	327	581
Total category 3 and above	1365	623	1988
Total	3229	2669	5898

It is clear from the data that the hospital acquired pressure damage is significantly lower in numbers compared to the number of patients who are admitted with this condition. The level of care and nursing time with additional days in hospital to manage and treat the more serious cases has been shown to impact on patient's experience, often incurring extra treatment and requiring a higher level of dependency. There is an improvement programme that has been underway over the previous few years, addressing the issues in relation to hospital acquired case. This workstream has had some impact however with this new approach it is hoped that the level of improvement will be greater. This programme identified that if they were to address/prevent all cases of hospital acquired pressure damage this would save 16 extra bed days per days across the Trust.

For the first year it has been agreed that hospital acquired pressure damage cases will be the focus of our third theme whilst also working with the Integrated Care Board (ICB) and Primary Care GP practices to look at initiating a project to launch in our second year of PSIRF. This will focus on the 'admitted with' cases with a view to reducing these numbers as they are significantly greater and therefore the solutions may have a greater impact on improvement within the Trust. This is a system wide project and will need the support of the ICB however it will provide a potential for learning across the region and potentially impact on improving the safety for many of our patients both in hospital and in the community.

Maternity Services – Deteriorating Patient

The deteriorating patient within the maternity services has been noted as a theme. Further improvement work is required specifically in Maternity Services to address this issue. Further scoping is required for this theme. This work will include both maternal and neonatal deterioration.

Stakeholder Engagement

The following stakeholders were included in the development and/or agreement of these the safety incident profile:

- Our Corporate Patient Safety Team including the Trust Patient Safety Specialists.
- Care Group Governance Business Partners
- Head of Risk
- Legal Services
- Complaints and PALS Services
- Governors
- Trust Board
- ICB Lead for PSIRF
- Head of Transformation (leads on Corporate Improvement Team)

Data Sources

Data sources for this work has included:

- Datix Incident Management System
- Complaints and PALS data
- Legal services data
- Themes from Freedom to Speak Up
- Discussions with key speciality leads for each of the key themes selected.

24/12.3 – APPENDIX 1

Defining our patient safety improvement profile

Improvement Projects Underway Across the Trust.	
These projects are led by local staff with the support and oversight of the Corporate Improvement Team.	
Project Name	**Details**
Reducing Hospital Acquired Pressure Damage	These projects are in a number of areas across the Trust and tailored to individual wards.
Improving the documentation of Fluid Balance charts for patients	These projects are in a number of areas across the Trust and tailored to individual wards.
Reducing Surgical Site Infection rates.	
Improving IPC compliance.	There is currently a campaign 'CLEAN' that is being implemented Trustwide promoting essential standards of infection control for all staff.
Improving Cannula Care	This is focusing on Visual Infusion Phlebitis tool across specific areas of the Trust.
Releasing time to Care	Focusing on the reduction in sourcing equipment.
Improving VTE Assessments	Focusing on the completion of the risk assessment tool.
Releasing time to Care	Focusing on the reduction of waste on drug rounds.
Catheter Care	Including fluid balance and reduction of dehydration.
Improving the Nutrition scores and plans	Focusing on prevention of the deterioration of our patients.
Quality Improvement Projects led by Junior Doctors	
Improvements in advanced care plans for patients who are approaching the end of life.	This links in with the Quality Priority for this year and the coming year for the Deteriorating patient workstream.
Improvements in the administration of time critical medication e.g. insulin, anti-epileptics and Parkinson's medications.	Reducing iatrogenic harm to our patients.
A reduction in the number of inpatient falls by having a walking aid within easy reach for those that had an aid prior to admission.	Reducing Harm to patients.
Improvement in the skills of doctors with regards to the Pleural Ultrasound Scan Procedure.	This will offer safer care to these patients in the acute medical departments, Same Day Emergency Care (SDEC) and respiratory wards during the on-call hours at the WHH site.
Improvement in timely administration of a nerve block for patients presenting in the emergency department with multiple rib fractures.	This will offer safer care to these patients in the acute medical departments and emergency departments.

Use of qFIT (test for blood in the stool) in the Colorectal Cancer Pathway.	This has increased by 250% whilst also reducing the rejection rates from 8.4% to 2.4%. This approach is supporting the endoscopy service and enables them capacity to meet their 62-day Cancer targets.
Evaluation of the physiotherapy treatment for complex spinal patients across the Trust.	Ensuring patients received the most effective care for their needs.
Improve accessibility to secondary care therapy services for newly diagnosed patients with early onset Parkinsons disease.	Ensuring patients received the most effective care for their needs.

Quality Priorities for 2023/2024

There are workstreams / improvement programmes for each of the patient safety areas below.

- Deteriorating Patient Improvement Work
- Embedding Governance Processes within the Care Groups.
- Implementation of the National Patient Safety Strategy
- Maternity Services
- Timely Access to Services

The Quality Priorities for 2024/2025

Work will continue with these priorities, some of which were also a focus for the previous year, however there will be a different emphasis.

- Implementation of the Patient Safety Incident Response Framework.
- Maternity Services
- Timely Access to Services
- Deteriorating Patient
- NICE Guidance

24/12.3 – APPENDIX 1

Our Patient Safety Incident Response Plan: National Requirements

Introduction

The areas below have either a national or a statutory requirement to be reported and therefore there is little flexibility in the Trusts response. Where we do not investigate will be ensure that the Trust captures the learning and uses the current continuous improvement process to demonstrate improvement.

Patient Safety Incident Type	Required Investigation Response	Anticipate Improvement Route
Never Events	Patient Safety Incident Investigation. (PSII)	• EKHUFT have taking a proactive approach to Never Events by way of an annual audit programme that has been created for each relevant Never Event. • The audit will identify where actions arising from the Alerts and previous Safety Incidents have identified learning to ensure that they are both in place and effective. • Targeted work will be undertaken proactively to ensure that areas of improvement are addressed. This work commenced with the aim of reducing the number of reported Never Events in the coming years. There has also been focused work in Main Theatres to address any areas for improvement within our standards of practice. We aim to significantly reduce the rate of Never Events over the next two years. *It is noted that NHSE are currently reviewing the Never Events List. When this is published the work that is underway may be adapted to meet the requirements from this review.*
Deaths of persons living with a learning disability.	Refer for Learning Disability Mortality Review (LeDeR). Consideration for additional learning response at the Incident Response Panel.	• Develop safety actions or improvement plans to address new insight and/or emerging safety issues identified. • Where improvements plans are already in place incorporate the learning.
Deaths where a Structured Judgement Review has determined that the care likely	Consideration for additional learning response at the Incident Response Panel.	• Develop safety actions or improvement plans to address new insight and/or emerging safety issues identified.

contributed to the patient's death.	Patient Safety Incident Investigation (PSII)	• Where improvements plans are already in place incorporate the learning.
Safeguarding Incidents	Refer to Local Authority Safeguarding leads. Where appropriate the Trust will collaborate with the Local Authority to promote system learning. *Also detailed in our local plan.*	• Develop safety actions or improvement plans to address new insight and/or emerging safety issues identified. • Where improvements plans are already in place incorporate the learning.
Child Deaths	Refer for Child Death Overview Panel review. A local response may also be required which will be determined at the Incident Response Panel.	• Develop safety actions or improvement plans to address new insight and/or emerging safety issues identified. • Where improvements plans are already in place incorporate the learning.
Maternity and Neonatal incidents meeting Maternity and Newborn Safety Investigations (MNSI) reporting criteria. (Including Maternal Deaths)	• Refer to MNSI for independent Patient Safety Incident Investigation. • Provide required information to Mothers and Babies Reducing Risk through Audit and Confidential Enquiries (MBRACE). • Undertake local investigation if the Maternal Death is not accepted by MNSI. AAR or PSII depending on the circumstances of the incident.	• Develop safety actions or improvement to address new insight and/or emerging safety issues identified. • Where improvements plans are already in place incorporate the learning.
Incidents in NHS Screening Programmes	Refer to local screening quality assurance service for consideration of locally-led learning response.	• Develop safety actions or improvement to address new insight and/or emerging safety issues identified. • Where improvements plans are already in place incorporate the learning.
Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies,	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration of an independent PSII.	• Relevant learning from these investigations will be identified for the Trust and implemented appropriately through either entry onto an existing Improvement plan or as a result of safety actions.

where this is reason to think that the death may be linked to problems in care.		
Deaths in Custody, where health provision is provided by the NHS.	In prison and Police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the independent Office for Police Conduct (IOPC) to carry out the relevant investigations. The Trust will support these investigations as required.	• Relevant learning from these investigations will be identified for the Trust and implemented appropriately through either the continuous improvement or as a result of actions arising out of investigations.
Accidental or unintended exposure to Ionising Radiation	Refer to Ionising Radiation (Medical Exposure) Regulation. Review at the Incident Response Panel for consideration for the most appropriate local response.	• Develop safety actions or improvement to address new insight and/or emerging safety issues identified. • Where improvements plans are already in place incorporate the learning.
Hemovigilance	Relevant incidents should be reported to Serious Hazards of Transfusion (SHOT). A local response will be considered at the Incident Response Panel.	• Develop safety actions or improvement to address new insight and/or emerging safety issues identified. • Where improvements plans are already in place incorporate the learning.

Our Patient Safety Incident Response Plan: Local Focus

Introduction

As this is such a significant change in approach, we have considered three main categories;

1. the themes that have come out of the patient safety incident profiling, of which there are four.
2. those incidents where there are clear incident types together with high numbers of repeat incidents.
3. those incidents that do not fit into the national requirements or category 1 or 2 above. As the Trust progresses through the first six months of the Plan, it is anticipated that further learning will emerge on areas within the plan which will then be updated.

There may be occasions when the Trust must undertake investigative work with other organisations that have not developed the Systems approach outlined within PSIRF.

In these circumstances the Trust needs to either offer to support the investigation using the new approach or to provide the required information to the relevant organisation using the Systems Engineering Initiative for Patient Safety (SEIPS) methodology. This is to ensure that the learning specific to the Trust is maximised.

Any of the outputs (including thematic reviews) from this process may be shared with our commissioners to provide assurance that the Trust is able to identify our themes accurately, understand the associated contributory factors and develop the learning solutions required to demonstrate improvements. This will be undertaken upon discussion with our commissioners using a collaborative approach.

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Four Key Themes as a focus for Improvement over the next 12 months.		
Delay / Failure	1 – 2 PSII (These may or may not have multiple incidents) is suggested, to ensure that the Contributory Factors have been fully identified/validated. When sufficient system learning has been identified and or the improvement work is effectively focused/measurably improving and this has been agreed by stakeholders the investigative response will cease and improvement will become the focus.	Within six months demonstration that the improvements have started to impact on the safety of our patients. Specific measures will be developed.

	Develop the Improvement Plan with associated Metrics for assessing progress.	
Medication (Administration)	1 – 2 PSII to ensure that the Contributory Factors have been fully identified/validated. Develop the Improvement Plan with associated Metrics for assessing progress.	Within six months demonstration that the improvements have started to impact on the safety of our patients. Specific measures will be developed
Pressure Damage (Hospital Acquired)	1 – 2 PSII to ensure that the Contributory Factors have been fully identified/validated. Develop the Improvement Plan with associated Metrics for assessing progress. After six months work will be initiated to start to consider the programme for the next year in collaboration with the ICB.	Within six months demonstration that the improvements have started to impact on the safety of our patients. Specific measures will be developed
Deteriorating Patient to include both Maternal and Neonatal Deterioration. (Maternity Services only)	1 – 2 PSII to ensure that the Contributory Factors have been fully identified/validated. Develop the Improvement Plan with associated Metrics for assessing progress.	Within six months demonstration that the improvements have started to impact on the safety of our patients. Specific measures will be developed
Repeated Patient Safety Incident themes managed by an overarching improvement plan. (see Appendix 1). These will be overseen by the ICB as well as through the Trust governance processes. Pressure Damage and Inpatient Falls will be progressing initially prior to the 1st April 2024. This is owing to there already being an improvement plan in place. IPC will be transitioning in the second quarter and Nutrition and Dementia in the third quarter.		

For those themes that will not be transitioning until after the transition date the learning responses to their incidents will be aligned with PSIRF. Serious Incident Investigations will cease for all incidents on the date of Transition to this plan.		
Pressure Damage (PD) Transitioning prior to the 1st April 2024.	Validation of the Contributory Factors via PSII or learning response tools depending on the current level of knowledge. Review and update the improvement plan and redirect resource to focus on the implementation of the plan. Appendix 1 This is a 'defined process which moves away from investigating high numbers of similar incidents and focuses on the improvement work. As this is one of our key four key themes work will start immediately however following further PSIIs the Improvement plan will be updated with further learning.	• An improvement plan is already in place once validated add additional learning from PSIIs or other learning responses. • Agree improvement targets and ensure accurate data collection to demonstrate improvement. • Where there is poor progress consider further review and learning responses.
Patient Falls Transitioning prior to the 1st April 2024.	Validation of the Contributory Factors via PSII or SEIPS tools depending on the current level of knowledge. Review and update their improvement plan and redirect resource to focus on the implementation of the plan. Appendix 1 Defined Process for not investigating high numbers of similar incidents.	• An improvement plan is already in place once validated add additional learning from the PSII or other learning responses. • Agree improvement targets and ensure accurate data collection to demonstrate improvement. Where there is poor progress consider further review and/or learning responses.
Deteriorating Patients Transitioning during Quarter two. July – September 2024	Validation of the Contributory Factors via PSII or learning response tools depending on the	• An improvement plan is already in place once validated add additional learning from the PSII

	current level of knowledge. Create an improvement plan and redirect resource to focus on the implementation of the plan. Appendix 1 Defined Process for not investigating high numbers of similar incidents.	or learning response tools. • Agree improvement targets and ensure accurate data collection to demonstrate improvement. Where there is poor progress consider further review and learning responses.
Nutrition Transitioning from the third quarter. October 2024.	Validation of the Contributory Factors via PSII or learning response tools depending on the current level of knowledge. Create an improvement plan and redirect resource to focus on the implementation of the plan. Appendix 1 Defined Process for not investigating high numbers of similar incidents.	• An improvement plan is already in place once validated add additional learning from the PSII or learning response tools. • Agree improvement targets and ensure accurate data collection to demonstrate improvement. Where there is poor progress consider further review and learning responses.
Dementia Transitioning from the third quarter. October 2024.	Validation of the Contributory Factors via PSII or learning response tools depending on the current level of knowledge. Create an improvement plan and redirect resource to focus on the implementation of the plan. Appendix 1 Defined Process for not investigating high numbers of similar incidents.	• An improvement plan is already in place once validated add additional learning from the PSII (Approx 1 -2 will be required) • Agree improvement targets and ensure accurate data collection to demonstrate improvement. Where there is poor progress consider further review and learning responses.
Infection Prevention and Control (IPC) Transitioning by the end of the second quarter.	Validation of the Contributory Factors via PSII or learning response tools depending on the current level of knowledge. Create an improvement	• An improvement plan is already in place once validated add additional learning from the PSII (Approx 1 -2 will be required)

1st September 2024.	plan and redirect resource to focus on the implementation of the plan. Appendix 1 Defined Process for not investigating high numbers of similar incidents.	• Agree improvement targets and ensure accurate data collection to demonstrate improvement. Where there is poor progress consider further review and learning responses.
Hospital Acquired Venothromboembolism	There is a plan towards the end of the year to use the defined process for repeat incidents using an Improvement Plan approach. See Appendix 1. Until this has been completed each case will be assessed and a proportionate response will be undertaken. There may be targeted reviews which may include Multidisciplinary Review (MDR) and AAR. For low and no harm incidents there will be a Case Note review undertaken which will be benchmarked again best practice standards.	• Agree improvement targets and ensure accurate data collection to demonstrate improvement. Where there is poor progress consider further review and learning responses.
Incidents that have not been investigated at a national level and are not contained within either the three key themes or have an Trustwide improvement plan.		
Safeguarding Incidents	During the previous year the Trust undertook two thematic reviews. As a result of these reviews Trustwide improvement plans are now in place to drive up the quality of care for our patients.	Sustained progress within Safeguarding against the key themes that were identified during the 2023/2024.

	For all new incidents that are not addressed by the thematic review a proportionate response using either an After Action Review (AAR) or a PSII should be undertaken.	
Maternal and Neonatal incidents that do not meet the threshold for national reporting/investigation.	These will be assessed on a case by case basis to ensure that a proportionate response has been agreed that ensures that the learning has been gained. The response can include, After Action Review, SWARM, Multidisciplinary Team Review, PSII.	Actions arising from the incident response will be added to relevant Maternity local Improvement plans.
Incidents that are not included either within our four key themes or our improvement plan approach, where there is concern, should be reviewed at the Incident Response Panel and a proportionate response agreed that will maximise the learning potential. All moderate and above harm incidents will be assessed and consideration given to the appropriateness of bringing it to the Incident Response Panel for discussion.	For a list of possible responses please see Appendix 2.	

Appendix 1

Process for managing repeat incidents using an Continuous Improvement Approach

Phase 1

1. Identify those incidents where there are a high number of repeated incidents every month.
2. Identify key staff/teams that lead on the subject matter areas of focus.
3. Identify if there are already learning/Quality Improvement projects in place to address these issues.
4. Evaluate if further learning is needed or if assurance evidence can be taken with the current improvement process in place.

Phase 2

1. If assurance has not been gained regarding the identification of contributory factors, investigate up to 3 further incidents using the PSII or learning response methodology. Statutory Duty of Candour will be completed for applicable incidents.
2. Add the learning to the overarching Trustwide improvement plan.
3. Every subsequent incident that occurs will have a desk top exercise (Work Systems Scan) undertaken looking to identify if there were any new contributory factors / issues identified. If this is confirmed then those issues will be investigated, not the entire incident, and added to the overarching improvement plan.
4. If no new contributory factors have been identified no further review or investigation is necessary. The resource that would have been spent on the investigation will now be redirected to spend time on developing and implementing the improvement plan. A response will still be required to the patient for the purposes of the Statutory Duty of Candour. This can be in the form of a letter with an attached summary of the project being undertaken together with achievements and areas of continued work.

Phase 3

1. The desk top review (work systems scan) process will be documented on a short template to provide evidence of a review and assurance that the issues are being addressed.
2. A detailed summary of the improvement plan and progress will be developed to use this as a response to incidents that require the Duty of Candour and therefore a response to specific incidents.
3. Close monitoring of the pre-determined areas for improvement will be completed monthly.
4. Where progress is slow further review and/or learning responses will be undertaken to understand why and the learning will be added to the current improvement plan.

Appendix 2

Types of Incident Responses open to the Trust. (This list is not exhaustive)

- Patient Safety Incident Investigation
- After Action Review
- Multidisciplinary Team Review
- Structured Judgement Review
- Audit
- Risk Assessment/New Risk on the Risk Register
- Observation Guide
- Walkthrough Guide
- Link Analysis Guide
- Interview Guide
- Timeline Mapping
- Work System Scan
- Thematic Reviews
- Audit
- Research
- Medical / Nursing Opinion

East Kent Hospitals University NHS Foundation Trust

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

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

Meeting date: **27 February 2024**

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

Paper Author: **Executive Assistant**

Quorate: **No**

Appendices:

None

Declarations of interest made:

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

Assurances received at the Committee meeting:

Agenda item	Summary
Improving experience of patients staying in the Emergency Department (ED) for over 24 hours – Jointly William Harvey and Queen Elizabeth Care Groups	The Committee **NOTED** the report. The Committee had a robust discussion around patient flow in ED and the multi-faceted nature of this problem. The Committee received assurance that there was an intervention in place at every point of the process. The Committee is due to receive a further update on progress in April 2024.
Integrated Performance Report – Focused review of complaints	The Committee **NOTED** the work on complaints, including the increase in numbers and complexity in 2023. The response rate had decreased and the focus was now on the quality of investigations and written responses.
Patient Safety Incidents Response Framework (PSIRF) update	The Committee received the report and **NOTED** that the PSIRF Plan would be presented to the Board for virtual approval. Significant training was required for PSIRF and the specialist training was commissioned for the Chief Medical Officer (CMO) and Chief Nursing & Midwifery Officer (CNMO), with additional in-depth training being delivered to the relevant staff.
Patient Voice and Involvement bi-annual report	The Committee received an update and **NOTED** that there had been improved support and additional work looking at the experiences of other Trusts in the area.

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Progress against deteriorating patient improvement plan	The Committee received an update and **NOTED** that the majority of milestones were on track or have been completed. The Deteriorating Patient Education Programme was in the preparation stages.
Commissioning for Quality and Innovation (CQUIN) quarterly report	The Committee received an update and **NOTED** progress for Quarter 3 2023/24.
Update on Fuller Report	The Committee were provided with an update on the Fuller Report, which was also shared in January 2024. The Committee **NOTED** the recommendations and were satisfied with the progress made.

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	4 April 2024

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

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

Meeting date: **26 March 2024**

Chair: **Richard Oirschot, Non-Executive Director (NED)**

Paper Author: **Deputy Group Company Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

None

Assurances received at the Committee meeting:

Agenda item	Summary
Board Assurance Framework (BAF) and Significant Risk Register (SRR)	The Committee received a report to provide a regular update on the current Board Assurance Framework (BAF) and risks associated with Performance and Finance metrics. The Committee received an update from the Interim Chief Finance Officer (CFO) on each of the key risks associated to the FPC and noted that this was the first meeting in which the new BAF shaped the agenda of the meeting. A further deep dive item on the principal risks associated to FPC will come to a future meeting. The Committee noted that a final review of all significant risks was due to be completed shortly, by the end of the week, with final review underway by Executives. A final version of the SRR will be coming to the next meeting. The Committee noted the current position and received **ASSURANCE** on the Board Assurance Framework (BAF) and principal mitigated finance and performance risks.
Annual Plan 2024/25	A report was provided to review the draft annual plan for 2024/25. The Committee noted that at the time of the meeting, NHS planning guidance for the financial year had not been published, however, some unconfirmed planning assumptions have been shared in advance of publication.

	The Interim CFO noted that there were key risks which had been factored in which primarily were associated with: • Plans for delivery of the £49m for Cost Improvement Programme (CIP) in 2024/25, which were currently in progress. • The Trust will be required to manage its cost base in a more robust way than it has done previously over the last three years. This business planning is the first step to ensure delivery, however, it is a high-risk area to ensure the Trust sticks to plan across all care groups. • The Trust must work with the Kent & Medway (K&M) System to support the release of beds which are as a result of patients who meet No Longer Fit to Reside (NLFT) criteria and ensuring there is appropriate support in place with the Trust's commissioners across the financial domain. The Committee noted current draft modelling for the Trust's deficit for 2024/25, which detailed an interim draft deficit at £85.8m. This deficit represents a balanced plan, taking into account the risks above which must be managed to set the deficit as planned, and is subject to planning guidance and therefore is subject to change. The current draft deficit has been shared with NHS England (NHSE), and the Integrated Care Board (ICB), and they are currently supportive of the business planning. However, further work is required to ensure mitigation are in place for the key risks highlighted previously. The Committee **RECCOMENDED** to the Board of Directors that this plan is used as the Trust's interim budget, pending the publication of planning guidance. The Committee noted the draft Annual Planning for 2024/25 and received **ASSURANCE** on the plan for next financial year. A further report will come to the next meeting, once guidance was formally published.
2024/25 Cost Improvement Programme (CIP) Update	The Interim CFO, in collaboration with PricewaterhouseCoopers (PWC), provided an update to the Committee on CIPs across the Trust. As reported previously, the Committee noted that the CIP Value for 2023/24 was finalised in January 2023 at the RAG-adjusted FOT of £13.1m and, for February M11, that cumulative Forecast Outturn (FOT) has held. The focus for the team will now be on CIP values for 2024/25. The Committee noted at the time of the meeting, the pipeline of CIPs, was risk adjusted to £36.0m, reflective of CIP schemes being worked up in detail (including financial input, quality sign-off, and ultimately Executive sponsor sign-off). The sizeable challenge remains both in increasing the pipeline and

	developing the ideas into deliverable action plans which total a minimum of £49m fully RAG- adjusted for the end of March 2024. There was clear progress towards a plan in place for hitting this target, in line with a clear quality risk process with the Chief Medical Officer (CMO) & Chief Nursing & Midwifery Officer (CNMO). Following identification for the pipeline of CIPs, work is underway to ensure additional programmes were underway in case of slippage, with relevant documentation and accountability for delivery across the Trust, including at Care Group level. The Committee noted the CIP update and received **ASSURANCE** on the 2023/24 CIP delivery, and pipeline for CIPs across 2024/25.
2024/25 Capital Plan & Medium-Term Development	The Committee received an update on the short, medium, and long term, capital plan from the Chief Strategy and Partnerships Officer (CSPO). The Trust's overall capital allocation for 2024/25 is £22.1m, factoring in specific streams of money dedicated for programmes of work. The capital plan has been reviewed, and refreshed, based on highest-risk items as approved at Board. The Committee noted that next year's capital plan will require a large focus to ensure delivery, and will be a much more significant plan then previous years. The capital plan will need to focus around the Trust's focus on mitigating some of the significant critical infrastructure risks that the organisation is currently carrying. Within the coming year, the Trust will refresh its organisational strategies, along with the necessary enabling strategies, including clinical and estates strategies. The current draft 5-year plan shows that for the Trust to cover all high-risk projects it would result in a cost circa. £438m, and this is not accounting for any in-year ad-hoc projects which may occur, given the current estate risk across the Trust. As a result, work is underway to prioritise projects across the Trust, with final review with the executive team to ensure all potential projects are described. A draft timetable for the medium-term capital plan to be created was shared with the Committee, which resulted in a final plan being ready by end of Financial Year (FY) 2024/25. The Committee noted the 2024/25 Capital Plan and received **LIMITED ASSURANCE,** given the current lack a medium/long-term capital plan and current unforeseen risks which may arise in-year.

Integrated Performance Report (IPR) – National Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee received an update on the current performance metrics across the Trust. The Committee noted a significant reduction in the 78-week waiting list for elective care, with a plan to support all care groups to deliver on the Trust planned target of 651 patients waiting. As of March 2024, the Trust has already hit this target, with 595 currently on the waiting list. There are however still specific areas to target for further reductions, specifically within Otology and Functional Endoscopic Sinus Surgery (FESS) with Endoscopy & Cardiology having made further reductions then planned which has resulted in the current position. For Cancer treatment, the Trust had 554 patients awaiting cancer treatment for over 62 days in February, that number has reduced to 196. Additionally, the number of patients waiting over 104 days has dropped from 105 to 55. This, again, shows a significant reduction in the waiting list for cancer services. The Committee noted that there is still a significant amount of work to fully reduce waiting lists across the Trust, however, it is a positive step which shows significant work which has been undertaken across the entire Trust. The Committee specifically highlighted the need to look forward into 2024/25, and requested a trajectory is shown for the next year, understanding what is possible and what are the lessons learnt from this process to ensure delivery. The Committee noted **ASSURANCE** on the levels of operational performance across the Trust.
Month 11 Finance Report	The Committee received a report on the current Month 11 position of the Trust. The Director of Finance (DoF) updated that the Trust have delivered the forecast position for month 11, in line with the £117.4m year-end deficit agreed with the national team. The Committee noted Month 11 shows further improvement in the group's financial position. Agency employee expenditure continues to fall, and substantive staffing spend also fell back in month (following the non-recurrent impact of January's industrial action). The Committee requested an update on a previous risk highlighted to the group regarding substantive staffing for the internal finance team, given recent planned departures. The DoF updated the committee on the current recruitment process for the finance team, which noted that all roles were substantively filled with final checks underway. The Committee received **ASSURANCE** on the Month 11 Finance Report

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Meeting Assurance Reports	The Committee noted the assurance report from the Capital Investment Group (CIG) and Business Case Scrutiny Group (BSCG) and received **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	04 April 2024
The BoD is asked to **APPROVE** the draft 2024/25 Annual Planning and use it as the trust's interim budget, pending the publication of planning guidance.	Decision	04 April 2024
The BoD is asked to **APPROVE** the Integrated Performance Report (IPR).	Decision	04 April 2024
The BoD is asked to **NOTE** the Month 11 Financial Position.	Information	04 April 2024

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East Kent Hospitals University NHS Foundation Trust

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

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

Meeting date: **27 February 2024**

Chair: **Richard Oirschot, Non-Executive Director (NED)**

Paper Author: **Deputy Group Company Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

None

Assurances received at the Committee meeting:

Agenda item	Summary
Business Planning Update – 24/25 Forecast	A report was provided by the Chief Strategy and Partnerships Officer (CSPO) with an updated forecast for 2024/25 business planning. The Committee noted that national guidance had yet to be issued, however, it was important the Trust was on a front foot for planning the next financial year given the current significant deficit. The planning highlighted the current indicative planning guidance, which will be a significant challenge for EKHUFT to currently meet. The Executive team confirmed a number of exercises were underway to kick-start the planning process, including capital planning for 2024/25. The Committee received **LIMITED ASSURANCE** on the current Business Plan for 2024/25 given the lack of national guidance to compare to. The Committee were **ASSURED** that work was already underway to start the planning process.
Cost Improvement Programme (CIP)	A report was provided in conjunction with Pricewaterhouse Coopers (PWC) on the current CIP across the Trust. The report provided high-level detail of the current programme, which was on target to deliver. Furthermore, a weekly Programme Management Office (PMO) update would be provided to the Committee moving forward, which started this week. The Committee noted that significant progress has taken place, with a revised governance structure, and recent leadership event mobilising the

	need for a strong cost improvement programme from all leaders across the Trust. It was noted that the next couple months will be key for delivery, as although good progress has been made, further work was required. The Committee noted that the Trust were moving at the expected rate to meet the Cost Improvements highlighted, however, there was a significant risk if any timelines were to slip. An importance was highlighted on the constant need to provide clear communication to senior leaders across the Trust, and a full Communications Campaign was underway to ensure this was at the front of all staff members minds. The additional grip and control measures previously put into place (such as the Non-Pay Panel and Vacancy Control Panel) remain in place, and have been working effective to reduce the run rate month-on-month. The Committee received **LIMITED ASSURANCE** on the CIP with work still required to clearly detail the CIP requirements for next financial year, although current CIP targets were on track.
Length of Stay (LoS), Flow and Theatre Utilisation Update	A report was provided to update on the Length of Stay (LoS) and Flow and Theatre Utilisation work underway across the Trust in collaboration with PRISM/KPMG. The Chief Operating Officer (COO) provided an extensive report on the work currently underway across the Trust, however, commented on the need for significant clinical behavioural change for implementations to take place. The Trust currently utilised a high number of escalation beds across the Trust, which needed to be stood down. The Committee noted a significant piece of work to provide bed modelling was underway, and this will be presented to the Board of Directors (BoD) at their next Development Day in February. The next stage was to engage with local Trusts and Social Care to review next steps. The Committee received **LIMITED ASSURANCE** on the work which can be completed for LOS across the Trust, including the potential opportunities at site level. The Committee will receive a further update on the next stages of the programme at a future meeting.
Month 10 Finance Report	The Committee received a report on the current Month 10 position of the Trust. The Interim Chief Finance Officer (CFO) noted that the monthly position continued to build on the positive progress seen in Month 9, although there was still a significant planned deficit.

	Agency and Bank expenditure continued to fall, and as a result, the Trust has met its forecast position in line with the £117.4m year-end deficit. The Trust's substantive staffing spend increased in month, which was expected, due to the prolonged industrial action during early January. The Committee noted that the Trust received confirmation of the 2gether Support Solutions (2gether) industrial action ending, due to an agreed position. The Committee received **ASSURANCE** on the Month 10 Finance Report.
Board Assurance Framework (BAF) and Corporate Risk Register (CRR)	The Committee received a report to provide a regular update on the current BAF and risks associated with Performance and Finance metrics. The Committee discussed current risks associated with Capital Expenditure, given the significant capital risk across the Trust's estates, however, noted the aspiration to improve risk scores and continually review on a monthly-basis. The Committee noted the current position, and **ASSURANCE** on the BAF and principal mitigated finance and performance risks.
Integrated Performance Report – National Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee received an update on the current performance metrics across the Trust. The Committee discussed the current endoscopy waiting list, which had over 12,000 on the current waiting list. The COO noted that Kent and Medway system had launched an endoscopy strategy, and further work was underway to ensure the Trust was complaint with the latest guidelines. Once the Trust has finished this work, the Committee will receive an update on next steps and what a sustainable waiting list will look like, and if the Trust had enough capacity to meet the current demand across East Kent. The Committee noted the current impact of the failure of facilities and estates conditions as this had not been detailed within the Integrated Performance Report (IPR), or the operational impact this has. The COO confirmed this would take place in future iterations of the IPR. The Committee noted **LIMITED ASSURANCE** on the levels of operational performance across the Trust.

Cancer Waiting Times and Diagnostics	A report was provided to the Committee on current Cancer Waiting times and Diagnostics across the Trust. The COO confirmed that the 62-day RTT standard refers to patients who have been referred for suspected cancer from any source and go on to receive a diagnosis should start treatment within 62 days of their referral. The Committee noted that as of w/c 15 January 2024: • The Trust reported 599 patients waiting over 62 days. • The Trust reported 113 patients waiting over 104 days. This number has reduced in February, with figures at w/c 12 February 2024: • The Trust reported 381 patients waiting over 62 days. • The Trust reported 76 patients waiting over 104 days. The COO confirmed that specific focus to improve the waiting list was underway, including the stand up of a Cancer Delivery Group which had representation from all cancer pathways. The Committee noted that this was an improved position, however, significant further work was required to tackle the backlog. The Committee discussed and received **LIMITED ASSURANCE** on the Cancer Waiting Times and Diagnostics.
Updated Workforce Review	The Committee heard an update from the Deputy Chief People Officer (DCPO) regarding the current Workforce Saving Schemes across the Trust. The Committee noted that a significant part of the CIP related to Workforce Saving Schemes, including an ongoing Admin and Clerical Consultation. The report highlighted that stage one of the process was to eliminate long-standing vacancies across the Trust's admin and clerical groups, which resulted in c.177 posts being removed from the Trust's baseline. This also included the introduction of an executive-led Vacancy Control Panel (VCP) which would be required for all substantive appointments across the Trust. The Committee noted that the next stage of the process was an Administration and Clerical Workforce Realignment, which aimed to review c. 90 posts across all clinical and back-office functions across the Trust. The report highlighted that further work was underway to identify roles across the Trust which could be realigned, with a consultation launched for affected staff.

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	The Committee were **PARTIALLY ASSURED** on the current Workforce Review underway, and requested regular updates to take place moving forward.

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	6 April 2024
The BoD is asked to **APPROVE** the Integrated Performance Report (IPR)	Decision	6 April 2024
The BoD is asked to **NOTE** the Month 10 Financial Position	Information	6 April 2024

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

Committee: Integrated Audit and Governance Committee (IAGC)

Meeting date: 26 January 2024

Chair: Dr Olu Olasode, Non-Executive Director

Paper Author: Board Support Secretary

Quorate: Yes

Appendices:

Appendix 1: Confirmation of Final Emergency Preparedness Resilience and Response (EPRR) Assurance Outcome and letter of confirmation from NHS Kent & Medway Integrated Care Board (ICB)

Declarations of interest made:

No additional declarations of interest made

Assurances received at the Committee meeting:

Agenda item	Summary

Internal Audit Progress Report	• The Committee received **Partial Assurance** from the Internal Audit progress report:
	• Four audit reports issued since last meeting:
	  • Serious Incidents (SIs) (Reasonable Assurance): Improvements in the governance and management of SIs, with issues raised and actions to be addressed to further improve timely management. There have been improved processes around lessons learnt and themes, and these being shared throughout the Trust;
	  • Locum Recruitment (Partial Assurance): great deal of work undertaken to improve processes, there remained gaps in compliance, with issues raised and actions to be addressed to ensure compliance was consistent. Additional work agreed in the 2024/25 audit plan to look at the financial implications and costs. The Committee highlighted this was a key risk impacting patient safety, actions needed to be addressed and embedded promptly to provide assurance of consistent compliance;
	  • Legal Services (Partial Assurance): review of obtaining external legal advice and associated costs, with issues raised and actions to be addressed for improvements;
	  • Staff Wellbeing (Reasonable Assurance): Review of risk of impact of staff sickness and turnover, noting the Trust has taken significant action with provision of support for staff. Issues raised and actions to be addressed relating to Medical Sickness

	to ensure processes in place to accurately record this information. The Committee noted it was important to see outcomes from initiatives implemented and impact whether improvements have been achieved. • Good progress on follow up of actions, with reduction in overdue actions since the previous Committee meeting, and no high priority actions overdue. • Final Internal Audit Reports to be presented to Executive Management Team (EMT) to ensure monitoring of progress of actions, that these were being implemented by the relevant teams, and oversight from the responsible Executive Director.
Local Counter Fraud Specialist (LCFS) RSM Risk Assurance Services LLP – Progress Report	• The Committee received **Assurance** and noted the LCFS progress report and detailed activity. • The Committee noted conflicts of interest testing had been finalised and the report outcome will be presented to the next Committee meeting. • The Committee noted twelve ongoing cases, four referrals closed, and since the report presented there had been two further referrals received.
External Audit Grant Thornton (GT): External Audit Progress Report and Sector Update	• The Committee received **Partial Assurance** from the External Audit progress report, the timeframe for the 2023/24 annual external audit, and the sector update. • The Committee noted strengthened support from the external audit team assisting the annual external audit, emphasising the required submission deadline must be met. Detailed planning, asset testing and audit work will progress in February 2024, and from this date regularly bi-weekly meetings would be held with the Interim CFO to monitor progress, plan being robustly project managed and any risks impacting delay in delivering against the deadline will be escalated. • The Committee requested a briefing be produced and circulated to IAGC members on the programme management, escalation and raising of any issues on the annual external audit, to provide the required assurance that the 2023/24 annual accounts will be submitted by the deadline.
Review and Lessons Learnt – Annual Audit 2022/23	• The Committee received **Partial Assurance** from a verbal report noting an initial draft report shared with IAGC members, this will be circulated to External Auditors and management for review. • The final report will be presented to the next Committee meeting, will include identified recommended actions, is forward looking addressing previous issues and assisting with the smooth running and submission of this year's 2023/24 annual audit.
Risk Register Review Update and Risk Review Group Chair Report	• The Committee received **Assurance** from improved Risk Register Report and activity taken by the Risk Review Group.

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	• The Committee noted review and validation work continued, expected to be completed at the end of March 2024. • Now one overarching risk register in place, with a separate Significant Risk Register highlighting risks scored 15 or above. • Positive progress in closing a number of risks, re-wording of risks to accurately describe the risks, as well as clarification around mitigating actions. • The Committee noted detailed discussions, review, monitoring and challenge of actions to mitigate risks at the Risk Review Group that included Executive Director and senior leadership representation, with escalation to the Clinical Executive Management Group (CEMG). Group meetings will include a rolling programme of deep dive reviews of risks. It was agreed the approved Group Terms of Reference (ToR) to be circulated to Committee members and attendees for information. • Internal Audit will be undertaking an annual review of the risk register, and the Committee noted the need for this to focus on risk definition and scores, and that the control actions were effective in mitigating and reducing the risk scores.
Board Assurance Framework (BAF) January 2024	• The Committee received **Assurance** from the improved new BAF format that reflected the corporate strategic risks, and clearly identified leads, provided concise heat map for risk scores along with monthly progress updates. The BAF had been presented, reviewed and discussed at the individual Board Committees. • Executive Director leads will continue to regularly review the BAF. • The Committee suggested an amendment incorporating details of the expected outcome from actions. • The Committee discussed the Trust's Cost Improvement Programme (CIP) and IAGC monitoring assurance against the governance process. It was agreed a report will be presented to the July 2024 Committee meeting on progress and assessment of the CIP year-end target, achieving efficiency savings against the 17 workstreams and themes, any identified gaps and risks, and actions being embedded. • The Committee emphasised staff culture was a vital component in ensuring the Trust's future financial sustainability, improving this, engaging and involving staff to affect change, and robust staff communications.
Good Governance Institute (GGI) Governance Review	• The Committee received **Partial Assurance** from the verbal update noting the finalised report will be presented to the April 2024 Committee meeting for discussion. • The Committee requested the finalised report be circulated to IAGC members for review, feedback and comments to the Chief Executive prior to its presentation in April.

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Risk Management and Governance: The New Governance Framework	• The Committee received **Assurance** from the further progress update report, noting implementation of the governance structure in the new Care Groups. • The Committee noted the GGI governance review also included looking at and testing this structure and feedback will be provide in the GGI finalised report.
PricewaterhouseCoopers (PwC) Financial Controls Report	• The Committee received **Assurance** and from the report, also presented and discussed at the Finance and Performance Committee and Board of Directors. • The Committee received assurance around robust monitoring, this will be through progress against recommendations that will be discussed bi-monthly at meetings of the Finance Improvement and Oversight Group (FIOG) and CEMG; • The Committee will receive a progress report at its July 2024 meeting following PwC's re-assessment of progress against the financial controls recommendations and future financial sustainability providing independent assurance of progress. • The Committee emphasised it was important to receive assurance around embedding financial control improvements, staff culture around robust financial management and responsibilities, and these being sustained.
2gether Support Solutions (2gether) Annual Report and Financial Statements for the year ended 31 March 2023	• The Committee received **Assurance** from the Annual Report and Financial Statements for the year ended 31 March 2023 for 2gether. • The Auditor confirmed unqualified opinion. • 2gether's Audit and Risk Committee had reviewed and discussed the Annual Accounts and Audit Report in detail.
Update on the Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD)	• The Committee received **Partial Assurance** from the update report on SFIs and SoD, noting the ongoing review work, and the revised document expected to be presented for approval at the April 2024 Committee meeting. • The Committee noted proposed changes to approval of requisitions and invoices for payment that would ensure correct and effective levels of budget holder authorisation.

Single Tender Waiver (STW) Report and Benchmarking Report	• The Committee received **Assurance** from the STW report for quarter three 2023/24.
	• The Committee noted:
	  • Trust approved 16 STWs with a total value of £864k;
	  • 20 STWs with a combined value of £1.97m had been rejected during Financial Year (FY) 2023/24 Year to Date (YTD);
	  • No Declarations of Interest;
	  • Four No Retrospective Approvals of STWs.
	• The Committee received **Assurance** from the STW benchmarking report noting:

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	• Reduction of 20% in STWs since 2021/22 (from 286 to 207); • Reduction in total value from £18m to £12m; • STWs will continued to be monitored by LCFS.
Confirmation of Final Emergency Preparedness Resilience and Response (EPRR) Assurance Outcome	• The Committee received and noted **Assurance** from the EPRR Assurance Outcome report, appended to this report (Appendix 1) for noting by the Board of Directors. • Report provided assurance of agreement by NHS Kent & Medway Integrated Care Board (ICB) of the Trust's self-assurance position of fully compliant in the annual assessment against the NHS England Core Standards for EPRR.

Other items of business
The Committee noted the 2024/25 IAGC Annual Work Programme, and following completion of the governance review and assurance of the governance structure map, there will be a review of the Committee annual work programme.

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

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this assurance report from IAGC.	Assurance	To Board on 4 April 2024.

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REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Confirmation of final Emergency Preparedness Resilience and Response (EPRR) Assurance Outcome**

Board sponsor: **Interim Chief Operating Officer (COO)**

Paper Author: **Head of Emergency Planning & Resilience**

Appendices:

Appendix 1: Letter of confirmation from NHS Kent & Medway Integrated Care Board (ICB)

Executive summary:

Action required:	Information
Purpose of the Report:	To provide assurance to the IAGC and subsequent Trust Board that NHS Kent & Medway ICB have agreed the Trust's self-assurance position of fully compliant in the annual assessment against the NHS England Core Standards for EPRR.
Summary of key issues:	A report was submitted to the IAGC on 7 November 2023 outlining that the Emergency Planning team had self assessed the Trust as fully complaint against the NHS England Core Standards for EPRR. This assessment was submitted, with evidence, to NHS Kent & Medway ICB, who have agreed with the position. NHS England define Fully Compliant as: The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards.
Key recommendations:	The Board of Directors is asked to **NOTE** this report for information.

Implications:

Links to Strategic Theme:	• Quality and Safety
Link to the Trust Risk Register:	N/A
Resource:	No
Legal and regulatory:	NHS England Core Standards for EPRR are aligned to the Trusts duties, as a Category 1 Responder, under the Civil Contingencies Act (2004). The Trust has met these duties.
Subsidiary:	No

Assurance route:

Previously considered by: Integrated Audit and Governance Committee (IAGC) – 26 January 2024

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NHS Kent and Medway ICB
Gail House
Lower Stone Street
Maidstone
Kent
ME15 6NB

Jane Dickson
Accountable Emergency Officer
East Kent Hospitals University Foundation Trust

Sent via email

Monday, 18th December 2023

Dear Jane,

RE: NHS England EPRR Assurance 2023 – East Kent Hospitals University Foundation Trust

Firstly, can I thank East Kent Hospitals University Foundation Trust EPRR Lead, Hayley Lingham, for her work with Kent and Medway ICB's EPRR team during this year's assurance process.

As discussed at the LHRP Executive Group meeting on 20th November 2023, East Kent Hospitals University Foundation Trust have been assessed as **Fully compliant** against this year's NHS England EPRR core standards.

NHS England define Fully Compliant as: The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards. Congratulations on this well-deserved achievement.

As outlined at the LHRP Executive Group meeting, Kent and Medway ICB and LHRP partners are looking to continue to build on the EPRR assurance process with an agreed ambitions for the coming year:

- For every LHRP member to either maintain their current level of compliance or for those requiring it – to move up at least 1 compliance level in the coming year.
- This will be delivered with support from the wider Local Health Resilience Partnership working collaboratively together

On behalf of the Kent and Medway Local Health Resilience Partnership and NHS Kent and Medway ICB, our sincere thanks for your help and assistance in completing this year's annual EPRR assurance process, and once again, well done.

Yours sincerely

Mike Gilbert
Executive Director of Corporate Governance
NHS Kent and Medway
Co-Chair of the Kent and Medway LHRP

Dr Anjan Ghosh
Director of Public Health

Kent County Council
Co-Chair of the Kent and Medway LHRP

Dr James Williams
Director of Public Health

Medway Council
Co-Chair of the Kent and Medway LHRP

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

Committee: Charitable Funds Committee (CFC)

Meeting date: 14 March 2024

Chair: Claudia Sykes, Non-Executive Director (NED)

Paper Author: Committee Chair

Quorate: Yes

Appendices:

No

Declarations of interest made:

None received

Assurances received at the Committee meeting:

Agenda item	Summary
Charitable activities	The Committee noted the very successful work of the Charity team over the festive season.
Investment fund	The Committee received a presentation from Cazenove on the Charity's £2.1m investment portfolio, which noted ongoing uncertainty in the financial markets. The Committee approved moving more of the portfolio into equities to have more likelihood of obtaining a financial return of Consumer Price Index (CPI) +3%, the agreed target.
Charity finance report	The Committee received assurance over the Charity's financial position at 31 January 2024, noting net assets of £2.1m. £673k of this has been committed from previous grant approvals. Income of £453k Year to Date (YTD) was below plan of £529k due to legacies in the pipeline.
Grant applications	The Committee approved three applications under £100k. The Committee recommended for approval to the Board an application for the relocation and refurbishment of the **William Harvey Hospital (WHH) Bereavement Suite for £169k**. The proposal will enable significantly improved facilities for families with separate access. It will enable parents to have time together in early labour and following delivery. Facilities will include a double bed, bathroom and kitchenette - a private and quiet space to spend time as a family, with the

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	opportunity to have baby by the bedside in a cold cot, according to the parents' wishes. The relocation of the suite was highlighted by the Care Quality Commission (CQC) as a "must do" for the Trust. The Committee noted that the Charity had limited funds available within maternity and WHH. The Committee therefore agreed: - A fundraising campaign should be launched to raise funds for this worthwhile cause, and also discuss with the Friends of WHH. - Review the Charity's funds to assess if there is an opportunity to utilise dormant restricted funds. **Should the Charity be unsuccessful in securing full funding, the Charity requests that the Trust underwrites any remaining cost of the application**.

Actions taken by the Committee within its Terms of Reference:

The Committee approved grant applications for:

- Reminiscence Interactive Therapy and Activities (RITA) machines to support patients living with dementia £60k.
- Cold Cap machines WHH and Queen Elizabeth the Queen Mother Hospital (QEQM) £76k.
- Chief Nurse Fellowship Programme £39k.

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

None

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

The Charitable Funds Committee ask the Board of Directors to **APPROVE** the £169k Maternity Bereavement Suite grant application agreeing to underwrite any remaining cost of the application should the Charity be unsuccessful in securing the full cost via fundraising.

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BOARD OF DIRECTORS (BoD) ASSURANCE REPORT

Committee: Women's Care Group Maternity and Neonatal Assurance Group (MNAG) Chair's Report

Meeting dates: 13 February 2024 and 12 March 2024

Chair: Chief Medical Officer (CMO) and Chief Nursing and Midwifery Officer (CNMO)

Paper Author: Director of Midwifery (DoM)

Quorate: Yes

Appendices:

Appendices Provided in Reading Room (Documents for Information)
Appendix 1: Perinatal Quality Surveillance Tool (PQST) – January and March 2024
Appendix 2: Maternity and Neonatal Improvement Programme (MNIP) – Workstreams 1, 2, 3, 4, 5 and 6
Appendix 3: Kent County Council (KCC) Consultation
Appendix 4: Care Quality Commission (CQC) Update: Estates and minor work – February and March 2024
Appendix 5: Maternity Information System
Appendix 6: Listening to Women and Families
Appendix 7: Obstetric Medical Workforce
Appendix 8: Small Steps Bereavement Team – One year on

Declarations of interest made:

No

Assurances received at the Committee meeting:

Papers for discussion /approval	Assurance
Perinatal Quality Surveillance Tool (PQST) and Maternity Dashboard	**PQST and Maternity Dashboard presented for the period January and February 2024** As presented both papers highlighting areas of positive performance and areas for improvement that the team are currently addressing from both the PQST tool and the overarching maternity scorecard. • The rate of reportable neonatal and perinatal deaths remains lower than the Trust comparator group average. The rolling 12 month Stillbirth rate is now at 1.59 per 1000 births compared to the comparator average of 3.92/1000.

	• The extended perinatal rate (Stillbirths and Neonatal deaths up to 28 days) is now at 3 per 1000 births compared to the comparator average of 5.87 per 1000 births. • There is a need to now explore disparities that may exist within these outcomes. • One:One care in labour and the supernumerary status of the coordinator were both achieved in month and 100% compliant. • Two Serous Incidents (SIs) declared in January both at the William Harvey Hospital (WHH) (one Maternity and Newborn Safety Investigations (MNSI) and one local SI) and none in February. • Practical Obstetric Multi-Professional Training (PROMPT): Anaesthetic consultant and doctors on trajectory for more than 90% compliance by the end of the financial year. • Friends and Family Test (FFT) response rate 11.7% with 92.2% of families responding that their care was very good or good.
Maternity and Neonatal Improvement Programme (MNIP) Update	The DoM discussed the highlights from each of the six maternity workstreams. A detailed report was provided for each workstream demonstrating progress against the year one milestones. Most of these have already been achieved (six months on) . The team met in January to review progress and agree priorities for year two. As a part of the programme the Maternity team are undertaking the perinatal culture programme. The results of the local score survey have been shared with the local team at a series of externally facilitated meetings in March 2024. A report will also be shared with the board. Ahead of this the Quad met with the external team to agree the 'purpose' of the Quad. This is important in relation to developing an integrated leadership approach and a shared common purpose.
Kent County Council (KCC) Consultation	This paper summarised the current consultation in relation to the proposed closures of children's centres and the impact on community midwifery antenatal care. 7 existing centres that are used to provide antenatal care will be closing resulting in a need to provide those services at alternative venues. There is currently a lack of clarity in relation to timescales (it is implied that this can be as early as May 2024). This issue has been added as a risk within the LMNS. DH suggested a letter to the ICB in relation to closures with a request for suitable timescales to enable planning and communication with women and families
Care Quality Commission (CQC) Update: Estates and minor work	The paper focussed on estates work that has been undertaken in response to the CQC must and should do's. Whilst there have been significant improvements across the sites, some larger projects are currently awaiting decisions in relation to funding. Until the completion of the new medication room (start date week commencing 19 February), the Bereavement Facility at WHH, WHH triage work and the second theatre at Queen Elizabeth the Queen Mother Hospital (QEQM) the Trust cannot declare full compliance with Regulation 15(1) (c).

	The plans to progress building the second theatre at QEQM with support from potential external funds from NHS England (NHSE) continue. Exploratory surveys to be conducted to support the exact costs to facilitate the bid to NHSE.
Clinical Negligence Scheme for Trusts (CNST) compliance- Quality Improvement System (QIS) and Prompt action plans	The Trust declared compliance with Maternity Incentive Scheme (MIS) Year 5 with two action plans to be reviewed and progressed prior to the end of the financial year. QIS Nurses: Papers presented in both the February and the March MNAG providing assurance to the MNAG that with existing mitigation all shifts were covered with a QIS nurse. A recruitment plan is in place. PROMPT Training: As provided the current data in relation to Anaesthetic compliance. The team are on track for achieving 90% compliance before March 2024.
Maternity Information System	The paper updated the MNAG on the National Patient Safety Alert in relation to the Maternity information system currently used at EKHUFT and all other maternity services in the local LMNS. The alert highlights a back-copying issue in which a number of answers in the Euroking System alters entries previously added to the system. This presents a risk in relation to the accuracy of clinical information accuracy and data quality. Other than to create a bespoke assessment for every contact to date the company have been unable to rectify the issue. The team are working with the LMNS in relation to a system wide procurement which given the national alert may need to occur at pace. Added to the Risk Register Risk 3386
Listening to Women and Families	As provided a report which summarised complaints received in the calendar year of 2023. During that period of time the maternity service received 105 complaints. In the same period 5624 gave birth at EKHUFT. The report outlines key themes arising from the complaints and actions taken in response to these themes. These actions have also been included in the annual workplan for the Maternity and Neonatal Voices Partnership (MNVP) to ensure coproduction. Key themes: Postnatal Care Consent Attitudes and Behaviours Delays – discharges, pain relief A number of actions have been undertaken including: Use of patient stories Observations of practice Consent training

	Development of a coproduced postnatal booklet Commencement of Facebook 'lives' QI projects linked to this feedback including improving discharge processes and antenatal education have been included as workstreams within the MNIP
Obstetric Medical Workforce	This paper was presented to the Clinical Executive Management Group (CEMG) to provide an update in relation to the Obstetric workforce across EKHUFT. A change was put in place recently from the 24 hour on call rota. The team will continue to monitor the impact of this.
Small Steps Bereavement Team – One year on	The Small Steps Bereavement team was launched in March 2023. The team was launched following a co-produced project team which included 27+ women and families. The team was recruited by bereaved families – the job descriptions (JDs) were developed and approved by the bereavement steering group. In 2023 East Kent adopted the National Bereavement Care Pathway. Bereaved women and their families are offered pure continuity of care during their subsequent pregnancy – antenatal, intrapartum and postnatal care. • The current caseload is >50 women. • 31 women have birthed their rainbow babies Any woman who has experienced a loss during their pregnancy or in the postnatal period have immediate access to a specialist bereavement midwife. The bereavement midwife will provide continuity of care and support the family for as long as required. There are 25 bereavement champions across gynaecology and maternity – in year two this training will continue. A New guideline has been developed and ratified – this was reviewed and approved by bereaved families. The team have been nominated by families for a Mariposa award.
Matters to escalate to Q&SC and Board	Letter to Integrated Care Board (ICB) requesting a suitable notice period – in relation to closure of children's centres and the impact on women and families. Maternity Information System - National Alert in relation to Euroking and back copying and procurement of an IT solution. Estates linked to CQC must dos that are still outstanding – Bereavement Suite. MNSI – Letter of escalation and actions taken. Feedback from Safety Champions. Staffing at WHH, CQC response and actions.

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

None

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

Item	Purpose	Date
MNAG asks the BoD to discuss and **NOTE** this MNAG Chair Assurance Report.	Assurance	4 April 2024

East Kent Hospitals University NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (BoD)

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

Meeting date: **4 April 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 Board of Directors to have greater oversight of all Patient Safety Incidents that have occurred in the Trust during the month of January 2024 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 compliance processes are currently reported to the CEMG as part of the monthly Quality Governance Compliance Report (QGCR). • In January 2024 the Trust declared 16 Serious Incidents (SIs). • In January 2024 the Trust held eight SI Declaration Panels and four SI Investigation Approval Panels (SIIAP), the purpose of these panels is described in the body of the report. • As of the 31 January 2024 the Trust had 62 open SIs, 55 (89%) are under investigation and 7 (11%) have been submitted to the Integrated Care Board (ICB) for closure. Three of the SI reports submitted in January breached the 60-day date or their extension date. One of these was declared prior to April 2023 and two were declared after April 2023. • During December there were 23 cases for which verbal Duty of Candour (DoC) applied with 95.7% compliance (due to one delayed DoC undertaken). One initial letter was late making the compliance 92.9%. Final DoC following submission of the SI report was 92.9% compliant as one case breached the timeframe. • During January 2024, 11 action plans were submitted to SIIAP for approval to close. Five required further work and to be returned at a later date.

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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 Strategic Theme:	• Quality and Safety
Link to the Trust Risk Register:	3125 Fundamentals of Care.
Resource:	N
Legal and regulatory:	Yes. The Trust is required to comply with NHSE Serious Incidents Framework.
Subsidiary:	N

Assurance route:

Clinical Executive Management Group (CEMG): 6 March 2024

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Serious Incident REPORT

February 2024 (January 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

JANUARY 2024

2375

Patient Safety Incidents

86% of 2766

total incidents reported

THE HARM

JANUARY 2024

No Harm 1355

Low Harm 979

Moderate 32

Severe 2

Death 7

Harm ungraded (under review) 0

TOTAL 2373

The figures for this report were validated on the Scorecard for December from the 31/01/2024 and at that time there were 7 deaths reported:

1. One via the Structured Judgement Review (SJR) process as anticoagulants were not restarted after an admission for urology treatment, discussed at Serious Incident Declaration Panel (SIDP) and not an Serious Incident (SI) but After Action Review (AAR) being undertaken for learning.
2. One was a patient who experienced prolonged bradycardia while their wound was being closed following a hemiarthroplasty. An SJR is awaited prior to discussion at SIDP.
3. One from COVID-19, pneumonia and clostridium difficile colitis which is being investigated by the Infection Prevention and Control (IPC) team and will come to SIDP.
4. One relates to an elderly, frail patient who had surgery to reverse their colostomy and was cared for in the private wing of the hospital where he deteriorated and died. Declared an SI.
5. One was a cardiac arrest in the community (an in-patient who regularly left the hospital) however the patient was known to misuse alcohol and substances. Declared an SI.
6. One patient had a witnessed fall incurring bilateral acute subdural haematomas. Review at the Tissue Viability and Falls Panel (TiVFaP) is awaited prior to SIDP.

7. One person died in the car park having driven their partner for an outpatient's appointment and arrested there. Not an SI but AAR being undertaken for learning.

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

Serious Incidents declared in January 2024

CATEGORIES OF HARM on StEIS

01/01/24 – 31/01/24

	No harm	Low	Moderate	Severe	Death	Total
Diagnostic incident incl delay	0	0	3	0	0	3
Maternity/Obstetric incident: baby only	0	1	1	0	0	2
Medication	0	0	0	0	1	1
Pressure ulcer	0	0	2	0	0	2
Sub-optimal care of deteriorating patient	0	1	0	1	1	3
Surgical/invasive procedure incident	1	1	2	0	0	4
Treatment delay	0	0	1	0	0	1
Total	1	3	9	1	2	16

**Please note: Table above shows incidents reported on StEIS from 1 to 31 January 2024, hence death figures are not comparable with those from the table on page 3, which shows incidents reported on Datix in January 2024. 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, 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) 2 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 ICB submission. The Care Group governance team and lead investigator attend this meeting.

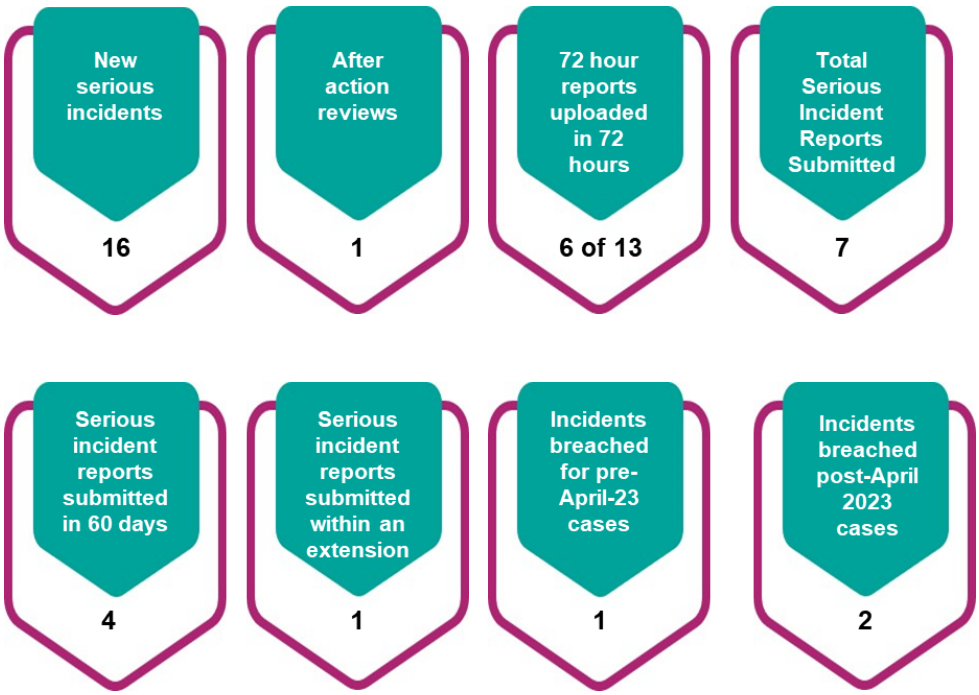
Once the report has been closed by the ICB a date is set three months hence for the action plan to be returned to the SIIAP meeting to ensure all actions are completed. This allows the CNMO and CMO full oversight of the actions and improvements being undertaken and completed. This report includes a section on the approval and closure of action plans on page 8.

In January 2024 there were eight SIDP meetings and 4 SIIAP meetings.

There were 7 Serious Incident reports submitted to the ICB in January 2024 of which 1 had an extension granted; this breached the extension date. In total three reports breached the original target/extension date.

INVESTIGATIONS Declared/Submitted

Activity and performance in January 2024



Non-SI investigations commenced during January 2024

(Investigations overview by type)

Investigation type	No.	Incident category
After Action Review (AAR)	1	Delay in providing treatment
Cancer 104-day Harm Review	0	
Case Review	0	
Infection Prevention and Control Root Cause Analysis (IPC RCA)	0	
Mortality and Morbidity (M&M) review, Perinatal Mortality Review	0	
Patient Safety Incident Investigation Report (PSIIR)	0	
Screening Incident Assessment Form (SIAF)	2	Appropriate clinical assessments/investigations not completed
Structured Judgement Review (SJR)	0	
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.

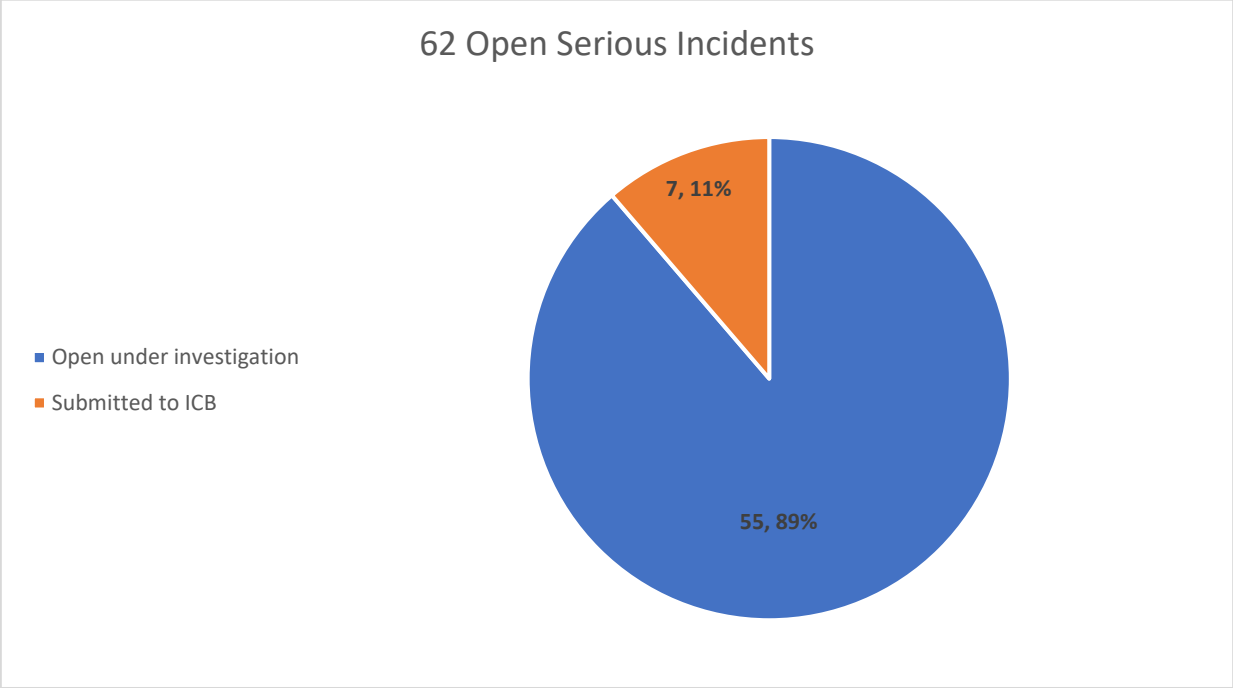
Cancer 104-day Harm Review: Any patient exceeding 104 days on a cancer pathway is subject to a clinically led investigation of potential harm which is known as a clinical harm review. This applies to all specialities managing patients on cancer pathways.

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 31 January 2024.



There are 62 open Serious Incidents under current investigation in the Trust including seven which have been submitted to the ICB for their closure and learning panel.

Of the 55 under investigation, 44 are not yet due, seven have NCRs pending and four cases have breached. Two breaches are under William Harvey Hospital (WHH) Care Group (CG), neither of which are ready for submission. The third breach is with the Corporate team on behalf of child health; it was declared before 01 April 2023 and is being prepared for downgrading. The fourth breach is with the Queen Elizabeth the Queen Mother Hospital (QEQM) CG and is not ready for submission.

The table below shows open SIs in the last five months. The new Care Groups have been operational for five months at this point. The number of cases represents the total number of cases 'open on StEIS' on per month. They are not cumulative.

When cases are closed on StEIS by the ICB, the overall figure per Care Group drops by that number and as we declare cases on StEIS the number increases. Therefore, if one case is closed and one opened in the same month, the aggregate figure remains the same.

Care Group	Sep	Oct	Nov	Dec	Jan
Corporate	1	0	2	2	2
Critical Care, Anaesthetics and Specialist Surgery	5	4	6	7	6
Diagnostics, Cancer and Buckland Care Group	3	1	2	2	2
Kent and Canterbury and RVHF Care Group	16	17	15	14	13
Queen Elizabeth the Queen Mother Care Group	15	14	13	10	11
William Harvey Care Group	14	14	21	17	14
Women, Children and Young People Care Group	18	20	20	14	14

Grand Total	72	70	79	66	62

Action Plans and learning from Serious Incidents

Each Serious Incident report includes an improvement plan to mitigate the risks identified during the investigation. The plan is a series of actions which combine to fulfil the requirements of recommendations made by the investigation team. Each action may be owned by a different clinician or they may all be owned by the same person, dependent on the types of actions required. They are added individually to the Datix and are monitored there by the governance team.

Since September 2023, there has been a new process to ensure executive oversight of compliance with actions from SIs. After three months, the original Serious Incident report's improvement plan is updated and returned to the SIIAP to be approved and closed by the executive panel. If actions remain outstanding or if the action has not produced the intended change, the action plan is not closed and further work is required before being returned to the SIIAP for re-review a number of weeks later, determined by the panel.

During January, 11 action plans were brought to SIIAP for approval. and 6 of those plans were closed as per the table on the next page. This has been moved to a separate page to make it clearly accessible to all.

Action plans presented to SIIAP in January 2024

StEIS number	Category of harm reported under	Approval given for Action Plan sign-off?
2023/11757	Unexpected/potentially avoidable injury causing serious harm	Action plan not approved and due to return 11/03/2024
2023/12018	Never Event (O2 attached to Air outlet).	Action plan approved
2023/12438	Unexpected/potentially avoidable injury causing serious harm	Action plan approved.
2023/15039	Unexpected/potentially avoidable injury causing serious harm.	Action plan approved
2023/14615	Never Event (wrong site surgery)	Action plan not approved and due to return 19/02/2024
2023/3624	Incident demonstrating existing risk that is likely to result in significant future harm.	Action plan approved.
2023/10461	Unexpected/potentially avoidable injury causing serious harm (fall).	Action plan not approved and due to return on 19/02/2024
2023/12320	Incident demonstrating existing risk that is likely to result in significant future harm.	Action plan not approved and due to return on 19/02/2024
2023/16655	Incident threatening organisation's ability to continue to deliver an acceptable quality.	Action plan not approved and to return on 19/02/2024
2023/12565	Unexpected/potentially avoidable death	Action plan approved
2023/15110	Unexpected/potentially avoidable injury causing serious harm.	Action plan approved.

Never Events

One Never Event was reported on StEIS in January.

This was a no harm incident and involved a mixed list of left and right ureteroscopy and laser fragmentation of stone. Dye was injected into the left kidney, instead of the right. This was realised soon after the dye was injected, before any instruments were inserted and the procedure was switched to the correct side straight away.

Duty of Candour

Between 1st and 31st January 2024, a total of 23 moderate, severe or death harm incidents (or declared as a Serious Incident) required duty of candour. The Trust has achieved a 95.7% compliance rate for verbal duty of candour this month because one case breached the timeframe.

This was followed up with written duty of candour letters within ten days for all but one case giving the Trust a 92.9% compliance rate.

For Serious Incident cases submitted to the ICB (seven cases), the final duty of candour had 92.9% compliance rate as one case breached the timeframe. This has since been sent.

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 3 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 February 2024 report, presented in March 2024, will include the next audit information on the Duty of Candour audit.

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 22 cases closed on StEIS in January 2024. 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 patient was seen at the Royal Marsden hospital in the Cancer Genetics department, where they were found to have an inherited genetic condition which increases the risk of developing cancers. They were referred to William Harvey Hospital Endoscopy Unit for surveillance of their colon every two years as well as an outpatient appointment in the colorectal clinic.

Following the outpatient appointment, approximately eight weeks later, the patient was referred for a routine colonoscopy as the patient did not have any symptoms.

The colonoscopy was carried out a little more than six months later and a lesion was found and marked so that it could be easily identified in the future. There were 10 biopsies taken for testing. The patient was informed at the time of the possibility of cancer. A CT of the patient's chest, abdomen and pelvis was requested, a cancer upgrade form was completed and the patient was referred to the colorectal Multi-Disciplinary Meeting (MDM).

At the MDM one week later, the result of the biopsies in the ascending colon confirmed cancer. A CT scan was also undertaken which showed shows tiny lesions that appear to be cysts rather than metastatic disease in the liver.

The patient was listed for right hemicolectomy (removal of bowel that contained the cancer), and an outpatient appointment in the colorectal clinic prior to this. The patient had the procedure laparoscopically, which was successful. The patient recovered well following the operation and returned home.

The Learning – what we found

The investigation has found that the delay was caused by process and system failures, there was a general lack of understanding of the referral process and multiple workstreams, together with a high number of patients and very limited capacity. These systems and processes are currently being reviewed in order to improve the Endoscopy service as a whole.

The recommendations – how we can prevent recurrence

- Support the additional activity of scopes with ID medical
- Review of referral system of patients with known risks.
- Ensure appropriate governance in place for Endoscopy department.
- Review of the Surveillance Patient Tracking List (PTL).
- Monthly Endoscopy bulletin.
- Re-establish monthly Trustwide and site based meetings.
- Endoscopy Recovery, Task & Finish Group
  Review of Endoscopy Operational Policy and associated Standard Operating Procedures (SOP's)

What do we need to do?

- There is now a process in place that ensures all Lynch patients are now looked after by the Bowel Cancer Screening Service.
- The Trust is currently recruiting a clinical endoscopist to concentrate on the Routine Pathway patients.
- There is an endoscopy recovery Task & Finish group working towards improvements within the endoscopy service.

The Incident – what happened?

This incident relates to an intra-operative injury which occurred during manipulation of a catheter, which could have potentially been avoidable.

This patient was admitted to Kent and Canterbury Hospital (K&C). The patient was under the care of the urology department and was attending for an elective da vinci robotic radical prostatectomy (RALP) and lymph node dissection due to confirmed cancer of the prostate. Towards the end of the procedure, when they were joining the bladder to the urethra, a catheter was manipulated through the urethra at the join. The catheter balloon was then inflated to test for leaks. It was identified that the catheter tip had been accidently sutured into the join so that when the balloon was inflated it caused trauma to the patient's urethra. A cystoscopy was performed and showed that an injury had occurred. Following discharge, the next day, the patient experienced ongoing issues with their catheter, requiring bladder washouts and an attendance at the emergency assessment centre at K&C.

The Learning – what we found

The injury which occurred during manipulation of the catheter could have potentially been avoided. It is likely that this patient will need further procedures and side effects as a result of the injury.

There was a lack of robust process in place in theatres to ensure that the catheter was in the correct place, during suturing and prior to inflation of the catheter balloon.

There was no verbal communication between the surgeon and the theatre team to ensure the catheter was in the correct place.

There was not an appropriate level of support and training given to ensure supporting theatre practitioners had the required knowledge and experience to assist in this complex procedure.

The recommendations – how we can prevent recurrence

- A formal step has been introduced whereby the consultant checks with a verbal instruction, regarding whether the catheter is inserted and mobile (in or out), before suturing and before the catheter balloon is inflated.
- A robust process has now been put in place to ensure theatre practitioners are appropriately supported and provided with the appropriate level of training to support these complex urological procedures. This includes completing the required urinary catheter course and relevant competency assessments to assist in the manipulation of urethral urinary catheters in male patients.
- An immediate review was undertaken of the number of competent supporting theatre practitioners, allocating those with the completed competencies to these procedures, with immediate effect.
- Support to be provided to those involved in the incident.
- The Association for Perioperative Practice (AfPP) to complete review of practice within theatres Trust wide.

Ensure staff introduce themselves and their skills during team brief to make sure any possible issue is identified before the procedure starts.

What do you need to do?

Share the learning Trust wide.

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

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Care Quality Commission (CQC) Update Report

Meeting date: 4 April 2024

Board sponsor: Chief Nursing and Midwifery Officer (CNMO)

Paper Author: Associate Director of Quality Governance
Compliance and Assurance Lead

Appendices:

None

Executive summary:

Action required:	Discussion
Purpose of the Report:	This report provides an update on CQC inspection activities, oversight, assurance and related improvement work. This report covers the period February to mid-March 2024. This report covers: • An update on refreshed governance arrangements; • CQC self-assessment programme; • An update on performance against the most recent CQC inspection reports (May and July 2023) published in December 2023; • An update on performance against 'historical' open CQC action plans (2018, 2020 and 2021); • An update on Maternity Section 31 Enforcement Notice; • CQC queries (quarterly update October - December 2023).
Summary of key issues:	The action plans relating to the most recent CQC inspections (General Medicine (GM), Urgent and Emergency Care (UEC) and Children and Young People (CYP) at the William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM)) as well as the Trust-wide Well Led action plan were approved and submitted to the CQC on 25 January 2024. Reporting commenced in February with the forecast position at the end of March 2024 provided (8% of Must Do actions closed and 10% of Should Do actions pending review of evidence). There continues to be sustained progress with the Maternity 2023 action plan. 80% of Must Dos and 89% of Should Dos are closed with the majority of remaining open requirements expected to be closed by the end of March 2024. There has been considerable work to provide assurance around closure for historic open actions relating to inspections in 2018, 2020 and 2021. There have been 14 closures since the last report with an expectation that the

East Kent Hospitals University NHS Foundation Trust

	remaining actions will be closed by April 2024 with the exception of mandatory and statutory training. A trajectory will be developed for medical staff, overseen by the Chief Medical Officer (CMO), to ensure we meet this requirement. The increased focus around ensuring pace in closing outstanding CQC Must and Should Do actions is important and in turn enables us to focus our attention on proactive assurance work, continual self-assessment and implementing the improvements we need to improve the quality and safety of the services we deliver to our patients.
Key recommendations:	Trust Board members are invited to discuss the report and progress of delivery of improvements related to CQC compliance to date.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients
Link to the Trust Risk Register:	There is a risk of noncompliance with CQC regulations which would have an impact on registration and may lead to repeat enforcement action, improvement notices and a critical report (ref 3636). Residual Risk 12 (moderate).
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 (2gether) in partnership with the Trust.

Assurance route:

Previously considered by:
Quality and Safety Committee, 26 March 2024.
CQC Oversight and Assurance Group, 5 March 2024.

East Kent Hospitals University NHS Foundation Trust

Care Quality Commission (CQC) Update Report

1. Purpose of the report

1.1 This report provides an update on CQC inspection activities, oversight, assurance and related improvement work. This report covers the period February to mid-March 2024. This report covers an:

- update on performance against the most recent CQC inspection reports (May and July 2023) published in December 2023;
- update on refreshed governance arrangements;
- update on performance against 'historical' open CQC action plans (2018, 2020 and 2021);
- update on Maternity Section 31 Enforcement Notice;
- CQC self-assessment programme;
- CQC queries (quarterly update October - December 2023);
- Recent publications.

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 improvement in maternity, quality and safety and leadership and governance.

3. Update on refreshed governance

3.1 Governance arrangements for the management and oversight of the new inspection action plans have been reviewed and updated. Key elements of the process include:

- Specialities to nominate a CQC lead, who will be the key liaison with Compliance and Assurance Team (C&AT).
- Specialities and Care Groups report CQC assurance via their governance meetings up to their board and include in Performance Review Meeting (PRM) updates.
- There will be a minimum of monthly (this is currently weekly for inspection action plans) CQC meetings between each speciality and C&AT. This is to discuss all elements of CQC assurance, with the focus initially on the inspection action plans.
- There will be monthly CQC Inspection Action Plan Review Meeting for each speciality with an open inspection action plan. The draft terms of reference for this were approved at the March Oversight and Assurance Group (O&AG). These meetings will be chaired by the Compliance and Assurance Lead and will look at proposed closures and overdue actions. Specialities will need to provide mitigations and request extensions if actions are not completed within the expected timeframe.
- Proposed closures, extensions, risks and issues will be reported by the C&AT to the Care Group leadership team for approval or escalation.

- A status report for each speciality will be provided to O&AG and onto the Regulatory Oversight Group. The same report will be used by the specialities for Care Group reporting.
- A shared drive has been created for storing CQC action plans and evidence, and meeting papers. Specialities will advise who they would like to have access to their folder.

3.2 The Regulatory Oversight Group (ROG), which oversees CQC plus other regulatory requirements, held its inaugural meeting on 22 February 2024; these will be bi-monthly, chaired by the CNMO. The terms of reference for the CQC Oversight and Assurance Group are being refreshed to reflect the new governance arrangements – with a focus on deep dive reviews and a programme of self-assessments based around the new CQC single assessment framework. Clinical Executive Management Group (CEMG) will receive reports from ROG. A schedule of quarterly reporting has been agreed to the Board of Directors with the first report received by the Trust Board on 1 February 2024.

4 CQC Self-Assessment Programme

4.1 A CQC Self-Assessment tool has been refreshed to reflect the updated CQC guidance and was approved at the March Oversight and Assurance Group. This tool will be rolled out to Care Groups and a programme will be established where triumvirate leads present the outputs at a bi-monthly CQC Check and Challenge meeting attended by the CNMO, CMO and Chief Operating Officer (COO). These meetings will commence in May 2024.

5. Update on performance against the most recent 2023 CQC Inspection Reports

5.1. The final inspection reports from the core service inspection in May 2023 and well led inspection in July 2023 were published on 20 December 2023. Speciality leads developed action plans to address the must and should do requirements, with the support of the C&AT, and these were approved by Care Group leadership teams and the executive team. They were submitted to the CQC on 25 January 2024, two days ahead of the CQC's deadline. There are eight action plans listed below:

- 2gether action plan
- CYP action plan
- Diagnostics, Cancer and Buckland (DCB) action plan
- QEQM GM action plan
- QEQM UEC action plan
- WHH GM action plan
- WHH UEC action plan
- Well Led action plan

5.2. In addition, there is an action plan associated with the Maternity inspection of January 2023.

5.3. Maternity closed two Should Do requirements during January 2024. 80% of the Must Do requirements are now complete with four remaining open. Three are expected to close by

31 March 2024. 89% of Should Dos are now complete with two remaining open; both are expected to close by 31 March 2024.

5.4. The first Inspection Action Plan Review Meetings were held with each speciality (UEC, Medical Care, CYP and Well Led) during February 2024, to review progress against the action plans submitted to the CQC in January 2024 following the May and July 2023 inspections. The tables below show the numbers of proposed and approved closures. Proposed closures become approved closures only once evidence has been reviewed and approved by the Compliance and Assurance Team, and then by a representative from the Care Group triumvirate. 8% of the Must Do actions have been approved for closure. 10% of the Should Dos actions have been proposed for closure with evidence reviews underway. It is anticipated these will result in closure.

5.5. The number of actions that have gone beyond their due dates with no proposal for closure are shown below, with the number of actions that the speciality has requested extensions for. The Care Group triumvirate approve such requests.

5.6. A number of actions (34% across all eight action plans) have become overdue this month indicating early slippage against progress with the plans. Specialities have cited unrealistic due dates, operational pressures and staffing shortages as the reasons for delays in progress. Of that 34%, 15% have resulted in extension requests. The remainder are planned for closure during March 2024.

MUST DO REQUIREMENT ACTIONS				
Care Group (CG)/Speciality (total no of actions in brackets) (149)	**No of proposed closures**	**No of approved closures**	**No of overdue actions**	**No of extension requests**
DCB CG (11)	2	0	0	0
CYP CG (16)	0	0	12	7
WHH CG GM (25)	3	0	13	6
WHH CG UEC (14)	2	0	0	0
QEQM CG GM (22)	0	0	17	10
QEQM CG UEC (21)	10	0	8	0
2gether (7)	1	1	0	0
Well led (33)	2	11	0	0
MUST ACTION TOTALS	**20**	**12**	**50**	**23**
MUST ACTION TOTALS %	**13%**	**8%**	**34%**	**15%**

SHOULD DO REQUIREMENT ACTIONS				
Care Group/Speciality (total no of actions in brackets) (51)	**No of proposed closures**	**No of approved closures**	**No of overdue actions**	**No of extension requests**
DCB CG (1)	0	0	0	0
CYP CG (15)	1	0	1	1
WHH CG GM (11)	0	0	1	1
WHH CG UEC (4)	0	0	0	0
QEQM CG GM (6)	1	0	2	1
QEQM CG UEC (7)	5	0	0	0
2gether (0)	N/A	N/A	N/A	N/A
Well led (23)	0	0	0	0
SHOULD ACTION TOTALS	**67**	**0**	**4**	**3**
SHOULD ACTION TOTALS %	**10%**	**0%***	**5%**	**4%**

(* review meetings happening between now and end of March 2024).

6. Update on performance against 'historical' open action plans (2018, 2020 and 2021)

6.1. There are four open inspection action plans relating to CQC inspections that have taken place between 2018 and January 2023. These action plans are also subject to regular review and update by the specialities, supported by the C&AT.

6.2. The Director of Quality Governance and Compliance and Assurance Lead has met with the Directors of Nursing and Medical Directors for QEQM and WHH during February 2024 to discuss the status of these historical requirements, potential blockages and agree support required to either close, or consider for discussion with the CQC the issues preventing full closure. The status of each outstanding requirement is shown below.

6.3. The following requirements have been closed since the last report to Quality and Safety Committee and the Board.

CYP July 2021

- The Trust should ensure that all staff complete their mandatory training *and* should take steps to improve mandatory training compliance rates for medical staff. – to be closed in March 2024.
- The Trust should ensure that all incidents investigations are completed in a timely way to allow opportunity for action on learning to be taken swiftly – closed February 2024.
- The Trust should ensure that all staff follow their policy for pre-operative fasting. Improvements in audit result – to be closed March 2024. Weekly spot checks in place and continued monitoring as part of business as usual (BAU) reporting to care group governance.

Medical care May 2021

- The Trust must ensure staff maintain comprehensive records of deprivation of liberty safeguards – closed February 2024
- The Trust ensure they improve consistence in their approach to managing sepsis – closed February 2024.
- The Trust should ensure that all medicines storage areas have ambient temperature monitoring – closed February 2024.

UEC March 2020

- The Trust must ensure medicines are stored securely, and staff complete records for controlled stationery – closed February 2024.
- The Trust should ensure all staff have an appraisal – closed March 2024.
- The Trust should consider their approach to meeting the staffing guidance from the Royal College of Emergency Medicine – closed March 2024.
- The Trust should ensure all patients have pain assessed, recorded, and analgesia given when needed – closed March 2024. Improvement Plan in place and ongoing monitoring via BAU and Fundamentals of Care Committee.
- The Trust must improve their approach to meeting the Department of Health's standard for 95% of patients to be admitted, transferred or discharged within 4 hours. This target is now 76%. Current Trust wide performance 72.6% (50.52% for Type 1 Emergency Departments (EDs) combined). This indicator is a key part of the Unplanned Care Programme of work. This will be closed from the CQC plan but with continued oversight by the COO.
- The Trust must ensure they improve their unplanned reattendance rate to be in line with the national target (national target is 10%). Data has improved. If re-attendances within 4 hours are excluded (majority are inaccurate and transfers between departments) Trust is at target. This is monitored closely as a Key Performance Indicator (KPI) as part of BIU. Oversight proposed as part of the ED Unplanned Care Board.

End of Life 2018

- The Trust must make sure that lessons are learned and improvements made when things go wrong. Closed March 2024. Processes in place to share End of Life (EoL) complaints and incidents. Patient Safety Incident Response Framework (PSIRF) programme of work will support embedding of learning across the Trust.

6.4. The following requirements remain open. It is anticipated that all of these Must Dos (MDs) and Should Dos (SDs) will be closed by the end of April 2024 with the exception of the actions around statutory and mandatory training (MD01.UEC WHH, SD05.WHH and SD02.MED KCH & WHH 21). A trajectory is being agreed with the CMO.

CG and Speciality	Requirement	Status
WHH UEC 2020	MD01.UEC.WHH The Trust must ensure staff complete their mandatory training and each module meets their compliance targets, including; Mental Capacity Act (MCA) training, life support training, and dementia training. (Also on May 2023 action plan)	Nursing expected to be compliant by 31.03.24. Learning & Development (L&D) have provided a report to People & Culture Committee (P&CC) with action plan for doctors. **CMO to agree trajectory for**

CG and Speciality	Requirement	Status
		achievement for medical staff with a view to full compliance by 30.09.24.
WHH UEC 2020	SD05.UEC.WHH The Trust should ensure all staff have access to the training needed for their role including advanced life support.	**As above. CMO to agree trajectory for medical staff.**
WHH & KCH GM 2021	SD02.MED.Kent & Canterbury Hospital (K&C) & WHH.2021 The Trust should ensure that all staff complete their mandatory training. (Also on May 2023 action plan)	**As above. CMO to agree trajectory for medical staff.**
WHH UEC 2020	MD16.UEC. WHH The Trust must ensure critical fluids and medicines are administered and recorded in a timely manner.	There have been delays in the Sunrise team creating a 'missed dose' dashboard to provide assurance in this area. **This was due in March 2024. To be escalated via Director of IT.**
WHH & QEQM UEC 2020	SD03.UEC.QEQM & WHH The Trust should ensure medicines reconciliation is undertaken in a timely manner	7 day pharmacy service in Acute Medical Unit (AMU) but large % of patients in ED for 24 hours (the time period when med rec must happen). Data now available but needs further work. **Model to be agreed and assurances around data. CMO oversight. Move to BAU from April 2024 once agreed.**
QEQM UEC 2020 S29a	SD01.UEC.QEQM & WHH (2020) The Trust should consider how to recruit a full establishment of emergency department consultants and SD02.UEC.QEQM (2021) and The Trust SHOULD meet the Royal College of Emergency Medicine requirements for the number of consultants employed within the department.	QEQM update 13.03.24: 5th consultant starts end of March 24. 1 ED consultant is on a 12 months fixed term contract due to expire in August 2024.**Clinical Director asked to provide a trajectory for recruitment.**
EOLC 2018	MD37 Ensure that consent to care and treatment is always sought in line with legislation and guidance in relation to records of mental capacity assessments relating to decisions regarding 'Do not attempt cardiopulmonary resuscitation' (DNACPR).	Meeting held between Director Quality Governance (DQG), safeguarding, resus, C&AT on 21/03/24. Recent DNACPR/MCA audit data to be analysed, and task and finish group led by Deputy CMO supported by MCA Lead to commence. Action plan identifying key issues from audit to be developed this month. **To be closed on CQC plan next month once above is in place.**
EOLC 2018	SD27 Make sure that staff responsible for training other staff have the skills, knowledge and experience to do so and that all ward staff receive training in the delivery of effective care,	Action plan to be developed and agreed by the End of Life Committee. Lead – Deputy CNMO. Timeframe – 4 weeks.

CG and Speciality	Requirement	Status
	support and treatment for patients at the end of life.	
EOLC 2018	SD29 Make sure there is a framework and focus for identifying patients with an uncertain recovery who were at risk of dying, together with a framework for advance care planning. Trust-wide:	Action plan to be developed and agreed by the End of Life Committee. Lead – Deputy CNMO. Timeframe – 4 weeks.
EOLC 2018	SD31 Ensure that discussions about preferred place of care are consistently held in advance of the last days of life and that the achievement of discharge to the preferred place of care is monitored.	Action plan to be developed and agreed by the End of Life Committee. Lead – Deputy CNMO. Timeframe – 4 weeks.
EOLC 2018	SD36 Take action to make sure that records for patients on the 'care of the dying patient and their family plan' are consistently completed.	Action plan to be developed and agreed by the End of Life Committee. Lead – Deputy CNMO. Timeframe – 4 weeks.

7. Update on Maternity Section 31 Enforcement

7.1. The Trust submitted the monthly Section 31 (S31) notice requirement for maternity update on 1 February and 1 March 2024 and informed the CQC that the Trust is ready to request the Section 31 notice be lifted. This will be discussed at the next engagement meeting between the CNMO and CQC on 30 March 2024. An internal quality review visit was held during February 2024, aligned to the accreditation visit programme, which looked specifically at the requirements from the S31 and the requirements from the inspection in January 2023. The output from this has been shared with the service to help inform inspection readiness.

8. CQC Queries Quarterly Update (October - December 2023)

8.1. There were 29 queries received from the CQC between October to December 2023, in comparison to July to September 2023 when 34 were received. These queries arose from safeguarding notifications, concerns raised to the CQC by staff or the public, and from discussions at the engagement meeting between the CQC and CNMO.

8.2. There was an increase in queries for the month of November which resulted in delays to responses. This was due to the time taken to gather the required information or investigate the concerns raised, and the internal approval process. A number of queries required at least one extension request to the CQC.

8.3. A regular meeting is held between the Trust's CQC relationship manager and CNMO to provide communication regarding any areas of concern and to provide assurance around enquiries. The last meeting took place on 30 November 2023 with further meetings delayed due to changes in the CQC's structures and personnel. The next meeting is anticipated to take place in late March 2024.

East Kent Hospitals University NHS Foundation Trust

9. Conclusion

9.1. Trust Board members are asked to receive the attached report and the assurance provided by the acceleration of closures related to CQC action plans in month.