Board of Directors Meeting - Open (Thursday 9 March 2023)

Thu 09 March 2023, 13:15 - 16:40

Cornwallis Room - The Spitfire Ground, Old Dover Road, Canterbury CT1 3NZ/WebEx

Agenda

OPENING/STANDING ITEMS

13:15 - 13:25
10 min

22/204
Welcome and Apologies for Absence

To Note *Chairman*

Verbal

13:25 - 13:25
0 min

22/205
Confirmation of Quoracy

To Note *Chairman*

Verbal

13:25 - 13:25
0 min

22/206
Declaration of Interests

To Note *Chairman*

22-206 - REGISTER 2022-23 V59 - from March 2023.pdf (4 pages)

13:25 - 13:25
0 min

22/207
Minutes of Previous Meeting held on 9 February 2023

Approval *Chairman*

22-207 - Unconfirmed BoD 09.02.93 Open Minutes.pdf (18 pages)

13:25 - 13:25
0 min

22/208
Matters Arising from the Minutes on 9 February 2023

Approval *Chairman*

22-208 - Front Sheet Public BoD Action Log.pdf (3 pages)

13:25 - 13:55
30 min

22/209
Staff Experience Story

Discussion *Chief People Officer (CPO)*

- 22-209.1 - Staff Experience Story Board Front Sheet.pdf (1 pages)
- 22-209.2 - Appendix 1 Case Study NS.pdf (2 pages)

13:55 - 14:05
10 min

TEA/COFFEE BREAK

14:05 - 14:10
5 min

22/210
Chairman's Report

Approval *Chairman*

- Approval of contract award for Cardiac Rhythm Management Contract

- 22-210.1 - Chairman Report March 23 Final.pdf (4 pages)
- 22-210.2 - App 1 Chairman Report NEDs commitments.pdf (1 pages)

14:10 - 14:15
5 min

22/211
Chief Executive's (CE'S) Report

Discussion *Chief Executive*

- 22-211 - CEO Report to Board March 2023.pdf (6 pages)

14:15 - 14:35
20 min

22/212
Board Committee - Chair Assurance Reports

Assurance *Board Committee Chairs*

22/212.1
People and Culture Committee (P&CC) - Chair Assurance Report

Assurance *Chair P&CC - Stewart Baird*

- 22-212.1 - PCC Chair Assurance Report BoD 28.02.23 V2.pdf (3 pages)

22/212.2
Finance and Performance Committee (FPC) - Chair Assurance Report

Assurance *Chair FPC - Richard Oirschot*

- 22-212.2 - FPC Chair Committee Assurance Report BoD 28.02.23 Final.pdf (6 pages)

22/212.3
Quality and Safety Committee (Q&SC) - Chair Assurance Report

Assurance *Chair Q&SC - Andrew Catto*

- 22-212.3 - QSC Chair Assurance Report 02.03.23 BoD v2 final.pdf (8 pages)

OUR PATIENTS OUR QUALITY AND SAFETY

14:35 - 15:25
50 min

22/213
Maternity Governance

Discussion *Chief Executive*

22/213.1
Transforming our Trust: Our Response to Reading the Signals - Update

Discussion *Chief Executive*

- 22-213.1.1 - FINAL Board Update Reading the Signals March 2023.pdf (5 pages)
- 22-213.1.2 - Appendix 1 Reading The Signals.pdf (4 pages)
- 22-213.1.3 - Appendix 2 Pillars of Change KPIs.pdf (1 pages)

22/213.2
Maternity Services: Clinical Negligence Scheme for Trusts (CNST) - Maternity Incentive Scheme Year 4

Chief Nursing and Midwifery Officer (CNMO)/Interim Director of Midwifery (DoM)

22/213.2.1
Maternity and Neonatal Assurance Group (MNAG) Report

Assurance *CNMO/Interim DoM*

- 22-213.2.1.1 - MNAG Board report S31 response maternity survey results.pdf (9 pages)
- 22-213.2.1.2 - App 1 S31 Submission Response EKHUFT WHH FINAL.pdf (16 pages)
- 22-213.2.1.3 - App 2 S31 reporting template QEQM.pdf (6 pages)
- 22-213.2.1.4 - App 3 EKHUFT NHS Maternity Survey 2022.pdf (75 pages)

22/213.2.2
Perinatal Quality Surveillance Tool (PQST) Report

Assurance *CNMO/Interim DoM*

- 22-213.2.2 - PQST January 2023.pdf (14 pages)

22/213.2.3
Safety Action 3: Transitional Care Services to minimise separation of Mothers and Babies and to support the recommendations made in avoiding long term admissions into Neonatal Units programme - Quarter 2 2022/23 Report

Information *CNMO/Interim DoM*

- 22-213.2.3 - CNST Safety Action 3_Transitional Care Quarterly Report.pdf (22 pages)

15:25 - 15:35
10 min

TEA/COFFEE BREAK

CORPORATE REPORTING (COVERING ALL 'WE CARE' STRATEGIC OBJECTIVES)

15:35 - 15:50
15 min

22/214
Integrated Performance Report

Discussion *Chief Executive/Executive Team*

- 22-214.1.1.1 - March Board IPR Header.pdf (4 pages)

22-214.1.1.2 - Appendix 1 IPR_v4.3_Jan23_finalv2.pdf (36 pages)

22/214.1
Month 10 Finance Report

Information *Chief Finance Officer*

22-214.1.1 - Front Sheet M10 Finance Report Board.pdf (2 pages)
22-214.1.2 - Appendix 1 M10 Finance Report.pdf (19 pages)

15:50 - 16:00
10 min

22/215
Chief Medical Officer's (CMO's) Report

Discussion *CMO*

22/215.1
Learning from Deaths - Quarter 2 and Quarter 3 2022/23

Discussion *CMO*

22-215.1 - CMO Board Q2 Q3 LfD.pdf (7 pages)

22/215.2
Clinical Ethics Committee (CEC)

Decision *CMO*

22-215.2 - CMO CEC report to Board.pdf (4 pages)

16:00 - 16:10
10 min

22/216
Infection Prevention and Control (IPC) Quarterly Update

Discussion *Executive Director of IPC*

22-216 - IPC_Quarterly_update_March_2023.pdf (5 pages)

OUR FUTURE OUR SUSTAINABILITY

16:10 - 16:20
10 min

22/217
Health and Safety and Statutory Compliance Update

Discussion *Managing Director - 2gether Support Solutions*

22-217 - Health and Safety and Stat Compliance Report (March 2023).pdf (6 pages)

FOR INFORMATION

16:20 - 16:20
0 min

22/218
Patient Voice and Involvement Quarterly Report

Information *CNMO*

22-218.1 - Patient Voice and Involvement Quarterly Report Board.pdf (2 pages)

22-218.2 - App 1 Patient Voice and Involvement Report Oct to Dec 2022.pdf (5 pages)

CLOSING MATTERS

16:20 - 16:25
5 min

22/219
Any Other Business

Discussion *All*

Verbal

16:25 - 16:40
15 min

22/220
Questions from the Public

Discussion *All*

Verbal

Date of Next Meeting: Thursday 6 April 2023

REGISTER OF DIRECTOR INTERESTS – 2022/23 FROM MARCH 2023

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 **Closed interest** MY Trust (started 11 November 2014/finished 20 July 2020) **(4)**	Appointed 1 September 2019
BAIRD, STEWART	Non-Executive Director	Stone Venture Partners Ltd (started 23 September 2010) **(1)** Stone VP (No 1) Ltd (started 15 August 2017) **(1)** Stone VP (No 2) Ltd (started 1 December 2015) **(1)** Hidden Travel Holdings Ltd (started 16 May 2014) **(1)** Hidden Travel Group Ltd (started 15 October 2015) **(1)** Trustee of Kent Search and Rescue (Lowland) (started 2013) **(4)** Non-Executive Director of Spencer Private Hospitals (started 1 November 2021) **(1)** Director of SJB Securities Limited (started 30 October 2013) **(1)** Non-Executive Director of Continuity of Care Services Ltd (started 1 October 2022) **(1)** **Closed interests** Stone VP (No 3) Ltd (started 20 November 2017/finished 21 March 2022) **(1)** Qunifi Holdings Ltd (started 30 November 2017/ finished 21 March 2022) **(1)** Qunifi Ltd (started 13 February 2015/ finished 21 March 2022) **(1)** Unicus Travel Ventures Ltd **(1)** **Companies Non-Trading interests** Tempco 0819 Ltd **(1)** Solution Telecom Holdings Ltd **(1)** Qdos Communications Ltd **(1)** Solution Builders Ltd **(1)** Hidden Travel (Flights) Ltd **(1)** Pebble Holidays Holdings Ltd **(1)**	1 June 2021 (First term)

REGISTER OF DIRECTOR INTERESTS – 2022/23 FROM MARCH 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
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)
CAVE, PHILIP	Chief Finance Officer	Wife works as Head of Contracts for NHS Kent and Medway Integrated Care Board (ICB) (started 1 April 2021) **(5)** **Closed interests** Wife worked as a Senior Manager for Optum, who run the Commissioning Support Unit (CSU) in Kent, which supports the Clinical Commissioning Groups (CCGs) (started 9 October 2017/finished 31 March 2021) Interim Managing Director for 2gether Support Solutions **(1)** (started 21 December 2021/finished 28 February 2022)	Appointed 9 October 2017
CORBEN, SIMON	Non-Executive Director	Director and Head of Profession, NHS Estates and Facilities, NHS England **(1)**	1 October 2022 (First term)
DICKSON, NIALL	Chair	Director, Leeds Castle Enterprises (started 31 May 2012) **(1)** Senior Counsel, Ovid Consulting Ltd (trading as OVID Health Company) (started November 2020) **(1)**	5 April 2021
FLETCHER, TRACEY	Chief Executive	None	Appointed 4 April 2022
FULCI, LUISA	Non-Executive Director	Director of Digital, Customer and Commercial Services, Dudley Council (started 6 April 2021) **(1)** Director of Dudley & Kent Commercial Services Ltd. (started 11 May 2022) **(1)**	1 April 2021 (First term)

REGISTER OF DIRECTOR INTERESTS – 2022/23 FROM MARCH 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
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)
MARTIN, REBECCA	Chief Medical Officer	None	Appointed 18 February 2020
OIRSCHOT, RICHARD	Non-Executive Director	To be confirmed	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)
POWLS, MATT	Interim Chief Operating Officer	None	Appointed 21 November 2022
SHINGLER, SARAH	Chief Nursing and Midwifery Officer	None	Appointed 7 June 2021
SYKES, CLAUDIA	Non-Executive Director	To be confirmed	1 March 2023 (First term)

REGISTER OF DIRECTOR INTERESTS – 2022/23 FROM MARCH 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
WIGGLESWORTH, NEIL	Executive Director of Infection Prevention and Control	Chair and Director of the International Federation of Infection Control (started 1 January 2018) **(1)** Trustee of the International Federation of Infection Control (started 1 January 2018) **(4)**	15 March 2021
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
Jane Ollis – Non-Executive Director in common

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

Categories:

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

UNCONFIRMED MINUTES OF THE ONE HUNDRED & TWENTY SIXTH MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 9 FEBRUARY 2023 AT 9.00 AM IN THE CORNWALLIS ROOM, THE SPITFIRE GROUND, CANTERBURY CRICKET GROUND, OLD DOVER ROAD, CANTERBURY CT1 3NZ AND AS A WEBEX TELECONFERENCE

PRESENT:

Mr N Dickson	Chairman	ND
Mr R Anakwe	Non-Executive Director (NED) (joined at 9.35 am)	RA
Ms A Ashman	Chief People Officer (CPO)	AA
Mr S Baird	NED/People and Culture Committee (P&CC) Chair	SB
Dr A Catto	NED/Quality and Safety Committee (Q&SC) Chair	AC
Mr P Cave	Chief Finance Officer (CFO)	PC
Mr S Corben	NED (WebEx)	SC
Ms T Fletcher	Chief Executive (CE)	TF
Ms L Fulci	NED	LF
Mr N Mansley	NED/Finance and Performance Committee (FPO) Chair (WebEx)	NM
Dr R Martin	Chief Medical Officer (CMO)	RM
Dr O Olasode	NED/Integrated Audit and Governance Committee (IAGC) Chair (WebEx)	OO
Mrs J Ollis	NED/Vice Chairman/Nominations and Remuneration Committee (NRC) Chair/Charitable Funds Committee (CFC) Chair	JO
Mr M Powls	Interim Chief Operating Officer (COO)	MP
Mrs S Shingler	Chief Nursing and Midwifery Officer (CNMO)/Executive Board Maternity Safety Champion	SSh

ATTENDEES:

Sir D Dalton	Improvement Consultant	DD
Mrs C Drummond	Interim Director of Midwifery (DoM)	CDr
Ms M Durbridge	Improvement Director, NHS England (NHSE)	MD
Professor C Holland	Associate NED/Dean, Kent & Medway Medical School (KMMS)	CH
Dr T Ivanov	Executive Director of Quality Governance (EDoQG)	TI
Mr P Ryder	Managing Director, 2gether Support Solutions (2gether) (minute number 22/)	PR
Dr N Wigglesworth	Executive Director of Infection Prevention & Control (EDIPC)	NW
Ms F Wise	Executive Maternity Services Strategic Programme Director (EMSSPD)	FW
Mrs N Yost	Executive Director of Communications and Engagement (EDoC&E)	NY

IN ATTENDANCE:

Miss L Coglan	Council of Governors (CoG) Support Secretary	LC
Miss S Robson	Board Support Secretary (Minutes)	SR

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Ms V Backshall	Member of the Public (WebEx)
Mr K Bradshaw	Member of the Public (WebEx)
Mr J Casha	Governor (WebEx)
Mr P Consigliere	Member of Staff (WebEx)
Mr L Craggs	Member of the Public (WebEx)
Mr H Craven	Member of the Public
Mr N Daw	Member of Staff
Mr J Fletcher	Governor (WebEx)
Ms D Fuller	Member of the Public (WebEx)
Ms G Gordon	Member of the Public
Ms C Heggie	Member of the Public
Mr N Kalli	Member of the Public
Ms C Knight	Member of Staff (WebEx)
Mr P Linehan	Member of the Public
Mr B Martin	Member of the Public (WebEx)
Mrs A Matheson	Member of the Public
Mr M Norman	Health Correspondent, BBC South East
Mr D Richford	Member of the Public (WebEx)
Mr P Schofield	Governor
Mrs M Warburton	Governor (WebEx)
Ms L Williams	Member of the Public (WebEx)

MINUTE NO.		ACTION
22/184	**WELCOME AND APOLOGIES FOR ABSENCE** The Chairman welcomed those in attendance. The Chairman welcomed Mr M Powls, Interim COO; and welcomed Ms M Durbridge, Improvement Director, NHSE. The Chairman reported a Closed BoD meeting had been held the previous month to consider the Clinical Negligence Scheme for Trusts (CNST) declaration and the East Kent Hospitals Charity Annual Report and Accounts 2021/22. He also stated a BoD Development Strategy session would be held that afternoon looking at the Trust's leadership arrangements as well as shaping its longer term strategy. The Chairman reported Ms L Shutler, Deputy CEO/Chief Strategy Officer (CSO), Group Company Secretary, Mrs A Fox, had left the Trust, and thanked Dr T Ivanov, Executive Director of Quality Governance, who would be leaving the Trust on 7 March. All of whom taking up positions elsewhere in the NHS. The Chairman wished farewell to Mrs J Ollis and Mr N Mansley, NEDs, who were standing down at the end of the month after nearly six years with the Trust, extending thanks to them both for their dedicated service and all they had done for the organisation, wishing them well and all the best for the future. He reported two new NEDs, Ms Claudia Sykes and Mr Richard Oirschot would be taking up their roles on 1 March, both of whom brought a wealth of experience and was delighted they would be joining the Trust. He noted Richard would chair the Finance and Performance Committee and Claudia the Charitable Funds Committee. The Chairman encouraged Board members to come forward to take part in a Diversity Photography Project, supported by the Trust in partnership with Canterbury Christ Church University (CCCU). Noting this was around highlighting diversity of staff, exploring their working life experiences and wellbeing. CCCU students would be taking photographic portraits of staff/volunteers as well as documenting a brief personal narrative about career pathways and religious/cultural identities, enabling students to learn about career pathways and the diverse make-up and value of staff and volunteers. This information would be used internally by the Trust and also presented at the end of year photography students show.	
22/185	**CONFIRMATION OF QUORACY** The Chairman **NOTED** and confirmed the meeting was quorate.	
22/186	**DECLARATION OF INTERESTS** There were no new interests declared.	
22/187	**MINUTES OF THE PREVIOUS MEETING HELD ON 8 DECEMBER 2022** **DECISION:** The Board of Directors **APPROVED** the minutes of the previous meeting held on 8 December 2022 as an accurate record.	

22/188 **MATTERS ARISING FROM THE MINUTES ON 8 DECEMBER 2022**

Action B/18/22 – Maternity Dashboard
The Board of Directors discussed and noted the Maternity Dashboard for December 2022, appended to the actions report.

The CNMO confirmed the dashboard had been developed by the Maternity leadership team with monthly oversight by the Maternity and Neonatal Assurance Group (MNAG), which she chaired and included Executive and NED representation. She stated all staff were now fully trained in respect of fetal monitoring and CTGs etc. following a training programme and that guidelines were updated reflecting national guidance over the last 12 to 18 months. The challenge now was ensuring staff consistently applied the learning, training, undertook required safety checks and followed guidelines in line within their professional responsibility. She highlighted the poor levels of compliance for mandatory training remained around fetal monitoring and fresh eyes reviews, this was known to the care group with a trajectory set to achieve compliance by March 2023. The dashboard provided assurance of the key performance indicators (KPIs) in place with robust oversight monitoring performance.

The NEDs enquired why compliance was low around Birthrate+ recording, antenatal admission, VTE risk assessment and baseline heart rate plotting. The CNMO stated as identified in the *Reading the Signals* report and acknowledged by the Board the significant culture challenges within the organisation as well as incidents of not following guidelines, checking equipment, fresh eyes checks that was a constant challenge to ensure these requirements were embedded and consistently adhered to. She reported Heads of Midwifery (HoM) and Matrons undertook daily checks to ensure these standard level of requirements were completed, as well as fresh eyes reviews and CTGs checked, that were part of staff roles as clinicians and not additional duties. She commented on the Open letter that would be issued to all staff from the Chairman and Chief Executive about the standard level of care expected to be provided and for which people would be held accountable.

The NEDs noted reassurance from the training activity and daily checks but raised the issue that some staff felt they were being asked to undertake additional duties in respect of safety checks and whether performance management would provide the necessary assurance to the Board that outcomes were being delivered. The CNMO reported the robust daily audit checks, increased from weekly, in place ensured safety of women and babies, this was in alignment with stepping up the cultural change programme to support embedding change. She emphasised the issue with additional duties raised related to a minority of staff. The CMO stated the Trust would continue to work with staff around re-enforcing the roles and responsibilities of healthcare professionals, their ownership to consistently meet the standard of care required and ensure this was embedded throughout the organisation, and holding individuals to account.

The Associate NED questioned how clinician non-compliance with adults and children's safeguarding training was being addressed. The CMO reported this was through the line management process ensuring clinicians were aware of their responsibilities to be compliant with the required training. This included working with the Clinical Director for Women's Health to enable clinicians the time to undertake mandatory training, noting previous gaps had been resolved. The Associate NED highlighted as part of the appraisal process clinicians were required to confirm their full mandatory training compliance.

The NEDs highlighted there was an element related to estates in respect of patient and staff experience and the need to include estates and facilities performance

criteria within this dashboard in response to the CQC inspection. The CE agreed with this suggestion, which would be explored and taken forward by the CNMO. She expressed disappointment about the continued culture issue within the organisation, emphasising this was a minority of staff, who would continue to be reminded of the importance of these consistent safety checks ensuring all staff worked to the high standard required in maternity services and throughout all areas in the Trust, noting improvements had been achieved. The Trust would continue communicating to staff the high standard all staff were required to work to. She stated the CNMO and Interim DoM had over the last six months addressed individual cases of poor culture and behaviours.

ACTION: Explore the inclusion of an estates and facilities performance criteria within the maternity dashboard to identify issues to be addressed in respect of patient and staff experience. — CNMO

The Chairman requested monthly exception reports to be provided to future BoD meetings to monitor performance and progress against the Maternity dashboard, as well as identifying areas of concern. The CNMO would look at MNAG monthly reports to include an exception summary report on the Maternity dashboard.

ACTION: Present monthly MNAG reports to future BoD meetings to include exception summary on performance and progress against the Maternity dashboard, and any areas of concern. — CNMO

Action B/19/22 – Numbers of Learning Disabilities (LD) and or Autism stranded patients
The Board of Directors noted the open action about the numbers of LD and or Autism stranded patients that were deemed medically optimised for discharge and should no longer be within acute services. The Interim COO confirmed one patient in terms of Kent & Medway (K&M), two patients in Queen Elizabeth the Queen Mother (QEQM) Hospital, and three in William Harvey Hospital (WHH). The Board of Directors **APPROVED** this action for closure.

DECISION: The Board of Directors **NOTED** the updates on the actions from the previous meeting, those for future meetings and **APPROVED** the two actions recommended for closure.

22/189 **CHAIRMAN'S REPORT**

The Chairman highlighted the key areas of focus for the Trust:

- Agree the Improvement Plan and its trajectory;
- Embracing and taking forward the transformation programme in response to the *Reading the Signals Report*;
- Achieving the 2023/24 Financial Plan that would be a challenge;
- Development of longer-term strategy, liaising with staff, partners, wider K&M system, patients and the community.

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

22/190 **CHIEF EXECUTIVE'S (CE'S) REPORT**

The CE reported:

- A detailed report on the 2023/24 Operational Business Planning would be presented to the next Board meeting;
- Kent and Medway Pathology Network (KMPN) update, with appointments

looking to be made to the Clinical Director and Managing Director to support advancing the development of this Network. This was a national initiative providing benefits to the provider organisations working within this collaborative, who continued to work closely together to develop a sustainable, high quality and cost-effective service;
- Locum registrar in paediatrics employed through an NHS Framework agency, who was arrested following a 'sting' operation. The Trust had undertaken a review of his employment and once completed, there was likely to be further learning, actions and recommendations.

The NEDs raised the KMPN, which was not included in the Trust's IPR and the importance of developing a set of metrics to monitor performance of this service at it developed, in respect of the benefits and outcomes for patients. The Executives were asked to consider how this information would be reported and monitored in respect of delivering an effective service to patients. The CE agreed this was needed and commented there was future work required that would look at other metrics for monitoring by the Board outside those within the IPR and part of the We Care programme, which included turnaround times for diagnostics and pathology.

The NEDs raised winter pressures and reflection of the support from the Integrated Care Board (ICB) during its first year of inception in respect of integrated planning and learning around managing winter pressures, flow and discharge across the local system. The CE commented ICB's support in providers working collaboratively with mutual aid across hospital sites to address peak periods of pressure for individual providers. She noted progress had been made but there was more work needed with the Integrated Care System (ICS) and Health and Care Partnership (HCP) about managing the Emergency Care pathway collectively with primary care, social care the voluntary sector, and there was commitment to do this.

The NEDs acknowledged and commended the hard work of all Trust staff in managing demand during the very busy winter and Christmas and New Year period, thanking them for their dedication in treating patients in pressured environments.

The NEDs commented the good work and benefits of other ICS and ICBs working together on data models across system providers in respect of notification of discharging ensuring forward planning, and that this was needed in the local system. The CE agreed this was needed to be taken forward and would be part of the future collaborative work across the local system.

DECISION: The Board of Directors:

- discussed and **NOTED** the Chief Executive's report;
- **AGREED** and **SUPPORTED** the proposals and recommendations for the Kent & Medway Pathology Network transformation case for change.

22/191 ***READING THE SIGNALS* – DELIVERING THROUGH PILLARS OF CHANGE**

The Chairman stated this report would support the work to reshape the organisation, to make changes and make a difference over the months and years ahead, not just within maternity but across all the Trust's sites and in the community. It was recognised it would take time to make changes, the importance of continuous monitoring, and bottom up approach listening to patients and families.

The EMSSPD highlighted key elements:

- Open letter for publishing, draft presented for approval, for printing the

following day, which was agreed by the Board;

- Letter for publishing to every member of Trust staff (hard copies and by e-mail);
- Pillars of change now included how the Trust would monitor and measure its success, these would be in an assurance framework with clear KPIs expected to be presented to the next Board meeting. It was agreed the framework would be circulated to NEDs for feedback and comments;
- Culture and Leadership Programme, Trust had rolled out the nationally recognised programme within maternity and would do so throughout the Trust in due course. The national lead for this programme would be attending the April Board meeting to have a discussion about the programme and its implementation;
- *Reading the Signals* Oversight Group, draft terms of reference had been developed that would be presented to the first meeting of the Group. Families had been invited to be part of the membership of the Group and interest had been received from 15 families, above the membership numbers, so a Families Voices meeting would be held first;
- Independent case review process, independent reviewers had been appointed following external recommendation and all outside the K&M system. Discussions taking place with individuals that had expressed an interest to be part of this process with the aim to commence in the next 10 days;
- NHSE's response would include a Maternity Delivery Plan covering recommendations likely to be published in the next couple of months, which the Trust would need to take into consideration as part of its improvement plan;
- Intention for the Minister to meet with families, and meetings held with Dr Kirkup and the Minister;
- The Trust's Communications Strategy had been refreshed with learning from the report and plans to engage with the public about what the Trust was doing and feedback on whether it was getting this right;
- A video by the Chairman and CE about the report shared with the Clinical Executive Management Group (CEMG), who would support the Pillars of Change, change of culture, engaging with staff, resetting Trust values, and providing feedback from staff. The video would be disseminated to Trust staff.

The NEDs acknowledged the significant work and progress made to date and engagement and involvement with the families. It was highlighted the need when reviewing the Pillars of Change to identify what would really be different and how the Serious Incident (SI) process could be more effective. As well as having outcome indicators. It was suggested that the Oversight Group could be chaired by a Governor with a NED vice-chair. It was also reiterated the issues with culture were not just within maternity and for addressing throughout the organisation, and the need to link all the various initiatives. The EMSSPD confirmed this had been considered and would be presented for discussion by the Group. The CE confirmed culture programme implementation would be across the organisation with specific elements in maternity services, having a combined document covering all the improvement initiatives, learning, actions and mitigations feeding into a robust governance structure, which was work in progress.

The NEDs asked what had been done to ensure communication of the report and its content to staff, as well as what was currently in place listening to women and families. The CE stated all communication methods had been utilised to make staff aware of the report, recognising their understanding of the severity was variable and the need for continuous communications. The implementation of the Your Voice is Heard programme following births with positive engagement and acting on

feedback. The CNMO stated two Patient Experience Midwives in post walking the wards talking to patients, as well as increasing Matron walkarounds and 2 hourly care rounds, ensuring a midwife spoke to everyone asking about their care, experience and whether everything was okay. Trust was working with families around what needed to be done if women were unhappy with their care received and how to raise this, with a digital system being reviewed to provide this function.

The CMO reported clinical leadership forums and clinical leadership programme sessions encouraging clinicians to read the report with open discussions reflecting on it.

ACTION: Circulate the Pillars of Change Assurance Framework to NEDs to provide feedback and comments prior to this being presented to the next Board meeting. EMSSPD

DECISION: The Board of Directors:

- discussed and **NOTED** the Transforming our Trust: our response to *Reading the Signals* report;
- **APPROVED** the draft open letter.

22/192 **MATERNITY SERVICES:**

- **CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) – MATERNITY INCENTIVE SCHEME**

22/192.1 **PERINATAL QUALITY & SURVEILLANCE TOOL (PQST) REPORT**

The Interim DoM reported:

- Engagement and listening to women, Your Voice is Heard response rate for December was at its highest to date of 74.3% of women being spoken to with honest and balanced feedback, with improvements in this feedback and changes in post-natal care in the community with the need to make changes within the in-patient care;
- Issues raised about the estates and an action plan to address these;
- Professional behaviours and culture, recognising the continued activity pressures and staff vacancies particularly at WHH impacting staff resilience, with resilience training for midwives as well as the wider staff within the maternity service;
- Co-production with women and staff, on-call midwife on occasions being used during periods of demand and working with staff to find a resolution to reduce usage;
- Positive feedback from staff in respect of team working, particularly at WHH;
- Training supporting staff on how to de-escalate.

The NEDs raised staffing capacity and whether both units at WHH and QEQM were functioning at a safe staffing level. The Interim DoM stated work undertaken in December reviewing staffing at WHH, QEQM and also in the community covered in the report, noting the hot spot at WHH impacted by vacancies, maternity leave and sickness absence working closely with P&C team on this. It was noted QEQM was at the level required as was the community. The CNMO raised WHH staffing and a deep dive review would be undertaken and outcome to be reported, all was being done to encourage staff to come and work at the Trust, as well as looking at how activity could be managed differently.

The NEDs raised the issue about analgesia, provision of pain for women and for a report to be presented to a future Q&SC meeting in respect of providing the level of

pain relief required by women. The CNMO stated there had been a change with the issues around analgesia, women in labour not being listened to and this was being addressed within post-natal care and implementation of the 2 hourly rounds.

The NEDs asked the reasons for the red non-compliance for training. The Interim DoM confirmed this related to the PRactical Obstetric Multi-Professional Training (PROMPT) and challenges for the anaesthetic team to attend training, and actions ongoing to address and resolve this.

DECISION: The Board of Directors:

- Discussed and **NOTED** the contents of the PQST report;
- Received **ASSURANCE** and **NOTED** that a monthly perinatal quality assurance report had been received, demonstrating full compliance in line with CNST standard and Ockenden 1 report, Immediate and Essential Action requirements; and
- **APPROVED** for the contents of the PQST report to be shared through the Perinatal Quality Surveillance Model Framework with the Local Maternity and Neonatal System (LMNS), Region and Integrated Care Systems (ICS).

22/193 **MATERNITY CARE QUALITY COMMISSION (CQC) ACTION PLAN UPDATE**

The CNMO reported:

- Trust was awaiting the formal CQC report following the inspection;
- Four areas of concern highlighted; fire safety at QEQM, effective processes for fetal monitoring and escalation at WHH, timeliness and effectiveness of maternity triage processes at WHH, and IPC at WHH;
- Immediate actions had been taken to address fire safety and IPC issues, with an ongoing fire safety review;
- Fetal monitoring, daily retrospective reviews of women's patient notes, and conversations with staff about adhering to this guidance, supporting staff to embed sustained improvements and culture and behaviours, formal processes for staff where required. Implemented IT process within the digital whiteboards with an icon providing an alarm when fetal monitoring fresh eyes reviews were needed;
- Maternity triage, part of the maternity improvement programme that was a challenge at WHH and work escalated on the medical rotas enabling medical 24/7 oversight on triage, expected to be in place by the beginning of May if not earlier, during the interim cover provided by a Consultant on a daily basis. Delays entering triage, with adjustments to junior doctor rotas enabling women to be seen sooner and improve patient flow.

The Chairman reported the disappointment on the issues raised by the CQC, when the Trust had been undertaking mock inspections, recognising the work and actions implemented. He noted a further review would be needed on receipt of the formal report and recommendations within that. The CNMO stated the mock inspections had identified the issues raised by the CQC in respect of IPC that were addressed at the time, and the challenge was around maintaining the required standards and professional responsibilities. Work had been done to improve the estate e.g. bathrooms, as much as could be done with the old estate.

The NEDs raised how assurance could be provided. The CNMO confirmed processes in place where changes made to clinical practices around audits. Training and development sessions with staff in March around their professional responsibilities, civility to patients, families and each other, as well as working as a team, emphasising it would take time to see changes in culture and behaviour. The

CE reported the organisation was not in the position it needed to be and to get to being an exceptional organisation required continuous staff development, empowering staff and enabling them to take initiatives, and cultural shift.

The NEDs highlighted the areas identified by the CQC that were basic elements and expected standard of care and service provision, and that staff were held to account performing to this required level. The CNMO commented a discussion with the Executive Management Team (EMT) about the issues raised outside of maternity services, e.g. fire wardens and fire safety. She stated the Senior Responsible Officer (SRO) for Journey to Outstanding Care was undertaking a deep dive review to understand the reasons why the Trust got to the position it did, considering checks and audit processes in place in respect of IPC and fire, and a report would be presented to the March Board meeting.

The NEDs raised the importance of lobbying for additional capital funding to address the estate issues due to the age of the estate. The CFO reported the FPC had approved £1.5m funding for upgrades in both WHH and QEQM maternity units, noting the significant total level of funding that would be required to achieve the level of improvements needed. The Chairman acknowledged the need to work with the ICB to reinforce the necessary capital funding to the Trust to meet its capital needs.

The Chairman opened the meeting for questions from members of the public.

Mr Linehan thanked the CE and CNMO for meeting with him and his family, listening to their feedback that had been provided at the time of their experience. He highlighted the report was massive and damming to EKHUFT, was one of the worst reports, and needed to be given appropriate respect by the Board and its members picking up a specific comment from a NED. He commented on the need to stop referring to the previous Trust leadership, noting the new leadership in place needed to make the necessary changes, and action the recommendations in the report. He asked when there would be inward focus looking at what was being done by the Board, noting this was already being done by the CNMO and her staff, and basic checks consistently done. He raised the Pillars for Change and stated these were not sufficient to ensure the necessary changes, and the importance to invest in all of these. He was working with the EMSSPD on the Oversight Group ToR, which he felt needed further work to develop these and would continue to attend these Board meetings to ensure the Trust and the Board were challenged on progressing the report recommendations. The NED apologised if any comment he made was inappropriate, which was not his intention, acknowledging the huge work around the report and that within it had lessons to be learnt across the wider Trust outside of maternity services and the key element being culture. The NEDs acknowledged the extent of the challenge ahead, changes would be led by the Oversight Group in liaison with working with families, and had set out a realistic plan over the next three years that would change as work progressed.

Mrs Warburton commented her sadness as a retired midwife hearing staff opposing the change of culture, and asked whether the Trust had sought advice and support from the NMC, as the regulatory body in respect of patient safety, and staff responsibility around fitness to practice. The CNMO confirmed the Trust was working closely with NMC and RCM, regular discussions, and re-iterated this related to a small minority of staff.

Ms Heggie raised the issue with fire safety that had been raised, reminding the Board that she had raised this previously over a number of years in respect of keeping corridors clear, fire doors being kept closed, and the need to do walkarounds to ensure this was happening. VTE performance remained poor and this was a historic issue. Care and compassion pillar, staff should be spoken to

with civility and this needed to be addressed immediately, and simple quick changes needed to happen to improve staff engagement. Staff were in place, whose role it was to ensure the necessary checks were being done. She would be meeting with the CPO outside the meeting to discuss her concerns. She commented on the need for investment and to push for additional funding to provide units that met current needs. It was noted the Bullying and Harassment Policy had recently been updated and the importance that all staff were aware of this policy. The CE agreed with the comments in respect of culture and that the Trust would not be waiting a couple of years to resolve this issue, it was committed to a long-term programme, this was fundamental within the organisation and recognised the changes would not happen in the immediate future and would take time. This would be supported by ongoing engagement with staff, for them to understand and adjust their behaviour and have the confidence to raise concerns and speak up if they had not been listened to and not treated well. The need to communicate to all staff of the support available and using all methods to ensure information was disseminated, utilising the leadership in the organisation, and that patients and patient safety was at the centre of everything the Trust did.

The Chairman reported it was recognised the need to make changes at pace, action needed to be taken, and be seen that this was as a major change to transform the organisation.

The Board of Directors:

- **NOTED** the content of the action plan and the progress being made to address the concerns raised by the CQC and;
- **NOTED** that the outcome of the review will be presented to the Board in March 2023.

22/194 **INTEGRATED PERFORMANCE REPORT (IPR)**

Hospital Standardised Mortality Ratio (HSMR)

The CMO reported progress to reduce mortality and be in the top 20% of all trusts for the lowest mortality rates in 5 to 10 years:

- Sustained improvement in the HSMR ratio and position being maintained;
- Continuing to focus on mortality metrics and where changes could be made to patient pathways to improve patient outcomes.

The NEDs questioned whether the HSMR target was ambitious enough and whether this needed to be reviewed. The CMO commented this target would need to be reviewed in alignment with the review and reset of the IPR and its metrics and whether focus on this area should continue or be monitored as Business As Usual (BAU). It was noted the positive current position.

Reduce Incidents (avoidable Harm)

The CNMO reported an update on the target to achieve zero patient safety incidents of moderate and above avoidable harm within five years:

- In December 40 incidents of harm and above, which was above the Trust's threshold, with no further deterioration of this position since November;
- Challenges continued due to increased activity in the Emergency Departments (EDs), overcrowding and patients treated in non-designated areas, with increased risk of harm. Demand pressures triangulated to harm in respect of falls, diagnostic and escalation of deteriorating patient that was

a key focus with ongoing work to address identifying deteriorating patient;
- QEQM in December had 1,069 patients treated in corridor with average wait of 5 hours, in WHH 1,149 patients treated in corridor with average wait of 29 hours, due to pressures in EDs impacting poor experience for patients.

The NEDs questioned the number of overdue incidents that was 6,000 and what incidents were included within this. The EDoQG stated incidents were reviewed locally and all remained on the system until completion of a review, action plan and approval for closure. She confirmed all incidents had been reviewed, none were moderate or above, and no themes for low incidents, these had been identified in IPR to ensure continued focus of action and completion of incident reviews, in turn reducing those overdue. Focus had been to action and close long standing incidents, noting some that remained overdue were approximately 12 months.

Trust Access Standards: 18 week Referral to Treatment (RTT), >12h total time in department, and Cancer 62 day
Theatre Session Opportunity
Same Day Emergency Care (SDEC)
Not fit to reside

The Interim COO reported:

- RTT – position remained stable, although out-patients was slightly above 18 weeks impacting performance, and action included looking at capacity. 104 weeks there were no breaches, 3 patients had taken the decision to wait longer that was patient choice, 78 weeks there were 302 patients of which 82 remained undated and work was ongoing to increase capacity to reduce those 78 week patients;
- Theatre opportunities lost during December was 44 compared with 37 the previous month, impacted by pressures in EDs and lack of patient flow;
- Time in ED over 12 hours, increased in December by 2.35% due to demand and pressure in ED;
- SDEC with positive increase in number of patients referred, with WHH reduced numbers during December due to pressures and use for inpatient beds to meet increased demand;
- Not fit to reside, currently 392 patients, with the key area of pressure patient pathway 3 related to very complex patients. All was being done internally to increase patient discharges, as well as good system discussions around capacity in the community and provision of additional beds currently 30.

The NEDs enquired what was being done supported by the system to address and reduce the increasing number of not fit to reside patients. The NEDs highlighted the need to ensure a robust and streamlined referral process in place to support discharging patients. The Interim COO reported discussions and working with the system looking at hubs, step down beds and support for prompt social care assessments, with ongoing discussions to provide a sustainable solution.

Patient Experience: Inpatient Survey

The CNMO reported on the ambition to improve performance against the focussed ten questions to achieve the national average score of 7.65 as a minimum by March 2023:

- In December against the monthly target of 2050, 1900 inpatient surveys completed, and in January 2200, overachievement against the national average score. The issue impacting this was being able to sleep at night due to patients being disturbed, with ongoing work to address this.

People domain
Staff Engagement: Staff Involvement Score

The CPO highlighted key points within the people domain, and to improve the staff engagement score to 6.8 by March 2023:

- Workforce planning identified the number of staff required against the safe staffing reviews, and the challenges in recruiting to these staff levels. National discussions taking place around workforce planning, business planning and the finances available;
- Premium pay currently did not take into account where there was Whole Time Equivalent (WTE) to off-set the cost of premium pay, it was known the Trust's needs for high volume nursing requirements for premium pay, in respect of staffing escalation areas. The real challenge related to doctors and the expected additional rates of pay for non-contractual activity, an additional cost to the organisation that was being encouraged to meet the increased rates published by the British Medical Association (BMA). There was on-going discussions as a local system and South East system about these increased BMA rates, which were currently not being met;
- National Staff Survey results were currently under embargo and would be published on 6 March, a high level update was provided in the report presented. Nationally there had been a deterioration in the staff engagement rate scores, the Trust had an action plan in place to address and improve this, acknowledging the multifaceted climate issues within the NHS affecting engagement with staff, as well as the impact of the *Reading the Signals* report on staff;
- Increased level and score of staff involvement and motivation that was positive, recognising there was still a long way to go to achieve the required engagement score of 6.8 against the national 7.1 that had been declining, and work was on-going to improve this score.

The CMO commented on looking at innovative methods for the workforce to reduce reliance on temporary staff and premium pay, that would support the culture change programme and a sustainable future workforce.

The Board of Directors discussed and **NOTED** the True North and Breakthrough Objectives of the Trust.

22/196 **FORECAST UPDATE ON EKHUFT 2022/23 FORECAST POSITION AND ASSESSMENT OF FURTHER FINANCIAL RISKS**

- **MONTH 9 FINANCE REPORT**
- **IPR - FINANCIAL POSITION (INCOME AND EXPENDITURE (I&E) MARGIN)**

The CFO reported:

- Board approval required of the reforecast financial position to a £30m deficit and approval of delegated authority for the CE and CFO to drawdown cash borrowing to support this reported position. This meant releasing non-recurrent measures to achieve this position, working closely with the ICB and NHSE, as well as additional funding provision that was yet to be confirmed;
- Year-to-date (YTD) position of £24.5m deficit, £21.4m adverse to the plan, main areas contributing to this included under delivery against the Cost Improvement Programme (CIP), overspend in escalation areas, and increased spend in mental health patient specialling;

- Mitigating actions included meetings with all care groups reviewing in detail their budgets, forecasts and additional controls in place around discretionary non-pay, pause on recruiting non-clinical patient facing roles with provision of justification information against these;
- Completion of the Healthcare Financial Management Association (HFMA) checklist assessing basic system processes were in place and the Trust's workforce changes over the last two to three years, which had been submitted to the system centre;
- Discussions about the 2023/24 business planning being held and a detailed report would be presented to the next meeting of the Board for consideration and approval, noting the significant financial challenge for the Trust the following financial year.

The NEDs highlighted the importance of having a clear Trust Strategy and Clinical Strategy in place to align with the Trust's finances and also to have a discussion about safety in respect of ensuring its sustainability. This was agreed by the Board for a future discussion that would need to cover comparison with other trusts in respect of patients no longer fit to reside and community provision.

The NEDs enquired about the impact of the £30m deficit, continued premium pay pressure and potential additional funding support to address these and future mitigations to reduce premium pay spend. The CFO commented additional income for mental health nurses was approximately £8m. The Trust's £30m deficit linked with the system to deliver as a whole a deficit position of approximately £30m that incorporated some partners providing an underspend and some an overspend agreed with NHSE. He stated the overall pressure with premium pay spend was circa £100m annually and the longer term plan to address this included the recruitment of Healthcare Assistants (HCAs). Noting the successful recruitment of overseas nurses and expectation to see the benefits of this in the next financial year. The NEDs highlighted the level of the Trust's deficit in comparison with other local system providers, noting it was a significantly larger organisation, and that this would be part of the 2023/24 business planning discussion the following month.

DECISION: The Board of Directors:

- **NOTED** and **APPROVED** the Trust's revised forecast and the reforecast of a £30m deficit in line with K&M ICB and national protocol for changes to in-year revenue forecasts;
- **APPROVED** delegated authority to the CE and CFO to drawdown cash borrowing to support the reforecast deficit position.
- Reviewed and **NOTED** the financial performance and actions being taken to address issues of concern.

22/198 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

- **2022/23 BORROWING REQUIREMENT AND PROPOSED INTER-COMPANY LOAN AGREEMENT**
- **BUSINESS PLANNING UPDATE AND GUIDANCE**
- **UPDATED FORECAST FOR 2022/23 TO A £30 DEFICIT**

The FPC Chair highlighted:

- The Deputy CFO had been requested to undertake a deep dive review into premium pay spend, to understand the reasons for this expenditure, in comparison with the Trust's WTE budgeted workforce hours and whether it was spending in excess of this, in respect of price vs volume. As well as reviewing for comparison the Trust against other trusts. A report was

expected to be presented to the next FPC meeting;
- Challenge for 2023/24 business planning in respect of returning to Payment by Results (PbR) that the Trust was Value for Money (VFM) negatively impacted by previously with not receiving sufficient income;
- The need for the Board to review the IPR and consider whether the current identified True Norths and Breakthrough Objectives were still appropriate, for consideration at a future Board Development session.

The Chairman thanked the FPC Chair for his support and commitment to the Trust and to the FPC as its Chair.

DECISION: The Board of Directors:

- **NOTED** the 31 January 2023 FPC Chair Assurance Report;
- **APPROVED** the:
  - 2022/23 Borrowing Requirement and Proposed Inter-Company Loan Agreement;
  - Business Planning Update and Guidance;
  - Updated forecast for 2022/23 to a £30m deficit.

22/195 **BOARD ASSURANCE FRAMEWORK (BAF) RISK REGISTER**

The CE reported:

- The changes to the risks included in red in the BAF;
- As covered within the IPR discussion, the risks reflected the majority of areas that were underperforming with the exception of mortality.

The NEDs questioned a timescale for reviewing the risk registers noting the items included were issues and facts and not risks. The IAGC Chair commented the need for a review and discussion of the Trust's risk appetite, and definitions of risks, the IAGC had agreed this needed to take place at the individual Board Committees in respect of review, discussion and challenge of the control actions and evidence prior to a Board discussion. He reported the IAGC took limited assurance from the risks report presented at the last IAGC meeting. The CE stated the importance that as part of these discussions the need to embed the responses and assessment of risk within the BAF.

The NEDs commented the need to review the format and structure of how the risks report was presented in the future. The CE accepted this and stated support was being explored to assist to review this report, which she had overall responsibility for with ownership from all the Executive Directors.

The Chairman reported the Trust was looking at appointing an Interim Group Company Secretary (GCS) and recruitment of a substantive GCS, who would support the management of risks.

DECISION: The Board of Directors **APPROVED** the latest update of the BAF.

22/200 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR ASSURANCE REPORT**

The IAGC Chair highlighted:

- The significant work being undertaken in respect of strengthening governance and assurance;
- A gap in the IAGC membership as the Chair of FPC was the only Board

Committee Chair who was not a member and did not attend IAGC meetings. This would be taken forward for consideration and inclusion in the ToR as a member, as it was crucial to receive feedback from FPC;
- The need for pace in management actions to address control gaps and the need for due diligence;
- Limited assurance from the Governance Mapping report with on-going work on the governance structure and integrated governance guide, and a further report would be presented to IAGC.

The CE would be meeting with the IAGC Chair outside of the Board meeting to have a discussion about risks and strengthening the governance structure to provide IAGC with the assurance required of the processes in place.

The Board of Directors **NOTED** the 24 January 2023 IAGC Chair Assurance Report.

22/197 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

The Board of Directors **NOTED** the 31 January 2023 P&CC Chair Assurance Report.

22/199 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

The Q&SC Chair highlighted:

- IPR - opportunity to re-align this with the operating framework published in December 2022 around the appropriateness and completeness of the metrics in the IPR. As well as looking at rationalising where this was presented and discussed, as currently by all Board Committees and the Board;
- CQC compliance, and the disconnect between the CQC assurance reports presented to Q&SC and the issues identified by the recent CQC visit, the effectiveness of the Trust's systems and controls in place, and compliance was a symptom of behaviours and culture and until turning the dial on this, delivering compliance with basic standards of care would remain a substantial challenge. Noting the importance of the Board having sight of progress of the culture change programme;
- Ophthalmology backlog, the follow-up backlog of circa 11,500 cases, external advice had been sought from the Royal College of Ophthalmologists on managing this backlog. This would be reviewed at the next Q&SC around the processes put in place and whether these were effective and having an impact on reducing the backlog cases;
- Q&SC were reviewing its overall structure and duration of the meetings to identify agenda items that could be considered by alternative groups to support reducing the duration of meetings and allowing focussed discussion on items.

The Chairman welcomed feedback from Board members on suggestions of how the duration of Board meetings could be reduced, with an aim of these being no more than 2.5 hours.

The Chairman extended thanks for the concise Board Committee Assurance reports that clearly identified and reflected the current issues, position and whether assurance, reassurance or limited assurance had been received.

The Board of Directors **NOTED** the 26 January 2023 Q&SC Chair Assurance Report.

22/201 **ANY OTHER BUSINESS**

There were no other items of business raised.

22/202 **QUESTIONS FROM THE PUBLIC**

Ms Gordon raised a question about the Trust's finances and premium pay, and that permanent members of staff could be undertaking additional working shifts to increase their income. She noted the result of the vote was to not take industrial action within the East Kent area in respect of pay and concern that this might not have related to contentment but despondency also reflected in the low response to the staff survey. She acknowledged the willingness and efforts of the Board to take forward improvements in many areas. The Chairman commented it was recognised that those who did not participate in completing the staff survey did not necessarily mean they were happy. He noted in respect of the industrial action vote that some staff might had been influenced and conscious about the number of acutely ill patients in the hospitals, staffing shortages and despondency. The CPO responded about premium pay confirming the standard practice of having a bank of staff, these were predominantly substantive staff that undertook additional working shifts for an agreed bank rate, with escalated rates for specific areas. It was noted some staff worked purely on the bank and some taking on additional shifts, recognising some staff could be utilising this to increase income. The Trust continued to work closely with medical, nursing and administrative Union representatives and the importance of these relationships, whilst recognising the tensions in respect of pay.

The Board of Directors received e-mailed questions from Mr B Martin, that was responded to by e-mail and included in Board of Directors minutes as noted below.
Question 1: What does the Board of East Kent Hospitals University NHS Foundation Trust do to ensure that patients and the public get as much information they need, for example how long a person has to wait for a colonoscopy at the Trust. I have been told there are four categories: routine, urgent, cancer, and urgent cancer. It cannot be impossible to say that the waiting time is about x number of weeks for each of these categories.
I have been told a private hospital colonoscopy costs a little short of £2,000. How can an informed decision be made. I find it hard to believe that no one in the department has even a rough idea of how long patients are waiting.
Apparently, before a colonoscopy can be done on the NHS, there has to be an assessment by an NHS gastroenterologist, when they are NHS staff at the East Kent Hospitals University NHS Foundation Trust.
By insisting on this work is being duplicated and probably at a cost to the NHS, when the cost of the private consultation has been borne, wasting money. This is not about jumping an NHS queue but making an informed decision as to whether to go privately, saving the NHS money and reducing the waiting list. It makes sense to provide the information even if an approximation.
Trust response
Response to Question 1
2 week wait as stated
Urgent up to 8 weeks
Routine undated for 1st TCI 44 weeks (patients further out from this who have been cancelled or Did Not Attend (DNA) and rebooked).
In relation to the patient moving across from their private consultation to the NHS.

- *Patients moving between NHS and private care*
- *Patients can choose to move between NHS and private status at any point during their treatment without prejudice. Where it has been agreed, for*

example, that a surgical procedure is necessary the patient can be added directly to the elective waiting list if clinically appropriate. The Referral to Treatment (RTT) clock starts at the point the GP or original referrer's letter arrives in the Trust and will be booked in chronological order and in accordance with the referral pathway.

- *The RTT pathways of patients who notify the Trust of their decision to seek private care will be closed with a clock stop applied on the date of this being disclosed by the patient.*
    - *Managing the transfer of private patients*
- *If a patient decides to have any appointment in a private setting they will remove themselves from the cancer pathway.*
- *If a patient transfers from a private provider onto an NHS waiting list they will need to be upgraded if they have not made a Decision to Treat (DTT) and the consultant wants them to be managed against the 62-day target. If a DTT has been made in a private setting the 31-day clock will start on the day the referral was received by the Trust.*

Question 2: What steps do the Board of East Kent Hospitals University NHS Foundation Trust indeed to take to improve patients and the public access to the East Kent Hospitals University NHS Foundation Trust by telephone?
More times than not when I call, I either have to wait for an exceedingly long time and get cut off before getting through or I don't even get though in the first place. The recorded message - like those of government departments, banks, and other organisations - informs the caller that there is an unprecedented number of callers. This cannot be true as this situation has been going on for more than a year so it's not "unprecedented" or unexpected.
The real reason is that the Trust does not employ enough people to answer the phones. This is something the Board needs to address. I realise money is tight and funds correctly need to go on medical care can administrative staff be seconded to the switchboards at times when said staff are not busy.
Response to Question 2
The Trust and 2gether Support Solutions (2gether) work very closely on the management and call answering of the Telephone Systems that we have in place at East Kent. The main system in use at the Hospital is an Auto attendant system which allows calls to be electronically filtered before reaching an operator. This is a standard way of operating when you have high call volumes such as those that we experience and allows calls to be filtered without initial human intervention. There are also other department based systems in place such as specific Booking Lines, that are managed locally. In the last 2-3 years our call volumes have increased exponentially and as a result of this we have spent a significant amount of time working through the challenges that this brings. Within the last 12 months there has been financial investment resulting in an upgrade to the system to transition calls/callers more promptly as we know how important it is for our patients and their relatives to be able to be directed quickly and correctly to their desired call location. Our switchboard operators are trained to a high standard and deal with a large number of very complex requests and calls each day. We map our call volumes and adjust our staffing levels according to the peaks and troughs of our call levels. We have recently increased our staffing levels to cope with the seasonal Winter Pressures. We are very mindful of how important it is for people to get through to the right place as quickly as possible when they phone a Hospital and this is something that we try and work on and improve every day. We are very grateful for the feedback and will use this within our monthly review meetings to help drive performance and improvements.

The Chairman closed the meeting at 12.10 pm.

Date of next meeting in public: Thursday 9 March 2023 in the Harris Room, Spitfire Ground - Canterbury Cricket Ground.

Signature _____

Date _____

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**MATTERS ARISING FROM THE MINUTES ON 9 FEBRUARY 2023**				
MEETING DATE:	**9 MARCH 2023**				
BOARD SPONSOR:	**CHAIRMAN**				
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	**Approval**	Information	Assurance	Discussion
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 Recommendation(s):	The Board of Directors is asked to **NOTE** the action log from the actions from the previous meeting and **APPROVE** the actions recommended for closure.				

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**

Link to the Board Assurance Framework (BAF):	None	
Link to the Corporate Risk Register (CRR):	None	
Resource:	Y/N	N
Legal and regulatory:	Y/N	N
Subsidiary:	Y/N	N
Assurance Route:		
Previously Considered by:	N/A	

East Kent Hospitals University NHS Foundation Trust

MATTERS ARISING FROM THE MINUTES ON 9 FEBRUARY 2023

1. Purpose of the report

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

2. Background

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

2.2. The Board is asked to note the updates on the action log.

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/14/22	Undertake a repeat analysis in March 2023 of the impact of We Care on staff engagement levels on the data provided by the National Staff Survey 2022 and National Quarterly Pulse Survey (NQPS) Quarter 4.	Apr-23	Chief People Officer (CPO)	Open	Item for future Board meeting.
B/17/22	Amend the IAGC Terms of Reference (ToR) reflecting the substitute Board Committee member attendance if Committee Chair was unable to attend an IAGC meeting. Circulate for virtual IAGC approval and once approved to be presented to the Board for approval.	~~Feb-23/~~ May-23	Integrated Audit and Governance Committee (IAGC) Chair/Group Company Secretary (GCS)	Open	Amended IAGC ToR to be presented to IAGC as part of its annual effectiveness review survey, approved ToR to be presented to the Board for approval as part of the IAGC Chair Assurance Report.

B/20/22	Circulate the Pillars of Change Assurance Framework to NEDs to provide feedback and comments prior to this being presented to the next Board meeting.	Mar-23	Executive Maternity Services Strategic Programme Director (EMSSPD)	To Close	Assurance Framework circulated to NEDs for feedback for incorporation in version to be presented to Board. **Action for agreement for closure at 09.03.23 Board meeting.**
B/21/22	Explore the inclusion of an estates and facilities performance criteria within the maternity dashboard to identify issues to be addressed in respect of patient and staff experience.	Mar-23	Chief Nursing and Midwifery Officer (CNMO)	To Close	Estates and facility issues are picked up in other Committees/meetings. The issue is how this information is escalated or shared with other Committees. Women's experience regarding estates/facilities is included within the Your Voice is Heard feedback and is triangulated with complaints. Details are included within the Maternity and Neonatal Assurance Group (MNAG) report regarding what we are doing to respond to concerns raised. MNAG is not the apporpriate Committee to be overseeing the 2gether Support Solutsions (2gether) contract arrangements. **Action for agreement for closure at 09.03.23 Board meeting.**
B/22/22	Present monthly MNAG reports to future BoD meetings to include exception summary on performance and progress against the Maternity dashboard, and any areas of concern.	Apr-23	Chief Nursing and Midwifery Officer (CNMO)	Open	Item for future Board meeting.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**STAFF EXPERIENCE STORY**				
MEETING DATE:	**9 MARCH 2023**				
BOARD SPONSOR:	**CHIEF PEOPLE OFFICER (CPO)**				
PAPER AUTHOR:	**HEAD OF STAFF EXPERIENCE**				
APPENDICES:	**APPENDIX 1: STAFF CASE STUDY**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	The report provides background for the staff experience story that will be heard at the Board meeting. The story relates to mental health, access to the Trust's innovative wellbeing bus and the *talking wellness* service.				
Summary of Key Issues:	The story offers insight into the support services available and the impact they have for staff. The Staff Experience service have actively promoted access to the wellbeing bus, with over 1,000 colleagues visiting on the last tour, as well as the *talking wellness* service. This story demonstrates how the service has contributed to a reduction in absence due to stress, anxiety and depression from 33% to circa 6% since its inception.				
Key Recommendation(s):	The Board of Directors is invited to **LISTEN** and **NOTE** the member of staff's experience.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	Our people	Our future	Our sustainability	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	N/A				
Link to the Corporate Risk Register (CRR):	**CRR 88 -** There is a risk of failure to support staff health and wellbeing.				
Resource:	Y/N	None.			
Legal and regulatory:	Y/N	None.			
Subsidiary:	Y/N	Not applicable.			
Assurance Route:					
Previously Considered by:	Not applicable.				

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Nigel Snow has one of the coolest job titles ever!

He was, up until 11 November 2022, the Cytosponge Co-ordinator at the William Harvey Hospital in Ashford.

He has however moved on from that brilliantly named job now, taking up a new role at the hospital - well done and congratulations.

Nigel is also a strong supporter in speaking up about mental health wellness.

"In the spring of this year [2022] I took the opportunity of visiting the *talking wellness* Project Wingman wellbeing bus that was on site at the William Harvey Hospital. In part I was curious, but I also knew that, recently, I'd been struggling a bit and felt it would be good to talk to someone about it. I am so glad I did."

When Nigel boarded the converted double decker bus he was served with a cup of tea and the offer of cake.

"Over a cuppa I got chatting to one of the team, and during our conversation it became clear that I was struggling a little more than I thought I was, and they suggested it may help to complete an online assessment using one of the iPads on the bus. There was no obligation to do so, but it felt right. The kindness of the person I was speaking with, the confidence of knowing I was in a safe space, and the general atmosphere of the bus all contributed to me feeling it was the right thing to do."

Nigel took advantage of one of the on-board iPads to access the *talking wellness* portal, where he used Limbic, an automated chatbot, to complete an online assessment.

"It was just so easy to do. No pressure. No stress. No delay. It was seamless. And I wasn't surprised to learn that I would benefit from some counselling. Again, I didn't feel alarmed or threatened by this, it simply felt right to agree. And I did. Right there and then, on this marvellous bus."

Once the assessment was submitted a member of the *talking wellness* team was in touch with Nigel to arrange a series of counselling sessions.

"It was such a speedy response. The service was first-class and my counsellor, Sophie, was the best, she was absolutely amazing.

"Thank you for your support Sophie, it made the world of difference to me, and ultimately, my wife too."

Nigel took up the offer of a series of telephone appointments with Sophie, during which time they were able to explore in more detail what was going on in his life, why that might be, if and how what was happening might be affecting his work homelife balance, and what they could work on together to help improve things.

"Sophie listened, like really listened to what I was saying, and as a result recommended a course of action that has been so beneficial. As a consequence, I cannot adequately put into words what hopping on the bus that day has meant to me. It has been one of the best personal mental health and wellbeing experiences, and I feel stronger because of it.

"I also realise that I am incredibly lucky to work for a Trust, East Kent Hospitals University NHS Foundation Trust [EKHUFT] that understands the importance of the *talking wellness* service. They actually get it.

"EKHUFT recognises, supports, and actively encourages staff to use the bus, with managers believing that a happy, healthy workforce is not only a good one, but also it's a productive one too. And I have to say, after my experience of using the bus, and the *talking wellness* service, I absolutely agree."

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**CHAIRMAN'S REPORT**				
MEETING DATE:	**9 MARCH 2023**				
BOARD SPONSOR:	**CHAIRMAN**				
PAPER AUTHOR:	**CHAIRMAN**				
APPENDICES:	**APPENDIX 1: NON-EXECUTIVE DIRECTORS' COMMITMENTS**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	**Approval**	Information	Assurance	Discussion
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; • Decision taken by the BoD outside of its meeting cycle; • East Kent Health and Care Partnership (HCP) Board; • Activity of the CoG; • Visits/Meetings.				
Key Recommendation(s):	The Board of Directors is requested to: • **NOTE** the contents of this Chairman's report; • **RATIFY** the Approval of the Contract Award for Supply of Cardiac Rhythm Management.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	N/A				
Link to the Corporate Risk Register (CRR):	N/A				
Resource:	~~Y~~/N	N			
Legal and regulatory:	~~Y~~/N	N			
Subsidiary:	~~Y~~/N	N			
Assurance Route:					
Previously Considered by:	N/A				

East Kent Hospitals University NHS Foundation Trust

CHAIRMAN'S REPORT

1. Purpose of the report

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

2. Introduction

As we emerge from winter, our hospitals remain under extraordinary pressure. In February, our Emergency Departments and Urgent Treatment Centres have between them treated 27,800 patients – we have had to open more than 60 escalation beds and we are caring for 437 patients who no longer need acute care. The biggest challenge we face remains managing the demand for acute care and allied to that, managing the flow of patients through our hospitals while providing safe, effective and timely care to every one of them.

Following the Care Quality Commission (CQC) inspection of our maternity services we have been served with two Section 31 notices requiring urgent action in both units. As with the major report into our maternity services, it will be so important that we are open to criticism and not defensive in any way. There are important lessons and we need to acknowledge that whatever progress we have made in recent years, we have still not achieved the level of consistency we aspire to. As a Board we also need to reflect on the degree to which we are sighted on front line care. We have been considering further ways in which we can be assured, not only that processes and checks are in place, but also that we know they are being carried out fully at all times.

There is a paradox here. We know that staffing levels are often strained and that the physical infrastructure in which maternity care is delivered is not fit for purpose on either site. Every day, we deliver first class care to mothers and their babies. The feedback we receive from Your Voice is Heard makes that clear and I have heard from mothers myself in the last two weeks who could not have been more pleased and grateful for the care and dedication of all our staff. Yet we all know there is room for improvement and for greater consistency. And this is a task for each of us, no matter where we are in the organisation. We value our staff and we need to do more to listen to them as we seek to learn the lessons from *Reading the Signals*, set out goals and priorities for the year ahead, and begin to develop a longer-term strategy for this organisation. Building that joint sense of purpose must be at the heart of what we do and that message was reinforced in the video Tracey and I delivered for all staff.

The CQC inspection was followed by a decision to withdraw midwifery students from the William Harvey Hospital. This has in turn been followed by a request by the Nursing and Midwifery Council (NMC) for assurance of the quality of the course at Christchurch University with potential implications for maternity units across Kent and Medway. I know Tracey and her fellow chief executives will be working with the university to establish what needs to be done to restore midwifery training at William Harvey Hospital as soon as possible. Although supernumerary, the students are a vital part of our maternity operation and they represent a key component of our future workforce.

These challenges are likely to continue in the months ahead. It will not be easy, but we must now chart our own way forward, recognising that transformation will take time and that external pressures, whether personnel, financial or from partners who themselves are under pressure, will continue. It will require much closer collaboration with these partners as well as renewed commitment within the Trust.

3. Decision taken by the BoD outside of its meeting cycle – Virtual Approval of Contract Award for Supply of Cardiac Rhythm Management

Since our last meeting the Board of Directors noted the competitive tendering exercise for the supply of Cardiac Rhythm Equipment, and approved the award of the contracts to Abbott Medical UK Ltd, Biotronik UK Ltd, Boston Scientific, Medtronic and Microport CRM UK Ltd for a period of 3 years. The total value of the agreement is £3,510,216.32 per annum and £10,530,649 over the 3-year life of the contract.

4. East Kent Health and Care Partnership (HCP) Board

The senior team at the East Kent Health and Care Partnership held an oversight meeting with the Integrated Care Board this month. We were able to report significant progress in thinking through our own structure and ways of working. A draft Memorandum of Understanding has been signed off through the Integrated Care Board (ICB) which will now go to the HCP Board on 16 March.

A new team has joined the partnership from the ICB and we made clear our determination to make this work, and for the HCP to deliver real value and real value for money. Behind it lies a shared view that collaboration can lead to new ways of working and more effective integrated care for patients and clients. We were also able to set out how partners across East Kent worked together this winter and how we felt this could be built upon as the partnership moves to a more formal standing with delegation from the ICB.

The Partnership has also taken forward its work with the voluntary and community sector and in the last quarter have worked with them to develop and provide additional support to accelerate discharge.

In terms of our partnership with our population and patient engagement, this continues to develop through our Healthy Communities programme for which the partnership secured £450k funding with the Voluntary, Community and Social Enterprise (VCSE) from the lottery.

5. Council of Governors (CoG)

The Council met in February, and much of the discussion reflected concerns around maternity and the implications of the CQC inspection. Governors were also advised on the review into Entonox and received a presentation on the Patient Safety Incident Response Framework. In the afternoon Council held a development session with non-executive directors (NED) facilitated by NHS Providers, which covered joint working and the financial challenges for 2023/24.

The Council has approved a new process for the NED Appraisals for 2022/23 and their objectives for 2023/24 and this will be implemented over the next two months with the aim of reporting back to Council by the end of May.

Two of our most active Governors left Council at the end of February, Marcella Warburton, public Governor for Thanet and Nick Hulme, the public Governor for Ashford. They have both contributed a great deal to Council and will be much missed. In other changes, we welcome back Paul Schofield the Governor for Thanet and new Governors, Tom Morris (Canterbury), Sarah Barton (Ashford), Richard Brittain (Swale) and Mike Trevethick (Thanet). They have taken up their posts from 1 March for 3 years.

As noted last month, we have also said goodbye to two non-executive directors, Jane Ollis and Nigel Mansley, and Council expressed its gratitude for their service to the Trust. The Council also extended a warm welcome to our two new non-executive directors, Richard Oirschot and Claudia Sykes who joined the Board on 1 March.

Joint Governor/non-executive directors visits have taken place at the Royal Victoria Hospital, Folkestone and QEQM, where they visited at the Fracture clinic, Rainbow ward and the Emergency Department. Going forward, these visits will include a meet the Governor session for patients and families.

6. Visits/Meetings/Talks

Among my visits and meetings this month I hosted Damian Green MP at the William Harvey, including a tour round our Emergency Department. I also visited the William Harvey Max Fax Department, the Ophthalmology Dept, Rotary Ward, ENT clinics and the Admin and Operations Offices. As well as chairing the Council of Governors meeting and attending its development session, I spoke to new staff at the Trust Welcome Day and visited the maternity units at the William Harvey and Queen Elizabeth the Queen Mother Hospitals.

East Kent Hospitals University NHS Foundation Trust

Non-Executive Directors' (NEDs) Commitments

NEDs February 2023 commitments have included:

Chairman	Meetings with individual NEDs Meetings with all NEDs Meetings with all NEDs and Chief Executive Meetings with newly appointment NEDs Meetings with Executive Directors Meeting with Director of Nursing Meeting with NHS England Improvement Directors Council of Governors (CoG) Open meeting CoG Development Session Meeting with Integrated Care Board (ICB) Chair Kent and Medway (K&M) NHS System Chairs meetings East Kent Quarterly Place Oversight meeting Meeting with MP for Ashford Meeting with MP for North Thanet Visit to Maternity (William Harvey Hospital (WHH))

Non-Executive Directors	Meetings with Chairman Meetings with Executive Directors All NEDs meeting with Chairman All NEDs meeting with Chairman and Chief Executive CoG Open meeting CoG Development Session Maternity and Neonatal Assurance Group (MNAG) meeting 2gether Support Solutions (2gether) Audit Committee meeting Joint NED/Governor site visits to Queen Elizabeth the Queen Mother Hospital and Royal Victoria Hospital, Folkestone K&M NEDs Forum (Black, Asian and minority ethnic (BAME))

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**CHIEF EXECUTIVE'S REPORT**				
MEETING DATE:	**9 MARCH 2023**				
BOARD SPONSOR:	**CHIEF EXECUTIVE (CE)**				
PAPER AUTHOR:	**CHIEF EXECUTIVE**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**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 Recommendation(s):	The Board of Directors is requested to **DISCUSS** and **NOTE** the Chief Executive's report.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	The report links to the corporate and strategic risk registers.				
Link to the Corporate Risk Register (CRR):	The report links to the corporate and strategic risk registers.				
Resource:	N				
Legal and regulatory:	N				
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	N/A				

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 (CEMG)

No Business Cases were approved by the CEMG at meetings held in February 2023, however, the Group did approve an Outline Business Case for Digital Pathology that will continue to be developed and presented for approval at a later meeting.

4. 2023/24 Operational Business Planning

4.1 Elective

Focus on the Trust's year-end elective position continues. The key ambition for end of March 2023 is to have no patients waiting over 78 weeks for treatment.

Daily reviews are taking place across the Trust and in collaboration with the Integrated Care Board (ICB) to determine the position of each patient in this 78 week wait cohort. National Guidance provided in January outlined key actions including assurance that all patients in the 78 week cohort without a Decision to Admit (DTA) must have a next appointment booked and 78 week cohort patients with a DTA must have a To Come In (TCI) date recorded on Patient Administration System (PAS) (the TCI must be scheduled before 31 March 2023) - this position has been achieved.

Further to this the Trust has worked to ensure the following national requirements were met:

- Patients who will be 52 weeks at the end of March need to be validated by 22 January 2023 (if they have not been validated in the previous 12 weeks);
- All duplicate pathway entries must be clinically reviewed and removed by 22 January 2023;
- Apply C1 patient choice code to all patients who wish to delay and will be 78wks+ in March 2023;
- Independent Sector (IS) patients to be treated before the end of March 2023.

The Trust has a recognised risk to meet the year-end target within the Otology specialty. A collaborative approach across the ICB and IS in

partnership with Maidstone and Tunbridge Wells NHS Trust (MTW), and via insourcing options, has ensured theatre slots have been identified and allocated for each of the 75 identified breaches.

If the Trust can mobilise theatre teams to deliver weekend insourcing lists and MTW take the full proposed number of patients, the Trust will be able to manage the remaining deficit through secured capacity via Spencer Private Hospitals (Spencer).

Achieving the targeted position at year-end is subject to all other elective activity being delivered as planned and there being no impact on elective activity from winter pressures or the three days of junior doctor strike action planned for 13, 14 and 15 March 2023.

4.2 Acute care

The Trust's Emergency Departments (EDs) continue to be pressurised. The Trust saw a slight decline in attendance in January compared to December, however, as an increasing number of patients continue under the Trust's care for longer than is needed, as they wait for on-going packages of care, the pressure within the EDs to place patients in admitted beds continues to be a daily challenge.

Despite these on-going pressures there has been some excellent work supported by the Trust Recovery, Treatment and Support (RTS) team to secure onward care placements for some of the Trust's highly complex and longest stay Pathway 3 patients.

In addition to the Adult Social Care funding released nationally before the end of December 2022 (and cascaded down via the ICB) the Kent & Medway (K&M) ICB is in receipt of £6.3m from the National Acute Hospital Discharge Fund.

The fund is designed to increase capacity in post-discharge care and support improved discharge performance, patient safety, experience and outcomes. Through use of this fund, the ICB is expected to deliver reductions in the number of patients who do not meet the criteria to reside but continue to do so, as well as improvements in patient flow which in turn will help waiting times in EDs and handover delays.

Currently the East Kent Healthcare Partnership (EK HCP) is targeting an element of this support towards Pathway 3 patients with complex needs who have the longest length of stay in acute hospital beds. It is pleasing to report that this approach is having a positive effect, with the first four weeks of the scheme enabling the discharge to care homes of 39 patients who had a total length of stay of over 2100 days in East Kent Hospitals beds. The transfer of these patients from a hospital environment into non-acute facilities has resulted in a vastly improved patient experience and improved relationships with local care homes.

5. Finance Update

5.1 Financial performance Year to Date (YTD)

At the end of month 10 (January) the Trust has a YTD deficit of £28.9m, which is £26.7m adverse to plan, with an in-month deficit of £4.4m. As in previous months, this deficit position continues to be driven by the number of escalation areas opened across the Trust (80 beds) due to patient demand

and flow (£7.2m), £6.4m of undelivered efficiency savings (Cost Improvement Programme (CIP)) and £5.1m related to 1:1/specialty mental health care.

The Trust has now formally agreed with the ICB and NHSE a revised deficit of £19.3m for the 2022/23 financial year, an improvement from the previously reported position of £30m. This is a result of a successful bid for £5.5m of funding from the system to support our increased levels of mental health specialist nursing support and small allocations totalling £5.2m received from the ICB.

5.2 Financial Planning 2023/24

As reported in February, the Trust continues to work closely with K&M system partners to develop the operational plan for 2023/24.

Capital prioritisation sessions have been held with Care Groups to address the allocation, whilst a £40m CIP for 2023/24 focussed on recurrent savings will be defined by the Programme Management Office (PMO).

6. Emergency Department (ED) Expansion – Queen Elizabeth the Queen Mother Hospital (QEQM)/William Harvey Hospital (WHH)

Delays to the Phase 2 works in the EDs) at the WHH (4 weeks) and QEQM (7 weeks) have been confirmed due to unforeseen issues in respect of services, the ability to access clinical areas given patient demand and the identification of unrecorded oxygen pipework and drainage. The Trust, 2gether Support Solutions (2gether) and contractors are now working to a targeted programme completion date for the WHH build that extends into July 2023, whilst the targeted completion date of the programme at QEQM has moved to December 2023.

Phase 2 of the programme at the WHH will include the opening of half of the new Majors towards the end of March, comprising of an isolation room and eight cubicles in the same style as Phase 1 (with walls and a glass front). This will be accompanied by other brand-new support services and a female changing room. The site and clinical teams have put a lot of work in to facilitate the transition from Phase 2 to Phase 3 (the final phase at the WHH). Other areas inducing WHH paediatrics (phase 2b), QEQM rapid assessment and treatment with new mental health facilities (phase 2) are due to be ready to open in late Spring/early Summer 2023.

7. Care Quality Commission (CQC)

Following the unannounced inspection of the Trust's Maternity Services on Tuesday 10 and Wednesday 11 January 2023, which identified a number of areas of concern, the Trust has been issued with a Section 31 Notice, which places conditions on the Trust's licence to provide healthcare and identifies areas where urgent action is required.

The Section 31 Notice requires a stipulated range of monitoring reports to be submitted to demonstrate that action has been taken and to confirm that the necessary improvements have been embedded within practice.

A number of meetings have been held with key personnel and subject matter experts to ascertain the current situation and progress the improvement initiatives, many of which had started before the unannounced inspection, including fetal monitoring and triage.

Although the CQC inspection focused on the Trust's Maternity services, there are clear lessons to be learnt more widely, particularly in relation to the assessment and monitoring of patients, daily equipment checks, cleanliness and environmental checks. All departments and service areas have been asked to take this opportunity to review the areas of concern and ensure that they are meeting the expected standards.

A detailed report which identifies why a mock inspection in August 2022 failed to identify issues and considers governance and oversight will be presented to the Board of Directors at the closed meeting.

8. Midwifery students

The Nursing and Midwifery Council (NMC) has written to Canterbury Christ Church University (CCCU) with regards to concerns they have with its midwifery programme. They have given the University until the end of March 2023 to provide reassurance about the safety and quality of the midwifery course, following which a final decision will be reached as to whether the course can continue or will have to close.

This has undoubtedly created uncertainty and distress for students. It has also had an impact on the midwives within our services who have been providing support and training to the students. The midwifery leadership team will work with the team at CCCU to do what we can to support an improvement in this position.

9. Vascular service reconfiguration

After many years of planning, the K&M Vascular Network implementation is imminent. The network, a recommendation from the vascular society, being overseen by NHSE, will see elective inpatients and emergency patients from Maidstone and Medway be treated at the new vascular hub, located at the Kent & Canterbury Hospital (K&C), while outpatient appointments and day cases will stay as local as possible and continue in Maidstone and Medway.

The network will be implemented with a phased approach over an eight-week period. Medway staff that are transferring to EKHUFT will do so at the start of the financial year on 1 April 2023. During this phased implementation, the K&M Vascular Network will maintain a presence at both K&C and Medway Hospital until the full transfer of patients is complete.

The vascular team has worked very hard to reach this point but especially since January 2020 when certain emergency patients (Abdominal Aortic Aneurysms) were transferred to the K&C. The east Kent vascular consultants have been supporting the Medway rota since this time and will continue to help provide the service at Medway during March and until the transfer occurs.

The implementation of the recommendation by the vascular society will mean that patients across K&M have better outcomes because they will be treated at a specialist centre which will be monitored through a benefits realisation process.

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

Moira Durbridge (Improvement Director) and Sir David Dalton, part of the national RSP team, have joined the Trust and will support the development of the

improvement plan, which will be presented to the Board of Directors at its next meeting on 6 April 2023.

11. Chief Finance Officer

Phil Cave, Chief Finance Officer, is joining Hertfordshire Partnership NHS Foundation Trust as Chief Finance Officer, after serving for five and a half years as our Chief Finance Officer. He leaves the Trust on 31 March 2023 and therefore, this is his final Board meeting. I would like thank Phil for his commitment and dedication to the Trust and to thank him personally for the support afforded to me since I arrived in April 2022.

12. Conclusion

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

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)				
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**
People & Culture	28 February 203	Stewart Baird Non-Executive Director	Executive Assistant	**Yes**
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:				
People & Culture Committee Report January 2023	**Partial Assurance** was received of the 'People' True North metrics for January 2023. The Committee members noted the National Staff Survey was still currently under embargo until Mid-March 2023. Detailed data will be provided on Staff Engagement and Staff Involvement once the embargo is lifted. Premium pay spend has increased by £0.6m in January 2023. This reverses the previous three months reduction in spend reflecting the increased staffing requirements of escalation beds which is outweighing the positive impact of reducing vacancies in nursing. The Finance & Performance Committee are tracking this workstream. Sickness absence decreased to 5.0% in January, mainly due to a fall in long term sickness. There are some promising improvements across sickness levels which is encouraging. Overall appraisal compliance had been on an upward trend from June 2022 to November 2022. However, compliance dropped to 68.9% in December, and returned to 69.9% in January. The metric remains below the reviewed alerting threshold of 80%. As has previously been reported, activity levels are preventing improvement in this metric. Staff turnover has improved for the fourth month in succession and now stands below the nationally desired standard (10%) at 9.99%. In-month staff turnover has remained below the 10% threshold for the fourth consecutive month and, at 9.12%, demonstrates an improved position. The Committee noted that the overall vacancy rate has improved to 9.7% in November with a slight increase to 9.8% in December, and a further drop to 9.1% in January. The Trust crossed the 9,000 Whole Time Equivalent (WTE) staff in post or the first time in January 2023. Committee members noted that a 'New Starter Experience Survey' launched on 30 January 2023 which will give greater intelligence into the experience of new colleagues.			

	NB: Measures of Doctor/ Consultant turnover and metrics from the New Starter Experience survey will be introduced from February.
Culture Development & HR Programme	**Partial Assurance** was received. The Committee noted the overview and update of the People & Culture Strategy Programme, the key pieces of work and ongoing actions. There was also a paper on the proposed rollout of the Culture & Leadership Programme (CLP). The Committee was pleased to welcome the new Culture and Leadership Programme Director.
Chief Nursing and Midwifery Officer (CNMO) Quarterly Nursing & AHP Workforce Update	**Assurance** was received. This report provides the Committee with an update on the initiatives and work being undertaken to recruit and develop the nursing and midwifery workforce in East Kent. The Committee noted the contents of the report and the progress made in recruiting and developing our nursing and midwifery workforce. **Assurance was not received** with regards to Midwifery staffing levels, particularly at the William Harvey Hospital (WHH). It was noted that there has been an increase in resignations of Midwives recently which is likely to impact staffing from April. The CNMO is developing a plan to mitigate this risk which will be shared shortly.
Hot Items	The Committee members noted a number of verbal updates on 'hot topics' within the Trust affecting the workforce. • The Trust is preparing proposals to reorganise the management structure – proposal will be presented to the Board once the necessary consultations with staff are complete. • The Committee received an update on potential future industrial action and interim workforce plans to minimise the impact to patients. • Development of national people policies and how these might be incorporated into the Trust.
Board Assurance Framework (BAF) & Corporate Risk Register (CRR)	**Assurance** was received and the BAF and People Risks were **Approved**. The risks relating to 'Our People' and 'Our Sustainability' are being appropriately mitigated with no new risks added to the BAF or CRR in the reporting period. The Committee will undertake a detailed review of the BAF and CRR later in the year.
Biannual Safe Staffing Review	**Partial Assurance** was received. The full impact of current activity levels and 'fit to reside' challenges came into focus. Despite having a record number of nursing colleagues, activity levels have grown to the extent that safe staffing is becoming increasingly challenging to achieve due to the increasing requirement for ward nurses to staff unfunded escalation areas and support Emergency Department (ED) when high numbers of patients are being placed in corridors. The Trust has 184 escalation beds, in addition to around 1,000 funded beds. Patients treated in corridors in December amounted to 1,069 at Queen Elizabeth the Queen Mother Hospital (QEQM) and 1,149 at WHH. It was noted that 392 patients were better suited to be treated outside of an acute hospital and that

	the combination of this and the significant activity levels at the front door was stretching staffing levels. **Partial Assurance** received with regards to Midwifery staffing levels, particularly at the WHH. It was noted that there has been an increase in resignations and sickness of Midwives recently which is likely to impact staffing from April. The CNMO is developing a plan to mitigate this risk which will be shared shortly.
Apprenticeship Scheme Report	**Assurance** was received that the Trust is engaging with more apprentices and sees these roles increasing as part of its strategic workforce plans.
Feedback from Local Negotiating Committee	• The Committee received an assurance report on the activities of the Local Negotiating Committee on 14 October 2022.
Feedback from Equality Diversity and Inclusion Steering Group	• The Committee received an assurance report on the activities of the Equality Diversity and Inclusion Steering Group on 1 November 2022
Feedback from Staff Committee	• The Committee received an assurance report on the activities of Staff Committee on 20 January 2023.
Feedback from Integrated Education Group (IEG)	• The Committee received an assurance report on the activities of the IEG on 6 February 2023.

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

N/A

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

Item	Purpose	Date
Board of Directors (CLOSED): – National Staff Survey 2022 results (embargoed)	TBC	TBC

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) PUBLIC					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Finance & Performance Committee (FPC)	28 February 2023	Nigel Mansley Non-Executive Director	Sarah Farrell, EA/Chief Finance Officer	**Yes**	
Appendices:	**N/A**				
Declarations of Interest made:					
No declaration of interest was made outside the current Board Register of Interest.					
Assurances received at the Committee meeting:					
Month 10 Finance Report Forecast Cash Position	Partial assurance received of the Trust's financial performance and actions planned to address issues of concern including delivery of the re-forecasted year-end deficit position of £19.3m currently as agreed by the Integrated Care Board (ICB) and NHS England (NHSE). The Group achieved a £4.4m deficit in January, which brought the year-to-date (YTD) position to a £28.9m deficit which is £26.7m adverse to the plan. The Trust worked with Kent & Medway NHS system partners to resubmit a financial plan for 2022/23 at the end of June following a national announcement confirming additional funding to mitigate inflationary pressures. In the resubmitted plan the Trust receives £22m of additional funding, consisting of £6m inflationary funding and £16m of non-recurrent income, bringing our overall plan to a breakeven position. The Trust has now formally agreed a revised deficit of £19.3m for year end. The deficit is driven by increased escalation bedded areas across the Acute sites.				
Month 10 Savings and Efficiencies Update	Partial assurance received of the Trust's progress of the programme against a £30m target. • The reported savings achieved in January were £1.8m vs a plan of £3.7m. All major areas underperformed in the month, with Surgery & Anaesthetics (S&A) (£0.5m), Urgent and Emergency Care (UEC) (£0.3m) and Corporate (£0.7m) being the main areas of under-performance vs Plan. • YTD the reported savings are £15.6m vs a YTD plan of £22.1m, with Clinical Support Service (CSS) (£1.6m), S&A (£1.7m), UEC (£1.4m) and Corporate/Other (£1.1m) being the major contributors the variance. • Non-recurrent efficiencies totalled £0.8m in the month, or 44% of the total (up from 35% last month, and now standing at 51% on a YTD basis). The forecast value of which indicates c£10m for the full year, as at Mth10, which will have to be played into the plan for 2023/24. • The full year forecast for all efficiencies is approximately £22m, with some risk still attached.				

	• The focus over the next three months will be on 2023/24 and helping Care Groups identify what is possible, so we can quickly populate the programme which is likely to be at least a similar value to this year. • As well as the Programme Management Office (PMO) having regular meetings and workshops with Care Groups and corporate areas, a revamped Financial Improvement Oversight Group (FIOG) commenced in January, as well as the new Clinical Leaders Efficiency Group, which meets monthly. • Additionally, we are working through business planning in all areas to scope opportunities from Model Hospital, Service Line Reporting (SLR), Getting it Right First Time (GIRFT) and internal ideas. • Currently, approximately £6m of ideas has been identified, but with no schemes as yet green and substantially off the anticipated £30m target.

2023/24 Business Planning Update and Guidance	Partial assurance received and Committee approved for the Trust's Business Planning process and guidance for the new financial year 2023/24.
	
	The paper gave an update on the:
	• National planning guidance for 2023/24
	• Local Financial Planning
	  ○ Financial Context
	  ○ Financial Bridge 2022/23 to 2023/24
	  ○ Financial Risks
	  ○ Efficiency Impact and Target
	• Capital Update
	• Activity Update
	• Process and Next Steps

We Care Integrated Performance Report (IPR)	Partial assurance received of the performance against key metrics for 2022/23 including the Breakthrough objectives: Improving theatre capacity, Same Day Emergency Care, Staff involvement and Premium Pay costs. The Trust has been engaged with a quality improvement programme called "We Care". The premise is that the Trust will focus on fewer metrics but in return will expect to see a greater improvement (inch wide, mile deep). This report is updated for the key metrics that the Trust will focus on in 2022/23.
Board Assurance Framework (BAF) and Principal Mitigated Risks	Partial Assurance received and the Committee approved the 11 risks relating to 'Our Future' and 'Our Sustainability' are being appropriately mitigated with one new risk added to the BAF and one risk added to the Corporate Risk Register (CRR). There was also one risk in the CRR which had been approved for a reduction in risk rating. • **Headlines**: There are 3 BAF risks and 8 risks on the CRR relating to 'Our Future' and 'Our Sustainability'. • **BAF**: There is one new risk in relation to 'Our Sustainability' recommended for addition to the BAF. Failure to deliver the financial plan of the Trust as requested by NHSE for 2023/24. There is one risk recommended for closure in relation to 'Our Sustainability'. Failure to deliver the financial plan of the Trust as requested by NHSE as this has crystallised for 2022/23.

	• **CRR**: There has been one risk approved for addition by the Clinical Executive Management Group (CEMG) in relation to 'Our Future'. Inadequate estates within maternity at EKHUFT. There has been one risk approved for a reduction in risk rating at CEMG in relation to 'Our Future'. CRR 124 – Failure to manage supply chain delays that may cause patient harm. Reduced from a high (16) to a moderate (12). • **Other key changes**: Other changes to the risk records are included in the risk register summaries on Pages 5 - 13. • **Tracker report**: The tracker report is presented to the Committee on Page 4 to enable the Committee to have oversight of risk movement over the past year. Risk score projections for 2023/24 are being reviewed and will be presented to the Committee at its next meeting.

Digital Pathology Outline Business Case	The Committee Approved the Digital Pathology Outline Business Case (OBC) for onward submission to the next stage.
	
	• This OBC seeks approval for Kent & Medway (K&M) wide revenue investment of £17.1m (see Table 3 Section 1.4.2 of the OBC) for a modern digital pathology solution that will transform the review, analysis and reporting processes of all Histopathology services provided by Kent & Medway Pathology Network (KMPN). **The EKHUFT share of the revenue is £9.131m over 12 years.**
	
	• The business case also includes a K&M requirement for £9.3m in capital which consists of:
	
	  • NHSE Funding: £6.990m
	  • K&M Trusts' Capital: £2.405m
	
	If there is a subsequent 3-year road map for digital diagnostic funding an application will be made to cover the additional capital costs from NHSE.
	
	Investment Proposal:
	• Seeking approval for revenue investment of £17.1m (uninflated) in a modern Digital Pathology solution (Source: Table 3 Section 1.4.2 in OBC) over the period of the project
	
	UNINFLATED / Year 1 2023/24 / Year 2 2024/25 / Year 3 2025/26 / Year 4 2026/27 / Year 5 to 12 2027/28 to 3034/35 / TOTAL
	Option 2 £'000 £'000 £'000 £'000 £'000 £'000
	WEST 81 238 375 368 2,948 3,848
	EAST 193 565 890 873 6,996 9,131
	DGS 42 122 192 189 1,512 1,974
	MEDWAY & SWALE 46 134 211 207 1,659 2,165
	Total I&E Impact 362 1,060 1,668 1,636 13,115 17,117
	
	• Also includes a requirement for £9.3m in capital which consists of:
	  • NHSE Funding: £6.990m
	  • Trust Capital: £2.405m
	
	21/22 £'000 / 22/23 £'000 / 23/24 £'000 / 24/25 £'000 / TOTAL £'000
	NHSE Approved 55 260 5,380 1,295 6,990
	NEW ASK 55 260 4,949 2,036 7,300
	Difference 0 0 (431) 741 310
	
	Discussions are ongoing with NHSE to see if the additional £310k can be funded from the current 3 year road map. The remaining system capital is required £45k in 25/26 and £2m in 29/30. If there is a subsequent 3 year road map for digital diagnostic funding we will make an application to cover these costs from NHSE.
	
	Digital Pathology will:
	
	• transform the review, analysis & reporting processes of all Histopathology services provided by KMPN.
	• align these services with services provided nationally, many of which are already on the way toward Digital Pathology.

	• build the foundation for the use of AI which will also help bring advances to pathology services. • Histopathology is a critical diagnostic activity within the cancer pathways, with targets set by NHSE. Investment in change is necessary to eventually maintain and even improve Histopathology turnaround times given the current difficulties faced by the service, such as a chronic shortage of consultant pathologists. The adoption of digital pathology in K&M will provide a solid foundation to support this going forward. • In order to address the workforce deficit of Consultant Histopathologists within KMPN, the deployment of Digital Pathology is imperative in making it a desirable place to train and work, enhancing recruitment and retention of existing and future workers. **Case for Change:** • Pathology is a key enabler to Government health delivery plans, including cancer services. • KMPN struggle to recruit & retain staff from a national pool of Consultant Pathologists that is shrinking. • The Recovery Action Plans across the networks, acknowledge the need for digitalisation, automation, accessibility of home reporting and flexible working arrangements, all of which Digital Pathology will enable. (Source: Forum for South-East Histopathology). • Strategic goals outlined in The 'South-East Digital Diagnostics Charter' will benefit from the network-wide adoption of Digital Pathology. The Committee asked for the full business case to ensure appropriate funding stream is identified to ensure the Trust's deficit is not increased.
Supply of Cardiac Rhythm Management and Associated Products Virtual approval	The Committee and Trust Board virtually approved the Supply of Cardiac Rhythm Management and Associated Products business case and was formally ratified at the Committee. Between April 2021 and March 2022 2gether Support Solutions (2gether) purchased approximately 1096 pacemakers, implantable cardioverter defibrillators (ICDs) and Cardiac resynchronisation devices on behalf of East Kent Hospitals NHS Foundation Trust ('the Trust'). Total Spend was **£3,541,455.91** excluding VAT. These devices are purchased via NHS Supply Chain but are not contracted formally. Whilst we do achieve a discount by purchasing via the NHS Supply Chain framework, as we have not made commitments to suppliers, we do not currently get the best prices available to us. We sought quotes from our 5 incumbent suppliers, guaranteeing them a share of our supply. This exercise resulted in: • A Cash Releasing saving of **£31,239** per annum. • A Cash Releasing rebate of 5% from Medtronic paid quarterly in arrears estimated value **£193,229.86** per annum. • A Cash Releasing of 2% from Abbott Medical paid quarterly in arrears estimated value **£73,000** per annum**.**

	• Boston Scientific are offering PACENET software licences. This will deliver a cost avoidance of **£54,000*** per annum. ** Pacenet is a database that will interface to any of the pacemaker manufacturers. It is a database that manages the pacemakers, the history, when they are due for service, replacement, product recalls etc. It will interface with Patient Administration System (PAS) to ensure accurate patient demographics are available. As the cardiology team do not currently utilise a database, they feel this will be significant service enhancement and will support them in delivering a safer service*. Factoring in the cash releasing saving, the rebates and the software, the saving is **£297,469.45** per annum plus **£54,000** of cost avoidance for the software licence. The value of the agreement is £3,510,216.32 per annum and £10,530,649 over the 3-year life of the contract. We are not proposing a change in supplier or a change in supply route. These savings are essentially a commitment discount. The clinical lead for this project is the Trust's Invasive Lead Cardiac Physiologist and from the Care Group we have been working with the Deputy Operations Director for General and Specialist Medicine. This project was initially run via the Cardiology Procurement Board but more recently via the General and Specialist Procurement Board who signed the project off in November with a recommendation to award.
Workforce Quarterly Report – Q3	Assurance received for the Workforce Quarterly Report Q3. Premium pay spend is above target. However, the position has improved each month through Q3 2023. The adverse position is a combination of vacancies and operational pressures, with some impact of covid related sickness although this has now reduced. Actions being taken to address the key contributory factors include: • Ongoing detailed analysis of the drivers of spend to identify additional actions to reduce spend. • Targeting recruitment to priority areas and ensuring a consequent reduction in temporary staffing. • Ensure that best practice and policy are applied to temporary staffing for escalation and specialling. • Ensure exit plans are in place for all long-term medical agency locums.
Deep Dive Report – Pay Base between Substantive on premium pay	The Committee noted the verbal update on the Deep Dive Report – Pay Base between Substantive on premium pay.
Strategic Investment Group (SIG)	The Committee received an assurance report on the activities of SIG on 15 December 2022.

Assurance Report	
Financial Improvement Oversight Group (FIOG) Assurance Report	The Committee received an assurance report on the activities of the FIOG on 24 January 2023.
Finance and Performance Committee Annual Work Programme 2022/23	The Committee received and noted the FPC Annual Work Programme for 2022/23.
Other items of business	There were no other items of business.
Referrals from other Board Committees	There were no referrals from other Board Committees at this meeting.

Items to come back to the Committee outside its routine business cycle:		
N/A		
Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
None	N/A	N/A

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Quality and Safety Committee (Q&SC)	2 March 2023	Dr Andrew Catto, Non-Executive Director (NED)	Committee Chair	**Yes**	
Appendices:	None				
Declarations of Interest made:					
No declaration of interest was made outside the current Board Register of Interest.					
In attendance: The Chair welcomed Moira Durbridge (NHS England (NHSE) Improvement Director) and Katy White (Interim Director of Quality Governance) to their first meeting of the Q&SC.					
Assurances received at the Committee meeting:					
Integrated Performance Report (IPR) – We Care Breakthrough Objectives & Watch Metrics	*Partial assurance* was received by the Committee of the True North metrics and Breakthrough Objectives for January 2023. The Committee had a robust discussion and noted the following key highlights/assurances: – **Mortality (Hospital Standardised Mortality Ratio (HSMR)):** assurance received that the fractured neck of femur position remains "as expected". The Trust's palliative care rate is above the national average at 2.89%. – **Incidents with harm: *was the greatest area of concern*** with 53 incidents in January 2023, which continues to be above threshold and is an increase from the previous month. The Chief Nursing and Midwifery Officer (CNMO) has requested that a deep dive is undertaken into the 7 deaths and 3 serious incidents (SIs) to identify any themes and trends and also to understand whether more moderate and severe harm incidents are occurring on any of the acute sites. – **Deteriorating patients:** The Committee was assured that the Integrated Care Board (ICB) secured £300k to support the Trust with the management of deteriorating patients. This area of work will also be supported by the NHSE Improvement Director. – **Falls**: there was no increase in falls for January 2023 despite the high number of patients and overcrowding in the Emergency Departments (EDs). The Committee was assured that this is monitored at Fundamentals of Care (FoC). – The Committee sought assurance that We Care programme was progressing despite the current pressures faced by the Trust. – NHSE Improvement Director highlighted the increase in avoidable harm for the 5 months running. The CNMO assured the Committee that actions were being taken to improve this. – **Inpatient Survey:** in January 2023 the survey was completed across 55 wards and the target of 2050 surveys had been exceeded. The Committee commended the fact that Patient Voice Champions were helping the most vulnerable patients to complete their surveys. – **Cancer 62-day target:** The Committee noted the dip in performance in January 2023 due to increase in breaches within Urology, the work is underway with the Surgery & Anaesthetics Care Group to support improvement in the 62-day target. The Trust remains in the top 3 performers nationally for 2-week wait access.				

	(Unfortunately, the Chief Operating Officer (COO) was unable to attend the meeting due to site operational pressures, meaning that those aspects of the IPR in his portfolio could not be assured in his absence).
Infection Prevention and Control (IPC) Report	The Committee received *partial assurance* of the current performance about nationally reportable infections and the on-going Covid-19 pandemic, noting the following: – Cases of *Pseudomonas aeruginosa* and *Klebsiella* bacteraemia are below trajectory. Numbers of cases of *Meticillin-Sensitive Staphlococcus aureus* (MSSA) are improving compared with the previous year. – The Trust has had only a single *Methicillin-resistant Staphylococcus aureus* (MRSA) bacteraemia year to date. Both *C. difficile and E. coli* have exceeded the external trajectory. The Committee was assured that a deep dive into *E. coli* cases would be undertaken, and the results would be shared with the Committee. – A further moderate surge in Covid-19 has been experienced with an overall reduction in Influenza cases and some sporadic Norovirus activity. – The Committee noted the audit of antimicrobial stewardship programme and that revised draft NHSE IPC Board Assurance Framework was received. Although the results of the antimicrobial stewardship audit were disappointing, this should improve as key management posts were filled. – The Committee sought assurance that all IPC audits were conducted against specific metrics using available technology and approved toolkits. – The Committee sought assurance that the Ventilation Group was being set up in partnership with 2gether Support Solutions.
Care Quality Commission (CQC) Update Report	The Committee received *partial assurance* of the following: – Work continues to map Trust policies to the detailed fundamental standards, and identify areas that are out of date. A gap analysis has also commenced to identify whether there are any areas within the standards where a policy should exist but does not currently. – There has been a review of the Care Groups' governance arrangements for managing their CQC self-assessments. – CQC monitoring scorecard to improve the visibility of key CQC metrics at the Trust and Care Group level and improve oversight and assurance is being developed. It is hoped that the scorecard can be used from March 2023 onwards. – A review of risks associated with Trust wide policy compliance has commenced. A review has identified that a proportion of Trust policies are out of date. – On 13 February 2023 the CQC issued the Trust with Section 31 notices for maternity and midwifery services at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM). The Trust is required to report on a monthly basis to the CQC, and a timetable, process and reporting template have been produced and shared at JTOCPSG. – The Chair sought assurance on capacity and capabilities of the Care Group teams to undertake the required CQC actions and to conduct effective self-assessments: there is variability in Care Group performance and the Q&SC agreed that clarity on responsibility and

	accountability are key. The Q&SC noted that care groups are not the only line of defence in assuring regulatory compliance.
Safeguarding (SG) Committee Chair's Assurance Report	The Chair commended the work undertaken by the Safeguarding team and felt that the *significant assurance* had been provided. The Safeguarding Committee agreed to escalate the following issues to Q&SC: – Addressing and mitigating safeguarding concerns and leadership at the Care Group level. – Care Group level SG training and continued non-attendance due to significant work pressures and clinical challenges. – Safeguarding Adults workforce issues and the concerns regarding the substantiality of services.
Corporate Principal Mitigated Quality Risks	The Committee received the following update and concluded only *limited assurance* (see also escalation notes): – There are 5 Board Assurance Framework (BAF) risks and 13 risks on the Corporate Risk Register (CRR) relating to 'Our Patients' and 'Our Quality and Safety'. – There were three new risks in relation to 'Our Quality and Safety' added to the CRR during this reporting period. – There is one risk for increase in risk rating in relation to 'Our Quality and Safety' – BAF 32 - There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered. – The Committee sought assurance that the Executive team had oversight of the risks and discussed them regularly. – The Committee again questioned the effectiveness of the BAF and CRR and felt that the BAF needed to be re-set against the strategy.
Patient Safety Committee (PSC) Chair's Report	The Committee received an assurance report on activities of the Patient Safety Committee on 4 January 2023 and approved the Terms of Reference (ToR). The opinion was of partial assurance. The following key points were noted: – 20 SIs were reported in month, there were currently 99 open SIs and 16 breached SIs. – Duty of Candour (DoC) – the Trust is not performing well based on the November 2022 data. However, the Committee was assured that the performance had since improved. – A Prevention of Future Deaths report was provided to His Majesty's Coroner, related to care in 2018. The key learning was related to management of paper health care records and the response outlined the transition to electronic records, recognising the risk relating to paper and electronic records still existed. – Deteriorating patient update - further work was needed on consistency of reporting, so progress could be effectively monitored. – The Committee sought assurance that the Trust had an accurate record of the number of deaths due to delay in care.
Fundamentals of Care (FoC) Chair's Report	The Committee noted the assurance report on the activities of the Fundamentals of Care Committee on 19 January 2023. The following key points were highlighted: – **Mixed sex accommodation**: the reported numbers of unjustified breaches continue to rise specifically for patients sharing bathroom facilities.

	– **Unwitnessed falls** have increased to 130 in December 2022 compared to 107 in November 2022. This accounts for 75% of all falls for December. The Falls team continue to share the key message with all wards to ensure that a member of staff is in the bay at all times. However, ward teams have expressed difficulty in ensuring a member of staff is in the bay due to Infection Prevention and Control reasons and the number of patients requiring enhanced observation or 1:1 care. – **Nutrition and hydration:** December 2022 the total number of nutrition related incidents increased to 57, two incidents resulted in moderate harm. – **Category 2 and above Pressure Ulcers** increased in December 2022 to 56 compared to 46 in November 2022. One moderate harm incident reported at WHH. – **Corridor care safety:** Corridor Care Standard Operating Procedure (SOP) breached during the reporting period due to the high demand. Every breach is reported via Datix. – The Committee was assured that the **Ward Accreditation Programme** was progressing well, and 18 clinical areas have been accredited since September 2022. – The Committee was made aware of the lack of resources in the **Falls team** and expansion would be difficult in the current resource climate. The Chair questioned the predominance of clinical management as a complaints theme as this was unusual (complaints typically relate to delays and staff attitude). This was explained as the patient view of the care given as distinct from the actual clinical effectiveness of the care given.
Clinical Audit and Effectiveness Committee Chair's Report	The Committee noted the assurance report on the activities of the Clinical Audit and Effectiveness Committee on 18 January 2023 and approved the Terms of Reference (ToR).
Mortality Steering and Surveillance (MSSG) Chair's Report	The Committee noted the assurance report on the activities of the Mortality Steering and Surveillance Group on 17 January 2023. The following key points were highlighted: – There were 27 Structured Judgment Reviews (SJRs) carried out in November 2022. A quality assurance exercise was completed looking at the SJRs and all 27 showed evidence of good review statements. – The report from Telstra Health was reviewed and it was noted that the HSMR remained lower than expected at 88.7, both WHH and QEQM were as expected and Kent & Canterbury Hospital (K&C) lower than expected. – The Lead Medical Examiner updated the Group on the work of their offices. This month has seen twice the number of cases referred for an SJR, approximately 25-30% of the deaths. These largely related to delays in treatment in the ED and failed discharges.
Mortality and Learning from Deaths – Quarterly Report	*Significant assurance* was received that the Trust's mortality position continues to improve and learning from deaths is shared via Care Group governance processes including morbidity and mortality meetings, patient safety communications and via the Patient Safety Committee.

Maternity and Neonatal Assurance Group (MNAG) Chair's Report	The Committee noted the assurance report on the activities of the Maternity and Neonatal Assurance Group on 10 January and 14 February 2023, noting the following: – There were no SIs reported in December 2022 and two SI reported in January 2023. – There has been a significant increase in bookings. – Staffing levels, especially for the midwifes at WHH, continue to be challenging. – The Committee received assurance that the CQC actions identified in the Section 31 notices were being addressed and the Board was seeing the submissions made to the CQC (and over the 3 weeks to date, weekly compliance checks were improving and at a slightly higher rate at QEQM for the reported metrics).
Safe Systems for Controlled Drugs	The Committee noted the annual report from the Controlled Drugs Accountable Officer (CDAO). This is an area of concern with limited assurance The CDAO highlighting: – Limited assurance was provided for overall safety and security of controlled drugs, and the progress in 2021 was also limited. – Currently the CDAO is allocated one programmed activity (1PA) every 2 weeks specific to this role. This has now been benchmarked with local Trusts and demonstrates this remains insufficient without support. – The Committee was assured that the Trust participates in National Audit of Care at End of Life (NACEL) audit, with the actions related to medications to be shared and followed up by the Opioid Safety and Effectiveness Group (OSEG). – The issues with training were brought to the Committee's attention. – The Committee sought clarification as to how much risk the limited assurance presented to patients and staff. It was confirmed that medicine management is on the CRR and is regularly discussed at Clinical Executive Management Group (CEMG).
Dementia Strategy	The Committee agreed to support the principles of the Dementia Strategy and to receive an update in August 2023. The Committee commended the work done on the Dementia Strategy and agreed this was an example of good practice. The Chair invited the team to bring an update on the implementation of the strategy to Q&SC in around 6/12.
Safe Staffing Review Update	The Committee noted the partial assurance in the Safe Staffing Review report. It was clear to Q&SC that the nursing leadership team knew where the staffing gaps were and had dynamic and responsive processes in place to ensure as safe a staffing as possible The Q&SC noted following key points: – Additional escalation areas plus additional unfunded beds on most wards continues to put pressure on the current nursing establishment as well as the significant corridor care in our EDs has resulted in substantive nursing staff being moved to support.

	– The result of this unfunded bed base has also resulted in increasing temporary staffing usage. – The vacancy rate improved for funded beds only. – The Committee received assurance that the wards are as safe as they can be and daily mitigations are undertaken due to the necessity to move staff around. It was noted that due to frequent move of the substantive staff, the morale is low. – The Committee was informed of the delay in obtaining PIN numbers for internationally educated nurses due to failure to pass the exams first time and waiting times to re-sit.
Cost Improvement Scheme Quality Impact Assessments (QIAs)	The Committee received and noted the Cost Improvement Scheme QIAs Assessment report.
Any other business	The Committee noted in response to a question from Associate NED, Professor Holland, that the Trust was making robust plans and working towards assurance that the services will continue during the junior doctors' strike on 13-15 March 2023.
Referrals from other Board Committees	There were no referrals from other Board Committees at this meeting.

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
Incidents of harm	An area of concern that the Board should be cited on. There has been a significant increase (special cause variation – therefore likely significant) - most likely resulting from a congested hospital system. The CMNO is undertaking a further analysis and staffing corridor care appropriately, but with a knock-on impact on ward staffing. [Q&SC 2 March 2023 papers: page 29].	Board 09/03/23
Effectiveness of We Care Programme	The Q&SC asked the BoD to reflect on the continued applicability of the 'We Care' programme to the current state of the Trust?	Board 09/03/23
NEDs and Governors' Report	Considerable efforts are made to produce the NED/Council of Governor (CoG) visit reports. Q&SC suggested they are submitted to the respective executive and / or Care Group leader. The CoG team are asked to	Board 09/03/23

	reflect on this and assure the Board that reports are noted, and where possible, acted on.	
BAF re-set against the strategy	This concern continues from the last BoD report (although only 4 weeks have elapsed since). Q&SC members commented that the target risk level drop seems ambitious and challenged if the required actions will deliver the required change. The NHSE Improvement Director commented that the BAF should be replaced in line with the impending Integrated Improvement Plan (IIP). The Q&SC noted the intended direction of travel and felt it should also include reference to a refreshed Trust strategy. The Q&SC also noted that responsibility for the BAF would sit in the Director of Quality Governance portfolio.	Board 09/03/23
Dementia Strategy - example of good practice	A comprehensive dementia strategy was noted and supported by the Q&SC. This is good practice with considerable stakeholder engagement and consultation.	Board 09/03/23
Safe staffing	The Committee noted the partial assurance in the Safe Staffing Review report. It was clear to Q&SC that the nursing leadership team knew where the staffing gaps were and had dynamic and responsive processes in place to ensure as safe a staffing as possible The Q&SC noted following key points: – Additional escalation areas plus additional unfunded beds on most wards continues to put pressure on the current nursing establishment as well as the significant corridor care in our EDs has resulted in substantive nursing staff being moved to support. – The result of this unfunded bed base has also resulted in increasing temporary staffing usage. – The vacancy rate improved for funded beds only.	Board 09/03/23

	– The Committee received assurance that the wards are as safe as they can be and daily mitigations are undertaken due to the necessity to move staff around. Frequent moving of substantive staff resulted in a lowering of morale. – The Committee was informed of the delay in obtaining PIN numbers for internationally educated nurses due to failure to pass the exams first time and waiting times to re-sit.	
Safe systems for controlled drugs	The Board should be cited on this trust-wide risk. Progress has not been made at the pace and scale that the CDAO had wished for, particularly with opiate stewardship. The Q&SC was assured that there was oversight at CEMG and that the Chief Nurse and CDAO would have a further discussion. The Q&SC would also keep controlled drugs processes under review.	Board 09/03/23
Complaints about clinical management	Clinical management as a complaints theme as this was unusual (complaints typically relate to delays and staff attitude). This was explained as the patient perception of the care given as distinct from the actual clinical effectiveness of the care given.	Board 09/03/23

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**TRANSFORMING OUR TRUST: OUR RESPONSE TO READING THE SIGNALS - UPDATE**				
MEETING DATE:	**9 MARCH 2023**				
BOARD SPONSOR:	**CHIEF EXECUTIVE OFFICER**				
PAPER AUTHOR:	**STRATEGIC PROGRAMME DIRECTOR**				
APPENDICES:	**APPENDIX 1: PILLARS OF CHANGE PROGRESS UPDATE** **APPENDIX 2: PILLARS OF CHANGE KEY PERFORMANCE INDICATORS (KPIs)**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	To update the Board on progress on Transforming our Trust - the Trust's Interim response to *Reading the Signals*, the independent report into maternity and neonatal services in east Kent.				
Summary of Key Issues:	This Report provides an update on the approach to responding to Reading the Signals Report to provide safer care and improved staff engagement.				
Key Recommendation(s):	The Board of Directors is asked to **NOTE** and **DISCUSS** progress to date and key next steps, including the plan to align some of the Pillar of Change deliverables with the Integrated action plan that is being developed to Exit NOF 4 .				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	**BAF 39:** There is a risk that women and their families will not have confidence in East Kent maternity services if sufficient improvements cannot be evidenced following the outcome of the Independent Investigation into East Kent Maternity Services (IIEKMS). **BAF 32:** There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered.				
Link to the Corporate Risk Register (CRR):	**CRR 118:** There is a risk of failure to address poor organisational culture.				
Resource:	N				
Legal and regulatory:	N				
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	NA				

East Kent Hospitals University NHS Foundation Trust

TRANSFORMING OUR TRUST: OUR RESPONSE TO "READING THE SIGNALS: MATERNITY AND NEONATAL SERVICES IN EAST KENT – UPDATE REPORT

1. Background

1.1. On 19 October 2022, the Independent Investigation published its report into our maternity and new-born services, *Reading the signals*. The Trust Board accepted the report in full and apologised unreservedly for the Trust's unacceptable failings which led to the harm and suffering experienced by women, babies and their families, in our care.

1.2. On 9 February 2023, the Trust set out its interim response to the report which was published alongside an Open letter of apology.

1.3. This report provides an update on the key elements of the Trust's response.

2. The Pillars of Change and Assurance Framework

2.1. This is how we are describing the programmes of work in our interim response. The Pillars of change cover the key areas for action included in *Reading the signals*: monitoring safe performance; standards of clinical behaviour; flawed team working; organisational behaviour, and a recommendation specifically for the Trust to accept the reality of the findings and embark on a restorative process addressing the problems identified in partnership with families, publicly and with external input.

2.2. The Pillars of Change set out the practical steps we have already begun to put into place and include the further work to be delivered over the next three years. They also link to our values: that people should feel cared for, safe, respected and confident that we will make a difference. Deliverables are both specifically focused on Maternity and Neonatal services but some are applicable to the whole trust.

2.3. Some of this work can be implemented quickly, but some outcomes may take longer to achieve. Sustained culture change takes time.

2.4. Since the last meeting of the Board there has been a review of the Pillars of Change and the initiatives to be undertaken in the first 6 months (December 2022 - May 2023) Good progress is being made in a number of areas and a summary update is included as Appendix 1.

2.5. At the Clinical Executive Management Group (CEMG) the day before the Board meeting we will be receiving and discussing the feedback the work the CEMG has been leading on to engage staff and listen to feedback on improving the culture across the Trust.

2.6. A number of the Pillar of Changes deliverables will also be included in the Trusts Integrated Action Plan to exit NOF4. Work is taking place on developing the Plan and it will come to the Board for approval in April 2023. As part of that process key outcomes

will be agreed. Some further work has been undertaken on these which will need to be aligned with the Improvement Plan and the current revised draft is set out in Appendix 2.

3. Culture and Leadership Programme

3.1. In 2021 we started to pilot NHS England's Culture and Leadership Programme, which was developed by Professor Michael West and colleagues, as part of the national Maternity Improvement Programme, in our Women's Health and Children's Health care groups. It is planned to roll out this programme throughout the organisation and a high-level implementation plan will be in place in May 2023.

3.2. Key aspects of the rollout plan include;

a. A Board Development Session with Professor Michael West on 6 April
b. Evaluation of the existing pilot in Maternity and Children's Health
c. Further work on the alignment of some of the Trusts existing initiatives, including WE Care with the CLP approach
d. Establishment of a CLP Steering Group
e. Identification of the Change team members and supporting training plan.
f. To support the development of the plan Rita Lawrence has been appointed as the CLP Director.

4. The Reading the Signals Oversight Group

4.1. The *Reading the signals* Oversight Group will include representatives from involve patients and families as well as our Council of Governors.

4.2. It will meet in public and be responsible and directly accountable to the Board of Directors. It will provide oversight of the programme, making sure there is engagement with those who use our services and that steps are taken to address the issues identified in the Reading the Signals report. The group will meet in public and report directly to the Board of Directors.

4.3. The trust has received 16 expressions of interest to be a family representative on the Group. This is positive response is very encouraging. In response to this a Family Voice meeting will be held on March 13th. The meeting will be chaired by Non-Executive Director Claudia Sykes and facilitated by the Trust's lead for Family Voices. The intention is to discuss a number of possible options going forward including increasing the number of family representatives on the Group.

4.4. It is anticipated the first meeting of the Oversight group will beheld at the beginning of April.

5. The Independent Case Review Process

5.1. We have established an Independent Case Review process to respond to families who have concerns about maternity or neonatal care they received from the Trust.

5.2. Families will be offered the opportunity to meet with or speak to experts independent of the Trust, regardless of whether their care had previously been reviewed or investigated by the Trust.

5.3. The Independent Panel members have been identified and 26 families have asked for reviews. The Operating Procedure for the Reviews has been agreed and the Panel has started work on its first review.

5.4. We have been advised by the IIEKMS Secretariat that the disclosure meetings have now been held with all the families who have asked for such a meeting which means the trust can now start to make contact with those families who have asked for further information following their participation in the Independent Review.

6. NHS England Response

6.1. Following the publication of the report NHS England wrote to all NHS Trusts with maternity departments, setting out their expectation that every Trust and Integrated Care Board review the findings of the report and be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals', and that the experiences bravely shared by families with the investigation team must be a catalyst for change.

6.2. They are reconfirming the requirement for Trust Boards to:

a. Remain focused on delivering personalised and safe maternity and neonatal care;
b. Ensure that the experience of women, babies and families who use maternity services are listened to, understood and responded to with respect, compassion and kindness;
c. Examine the culture within their organisation and how they listen and respond to staff.
d. Assure themselves, and the communities they serve, that the leadership and culture across their organisation(s) positively supports the care and experience they provide.

6.3. In 2023 NHS England will publish a single delivery plan for maternity and neonatal care which will bring together action required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust, and NHS Long-Term Plan and Maternity Transformation Programme deliverables.

7. Listening, Communicating and Engaging

7.1. The Trust's response to *Reading the signals* identifies the importance of listening to and engaging with the public, our patients, families, staff, partner organisations and stakeholders, as well as the need to communicate the Trust's response to the report.

7.2. The Trust's Communications and Engagement Strategy sets out work we will do over the next 3 years to support better listening, communication and involvement with the public, our patients, families, staff, partner organisations and stakeholders and has been refreshed to take into account the Trust's learning from and response to Reading the signals.

7.3. Following the February Board meeting an open letter from our Chairman and Chief Executive acknowledging the harm and suffering caused by the failings of the Trust and setting out the actions the Trust is taking in response to Reading the signals, was printed in the east Kent editions and digital platform of the Kent Messenger

newspaper. The letter, was also reported on in other local press and broadcast media, published on our public website and sent out via the Trust's social media platforms.

7.4. A video and message has been sent to all staff and this is being followed up with hand delivered letters. Every team has been asked to discuss Dr Kirkup's report and what it means to them and their service, and the report and our values were also discussed at the latest monthly staff forum.

Our response to *Reading* the signals: 0 - 6 month deliverables update

East Kent Hospitals University NHS Foundation Trust

Pillar of change	Building our foundations (Dec 2022 – May 2023)	Progress update
Reducing Harm and Safe Service Delivery *Value: People feel safe, reassured and involved* *Lead Executive: CMO*	We will eliminate the backlog of SI investigations and will be fully compliant against agreed timelines for all new reported incidents in order to give patients and families answers in a timely way	SI backlog now cleared. The Serious Incident Policy, SI Declaration Panel and SI Investigations Panel Terms of References are all under review, due for completion by end February. This supports achieving compliance going forward as process is clear.
	We will introduce the new complaints process to ensure transparency and candour in our responses	Discussions with People and Culture Team to devise an engagement programme for the Care Group and Complaints Department to improve working practices in complaints (DATE – TBC). "Taking Ownership of Complaints" – learning campaign topic (as part of 2023 learning plan – month to be confirmed).
	We will commence the pilot 'Calls for concern' (Ryan's Rule) to support patients of any age, their families and carers, to raise concerns if a patient's health condition is getting worse or not improving as well as expected	Currently being piloted at WHH by critical care outreach team, before being rolled out further. Discussed by staff and patient panel.
	We will refocus our Quality Improvement programme on We Care for Winter	We are focussing our quality improvement programme on six workstreams linked to Winter pressures. The Emergency Care Delivery Programme workstreams are: Same Day Emergency Care and Direct Access Pathways Emergency Department Front Door Patient Flow Simple Discharge Emergency Department Builds Virtual Ward We Care also continues to focus on the priorities of Staff Engagement and reducing actual harm
Care and Compassion	We will pilot 'Civility Saves Lives' in maternity, a programme to eliminate rudeness and incivility, which has been shown to have a positive impact on patient care	Pilot discussed with senior leadership team. First session arranged for end of May 2023.

Our response to *Reading* the signals: 0 - 6 month deliverables update

Value: People feel cared for as individuals. *Lead Executive: CNMO*	We will re-state the Trust's values	CEMG have been asked to work with leadership teams to discuss the values with staff. Values discussed at monthly all staff forum. New resources and communications materials in use across the Trust.
	Establish a programme of engagement and listening with all Maternity staff	Completed post publication of *Reading the signals* report.
	We will introduce a simple tool to assist staff to challenge poor behaviours	Part of Working Well Together booklet and resources discussed with CEMG to take forward in their care groups.
	We will share and actively engage on the 'Importance of Caring' video which focusses on care and compassion for patients	Working towards a launch / campaign in Dying Matters Week – which is 8th - 14th May 2023. Film focuses on the importance of compassionate individualised care – seeing the person. Small changes, big impact The film will contain these key learning messages: • *Be kind* • *There is always time to see the person in front of you. To Care.* • *To think – what's most important right now?* • *To notice and respond* • *To take a moment in your day to make a difference to theirs*
	We will implement the Inclusion and Respect Charter which sets out the behaviours we should expect from ourselves and others	Part of Working Well Together booklet and resources discussed with CEMG to take forward in their care groups.
	We will reinforce our Internal Professional Standards, the standards of clinical care patients can expect, and build into work contracts, co-produced with our staff	Internal professional standards have been published to all staff, plan to be developed and rolled out to engage staff further.

Our response to *Reading* the signals: 0 - 6 month deliverables update

Engagement, Listening and Leadership *Value: People feel teamwork, trust and respect sit at the heart of everything we do.* *Lead Executive: CPO*	We will revise our Trust-wide Communications and Engagement Strategy and deliver a communications and engagement plan consistently to reinforce the messages from Reading the signals	Refreshed strategy published February 2023, updates on plan sent to Board quarterly and Council of Governors. Strategy to be kept under review with Patient Voice and Involvement Team.
	We will continue the Cultural and Leadership Programme (CLP), focussed on maternity, and review its effectiveness	Trust CLP Programme Director appointed. CLP continuing in maternity supported by local OD Business Partner. Effectiveness due to be reviewed as part of development work for trust wide programme.
	We will develop our Leadership Framework	Framework developed and incorporated into the Cultural and Leadership Programme.
	We will start the leadership programme to support the development of our team leaders, first-line and middle managers	Programmes underway and initial cohorts for first line leader delivered with positive feedback. These have been supported by the design team sponsored by NHSE. Delivery as part of suite of leadership offers to staff.
	We will introduce a mandatory Team Brief to help leaders communicate with their teams	Team brief started January 2023, scheduled in all leaders diaries monthly.
	We will establish a doctors-in-training group	First junior doctors' forum undertaken and supported by CMO and CEO.
	We will engage all students on placement in our transformation programme seeking their views and feeding back actions take	Nursing council attended/ supported by CNMO.
Organisational Governance Development *Value: People feel confident we are*	We will continue oversight of the Maternity Improvement Programme through the Maternity and Neonatal Assurance group	Monthly meetings of MNAG, reports through QC. Maternity Dashboard.
	We will revise and consult on the new organisational structure of the Trust	Consultation starting in mid-March.

Our response to *Reading* the signals: 0 - 6 month deliverables update

making a difference. *Lead Executive: CEO*	We will achieve compliance in Duty of Candour. Duty of Candour compels every health and care professional to be open and honest with patients when something goes wrong	Above 95% in all categories.
	We will commission an external review of the effectiveness of our Board	The timing of this needs to be reviewed and aligned with the statutory requirements of well-led reviews.
Patient, Family and Community Voices *All values: people feel cared for, safe, respected and confident we are making a difference.* *Lead Executive: CNMO*	We will establish a Reading the Signals Oversight Group to include representatives from patients and families as well as our Council of Governors	Claudia Sykes agreed to be NED chair, first meeting is expected to be in April. In the meantime, a meeting of families who have come forward as representatives on group will take place on 13 March.
	We will establish a programme of community engagement	Scope of programme of work to be agreed. Patient Voice and Involvement Team holding outreach sessions with community.
	We will also implement a Trust-wide Patient Participation Group which is fully inclusive, with a patient representative as joint chair	The Patient Participation and Action Group has been launched and has a participation partner as co-chair. The group has nine participation partners, and representation from voluntary organisation and Healthwatch.
	We will expand Your Voice Is Heard in maternity to include a process for women to feel safe raising concerns, co-produced with families	First project meeting scheduled mid-March 2023.
	We will establish and implement a process for case reviews for families where required	Independent review panel in place – first case being reviewed and contact being made with families who have contacted us about a review.
	Lay chairs will be appointed to consultant appointment panels	This has been completed

PILLAR	MEASURES	BASELINE	TIMEFRAME	PERCENTAGE	RAG
Pillar One: Monitoring Safe Performance: Reducing Harm and Safe Service Delivery	To demonstrate learning and improvement from incidents: Reduction in reported harm from incidents with the underlying theme of: identification and response to the deteriorating patient.				
	To demonstrate learning and improvement from incidents: Reduction in reported harm from incidents with the underlying theme of: diagnostic delay or failure to act on a result.				
	Percentage reduction for maternity incidents leading to harm in our recurrent themes: fetal monitoring.				
	Percentage reduction for maternity incidents leading to harm in our recurrent themes: escalation and reponse to the deteriorating mother or baby.				
Pillar Two: Standards of clinical behaviour: Care and Compassion	The standard of documentation will improve against recognised compliance tool.				
	We will see improvement in the Trust inpatient survey relating to medical staff attitude/behaviour/patients feeling involved and listened to.				
	Staff engaged in and attended 'Importance of Caring' sessions.				
	Staff say they feel engaged and involved in the future of the organisation.				
Pillar Three: Flawed team working: Engagement, Listening and Leadership	Use of the Freedom to Speak Up Guardian service increases with evidence of positive outcomes in response.				
	The number of colleagues recommending us as a place to work increases.				
	Inclusive management and succession planning are embedded across the Trust.				
	Reduction of turnover of colleagues in the first year.				
	Appointments to new structure with development programme in place.				
Pillar Four: Organisational behaviour: Organisational Governance Development	Percentage of patients and families who have been invited to contribute to investiagtion of incidents (plan to develop a tool for gathering feedback from families on their experience of being involved, where they chose to be so, and add KPI). Reduction in complaints returned as patient/ family questions have not been fully answered in initial response.				
	Staff feedback on their experience of using the new approach to reviewing patient safety concerns when they havent felt fully addressed. All staff will be contacted with outcome of the review and asked to particpate in a short survey on experience.				
	Patients feel listened to and their questions are answered.				
Pillar Five: Listening & Restoration: Patient, Family and Community Voices	Patients feel midwives and doctors worked as a team (The above measured through an additional question added to the Friends and Family survey and Your Voice is Heard feedback in maternity).				
	People with protected characteristics and from areas of social deprivation do not have a poorer experience of care, measured by demographic data of patients who respond to FFT survey and triangulated with themes from SIs and complaints.				
	There is a reduction in number of formal complaints received about staff attitude, communication, patients not feeling listened to, including complainant satisfaction and evidence of learning.				

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**MATERNITY AND NEONATAL ASSURANCE GROUP (MNAG) QUARTERLY UPDATE REPORT**				
QUA	**9 MARCH 2023**				
BOARD SPONSOR:	**CHIEF NURSING & MIDWIFERY OFFICER: EXECUTIVE MATERNITY AND NEONATAL BOARD SAFETY CHAMPION**				
PAPER AUTHOR:	**INTERIM DIRECTOR OF MIDWIFERY**				
APPENDICES:	**APPENDIX 1: RESPONSE TO SECTION 31 NOTICES FROM CARE QUALITY COMMISSION (CQC) (WILLIAM HARVEY HOSPITAL (WHH)** **APPENDIX 2: RESPONSE TO SECTION 31 NOTICES FROM CQC (QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL (QEQM)** **APPENDIX 3: RESULTS OF CQC PATIENT SURVEY**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	**Assurance**	Discussion
Purpose of the Report:	The purpose of this paper is to provide the Board with an update on the work undertaken by the Maternity and Neonatal Assurance Group.				
Summary of Key Issues:	The Maternity and Neonatal Assurance Group (MNAG) has been established to oversee the improvement of maternity services as well as the adherence to national regulatory requirements. A number of papers have previously been reported to the Board following consideration by MNAG. This paper collates a number of key areas which have been the focus for MNAG over the last 5 months, incorporating Q3. The Maternity dashboards are presented monthly and have evolved to provide more granular information around key areas across the service. The dashboard moving forward will incorporate a collation of the weekly results of the quality rounds aligned to the requirements for the reporting to the CQC. Newborn Life Support (NLS), fetal heart monitoring and PRactical Obstetric Multi-Professional Training (PROMPT) training were reported as compliant for all staff groups across midwifery and obstetrics during both December and January. However, PROMPT training for anaesthetics remains a challenge due to the workforce constraints for the anaesthetists. **This is a known issue and work has begun with the appropriate medical leads to build a plan to address. It should be noted that this is a limiting factor for compliance with Clinical Negligence Scheme for Trusts (CNST).** **Other mandatory and statutory training remains below compliance levels**, in the **main in the obstetric medical workforce.** The Clinical Director is working with site leads to support improvement in compliance over the next 2 months.				

	The response rate for Your Voice is heard continues to be high with rates recorded at 74.3% for December and 72.5% in January. Overall there was significant positive feedback across all areas, which included feeling listened to and also good midwifery care in labour. **The concerns around pain relief remain and also for the William Harvey Hospital (WHH) concerns raised around how long the discharge process is taking from the postnatal ward.** Whilst the number of **women booking for care** with maternity services during December reduced in month, in **January there was an in month increase of 30%.** The Perinatal Quality Surveillance Tool continues to **highlight concerns around staffing levels, particularly at WHH related to vacancy, maternity leave and sickness**. However, 1:1 care in labour and also the supernumerary status of the band 7 labour ward coordinators was compliant across both sites during these 2 reporting periods. A working group with staff representation has been commenced to jointly agree a plan to address the ongoing concerns for staffing and to address the use of the on-call roles, to ensure an equitable approach for all staff. Following the unannounced visits in January from CQC, quality rounds have been formalised and the findings from these during the beginning of February were reported at the February MNAG meeting. The key metrics reported related to: - Environmental and Infection Prevention and Control (IPC) weekly rounds. These are now in place and supported by the matron or head of midwifery on each site. This also includes hand hygiene and Personal Protective Equipment (PPE) audits. - Fresh Care compliance – daily audits are in place to review compliance on both sites. - Equipment safety checks, including resuscitaire checks. These are now showing as compliant for both sites and there is close oversight by the matrons and heads of midwifery. The Maternity Improvement plan was reviewed for the January meeting. The decision was taken to remove actions related to CNST and Ockenden from the core improvement plan, as this would form part of business as usual for all units. Oversight of the work for both areas will continue to be reported through the Perinatal Quality Surveillance report each month. The remaining open actions for the maternity improvement plan, have been aligned to the pillars of change, however in view of the recent notices from CQC, there is a need to review and agree the priorities going forward. The concerns raised by the Nursing and Midwifery Council (NMC) around the student midwifery programme at Canterbury Christ Church University (CCCU) was discussed along with the initial

	plans to address locally within EKHUFT. Despite the work that was undertaken a decision was taken subsequently to withdraw the students from WHH in February 2023. The Q3 Serious Incident (SI) report was presented to the January MNAG. **A significant reduction in quarter was noted with 4 SIs reported.** The plan for closing the overdue open SIs was presented, with **all overdue SIs submitted by the end of January.** Analysis within the quarterly report now includes a breakdown aligned to Black, Asian and Minority Ethnic (BAME) and deprivation indices. MNAG has been supporting the ongoing discussions and case for change across sonography services with respect to obstetric scanning. There is a known capacity issue which has caused a delay in some scans being performed at the appropriate time. A business case has been developed for submission. Further work is also being supported by NHS England (NHSE) colleagues around the antenatal screening pathway, which is heavily reliant on sonography services. The CNST declaration was presented and discussed prior to final submission to Trust Board. Sadly, based on **non-compliance for Perinatal Mortality Review Tool (PMRT) criteria and PROMPT training, overall declaration was that the CNST standards had not been met.** The **CQC patient survey, as well as a postnatal survey conducted by the Maternity Voices Partnership (MVP)** was presented at the February MNAG meeting. The results across the **2 surveys were felt to correlate with feedback from Your Voice is heard.** It was recognised that the CQC survey results were from 1 year ago. There was good engagement from the Trust, 51.47% compared to the national response of 47%. There were two areas where the Trust scored some somewhat better than others, and there were 4 areas where EKHUFT scored worse than other Trusts. For the majority EKHUFT was the same as other Trusts. One of the areas, that EKHUFT was worse, was around feeding support for women. Since the report was issued, there has been an increase in the team providing support in this area. The service conducted a survey of staff during January. The response was very good. The feedback was not a surprise; however, it is clear that there is a need to improve how staff are engaged with in the work on the improvements. The plan was agreed to repeat in 3 months times.
Key Recommendation(s):	The Board of Directors are invited to: 1. **NOTE** the content of the report and the key risks highlighted; anaesthetic staffing and midwifery safe staffing on the WHH site.
Implications:	

Links to 'We Care' Strategic Objectives:				
Our patients: Yes	Our people: Yes	Our future Yes	Our sustainability Yes	Our quality and safety Yes
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.			
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.			
Resource:	Y/N	No		
Legal and regulatory:	Y/N	Aligned to external assurance process		
Subsidiary:	Y/N	No		
Assurance Route:				
Previously Considered by:	Maternity and Neonatal Assurance Group			

East Kent Hospitals University NHS Foundation Trust

MATERNITY AND NEONATAL ASSURANCE GROUP/MATERNITY SAFETY CHAMPIONS REPORT

1. Purpose of the report

1.1 The purpose of this report is to provide an update on the progress to date against the Maternity Improvement Programme, which is monitored and coordinated by the Maternity and Neonatal Assurance Group.

2. Background

2.1 In September 2021, the Maternity and Neonatal Assurance Group (MNAG) was formed to continue the targeted oversight of maternity and neonatal services, as work continued in relation to the improvement programme previously commenced by the Maternity Improvement Committee.

2.2 There is an extensive programme of work to improve maternity services and currently the oversight into the delivery of this requires concentrated and in-depth attention under the guidance of Executive leadership. The Chief Nursing Officer (CNO) as the Executive Maternity Safety Champion is the chair of the group, supported by the Non-Executive Maternity Safety Champion.

2.3 Following the publication of the Independent Inquiry into East Kent Maternity Services, and subsequent feedback from CQC, MNAG has incorporated the actions identified through these reports to inform and adapt the overarching maternity improvement programme.

3. Maternity Improvement Programme Evolvement

3.1 The Maternity Improvement plan was reviewed for the January meeting. The decision was taken to remove actions related to CNST and Ockenden from the core improvement plan, as this would form part of business as usual for all units. Oversight of the work for both areas will continue to be reported through the Perinatal Quality Surveillance report each month. The remaining open actions for the maternity improvement plan, have been aligned to the pillars of change, however in view of the recent notices from CQC, there is a need to review and agree the priorities going forward.

4. Progress Report against Key areas

4.1 Training Compliance:

The monthly meetings have continued to focus significantly on the training compliance of the multi-disciplinary team against the mandatory requirements for maternity services. The key elements of training are related to; fetal heart monitoring, neonatal life support, and PROMPT (Practical Obstetric Multi-Professional Training).

NLS, fetal heart monitoring and PROMPT training were reported as achieving compliance for all staff groups across midwifery and obstetrics at the end of January 2023 for the reporting year, aligned to CNST. However, PROMPT training for anaesthetics remains a challenge due to the workforce constraints for the anaesthetists. This is a known issue and work has begun with the

appropriate medical leads to build a plan to address. It should be noted that this is a limiting factor for compliance with CNST.

Other mandatory and statutory training remains below compliance levels, in the main in the obstetric medical workforce the Clinical Director is working with site leads to support improvement in compliance.

4.2 Maternity Dashboard

The maternity dashboard has continued to be a standing item on the agenda, with a more robust exception reporting established. The December dashboard was previously presented to the Board at February 2023 Board meeting.

Following the unannounced visits in January from CQC, the quality rounds have been formalised and the findings from these during the beginning of February were reported at the February MNAG meeting. There is noted improvement with overall compliance.

The key metrics reported related to:

- Environmental and IPC weekly rounds. This are now in place and supported by the matron or head of midwifery on each site. This also includes hand hygiene and PPE audits.
- Fresh eyes compliance – daily audits are in place to review compliance on both sites.
- Equipment safety checks, including resuscitaire checks. These are now showing as compliant for both sites and there is close oversight by the matrons and heads of midwifery

The 1st submission to the CQC was submitted on the 24 February 2023 **(Appendix 1)**

4.3 Governance

The NHSE maternity advisor has continued to work closely with the governance team within maternity to review and embed systems and processes

During this reporting period, all incidents that had been reported to Healthcare Safety Investigation Branch (HSIB) and subsequent reports received, have been reviewed within the service, an action plan developed and subsequently submitted to the Integrated Care Board (ICB) for closure. There is currently at the time of reporting, only 1 active HSIB case.

The Q3 SI report was presented to the January MNAG. A significant reduction in quarter was reported with 4 SIs reported. The plan for closing the overdue open SIs was presented, with all overdue SIs submitted by the end of January, confirmed at the February meeting. Analysis within the quarterly report now includes a breakdown aligned to BAME and deprivation indices.

It has previously been reported around the lack of resources within the Governance team. During this reporting period, progress has been made to complete recruitment to a number of vacant roles.

4.4 Service User engagement and involvement

The response rate for Your Voice is heard continues to be high with rates recorded at 74.3% for December and 72.5% in January. Overall there has been significant positive feedback across all areas, which included feeling listened to and also good midwifery care in labour. The concerns around pain relief remain and also for the WHH concerns raised around how long the discharge process was from the postnatal ward. Actions have been taken to improve how women are supported on the postnatal ward, and it is hoped that this will be reflected in the feedback moving forward.

A programme of work, led by one of the Heads of Midwifery has bought together a number of families, who have previously suffered a bereavement within East Kent. It has been an ongoing concern that the current pathway for bereavement was not to the standard required. Considerable work has been completed, including redesign of the workforce model to support these families as well as the pathway itself. The new model of care is due to launch on the 20 March 2023.

The CQC 2022 Maternity Survey report provides benchmark results for East Kent Hospitals University NHS Foundation Trust.

The 2022 maternity survey involved 121 NHS trusts in England. All NHS trusts providing maternity services that had at least 300 live births were eligible to take part in the survey. Women aged 16 years or over who had a live birth between 1 and 28 February 2022 (and January if a trust did not have a minimum of 300 eligible births in February) were invited to take part in the survey. **Please see Appendix 2.**

There were 245 respondents for the Trust, giving a response rate of 51.47% compared to a national response rate of 47%.

The results identified that there were:

- 2 areas where East Kent was better than most trusts.
- 1 are where East Kent was somewhat better than most trusts.
- 4 area where East Kent was worse than most trusts
- 1 area where East Kent was somewhat worse than other trusts.
- 43 areas where East Kent results were the same as most trusts.

The areas where East Kent was worse were:

- *Were your decisions about how you wanted to feed your baby respected by midwives?*
- *Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?*
- *In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?*

5.0 Workforce

Workforce encompasses a number of different areas across the maternity and neonatal services.

The recruitment of both midwifery and obstetric staff. However, in this reporting period, full papers have also been presented around neonatal and anaesthetic workforce.

MNAG has been supporting the ongoing discussions and case for change across sonography services with respect to obstetric scanning. There is a known capacity issue which has caused a delay in some scans being performed at the appropriate time. A business case has been developed for submission. Further work is also being support by NHSE colleagues around the antenatal screening pathway, which is heavily reliant on sonography services.

The Perinatal Quality Surveillance Tool, presented each month to Board has continued to highlight concerns around staffing levels, particularly at WHH related to vacancy, maternity leave and sickness. Despite the ongoing staffing challenges, there has been improvement in the compliance for 1:1 care in labour as well as the supernumerary status for the band 7 coordinator. Unfortunately to support this, there has become an over reliance on the use of the hospital on call midwife. To try and resolve this, the senior midwifery team are working with representatives from the core staff groups, supported by representatives from the Royal College of Midwives (RCM) to find solutions to the overall workforce challenges.

The concerns raised by the NMC around the student midwifery programme at CCCU was discussed along with the initial plans to address locally within EKHUFT. Despite the work that was undertaken a decision was taken subsequently to withdraw the students from WHH in February 2023.

The service conducted a survey of staff during January. The response rate was very good. The feedback was not a surprise; however, it is clear that there is a need to improve how staff are engaged with in the work on the improvements. The plan was agreed to repeat in 3 months times.

6.0 Reporting aligned to CNST requirements

Despite a significant effort, under pressured circumstances, the maternity service was not able to report a positive declaration for year 4 CNST submission. The main reason for this, was due to non-compliance with PMRT reporting and PROMPT training, as previously reported.

7.0 Key Area of Challenge

7.1 Staffing has been significantly challenged during this reporting period with a rise in vacancies, sickness and maternity leave, especially at WHH.

7.2 The level and pace for transformation is significant, and particularly challenging for the maternity services and resources available.

8.0 Conclusion

8.1 The Maternity and Neonatal Assurance Group has established robust reporting mechanisms ensuring line of sight on key areas within maternity to the Trust Board.

8.2 There is a need to revise the improvement plan aligned to the priorities from CQC as well as the remaining outstanding actions.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**CARE QUALITY COMMISSION (CQC)**
REPORT TITLE:	**SECTION 31 REPORTING: MATERNITY & MIDWIFERY SERVICES WILLIAM HARVEY HOSPITAL (WHH)**
DATE:	**24 FEBRUARY 2023**
FROM:	**CHIEF NURSING & MIDWIFERY OFFICER: EXECUTIVE BOARD MATERNITY SAFETY CHAMPION**

CQC Reference: RGP1-15004847857 (QEQM) RGP1-15003286303 (WHH)
Organisation: RYY

This report provides the organisation's response to the letter dated 13 February 2023 received from Deane Westwood, Director of Operations South, at the Care Quality Commission, in relation to the regulated activity maternity and midwifery services, at William Harvey Hospital (WHH).

1. By 20.02.23: **Requirement:** Effective assessing, managing and monitoring the safety of the environment and equipment at the maternity department at William Harvey Hospital

System implemented

The Senior Midwifery Team (Director of Midwifery, Heads of Midwifery and Matrons) a systematic approach on the 19th January, which is now embedded to ensure there is daily oversight to maintaining a safe environment across the maternity unit at WHH. The process includes:

- Daily rounds by the matron or Band 7 ward manager commenced on the 19th January 2023 to ensure equipment checks have been completed for emergency equipment and resuscitaires in the previous 24 hours. During these rounds the environment is checked for general cleanliness as well as ensuring there is no blockage to fire egress routes. Any issues are dealt with immediately. ***(points a and d below)***

- Formal joint weekly IPC rounds, supported by a SOP with a matron or Head of Midwifery commenced 19th January 2023. This is a 3-hour audit and incorporates (***points b and c below***):
  - Cleanliness of all general, clinical and sanitary areas as well as clinical equipment and soft furnishings
  - Issues identified are actioned at the time and conversations where necessary take place with the team who are on duty at the time.

Environmental Audit Standard Operating Procedures (SOP)

- A review of existing contractual arrangements for cleaning was undertaken the week commencing the 16th January 2023, which resulted in a revised SOP which was agreed by the Care Group Operational Governance meeting on the 20th January 2023. The day to day operational arrangements were amended to increase the daily checks around standards of cleaning, especially for bathrooms and high traffic areas, as well as the level of supervision for the contracted cleaning staff. There are clearly defined roles and responsibilities in relation to who cleans which areas and or equipment i.e. what clinical staff are responsible for and what cleaning staff are responsible for.

- The Head of Midwifery collates the results of the weeks assurance checks, detailed above and provides a report to the Director of Midwifery as part of a ''Stop the Clock'' process, which was implemented on the 7 February 2023 for each Friday to review the results of pre-ceding weeks compliance audits, discuss issues raised and confirm actions taken and/or further actions required to improve compliance. This is also an opportunity for further escalation and action if required to the Chief Nursing and Midwifery Officer.

2. By 24.02.23: **Requirement:** Effective Assessing, managing and monitoring the safety of the environment and equipment at the maternity department at the William Harvey Hospital

   The report must include **results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and must include the following:**
   a. Daily quality round checklist audit;
   b. Clinically led environmental audit;
   c. Master environmental audit and;
   d. Equipment checks in the monthly environmental audit.

Actions taken to ensure system's effectiveness

- The actions taken to address the above points have been outlined above. (**a,b,c,d)**

Monitoring data and audits that provide assurance

- **Evidence of the collated quality rounds completed on a daily basis and reported weekly to the Director of Midwifery by the Head of Midwifery (point a)**

- The table below shows the results for the last 2 weeks, and following the initial actions taken, is demonstrating improvement.

- The significant improvement around the cleaning of the pools related to providing clarity to the maternity support workers around the requirement for the pools to be cleaned, even when there may be a woman in room D, where the pool is located. Due to the challenges around ventilation and the use of Entonox, the room cannot be used for labour care, and therefore is used as a room for an induction of labour.

Criteria	W/C 6/2/23	W/C 13/2/23
Environmental clean checks including birthing pool	71.5%	100%
Emergency equipment checks	79% (3-night shifts poor compliance but daytime checks compliant)	100%
Resuscitaire checks	86% (3-night shifts poor compliance but	100%

	daytime checks compliant)	
Fire routes clear	Clear	Clear
Hand hygiene audits (x5 per day)* completed	100%	100%
Hand hygiene results	*results not available until 1 March	
PPE compliance	See IPC sheets below	See IPC sheets below

Key

Results not available	
Fully compliant	
Compliance 80% and improving	
Compliance less than 80%	

- *The compliance for Hand Hygiene audits above, is in relation to the number of audits being undertaken each day. The standard is for 5 audits per day to be completed within the unit. The results of the audits are loaded into an electronic system. The results will be available for the weeks above on the 1st March 2023. Moving forward the team will retain paper-based results so that these can be reviewed at the weekly ''stop the clock'' meetings with the Director of Midwifery. Unfortunately, at the time of inputting the results, the team were not aware that results could not be retrieved each week.

Evidence of IPC audits, which cover points b,c and d

- Audits are completed each week by the IPC and midwifery team on a Tuesday

Summary of themes from IPC/Environmental weekly reviews

- The table below summarises the common themes highlighted through the IPC audits. The next step is to pull these into a collated action plan so they can be monitored at the weekly ''Stop the Clock'' with the Director of midwifery. This will be completed by the 1/3/23. The majority of issues are aligned to minor estates works, which are actioned at the time. There may be a lead in time for some, due to orders needing to be placed eg wall mounted holders. We will confirm in our monthly submissions an update to provide assurance that the issues are being addressed.

Theme	Action taken	Action addressed
Minor estates work	Minor requests submitted and estates team deployed to address.	*will update in future submissions
Repositioning of apron holder	Submitted request for work to be completed	
Compliance with uniform policy and PPE guidance	Addressed with individual staff at the time	
Need to replace some of the paper labels so that IPC compliant	New labels ordered that will be compliant with IPC	

3. By 20.02.23: **Requirement:** Effective system for assessing, managing and monitoring the safety of women and babies using Cardiotocography (CTG) monitoring and fresh eyes/ears at the maternity service at the William Harvey Hospital

System implemented

- As part of the fetal monitoring guidance it is a requirement to undertake a ''fresh eyes'' review on an hourly basis where there is continuous CTG in progress. As a service a formal prospective audit has been developed and agreed, which will commence the week of the 6 March, once the final audit tool has been built into the Trust audit system (Snap Tool).
- The Heads of Midwifery and Matron have strengthened their oversight around the compliance with 'Fresh Eyes on an hourly basis for women who are requiring a continuous CTG. As part of this, from the 23rd January, daily audits were commenced of 5 sets of notes per day to monitor compliance, and identify the issues around non-compliance. Where compliance is not achieved individual conversations take place with the midwives and medical staff who were looking after the woman, to ensure there is a complete understanding of expectations, and to address any gaps in knowledge.
- From the 23rd January 2023, an alert system was built into the electronic Patient Tracking board, where an icon flashes to alert when fresh eyes is due, as an additional reminder to the band 7 coordinator.
- A prospective audit of fetal heart monitoring will commence the week of 6 March 2023.

4. By 24.02.24: **Requirement**: Actions taken to ensure the system in place for assessing, managing and monitoring the safety of women and babies using Cardiotocography (CTG) monitoring and fresh eyes/ears at the maternity service at the William Harvey Hospital is effective.

   The report **must include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and patients are escalated appropriately for medical support and review in line with national clinical guidelines and must include:**
   a. **Intermittent auscultation (IA) and CTG audits.**

Actions taken to ensure system's effectiveness

- A daily fresh eyes audit has been implemented of 5 cases per day, results and actions are presented to the Director of Midwifery at the weekly ''Stop the Clock''.
- A prospective audit for ongoing monitoring of compliance with guidance has been agreed, which will include escalation for medical review/support. This will commence on 6 March 2023. See P.I.D below. Due to previous lack of audit capacity within the Governance team, this had been delayed. With the appointment of an audit lead midwife this has now been prioritised as one of the core audits within the service.

Prospective fetal monitoring audit plan

- This has been developed from a previous audit, and will be reviewed on a regular basis as the audit progresses. This audit will look at the wider requirements around compliance

with the whole fetal monitoring guideline, which includes the appropriate escalation of concerns as well as the correct interpretation of CTG traces.

Monitoring data and audits that provide assurance

Fresh eyes weekly results of daily audits:

There are 3 points of compliance that are audited:

- Completion of hourly fresh eyes where applicable
- 2 signatures on the fresh eye's sticker in the medical record
- 2 signatures on the CTG tracing at the time of fresh eyes completion

Results:

Criteria	w/c 20/1/23	w/c 6/2/23	w/c 13/2/23
Completion go hourly fresh eyes where applicable	64%	81%	88%
2 signatures on the fresh eye's sticker in the medical record	54%	79%	69%
2 signatures on the CTG tracing at the time of fresh eyes completion	30%	66%	53%

Key

Fully compliant	
Compliance 80% and improving	
Compliance less than 80%	

- There has been improvement around the action of performing ''fresh eyes'', however further work is being undertaken to ensure all staff are aware of the need for 2 signatures, within the maternal record as well as on the CTG tracing itself. From 23/2/23, this will involve the use of the Clinical Skills Facilitators who are already working clinically (not in the numbers), supporting the newly qualified midwives, to reinforce the education with every clinical midwife.

5. By 20.02.23: **Requirement:** Effective system for assessing, managing and monitoring the safety of women and babies using triage services at the maternity service at the William Harvey Hospital.

System implemented

There is an agreed triage guideline in place, which includes the Birmingham Symptom-specific Obstetric Triage System (BSOTS) model, as well as the staffing arrangements and roles responsibilities.

The service has implemented the BSOTS model for the management of triage areas within maternity. This system after earlier adoption at QEQM, has been implemented at WHH. The monitoring of the triage service is built on the framework from the BSOTs programme and includes the following metrics:

- Number of women seen in the triage area.
- The number of women seen divided across the BSOTs RAG status which defines the urgency with which the woman needs to be attended to
- The number of women seen in triage, who do not fulfil the BSOTs criteria and therefore should not have been seen in triage
  The time taken for the initial midwifery assessment and this also includes where expected times are breached
- The time taken for the obstetric assessment and this also includes where expected times are breached

It was already recognised that further dedicated medical support was required to support triage, to ensure timely obstetric reviews. A plan was agreed and implemented to increase the medical cover during the day over 7 days for WHH triage. From the 20 the February 2023, weekdays have been supported by consultants undertaking extra hours, 1300 – 1700 hours and from the 7th January 2023 weekends has been supported by a registrar 1000 – 1700 hours.

It is recognised that there has been non-triage activity being handled within the triage department. This, in main, has been women who require scan plots at the WHH and who were attending triage for this, (non-triage activity) have now been diverted to another area on the hospital site to reduce impact on the workload in the triage department. This does not require women to travel between sites.

This action was put in place from Friday the 17 February 2023.To facilitate this a separate rota over 6 days a week, aligned to the times of scans being performed, has been put in place, utilising midwives over a number of specialist roles. This means that women will be seen face to face, immediately after their scan, if they require the growth of the baby plotting, and will not be expected to wait in the triage department. This will reduce the overall number of women attending the triage area, including waiting in the seated area and will also improve the experience for our women and partners. This also demonstrates that we have listened and acted on the concerns raised by the triage midwives.

6. By 24.02.23: **Requirement**: Actions taken to ensure the system in place for assessing, managing and monitoring the safety of women and babies using triage services at the maternity service at the William Harvey Hospital is effective.

   The report **must include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and patients are escalated appropriately for medical support and review in line with national clinical guidelines**. The **report to the Care Quality Commission must include:**
   a. **Triage audit tool data.**

Actions taken to ensure system's effectiveness

- The above process has been implemented.
- Working with the clinical team to embed consistent reporting for the above metrics and the escalate promptly when concerns are raised.

- The triage data will be reported in full on a monthly basis to the Executive Maternity and Neonatal Assurance Group (MNAG) chaired by the Chief Nursing and Midwifery Officer.

Monitoring data and audits that provide assurance

Maternity Triage Guideline – adopting BSOTS methodology

- There is an overarching working group to oversee the implementation of the triage process for maternity services. This is an MDT approach. The guideline below has been developed, coordinated through the group, with oversight through the Women's Clinical leadership team.

- For this reporting period there is 1 week's data for sharing. A score card is in place, which will provide the ability to map progress in future reports.

Triage activity data week commencing 6/2/23

Criteria	Number of women	% of activity
Attendances	171	n/a
BSOTS Red RAG	0	0%
BSOTS Orange RAG	28	16.5%
BSOTS Yellow RAG	25	14.5%
BSOTS Green RAG	8	4.5%
BSOTS N/A	71	41.5%
BSOTS not recorded where applicable	39	23%

The above table shows that there is a high level of activity which is not triage related and actions have been put in place to remove scan plots, which is the main reason for this. This will be monitored weekly to determine if further actions are required.

Triage performance data for week commencing 6/2/23

Criteria	Target (%)	Compliance (%)
Seen by Midwife within 15 minutes of arrival	**75%**	**98.6%**
Green = MDT review within 4 hours.	**75%**	**100%**
Yellow = medical review within an hour.	**75%**	**88%**
Orange = medical review within 15 mins	**75%**	**86%**
Red = immediate medical attention and urgent transfer to Labour Ward or other relevant area.	**100%**	**100%**

The targets above have been benched marked to Birmingham Women's services, where the original tool was developed following the advice of our National Maternity Improvement Advisor.

At WHH the BSOTs system is still being embedded. Once more data is available the targets will be reviewed and approved through MNAG, we aim to do this at the May 2023 meeting.

Key

Green = MDT review within 4 hours.
Yellow = medical review within an hour.
Orange = medical review within 15 mins
Red = immediate medical attention and urgent transfer to Labour Ward or other relevant area.

7. By 20.02.23: **Requirement:** Effective system for assessing, managing and monitoring infection prevention and control practices at the maternity service at the William Harvey Hospital

System implemented

There is a formal joint weekly IPC round with a senior midwifery representative in place. This is a 3-hour audit and incorporates (***points b and c below***):

- Cleanliness of all general, clinical and sanitary areas as well as clinical equipment and soft furnishings
- Issues identified are actioned at the time

- Hand hygiene audits, as described in Section 1 are completed on a daily basis and reported weekly by the Head of Midwifery to the Director of Midwifery and reviewed at the Stop the Clock weekly meeting.

- A review of existing contractual arrangements for cleaning was undertaken the week commencing the 16th January 2023, which resulted in a revised SOP which was agreed by the Care Group Operational Governance meeting on the 20th January 2023. The day to day operational arrangements were amended to increase the daily checks around standards of cleaning, especially for bathrooms and high traffic areas, as well as the level of supervision for the contracted cleaning staff. There are clearly defined roles and responsibilities in relation to who cleans which areas and or equipment i.e. what clinical staff are responsible for and what cleaning staff are responsible for.

8. By 24.02.23: **Requirement:** Report setting out the actions taken to ensure the system in place for assessing, managing and monitoring infection prevention and control practices at the maternity service at the William Harvey Hospital is effective.

   The report **must include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and must include:**
   a. **Weekly Personal Protective Equipment (PPE) audits and;**
   b. **Weekly hand hygiene audits**.

Actions taken to ensure system's effectiveness

- The above has been implemented

Monitoring data and audits that provide assurance

Please see data in Section 2

IPC – Trust Overview

IPC Roles and Responsibilities: Written guidelines to identify roles and responsibilities for cleaning in line with national cleaning standards. (They have clear written guidelines to identify roles and responsibilities for cleaning, who cleans what, **example clinical** OR domestic staff in line with national cleaning standards)

- The Trust has an approved trust policy based on the 2021 National Cleaning Standards which were implemented by 2gether support solutions by October 2022 as required. In the environmental and equipment cleaning policy appendices we identify who is responsible for cleaning.

Planned Preventative Maintenance: The trust has a programme of planned preventative maintenance for the care environment in place (The audits have identified many environmental defects that will not support effective cleaning).

- The Trust has a capital backlog of critical infrastructure work, which includes the need for refurbishment of our generally poor physical infrastructure. Items identified in IPC audits or by clinical staff are reported to 2gether via the helpdesk and prioritised for repair (this is not planned preventative maintenance). With the constraints on capital, we have no capital budget for refurbishment of clinical areas as an ongoing programme. Also, we have no clinical capacity to decant patient areas for refurbishment (with many escalation areas in use).

- In September 2020, 2gether Support Solutions presented to the Board of Directors, the impact of the six-facet survey. This demonstrated an increase to the backlog to £120m in 2020 and £147m (without on-costs) by 2025. This confirmed the Trust's backlog maintenance programme would be placed in the top 10 nationally from a position of 44.

- The six-facet survey identified that 48% of our total estate is either condition C or D i.e. poor, exhibiting defects and / or not operating as intended; and bad, life expired and / or serious risk of imminent failure. The six-facet survey has been used to allocate the capital funding to the backlog priority schemes.

- The six-facet survey is a minimum data set, to further inform the Trust and 2gether Support Solutions of the backlog maintenance risks, 2gether has commissioned an ARUP Critical Infrastructure review which was completed in June 2021

- These assessments will be used to future inform the Patient Experience Committee (PEIC) and Strategic Investment Group of the prioritisation of spend on the critical infrastructure over the next 5 years. Senior clinical leads are part of the PEIC committee i.e. DIPC and Director of Nursing for William Harvey Hospital.

- The PEIC priority funding has been risk assessed by 2gether's technical directors, the Trust's DIPC and finally by the Hospital Triumvirates (leadership teams) to ensure infection control and clinical assessments are part of the risk assessed process.

- The annual capital schedule is submitted to the Trust's Strategic Investment Group (SIG) for approval and the spend is monitored each month at SIG and the Patient Environment and Investment Committee (PEIC). PEIC prioritises and recommends allocation of the annual capital and revenue budgets to SIG. Membership of PEIC includes the Trust's Intelligent Client, Director of Infection Prevention and Control (DIPC), Director of Nursing for William Harvey Hospital, Assistant Finance Director and 2gether's Director of Capital and Estates.

Water Safety Plan: The Trust has a water safety plan in place and we are compliant against regulations set out in the HTM 04 01 (safe water in healthcare premises). On the QEQMH audit of Kingsgate there is a rag rated red against flushing of low use outlets

- The Trust water safety plan and the water safety risk assessment are overseen by the water safety group, and we have an ongoing programme of water environmental works (as part of the backlog maintenance programme described above) and use Point of Use Filters where necessary to maintain patient safety. In addition:

    - we continue to work to the existing SOP (Standing Operating Procedures) associated to the current risk assessment.
    - 2gether undertake regular flushing and/or other works that is aligned to these risk assessments.
    - New assessments have been signed off for KCH & Buckland's – work is ongoing to cross reference and close out the other 3 sites.

9. By 20.02.23: **Requirement:** Implement an effective system for assessing, managing and monitoring the safety of staffing levels to keep women safe from avoidable harm and there is appropriate escalation to provide the right care and treatment at the maternity service at the William Harvey Hospital.

System implemented

- There is ongoing oversight and monitoring of the day to day service in relation to staffing and activity. This is underpinned by an escalation guideline and supported through daily huddles and sit rep meetings where a service wide review is undertaken to assess the situation and to make plans accordingly to maintain safety.

- Staffing is reviewed each day by the senior midwifery team and also the DSA team for medical staff. Where gaps are identified, staff are re-deployed where possible to ensure core care is secured. For midwifery there is an on-call rota and if 1:1 care is impacted then the on-call midwives are utilised.

- When capacity is becoming constrained a divert will be put in place, coordinated by the senior midwife onsite (in hours) and manager on call (out of hours) with support by the Head of Midwifery or Director of Midwifery. For the WHH the divert is normally to QEQM if activity allows. Where this is not possible then a divert is requested out of the Trust. All diverts are supported and coordinated through the site team and Strategic on call director as well as the ambulance service.

Consultant cover and availability of a 2nd rota.

- The RCOG published a statement in July 2022 urging units to consider different options. There is currently an appendix in the Trust 'consultant obstetricians' referral to and attendance on labour ward when on call' guideline which explains the process and criteria for calling in a 2nd consultant. *See guideline below.* In the last 6 months there have been 4 occasions across both sites when a second on call consultant has been called in. Moving forwards from the 20 February all cases when a 2nd consultant has been required will be datixed so that we can fully understand the reasons for this and taken action as required.

10. By 24.02.23: **Requirement**: Report actions taken to ensure the system in place for assessing, managing and monitoring the safety of staffing levels to keep women safe from avoidable harm and there is appropriate escalation to provide the right care and treatment at the maternity service at the William Harvey Hospital is effective.

    The report must include **results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and must include the following:**
    a. **Emergency second on-call consultant rota;**
    b. **Where there are gaps in the rota, a rationale for how gaps are covered;**
    c. **Update on progress of recruitment into the vacant medical and midwifery posts and;**
    d. Staffing arrangements to make sure women are protected from risk of unsafe care.

Actions taken to ensure system's effectiveness

- There is an escalation guideline in place - see guideline below
- A SBAR communication is sent to all relevant team members following the 10 am sit rep meeting.
- The process for obtaining a 2nd consultant in an emergency has been implemented
- A workforce review has been completed and there are regular reviews of the midwifery and medical workforce numbers. The reviews have identified that the funded establishment is Birth rate compliant, the main focus is now on the recruitment to the vacancies

Medical Workforce WHH:

Consultant vacancy: there has been 2 new consultant appointments and remaining vacancies (1.1 FTE) are subject to ongoing recruitment with Locum arrangements in place to back fill

Non-Career grade doctor vacancies for WHH are 4.2 FTE. Recruitment is ongoing and locums used accordingly.

Midwifery Workforce:

The establishment table below provides the current status of the midwifery recruitment for the WHH. There is ongoing recruitment, including international midwives, of which 7 have been appointed and start dates are dependent on the completion of the required processes. In addition, recent agreement to increase the number of support roles, as well as introduce a nurse model to reduce the workload for midwifery team.

On a day by day basis the medical rotas are managed by the Directorate Support Assistant to ensure gaps created through sickness, vacancy etc are managed. Where gaps become difficult to fill this is escalated to the Site Obstetric lead and Director of Operations for decisions to made in terms of locum use or cancellation of elective work within gynaecology. Every effort is made in advance to cover gaps by working with locum services.

Midwifery rotas are managed on a continuous basis across the day. Due to vacancies and maternity leave levels, coupled with short term sickness, there are known gaps at the beginning of each rota. Gaps are addressed through the use of NHSP and long line bookings for agency midwives. Any remaining gaps and additional gaps that occur due to short term sickness on the day are managed by the senior midwifery team and supported by the manager on call out of hours. If required, depending on the acuity/activity midwives are deployed from other areas, including on calls to address shortfall. If this is not sufficient then using the escalation guideline, a divert will be activated. This may also result in suspension of the homebirth service. Below are the rotas for the last 2 weeks for WHH for midwifery. During this time gaps were managed accordingly as well as the escalation process. No harms have been identified as a result of the remaining gaps.

On the 23 February a forward look exercise was completed of maternity staffing for the next 6 months with the support of our National Maternity Improvement Advisor. This was completed due to staffing concerns that were raised with the Chief Nursing and Midwifery Officer (CNMO) and the Chief Executive on the 22 February at a listening event. The review has highlighted that due to increased vacancy levels on the WHH site that urgent action is required in order to ensure safe staffing levels from April 2023 onwards. Options were explored with the clinical and management team on 23 February including the CNMO. An options paper is being written which will be presented to the Executive Management Team on 1 March and then shared with the ICB. The options will include how elective activity can be safely diverted away from the WHH site so that the midwifery staffing templates can be reduced and also additional options for securing additional bank and agency staff. Learning has been taken from other Trusts to inform the options paper.

Immediate actions have been taken to ensure that the staffing levels are safe over the next 2 weeks which include:

- Commencing Saturday 25/2/23 a senior midwife, band 7 manager or above will be onsite at the WHH to provide support and operational oversight during the day.
- Commencing Monday 27/2/23 the number of IOLs will be limited to 3 per day at WHH with an additional IOL transferred to QEQM each day to support.
- Midwives in specialist roles are developing a rota to provide 0.4 clinical shifts at WHH from the week beginning 6/3/23
- Commencing the 28/2/23 the telephone triage will be centralised at night to QEQM, to reduce midwifery staffing requirements at WHH
- The threshold for activating a divert from WHH to QEQM has been adjusted to a lower threshold to ensure acuity is managed aligned to staffing and activity, this will continue to be monitored by the HOM in the twice daily safety huddles.
- Fast track the recruitment checks of 10 Health care assistants to work in maternity to support roles currently undertaken by midwives. Prior to commencement on the unit individuals will undertake a 2 week induction programme, followed by supported induction in the unit aligned to a competency framework.

Monitoring data and audits that provide assurance

Escalation Guideline

Consultant Obstetrician Guideline

Daily SBAR tool example

Medical workforce rota for medical workforce – WHH 5/2/23 – 19/2/23

The rota is a live document which is managed on a day by day basis. During this reporting period there were no gaps within the medical rota for obstetrics across the WHH

Midwifery workforce rota for WHH 5/2/23 – 19/2/23

During the above reporting period the table below shows the times when the on-call midwife was utilised. The on-call midwife should only be called in to support where activity is such that 1:1 care cannot be provided safely.

The maternity services have deployed the Birth Rate Plus acuity tool, which includes a number of red flags as part of a safer staffing methodology. Compliance with recording the acuity on a 4 hourly basis needs to meet a threshold of 80% for data validity. For WHH the compliance is not at 80% and as part of the improvement this is monitored through the Maternity and Neonatal Assurance group, as part of the maternity dashboard. The team are working towards achieving the 80% threshold for the labour ward by the end of March 2023.

Unfortunately, at the time of this submission, the Birthrate acuity system was undergoing an upgrade and therefore the compliance and red flags highlighted during February, aligned to the staffing rotas above, could not be accessed from the reporting function. However, from January data the leading impact of staffing levels in terms of red flags was the delay between admission for induction and commencement of induction, and local day to day discussions would support this remaining the same for February.

On-call information

Date	Day time on-call weekend	Night on-call	Other	Divert
7/2/23		Yes x1		
10/2/23		Yes x2	Midwife extended shift to long day	
11/2/23	Yes x1	Yes x1		Divert to neighbouring Trust day time due to high activity and acuity
12/2/23		Yes x1		
13/2/23		Yes x1		
15/2/23		Yes x1		
16/2/23		Yes x1		

The number of hours worked by staff when they attend, as part of an on call, is monitored within the Health roster. For the above period, staff who were called in, the number of hours

worked ranged from 4.3 to 12.8 hours, but these staff were not performing any other clinical hours in the same 24-hour period.

11. By 20.02.23: **Requirement:** Implement an effective system for assessing, managing and monitoring the safety and timeliness of discharge to keep women safe from avoidable harm and to provide the right care and treatment at the maternity service at the William Harvey Hospital

System implemented

There are a number of workstreams that have been commenced as part of the wider maternity improvement work to improve the overall pathways in relation to triage as well as postnatal discharges. This includes:

- A system being established in triage to record all women where the transfer to the labour ward or antenatal ward is delayed by more than 30 minutes and the reason why and the actions taken/escalation.

- A review of current time of discharge from the postnatal ward has been undertaken as a baseline to monitor the impact of changes, for the last 6 months. Initial review of the data comparing weekday and weekend patterns, shows a peak in discharges at 1400 hr and then again 1700 – 1800 hours. At the weekend, there are slightly more discharges between 1500 – 1600 hours. This is an early analysis but further review of data in detail will form part of the programme of work for improving the timeliness of discharges.

- An agreement has been made with the neonatal team to deploy a neonatal doctor to the postnatal ward earlier in the morning to support discharges and an additional doctor on the long day will review potential discharges for the next day.

- Women who require scan plots at the WHH and who were attending triage for this, (non-triage activity) have now been diverted to another area on the hospital site to reduce impact on the workload in the triage department. This does not require women to travel between sites. This action was put in place from Friday the 17 February 2023.To facilitate this a separate rota over 6 days a week, aligned to the times of scans being performed, has been put in place, utilising midwives over a number of specialist roles. This means that women will be seen face to face, immediately after their scan, if they require the growth of the baby plotting, and will not be expected to wait in the triage department. This will reduce the overall number of women attending the triage area, including waiting in the seated area and will also improve the experience for our women and partners.

- An end to end review of the discharge process has been completed.
- A task and finish group has been established to action the issues identified through the review of the discharge processes. The issues identified include:
  - Delay in preparation of take-home medications.
  - Delay in neonatal discharges
  - Incomplete records that need to be collated
  - Delay in EDNs being completed

The review of the discharge process is included and the discharge action plan. Progress against delivery of the action plan will be included in our monthly submissions.

Completed actions:

- An agreement has been made with the neonatal team to deploy a neonatal doctor to the postnatal ward earlier in the morning to support discharges and an additional doctor on the long day will review potential discharges for the next day.

- Recruitment is in progress for additional care support staff to complement the midwifery workforce on the postnatal and labour wards.

- EDNs for elective caesarean sections will be completed by the operating team at the time of surgery, and this has been communicated to all of the obstetric team.

- When the on call SHO has completed the labour ward round (earlier if there are significant bed pressures), they will attend the postnatal ward to complete discharges. At the weekend the SHO starting at 0800 will go straight to the postnatal ward. On days where additional SHO cover is available, they will be deployed to the postnatal ward.

- Progress made in delivery of the action plan will be reported in subsequent monthly reports, as the task and finish group move forward.

12. By 24.02.23: **Requirement:** Provide a report setting out the actions taken to ensure the system in place for assessing, managing and monitoring the safety and timeliness of discharge to keep women safe from avoidable harm and to provide the right care and treatment at the maternity service at the William Harvey Hospital is effective.

    The report **must include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and must include the following:**
    a. **The number of delayed discharges at triage and postnatal;**
    b. **Reason for delayed discharge and;**
    c. **Update on progress against the mapping of discharge process review**.

Actions taken to ensure system's effectiveness

- A baseline review of time of discharge has been completed for the postnatal ward, so that the impact of any actions can be measured. Currently the data shows that the majority of discharges are happening from 2pm onwards.

- A system has been implanted to record the women delayed by more than 30 minutes from triage for onward care. This data will be provided in the next report, and will identify reasons.

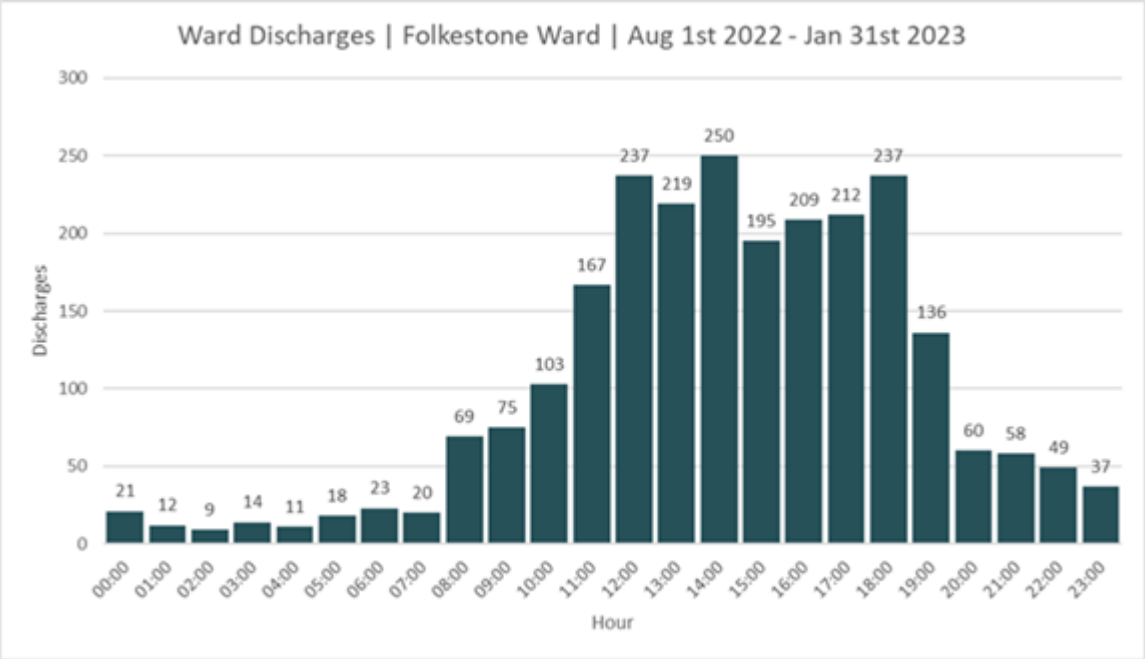
- A review of the discharge pathway has been mapped and a reason for delay identified. Actions need to be developed with the MDT and implemented.

- The number of discharges is also reviewed at the 10 am sit rep. (see example in section 10)

- Non-triage activity related to scan plots has been removed. Ongoing monitoring will be in place to ensure there is a positive impact. (During the period of 5/2 to 11/2 the number of women attending the WHH who did not meet the triage criteria was 71). This will be reported under the triage audit data in future submissions.

Monitoring data and audits that provide assurance

Baseline data for time of discharge for the last 6 completed months 22/2023



East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**CARE QUALITY COMMISSION (CQC)**
REPORT TITLE:	**SECTION 31 REPORTING: MATERNITY & MIDWIFERY SERVICES AT QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL (QEQMH)**
DATE:	**24 FEBRUARY 2023**
FROM:	**CHIEF NURSING & MIDWIFERY OFFICER**

CQC Reference: RGP1-15004847857 (QEQM) RGP1-15003286303 (WHH)
Organisation: RYY

This report provides the organisation's response to the letter dated 13 February 2023 received from Deane Westwood, Director of Operations South, at the Care Quality Commission, in relation to the regulated activity maternity and midwifery services, at Queen Elizabeth the Queen Mother Hospital (QEQMH).

1. By 20.02.23: **Requirement:** Implement an effective system for assessing, managing and monitoring the safety of the environment and equipment at the maternity department at the Queen Elizabeth the Queen Mother Hospital.

System implemented

The Senior Midwifery team (Director of Midwifery, Heads of Midwifery and Matrons) implemented a systematic approach on the 19th January 2023 to ensure there is daily oversight to maintaining a safe environment across the maternity unit at QEQM. The process includes:

- Daily rounds by the matron or Band 7 ward manager were commenced on the 19th January 2023 were implemented to ensure equipment checks have been completed for emergency equipment and resuscitaires in the previous 24 hours. During these rounds the environment is checked for general cleanliness as well as ensuring there is no blockage to fire egress routes. Any issues are dealt with immediately. ***(points a and d below)***

- Formal joint weekly IPC rounds, supported by a SOP, with a matron or the Head of Midwifery were commenced on the 19th January 2023. This is a 3-hour audit and incorporates (***points b and c below***):
  - Cleanliness of all general, clinical and sanitary areas as well a clinical equipment and soft furnishings
  - Issues identified are actioned at the time and conversations where necessary take place with the team who are on duty at the time.

Standard Operating Procedure (SOP) for Clinically Led IPC Environmental Audits

- A review of existing contractual arrangements for cleaning was undertaken week commencing the 16th January, which resulted in a revised SOP which was agreed by the Care Group Operational Governance meeting on the 20th January 2023. The day to day operational arrangements were amended to increase the daily checks around standards of cleaning, especially for bathrooms and high traffic areas, as well as the level of supervision for the contracted cleaning staff. There are clearly defined roles and responsibilities in relation to who cleans which areas and or equipment i.e. what clinical staff are responsible for and what cleaning staff are responsible for. See Cleaning responsibilities below.

Cleaning Responsibilities

- The Head of Midwifery collates the results of the weeks assurance checks, detailed above and provides a report to the Director of Midwifery as part of a ''Stop the Clock'' process, which was implemented on the 7th February 2023 for each Friday to review the results of preceding weeks compliance audits, discuss issues raised and confirm actions taken and/or further actions required to improve compliance. This is also an opportunity for further escalation and action if required.

- Work requests were submitted to address the concerns raised in ***point e below***, and this work has been completed as show in section 2 below.

2. By 24.02.23: **Requirements:** Actions taken to ensure the system in place for assessing, managing and monitoring the safety of the environment and equipment at the maternity department at the Queen Elizabeth the Queen Mother Hospital is effective.

   The report should **include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and should include the following:**

a **a. Daily quality round checklist audit;**

b **b. Clinically led environmental audit;**

c **c. Master environmental audit;**

d **d. Equipment checks in the monthly environmental audit;**

e **e. Evidence of works request completion for: the leaking roofs and bowing doors in the midwifery led unit and rusty shelf and flooring in the patient bathroom in the triage department** at the Queen Elizabeth the Queen Mother Hospital.

Actions taken to ensure system's effectiveness

- The actions taken to address the above points have been outlined above. (**a,b,c,d)**
- Immediate actions were taken to address the leaking roofs and bowing doors in the midwifery led unit and rusty shelf and flooring in the patient bathroom in the triage department (**e)**
- The pictures in the section below provide the evidence of assurance that this has been completed. The process for weekly IPC and environmental rounds will provide ongoing monitoring of any estate's issues, and actions taken are incorporated as part of this. Where there is a delay in remedial repairs being completed, these are escalated by the Head of Midwifery to the Director of Midwifery to take forward with the head of Estates.
- The maternity team have worked with EME to ensure there is a clear understanding of the current status regarding the preventative maintenance for equipment. The table below summarises the current position. Where there is a delay in external companies coming on site to complete maintenance, the internal EME team ensure calibrations are undertaken. If there is ongoing delay this is escalated to the Head of medical engineering.

Monitoring data and audits that provide assurance

Evidence of the collated quality rounds completed on a daily basis and reported weekly to the Director of Midwifery by the Head of Midwifery (point a)

Criteria	W/C 6/2/23	W/C 13/2/23

Environmental clean checks including birthing pool	100%	100%
Emergency equipment checks	100%	100%
Resuscitaire checks	100%	100%
Fire routes clear	clear	clear
Hand hygiene audits (x5 per day)* completed	100%	100%
Hand Hygiene results	Not available until 1 March	
PPE compliance	100% See IPC results	90% See IPC results

Key

Results not available	
Fully compliant	
Compliance 80% and improving	
Compliance less than 80%	

- The compliance for Hand Hygiene audits above, is in relation to the number of audits being undertaken each day. The standard is for 5 audits per day to be completed within the unit. The results of the audits are loaded into an electronic system. The results will be available for the weeks above on the 1st March 2023. Moving forward the team will retain paper-based results so that these can be reviewed at the weekly ''stop the clock'' meetings with the Director of Midwifery. Unfortunately, at the time of inputting the results, the team were not aware that results could not be retrieved each week.

Evidence of IPC audits, which cover points b, c and d

The embedded audits are completed each week by the IPC and midwifery team on a Tuesday

Environmental Audit Results

Summary of key points:

The table below summarises the common themes highlighted through the IPC audits. The next step is to pull these into a collated action plan so they can be monitored at the weekly ''Stop the Clock'' with the Director of midwifery. This will be completed by the 1/3/23. The majority of issues are aligned to minor estates works, which are actioned at the time. There may be a lead in time for some, due to orders needing to be placed e.g. wall mounted holders. Assurance that actions have been completed will be provided in future monthly submissions.

Theme	Actions	Completed Actions
Minor Estates works	Minor requests submitted and estates team deployed	

Damaged patient furniture	Removed form use and replacement ordered	
High Dust	Working with cleaning team to address. Supervisor on site to monitor	
Dates on curtains	Requested this was rectified immediately	Action completed
Flushing regime	Working with estates to establish	
Signing of cleaning sheets	Working with Cleaning team to address. Supervisor on site to monitor	
Clinical equipment cleaned	Addressed at the time with staff by the matron	Action completed

Evidence for assurance for point E

The pictures below demonstrate the completion of minor works to address concerns raised.

MLU Toilet – Door and roof fixed.

Triage patient washing area shelf above the radiator has been removed

Equipment maintenance

Total No. Devices	226	**Site**	QEQM	
Risk Level	In service	Service due > 30 days	Service expired < 30 days	**Totals**
Low	36	5	2	43
Medium	82	4	13	99
High	82	2	0	84
Very High	0	0	0	0
Totals	**200**	**11**	**15**	**226**
%	88.5%	4.9%	6.6%	100.0%
Notes				
Notes				
* Of the 15 'Service expired < 30 days' devices, 9 are in the EME Workshop and 6 are on the unit				
* 7 Devices are categorised as 'End of life but in service' - these are all within their scheduled PPM date, and within the Trust's maintenance framework; the categorisation acts as a flag to EME that these devices will be due for decommissioning as part of the medical devices replacement programme < 3yrs				

IPC – Trust Overview

IPC Roles and Responsibilities: Written guidelines to identify roles and responsibilities for cleaning in line with national cleaning standards.

- The Trust has an approved trust policy based on the 2021 National Cleaning Standards which were implemented by 2gether support solutions by October 2022 as required. In the environmental and equipment cleaning policy appendices we identify who is responsible for cleaning.

Planned Preventative Maintenance: The trust has a programme of planned preventative maintenance for the care environment in place (The audits have identified many environmental defects that will not support effective cleaning)

- The Trust has a capital backlog of critical infrastructure, which includes the need for refurbishment of our generally poor physical infrastructure. Items identified in IPC audits or by clinical staff are reported to 2gether via the helpdesk and prioritised for repair (this is not planned preventative maintenance). With the constraints on capital, we have no capital budget for refurbishment of clinical areas as an ongoing programme. Also, we have no clinical capacity to decant patient areas for refurbishment (with many escalation areas in use).

- In September 2020, 2gether Support Solutions presented to the Board of Directors, the impact of the six-facet survey. This demonstrated an increase to the backlog to £120m in 2020 and £147m (without on-costs) by 2025. This confirmed the Trust's backlog maintenance programme would be placed in the top 10 nationally from a position of 44.

- The six-facet survey identified that 48% of our total estate is either condition C or D i.e. poor, exhibiting defects and / or not operating as intended; and bad, life expired and / or serious risk of imminent failure. The six-facet survey has been used to allocate the capital funding to the backlog priority schemes.

- The six-facet survey is a minimum data set, to further inform the Trust and 2gether Support Solutions of the backlog maintenance risks, 2gether has commissioned an ARUP Critical Infrastructure review which was completed in June 2021

- These assessments will be used to future inform the PEIC and SIG of the prioritisation of spend on the critical infrastructure over the next 5 years. Senior clinical leads are part of the PEIC committee i.e. DIPC and Director of Nursing for William Harvey Hospital.

- The PEIC priority funding has been risk assessed by 2gether's technical directors, the Trust's DIPC and finally by the Hospital Triumvirates (leadership teams) to ensure infection control and clinical assessments are part of the risk assessed process.

- The annual capital schedule is submitted to the Trust's Strategic Investment Group (SIG) for approval and the spend is monitored each month at SIG and the Patient Environment and Investment Committee (PEIC). PEIC prioritises and recommends allocation of the annual capital and revenue budgets to SIG. Membership of PEIC includes the Trust's Intelligent Client, Director of Infection Prevention and Control (DIPC), Director of Nursing for William Harvey Hospital, Assistant Finance Director and 2gether's Director of Capital and Estates.

Water Safety Plan: The Trust has a water safety plan in place and we are compliant against regulations set out in the HTM 04 01 (safe water in healthcare premises). On the QEQMH audit of Kingsgate there is a rag rated red against flushing of low use outlets

- The Trust water safety plan and the water safety risk assessment are overseen by the water safety group, and we have an ongoing programme of water environmental works (as part of the backlog maintenance programme described above) and use Point of Use Filters where necessary to maintain patient safety. In addition:

    - we continue to work to the existing SOP (Standing Operating Procedures) associated to the current risk assessment.
    - 2gether undertake regular flushing and/or other works that is aligned to these risk assessments.
    - New assessments have been signed off for KCH & Buckland's – work is ongoing to cross reference and close out the other 3 sites.

NHS Maternity Services Survey 2022 Benchmark Report

East Kent Hospitals University NHS Foundation Trust

Contents

Background and methodology

This section includes:

- explanation of the NHS Patient Survey Programme
- information on the Maternity 2022 survey
- a description of key terms used in this report
- navigating the report

Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Maternity Survey started in 2007 and the 2022 Maternity Survey will be the ninth carried out to date. The CQC use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

The Maternity Survey 2022

The survey was administered by the Coordination Centre for Mixed Methods (CCMM) at Ipsos. A total of 45,621 mothers were invited to participate in the survey across 121 NHS trusts. Completed responses were received from 20,927 respondents, an adjusted response rate of 46.5%.

Individuals were invited to participate in the survey if they were aged 16 years or over at the time of delivery and had a live birth at an NHS Trust between 1 February and 28 February 2022. A full list of eligibility criteria can be found in the survey sampling instructions. If there were fewer than 300 people within an NHS trust who gave birth in February 2022, then births from January were included.

Fieldwork took place between April and August 2022.

Trend data

In 2021 the Maternity survey transitioned from a solely paper based methodology to both paper and online. This dual approach was continued in 2022.

Analysis conducted prior to the 2021 survey, concluded that this change in methodology did not have a detrimental impact on trend data. Therefore, data from the 2021 survey and subsequent years are comparable with previous years, unless a question has changed or there are other reasons for lack of comparability such as changes in organisation structure of a trust.

Where results are comparable with previous years, a section on historical trends has been included. Where there are insufficient data points for historical trends, significance testing has been carried out against 2021 data.

Further information about the survey

- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Surveys website.
- To learn more about CQC's survey programme, please visit the CQC website.

Background and methodology continued

Antenatal and Postnatal data

The maternity survey is split into three sections that ask questions about:

- antenatal care
- labour and birth
- postnatal care

It is possible that some respondents may have experienced these stages of care in different trusts. This may be for many reasons such as moving home, or having to travel for more specialist care, or due to variation in service provision across the country. For the purpose of benchmarking, it is important that we understand which trust the respondent is referring to when they are completing each section of the survey.

When answering survey questions about labour and birth we can be confident that in all cases respondents are referring to the trust from which they were sampled. It is therefore possible to compare results for labour and birth across all 121 NHS trusts that took part in the survey.

Trusts were asked to carry out an “attribution exercise”, where each trust identifies the individuals in their sample that are likely to have also received their antenatal and postnatal care from the trust. This is done using either electronic records or residential postcode information. This attribution exercise was first carried out in the 2013 survey. In 2022, 114 of the 121 trusts that took part in the survey completed this exercise.

The survey results contained in this report include only those respondents who were identified as receiving care at this trust.

Those trusts that did not provide the results of the attribution exercise to the CCMM at Ipsos do not receive results on the postnatal and antenatal sections of the survey.

Limitations of this approach

Data is provided voluntarily, and not all trusts provided this data. The antenatal and postnatal care sections of this report are therefore benchmarked against those other trusts that also provided the required information.

Some trusts do not keep electronic records of antenatal and postnatal care. Where this is the case, location of antenatal and postnatal care is based on residential location of respondents. This is not a perfect measure of whether antenatal and postnatal care was received at the trust. For example, respondents requiring specialist antenatal or postnatal care may have received this from another trust. This may mean that some respondents are included in the data despite having received care from another trust.

Key terms used in this report

The ‘expected range’ technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the ‘expected range’ to determine if your trust is performing ‘about the same’, ‘better’ or ‘worse’ compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement. More information can be found in the Appendix.

Standardisation

Demographic characteristics, such as age can influence care experiences and how they are reported. Since trusts have differing profiles of maternity service users, this could make fair trust comparisons difficult. To account for this, we ‘standardise’ the results, which means we apply a weight to individual patient responses to account for differences in profiles between trusts. For each trust, results have been standardised by parity (whether or not a mother has given birth previously) and age of respondents to reflect the ‘national’ age distribution (based on all respondents to the survey).

This helps ensure that no trust will appear better or worse than another because of its profile of maternity service users, and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results.

Scoring

For selected questions in the survey, the individual (standardised) responses are converted into scores, typically 0, 5, or 10 (except for questions B3 and D8). A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are descriptive and others are ‘routing questions’, which are designed to filter out respondents to whom subsequent questions do not apply (for example C3). These questions are not scored. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied.

Trust average

The ‘trust average’ mentioned in this report is the arithmetic mean of all trusts’ scores after weighting is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to). This is to prevent individual responses being identifiable.

Further information about the methods

For further information about the statistical methods used in this report, please refer to the survey technical document.

Using the survey results

Navigating this report

This report is split into **five** sections:

1. Background and methodology – provides information about the survey programme, how the survey is run and how to interpret the data.

2. Headline results – includes key trust-level findings relating to the mothers who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.

3. Benchmarking – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve. Only trusts that provide data on antenatal and/ or postnatal care and have sufficient respondent numbers are also provided with survey results for antenatal and postnatal care within this report.

4. Trends over time – includes your trust's mean score for each evaluative question in the survey. This is either shown as a historical trend chart or a significance test table, depending on the availability of longitudinal data.

Where possible, significance testing compares the mean score for your trust in 2021 to your 2022 mean score. This allows you to see if your trust has made statistically significant improvements between survey years.

Historical trends are presented where data is available, and questions remain comparable for your trust. Trends are presented only where there are at least five data points available to plot on the chart. Historical trend charts show the mean score for your trust by year, so that you can see if your trust has made improvements over time. They also include the national mean score by year, to allow you to see whether your performance is in line with the national average or not.

Significance test tables are presented where there are less than 5 data points available and questions remain comparable between 2021 and 2022.

5. Appendix – includes additional data for your trust; further information on the survey methodology; interpretation of graphs in this report.

Using the survey results continued

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey.

The two chart types used in the section 'benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the Appendix.

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; A-Z list to view the results for each trust; technical document: www.cqc.org.uk/maternitysurvey
- National and trust-level data for all trusts who took part in the Maternity 2022 survey: www.cqc.org.uk/maternitysurvey. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how the CQC monitors services: https://www.cqc.org.uk/what-we-do/how-we-use-information/using-data-monitor-services

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the top and bottom scores for your trust

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of mothers who took part in the survey.

482 invited to take part

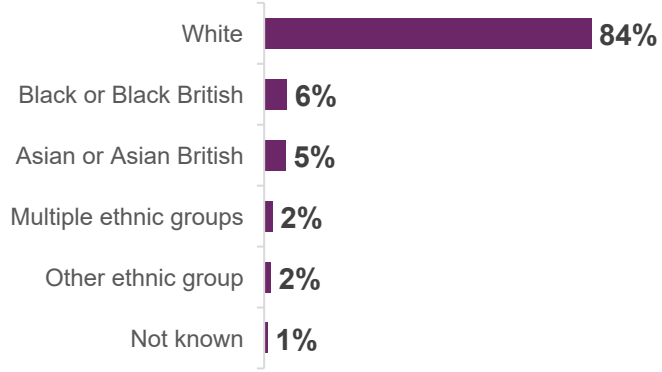
245 completed

51% response rate

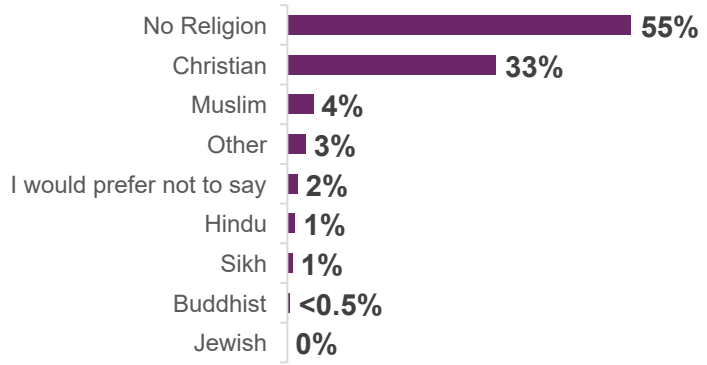
47% average trust response rate

47% response rate for your trust for 2021

ETHNICITY



RELIGION



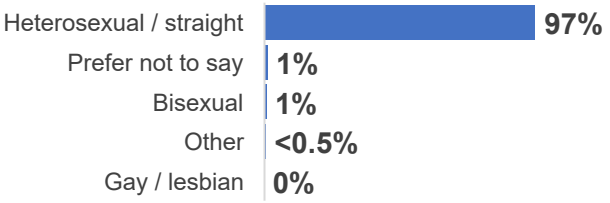
PARITY

How many babies have you given birth to before this pregnancy?

of respondents gave birth to **their first baby.**

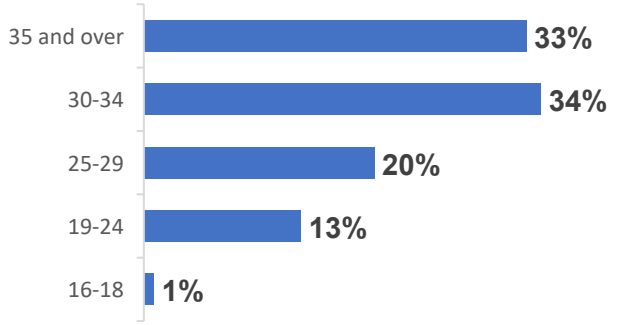
SEXUALITY

Which of the following best describes how you think of yourself?



97% of participants described themselves as heterosexual or straight.

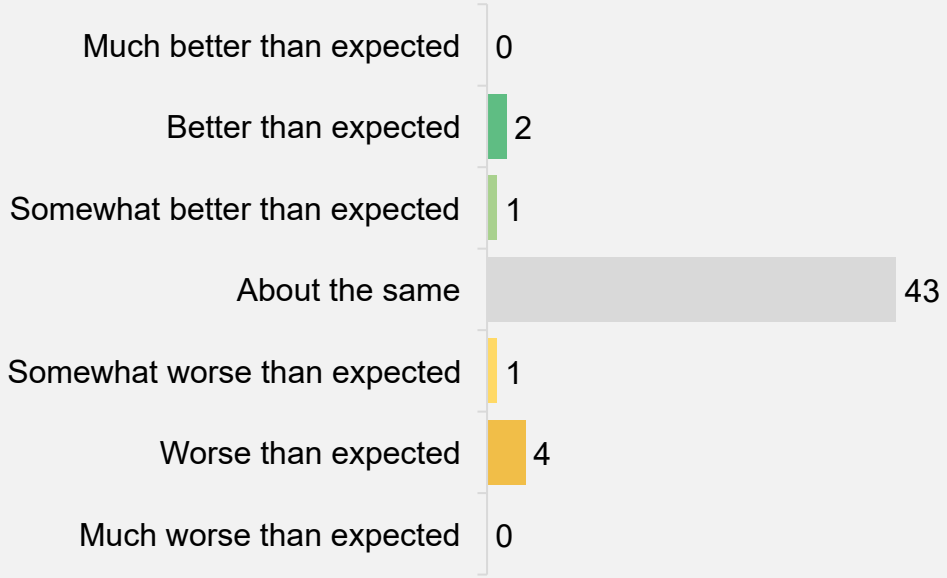
AGE



Summary of findings for your trust

Comparison with other trusts

The **number of questions** in this report at which your trust has performed better, worse, or about the same compared with most other trusts.



Comparison with results from 2021

The **number of questions** in this report where your trust showed a statistically significant increase, decrease, or no change in scores compared to 2021 results.

For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section "comparison to other trusts".

Best and worst performance relative to the trust average

These five questions are calculated by comparing your trust's results to the trust average (the average trust score across England).

- **Top five scores**: These are the five results for your trust that are highest compared with the trust average. If none of the results for your trust are above the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's best performance may be worse than the trust average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the trust average. If none of the results for your trust are below the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's worst performance may be better than the trust average.

Top five scores (compared with average trust score across England)

Bottom five scores (compared with average trust score across England)

Benchmarking

This section includes:

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part
- an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts.
- for more guidance on interpreting these graphs, please refer to the appendix

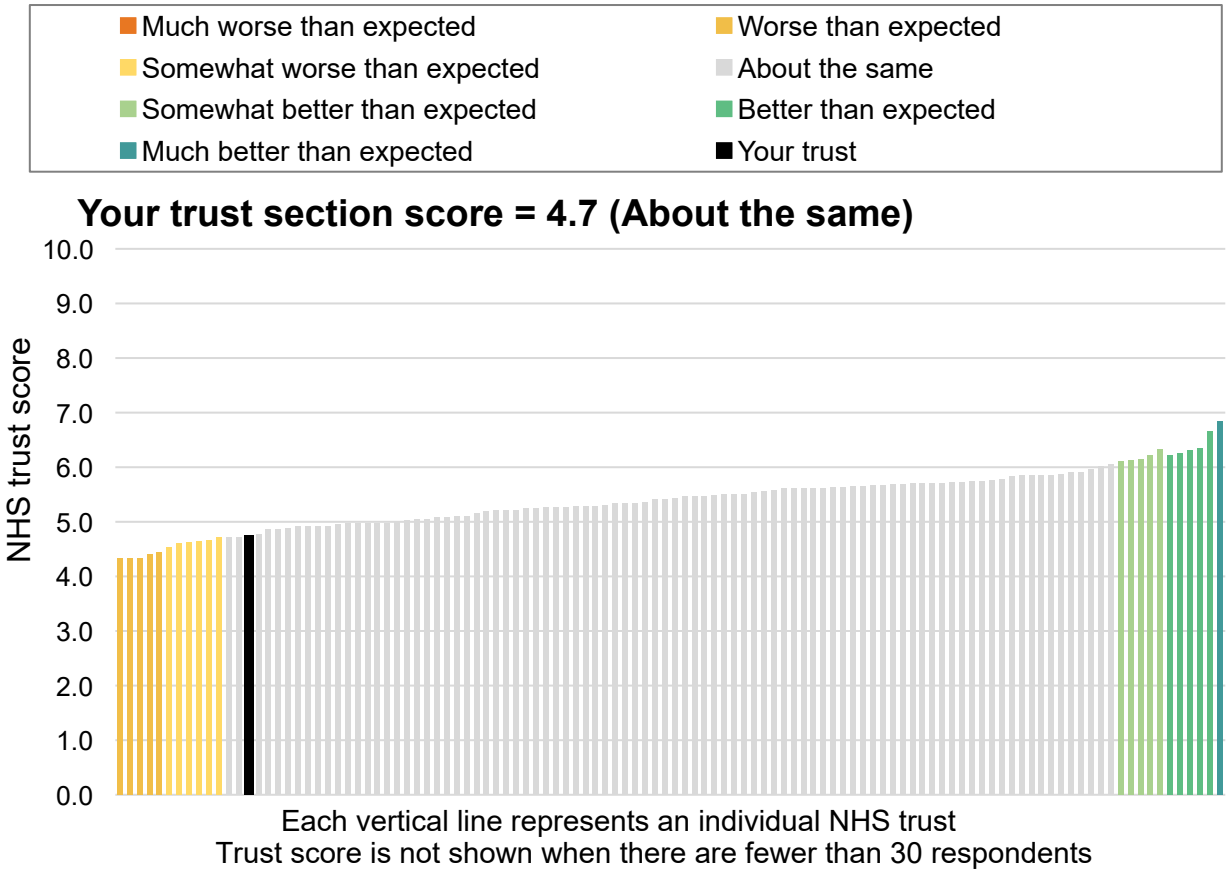
Benchmarking

Antenatal care

The start of your care during pregnancy

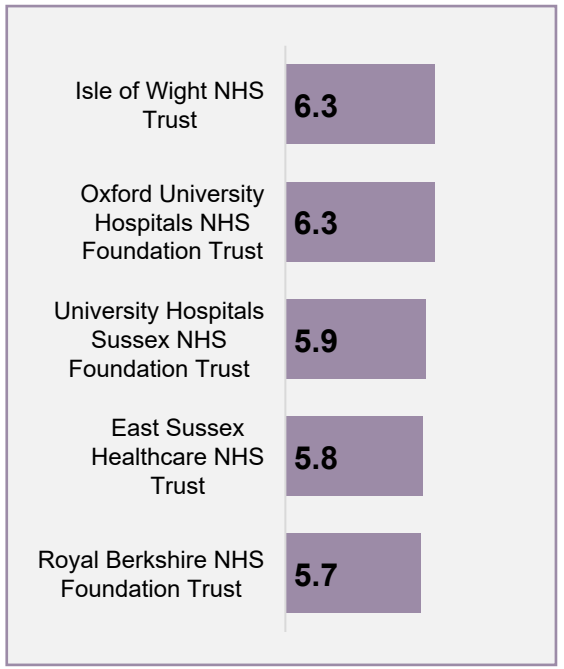
Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'the start of your care during pregnancy' is calculated from questions B3 to B5. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

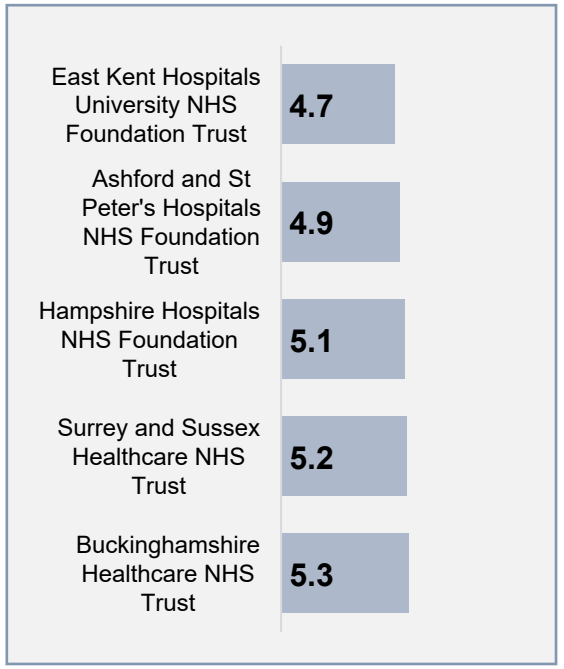


Comparison with other trusts within your region

Trusts with the highest scores



Trusts with the lowest scores

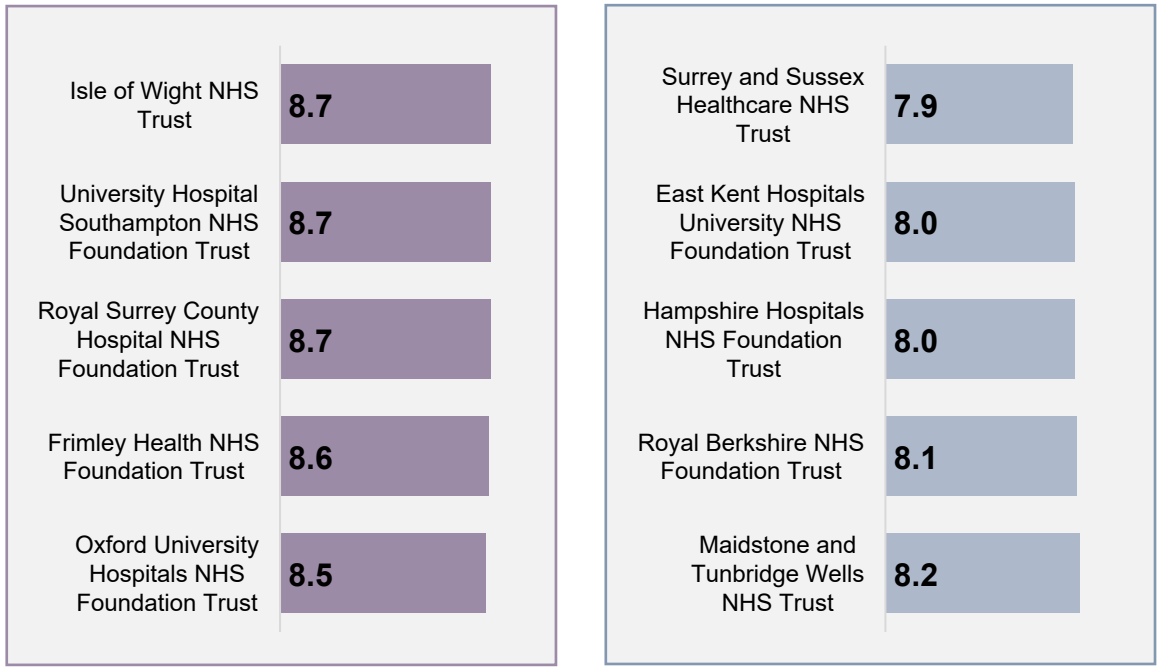


Antenatal check-ups

Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'antenatal check-ups' is calculated from questions B8 to B11. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Comparison with other trusts within your region



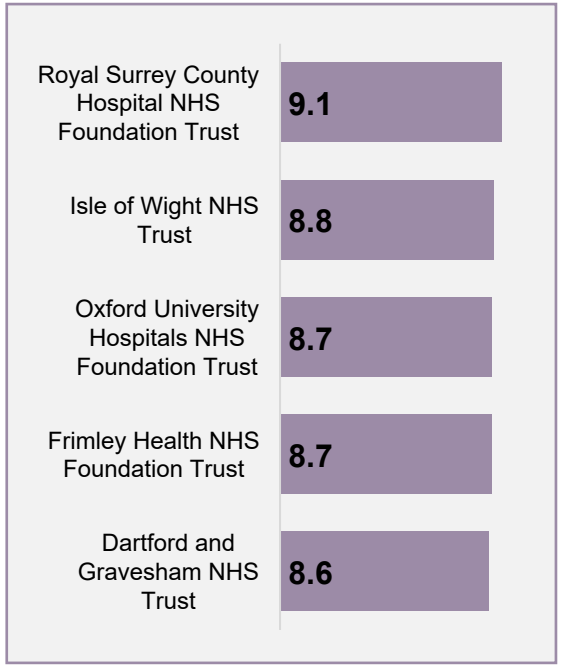
During your pregnancy

Section score

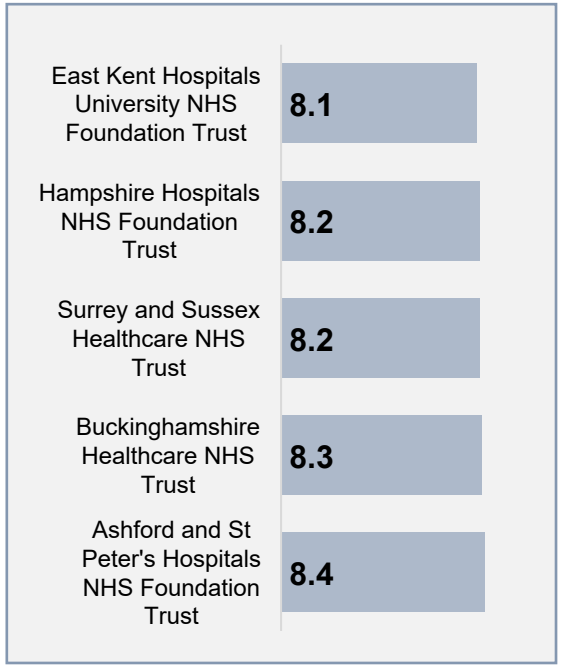
This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'during your pregnancy' is calculated from questions B12 to B18. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Comparison with other trusts within your region

Trusts with the highest scores

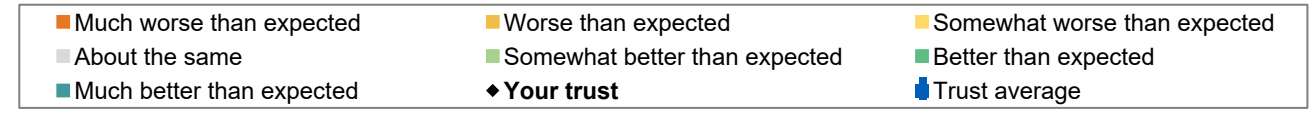


Trusts with the lowest scores



Benchmarking - Antenatal care

Question scores: Start of your pregnancy

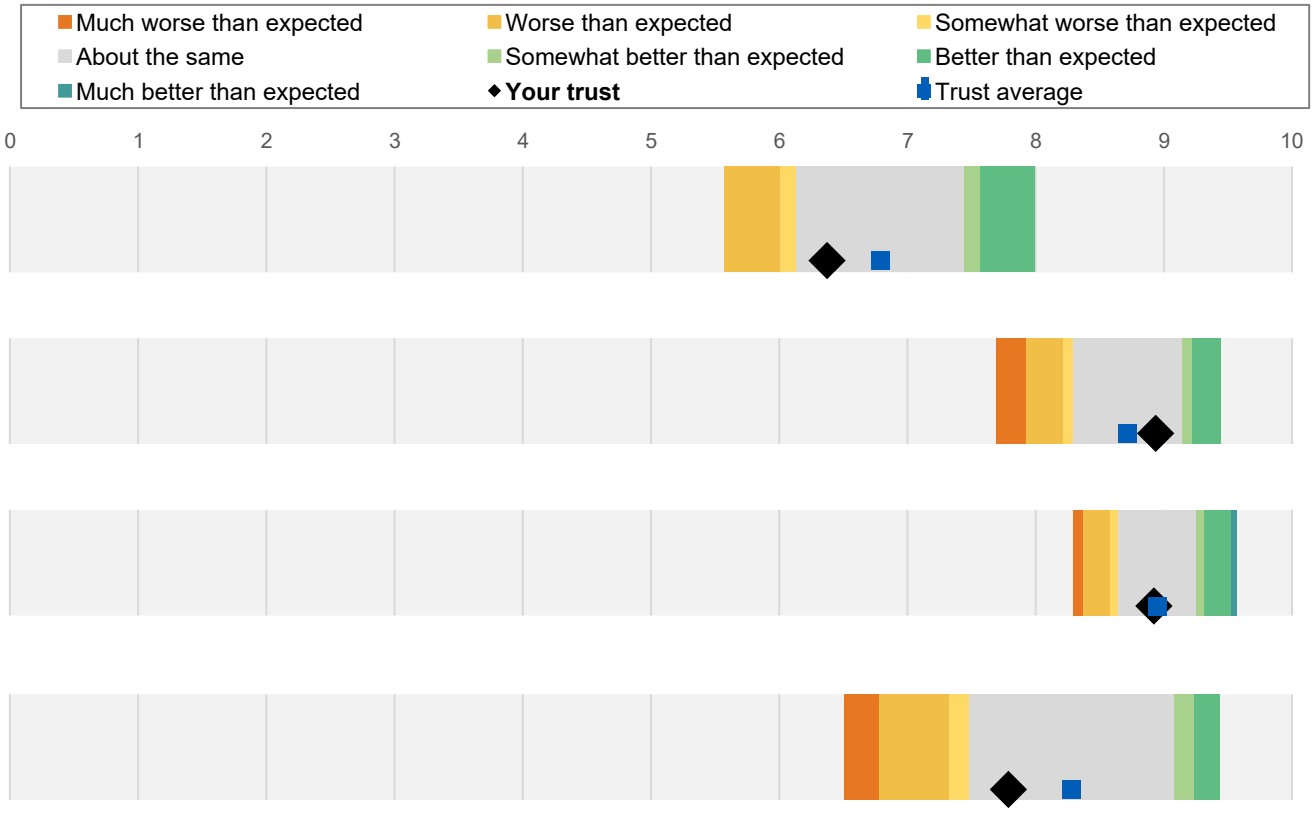


		All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
B3. Were you offered a choice about where to have your baby?	177	3.1 (About the same)	3.6	2.0	5.1
B4. Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	217	5.8 (About the same)	6.6	5.0	8.6
B5. At the start of your care in pregnancy, did you feel that you were given enough information about coronavirus restrictions and any implications for your maternity care?	224	5.3 (Somewhat worse)	6.0	4.7	7.5

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Antenatal care (continued)

Question scores: Antenatal check-ups



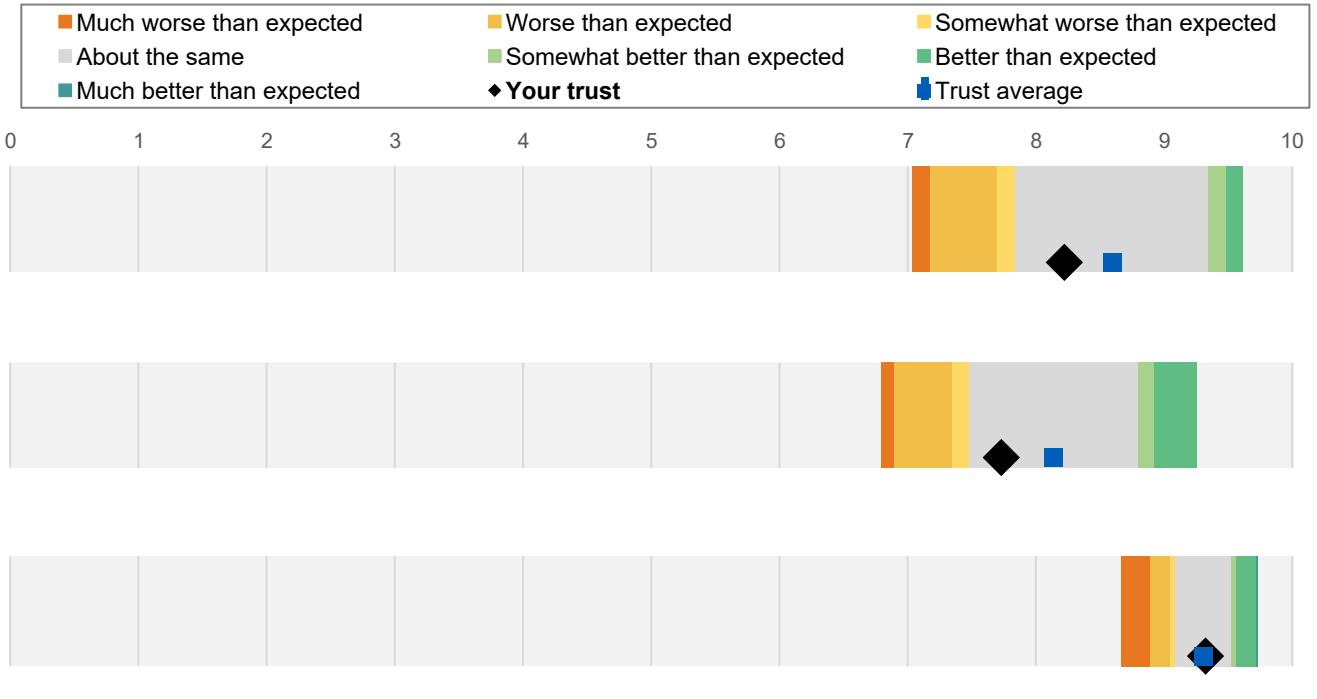
		All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
B8. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?	229	6.4	6.8	5.6	8.0
B9. During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?	230	8.9	8.7	7.7	9.4
B10. During your antenatal check-ups, did your midwives listen to you?	230	8.9	8.9	8.3	9.6
B11. During your antenatal check-ups, did your midwives ask you about your mental health?	223	7.8	8.3	6.5	9.4

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Antenatal care (continued)

Question scores: During your pregnancy



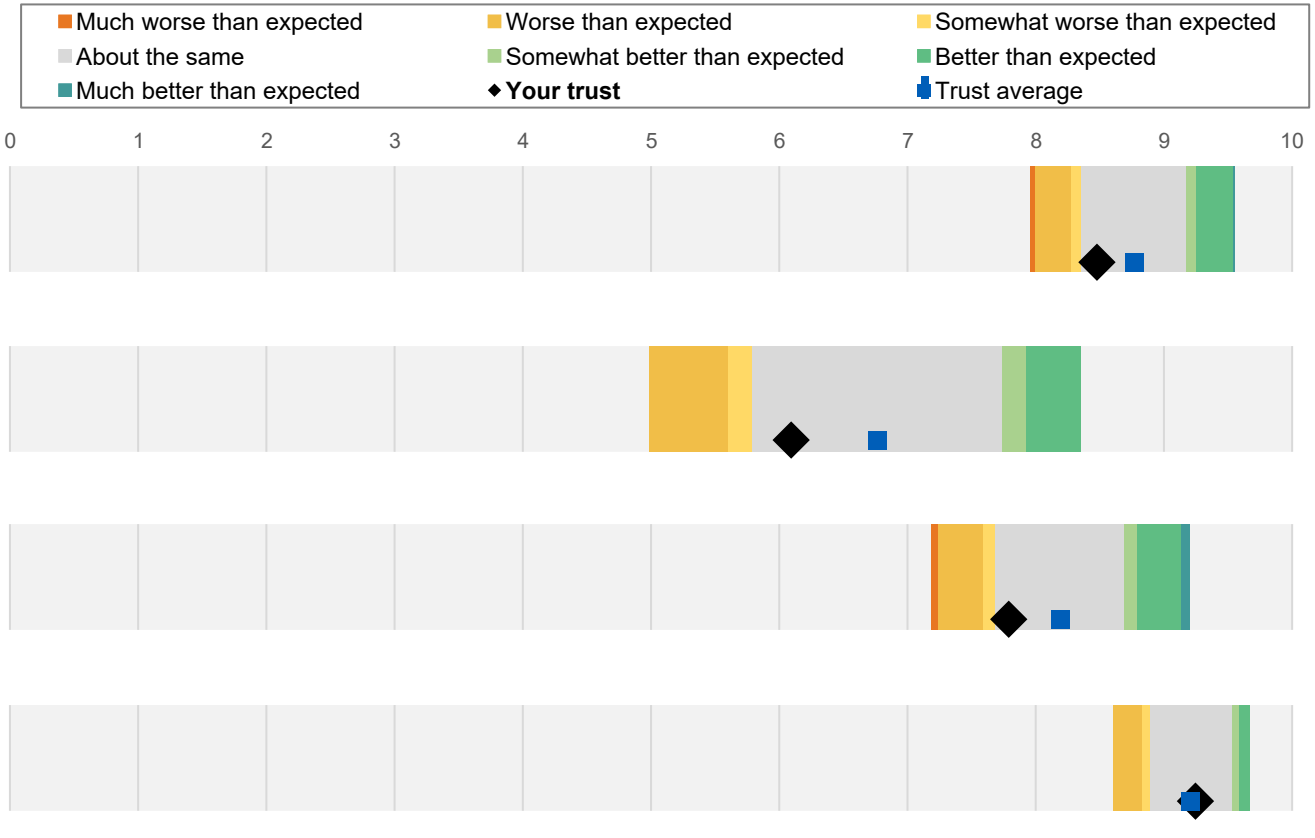
		All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
B12. Were you given enough support for your mental health during your pregnancy?	133	8.2	8.6	7.0	9.6
B13. During your pregnancy, if you contacted a midwifery team, were you given the help you needed?	223	7.7	8.1	6.8	9.3
B14. Thinking about your antenatal care, were you spoken to in a way you could understand?	230	9.3	9.3	8.7	9.7

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Antenatal care (continued)

Question scores: During your pregnancy



		All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
B15. Thinking about your antenatal care, were you involved in decisions about your care?	223	8.5	8.8	8.0	9.5
B16. During your pregnancy did midwives provide relevant information about feeding your baby?	224	6.1	6.8	5.0	8.4
B17. Did you have confidence and trust in the staff caring for you during your antenatal care?	229	7.8	8.2	7.2	9.2
B18. Thinking about your antenatal care, were you treated with respect and dignity?	227	9.2	9.2	8.6	9.7

About the same

Trust score is not shown when there are fewer than 30 respondents.

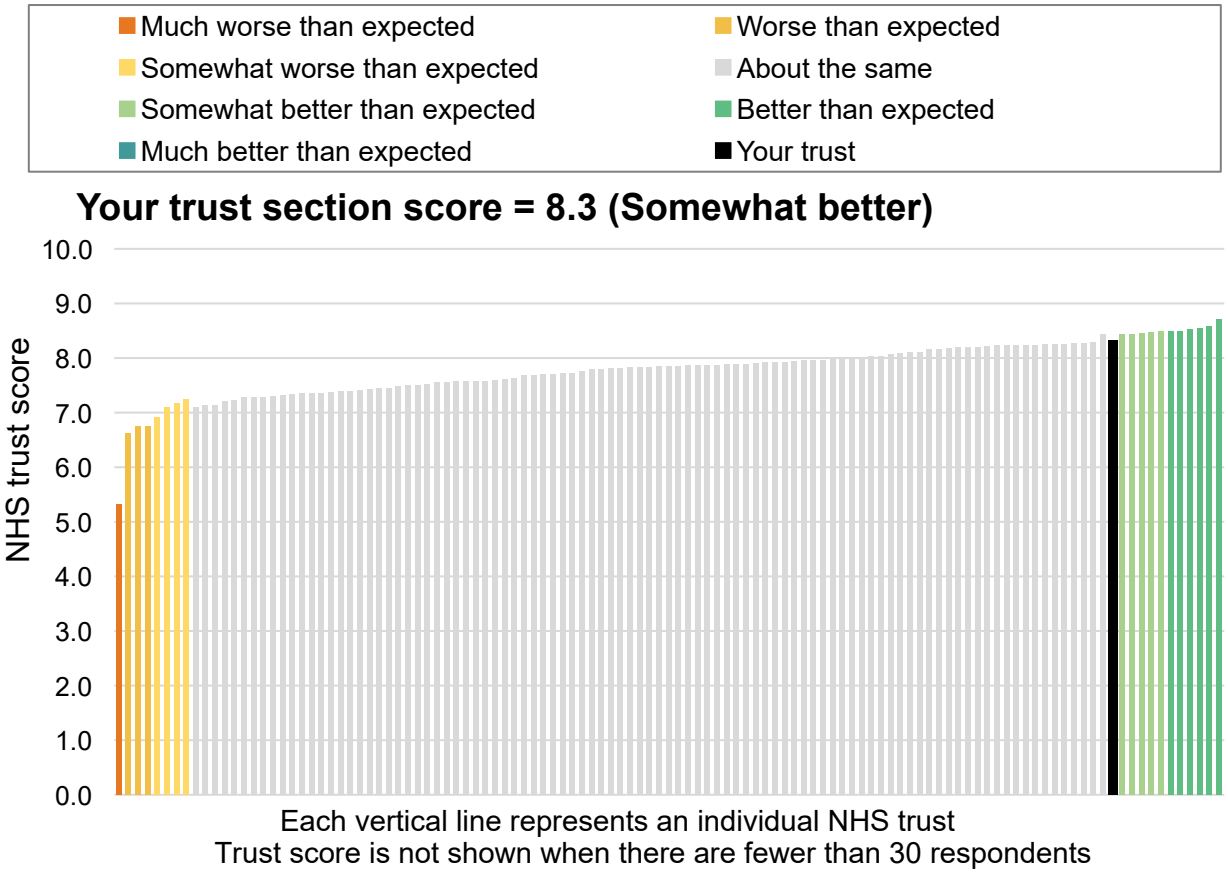
Benchmarking

Labour and birth

Your labour and birth

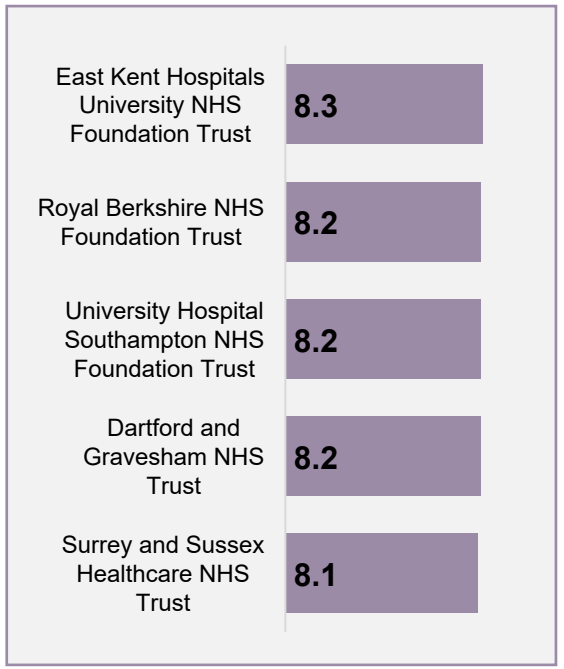
Section score

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'your labour and birth' is calculated from questions C4 to C7 and C12. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

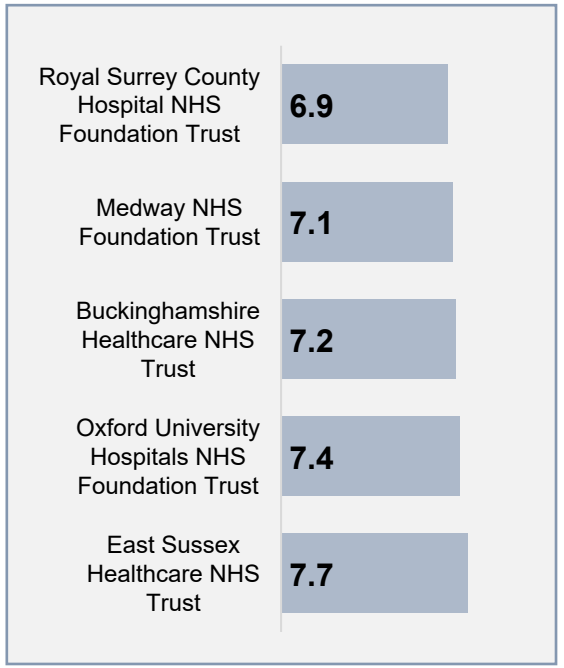


Comparison with other trusts within your region

Trusts with the highest scores



Trusts with the lowest scores

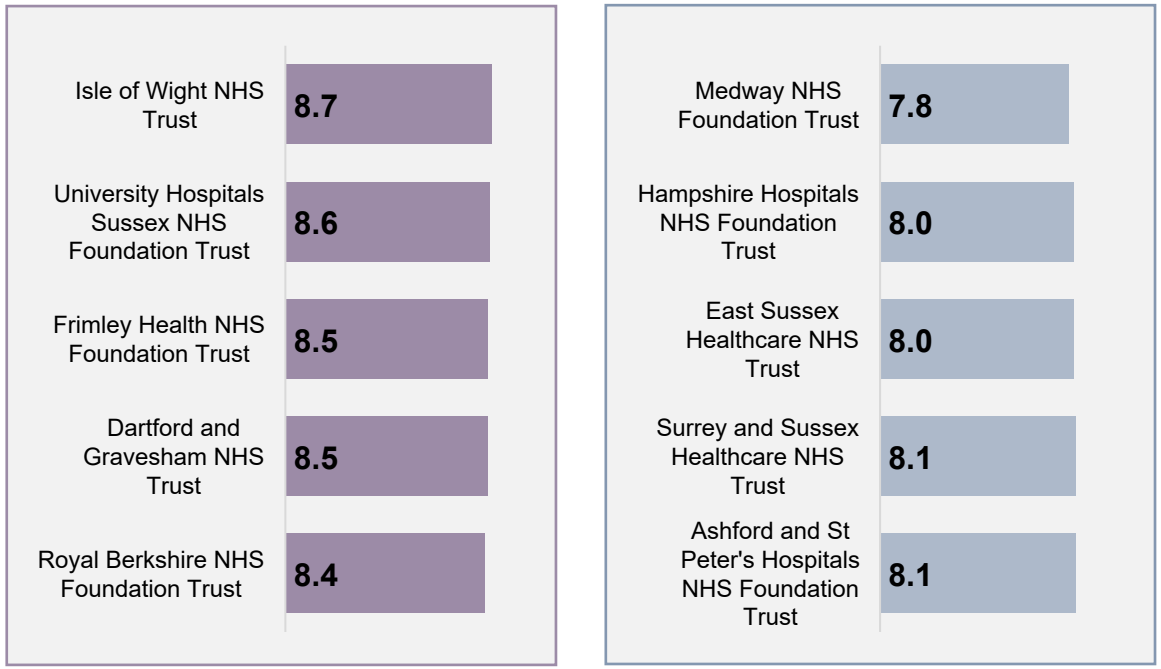


Staff caring for you

Section score

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'staff caring for you' is calculated from questions C14 and C16 to C24. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

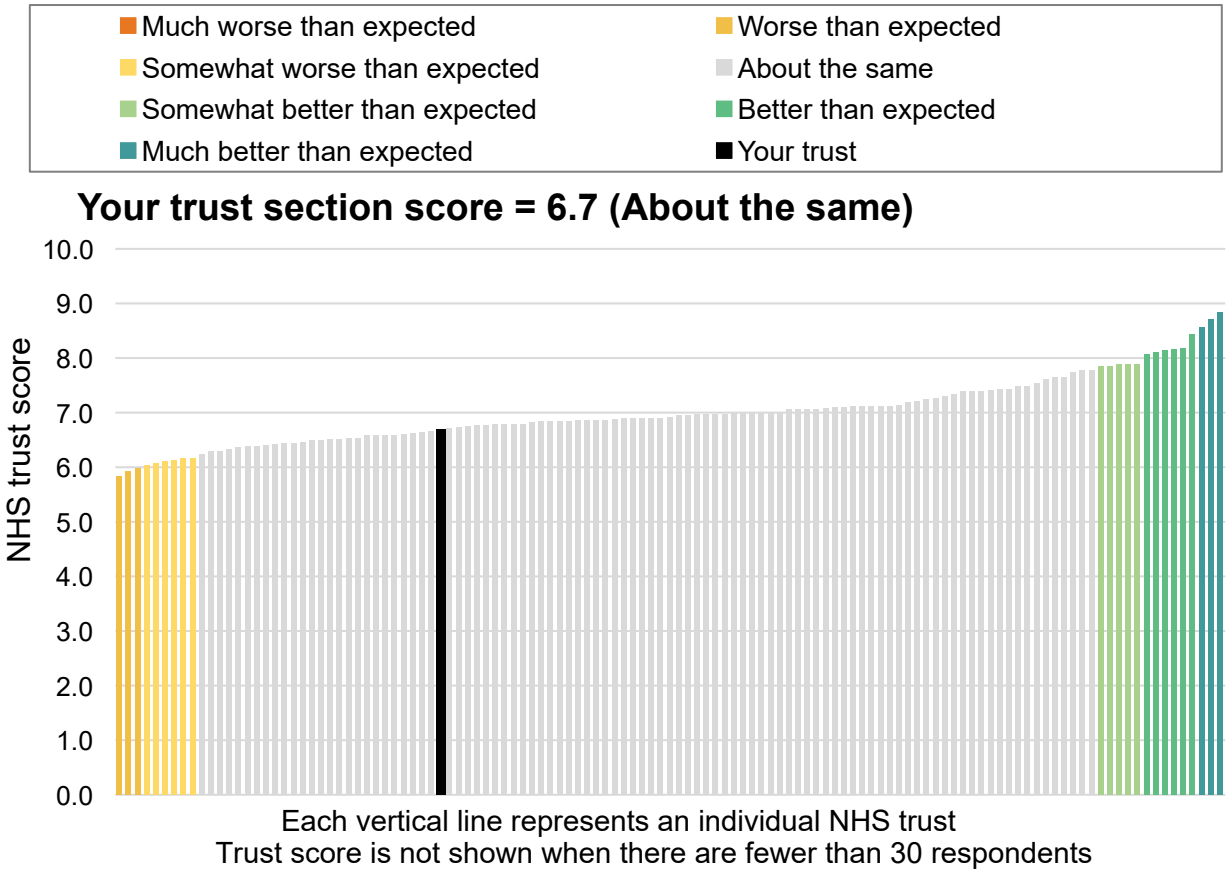
Comparison with other trusts within your region



Care in hospital after birth

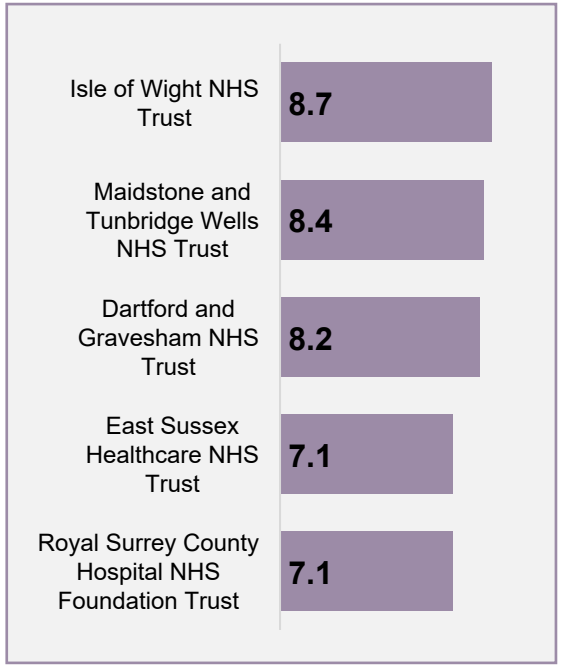
Section score

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care in hospital after birth' is calculated from questions D2 and D4 to D8. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

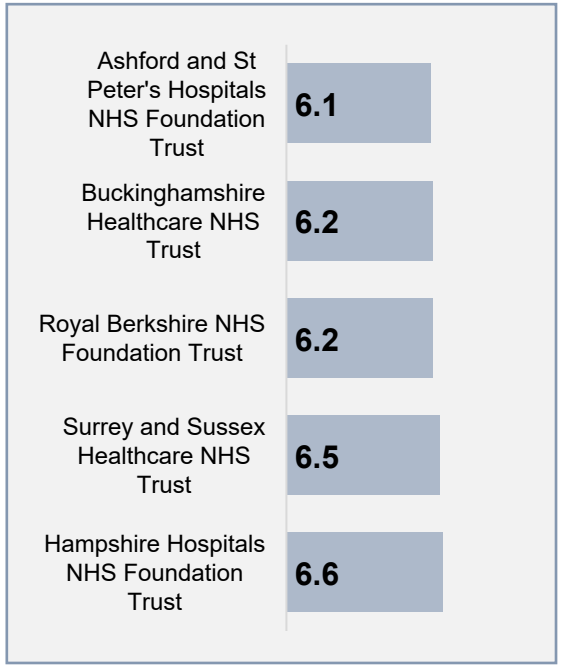


Comparison with other trusts within your region

Trusts with the highest scores

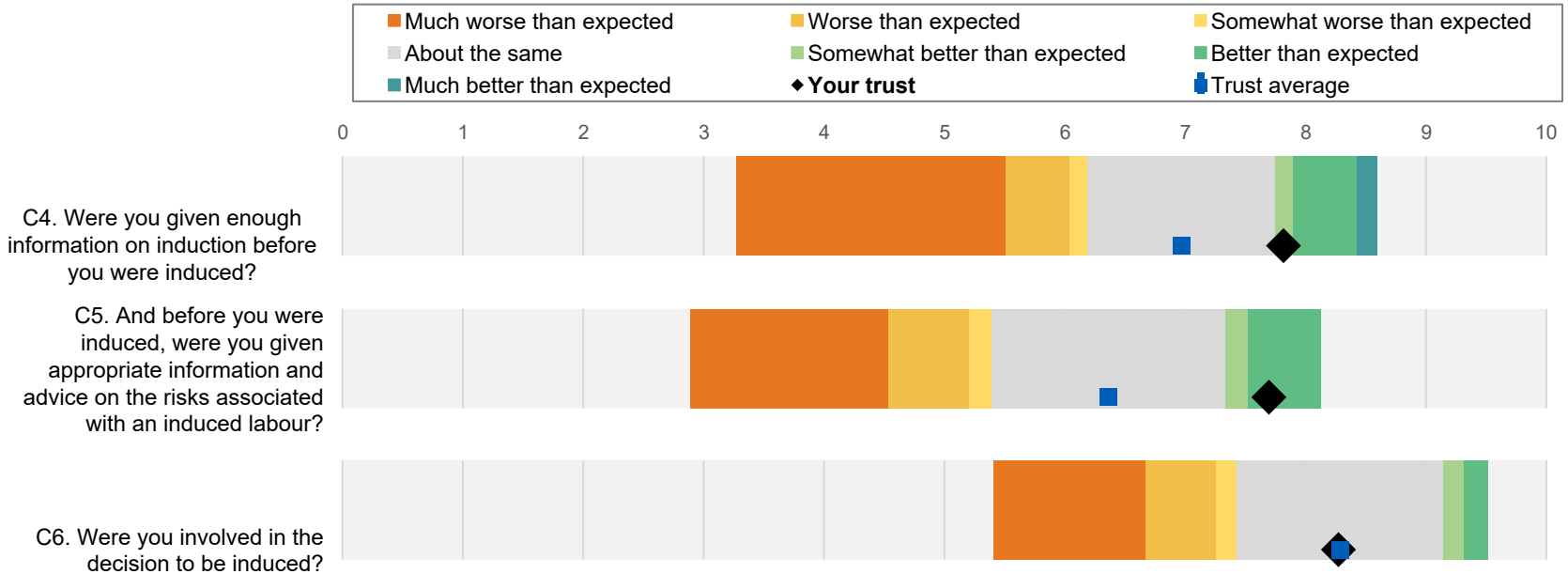


Trusts with the lowest scores



Benchmarking - Labour and birth

Question scores: Your labour and birth



		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
82	7.8	7.0	3.3	8.6
75	7.7	6.4	2.9	8.1
75	8.3	8.3	5.4	9.5

Somewhat better

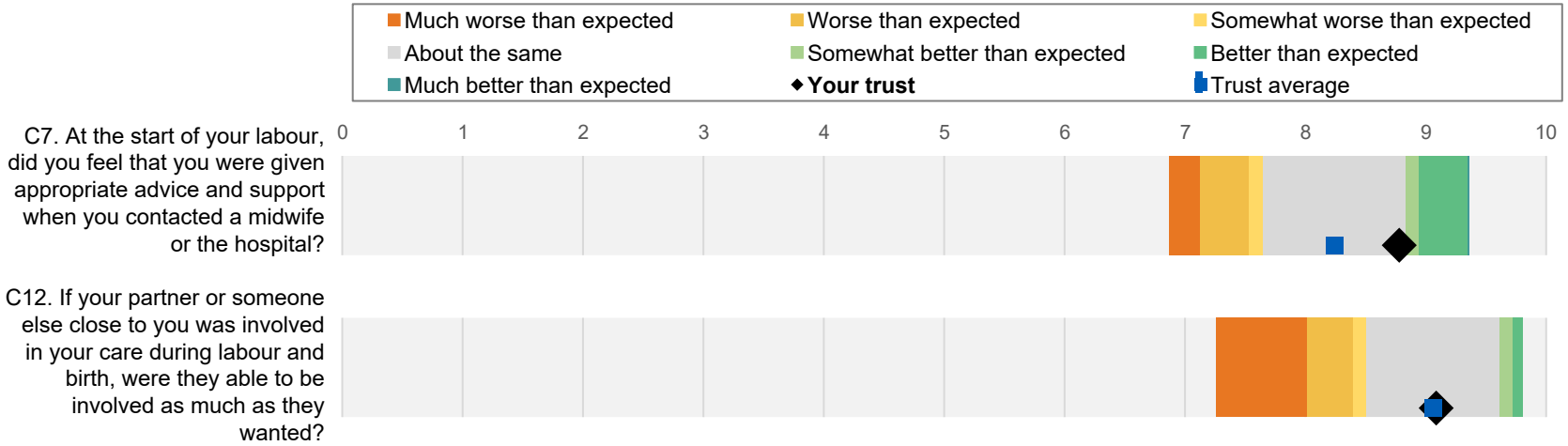
Better

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Your labour and birth

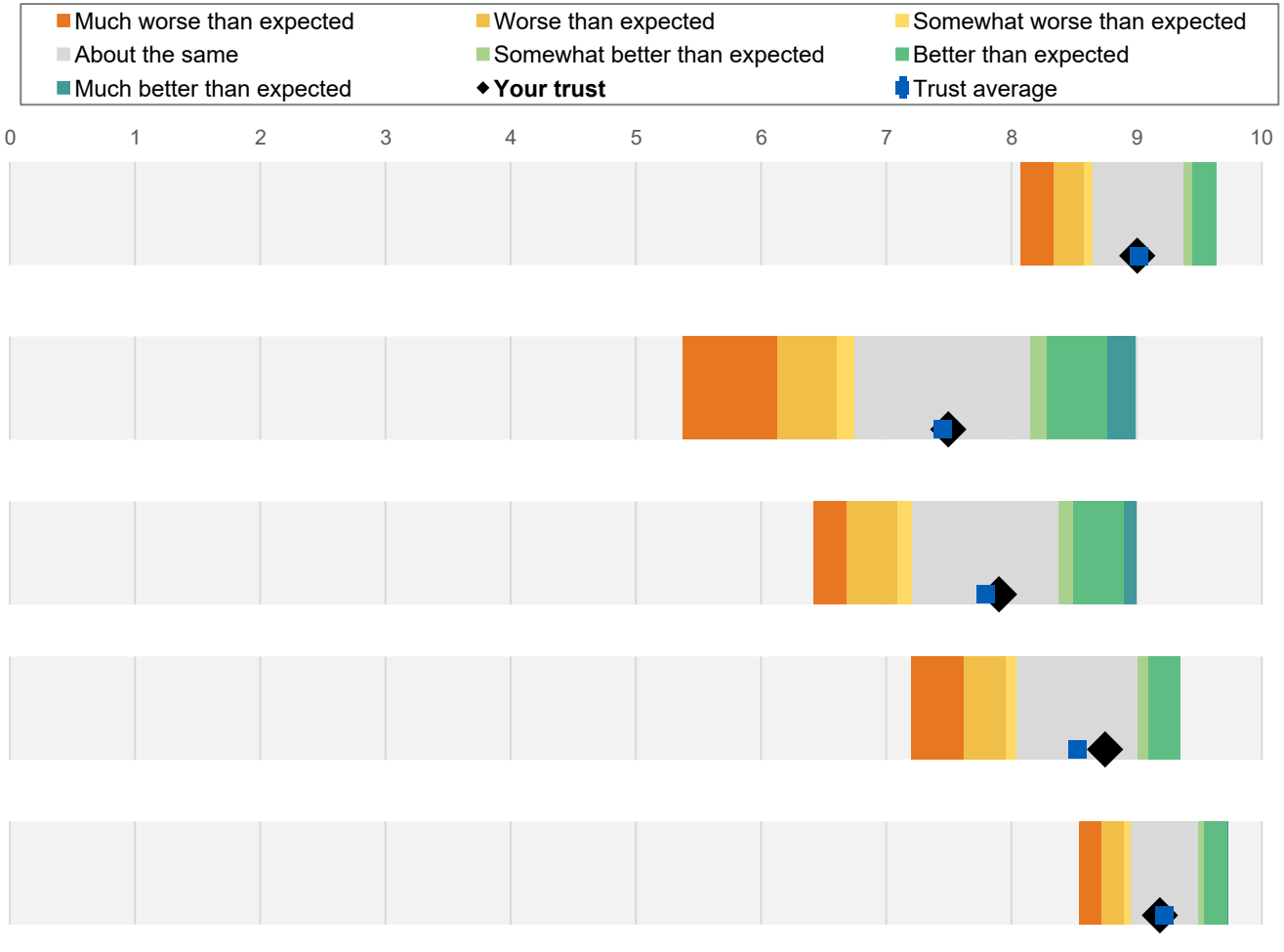


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
144	8.8	8.2	6.9	9.4
233	9.1	9.1	7.3	9.8

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Staff caring for you



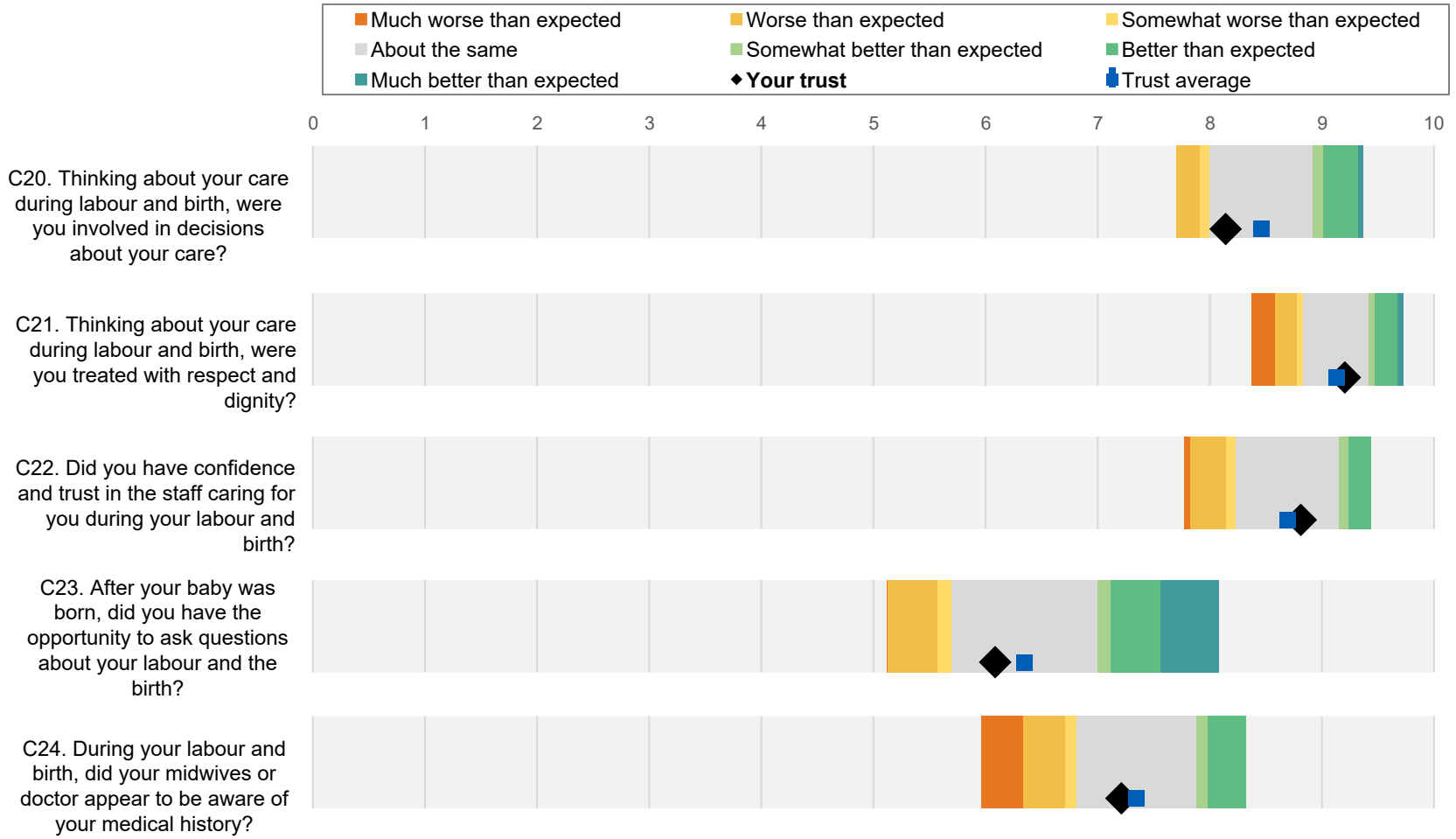
		All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
C14. Did the staff treating and examining you introduce themselves?	234	9.0	9.0	8.1	9.6
C16. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?	238	7.5	7.4	5.4	9.0
C17. If you raised a concern during labour and birth, did you feel that it was taken seriously?	154	7.9	7.8	6.4	9.0
C18. During labour and birth, were you able to get a member of staff to help you when you needed it?	230	8.7	8.5	7.2	9.4
C19. Thinking about your care during labour and birth, were you spoken to in a way you could understand?	234	9.2	9.2	8.5	9.7

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Staff caring for you

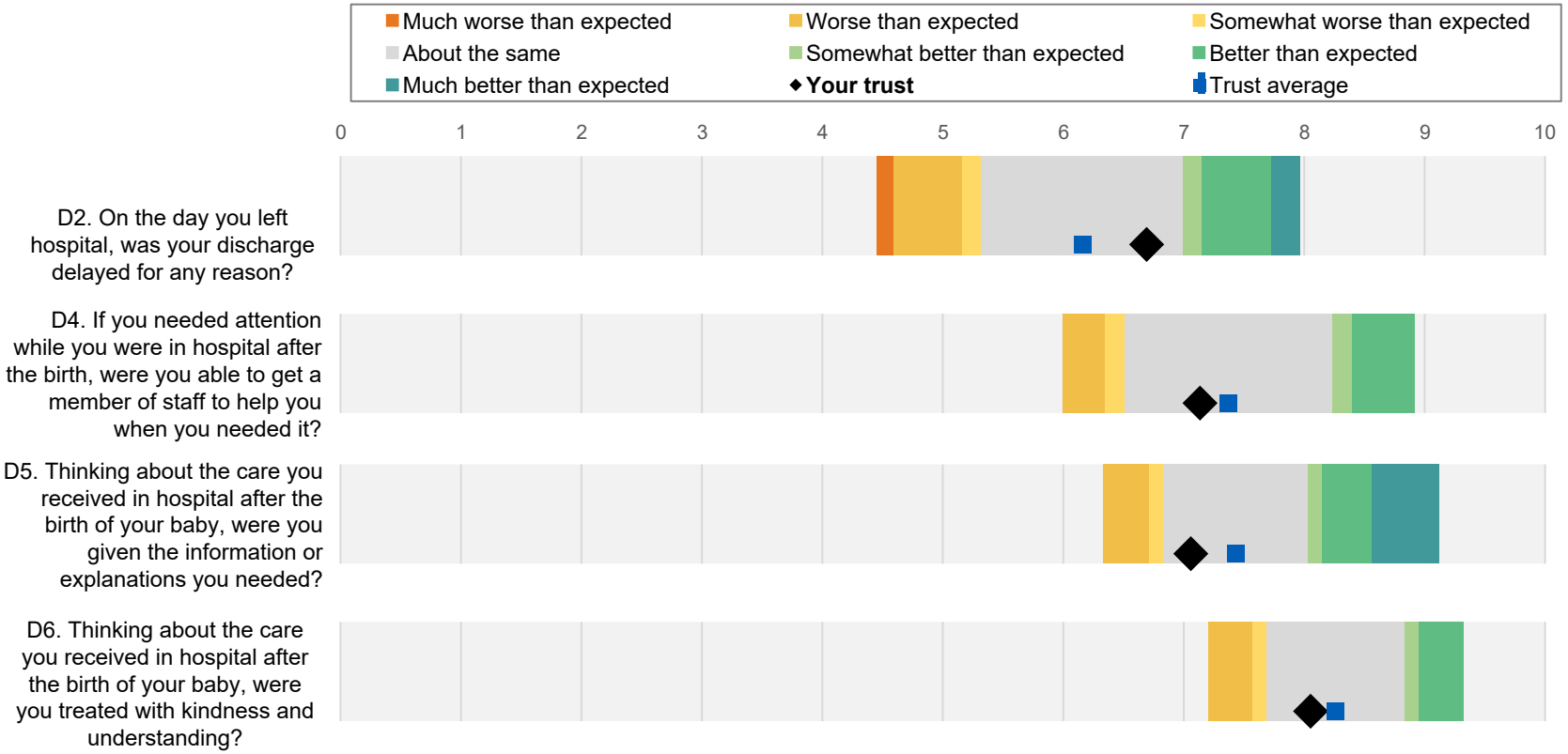


	Number of respondents (your trust)	Your trust score	All trusts in England: Trust average score	All trusts in England: Lowest score	All trusts in England: Highest score
C20. Thinking about your care during labour and birth, were you involved in decisions about your care?	232	8.1	8.5	7.7	9.4
C21. Thinking about your care during labour and birth, were you treated with respect and dignity?	239	9.2	9.1	8.4	9.7
C22. Did you have confidence and trust in the staff caring for you during your labour and birth?	238	8.8	8.7	7.8	9.4
C23. After your baby was born, did you have the opportunity to ask questions about your labour and the birth?	219	6.1	6.3	5.1	8.1
C24. During your labour and birth, did your midwives or doctor appear to be aware of your medical history?	222	7.2	7.3	6.0	8.3

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Care in hospital after birth

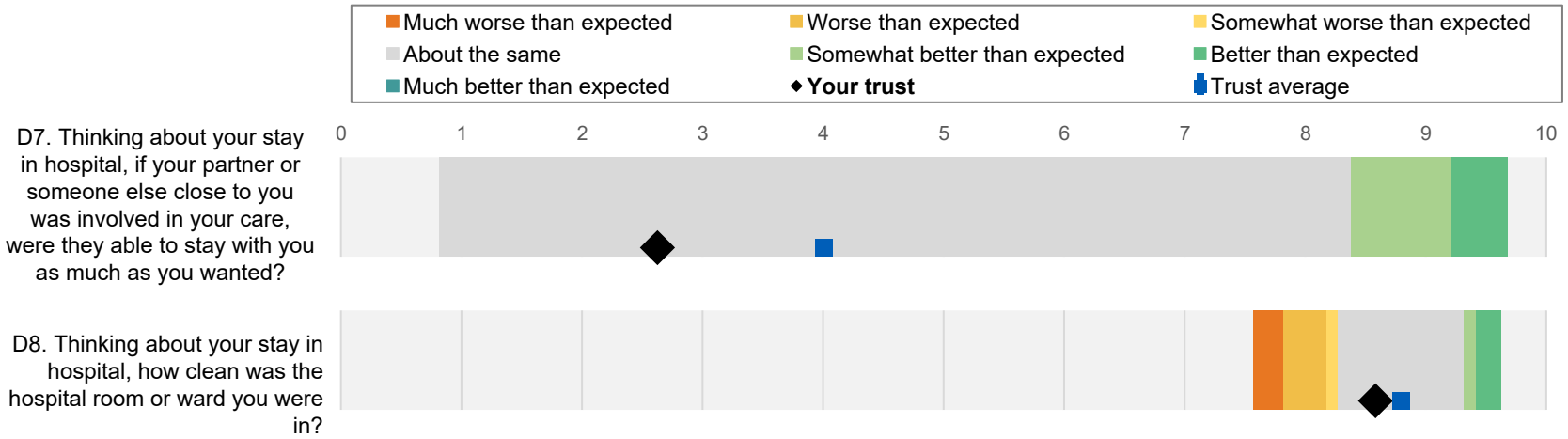


			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
About the same	240	6.7	6.2	4.5	8.0
About the same	230	7.1	7.4	6.0	8.9
About the same	237	7.1	7.4	6.3	9.1
About the same	240	8.1	8.3	7.2	9.3

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Care in hospital after birth



		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
214	2.6	4.0	0.8	9.7
237	8.6	8.8	7.6	9.6

Trust score is not shown when there are fewer than 30 respondents.

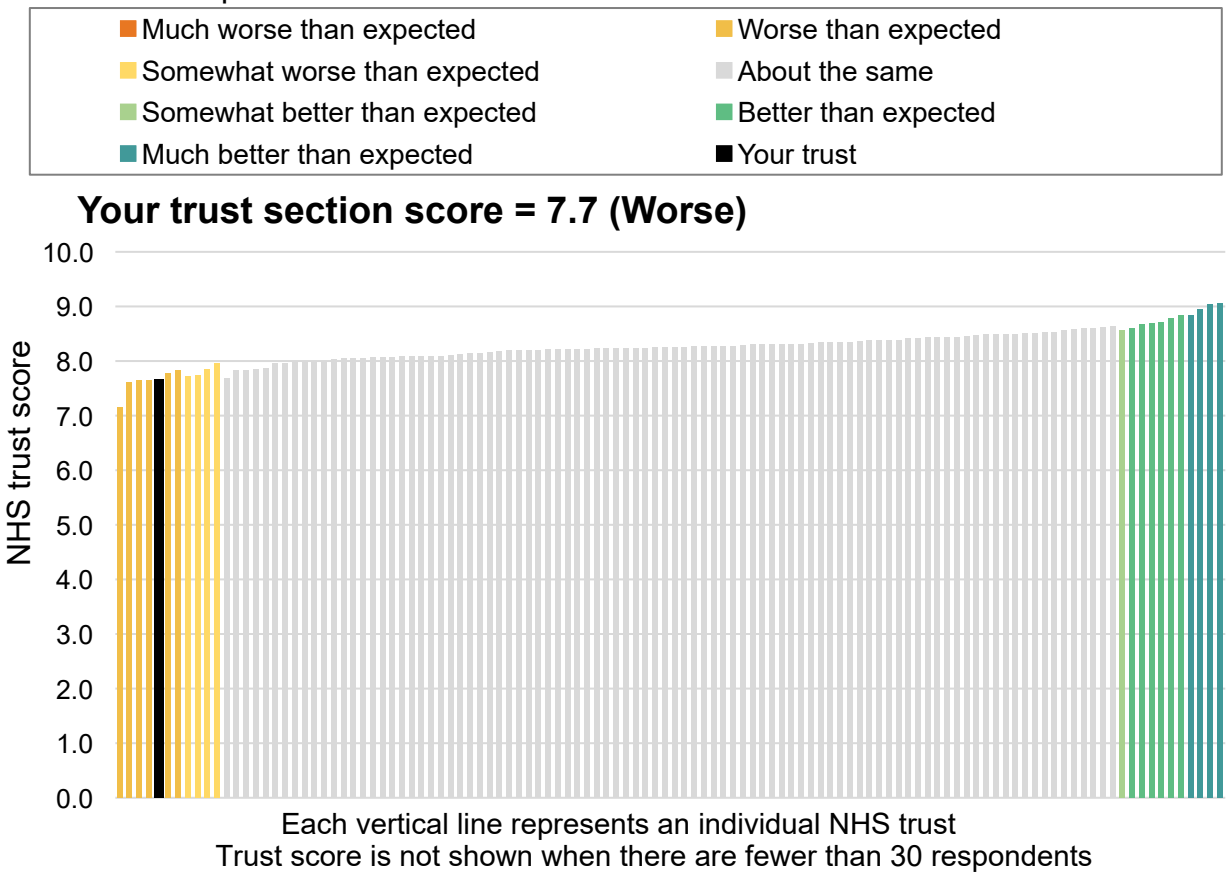
Benchmarking

Postnatal care

Feeding your baby

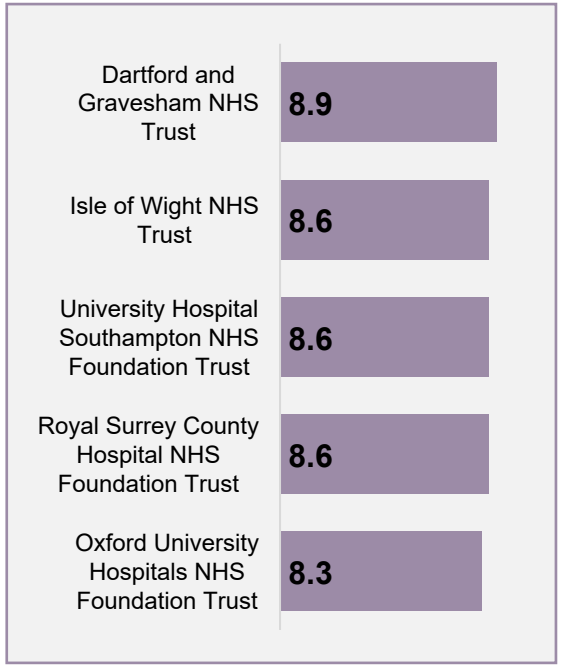
Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'feeding your baby' is calculated from questions E2 and E3 The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

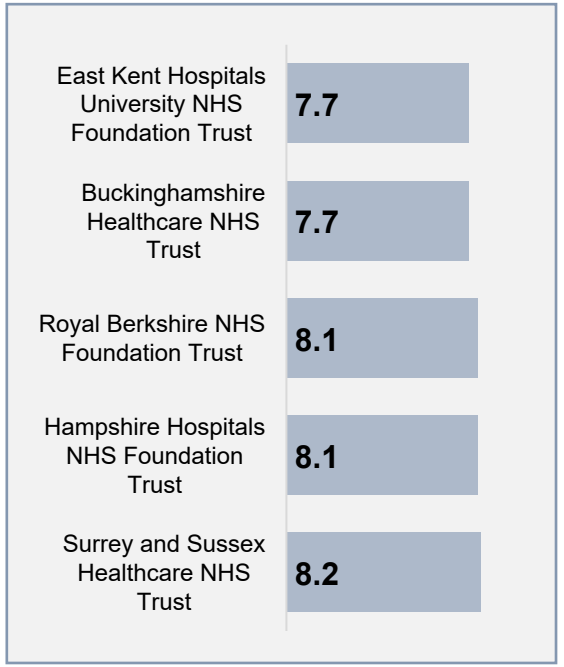


Comparison with other trusts within your region

Trusts with the highest scores



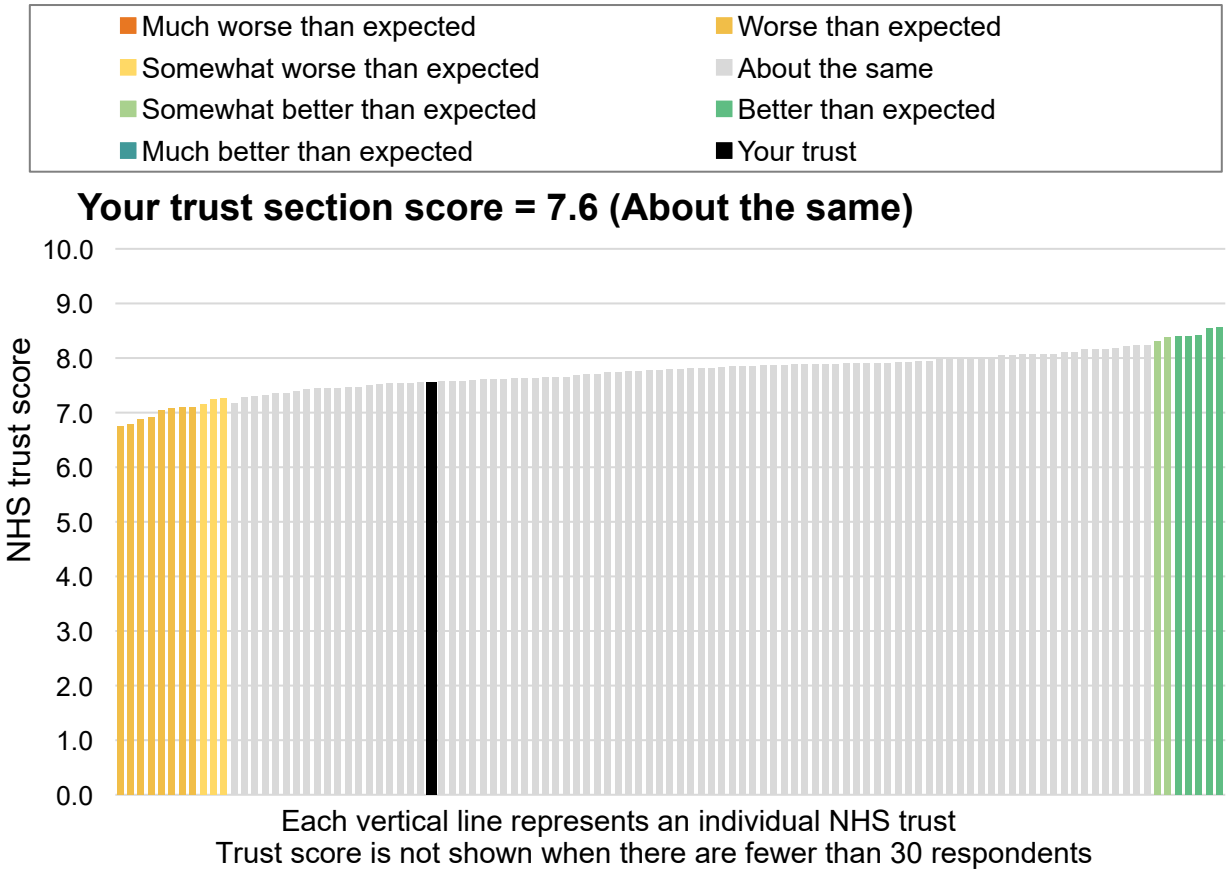
Trusts with the lowest scores



Care at home after birth

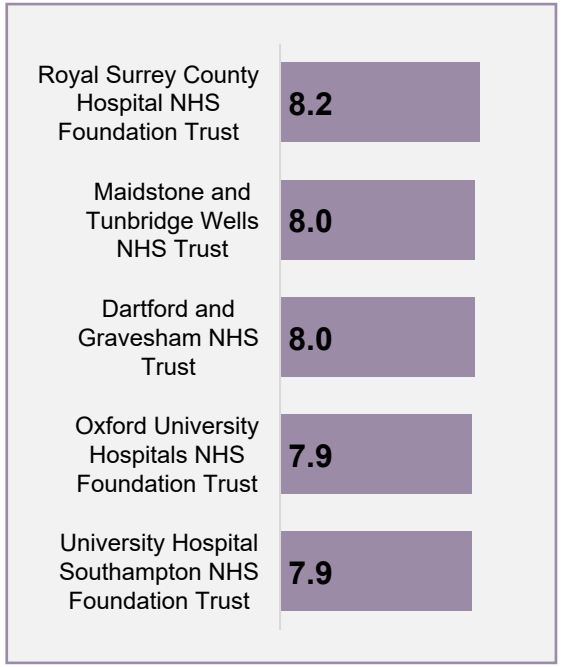
Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care at home after birth' is calculated from questions F1 to F2, F5 to F9 and F11 to F17. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

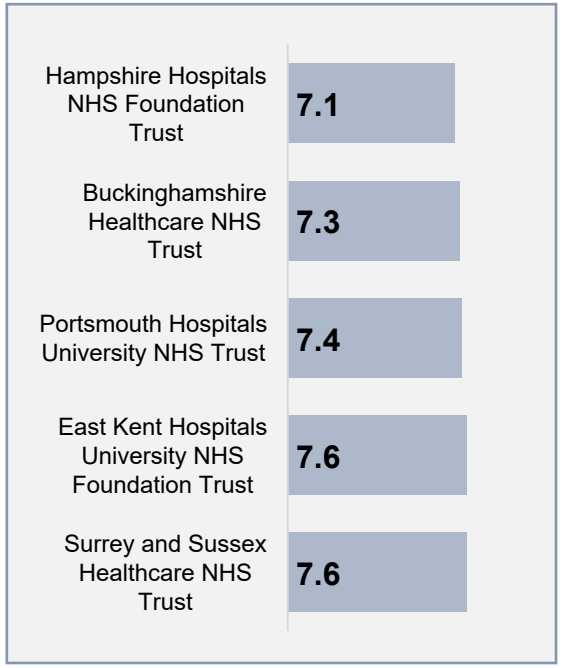


Comparison with other trusts within your region

Trusts with the highest scores

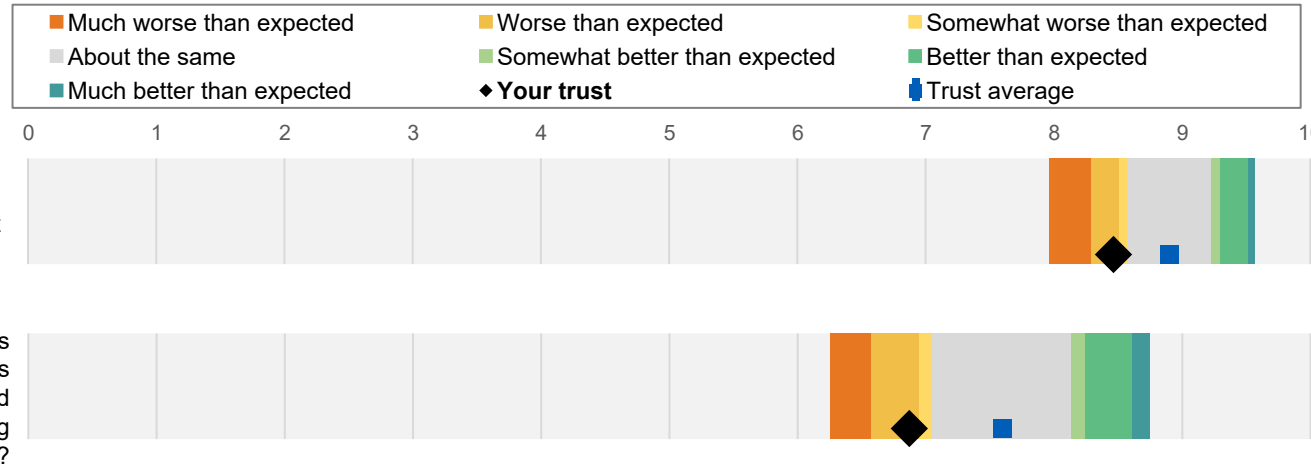


Trusts with the lowest scores



Benchmarking - Postnatal care

Question scores: Feeding your baby

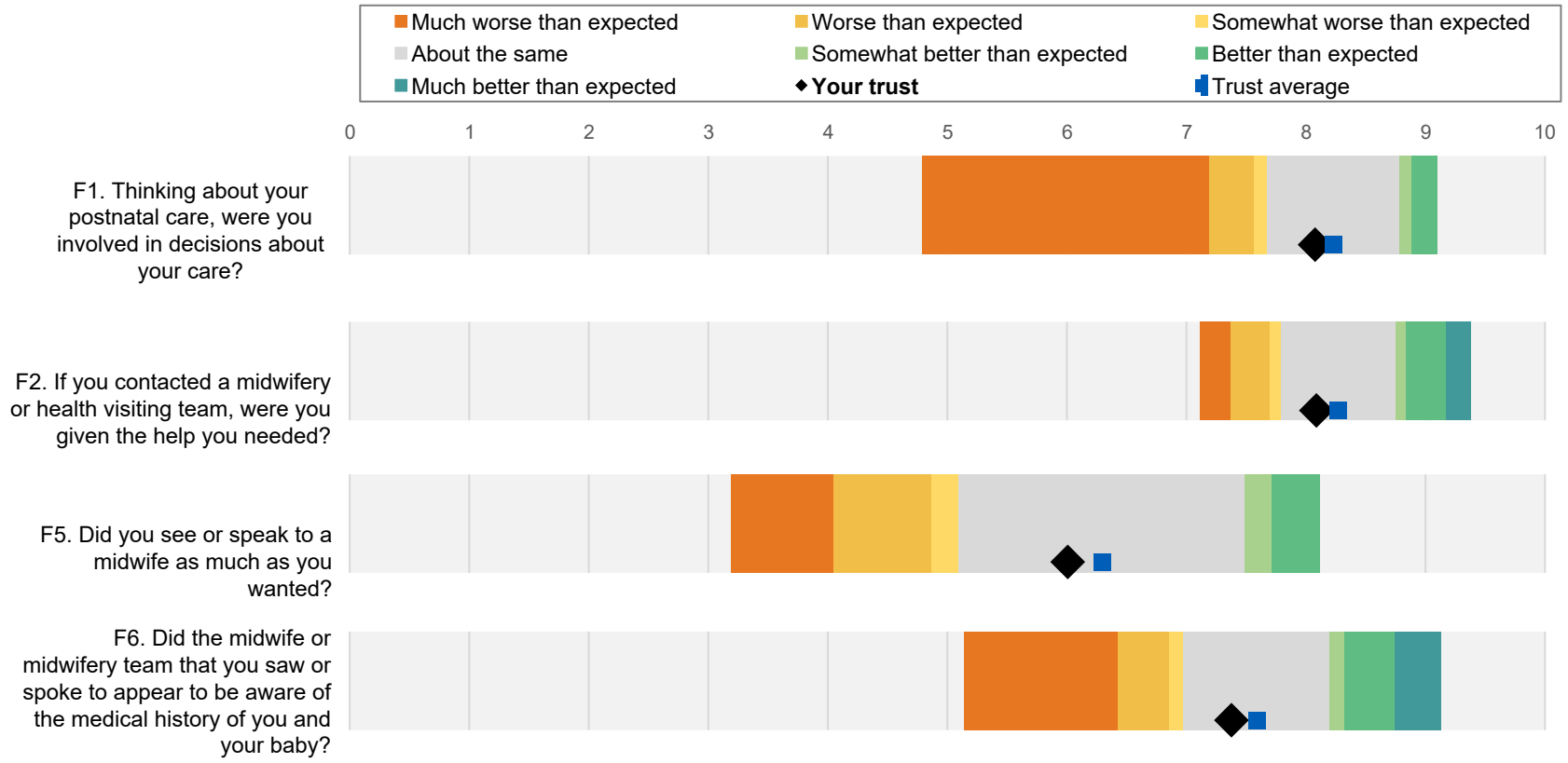


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
234	8.5	8.9	8.0	9.6
221	6.9	7.6	6.3	8.7

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Postnatal care (continued)

Question scores: Care at home after birth

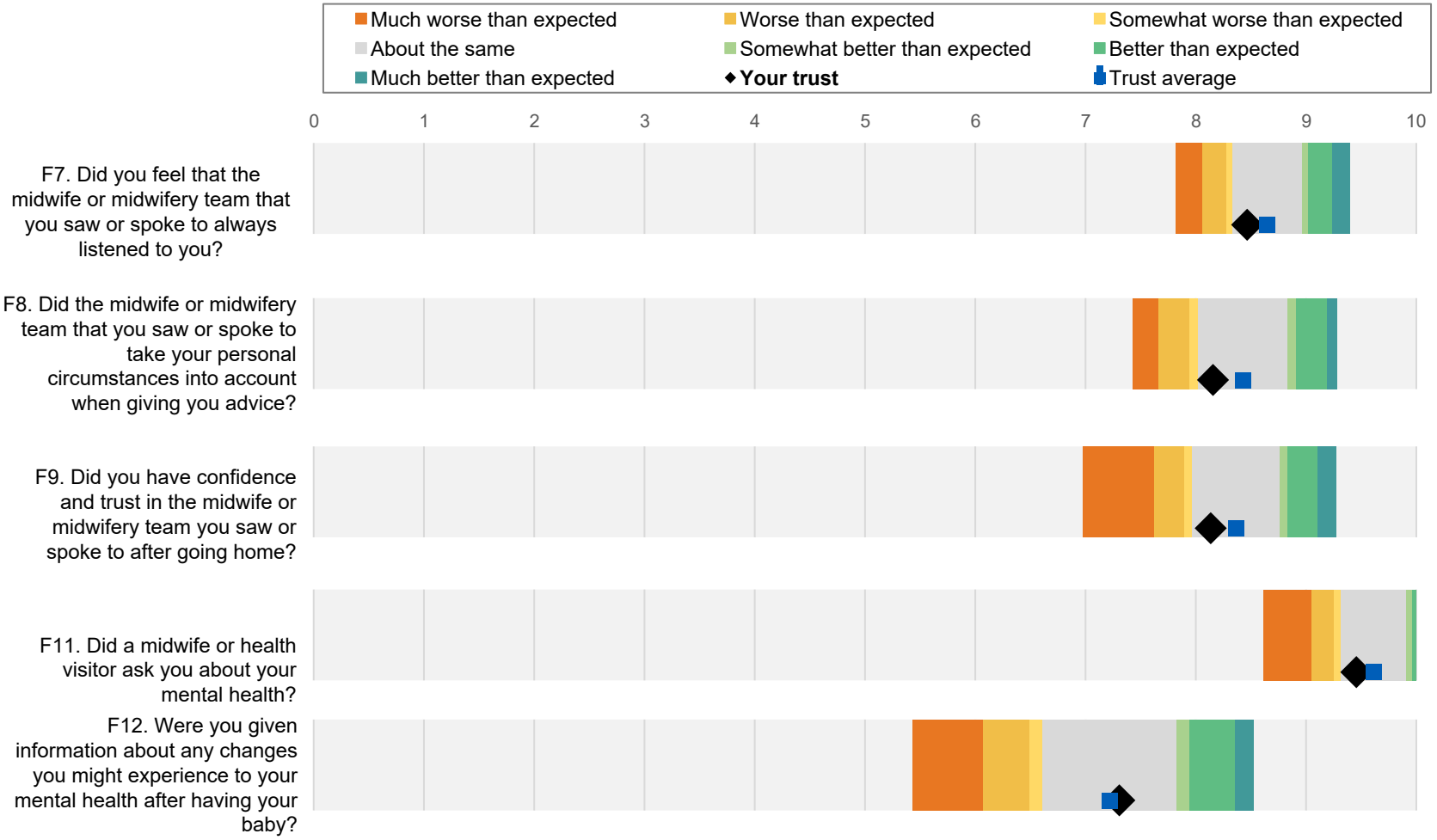


		All trusts in England				
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score	
F1. Thinking about your postnatal care, were you involved in decisions about your care?	232	8.1	8.2	4.8	9.1	About the same
F2. If you contacted a midwifery or health visiting team, were you given the help you needed?	215	8.1	8.3	7.1	9.4	About the same
F5. Did you see or speak to a midwife as much as you wanted?	229	6.0	6.3	3.2	8.1	About the same
F6. Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?	209	7.4	7.6	5.1	9.1	About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Postnatal care (continued)

Question scores: Care at home after birth



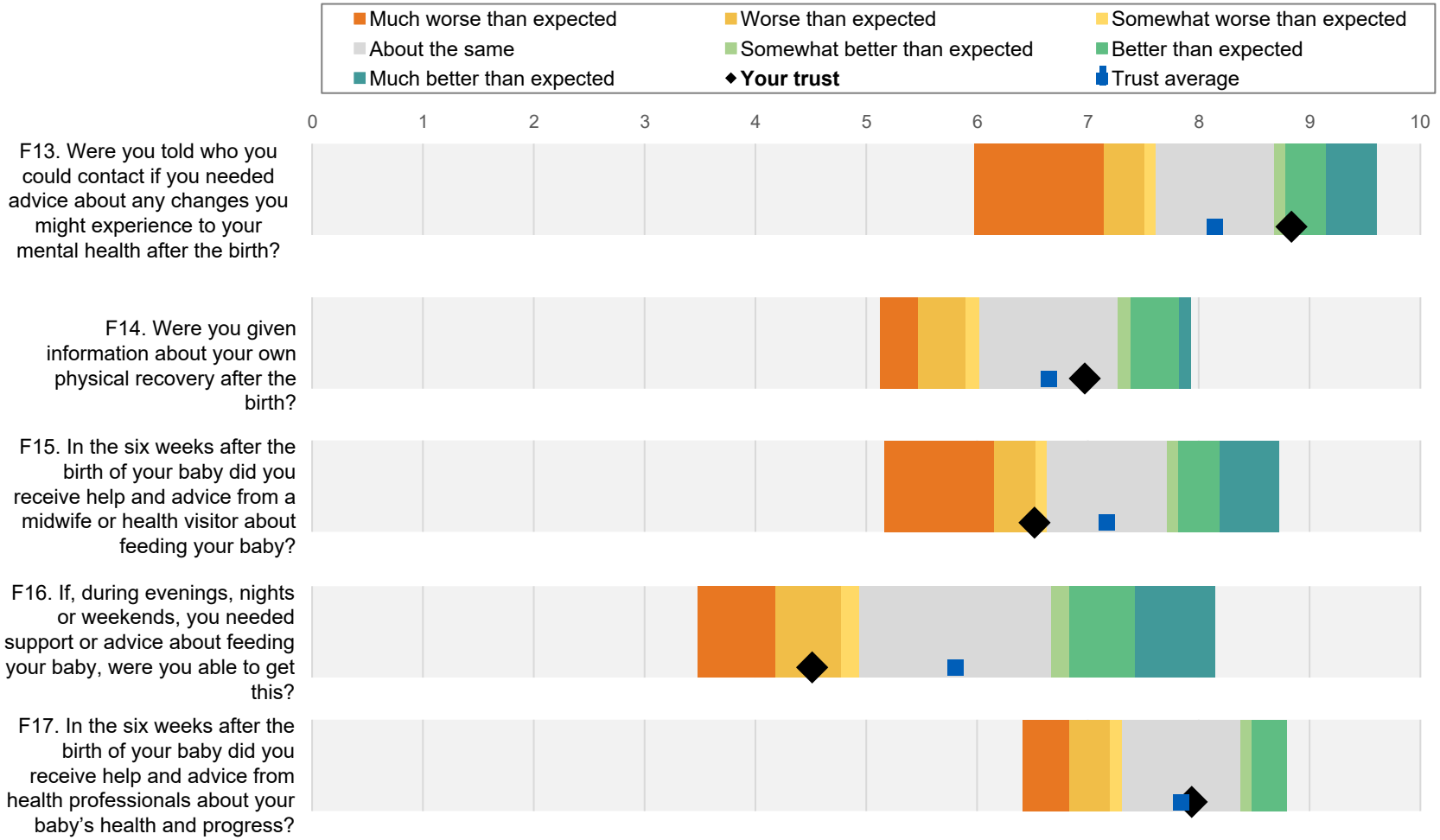
			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
F7. Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?	231	8.5	8.6	7.8	9.4
F8. Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?	216	8.2	8.4	7.4	9.3
F9. Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?	230	8.1	8.4	7.0	9.3
F11. Did a midwife or health visitor ask you about your mental health?	230	9.5	9.6	8.6	10.0
F12. Were you given information about any changes you might experience to your mental health after having your baby?	232	7.3	7.2	5.4	8.5

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Postnatal care (continued)

Question scores: Care at home after birth



	All trusts in England				
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
F13. Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	227	8.8	8.1	6.0	9.6
F14. Were you given information about your own physical recovery after the birth?	233	7.0	6.6	5.1	7.9
F15. In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?	215	6.5	7.2	5.2	8.7
F16. If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?	103	4.5	5.8	3.5	8.2
F17. In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?	217	7.9	7.8	6.4	8.8

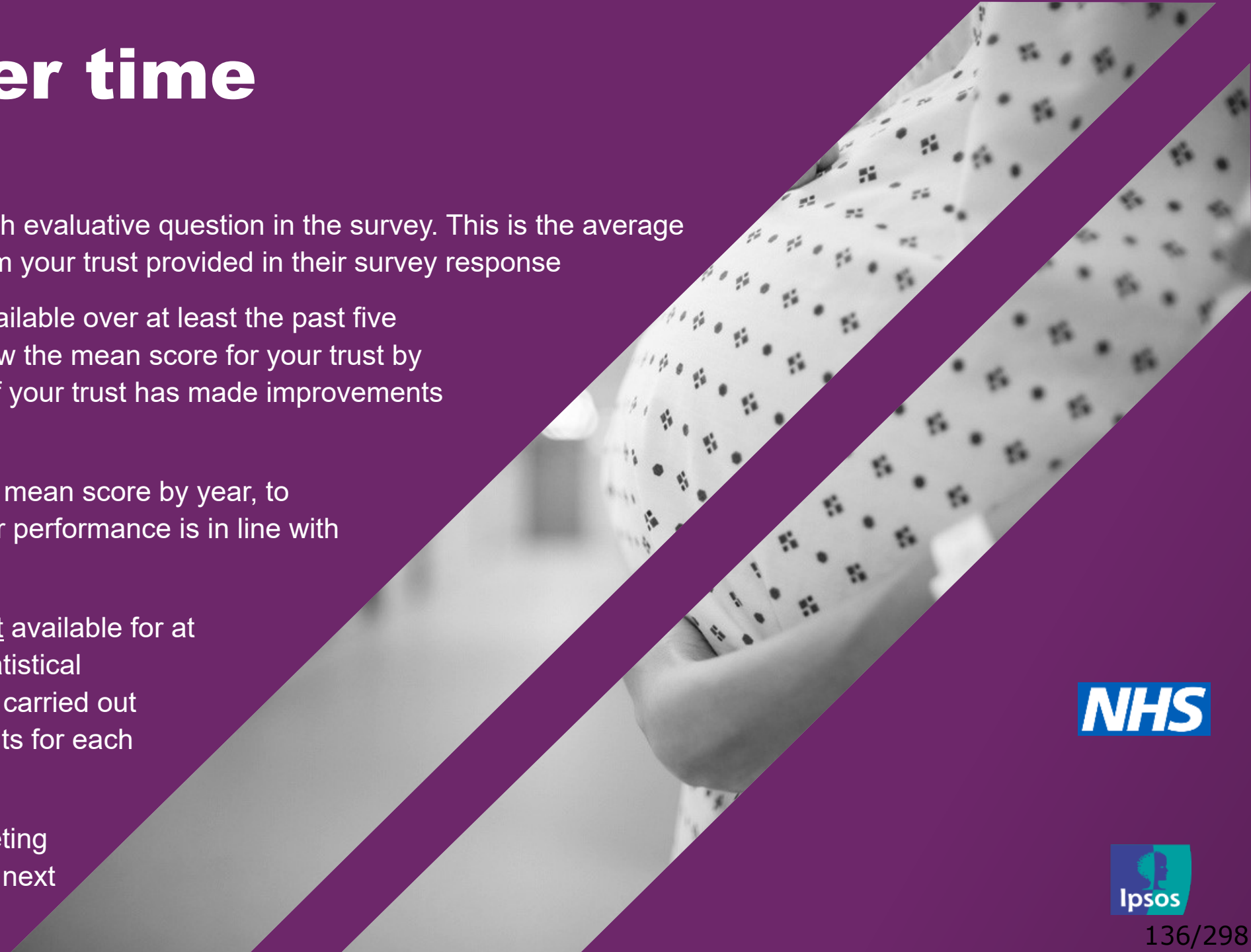
Better
About the same
Worse
Worse
About the same

Trust score is not shown when there are fewer than 30 respondents.

Trends over time

This section includes:

- your mean trust score for each evaluative question in the survey. This is the average of all scores that mothers from your trust provided in their survey response
- where comparable data is available over at least the past five surveys, the trend charts show the mean score for your trust by year. This allows you to see if your trust has made improvements over time
- they also include the national mean score by year, to allow you to see whether your performance is in line with the national average or not
- where consistent data are not available for at least the past five surveys statistical significance testing has been carried out against the 2021 survey results for each relevant question
- for more guidance on interpreting these graphs, please see the next slide



Trends over time

The following section presents comparisons with previous survey results. Statistically significant differences in the trust mean score between 2021 and 2022 are highlighted to show where there is meaningful change between years.

Historical trend charts are presented when there are at least five data points available to plot on the chart. Five data points may not be available due to:

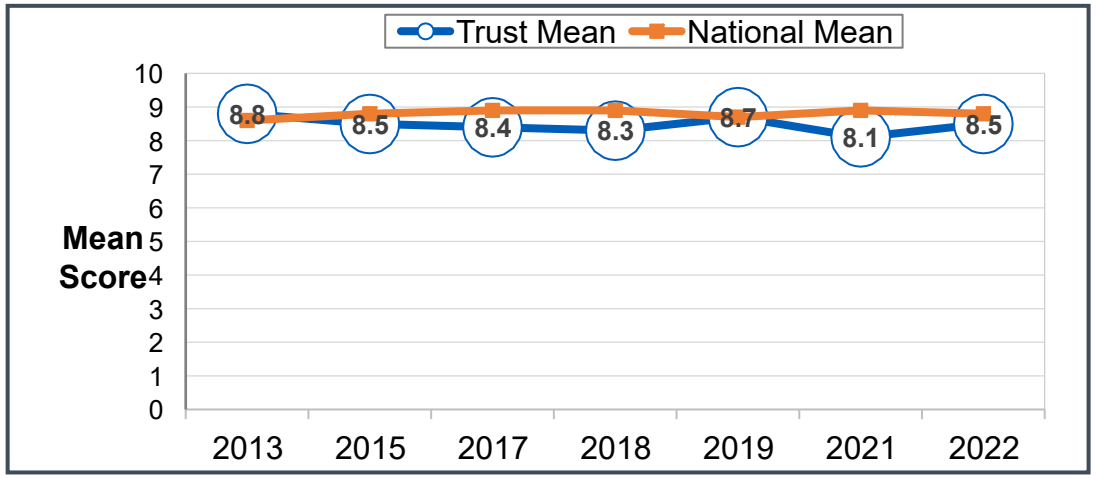
- changes to the questionnaire mean that a question is no longer comparable over time;
- organisational changes which impact comparability of results over time; or,
- historical errors with sampling or issues with fieldwork which impact comparability.

Statistically significant differences in the trust mean score between 2021 and 2022 are highlighted. These are carried out using a two sample t-test. Where a change in results is shown as 'significant', this indicates that this change is not due to random chance, but is likely due to some particular factor at your trust. Significant increases are indicated with a filled green circle, and significant decreases are in red.

Where comparable data is not available, statistical significance test tables are provided. Statistically significant changes in your trust score between 2021 and 2022 are shown in the far right column 'Change from 2021 survey', significant increases are indicated with a green arrow and significant decreases are indicated with a red arrow.

The following questions were new or changed for 2022 and therefore are not included in this section: B17, B18, C5, C24 and F1.

Historical trend chart example



Significance test table example

		2022 Trust Score	2021 Trust Score	No. of respon dents	Change from 2021 survey
The start of your care in pregnancy					
B4.	Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	4.3	7.1	178	▼

Trends over time

Antenatal care

Trends over time - Antenatal care

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
The start of your care in pregnancy					
B3.	Were you offered a choice about where to have your baby?	3.1	2.7	177	
B4.	Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	5.8	5.2	217	
B5.	At the start of your care in pregnancy, did you feel that you were given enough information about coronavirus restrictions and any implications for your maternity care?	5.3	4.9	224	

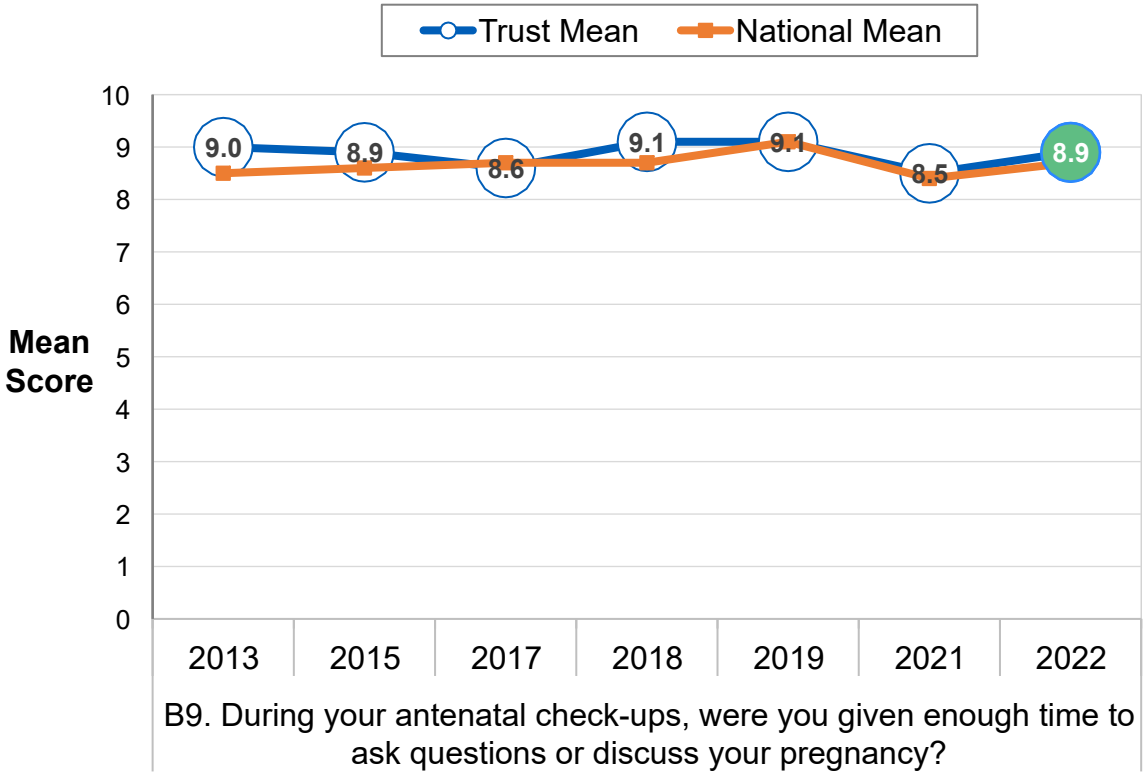
▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

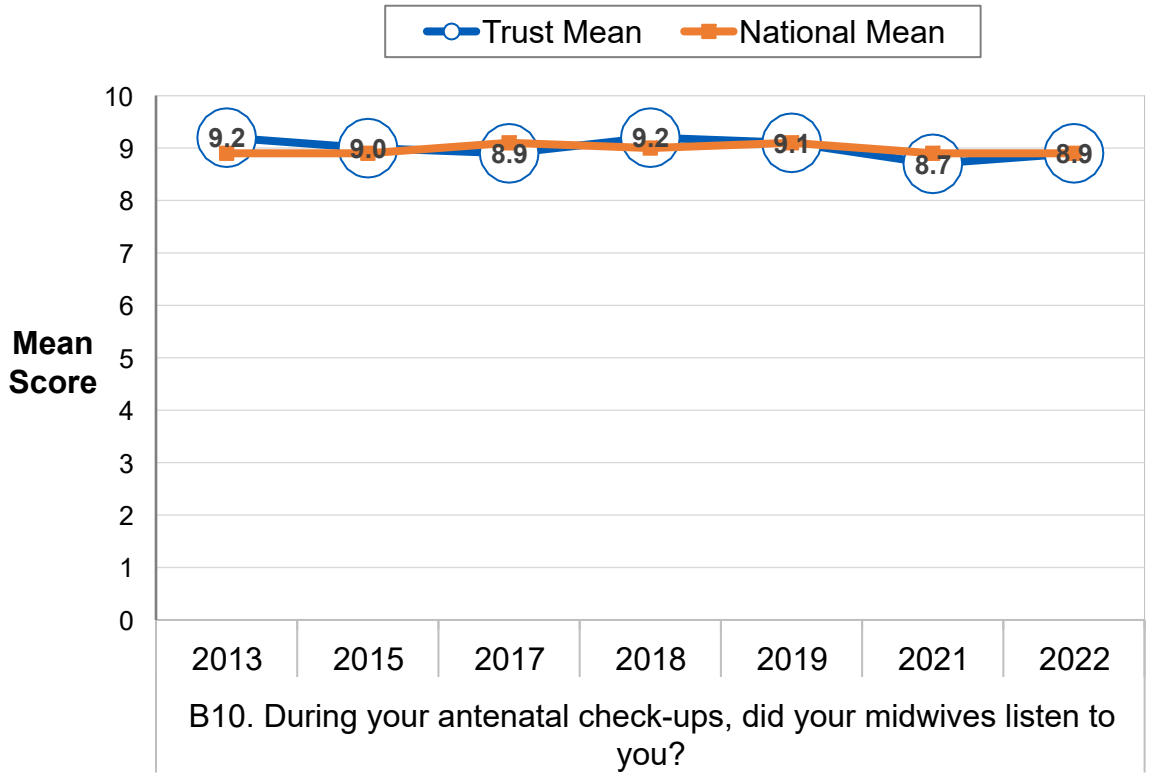
Trends over time - Antenatal care

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Antenatal check-ups



B9. During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?



B10. During your antenatal check-ups, did your midwives listen to you?

This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Antenatal care (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
Antenatal check-ups					
B8.	During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?	6.4	6.0	229	
B11.	During your antenatal check-ups, did your midwives ask you about your mental health?	7.8	7.7	223	

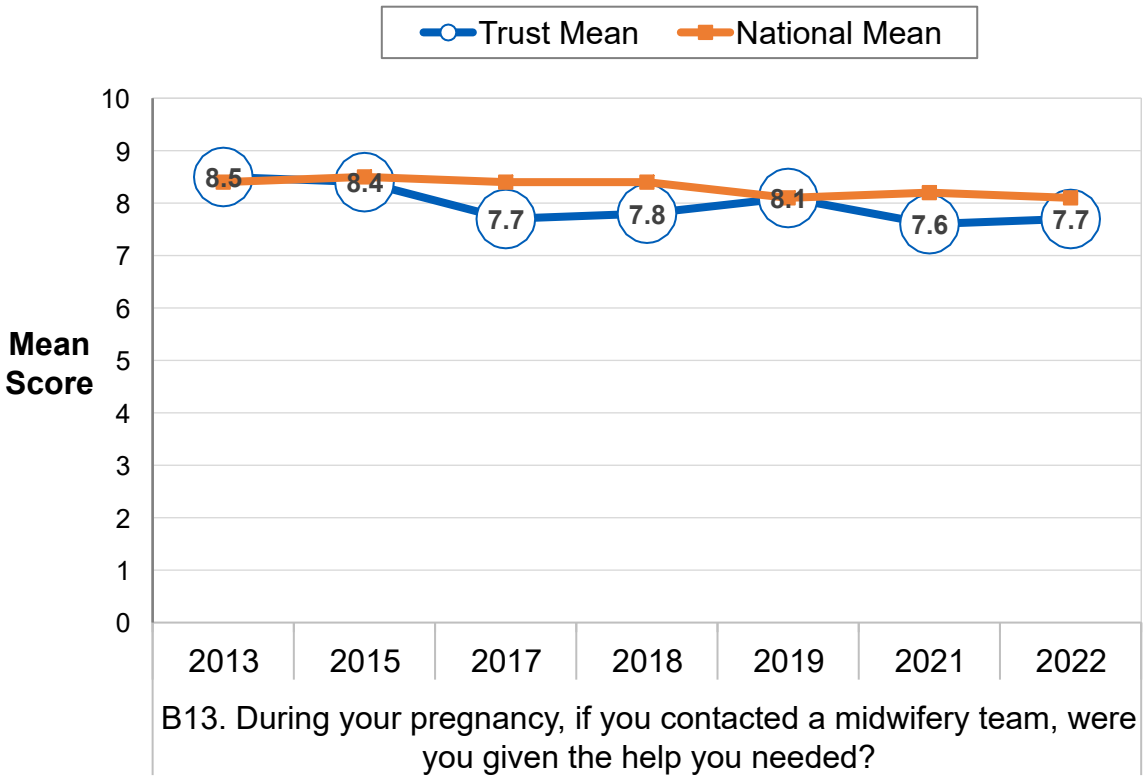
▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

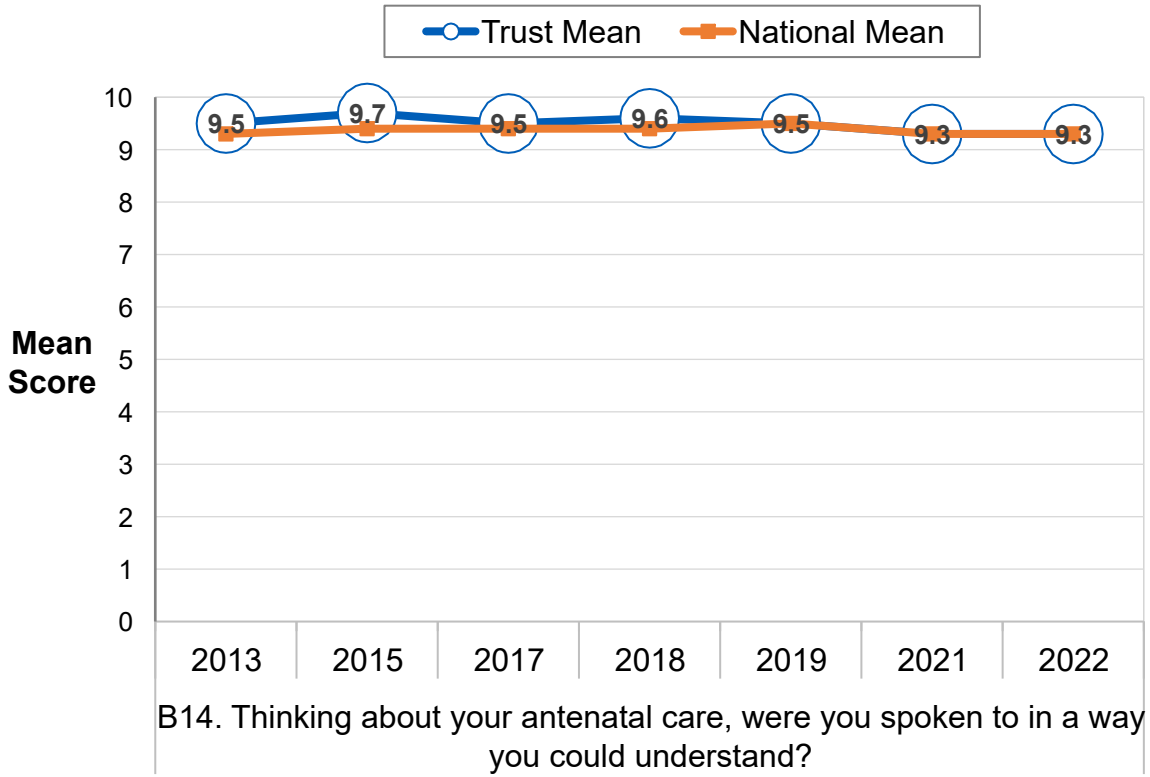
Trends over time - Antenatal care

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

During your pregnancy



B13. During your pregnancy, if you contacted a midwifery team, were you given the help you needed?



B14. Thinking about your antenatal care, were you spoken to in a way you could understand?

This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Antenatal care (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
During your pregnancy					
B12.	Were you given enough support for your mental health during your pregnancy?	8.2	7.7	133	
B15.	Thinking about your antenatal care, were you involved in decisions about your care?	8.5	8.4	223	
B16.	During your pregnancy did midwives provide relevant information about feeding your baby?	6.1	5.5	224	

▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

Trends over time

Labour and birth

Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
Your labour and birth											
C4.	Were you given enough information on induction before you were induced?							7.8	6.5	82	▲
C6.	Were you involved in the decision to be induced?							8.3	8.2	75	

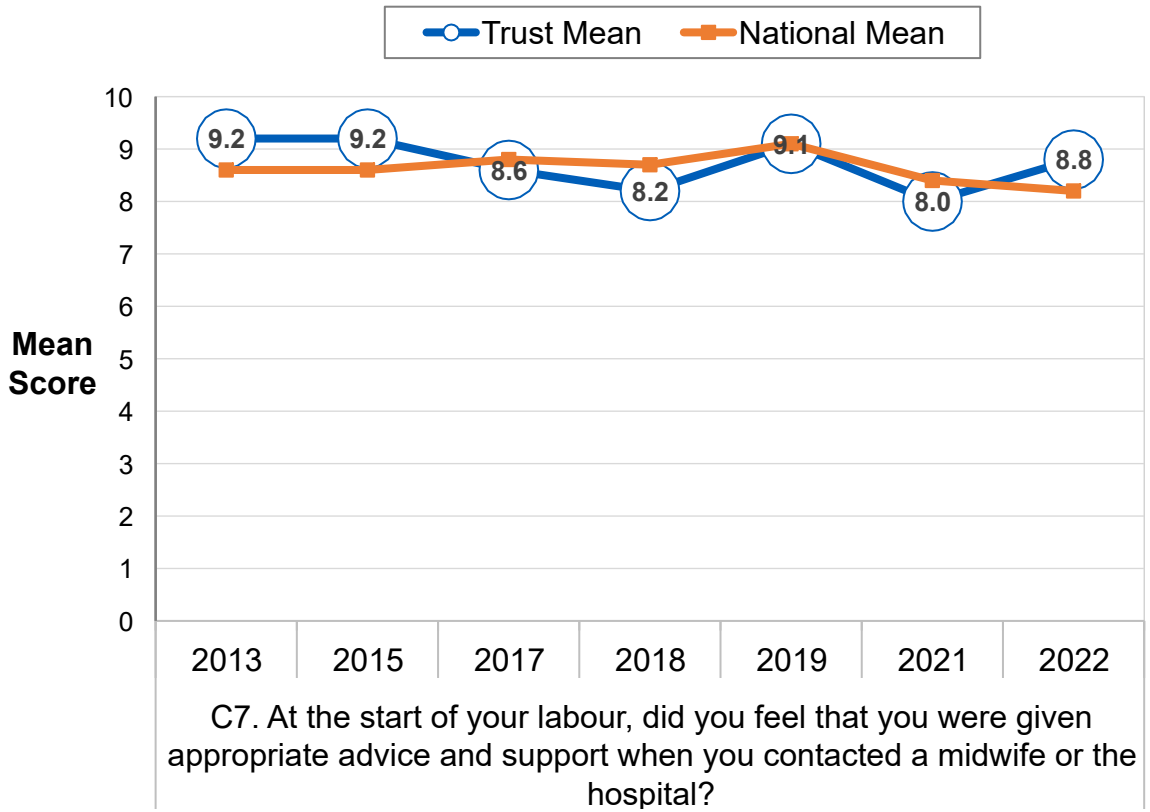
▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

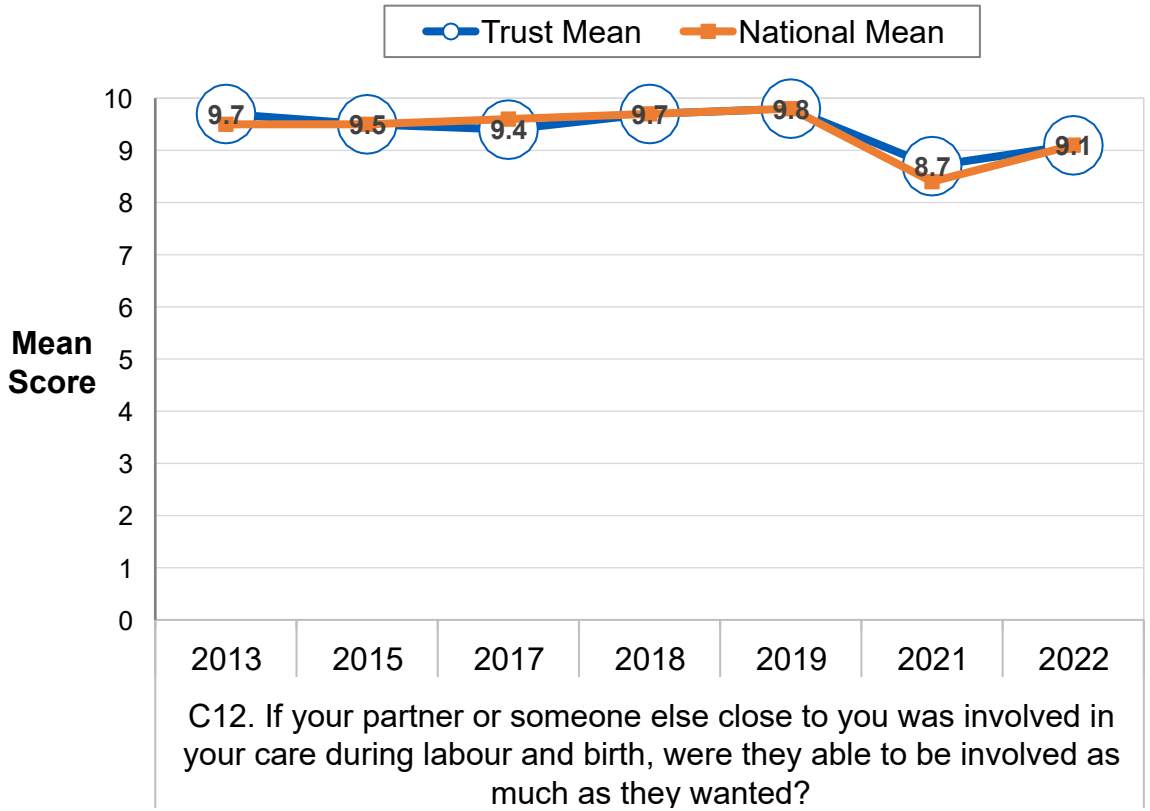
Trends over time - Labour and birth

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Your labour and birth



C7. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?



C12. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?

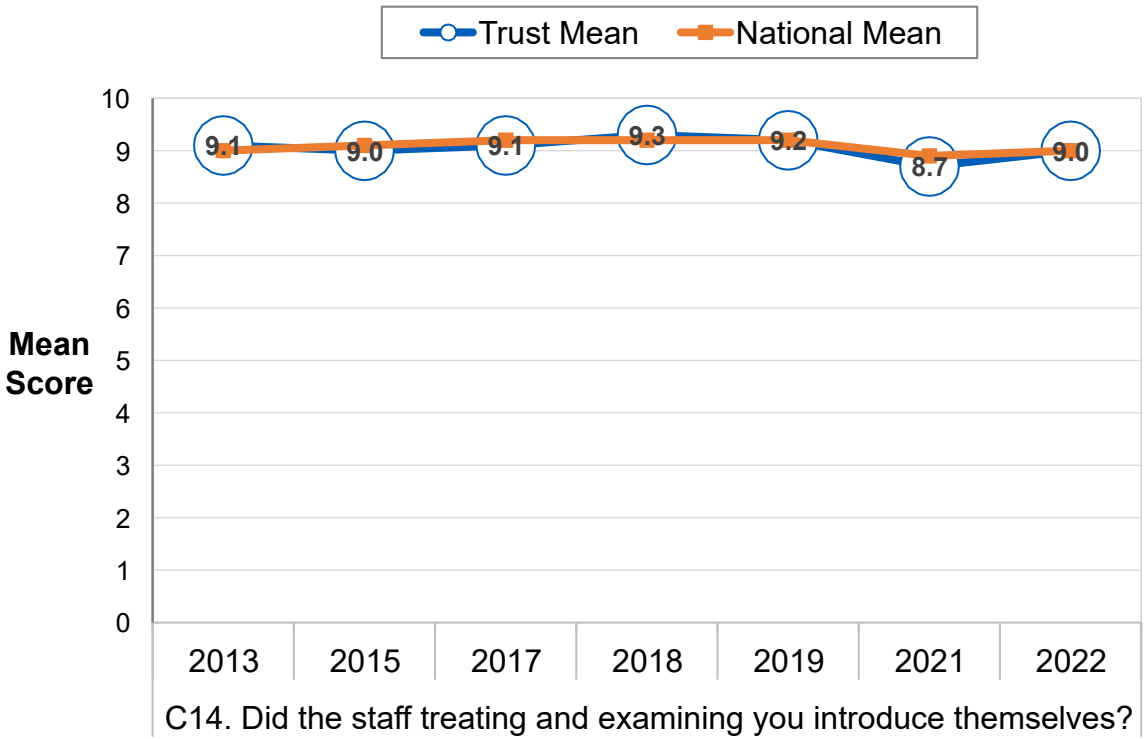
This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

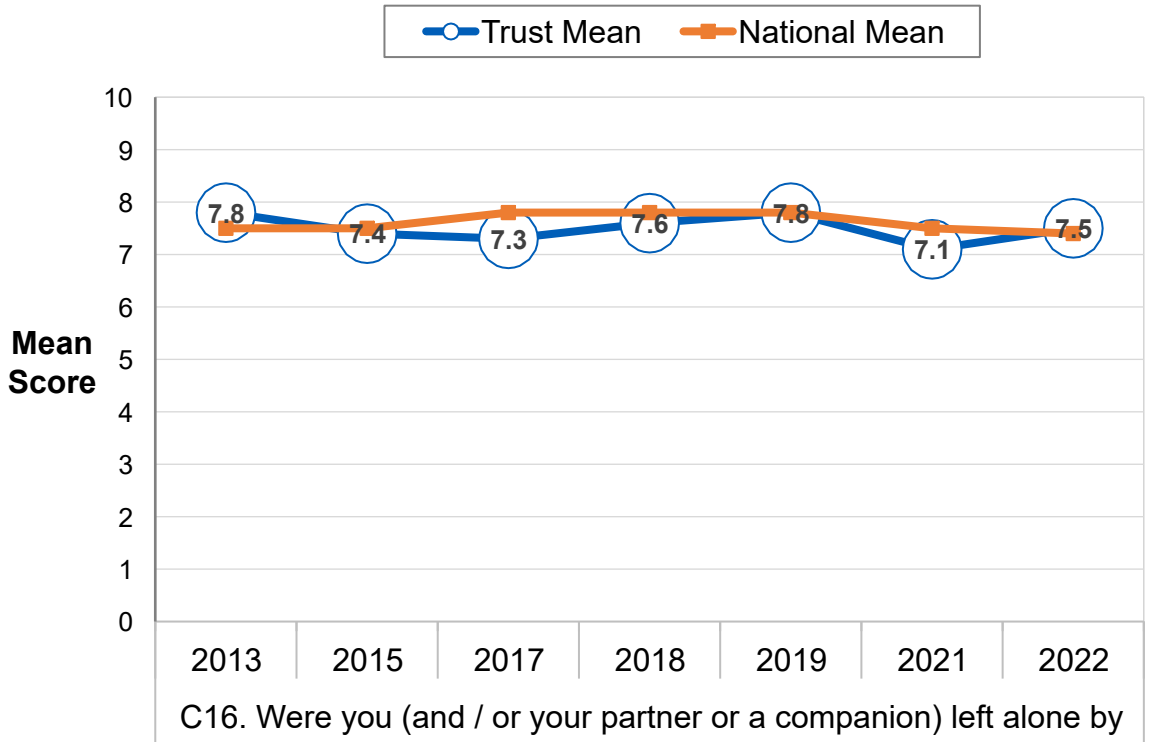
Trends over time - Labour and birth

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Staff caring for you



C14. Did the staff treating and examining you introduce themselves?



C16. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?

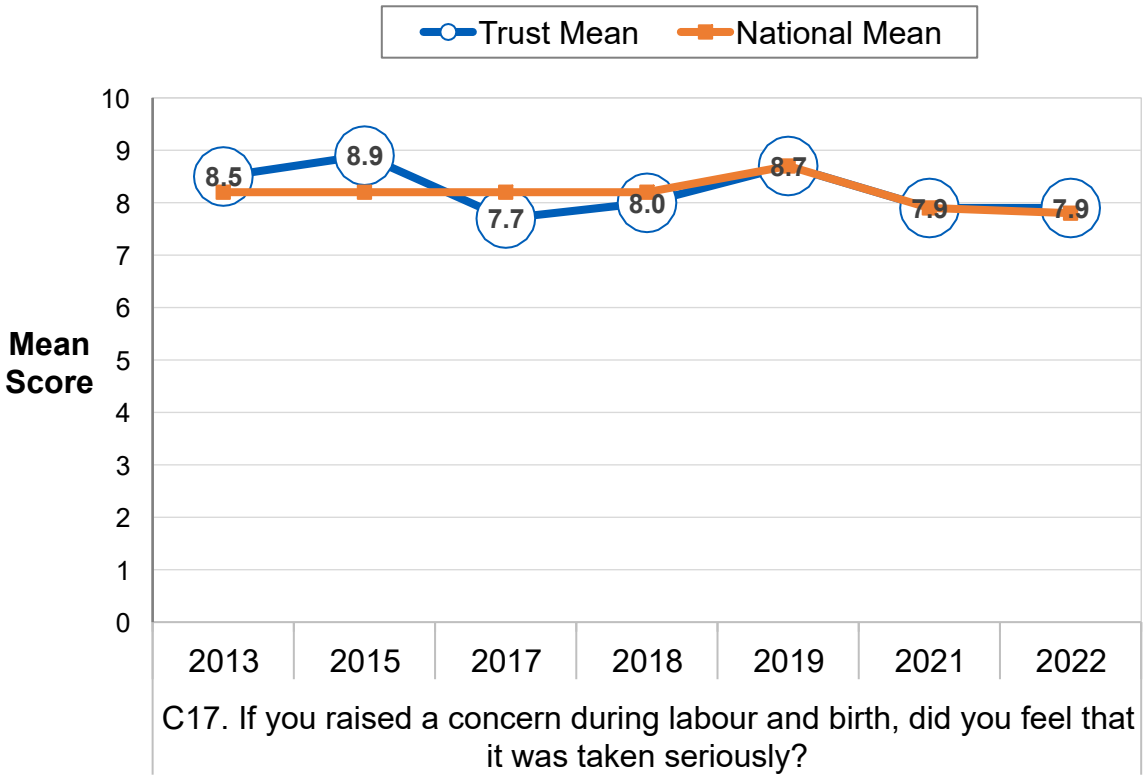
This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

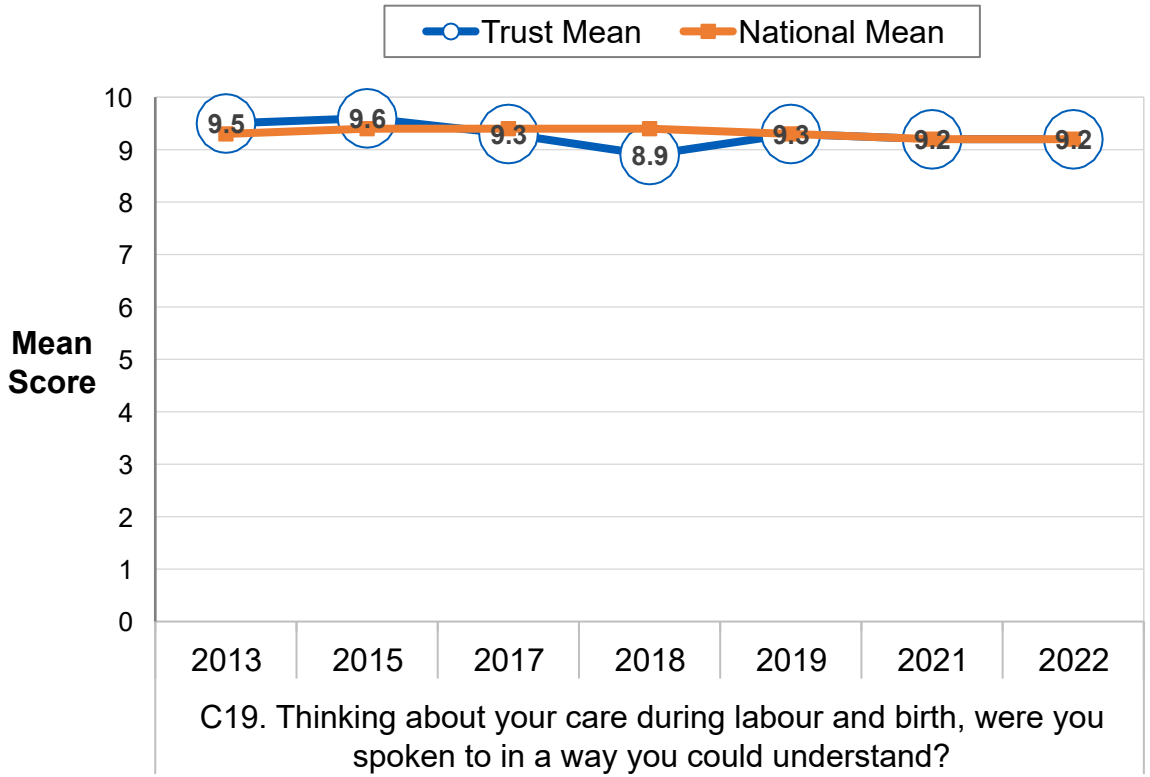
Trends over time - Labour and birth

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

The birth of your baby



C17. If you raised a concern during labour and birth, did you feel that it was taken seriously?



C19. Thinking about your care during labour and birth, were you spoken to in a way you could understand?

This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
The birth of your baby											
C18.	During labour and birth, were you able to get a member of staff to help you when you needed it?							8.7	8.3	230	

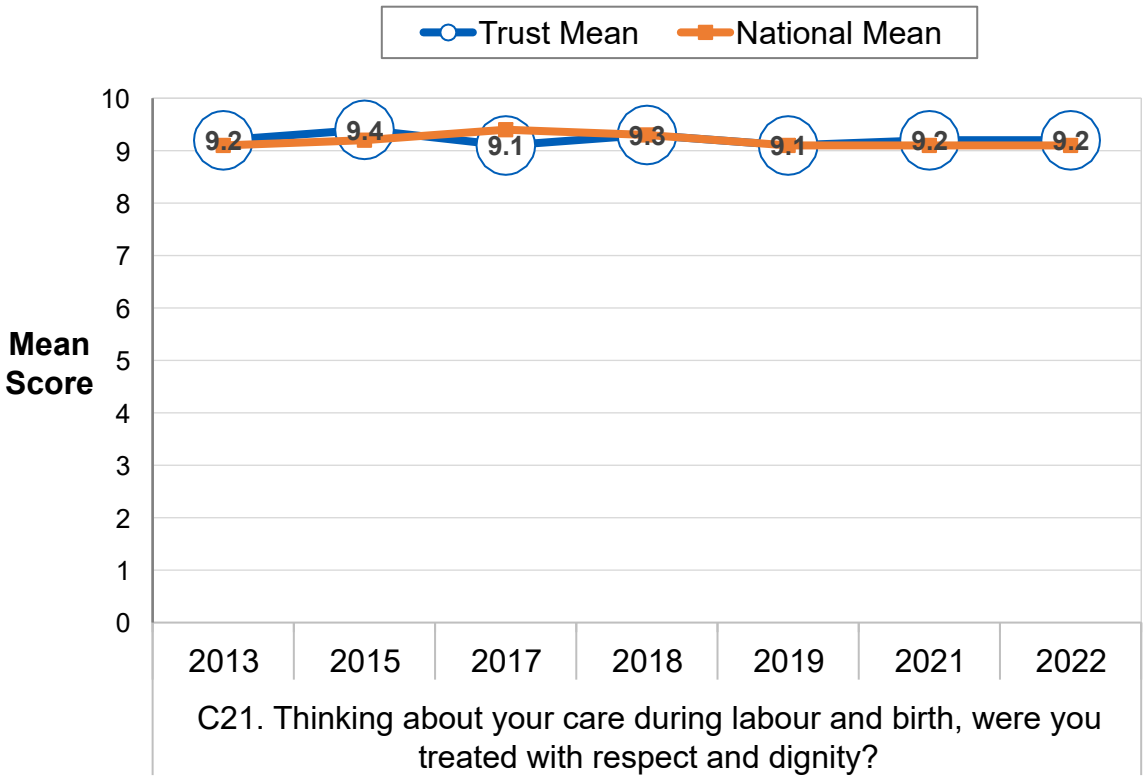
▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

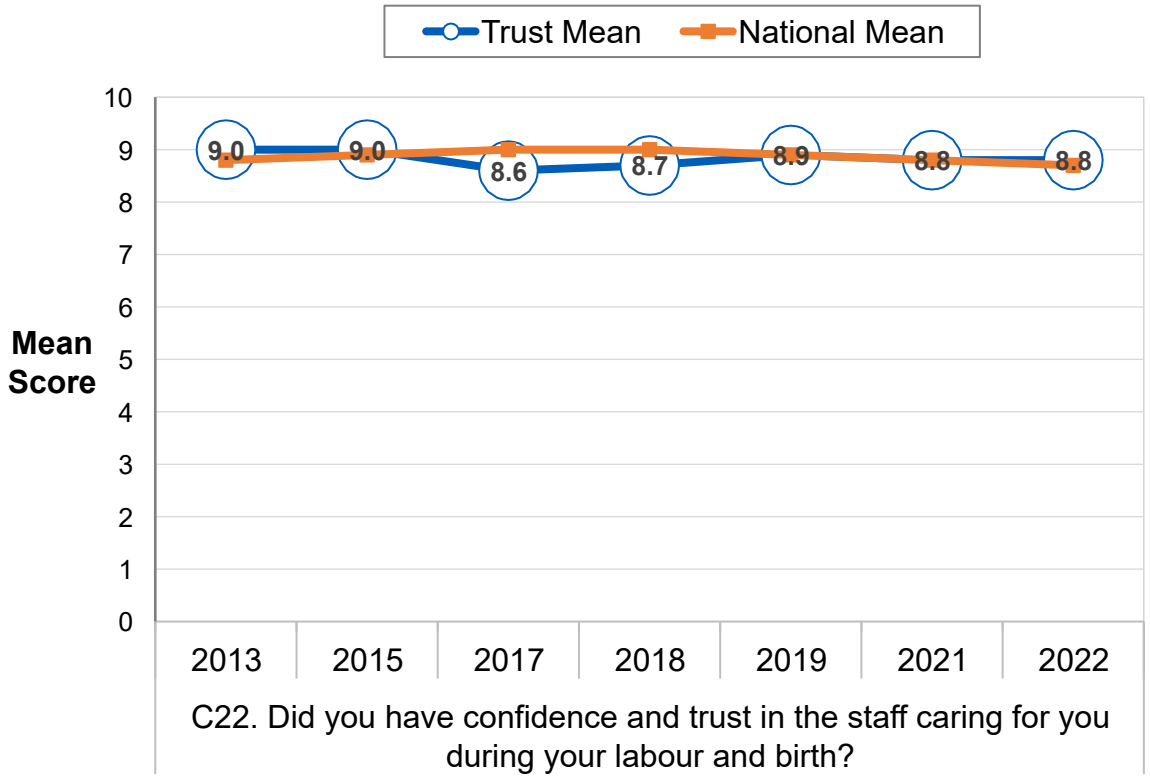
Trends over time - Labour and birth

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Staff caring for you



C21. Thinking about your care during labour and birth, were you treated with respect and dignity?



C22. Did you have confidence and trust in the staff caring for you during your labour and birth?

This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
Staff caring for you											
C20.	Thinking about your care during labour and birth, were you involved in decisions about your care?							8.1	8.1	232	
C23.	After your baby was born, did you have the opportunity to ask questions about your labour and the birth?							6.1	5.7	219	

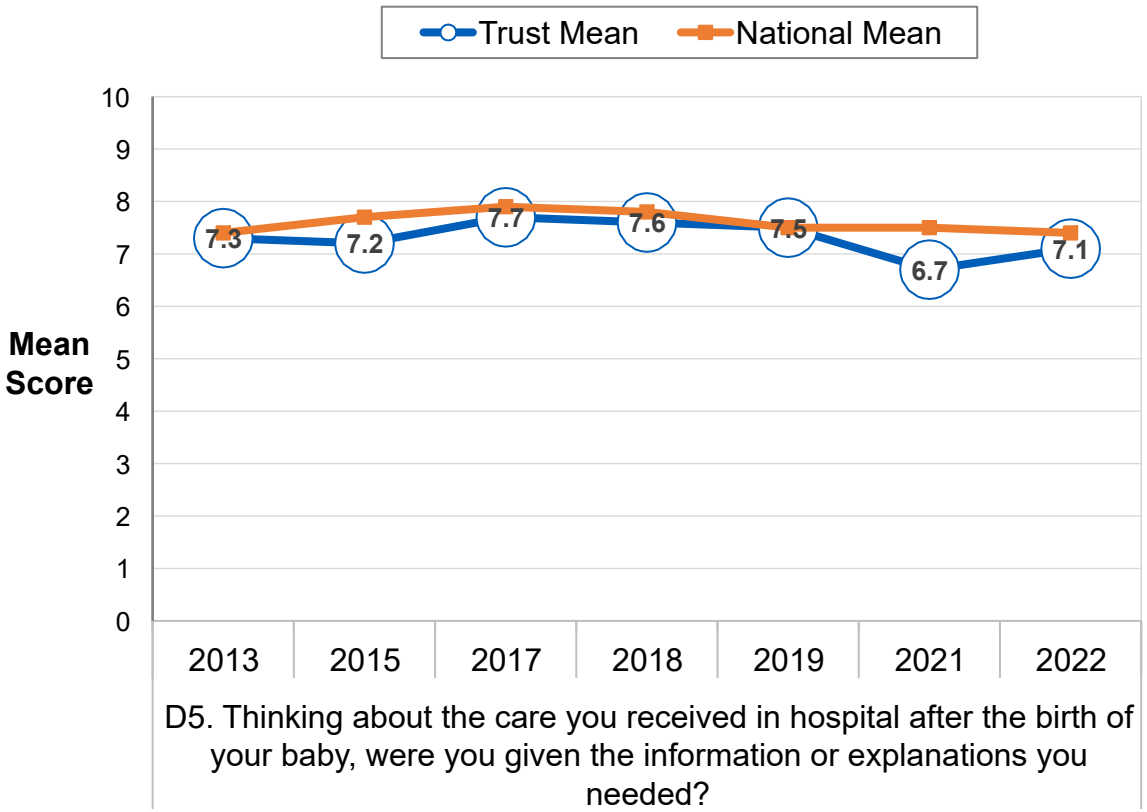
▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

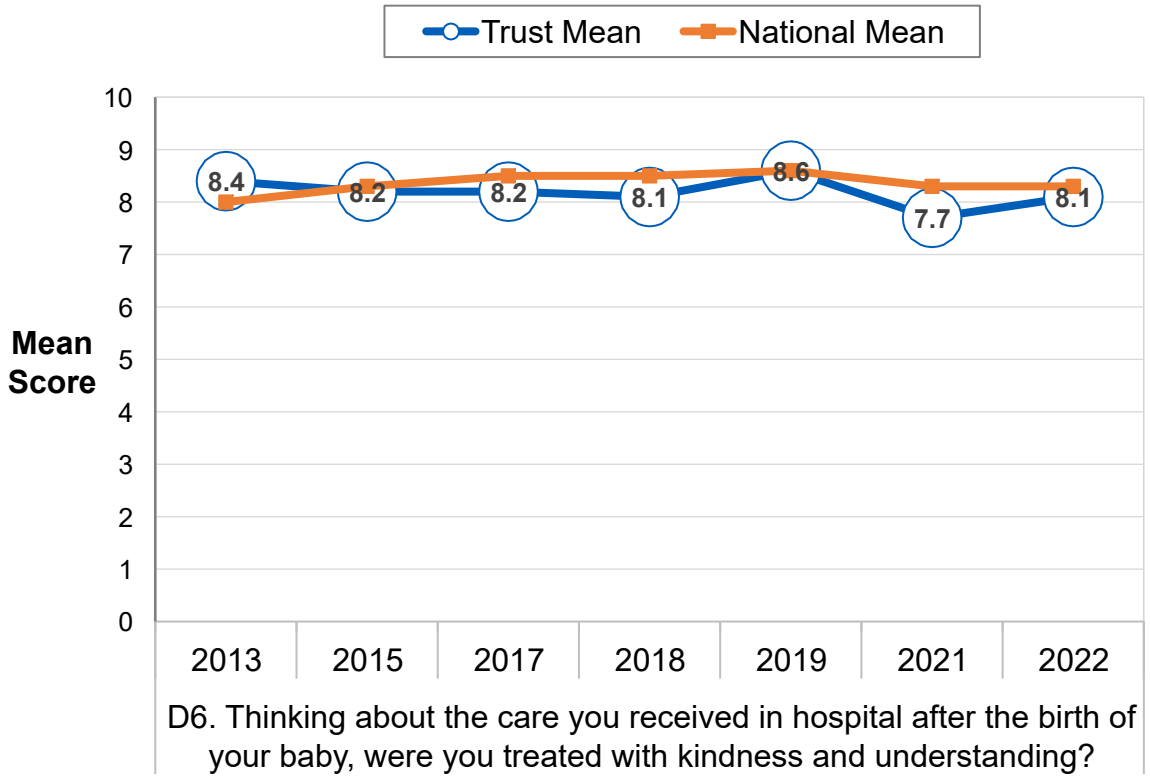
Trends over time - Labour and birth

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care in hospital after birth



D5. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?



D6. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

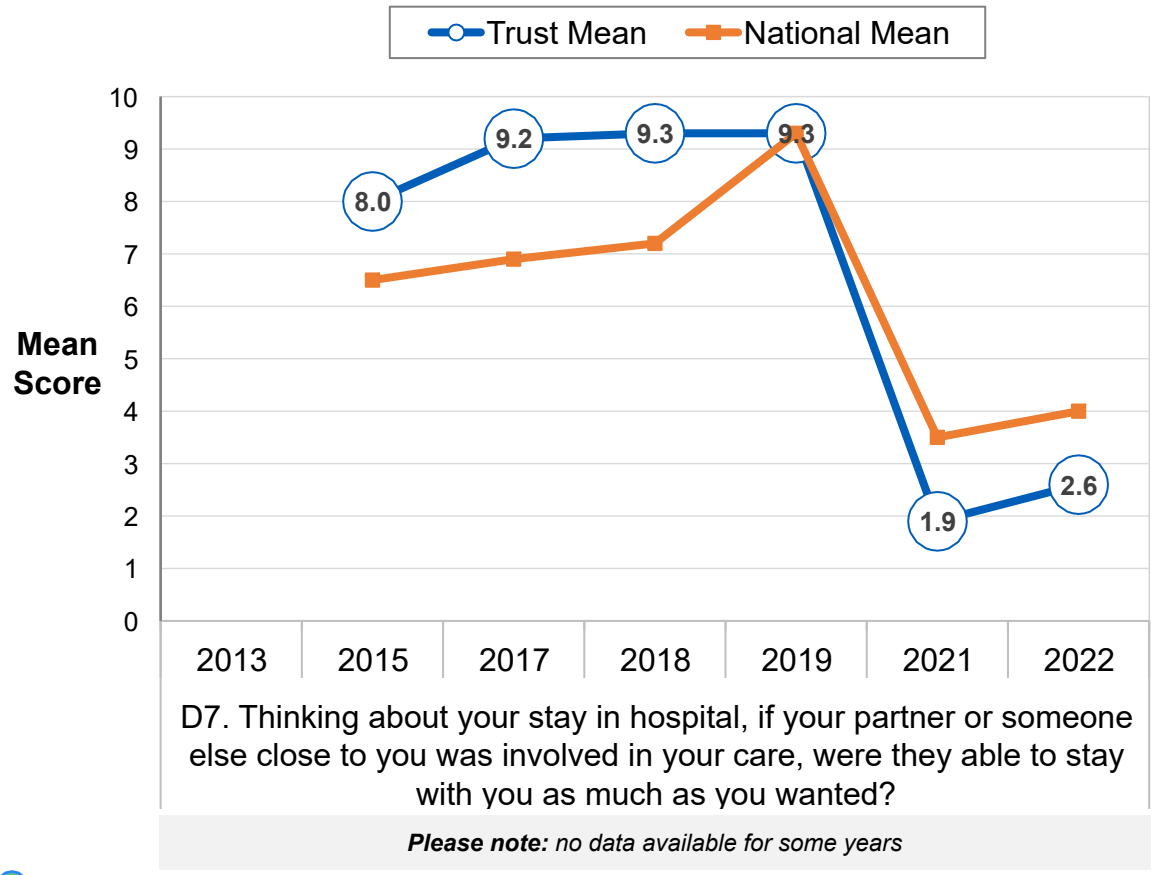
This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Labour and birth

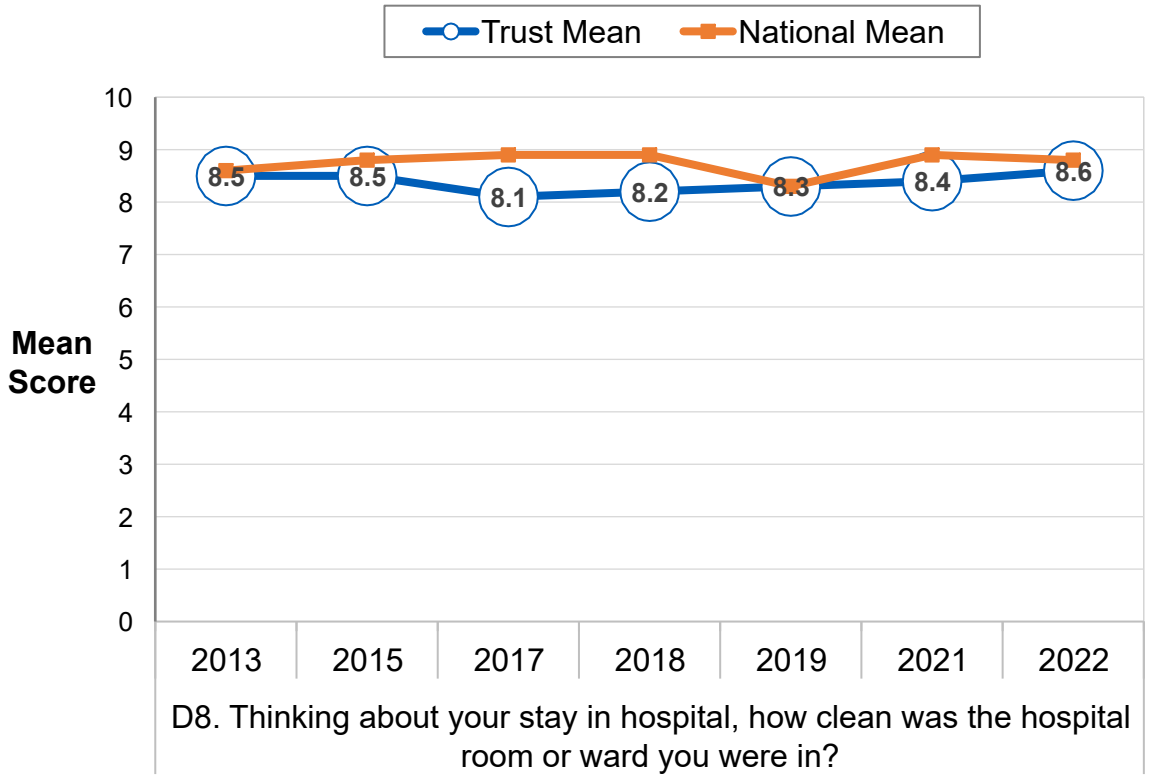
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care in hospital after birth



D7. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?

Please note: *no data available for some years*



D8. Thinking about your stay in hospital, how clean was the hospital room or ward you were in?

This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
Care in hospital after birth											
D2.	On the day you left hospital, was your discharge delayed for any reason?							6.7	5.6	240	▲
D4.	If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?							7.1	6.5	230	

▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

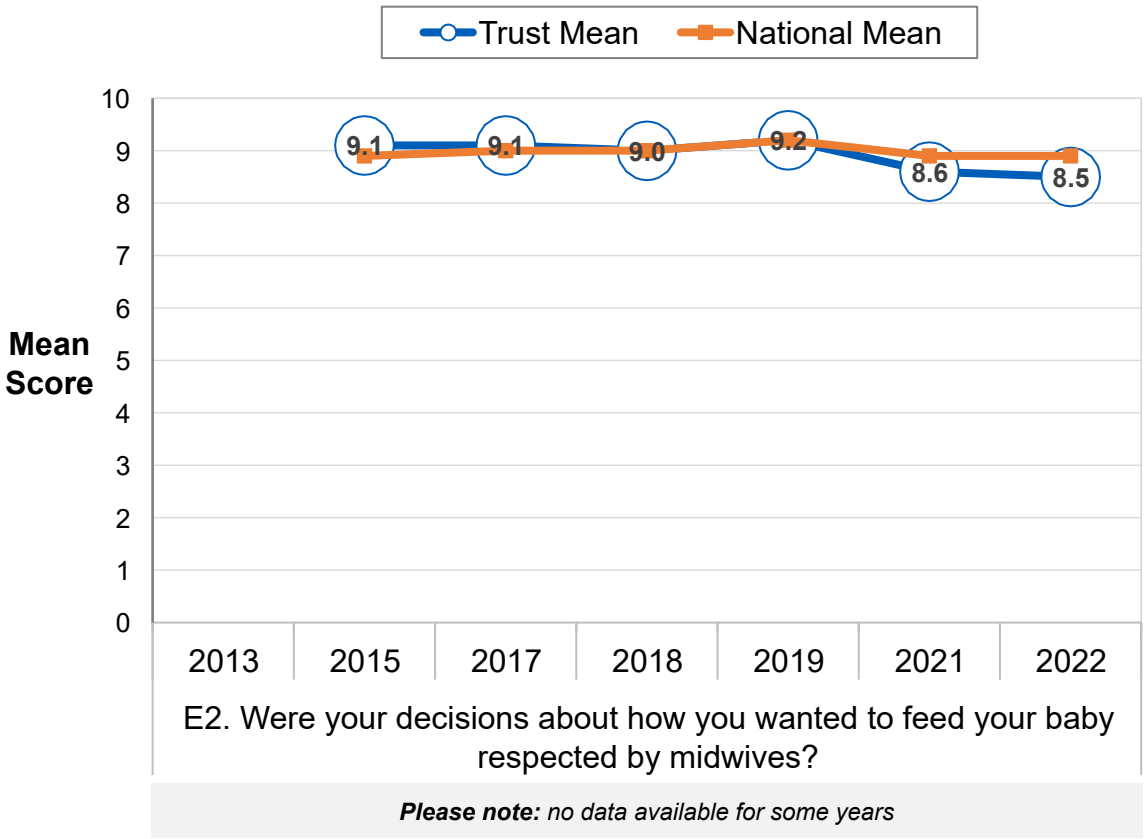
Trends over time

Postnatal care

Trends over time - Postnatal care

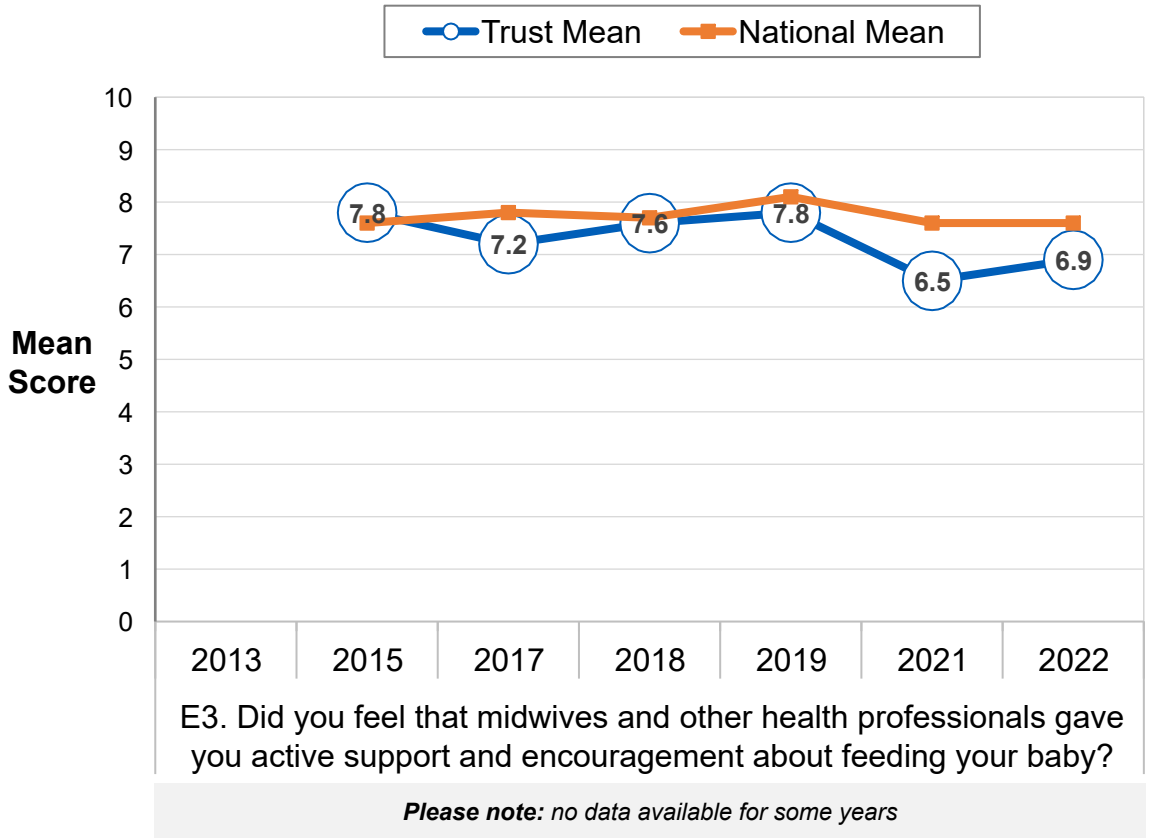
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Feeding your baby



E2. Were your decisions about how you wanted to feed your baby respected by midwives?

Please note: *no data available for some years*



E3. Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?

Please note: *no data available for some years*

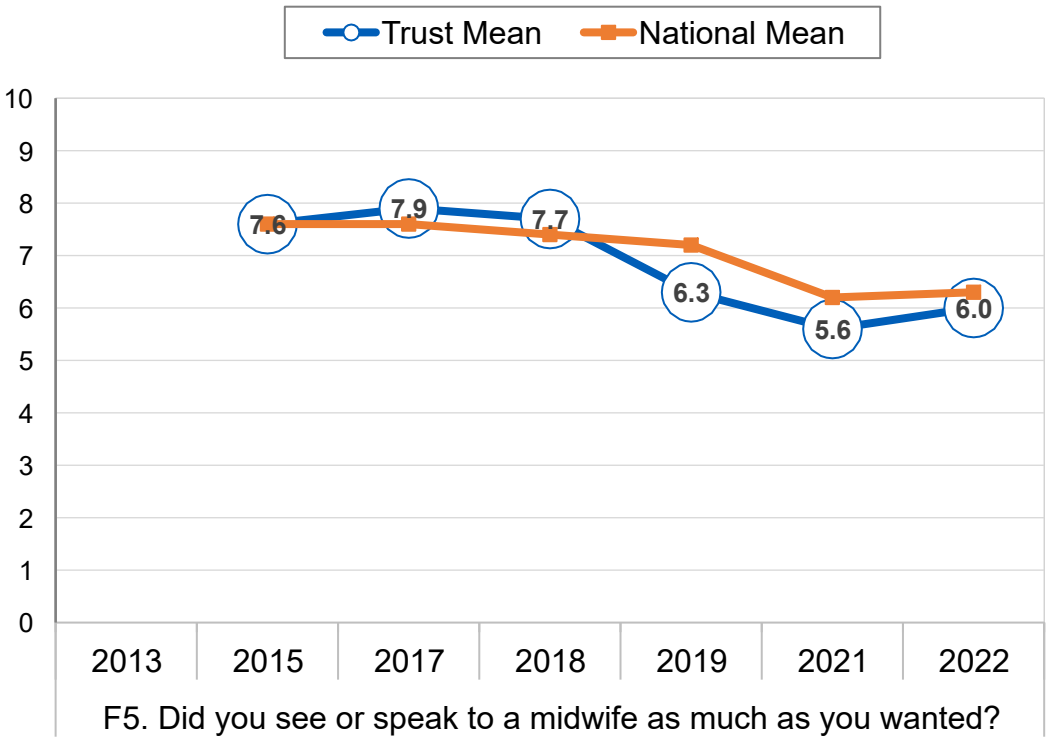
This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time – Postnatal care

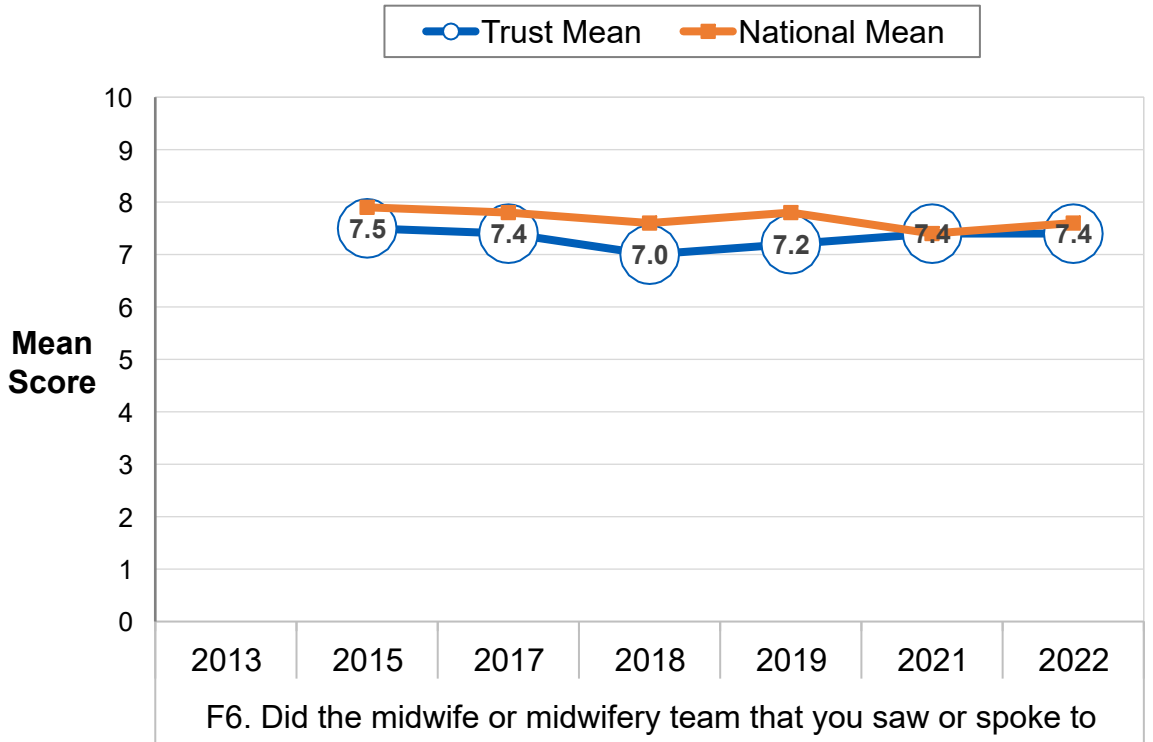
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care at home after the birth



F5. Did you see or speak to a midwife as much as you wanted?

Please note: *no data available for some years*



F6. Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Postnatal care (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
Care at home after the birth											
F2.	If you contacted a midwifery or health visiting team, were you given the help you needed?							8.1	8.4	215	

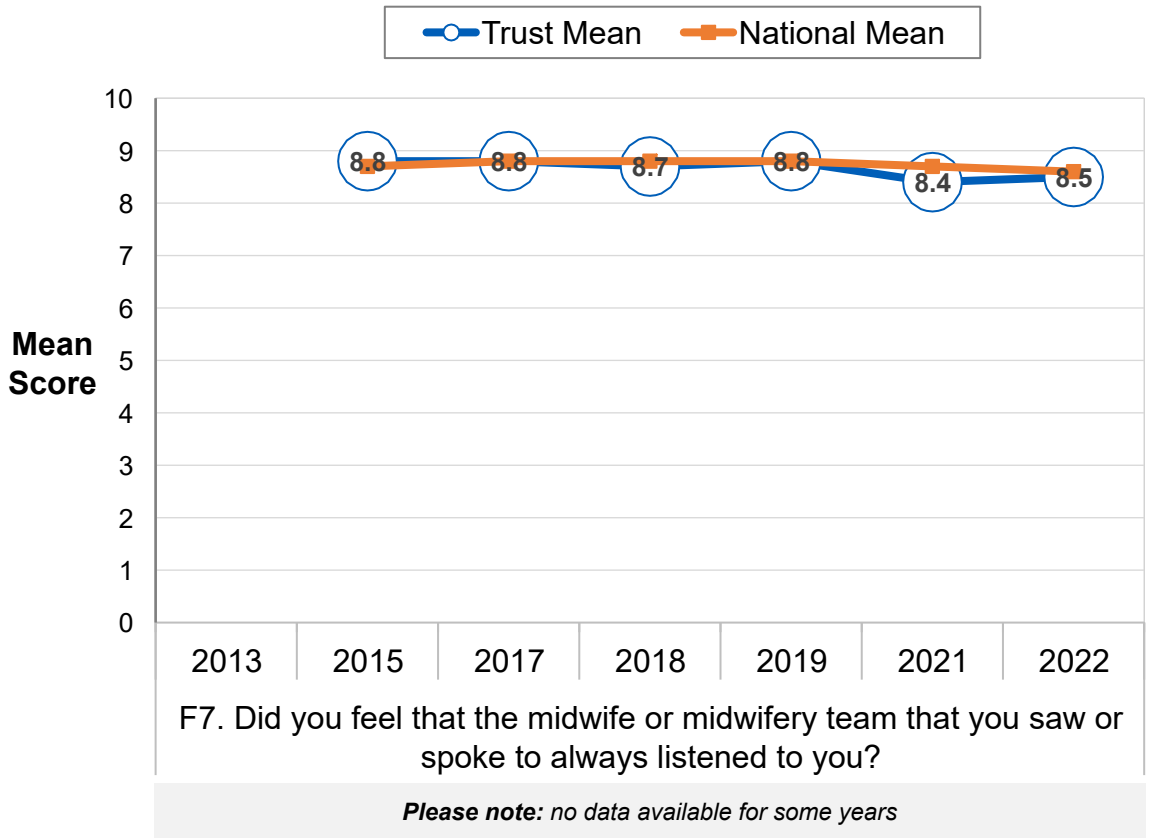
▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

Trends over time - Postnatal care

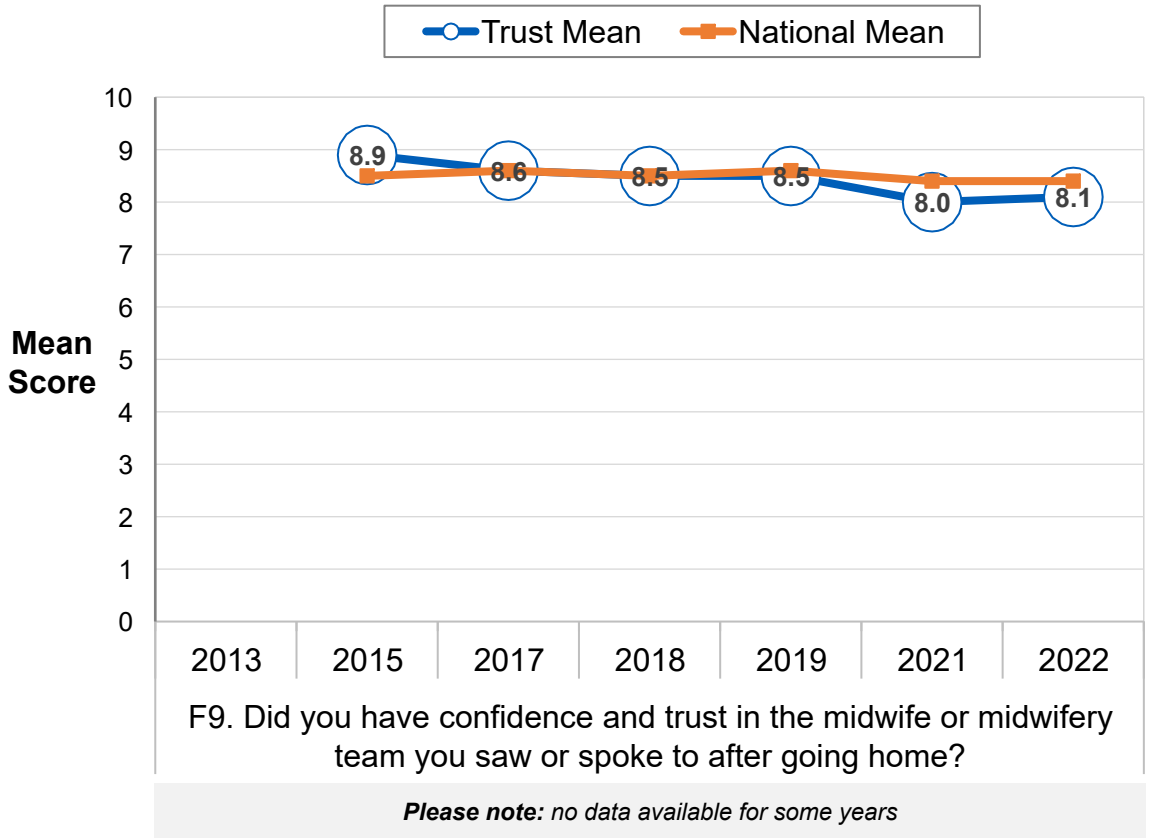
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care at home after the birth



F7. Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?

Please note: *no data available for some years*



F9. Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Postnatal care (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
Care at home after the birth											
F8.	Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?							8.2	8.2	216	
F11.	Did a midwife or health visitor ask you about your mental health?							9.5	9.8	230	
F12.	Were you given information about any changes you might experience to your mental health after having your baby?							7.3	7.2	232	

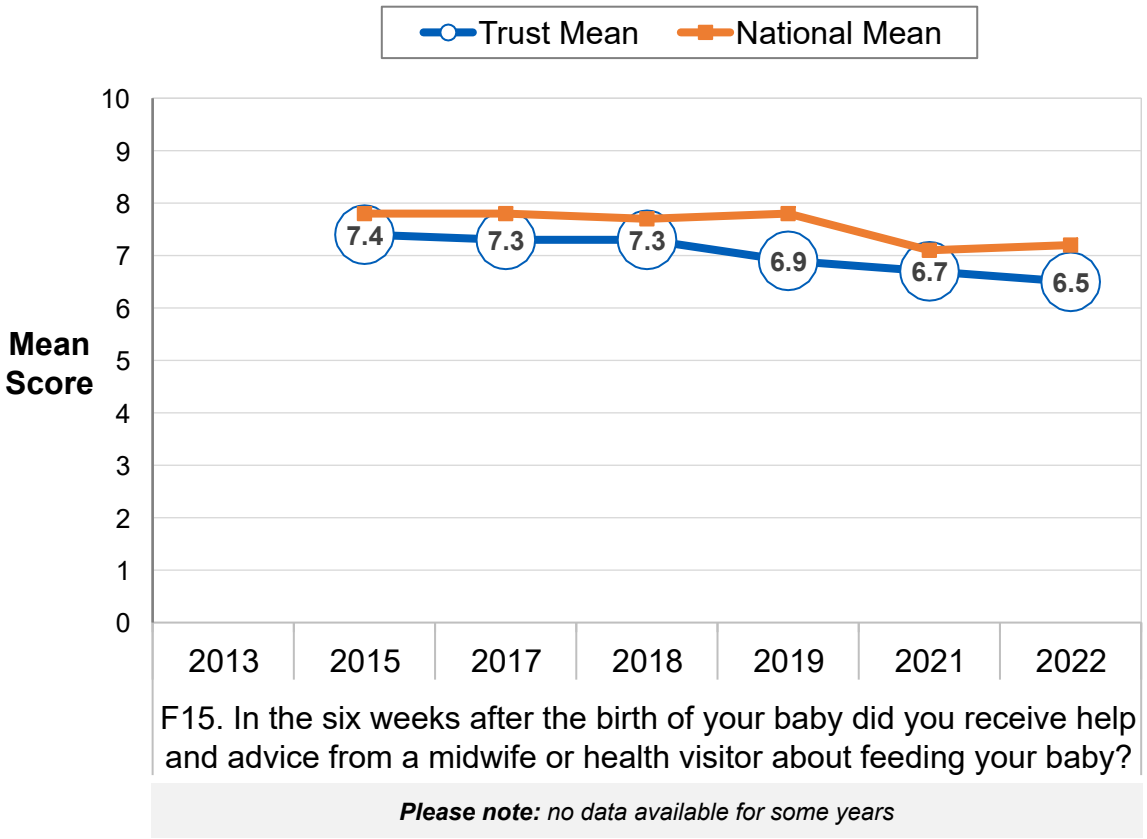
▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

Trends over time - Postnatal care

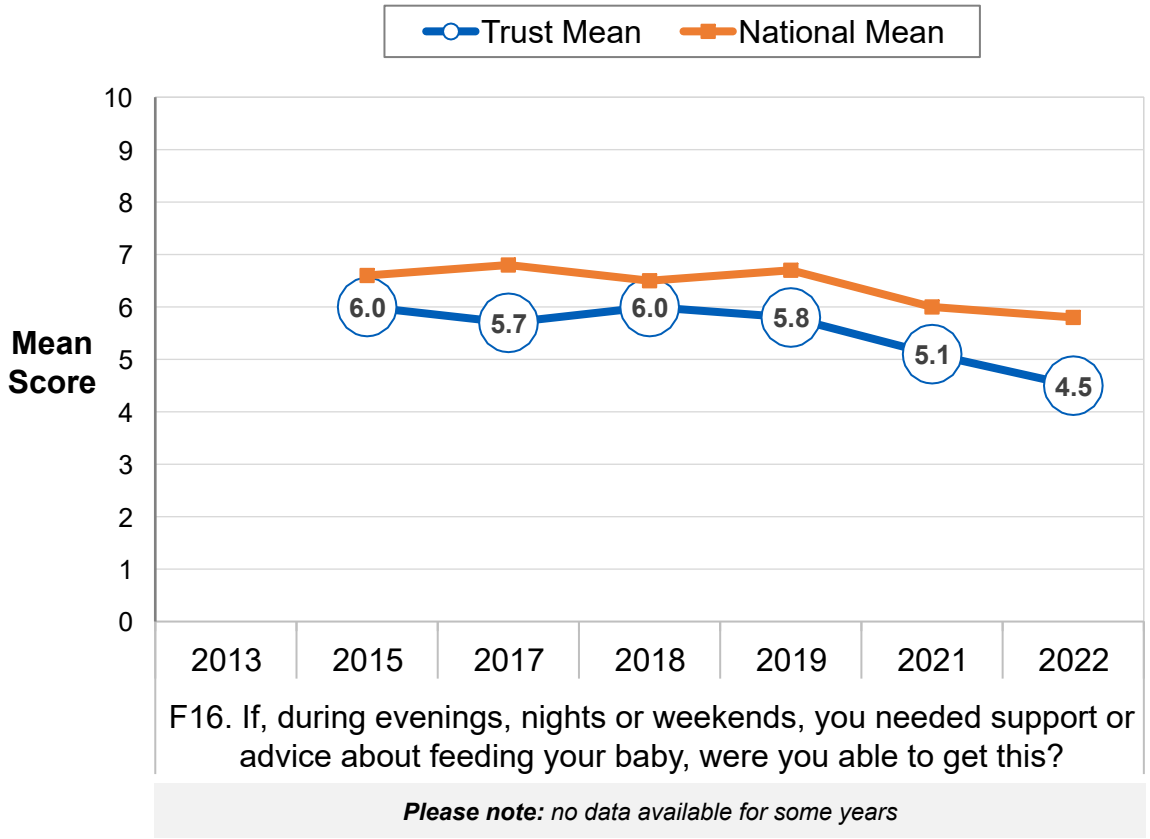
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care at home after the birth



F15. In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?

Please note: *no data available for some years*



F16. If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?

Please note: *no data available for some years*

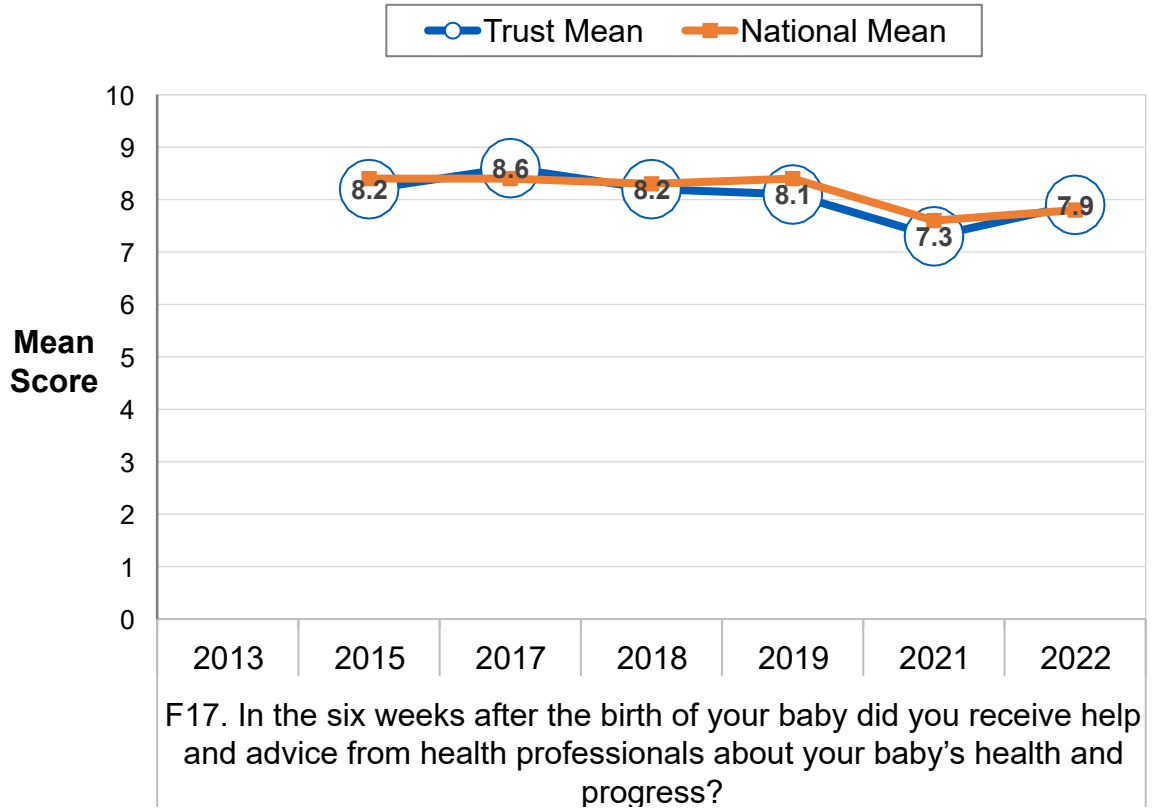
This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Postnatal care

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care at home after the birth



F17. In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Postnatal care (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
Care at home after the birth											
F13.	Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?							8.8	8.5	227	
F14.	Were you given information about your own physical recovery after the birth?							7.0	6.7	233	

▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

Appendix

Comparison to other trusts

The questions at which your trust has performed worse compared with most other trusts are listed below. The questions where your trust has performed about the same compared with most other trusts have not been listed.

Much worse than expected	Worse than expected
• Your trust has not performed “much worse than expected” for any questions.	• E2. Were your decisions about how you wanted to feed your baby respected by midwives? • E3. Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby? • F15. In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby? • F16. If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?

Comparison to other trusts

The questions at which your trust has performed somewhat better or worse compared with most other trusts are listed below. The questions where your trust has performed about the same compared with most other trusts have not been listed.

Somewhat worse than expected	Somewhat better than expected
• B5. At the start of your care in pregnancy, did you feel that you were given enough information about coronavirus restrictions and any implications for your maternity care?	• C4. Were you given enough information on induction before you were induced?

Comparison to other trusts

The questions at which your trust has performed better compared with most other trusts are listed below. The questions where your trust has performed about the same compared with most other trusts have not been listed.

Better than expected	Much better than expected
• C5. And before you were induced, were you given appropriate information and advice on the risks associated with an induced labour? • F13. Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	• Your trust has not performed “much better than expected” for any questions.

NHS Maternity Survey 2022

Results for East Kent Hospitals University NHS Foundation Trust

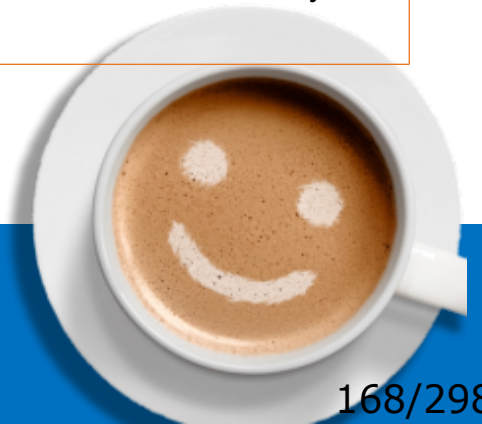
Where mothers' experience is best

- ✓ Mothers being given appropriate information and advice on the risks associated with an induced labour, before being induced.
- ✓ Mothers being given enough information on induction before being induced.
- ✓ Mothers being told who they could contact if they needed advice about any changes they might experience to their mental health after the birth.
- ✓ Mothers feeling they were given appropriate advice and support when they contacted a midwife or the hospital at the start of their labour.
- ✓ Mothers discharge from hospital not being delayed on the day they leave hospital.

Where mothers' experience could improve

- Partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in the hospital.
- Mothers being able to get support or advice about feeding their baby during evenings, nights, or weekends, if they needed this.
- During antenatal check-ups, mothers being given enough information from either a midwife or doctor to help decide where to have their baby.
- Mothers feeling that midwives and other health professionals gave them active support and encouragement about feeding their baby.
- At the start of their pregnancy, mothers being given enough information about coronavirus restrictions and any implications for their maternity care.

These questions are calculated by comparing your trust's results to the average of all trusts who took part in the survey. "Where mothers' experience is best": These are the five results for your trust that are highest compared with the average of all trusts who took part in the survey. "Where mothers' experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts who took part in the survey.



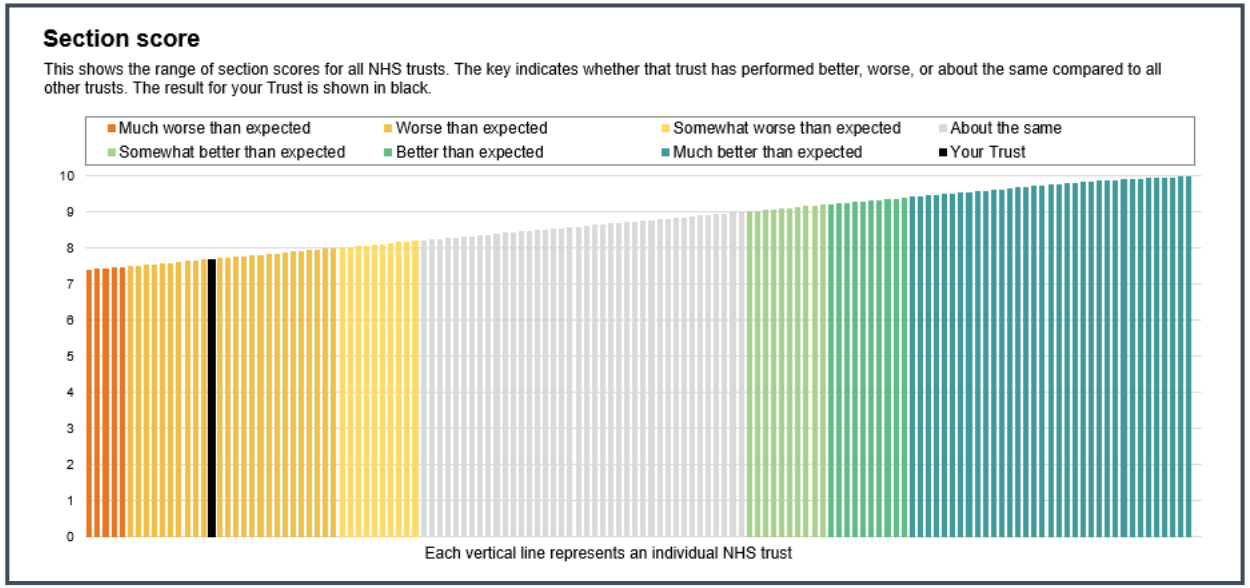
This survey looked at the experiences of individuals in maternity care who gave birth in February 2022 at East Kent Hospitals University NHS Foundation Trust. Between April 2022 and August 2022 a questionnaire was sent to 482 individuals. Responses were received from 245 individuals at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

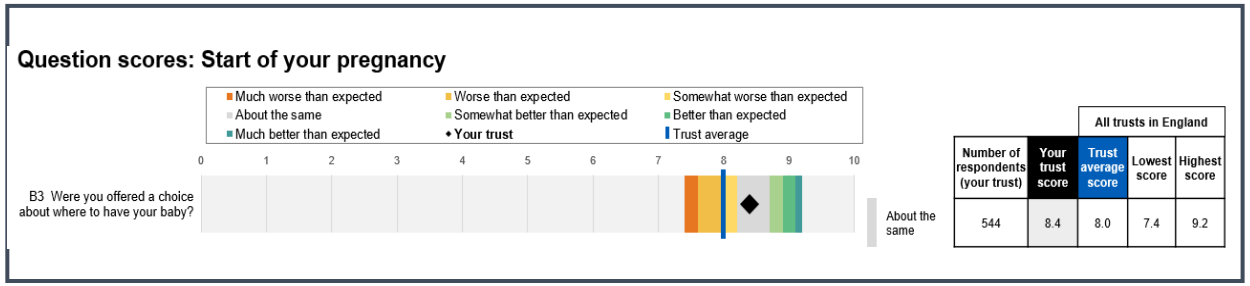
How to interpret benchmarking in this report

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange** section of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange** section of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.





How to interpret benchmarking in this report (continued)

The ‘much better than expected,’ ‘better than expected’, ‘somewhat better than expected’, ‘about the same’, ‘somewhat worse than expected’, ‘worse than expected’ and ‘much worse than expected’ categories are based on an analysis technique called the ‘expected range’. Expected range determines the range within which a trust’s score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust’s performance is ‘about the same’ as other trusts. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, the result is unlikely to have occurred by chance.

The question score charts show the trust scores compared to the minimum and maximum scores achieved by any trust. In some cases this minimum or maximum limit will mean that one or more of the bands are not visible – because the range of other bands is broad enough to include the highest or lowest score achieved by a trust this year. This could be because there were few respondents, meaning the confidence intervals around your data are slightly larger, or because there was limited variation between trusts for this question this year.

In some cases, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust. This occurs as the bandings are calculated through standard error rather than standard deviation. Standard error takes into account the number of responses achieved by a trust, and therefore the banding may differ for a trust with a low numbers of responses.

Please note, the benchmark bandings were updated for the 2021 survey to provide a greater level of granularity in the expected range score. The 2022 survey uses the same approach.

Additional information on the ‘expected range’ analysis technique can be found in the survey technical report on the NHS Surveys website.

An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the mother's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive patient experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of patient experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question B8 "During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?":

- The answer code "Yes, always" would be given a score of 10, as this refers to the most positive patient experience possible.
- The answer code "Yes, Sometimes" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer code "No" would be given a score of 0, as this response reflects considerable scope for improvement.
- The answer codes "Don't know / can't remember" would not be scored, as they do not have a clear bearing on the trust's performance in terms of the mother's experience.

Calculating the trust score for each question

The weighting mean score for each trust, for each question, is calculated by dividing the sum of the weighting scores for a question by the weighted sum of all eligible respondents to the question for each trust. Weighting is explained further in the quality and methodology report.

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

For further information

Please contact the Coordination Centre for Mixed Methods at Ipsos.

MaternityCoordination@ipsos.com

NHS
East Kent
Hospitals University
NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**PERINATAL QUALITY SURVEILLANCE TOOL (PQST) REPORT**
MEETING DATE:	**9 MARCH 2023**
BOARD SPONSOR:	**CHIEF NURSING AND MIDWIFERY OFFICER: EXECUTIVE MATERNITY AND NEONATAL BOARD SAFETY CHAMPION**
PAPER AUTHOR:	**INTERIM DIRECTOR OF MIDWIFERY IMPROVEMENT AND TRANSFORMATION MANAGER**
APPENDICES:	**APPENDIX I: PERINATAL QUALITY SURVEILLANCE TOOL**

Executive Summary:					
Action Required:	Decision	Approval	Information	**Assurance**	Discussion
Purpose of the Report:	• The purpose of this report is to assure the Board that maternity services are aligned to the key elements included within the perinatal quality assurance framework as defined by NHS England (NHSE). • This is in accordance with the standards set out in NHS Resolutions (NHSR) Maternity Incentive Scheme, Safety Action 9, which aims to continue to support the delivery of safer maternity care and Ockenden Report Recommendations. • Provide assurance that the service is using the tool and reporting to the required standard, as set out in the NHS Implementing a Revised Perinatal Quality Surveillance Model Report December 2020, NHS Resolutions Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4 - Safety Action Nine and Ockenden 1 Report Immediate and Essential Actions.				

Summary of Key Issues:	• The report confirms that the service is using the tool to the required standard, as set out in the NHS Implementing a Revised Perinatal Quality Surveillance Model Report December 2020.
	• The report includes the following key messages for the Board's attention:.
	• CNST declaration position was submitted as non-compliant against:
	  ○ Safety Action 1:PROMPT standard ai) and aii).
	  ○ Safety Action 8: PROMPT Anaesthetic team Training compliance is below the 90% required standard.
	• Ockenden Immediate and Essential Actions (IEA) compliance 98%. Personalised Care and Support Plan (PCSP) Pilot across 1 Ashford and 1 Thanet community team. Risk assessment for Physiological Fetal Monitoring has been approved following Local Maternity and Neonatal System (LMNS) CNST Evidence review but formal process to be agreed going forward.
	• **No Healthcare Safety Investigation Branch (HSIB) referrals for the 5th consecutive month.**
	• Supernumerary status of the co-ordinator was 100% at Queen Elizabeth the Queen Mother Hospital (QEQM) and 99% at William Harvey Hospital (WHH). This relates to 3 care episodes.
	• 1:1 care in labour- 2 patients recorded as not receiving 1:1 care. 1 at WHH and 1 at QEQM. Both were instrumental deliveries, however validation of records confirms that 1:1 care was provided in				

East Kent Hospitals University NHS Foundation Trust

	both cases. • There were 3 Serious Incidents (SIs). 2 at QEQM and 1 at WHH. • The Your Voice Is Heard recorded a response rate of 72.5% in January. Some additional work has been carried out looking at women from an ethnic minority background and index of multiple deprivation (IMD). • Friends and Family Test (FFT) 227/15.2% response rate with 92.9% extremely likely or likely to recommend which is an increase from 85.2% the previous month. 115 /79.4% positive comments. • **Training compliance was not above the 90% standard for Obstetric Doctors in Fetal Monitoring and PROMPT and for Obstetric Consultants in NLS.** • **Anaesthetic training compliance for PRactical Obstetric Multi-Professional Training (PROMPT) remains below the 90% standard**. • Feedback from Safety Champion Walkabouts raised ongoing concerns from staff around Obstetric and Midwifery staffing gaps, sickness and vacancies and use of on call MW to cover gaps. **Clarity and support to staff on sleeping at night guidance provided** and positive feedback around support offered by B7 midwives to junior Midwives on the WHH site.
Key Recommendation(s):	• The Board of Directors is invited to: 1. **DISCUSS** the contents of this report and; 2. **NOTE** the key risks**:** non-compliance with PROMPT, Newborn Life Support (NLS) and Foetal Heart Monitoring training for obstetric Doctors and PROMPT training for Anaesthetists. 3. Receive **ASSURANCE** and **NOTE** that a monthly perinatal quality assurance report has been received, demonstrating full compliance in line with CNST standard and Ockenden 1 report, Immediate and Essential Action requirements. 4. **APPROVAL** for the contents of this report to be shared through the Perinatal Quality Surveillance Model Framework with the LMNS, Region and Integrated Care Systems.

Implications:				
Links to 'We Care' Strategic Objectives:				
Women and Families	**Our people**	Our future	Our sustainability	**Our quality and safety**

Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.	
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.	
Resource:	N	
Legal and regulatory:	Y	NHSR, CNST, Ockenden 1.
Subsidiary:	N	

East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals Perinatal Quality Surveillance Reporting January 2023

Month: January 2023	**East Kent Hospitals Hospital NHS Trust Perinatal Quality Surveillance Reporting**

Care Quality Commission (CQC) Maternity Ratings

Overall	Safe	Effective	Caring	Well-led	Responsive
Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement

Maternity Safety Support Programme

Yes

Support Lead: Mai Buckley

Findings of review of cases eligible for referral to HSIB

No HSIB Referrals

The number of incidents logged graded as moderate or above and what actions are being taken.

There were 8 Moderate harm incidents reported and 3 SIs. The table below summarises the SIs

Site	Location	Category	Subcategory
QEQMH	Kingsgate ward (maternity)	Women's Health - unexpected problem/outcome for baby	Unanticipated admission to SCBU
WHH	Labour ward / delivery suite (WHH)	Women's Health - unexpected problem/outcome for baby	Neonatal death
QEQMH	Early pregnancy unit (QEQM)	Delay / failure	Failure - to act on abnormal test results

Themes from reviews of perinatal deaths

Themes

- The follow up care aligned to the bereavement pathway
- The use of interpreter services to support women

Actions

- Aligned to the overall improvement pathway for bereavement care. Recruitment to new posts in progress
- This is linked to wider work around how as a service interpreter are used. Head of Midwifery (HOM) at WHH has linked with the central team to improve this.

100% of perinatal mortality reviews include an external reviewer

Compliant in all cases

Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training.

Fetal Monitoring All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	211	228	92.5%
Midwife - Community	102	110	92.7%
Other Obstetric Doctor	32	36	88.9%
Obstetric Consultant	29	31	93.5%
Total	**374**	**405**	**92.3%**

Fetal Monitoring Mat Leave and LTS Removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	203	206	98.5%
Midwife - Community	94	95	98.9%
Other Obstetric Doctor	31	35	88.6%
Obstetric Consultant	29	31	93.5%
Total	**357**	**367**	**97.3%**

Training compliance was not above the 90% standard for Obstetric Doctors in Fetal Monitoring and PROMT and for Obstetric Consultants in NLS.

Anaesthetic training compliance for PROMT remains below the 90% standard.

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Prompt All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	199	227	87.7%
Midwife - Community	96	110	87.3%
Maternity Support Worker	71	79	89.9%
Obstetric Consultant	30	30	100.0%
Other Obstetric Doctor	29	34	85.3%
Total	**425**	**480**	**88.5%**

PROMPT Mat Leave and LTS Removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	193	205	94.1%
Midwife - Community	86	95	90.5%
Maternity Support Worker	67	71	94.4%
Obstetric Consultant	30	30	100.0%
Other Obstetric Doctor	29	33	87.9%
Total	**405**	**434**	**93.3%**

Anaesthetists Covering Maternity	Number requiring training	Number of staff trained	Percentage compliance by staff group
Anaesthetic Consultant	41	29	71%
All other Anaesthetic Doctors	35	18	51%

NLS All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	197	226	87.2%
Midwife - Community	99	111	89.2%
Obstetric Consultant	29	31	93.5%
Other Obstetric Doctor	29	34	85.3%
Total	**354**	**402**	**88.1%**

NLS Mat Leave and LTS removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	190	204	93.1%
Midwife - Community	89	96	92.7%
Obstetric Consultant	29	31	93.5%
Other Obstetric Doctor	29	33	87.9%
Total	**337**	**364**	**92.6%**

Minimum safe staffing in maternity services to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively

1 to 1 care in Labour (target 100%)

Month	QEQM	WHH
August	100%	100%
September	100%	100%
October	100%	100%
November	100%	100%
December	98.8%	100%
January	99.2%	99.6%
Total Average	99.8%	99.7%

Supernumerary Maintained (target 100%)

Month	QEQM	WHH
August	99.4%	96.5%
September	99.4%	95.7%
October	100%	96.5%

1:1 Care in Labour: 2 women not recorded as receiving 1:1 care – 1 at WHH and 1 at QEQM. Both instrumental deliveries. A review of the maternal records confirmed 1:1 care was provided

Supernumerary Status: WHH 99% -3 episodes where not maintained. 100% at QEQM

Midwifery
QEQM

Demands
Registered 69.25% WTE Availability 50.07% WTE Difference 19.8 WTE

Unavailability 34.6% AL 16.5% Sickness 7.7% Working 1.8%
Study Leave 6.1% other 2.3%

Vacancy
Band 7: 1 WTE , On TRAC for interview
Band 6 : 4.87 WTE,
Band 5: 4.47 WTE over established
Band 3 full 0.2 WTE vacancy, have appointed 2 WTE (recovering posts for band 3 doing the NA course)

Obstetric
QEQM
No incidents of non-attendance escalated.
Consultant rota:
2 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)

1 full time equivalent vacancies in recruitment. Two posts going back out as locum posts until Royal College of Obstetricians and Gynaecologists (RCOG) approval of them as substantive posts.
2 locum agency consultants providing cover. Two agency consultants left in February.
Registrar rota:
Recruited into all posts. One has started (not yet assessed as able to do nights independently) but awaiting a visa for our other post. 1 registrar remains off after surgery hopefully back in March.

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November	100%	97.5%
December	100%	99%
January	99%	97.9%
Total Average	99.5%	96.3%

Band 2 0.11 WTE Vacancy
Band 2admin 2.05 WTE vacancy
Band Equipment role on TRAC

WHH

Budgeted Registered: 95.00 WTE Staff contracted 73.99 WTE

Unavailability:

AL 14.35% Sickness 11.3% Study leave 3.2% parental leave/mat leave 8.9% other leave 0.5% : **Total 42.4%**

Vacancy
Band 7: 3.43WTE - however, job out to advert, 1 x 0.9 WTE starting early March
Band 6 : 14.64 WTE
Band 5: 2.94 WTE
Band 3 : Fully established
Band 2: 4.84 WTE going through recruitment now, numbers should improve. We lost several due to starting midwifery course at Greenwich
Band 2 Clerical 4.44 Interviews 27/1/2023 2 WTE appointed

Made an offer to replace a registrar who is leaving in April.
One registrar going on maternity leave at the end of April.
Senior House Officer (SHO) rota: fully covered

WHH
No incidents of non-attendance escalated.
Consultant rota:
2 substantive consultants not doing full on call duties due to OH recommendations
2 x consultant post recruited. One due to commence in post April 23 and other post out to advert closing end of March
Registrar rota:
2 middle grade gaps. 1 stepped up to locum consultant and 1 post out to advert. Unfortunately several applicants withdraw from post during previous advertisements. Interview date for 13 March 2023, but may change due to strike.
SHO rota:
1 SHO rotational GPST gap

From February there is a new RCOG national requirement for all short-term locums to have a Certificate of eligibility to work. We anticipate this will make it harder to employ agency locums to support our rota. We have applied for an increase in reg internal locum rate to try and help mitigate this.

FFT Feedback

FFT Main Themes January 2023 (collated on 1/2/23)	Actions
227 responses which is a 15.2% response rate with 92.9% extremely likely or likely to recommend which is an increase from 85.2% the previous month. 145 comments in total, 115 positive comments-79.4% Positive experiences and Named staff in comments- 29 members of staff named Good comments for Hearing screening feedback to them.	Reported back to staff via personalised email and new posters on the wards, hard to define good care Hearing screening manager is aware of the results
Postnatal care and lack or delay in care/medications or discharge- Reoccurring theme.	Essential round started in October and positive comments increasing. A robust review of the discharge processes has been completed and this has highlighted a number of actions that are required to improve
Birth Partners not considered during stay- lack of provision of food/ drink and blankets, uncomfortable chairs to stay on in labour ward and Postnatal ward (majority at QEQM).	The food and drink for partners is currently costed. Chair research is still being done by procurement and the a trial event will be organised
Short/ Under staffed on labour ward and postnatal ward- mentioned that night has less staff than day	This is known to be bigger issue at WHH where the vacancy rate is higher. Linked to a wider staffing plan
Rushed discharge information	There has been a group set up to look at the discharge process and information in this to see how we can improve this area. Key areas have been identified where improvement required
Unsuitable Postnatal facilities- ward: Cramped ward Hard to sleep- too noisy due to staff/other patients and visitors Lights on at night on the ward Toilets not suitable for post caesarean section	Estate plans to be approved but some of this are issue due to the age of the building.
Improve communications and listening about choice of births around IOL	To feed back to the obstetric leads. IOL guidance currently being reviewed by obstetric leads and this includes update of information for women

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Lack of Breastfeeding support from the non-specialist's staff	Will feedback to the Matrons and ward managers to talk to all staff about breastfeeding support Review training of staff on ward by infant feeding leads
Delay in pain relief in labour	Midwives are reminded to offer pain relief throughout the induction process and through birthing plans on the options available to women and their preferred choice. A poster has been developed with quotes from your voice is heard as a reminder to midwives to help promote pain relief options for women. The poster has been placed in all staff areas. Essential rounding continues and is beginning to improve the situation.

Service user feedback

Service User Feedback Themes	Actions
Your Voice is Heard – January	Patient experience midwives are looking at feedback from these conversations and see if themes are re-occurring and how to improve these themes
• The Your Voice Is Heard team recorded a response rate of 72.5% in January. Some additional work has been carried out looking at women from an ethnic minority background and IMD (index of multiple deprivation) representation in the responses received. In January, we spoke to 71.6% of our White British population, 70% of women from an Asian background, 72.7% of Black African, Caribbean and Black British women, 88.8% of women from 'any other ethnic group' and 100% of women with a mixed or multiple ethnicity that accessed our maternity services. • IMD response rate – This month we noted that our lowest response rate was from women in level 3 at 61.7% (29 answered out of a possible 47). Our highest response rate of answered calls remains from families in Level 10 at 85.7% (6 out of a possible 7). Overall however, our highest number of responses was from women in level 2 with 61 out of a possible 83 women answering = 73.4%. • 239 compliment emails sent to staff members	January is themed but the collating the numbers and trends are in progress with a system being looked at to see if this works. There have been more compliments sent to staff this month but also more formal complaints than December. The themes for January will be discussed in the 1 March 2023 meeting. When the Band 4s have been hired to run this service, the PEM will be able to go to the IMD areas that have the lowest response rates to gather feedback from those areas that YVIH has been unable to reach.
8 formal complaints sent by Post Event Messaging (PEM) on behalf of families in January	PEM continue to report complaints either by Patient Advice and Liaison Service (PALS) or formal complaints team
Similar themes as the previous months: • More comfortable chairs for partners more at QEQM than WHH, some positive comments about the chairs at WHH • Food and drinks for partners Lack of pillows and blankets for partners	PEM are still in discussion with procurement scoping out the size of the available space at QEQM and which chairs would be suitable for the space and then to organise an event for families to try them and be involved in choosing the chairs. Emails have been sent to Heads of Midwifery (HoMs) and Matrons of each site to ask how many snack boxes they think would need for the ward and we will get costing for this and report back to HoMs.
Lack of Analgesia, catheter care, bedding being changed and water offered on PN wards	Essential rounding is still occurring but is not consistent. Drug rounds have now been commenced on the ward and an extra drugs trolleys order has been submitted to procurement. We are hoping this will make the drug rounds easier for the staff.
Lack of Analgesia in Induction of Labour (IOL) and labour	This is being discussed and followed up with the pain management group on a monthly basis on how we can assess our birthing parents pain score.
Postnatal wards lots of comments about the environment of the postnatal wards, extreme temperature fluctuation, cramped rooms, not fit for purpose toilets at the QEQM site	Limitations due to the estates that PEM have put forward some suggestions from the YVIH calls about the estates.

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Maternity Voice Partnership – feedback gathered via survey on social media about postnatal care. Feedback ranges from years 2015-2022		
26 positive comments / 40 negative comments 39% positive experience 61% negative experience No wash 54% Yes Wash 46% No Food 59% Yes Food 41%	2015 – 1 comment 2016 – 2 comments 2017 – 3 comments 2018 – 5 comments 2019 – 5 comments 2020 – 8 comments 2021 – 22 comments 2022 – 24 comments	• Feedback has been sent to HoM's and Matrons for comment. Themes generally the same as feedback we receive now. • Essential rounding in place on PN ward since Oct 2022 to address issues although apparently not consistent among staff.

Number of Complaints

Site	Ward	Complaint subject	Complaint subject
WHH	FOLKESTONE WARD	Nursing care	Delay in receiving treatment
WHH	OTHER	Delays	Delays in receiving treatment
WHH	LABOUR WARD	Communication	Doctor communication issues
WHH	FOLKESTONE WARD	Communication	Doctor communication issues
WHH	FOLKESTONE WARD	Discharge arrangements	Lack of information given upon discharge
WHH	LABOUR WARD	Privacy and dignity issues	Personal hygiene
QEQM	LABOUR WARD (MUMS)	Attitude	Problems with doctor's attitude
WHH	FOLKESTONE WARD	Nursing care	Problems with Nursing Care
QEQM	LABOUR WARD (MUMS)	Nursing care	Problems with Nursing Care
WHH	LABOUR WARD	Nursing care	Problems with Nursing Care

Number of PALS

Site	Location	Synopsis	Subject	Sub Subject
KCH	OFFICK	Client has been in contact to advise that patient has suffered a miscarriage and wants staff to cancel any future appointments.	ENQUIR	ENQUIR
KCH	OFFICK	patient missed the deadline for tests in first trimester and is concerned regarding tests for downs syndrome and other family disabilities	NURS	DELATM
QEQMH	MDCUQE	Client was upset that someone could her hear her conversation she had to the Maternity 24/7 Triage Team .	CONFID	CONFID
BHD	USSB	Patient would like a copy of Ultrasound report	HRECO	COPY
QEQMH	USSQE	Patient emailed following ultrasound scan with concerns on how was treated and lack of empathy from sonographer or information.	ATTIT	STAATT
WHH	OFFICW	Email to PALS, Not a concern, the staff at hospital acted quickly and professionally. I was wondering if could have some sort of debrief about the birth, which was very quick, as there was mention of placental abruption/ unbalanced pH levels by the consultant, in case it affects any future pregnancies.	ENQUIR	ENQUIR
WHH	OFFICW	Client would like to know if she was included in the Kirkup report.	ENQUIR	ENQUIR
KCH	MDCUKC	The Client not happy with treatment in Maternity received.	NURS	NURSIN
WHH	MDCUWH	Client is concerned that they are at risk from DVT and has obstetric cholestasis. Client advised that they should be having a c-section, but this has now been moved back a week, despite the high risk factors.	CONCCM	UNHTMT

Listening to women engagement activities and evidence of co-production

- Personalised Care and Support Plan workstream
- Ockenden Peer Review
- Perinatal Equity Strategy

Staff feedback from frontline safety

champions and walk-abouts	**Theme from walkabouts across all sites (**WHH and QEQM) 1. Ongoing concerns over how the Midwifery on calls are being used as an automatic default position to address staffing gaps. 2. From the obstetric side, we have ongoing challenges on both sites due to rota gaps created by sick leave and vacancies 3. Responding to concerns raised around dissemination of information to Obstetric teams. 4. Concerns raised with Board Safety Champion re sleeping on night shift guidance, staff seeking clarity on what is acceptable. Staff on QEQM site emotional following CQC feedback, additional support provided. 5. WHH junior midwives describe feeling more supported by Band 7 midwives when on shift, however concerns remain re staffing levels. **Actions** 1. To address this we have established a working group, with staff, HR and RCM representation to identify solutions to ensuring a more equitable and appropriate approach. We have also asked that recruitment/HR support us with a more targeted approach for recruitment, including our social media presence. 2. See Obstetric workforce 3. The restructuring of the Friday afternoon meetings is now in its 2nd month. This has improved the dissemination of information related to our risk register, complaint themes and your voices heard feedback 4. Staff on QEQM site emotional following CQC feedback, additional support provided.
HSIB/NHSR/CQC or other organisation with a concern or request for action made direct to the Trust	Unannounced CQC visit and urgent safety actions applied following immediate feedback from the CQC team. The main areas were: • Fire safety • Infection and Prevention Control • Fetal heart monitoring – fresh eyes • Process impacting on wait times in triage at WHH
Coroner Reg 28 made directly to the Trust	NA

Progress in achievement of CNST 10 Safety Standards

	Safety Action	Rational for Red/Green status	BRAG status (not due to deliver until 30 June 2022)
1.	Use of the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard	**Standard ai) has not been met** All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards have been notified to MBRRACE-UK within seven working days **BUT** the surveillance information has not been completed, using the tool, within one month of the death for 3 cases. The reports had been completed but not closed within the time period. It is acceptable for the surveillance to be closed and reopened when waiting for information but this was not understood by the lead new in post at that time. There was no impact to patient or families but learning has been shared and embedded within the team. Mitigations have been put in place. The PMRT Lead MW role is to be appointed to and a Maternity Warning and Control System (MWACS) PMRT Patient tracking list is being developed. **Standard aii) has also not been met** for 3 cases- resulting in 87% compliance against required 95% Standard. The perinatal mortality review tool is used to review the care and draft reports are generated via the PMRT but for the three cases noted, the review had been completed but recorded outside of the tool. There was no impact to patient or families but learning has been shared and embedded within the team **Quarter 3 report submitted to MNAG and compliance across this met for this reporting period**	**Not Met**
2.	Submitting data to the Maternity Services Data Set to the required standard	This Safety Action is made up of 7 standards and the Trust is compliant in all standards Standard 1-Digital Strategy is in place following internal and external governance sign off July Scorecard shows us meeting 11/11 data quality standards and all other standard have been passed.	**Met**
3.	Demonstrating transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme	All standards met Data collated by the Kent Surrey and Sussex Neonatal Operational Delivery Network (ODN) shows that in the William Harvey Hospital the percentage of term babies admitted to the neonatal unit is 3% and the Queen Elizabeth Queen Mother Hospital is 3.6% both which are below the nationally agreed threshold of 5%. Weekly ATAIN reviews take place with a multi-professional maternity and neonatal team. Learning and themes are generated including details of babies that could have been cared for in a Transitional Care setting if the service was developed further, for example to include tube feeding. Learning posters are shared by leads. The ATAIN action plan	**Met**

	and evidence of how themes are being acted upon are included in the quarterly report to the Maternity and Neonatal Assurance Group. The Trust Transitional Care Policy which has been endorsed by the Director of Midwifery, obstetric labour ward leads and the neonatal leads, and is based on the British Association of Perinatal Medicine principles. Avoiding Term Admissions into Neonatal Units (ATAIN) data transitional care reviews and related audits have been presented quarterly to the Trust Maternity and Neonatal Assurance Group and LMNS Quality Assurance Group (QAG) meetings, along with the progress with the associated action plans. The audit also now includes babies transferred as well as admitted to the NNU for example babies who require observations or review.	
4. Demonstrating an effective system of clinical* workforce planning to the required standard	Trust Board papers demonstrate that the Board have been provided with reports regarding engagement with the RCOG document (by 16 June 2022) along with an action plan to review any non-attendance to the clinical situations listed in the RCOG document. This was also presented to the Kent and Medway Local Maternity System (LMNS) Quality Assurance Group in December as required for this safety action. The Trust continues to evidence the compliance of consultant attendance for clinical situations to Trust Board, Trust Board level safety champions through Perinatal Quality Surveillance Tool reporting each month, with monitoring through tracking of Datix reports to which an addition section has been added. A new workflow has been developed on Euroking (maternity information system) to capture compliance and support ongoing audit. Implementation by the supplier is awaited. One episode of non-attendance occurred in October 2022. The consultant was on site and in the consultant office, but poor mobile phone signal affected the call getting through. An action plan is now in place which was presented to December Trust Board. The neonatal clinical reference group nursing workforce calculator has been completed and continues to show gaps in nursing staff. Progress has been made against the action plan that was developed as part of the Maternity Incentive Scheme in year 3 but the completion of the neonatal clinical reference group nursing workforce calculator has shown that there continue to be gaps in the nursing workforce. A refreshed action plan was presented to the Trust's Maternity and neonatal Assurance Group in October 2022. Anaesthetic medical workforce rota evidences compliance with ACSA standard 1.7.2.1. Neonatal medical workforce meets the recommendations of the neonatal medical workforce.	**Met**
5. Demonstrating an effective system of midwifery workforce planning to the required standard?	Midwifery recruitment continues to work towards achieving full establishment which will further support the labour ward coordinators to always remain supernumerary. A full BirthRate Plus midwifery workforce assessment will be completed in 2023 across all maternity services in Kent and Medway, funded by the LMNS. Overall compliance of labour ward coordinator supernumerary status is 97%. The Director of Midwifery conducted a deep dive which confirmed that this was not a regular occurrence and was attributed to incidences where the labour ward coordinator was overseeing women at the start of their induction of labour process during periods of high activity and acuity. Clarification of what it means for the labour ward coordinator to be supernumerary shared with the individuals who undertake the role, and a new bed state form has been introduced that supports real time recording of occasions where the supernumerary status is not maintained. Previous NHSR guidance from October 2022 required 100% compliance with supernumerary status of the labour ward coordinator. The new guidance published by NHSR on 1st December 2022 accepts the unpredictability of the labour ward environment and values professional judgement in challenging and unpredictable situations regarding supernumerary status of the coordinator. This, together with the findings of the deep dive, allows for compliance with this element to be declared. 1:1 care in labour is 99.8% average since May and an action plan is in place to meet 100% compliance. Biannual Midwifery workforce papers are submitted to Trust Board.	**Met**

	6. Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2	A quarterly report including all risks, mitigating actions and escalations is included in February Maternity and Neonatal Assurance Group (MNAG) Reporting.		**Met**

Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

5 Elements of SBLCBV2	**RAG**	Risks
ELEMENT 1: Reducing smoking in pregnancy		CO monitoring-Booking 96.2%, 36 weeks 76% in January Note: The Trust board should receive data from the organisation's Maternity Information System (MIS) evidencing an average of 80% compliance over a four-month period. Compliance for asking women if they smoke at booking 4-month average is 94%. Action plan is in place to achieve over 95% and was appended to Board papers as part of SBLCBv2 reporting in May and November 2022. Compliance for asking women if they smoke at 36 weeks is 4-month average is 80.7%. Action plan is in place to achieve over 95% and was appended to Board papers as part of SBLCBv2 reporting in May and November 2022. January CO Monitoring has dropped below 80% standard. A review of cases were not performed shows the following themes that Matrons are now working with teams to better understand • 13 are around virtual appointment • 40 around straws • 26 around machine/no equipment. • 63 The majority have no reason given for not performing and Matrons are working with teams to clarify understanding as there are some recorded as not taken as non-smoker and not required.
ELEMENT 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction		20-week risk assessment is not electronically captured but the Fetal Growth Guideline has been updated to describe how women with significant bleeding after booking, echogenic bowel or EFW <10th centile are triaged to the appropriate pathway described in fig. 6 of appendix D in SBLCBv2. Guideline has been updated and ratified and audit of 40 cases to be completed showing compliance with identifying and appropriately referring following booking.
ELEMENT 3: Raising awareness of reduced fetal movement		Compliance 94.7% (requirement 80%) for women attending with reduced Fetal Movements having Computerised CTGs and 87.3% receive Reduced Fetal Movements Information Leaflet. Action plan in place to achieve over 95%

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	ELEMENT 4: Effective fetal monitoring during labour		Position end December 2022 Role Type / Compliant / Total Staff / Compliance % Midwife - Acute 207 218 95.0% Midwife - Community 74 75 98.7% Obstetric Consultant 30 30 100.0% Other Obstetric Doctor 27 27 100.0% Maternity Support Worker 0 0 NaN Unknown 0 0 NaN **Total 338 350 96.6%**	
	ELEMENT 5: Reducing preterm births		Not meeting Steroid and Magnesium Sulphate standards but will not result in failure of this standard-action plan in place Action plan and Mat Neo Quality Improvement work in progress to support. Risk assessment and management in multiple pregnancy complies with NICE guidance-guideline updated and going through guideline group 2 December to be ratified.	
7. Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local services			The MVP Chair was present at the LMNS assurance visit and confirmed verbally that they feel the MVP is embedded in the work of the department. MVP terms of reference are agreed across Kent and Medway and meet the principles required by Better Births and processes for remuneration are set out. The MVP annual work plan was ratified at the LMNS Executive Board meeting in November 2022. The MVP chair is an active member of the Maternity and Neonatal Assurance Group. They have co-produced the Trusts Maternity strategy amongst other projects and have regular contact with the Director of Midwifery where they feel they can raise any concerns or feedback in a constructive way. The MVP chair has set up meetings with the patient experience midwives to review feedback themes from MVP activity and the 'Your Voice is Heard' programme, and to support the triangulation of information and progress with resulting actions.	**Met**
8. a. Evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? b. In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, Multiprofessional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4			**Not achieved** Compliance with PROMPT (Practical Obstetric Multi-Professional Training) for the anaesthetists is below 90% and will not meet the compliance threshold by the end of the scheme reporting period. The Trust do not have a dedicated anaesthetic roster for maternity meaning that all 74 anaesthetists are required to attend PROMPT training. The Maternity team have now secured training space available on both hospital sites meaning that PROMPT can be delivered on both sites. The Trust team believe that this will improve compliance for both staff groups in 2023/2024. Current compliance rates have also been shared with the LMNS Training Assurance Group. The LMNS have reviewed the local maternity training plan which contains the six core modules of the core competency framework. Training compliance will continue to be monitored through this process.	**Not Met**
9. Demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues			The Board has received evidence of a revised pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other b) the Board c) new LMNS/ICS quality group, and	**Met**

		d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model. Evidence of compliance includes, pathways for sharing safety intelligence flow chart, Maternity Champions Standard Operating Procedure, and poster and Maternity and Neonatal assurance Group papers. Staff feedback themes from Board and frontline safety champion walkabouts have been shared with the Kent and Medway Local Maternity System. The perinatal Optimisation Workstream leads on work aligned to the MatNeoSip Drivers.	
	10. Reporting 100% of qualifying 2019/20 incidents under NHS Resolution Early Notification scheme	New reporting process in place from 1 April requiring cases to be referred through the Trust Legal Team to NHSR. Maternity will continue to also refer all relevant cases to HSIB. Process agreed to ensure reporting with Legal and Maternity Teams. NHSR Webinar attended. 8 cases were reported to NHSRs Early Notification Scheme, two of which have been rejected and families are being directly communicated with via the Early Notification Scheme NHSR Team The information shared with the families includes content on the role of HSIB and the EN scheme and this supports compliance with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour. Duty of candour is undertaken in line with guidance and is conducted by a senior and experienced member of the team. As a result of the Independent Investigation into East Kent Maternity Services (IIEKMS) and publication of “Reading the Signals” the Trust developed a process through which independent case reviews can be undertaken for families who approach the Trust. For families who have been part of the IIEKMS an agreement has been reached for the Kirkup disclosure letter to be shared with the Trust to ensure that the families experience is more streamlined and effective. If, through the case review process, further investigation or reporting is indicated, this will be completed.	**Met**

Proportion of midwives responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	No new reports
Proportion of specialty trainees in obstetrics and gynaecology responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	No new reports
Outstanding Ockenden recommendations	98% compliant We have 3 outstanding actions which are all around Personalised Care and Support Plans-these have been coproduced across the LMNS and a 3 month pilot is being planned currently

IEA No:	Phase 2 score	Current compliance following LMNS Peer review 2022	Areas now compliant since Phase 2	Outstanding Actions
1: Enhanced Safety	81%	100%	PMRT Audit and 100% compliance in external reviewer and parent notified. PQST structures are now in place	All actions closed
2: Listening to Women and Families	88%	100%	Q13.1, Q15.1 Coproduction plan developed and approved.	All actions complete and closed
3: Staff Training and Working Together	72%	100%	LMNS SOP in place TNA Approved at Trust Level Q17.2 and Q23.2 LMS reports showing regular review of training data (	All actions Closed

			Q21.3 LMS reports showing regular review of training data	
4: Managing Complex Pregnancy	86%	100%	Q29.1 Agreed MM Pathways Q29.2 Criteria for referrals to MMC	All actions closed
5: Risk Assessment Throughout Pregnancy	73%	83%	Definition of antenatal risk assessment as per NICE guidance in place	Q30.2, Q31.3, Q33.3 Personalised Care and Support plans are not in place-LMNS Coproduction of draft PCSP has completed and once delivered to sites, a 3 month pilot is to launch in January 2023. Pilot sites identified as WHH Ashford Community and Thanet Teams due to them being the areas of highest deprivation.
6: Monitoring Fetal Wellbeing	67%	100%	Fetal monitoring leads involved in adverse outcome reviews, run regular sessions and raise the profile of fetal wellbeing monitoring now evidenced TNA Trust Level sign off	Fully implemented
7: Informed Consent	50%	100%	Gap analysis has been completed and plan to improve in place Q43.1 Coproduction Plans-Coproduction plan in place and evidence of embedding peer reviewed and approved Q41.1 Women must be enabled to participate equally in all decision-making processes. An audit of 1% of notes demonstrating compliance. Q42.1 An audit of 5% of notes [or a total of 150 which is ever the least from January 2021] demonstrating compliance	07.09.22 Presented audit findings supported by YVIH findings and next step actions in a narrative paper to LMNS Peer Review Panel. After much discussion it was agreed that the action had been met in terms of an audit taking place but that the audit alone did not demonstrate that there was compliance against the actual recommendation. It was agreed that the action could be approved as met but as a system there would be an agreed approach to take forward this work supported by existing workstreams i.e. PCSP
Workforce	70%	100%	Q49.2 Evidence of risk assessment where NICE guidance is not implemented. Risk assessments submitted and waiting to go through peer review at next meeting	Risk assessment approved by the LMNS Following CNST assurance visit. This is only in an email currently but there is a plan to develop a SOP and take through QAG as a formal approval process.
Total	73%	98%		

Glossary

CCG: Care Quality Commission

CNST: Clinical Negligence Scheme for Trusts. An insurance scheme whereby NHS organisations pay an annual premium to mitigate against the cost of clinical negligence claims

CNST: Maternity Incentive Scheme. Aims to support the delivery of safer maternity care through an incentive element to trusts CNST insurance contributions. The maternity pricing is inflated by 10% which trusts are incentivised to recover through the delivery of 10 safety actions.

DATIX: The trusts incident reporting system

ENS: Early Notification Scheme. FFT-Friends and Family Test. A quick anonymous survey for service users to give views after receiving care or treatment and for staff to feedback on whether they would recommend as a place to work or receive treatment.

HSIB: Healthcare Safety Investigation Branch. Independent investigation body tasked with carrying out investigations and reporting using a standardised approach without attributing blame or liability

IEA: Immediate and Essential Actions (in relation to the Ockenden Report Recommendations December 2020)

Kleihhauer test: A test performed to understand if there is any fetal blood in the maternal circulation on Rh-negative mothers. The test should be done and any subsequent Anti D immunoglobulin administered within 72 hours of delivery, sensitising event (i.e. abdominal trauma) or invasive procedure.

MIS: Maternity Information System. At East Kent we use Euroking as our MIS provider

MNAG: Maternity and Neonatal Assurance Group. Governance reporting forum.

MSDS: Maternity Services Data Sets. A patient level data set that captures information about activity carried out by Maternity Services relating to mother and baby(s), from the point of the first booking appointment until discharge from maternity services

MVP: Maternity Voices Partnership. A team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.

NLS: Neonatal Life Support Training

NHSR: NHR Resolution

Partogram: A tool used to monitor labour and prevent prolonged and obstructed labour focusing on observations related to maternal, fetal condition and labour progress.

PMRT: Perinatal Mortality Review Tool. Aims to support a standardised process of perinatal mortality reviews, learning reporting and actions to improve care across NHS maternity and neonatal units.

PROMPT: Practical Obstetric Multi-Professional Training. Covers the management of a range of obstetric emergency situations

SBLCBv2: Saving Babies Lives Care Bundle Version 2. A care bundle for reducing perinatal mortality

Uterine artery Doppler screening: An ultrasound scan that uses waveform analysis in the second trimester of pregnancy as **a predictive marker for** the later development of preeclampsia and fetal growth restriction.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) MATERNITY INCENTIVE SCHEME YEAR 4 SAFETY ACTION 3: TRANSITIONAL CARE (TC) SERVICES TO MINIMISE SEPARATION OF MOTHERS AND BABIES AND TO SUPPORT THE RECOMMENDATIONS MADE IN THE AVOIDING LONG TERM ADMISSIONS INTO NEONATAL UNITS (ATAIN) PROGRAMME QUARTER 2 2022/23 REPORT**
MEETING DATE:	**9 MARCH 2023**
BOARD SPONSOR:	**CHIEF NURSING AND MIDWIFERY OFFICER: EXECUTIVE BOARD MATERNIY SAFETY CHAMPION**
PAPER AUTHOR:	**IMPROVEMENT AND TRANSFORMATION MANAGER**
APPENDICES:	**APPENDIX 1: TC AND ATAIN ACTION PLAN**

Executive Summary:

Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion

Purpose of the Report:	• The purpose of this report is to update the Trust Board on East Kent Maternity's progress in implementing Safety Action 3 and provide a quarter 2 2022/23 update on the audits required against the standards. • Raise awareness of risks in achieving CNST Standards and actions developed in response to case reviews and the action plans in place to improve (see Appendix 1: ATAIN and Transitional Care Action Plan). • Highlight recommendations for future service development that would support the principles of Avoiding Term Admissions to Neonatal Unit and keep mothers and babies together in a fully functioning Transitional Care Environment.
Summary of Key Issues:	• Weekly ATAIN review meetings and Monthly Transitional Care audits continue with Transitional Care now have now included in the formal Trust Audit programme to support visibility of themes and learning through reviews. • Require formal agreement that the Transitional Care and ATAIN reviews and action plan findings will also be shared with the Local Maternity and Neonatal System (LMNS) and Integrated Care System (ICS) quality surveillance meeting
Key Recommendation(s):	The Board of Directors is invited to: 1. **NOTE** and **DISCUSS** the report; 2. Receive **ASSURANCE** that there is an effective process established of ongoing assessment and that the evidence provided is sufficiently robust; 3. **NOTE** the receipt and content of this CNST Safety Action 3 Quarterly update report; 4. **NOTE** review of the Transitional Care and ATAIN action plan;

	5. **SUPPORT** the broader considerations and the development of further improvements as defined within the appended action plan.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**		**Our future**	**Our sustainability**	**Our quality and safety**
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.				
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.				
Resource:	Y	Staffing and training resource required to develop Transitional Care into a fully functioning service.			
Legal and regulatory:	Y	Clinical Negligence Scheme for Trusts (CNST), British Association of Perinatal Medicine (BAPM) standards.			
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	Maternity and Neonatal Governance Team Maternity and Neonatal Assurance Group				

East Kent Hospitals University NHS Foundation Trust

CNST Maternity Incentive Scheme Year 4

Safety action 3: Transitional care services to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme

Quarterly Report Q2 2022/23

1. Purpose of the report

1.1 The purpose of this report is to update the Trust Board on East Kent Maternity's progress in implementing Safety Action 3 and provide a quarter 2 2022/23 update on the audits required against the standards.

1.2 Raise awareness of risks in achieving CNST Standards and actions developed in response to case reviews and the action plans in place to improve (see Appendix 1: ATAIN and Transitional Care Action Plan).

1.3 Highlight recommendations for future service development that would support the principles of Avoiding Term Admissions to Neonatal Unit and keep mothers and babies together in a fully functioning Transitional Care Environment.

2. Standard a)

Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

2.1. The Neonatal Transitional Care (NTC) Guideline was developed in 2018, updated in September 2021 and is based on the principles of British Association of Perinatal Medicine (BAPM) transitional care.

2.2. The policy is was developed jointly by maternity/neonatal clinical leads and includes auditable standards that inform the quarterly audits that are in progress.

2.3. There is evidence of neonatal involvement in care planning through discussions that take place at board rounds, ward rounds and documentation in care records and discharge summaries.

2.4. Admission criteria is defined within the 'Bobble Hat' risk assessment proforma that is completed on all babies and identifies the appropriate care setting based on need. NTC admission criteria meets a minimum of at least one element of HRG XA04

2.5. There is an explicit staffing model with maternity staff identified on the e-Roster system as NTC on each shift. Midwives lead on the care of NTC mothers and babies There is an allocated Neonatal Nurse also allocated as point of contact.

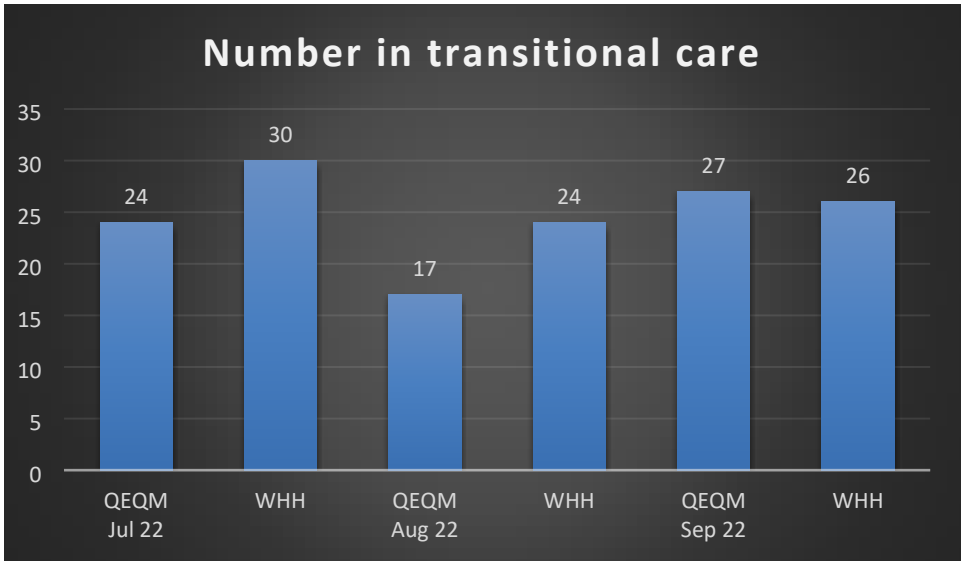
2.6. **To develop the service into a fully functioning NTC, Neonatal and Midwifery staffing, training, equipment and estates resource investment is required**. The estates requirements are captured within the maternity estates workstream.

3. Standard b)

The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.

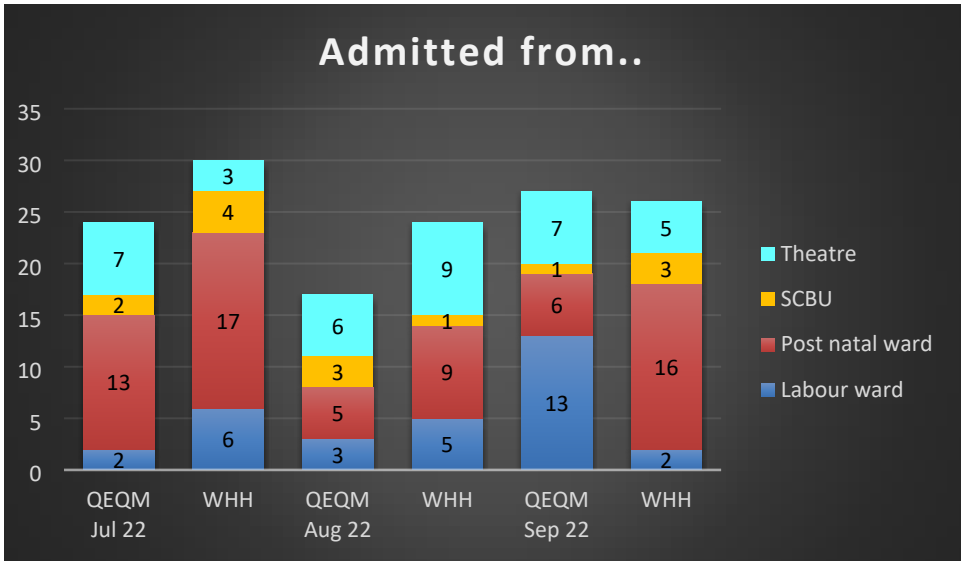
3.1. Audit data is captured on all babies who have care within NTC to monitor compliance against the guideline and auditable standards.

Graph 1: Number of Transitional Care Admissions for Quarter 2



All babies admitted to Transitional Care are included in this audit. A total of **148** babies were admitted to Transitional Care at EKHUFT in quarter 2 of 2022/23. This is up 1 baby since Q1. Queen Elizabeth the Queen Mother Hospital (QEQM) had a total of **68** babies admitted. William Harvey Hospital (WHH) had a total of **80** babies admitted. There has been a marked improvement in the data collection at WHH with no measures being recorded as 'unknown'.

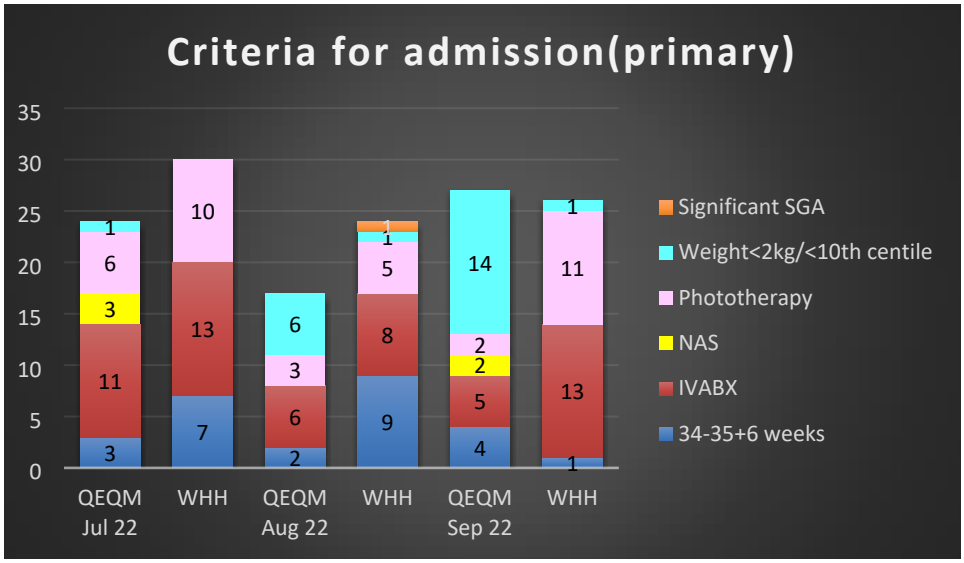
Graph 2: Admissions by Location



QEQM	Babies were admitted to Transitional Care from the Postnatal Ward (**35%**), Labour Ward (**26%**), SBCU (**9%**), Theatres (**29%**) and no Re-admission.

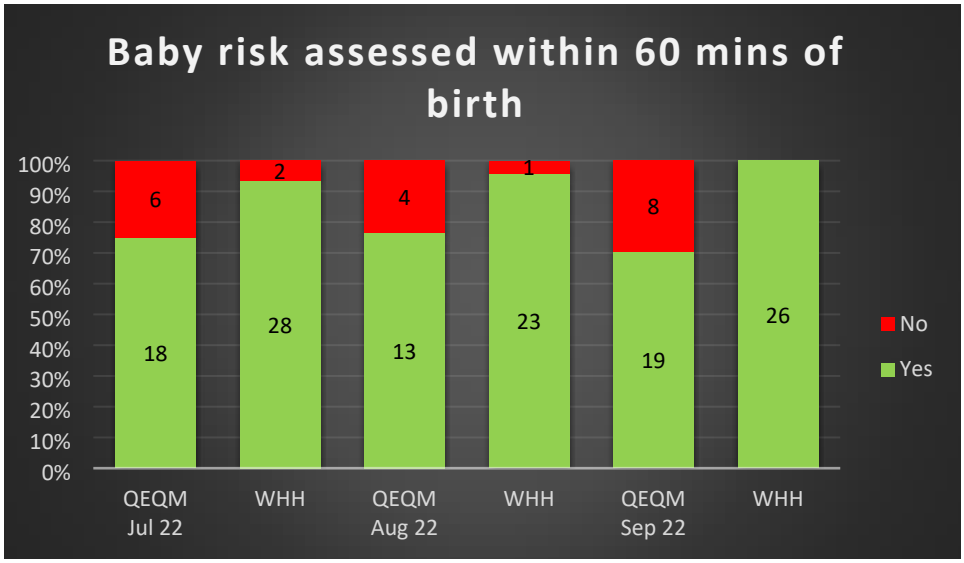
WHH	Babies were admitted to Transitional Care from the Postnatal Ward (**53%**), Labour Ward (**16%**), SBCU (**10%**), Theatres (**21%**) with no Re-admission.

Graph 3: Primary Transitional Care Criteria Reason for Admission



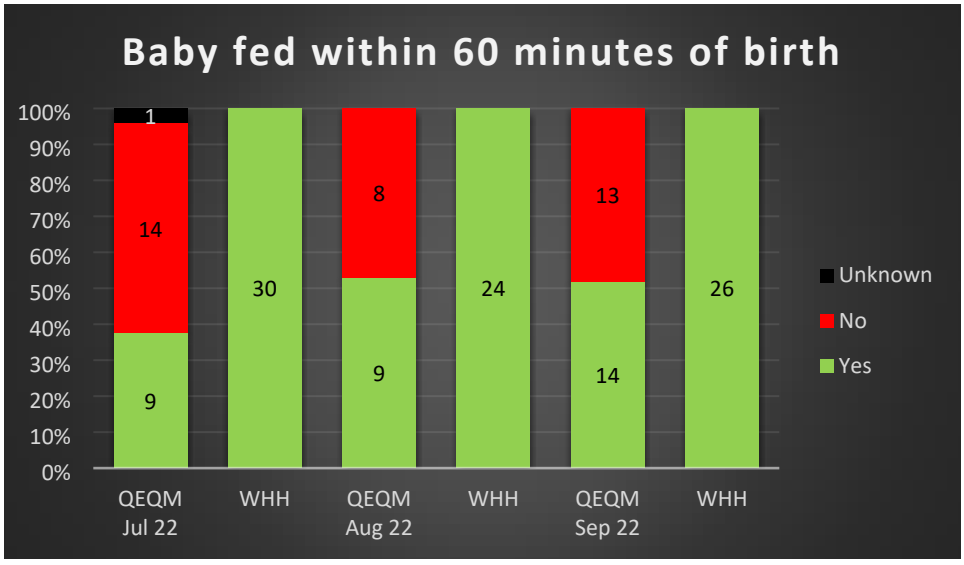
QEQM	The primary criteria for admission to Transitional Care during quarter one were; IVABX (32%), 34-35+6 weeks (13%), Phototherapy (16%), Weight<2kg/<10th centile (31%), NAS (7%) and none for Significant SGA.
	88% of the cohort were recorded as being admitted to Transitional Care by meeting just one of the criteria. 9% of the cohort fulfilled a second criteria for admission and a further 3% met 3 of the criteria.
	Of the total cohort, 37% were admitted for IVABX, 13% due to 34-35+6 weeks, 22% for Phototherapy, 31% due to Weight<2kg/<10th centile, 7% for NAS and 3% for Significant SGA.
WHH	The primary criteria for admission to Transitional Care during quarter one were; IVABX (43%), 34-35+6 weeks (21%), Phototherapy (33%), Weight<2kg/<10th centile (3%), NAS (0%) and Significant SGA (1%).
	69% of the cohort were recorded as being admitted to Transitional Care by meeting just one of the criteria. 24% of the cohort fulfilled a second criteria for admission and a further 8% met 3 of the criteria.
	Of the total cohort, 51% were admitted for IVABX, 21% due to 34-35+6 weeks, 61% for Phototherapy, 3% due to Weight<2kg/<10th centile, 1% for NAS and 1% for Significant SGA.

Graph 4: TC Babies risk assessed within first hour of birth



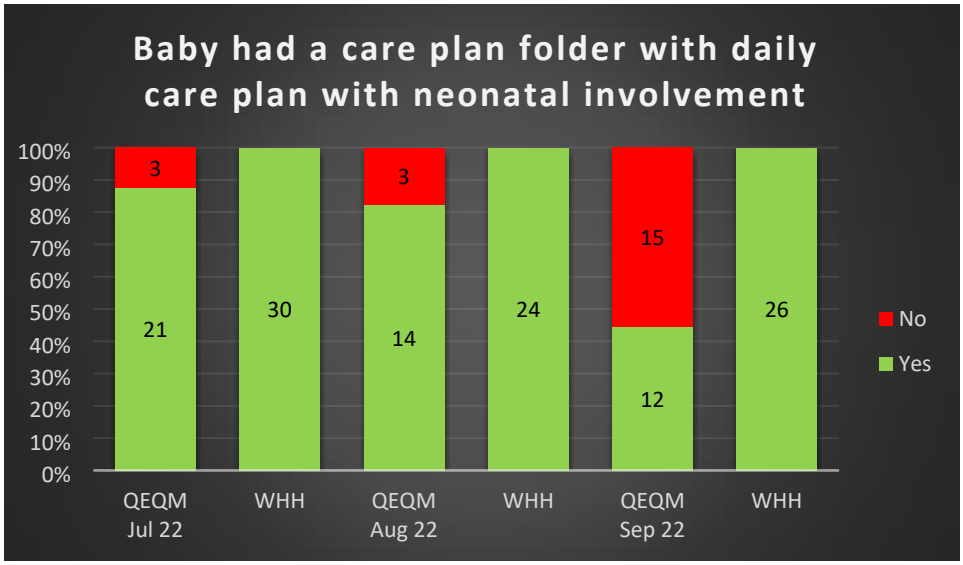
QEQM	**74%** of babies were risk assessed within 60 minutes of birth.
WHH	**96%** of babies were risk assessed within 60 minutes of birth.

Graph 5: Number of TC babies that were fed within first hour of birth



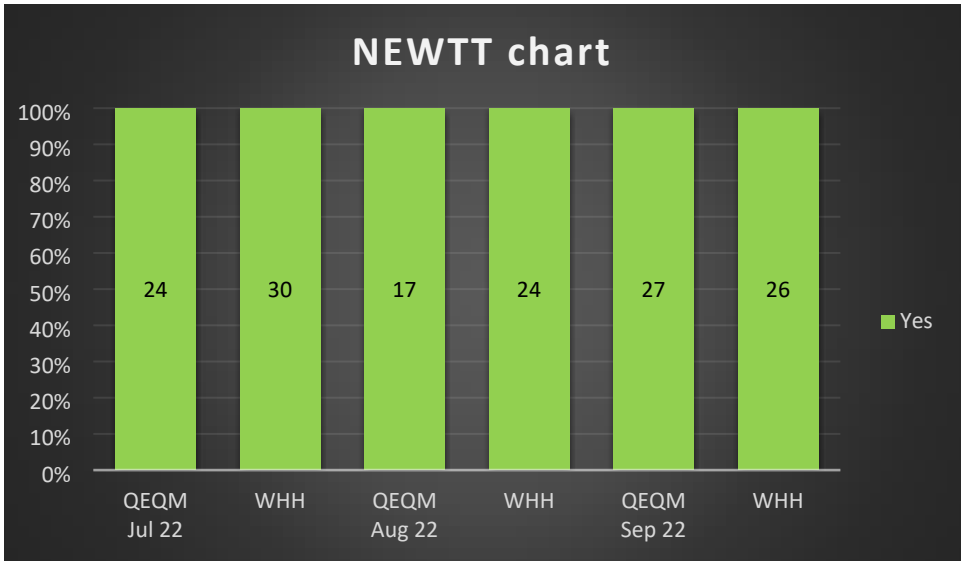
QEQM	Excluding the 1 baby that was recorded as 'unknown' for this measure, **48%** of babies were fed within 60 minutes of birth. As the number of 'unknowns' is minimal, this result can be viewed with the usual level confidence.
WHH	**100%** of babies were fed within 60 minutes of birth.

Graph 6: Number of babies with a care plan folder showing a daily care plan completion with neonatal involvement



QEQM	**69%** of babies had a care plan folder containing a completed daily care plan with neonatal involvement. There appears to be an unusually low number of care plans folders with a completed daily care plan with neonatal involvement in September at QEQM **(44%)**. This also correlates with an unusual increase in the number being admitted from labour ward and those with an admission criterion of Weight<2kg/<10th centile.
WHH	**100%** of babies had a care plan folder containing a completed daily care plan with neonatal involvement.

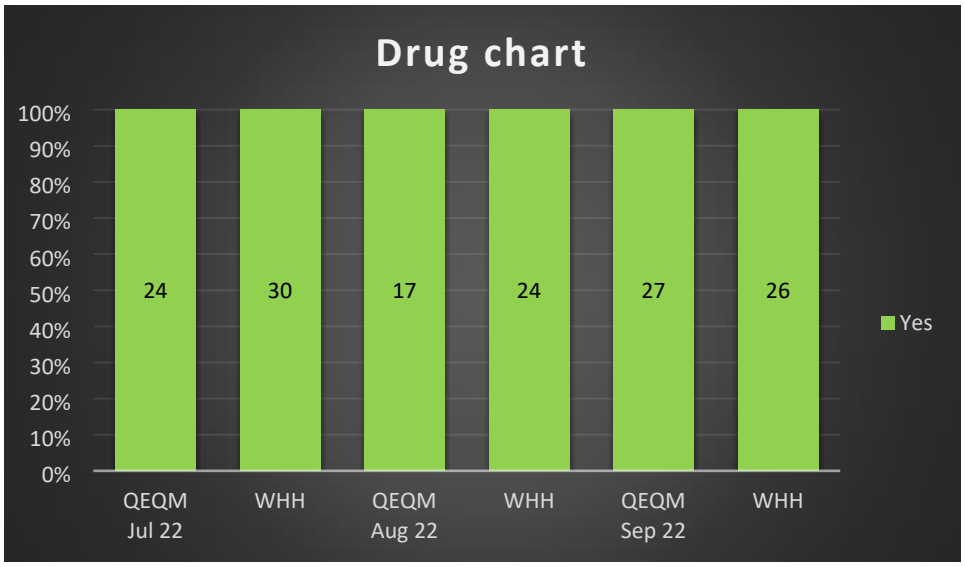
Graph 7: Number of babies that had a Newborn Early Warning Trigger and Track (NEWTT) Charts



QEQM	**100%** of babies had a NEWTT chart completed.

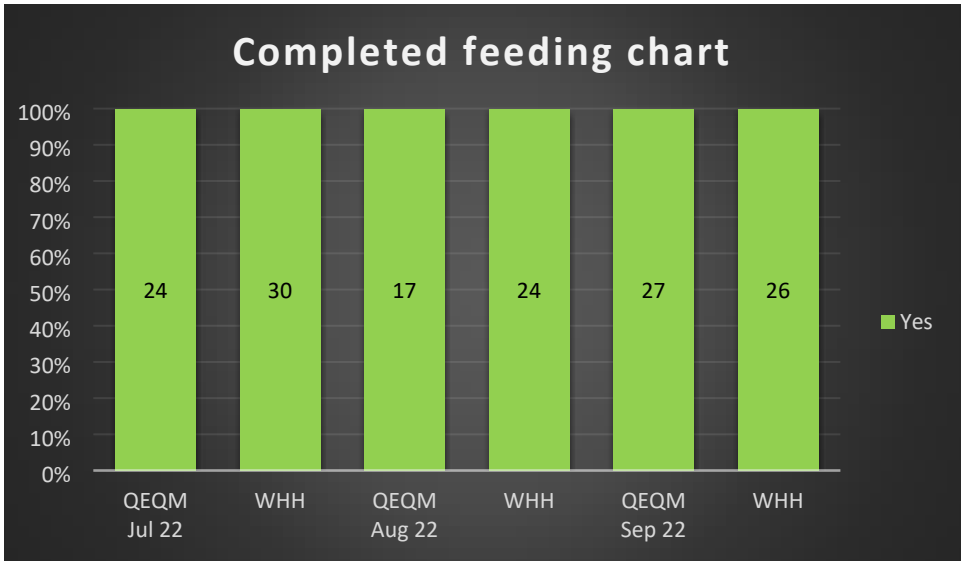
WHH	**100%** of babies had a NEWTT chart completed.

Graph 8: Number of babies that had a Drug Chart



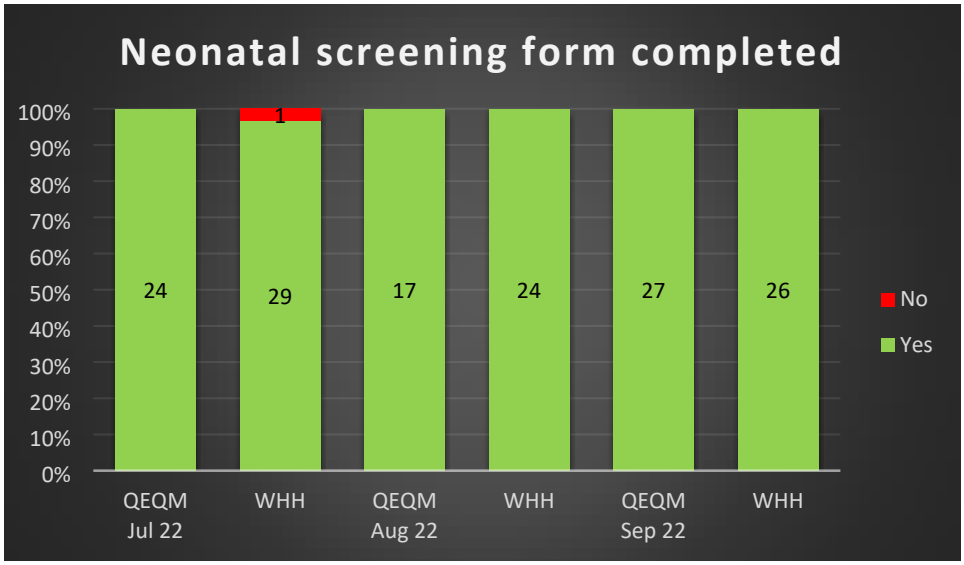
QEQM	**100%** of babies had a drug chart completed.
WHH	**100%** of babies had a drug chart completed.

Graph 9: Number of babies that had a feeding Chart completed



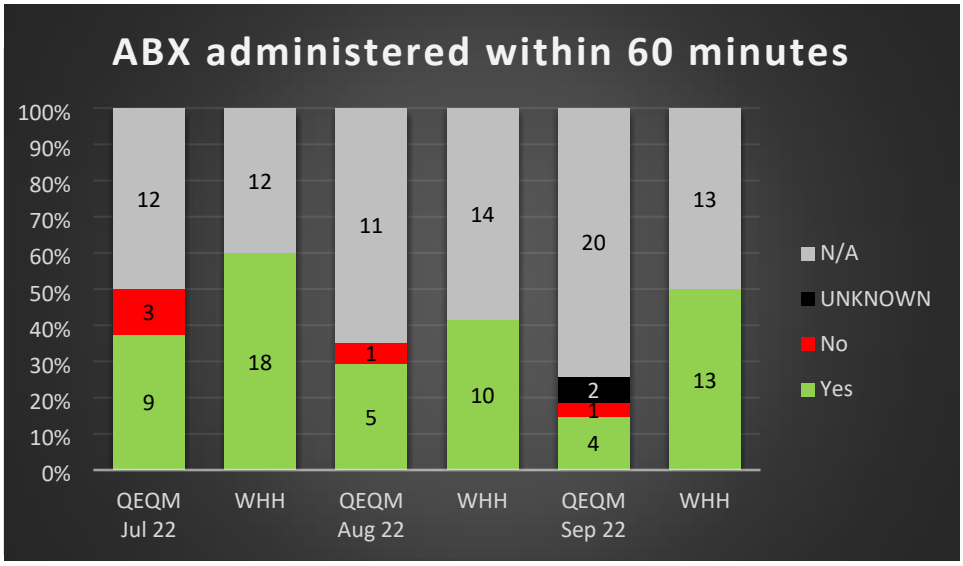
QEQM	**100%** of babies had a feeding chart completed.
WHH	**100%** of babies had a feeding chart completed.

Graph 10: Number of babies that had a Neonatal Screening Form completed



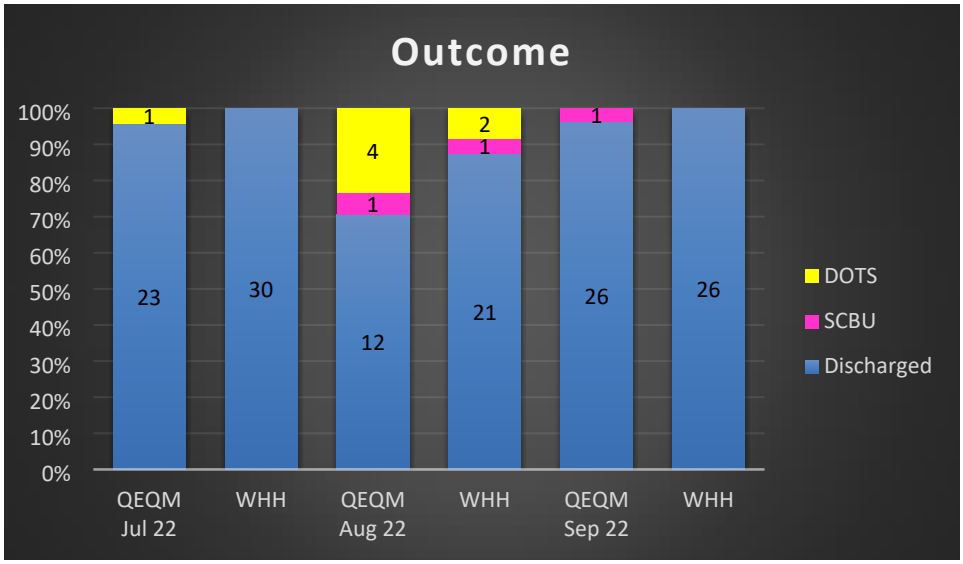
QEQM	**100%** of babies had a screening form completed.
WHH	**99%** of babies had a screening form completed.

Graph 11: Antibiotics administered within 60 Minutes



QEQM	**53%** of babies were admitted to Transitional Care for antibiotics. Of those who required antibiotics, **66%** received them within the required 60 minutes of the decision being made to administer.
WHH	**58%** of babies were admitted to Transitional Care for antibiotics. Unfortunately due the lack of data collected for this measure, a reliable result cannot be generated. **67%** of babies included in this cohort were recorded as 'unknown' for this measure. It is essential to enter all required data to be able to draw reliable conclusion regarding the care given to babies in our care. Of the **17** babies where data was collected, **88%** received antibiotics within the required hour but this result must be viewed with caution due to the large amount of missing data for this measure.

Graph 12: Outcome of admission



QEQM	**90%** of babies were discharged home, **3%** to SCBU and **7%** to DOTS.
WHH	**96%** of babies were discharged home, **1%** to SCBU and **3%** to DOTS.

Overall Summary

3.2. Data completion has significantly improved since quarter 1 which has evidenced the effectiveness of the interventions made at WHH. Any measures that are not 100% compliant with guidelines will be reviewed by ward managers.

3.3. Audit findings are shared with the Neonatal Safety Champion monthly and quarterly with the Board Safety Champion through the Maternity and Neonatal Assurance Group.

3.4. Barriers to achieving full implementation of the policy are captured on an action plan and shared with the neonatal safety champion and appended to the quarterly reports.

3.5. A process for sharing with the LMNS, Commissioners and integrated care system is now in place.

4. **Standard c)**

A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.

4.1. An electronic data recording process is established for all term admissions to the Neonatal Units and this is captured and reported on the Maternity dashboard.

4.2. A paper-based process was in place by Monday 18 July 2022 for the capturing of all term babies transferred to the neonatal unit, regardless of the length of stay.

QEQM	Month		
Transfer Theme	June	July	August
X-ray	1		
IVAB	1		
Obs	1	1	
LP	1	1	
4 Limb BP			5
Obs, Xray, IVAB			1

WHH	Month		
Transfer Theme	June	July	August
Chest x-ray	1	1	1
Obs	1	1	1
LP	1	1	1
4 Limb BP	2		

5. **Standard d)**

A data recording process for capturing existing transitional care activity, (regardless of place which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0 and 36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of
special care or normal care days where supplemental oxygen was not delivered.

5.1. Transitional Care was developed in partnership with BAPM to enable the safe management of babies with medical conditions, whilst allowing baby to remain with mother.

5.2. Babies suitable for management on a fully equipped TC unit;

- Of at Least 34weeks gestation and at least 1600g birth weight who do not fur fill criteria for High Dependency Care (HDC)/Neonatal Intensive Care Unit (NICU) admission
- Well babies with Suspected Sepsis requiring IV Antibiotics
- Congenital Anomalies requiring nasogastric (NG) assisted feeding
- Jaundiced babies requiring phototherapy (Single or Enhanced)
- Babies requiring feeding support with NG assisted feeding
- Babies under observation or treatment for Neonatal Abstinence Syndrome
- Babies who require assistance with thermoregulation

5.3. Transitional Care has been provided on the Postnatal Wards on each acute site since 2018

5.4. The Neonatal Transitional Care Guideline was jointly developed with Maternity and Neonatal Leads in 2018 and reviewed in 2021.

5.5. Criteria for admission is aligned to BAPM and defined within the 'Bobble Hat' Risk Assessment Tool.

5.6. Data on Transitional Care activity is captured on the Maternity Dashboard and is shown on the table below both by bed days and number of babies

Transitional Care Activity						
	July		**August**		**September**	
KPI	**WHH**	**QEQM**	**WHH**	**QEQM**	**WHH**	**QEQM**
Transitional Care Location/Care Days	**66**	**49**	**76**	**26**	**35**	**29**

Transitional Care Location/ Care Babies	**19**	**16**	**20**	**12**	**13**	**10**

5.7. The Neonatal Outreach service was implemented in 2021 and further supports the principles of Transitional Care by keeping mothers and babies together and facilitating earlier discharge from hospital.

5.8. A Secondary Data Recording Process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting.

5.9. The following table shows Babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special or normal care days where supplemental oxygen was not delivered

5.10. This provides information on late preterm babies who are currently cared for in the Neonatal Unit, who could be cared for in a fully functioning TC setting, to inform future capacity planning/management.

Secondary Data Recording to inform future capacity management for late preterm babies who could be cared for in a TC setting.						
	July		**August**		**September**	
KPI	**WHH**	**QEQM**	**WHH**	**QEQM**	**WHH**	**QEQM**
Babies 34-36+6 Weeks, Special Care and normal care days w/o O2 total	**117**	**38**	**79**	**26**	**101**	**53**
Babies 34-36+6 Weeks, Special Care and normal care days w/o O2 cared for on Neonatal Unit	**44**	**26**	**28**	**14**	**84**	**24**

6. **Standard e)**

Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), Local Maternity and Neonatal System (LMNS) and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.

6.1. The Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 is captured and recorded locally on the Badgernet Neonatal Information System and may be used for the purposes of direct care, clinical audit, Reference Costs, and other local uses.

6.2. There is not a requirement for the Trust to regularly submit this data but the fact that we are able to download it from Badgernet, if requested, means we meet the CNST criteria.

6.3. The National Target set for ATAIN is under 5%, both QEQM and WHH have consistently remained well below this level. Data is recorded on the Neonatal section of the Maternity Dashboard

6.4. The following table shows the Kent Surrey Sussex ATAIN Unit Summary 2021/22 All Quarters. Quarterly ATAIN summary reports that are provided by the Neonatal Operational Delivery Network (ODN).

6.5. **Term admission rates were 3/100 live births at WHH which is the lowest among all level 3 NICUs at KSS and Thames Valley and Wessex network.**

6.6. **Corresponding rates for QEQM were 3.6/100 live births which is well below the recommended admission rate for term infants.**

6.7. The highest reason for admission is of babies with respiratory problems and of note, we had only 3 admissions for observation across EKHUFT.

NHS
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ATAIN Unit Summary Q2 2022-23 (Apr-Sep 2022)

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SCU | LNU | NICU

Network	Unit	Live births (all)	Term		Respiratory			Infection			Hypoglycaemia			Jaundice			Monitoring			HRG 3-5 only			
			n	% live births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	NNU 1 Day	% term ads	NNU>1 Day	% term ads
Thames Valley & Wessex	Milton Keynes	1725	106	6.1%	60	57%	34.8	5	5%	2.9	1	1%	0.6	10	9%	5.8	10	9%	5.8	18	17%	27	25%
	Royal Berkshire, Reading	2488	130	5.2%	90	69%	36.2	5	4%	2.0	3	2%	1.2	9	7%	3.6	6	5%	2.4	18	14%	38	29%
	Stoke Mandeville	2288	102	4.5%	45	44%	19.7	9	9%	3.9	2	2%	0.9	9	9%	3.9	7	7%	3.1	12	12%	40	39%
	Wexham Park Hospital	2031	64	3.2%	31	48%	15.3	7	11%	3.4	1	2%	0.5	6	9%	3.0	2	3%	1.0	15	23%	37	58%
	John Radcliffe, Oxford	3817	192	5.0%	94	49%	24.6	7	4%	1.8	11	6%	2.9	15	8%	3.9	12	6%	3.1	20	10%	55	29%
	Dorset County Hospital FT	802	54	6.7%	22	41%	27.4	10	19%	12.5	13	24%	16.2	2	4%	2.5	1	2%	1.2	10	19%	17	31%
	St Marys Isle of Wight	537	20	3.7%	12	60%	22.3	1	5%	1.9	0	0%	0.0	0	0%	0.0	3	15%	5.6	6	30%	3	15%
	HHFT - Basingstoke	1253	57	4.5%	20	35%	16.0	1	2%	0.8	2	4%	1.6	2	4%	1.6	13	23%	10.4	12	21%	23	40%
	HHFT - Winchester	1140	45	3.9%	25	56%	21.9	2	4%	1.8	5	11%	4.4	4	9%	3.5	2	4%	1.8	5	11%	15	33%
	Poole Hospital FT	2059	82	4.0%	45	55%	21.9	2	2%	1.0	3	4%	1.5	1	1%	0.5	5	6%	2.4	7	9%	28	34%
	Salisbury NHS FT	1150	75	6.5%	38	51%	33.0	1	1%	0.9	4	5%	3.5	11	15%	9.6	5	7%	4.3	3	4%	36	48%
	St Richard's Hospital	1154	40	3.5%	24	60%	20.8	6	15%	5.2	3	8%	2.6	2	5%	1.7	0	0%	0.0	3	8%	13	33%
	Queen Alexandra Hospital	2389	94	3.9%	31	33%	13.0	1	1%	0.4	9	10%	3.8	0	0%	0.0	15	16%	6.3	11	12%	27	29%
	University Hospital Southampton FT	2587	126	4.9%	40	32%	15.5	6	5%	2.3	11	9%	4.3	4	3%	1.5	5	4%	1.9	17	13%	28	22%
	TV & W Network Total	**25420**	**1187**	**4.7%**	**577**	**49%**	**22.7**	**63**	**5%**	**2.5**	**68**	**6%**	**2.7**	**75**	**6%**	**3.0**	**86**	**7%**	**3.4**	**157**	**13%**	**387**	**33%**
Kent Surrey Sussex	Conquest Hospital	1427	68	4.8%	19	28%	13.3	26	38%	18.2	5	7%	3.5	1	1%	0.7	3	4%	2.1	24	35%	23	34%
	Darent Valley Hospital	2408	116	4.8%	49	42%	20.3	13	11%	5.4	8	7%	3.3	17	15%	7.1	3	3%	1.2	21	18%	56	48%
	Princess Royal Hospital	1065	51	4.8%	29	57%	27.2	0	0%	0.0	2	4%	1.9	2	4%	1.9	2	4%	1.9	8	16%	13	25%
	Queen Elizabeth the Queen Mother H	1294	47	3.6%	27	57%	20.9	7	15%	5.4	1	2%	0.8	4	9%	3.1	1	2%	0.8	3	6%	21	45%
	Royal Surrey County Hospital	1400	45	3.2%	21	47%	15.0	5	11%	3.6	2	4%	1.4	4	9%	2.9	4	9%	2.9	7	16%	16	36%
	Worthing Hospital	1099	25	2.3%	11	44%	10.0	0	0%	0.0	4	16%	3.6	2	8%	1.8	0	0%	0.0	4	16%	9	36%
	East Surrey Hospital	2306	103	4.5%	47	46%	20.4	16	16%	6.9	5	5%	2.2	7	7%	3.0	4	4%	1.7	23	22%	31	30%
	Frimley Park Hospital	2528	49	1.9%	17	35%	6.7	11	22%	4.4	2	4%	0.8	4	8%	1.6	3	6%	1.2	16	33%	12	24%
	Tunbridge Wells Hospital	2932	106	3.6%	67	63%	22.9	11	10%	3.8	4	4%	1.4	2	2%	0.7	3	3%	1.0	4	4%	19	18%
	Medway Maritime Hospital	2248	113	5.0%	54	48%	24.0	8	7%	3.6	2	2%	0.9	6	5%	2.7	0	0%	0.0	11	10%	31	27%
	Royal Sussex County Hospital	1204	38	3.2%	25	66%	20.8	0	0%	0.0	2	5%	1.7	0	0%	0.0	0	0%	0.0	0	0%	9	24%
	St Peter's Hospital	1695	89	5.3%	39	44%	23.0	15	17%	8.8	3	3%	1.8	9	10%	5.3	1	1%	0.6	12	13%	28	31%
	William Harvey Hospital	1846	56	3.0%	29	52%	15.7	6	11%	3.3	1	2%	0.5	0	0%	0.0	2	4%	1.1	6	11%	15	27%
	KSS Network Total	**23452**	**906**	**3.9%**	**434**	**48%**	**18.5**	**118**	**13%**	**5.0**	**41**	**5%**	**1.7**	**58**	**6%**	**2.5**	**26**	**3%**	**1.1**	**139**	**15%**	**283**	**31%**

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WHH and QEQM Data for all Quarters

Kent Surrey Sussex SELECT UNIT: Queen Elizabeth the QM Margate

Queen Elizabeth the QM Margate	Live births	Term Admissions		Respiratory Symptoms			Suspected Infection			Hypoglycaemia			Jaundice			Monitoring			HRG 3-5 Only NNU 1 day only		HRG 3-5 Only NNU >1 day	
		N	% live births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	n	% term ads
Q1 - Apr-June	628	22	3.5%	14	64%	22.3	2	9%	3.2	1	5%	1.6	2	9%	3.2	0	0%	0.0	1	5%	8	36%
Q2 - July-Sept	666	25	3.8%	13	52%	19.5	5	20%	7.5	0	0%	0.0	2	8%	3.0	1	4%	1.5	2	8%	13	52%
Q3 - Oct-Dec	0	0	0.0%	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0	0%
Q4 - Jan-Mar	0	0	0.0%	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0	0%
Year to Date	**1294**	**47**	**3.6%**	**27**	**57%**	**20.9**	**7**	**15%**	**5.4**	**1**	**2%**	**0.8**	**4**	**9%**	**3.1**	**1**	**2%**	**0.8**	**3**	**6%**	**21**	**45%**

Kent Surrey Sussex SELECT UNIT: William Harvey Ashford

William Harvey Ashford	Live births	Term Admissions		Respiratory Symptoms			Suspected Infection			Hypoglycaemia			Jaundice			Monitoring			HRG 3-5 Only NNU 1 day only		HRG 3-5 Only NNU >1 day	
		N	% live births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	n	% term ads
Q1 - Apr-June	901	32	3.6%	15	47%	16.6	4	13%	4.4	1	3%	1.1	0	0%	0.0	1	3%	1.1	4	13%	7	22%
Q2 - July-Sept	945	24	2.5%	14	58%	14.8	2	8%	2.1	0	0%	0.0	0	0%	0.0	1	4%	1.1	2	8%	8	33%
Q3 - Oct-Dec	0	0	0.0%	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0	0%
Q4 - Jan-Mar	0	0	0.0%	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0	0%
Year to Date	**1846**	**56**	**3.0%**	**29**	**52%**	**15.7**	**6**	**11%**	**3.3**	**1**	**2%**	**0.5**	**0**	**0%**	**0.0**	**2**	**4%**	**1.1**	**6**	**11%**	**15**	**27%**

7. Standard f)

Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been 27 cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.

7.1. Weekly cross site Multidisciplinary Maternity and Neonatal Review meetings take place to discuss in detail all term admissions into the Neonatal Unit and critically assess whether the admission could possibly have been avoided if risk had been identified and/or care had been provided differently.

7.2. Learning theme posters are generated to communicate opportunities to improve with the wider team.

7.3. An audit tool template has been formalised to support improved capture of themes and tracking of learning from cases.

7.4. From Monday 18 July 2022 reviews have also included all term babies transferred to the neonatal unit, regardless of the length of stay.

7.5. The ATAIN and TC Action Plan (Appendix 1) shows areas of focused improvement.

7.6. The following Table shows the data collected on the neonatal section of the Maternity Dashboard Term Admissions to Special Care Baby Unit (SCBU)/Neonatal Unit (NNU).

Neonatal Unit Dashboard (Month)

Period: Month | Sliced by: TOTAL | Domain: All | SPC Alert: All | Linked Report

Domain	KPI	SPC	Thres.	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Neonatal Unit	Therapeutic Hypothermia		2	0	1	2	2	0	2	3	1	1	0	0	0
	ATAIN %		4.2%	3.7%	4.1%	5.0%	2.9%	3.3%	3.3%	3.7%	2.3%	3.3%	3.4%	3.2%	3.5%
	PO: All Criteria Met		85.0%	36.4%	40.0%	38.5%	23.1%	26.7%	20.0%	40.0%	20.0%	45.5%	25.0%	42.9%	33.3%
	PO: Optimised Cord Clamping		85.0%	81.8%	60.0%	76.9%	30.8%	73.3%	60.0%	70.0%	66.7%	72.7%	50.0%	85.7%	53.3%
	PO: AN Steroids <7d		85.0%	45.5%	50.0%	53.8%	69.2%	40.0%	55.6%	50.0%	26.7%	63.6%	43.8%	85.7%	46.7%
	PO: Mag Sulph <24h		85.0%	100%	0.0%	60.0%	100%	100%	100%		100%	75.0%	50.0%	100%	25.0%
	PO: Normal Temp		90.0%	100%	100%	40.0%	83.3%	70.0%	57.1%	100%	62.5%	100%	60.0%	25.0%	70.0%
	Pneumothorax		0	0	1	0	0	0	0	0	0	1	2	2	0
	Transfers for Surgical Opinion		2	0	1	2	0	2	1	5	4	3	1	2	1
	IVH Grade 3 & 4		1	0	0	3	0	0	2	0	1	0	0	0	2
	Antibiotics within 60 mins		80.0%	68.3%	79.5%	83.0%	75.0%	80.4%	73.1%	84.4%	72.7%	82.9%	83.8%	70.6%	83.3%
	Antibiotics timing complete		90.0%	91.1%	84.6%	85.5%	85.1%	92.0%	96.7%	85.3%	93.6%	92.1%	84.1%	89.5%	90.0%
	Total Cot Days		Sigma	1,008	907	1,060	819	860	769	1,173	888	815	575	997	724
	SC & NC Days w/o O2		Sigma	63	123	96	132	114	97	139	155	105	154	103	141
	SC & NC Days w/o O2 on NNU		Sigma	41	80	33	91	68	65	70	78	42	108	65	65
	TC Location/Care Days		Sigma	89	61	117	93	98	84	139	115	102	64	95	98
	TC Location/Care Babies		Sigma	33	21	36	32	31	27	44	35	32	23	31	36

7.7. The following table shows the themes of term admissions reviews

Site Themes of Term Admissions						
Theme						
	QEQM	WHH	QEQM	WHH	QEQM	WHH
Respiratory	1	6	7	6	5	4
Infection	1	1				1
Congenital Anomaly suspected	1					1
Cardiovascular Disease		1				
Poor feeding or weight loss		1	2		1	1
Social issues/foster care		1	1			1
Monitoring						
Neurological disease			1			
Surgery				1		
Suspected HIE				1		
Jaundice					2	1
GIT Disease					1	

7.8. Learning recommendations from ATAIN reviews

Month	**Site**	**Learning Recommendations:**
July	WHH	Ensure all resuscitation equipment available and working
		No sepsis form
		Parent communication must be fully recorded.
		Nnap data to be completed in all relevant cases
Aug	WHH	Remember to check that the team has screened for diabetes.
		Sats to be completed and recorded
		neonatal - badger paperwork for admission or discharge-transfer to PN Ward must be completed
		Documentation on why baby was cooled to be completed
		Baby Not admitted correctly on badger. Parent communication recorded before admission.
	QEQM	Neonatal - lack of Kaiser permante scoring. Maternity - consider offering EBM as alternative to formula
		Maternity - No admission SBAR/no latent phase proforma/synto at 6ml/hr is not within guideline/no gases taken at del for resuscitation
		Maternity - When AFI >95th centile – should be referred to neonatal team at delivery for NG tube/care of temp during resuscitation
		Neonatal - Not all SCBU entries documented/dated/timed
		Neonatal - if following the respiratory care pathway, the pre/post ductal saturations should be recorded.
		Neonatal learning - No admission summary on Badger
		Maternity - no resus proforma found in notes
		Maternity - Proper documentation of apgars should be in blue neonatal notes. Just apgars at 1 and 5 minutes recorded non for 10 mins although documented elsewhere.

		Neonatal - SCBU staff should provide more accurate documentation.
Sept	QEQM	If there is difficulty in getting adequate chest rise consider two person manoeuvres or using an igel
		Proper parent communication
		Use of propes in 3 cm dilated women (obs) the use of double dose antibiotics in an otherwise well baby (neonatal)
		No Sepsis form complete
	WHH	Start phototherapy prior to SBR result if symptomatic. Complete Newt chart
		No Sepsis form complete X2
		To complete history and information

7.9. The following table shows babies that could have been cared for in the existing Transitional Care (TC) and those that could have been cared for if there was a fully functioning TC.

	Could Care have been provided in existing TC	Could care have been provided in fully functioning TC (i.e. babies that were admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there)
July	No	1 X NG Tube feeding
August	No	1 X NG Tube feeding and IV ABX
	No	1 x NG Tube Feeding
	Yes	1 x Neuro obs can occur enhanced TC input
September	Yes	1 x phototherapy could have been given on PN ward

8. **Standard g)**

An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion.

8.9. The Transitional Care and ATAIN action plans have been developed and approved by the Clinical and Midwifery Leads and Neonatal Safety Champion and are shared with the Maternity and Board Safety Champions through the Bi Monthly meetings and MNAG and Board reporting arrangements.

8.10. Evidence that progress with the action plan has been shared with the neonatal, maternity safety champion, and Board level champion, LMNS and ICS quality surveillance meeting each quarter is through the agreed Trust Board reporting structure.

8.11. See Appendix 1 for the Transitional Care and ATAIN action plan

8.12. In addition, ATAIN Learning Posters are developed and shared with staff

9. **Standard g)**

Progress with the revised ATAIN action plan has been shared with the maternity neonatal and Board level safety champions LMNS and ICS quality surveillance meeting.

9.1. An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from the pathway audit (point b) and the ATAIN reviews (point e).

9.2. Presentations have been provided by leads at Care Group Audit Days, an audit tool has been developed with support from the Trust Audit Team to formalise the process and reporting structures have been agreed with Trust Board.

9.3 Evidence that progress with the action plan has been shared with the neonatal, maternity safety champion, and Board level champion, LMNS and ICS quality surveillance meeting each quarter is through the agreed Trust Board reporting structure.

9.4 See Appendix 1 for the Transitional Care and ATAIN action plan

10. **Next steps**

10.1. Transitional Care and ATAIN working party group continue to review cases and explore opportunities to expand Transitional care services. Nursery Nurses have been appointed on the WHH site and are currently working through competencies to allow them to support NG Tube feeding in the TC setting.

10.2 Quarter 2 Transitional Care and ATAIN audits, data reviews and action plan findings will also be shared with the LMNS and ICS quality surveillance meeting

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Appendix 1:
ATAIN Action Plan

Item No	Link to ATAIN admission criteria (i.e. Respiratory, Jaundice, Hypoglycaemia, HIE, Observation, Poor feeding)	Recommendation identified following case review	Action plan to achieve compliance with recommendation (SMART)	Lead Responsible	Date for completion	RAG rating	Progress/comments	Date completed
1.	Respiratory	1.1. Reduce the number of babies admitted with respiratory issues there needs to be a reduction in the number of elective CS performed under 39 weeks unless there is a clear contraindication	• Not arranging elective LSCS before 39 weeks unless clinically indicated. • If needed, ensuring mother is given antenatal steroids as per RCOG guideline	Consultant Neonatologist Midwifery Sister & Kingsgate Ward Manager Midwife	Dec-22	Complete	Weekly review meeting and feedback of any cases and learning. Understand route cause against individual cases. Compliance monitored against RAG rating for C/S	Ongoing
2.	Hypoglycaemia	Reduce admission of babies at risk of hypoglycaemia	Educate and share awareness of importance of feeding within 60 minutes of delivery and feeding support during postnatal period. Audit compliance within auditable standards of Transitional Care Guideline and ongoing audit	Consultant Neonatologist Midwifery Sister & Kingsgate Ward Manager Midwife	Dec-22	Complete	Audit template agreed for Transitional Care. Monthly audits in progress. **03.10.22** 35% of babies on the QEQ site and 99% on the WHH were fed within 60 minutes. Further work is to be done to improve this on the QEQM site. Further work around feeding assessments completed with support form infant feeding. On going compliance will be monitored	Ongoing
3.	ATAIN review process	To ensure that all admissions to the Neonatal Unit are reviewed using an agreed audit template to identify areas of improvement	To agree NEW Audit Review Template and begin using within review meeting/as part of monthly audits	Consultant Neonatologist Midwifery Sister & Kingsgate Ward Manager Midwife	Sept-22	Complete	Audit template has been developed that aligns to weekly case review template but will generate data trend information to support learning. Data to be populated on new template from May 2022	Ongoing
4.	Reduction in repeat themes and improved learning	Identifying themes/trends in term admissions on action plan template	• An audit tool and Action plan for ATAIN and Transitional Care admissions has been created. • Reviewing how data is presented in clinical areas and as part of monthly reporting to align with the quarterly reporting coming from the ODN based on Badgernet data. • Neonatal and Maternity leads to attend weekly review meeting to review antenatal and intrapartum care elements and support shared learning that comes out of the meetings.	Consultant Neonatologist Midwifery Sister & Kingsgate Ward Manager Midwife	Sept-22	Complete	Monthly local data collection via Badgernet and Maternity Dashboard data reporting to Care Group Governance, Maternity and Neonatal Assurance Group and into Trust Board. Action plan reviewed in the weekly meetings, the Safety Champion/MNAG meetings and from July 2022 will be shared quarterly at the LMS Quality Assurance Group meetings.	Ongoing
5.	To monitor opportunities for future development of Transitional Care service to reduce Neonatal Admissions and keep mums and babies together	• Monitor babies that could have been looked after in Transitional Care if Nasogastric tube feeding was offered • Secondary Data Recording Process is set up to inform future	• To increase cot capacity at LCH by 8 Recruitment of staff to comply with Neonatal staffing template to ensure appropriate cover and skill mix Implementation of outreach service to increase cot capacity	Consultant Neonatologist Midwifery Sister & Kingsgate Ward Manager	October-21	Complete	Data is recorded on the Maternity Dashboard and included within Quarterly reporting	Ongoing

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		capacity management for late preterm babies who could be cared for in a TC setting. • Babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number	• Babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of normal care days and special care days is now recorded on the Maternity Dashboard	Midwife				
6.	Develop the Transitional Care Service to include full care criteria and expand opportunities to keep mums and babies together	• Scope opportunities/requirements to support transformation of the TC service	• Current position • Required standard • What expansion opportunities are there within existing estates footprint • What additional capacity requirements are required • What are the additional staffing requirements to support this expansion • What are the training needs and who/how can these be met • What additional equipment/resource requirements	TC working party group	December 2022	30/4/23	Working party group to scope requirements and present paper to leadership team in August. Work at WHH has begun on the full utilisation of the Nursery Nurse role, and 2 neonatal nurses have been appointed for the PN ward. This will inform the revised model of care for TC	Started

Transitional Care Action Plan from Audit Findings

Date action entered	Action number	Recommendation	Action (SMART)	Evidence of assurance	Lead (for action)	Completion date	Evidence received	Date achieved	Comments
27/10/2022	1	Ensure that local guidelines instructing staff are aligned to National guidance.	Update Trust Post Natal care (women and babies) and publish on Policy centre (current review date Feb 2021).	Screen shot of updated policy on Policy Centre	Guidelines and Policies Midwife	31/03/2023			27/10/2022 Clinical Effectiveness – Audit & Research Midwife to speak to Guidelines and Policies Midwife
			Update Trust Infant Feeding published Apr 2019 (current review date Apr 2022).	Screen shot of updated policy on Policy Centre	Infant feeding co-ordinators	31/03/2023			27/10/2022 Clinical Effectiveness – Audit & Research Midwife to speak to Infant feeding co-ordinators
	2	Provide robust data to be able to draw reliable conclusions of the care given and therefore be able to implement improvements where required.	Ensure that all data is captured for the audit by ensuring all paperwork is available i.e. scanning drug charts.	1. Scanned drug chart. 2. Fully completed Q2 report.	1. Newborn Care Co-Ordinator SCBU 2. Compliance, Assurance and Quality Improvement Facilitator	Completed	1. E mail confirmation from CW with example attached. 2. Q2 report.	1. 27/10/2022 2. 7/11/2022	
	3	Increase the number of babies being fed during the first hour to reduce hypoglycaemia.	Display a poster in the delivery rooms and theatre recovery rooms (obstetrics and main).	Poster & pic of them in situ.	Compliance, Assurance and Quality Improvement Facilitator to create poster and e mail to labour ward managers.	14/11/2022			

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	4	Increase awareness of this workstream by sharing the results of this audit.	1. Create and display/ distribute a summary poster.	Poster & pic of them in situ.	Compliance, Assurance and Quality Improvement Facilitator to create poster and e mail to labour ward managers.	Completed	E mail circulated to all	01/11/2022	
			2. Present findings at audit day in December.	Presentation and agenda.	Midwifery Sister & Kingsgate Ward Manager and Midwife	21/12/2022			27/10/2022 Midwifery Sister & Kingsgate Ward Manager on admin day so agreed to attend.
	5	Further investigate any compliance issues, including when measures are recorded as 'unknown' to identify where improvements can be made.	1. Add an 'exceptions' tab on the quarterly transitional care audit report. 2. Data collectors to notify ward managers to investigate any 'fail' cases as they are identified who will complete the exceptions tab and either make amendments to the data collected and/or add any actions to this action plan.	1. Report template with new tab. 2. Completed exception tab for Quarter 3.	1. Compliance, Assurance and Quality Improvement Facilitator 2. Midwifery Sister & Kingsgate Ward Manager and Midwife	1. Completed 2. 31/01/2023	1. Q3 spread sheet	1. 7/11/2022	QEQM Q1 antibiotics administration exceptions be mailed to Midwifery Sister & Kingsgate Ward Manager 27/10/2022

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**INTEGRATED PERFORMANCE REVIEW (IPR)**				
MEETING DATE:	**9 MARCH 2023**				
BOARD SPONSOR:	**CHIEF FINANCE OFFICER**				
PAPER AUTHOR:	**CHIEF FINANCE OFFICER**				
APPENDICES:	**APPENDIX 1: JANUARY 2023 IPR**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	The Trust has been engaged with a quality improvement programme called "We Care". The premise is that the Trust will focus on fewer metrics but in return will expect to see a greater improvement (inch wide, mile deep). This report is updated for the key metrics that the Trust will focus on in 2022/23.				
Summary of Key Issues:	The attached IPR is now ordered into the following: **True Norths-** These are the Trust wide key strategic objectives which it aims to have significant improvements on over the next 5 years, as these are challenging targets over a number of years it may be that the targets are not met immediately and it is important to look at longer term trajectories. The areas are: • our **quality and safety.** The two metrics the Trust has chosen to measure against incidents with harm and mortality rate. • our **patients.** The four metrics being measured are the Cancer 62-day target, the Accident & Emergency (A&E) over 12-hour target, the Referral to Treatment (RTT) 18-week target and the Friends and Family recommended %. • our **people.** The one metric chosen is for staff engagement. • our **sustainability.** The two metrics chosen to improve are the Trust's financial position and carbon footprint. • our **future.** The two metrics chosen are the medically fit for discharge % and virtual outpatients usage. **Breakthrough objectives-** These are objectives that we are driving over the next year and are looking for rapid improvement. The four key areas are: • **Improving theatre capacity.** By counting every minute of theatre time not utilised we describe an opportunity for more effective utilisation. In January the potential opportunity decreased to 41 lists, from 44 in the previous month. • January's utilisation was impacted due to site pressure and a phased incremental to Elective Orthopaedic Centre (EOC) recovery up to 30 January 2023.				

	• The number of cases per list in the most recent week has been maintained at 2.3 from an average of 1.9 across the last 20 weeks. • Ophthalmology saw a reduction in cancelled sessions where they have implemented dedicated operational support and pre-assessment. • Further improvement measures that have been implemented are continuously reviewed ensuring shared learning across the Care Groups; • Urology working closely with pre-assessment to reduce urinary tract infection (UTI) on the day cancellations. • All specialities are reviewing where standby patients can enable reduced cancellations on the day by increasing pre-assessment pool discussed through the Theatre Optimisation Group. • The Trust is optimising scheduling opportunities with the booking teams with an aim of booking all lists to 95% and increasing actual utilisation to over 85% in February. • Late starts continue to remain a focus for General Surgery where it was identified that delays were due to Intensive Therapy Unit (ITU) bed. The action was to add a small case first on the list to enable allowance for ITU capacity. • An improvement day was held for the EOC in January to further improve patient experience, theatre productivity and reduce length of stay. • The theatre optimisation group continues to meet fortnightly led by the Surgery & Anaesthetic leadership team. This group continues to focus on the development of Standard Operating Procedures regarding theatre utilisation and the analysis of the data regarding early finishes/late starts and cancellations with actions to improve performance. The group has ensured specialities focus on key metrics to analyse themes and trends. We aim improve and maintain actual utilisation to 85% by March 2023. • We have continued to successfully appoint theatre staffing across the sites. • **Same Day Emergency Care (SDEC) Admissions.** The SDEC activity across all services saw a slight decrease in the total numbers of patients accessing Ambulatory services across the Trust (2141 v 2230 in December) with a decrease in both frailty and children's SDEC activity. The decrease in children's correlates to the overall decrease in paediatric activity (5220 v 7913 in December) which was significantly above plan in December possible reflecting the national strep A concerns during that period. The William Harvey Hospital (WHH) continues with its extended hours of operation with the numbers increasing month on month since commencing in November 2022. However, it remains important to note that the SEAU at WHH/Queen Elizabeth the Queen Mother Hospital (QEQM) was partially used in January to manage the increased inpatient bed requirements (Operational

	Pressures Escalation Level (OPEL4)) together with the change to the frailty model at the WHH as part of the use of the dedicated space to support the Emergency Department (ED) build. • The Direct Access Pathway/SDEC workstream, is working on delivering an extended SDEC model for winter. Patients with long term conditions attending ED require the support of an integrated approach from community clinicians and acute hospital specialists. Virtual Wards for Respiratory conditions are evolving and will provide further integration, these are planned to come on-line in February 2023. • As part of the workstreams within the Emergency Care Delivery Programme, clinical pathways have been developed in collaboration with the surgical, acute medical and orthopaedic leads to increase the cohort of patients accessing the SDEC services. These pathways reduce the demand within the ED, supporting the right place, first time approach and are planned to go live end of February. • The development of the Medical Day Unit at the Kent & Canterbury Hospital (K&C) site, to release capacity in the medical SDEC services on the QEQM/WHH sites to increase the cohort of patients identified against the Ambulatory Care Conditions • The use of 'Hot Slots' for referral into SDEC the next day has proven successful reducing some patients waiting overnight to access the service. • Plans being developed for access to specialty Hot Clinics within the SDEC are being progressed to enable more patients to be seen urgently as an outpatient reducing the need for in patient stay. • **Staff Involvement.** Staff Involvement has improved significantly both quarter-on-quarter (from Q2 to Q3) and year-on-year (from 2021 to 2022). High-performing bright spots have been identified along with more challenged hotspots. Intensive support will be provided to hotspots and learning will be applied from those performing well. • 45 areas have now been trained as part of the Team Engagement and Development (TED) pilot, including Cardiology and Rheumatology. • The We Care rollout has been extended and will also include Urology and Cardiology. • Two of the priority areas identified as part of the National Staff Survey 2021 data review (those with the lowest scores for involvement) have completed the KENT Fundamentals programme. • The new staff intranet, Interact, has been reviewed and can provide; sentiment analysis, target pulse surveys and an online suggestion area, the effectiveness of which will be piloted. • An 'Involvement Toolkit' is being finalised to provided support at team leader, speciality and Care Group level and will be launched to support work following release of 2022 Staff survey results.

	• **Premium Pay costs.** The Trust spends £87m per annum on premium pay with an aim to reduce this by 10% over the year. In January premium pay increased by £600k in relation to increased escalation areas opened. • Key Interventions include: • The breakthrough objective although having a finance executive lead will be run by senior HR colleagues and will need support of all Care Groups to help deliver. • Detailed focus by Care Groups on drivers of premium pay. • Review of bank, agency and overtime rates across all staff groups. • Ensure improved sign off processes and governance across the Trust. • Recruitment to key clinical posts to reduce the need for temporary staffing. • Ensuring exit plans in place for high cost medical agency locums. **Watch Metrics -** these are metrics we are keeping an eye on to ensure they don't deteriorate.
Key Recommendation(s):	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the True North and Breakthrough Objectives of the Trust.

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**

Link to the Board Assurance Framework (BAF):	**BAF 32**: There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 34**: Failure to deliver the operational constitutional standards due to the fluctuating nature of the Covid-19 pandemic necessitating a localised directive to prioritise P1 and P2 patients. **BAF 31:** Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements and Covid-19, leading to harm, including death, breaches of externally set objectives, possible regulatory action, prosecution, litigation and reputational damage.	
Link to the Corporate Risk Register (CRR):	**CRR 77:** Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 78:** There is a risk that patients do not receive timely access to emergency care within the 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:	Finance Performance Committee (FPC) 28 February 2023 Quality and Safety Committee (Q&SC) 2 March 2023	

East Kent Hospitals University NHS Foundation Trust

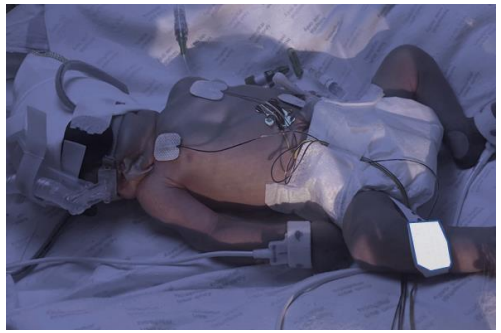
Integrated Performance Report

January 2023







We care

Our vision, mission and values

We care' is how we're working to give great care to every patient, every day. It's about being clear about what we want to focus on and why and supporting staff to make real improvements, by training and coaching everyone to use one standard method to make positive changes.

We know that frontline staff are best placed to know what needs to change. We've seen real success through initiatives like 'Listening into Action', 'We said, we did', and 'I can'.

'We care' is a bigger version of this – it's the new philosophy and new way of working for East Kent Hospitals. It's about empowering frontline staff to lead improvements day-to-day.

It's a key part of our improvement journey – it's how we're going to achieve our vision of great healthcare from great people for every patient, every time.

For 'We care' to be effective, we need to be clear about what we are going to focus on – too many projects will dilute our efforts.

For the next five years, our focus centres on five "True North" themes. These are the Trust-wide key strategic objectives which it aims to significantly improve over the next 5 years:

- our **patients**
- our **people**
- our **future**
- our **sustainability**
- our **quality and safety**

True North metrics, once achieved, indicate a high performing organisation.

What is the Integrated Performance Report (IPR)?

To turn these strategic themes into real improvements, we're focusing on five key objectives that contribute to these themes for the next year. These are the "breakthrough" objectives that we are driving over the next year and are looking for rapid improvement.

- Reducing Patient Safety Incidents resulting in harm
- Reducing time spent in our ED Departments
- Improving theatre capacity
- Improving our Staff Involvement Score
- Reducing Premium Pay Spend

We have chosen these five objectives using data to see where focusing our efforts will make the biggest improvement. We'll use data to measure how much we're making a difference.

Frontline teams will lead improvements supported by our Improvement Office, which will provide the training and tools they need. Our Executive Directors will set the priorities and coach leaders in how to support change. Our corporate teams will work with frontline teams to tackle organisation-wide improvements.

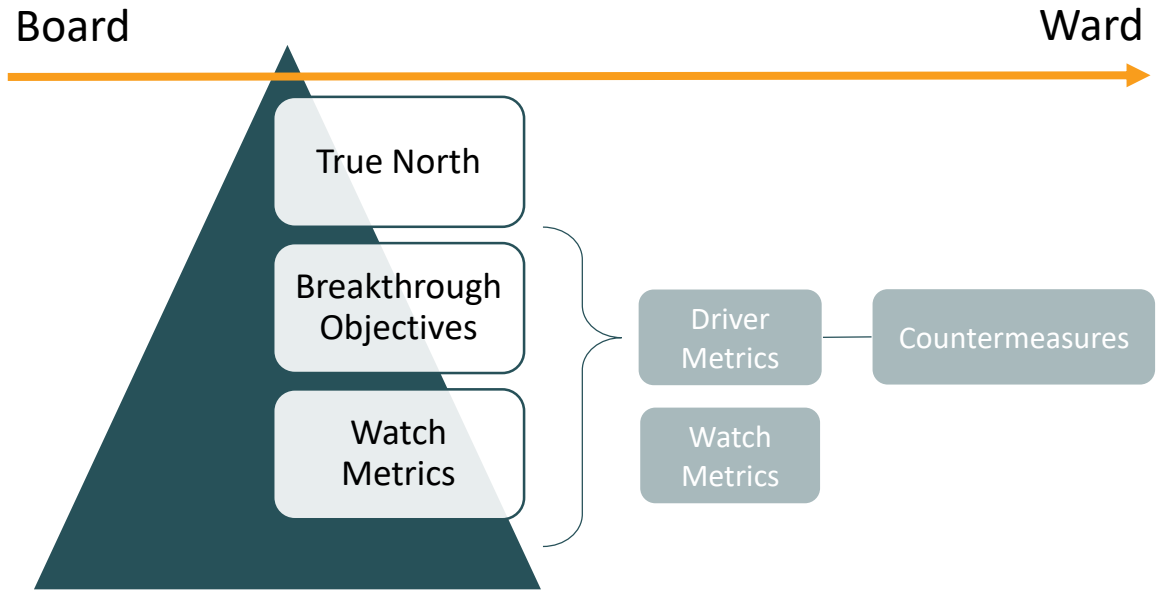
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our improvement journey.

Integrated Performance Report

IPR

Performance Review Meetings

PRM



The IPR forms the summary view of Organisational Performance against these five overarching themes and the five objectives we have chosen to focus on in 2022/23. It is a blended approach of business rules and statistical tests to ensure key indicators known as driver and watch metrics, continue to be appropriately monitored.

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

The 'We Care' methodology incorporates the use of SPC Charts alongside the use of Business Rules to identify common cause and special cause variations and uses **NHS Improvement** SPC icons to provide an aggregated view of how each KPI is performing with statistical rigor.

The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

A minimum of 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels.

If data point falls outside these levels, an investigation would be triggered.

It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Where to find them

What are the Business Rules?

Breakthrough objectives will drive us to achieve our "True North" (strategic) goals, and are our focus for this year.
These metrics have a challenging improvement target and the scorecard will show as red until the final goal is achieved when it then turns green. Once achieved a further more stretching target may be set to drive further improvement, turning the metric back to red, or a different metric is chosen.

Metrics that are not included in the above are placed on a watch list, where a threshold is set by the organisation and monitored. More of these metrics should appear green and remain so. Watch Metrics are metrics we are keeping an eye on to ensure they don't deteriorate.

Business rules work in conjunction with SPC alerts to provide a prompt to take a specific action.

This approach allows the organisation to take a measured response to natural variation and aims to avoid investigation into every metric every month, supporting the inch wide mile deep philosophy.

The IPR will provide a summary view across all True North metrics, detailed performance, actions and risks for Breakthrough Objectives (driver) and a summary explanation for any alerting watch metrics using the business rules as shown here as a trigger.

#	Rule	Suggested rule
1	**Driver** is **green** for reporting period	Share success and move on
2	**Driver** is **green** for six reporting periods	Discussion: 1. Switch to watch metric 2. Increase target
3	**Driver** is **red** for 1 reporting periods (e.g. 1 month)	Share top contributing reason, and the amount this contributor impacts the metric
4	**Driver** is **red** for 2 reporting periods	Produce Countermeasure summary
5	**Watch** is **red** for 4 months	Discussion: 1. Switch to driver metric (replace driver metric into watch metric) 2. Reduce threshold
6	**Watch** is out of control limit for 1 month	Share top contributing reason (e.g. special / significant event)

Our quality and safety

Our quality and safety

Rebecca Martin

Mortality (HSMR)

Mortality metrics are complex but monitored and reported nationally as one of many quality indicators of hospital performance. While they should not be taken in isolation they can be a signal that attention is needed for some areas of care and this can be used to focus improvement in patient pathways.

Our aim is to reduce mortality and be in the top 20% of all Trusts for the lowest mortality rates in 5 to 10 years. We have set our threshold for our rolling 12 month HSMR to be below 90 by January 2027 to demonstrate achievement of our ambition.

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
86.4	85.0	86.0	86.9	87.7	89.1	88.7	87.5	88.8			

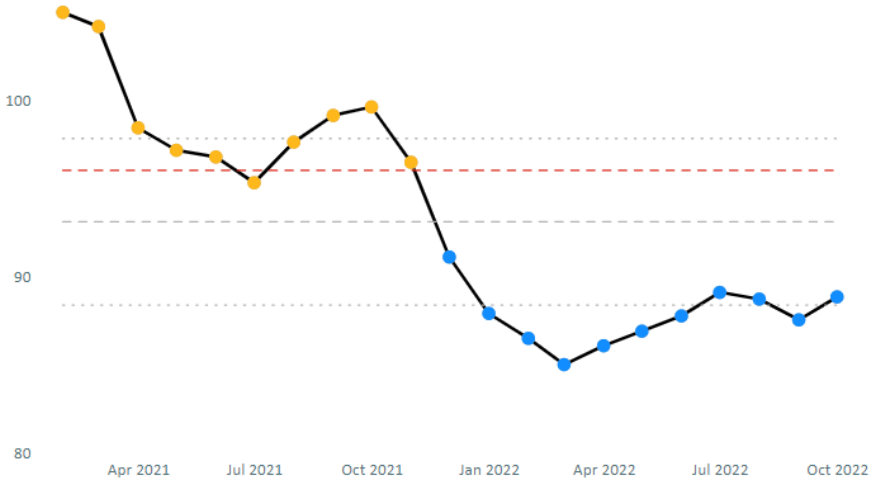
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Below Mean Run Group Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

The Trust HSMR is around the lower control limit, overall showing 'special cause variation of improving nature'. The metric demonstrates a 12 month rolling position to October 2022 which is the last data release. At time of reporting this remains 'lower then expected' for the Trust as a whole and the K&CH site (66.1), with WHH (95.3) and QEQM (90.6) both 'as expected'. This represents an increase in the relative risk of dying with the admission diagnosis, alongside an increase in the number of expected deaths, to last months position. Our Palliative care rate 2.89% is above the national average and peer rates.

The Trust now lies 19th out of the 121 acute non-specialist Trusts on the Telstra Health platform for the third month, with 5 Trusts clustering within in one point.

Intervention and Planned Impact

- The fracture Neck of Femur pathway is our focus for 2022/23 to improve outcomes for this group of patients and time to theatre had been a driver metric for Surgery and Anaesthetic Care group. A Trust Priority Improvement Project (TPIP) is underway for 2022/23 to support driving this at WHH and QEQM sites
- Current 12 month rolling HSMR for fractured neck of femur patients is 90.1 (to October 2022) and remains 'as expected'.
- Mortality metrics continue to be reported and discussed at monthly Mortality Surveillance Group (MSSG) and intelligence used to drive deep dives into pathways where indicated.
- Inclusion as quality metric driver to be reviewed for 2023/24 with monitoring and response to mortality metrics to continue through MSSG

Risks/Mitigations

The impact of Covid-19 on national mortality surveillance is a risk with the national baseline not stabilised. The impact on health due to the consequences of the pandemic are still not fully understood and it is likely will impact on national and local mortality metrics.

Our quality and safety

Sarah Shingler

Incidents with Harm

The True North target is to achieve zero patient safety incidents of moderate and above avoidable harm within 5 years. We want to reduce harm caused to patients, to improve their experience and outcomes. **Our target for the next 12 months is to reduce avoidable harm incidents of moderate harm and above to no more than 26 incidents per month by March 2023 (5% reduction).**

The breakthrough objective will be to reduce all patient safety harm incidents with a harm severity score of moderate and above, this will be achieved through the Fundamentals of Care and Patient Voice and Involvement workstreams.

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
25	25	20	13	21	30	19	31	33	37	37	53

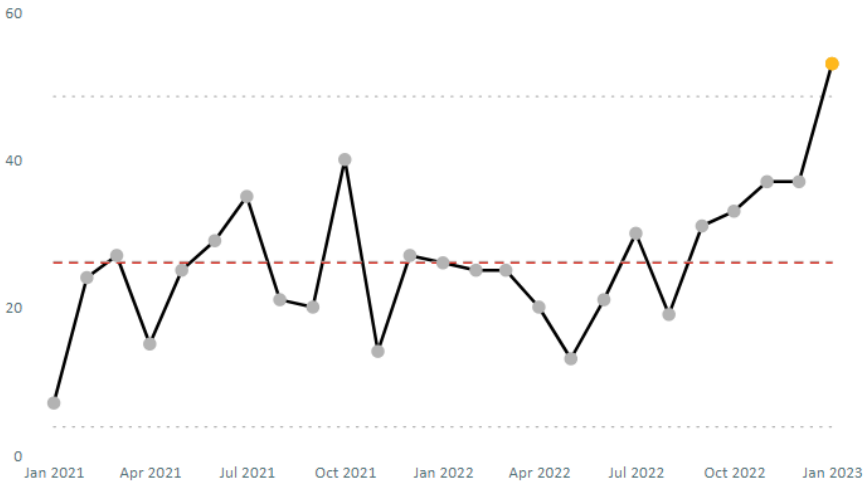
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Astronomical Point

XMR Run Chart



What the chart tells us

The chart details all patient safety incidents with a harm severity score of moderate and above. There were 53 incidents in January, which continues to be above threshold and is an increase from the previous month. The highest contributors to harm this month were care/treatment with 11 incidents, which is a decrease from the previous month, delay/failure was the second highest with 8 incidents which is an increase from the previous month. The third highest was patient falls with 7 which remains the same as last month. In fourth place was operations/procedures with 6 incidents all of which were related to recognised complications.

Intervention and Planned Impact

The site triumvirates continue to report the deteriorating patient themes at the Patient Safety Committee. As a result site based focus groups, facilitated by the governance team as part of the deteriorating patient pathway, Quality Intelligence Forums will commence In February. Task and finish groups at QEQM and WHH led by the site director's of nursing are exploring site specific issues and processes relating to the deteriorating patient. A monthly Trust wide meeting with site medical and nursing directors will commence in March to ensure that there is a system based approach to addressing themes identified in the site based focus groups and prevent silo working. Conversations have taken place with the BI team as we need to better understand the incidents that sit within care and treatment category. The CNMO has requested that a deep dive is undertaken into the 7 deaths and 3 serious incidents to identify any themes and trends and also to understand whether more moderate and severe harm incidents are occurring on any of the acute sites.

The development of a deteriorating patient dashboard remains challenging due to the complexity of data retrieval required. Regular meetings with IT and BIU continue to resolve these problems. There is an estimated 6-week wait for the deteriorating patient form on Sunrise to be updated due to the launch of EDN.

Safe staffing and our current capacity challenges continue to be a factor contributing to patient harm. These challenges have been further compounded with the recent industrial action by SECAMB.

There was no increase in falls for January despite the high number of patients and overcrowding in the ED's. This is monitored at Fundamentals of Care where it is felt that due to department learning and mitigations the risk is low . Escalation areas which are not included within the ED staffing establishment continue to be utilised due to high numbers of patients being cared for in corridors and other non-clinical areas. In both ED's there is direct correlation between audit compliance staffing and overcrowding.

Risks/Mitigations

Temporary staffing strategies are in place to support all areas where staffing is significantly compromised and where high risk patients are cared for. Ward leaders, Matron, Movement & Handling and Therapy teams are on the floor supporting ward teams, increasing oversight that risk assessments for pressure areas, falls and nutritional requirements are completed and reduction strategies are being used. The risk register is being reviewed, along with a meeting in February with the CNMO and CMO to identify any additional support that may be required.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Oct-22	Nov-22	Dec-22	Jan-23
Harm Events	W4		IPC: CDiff Infections		6	13	12	12	7
			IPC: EColi Infections		10	8	10	12	13
	W4		Medication Errors; Severity C+		1	2	2	4	6
			IPC: Audits Composite		85.0%	86.4%	83.9%	85.5%	86.1%
	W4		VTE Assessment Compliance		95.0%	94.4%	93.5%	92.9%	
			Safeguarding Incidents		Sigma	19	23	28	32
	W4		Overdue Incidents		Traj.	6,532	6,579	6,637	6,635

IPC: C diff Infections

This position continues to reflect a local, regional and national change that remains unexplained. Each hospital onset case is investigated using a Root Cause Analysis to identify learning. No cases of transmission have been identified in the reporting year to date, nevertheless existing infection prevention measures are being reinforced. A pilot audit of patient outcomes is in progress.

IPC: *E coli* Infections

The increase in *E. coli* bloodstream infections is being investigated and a 'deep dive' will be done to better understand the root causes. RCAs of individual cases. Other reportable Gram negative bloodstream infections have not risen similarly despite similar IPC interventions which are continuing.

IPC: Audits Composite

The audits are above the threshold in December and January after a small reduction in November. Monitoring will continue to ensure this is maintained.

VTE Assessment Compliance

There are ongoing issues with the reporting of VTE Assessments. This has been raised with the system provider and is being investigated.

Serious Incidents Breached

In February 2022 there were over 100 breached Serious Incidents. This month we have reported zero breached serious incidents. An exceptional amount of work has been done to address the backlog, and to maintain consistent compliance. 1 Never Event has been recorded due to the incorrect route of drug administration (oral medication given via PICC). Mitigation is in place and Duty of Candour completed. The focus now centres on the 6,635 overdue incidents. These are incidents entered on Datix that have not been actioned and closed within the defined timeframes, mostly categorised as no/low harm. Regular review occurs to assess safety. The central quality governance team is working with care groups directly to close them.

Our patients

Our patients

Matt Powls

Trust Access Standards: 18wk Referral to Treatment

The National RTT Standard is to achieve a maximum of 18 weeks wait from GP referral to 1st definitive treatment for every patient. It is a priority to ensure patients have access to timely care whilst also reflecting patient choice regarding timing and place of treatment.

Performance has been adversely affected by the global pandemic and as we enter our recovery phase we are committed to improving our elective waiting times moving towards delivery of the constitutional standard. As part of the population health work with the Health Care Partnership early work has commenced with system partners regarding demand management, pathway design, and an early focus on waiting times for 1st Outpatient Appointment.

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
59.1%	58.4%	58.4%	60.2%	59.7%	59.5%	59.7%	58.4%	58.3%	59.0%	58.1%	56.7%

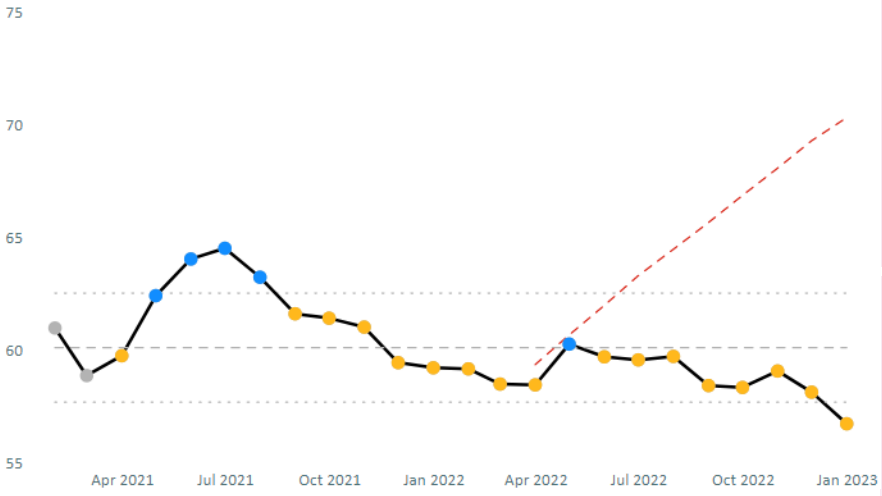
F — Variation indicates consistently falling short of the target

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

Flag Description

Below Mean Run Group
Astronomical Point
Two Out Of Three Beyond Tw...

XMR Run Chart



What the chart tells us

Performance in January deteriorated further, this is due to winter pressures impacting elective services in December and January. Less patients have been treated in January and we continue to see a critical mass of patients waiting longer than 18 weeks for their first out patient appointment. Despite the reduced treatments in month our most urgent patients continued to receive treatment in January. Elective surgery for our longest waiting patients resumed at the end of January and specialities are maximising the volume of patients for treatment in February and March to ensure patients do not wait longer than 78 weeks for treatment at the end of March 2023.

Intervention and Planned Impact

- The risk of 104 week breaches is reducing rapidly as EKHUFT is treating patients earlier in their pathway. In January 4 breaches were reported as a result of covid and patients choosing to wait longer for treatment.
- Patients continue to be offered choice of alternate providers, where Provider capacity and criteria allows.
- Validating our patient pathways and making contact with patients has been a key focus throughout December and January. This process will continue and will ensure our waiting lists are validated and patients are offered choice where regional provider capacity allows.
- Maximising our theatre capacity and ensuring our patients are fit, ready and able to proceed with surgery is a priority for our clinical specialities.
- Identify options to secure capacity to treat our longest waiting ENT (otology) patients due to unexpected absence of one Consultant – seeking support to mitigate the impact to our patients who will breach 78 weeks in March 2023 via the Integrated Care Board (ICB).

Risks/Mitigations

- Impact of Otology breaches against plan to eliminate 78 week breaches at the end of March 2023 – inability to secure complex otology capacity/surgeon within the Trust and regionally.
- Mitigating the risk of further elective cancellations through the remaining two months of the financial year due to emergency demand and flow out of hospital.
- Theatre staffing recruitment and sickness levels remain an issue in our elective recovery journey. Oversight of staffing levels and scheduled activity are being monitored closely and solutions to address areas of risk will continue to be mitigated where possible through the weekly theatre scheduling meetings.
- Outpatient waiting times continue to be elongated and will continue to impact RTT 18 week performance until out patient waiting times are significantly reduced. Working in collaboration with our Integrated Care Board to seek support in referral demand management and development of an Electronical Referral Optimisation Service (EROS).

22/23 breakthrough objective

Theatre Session Opportunity
Efficient use of our theatre complex is key to maximising the throughput of routine elective care.
It is imperative that elective surgery deferred during the global pandemic is prioritised alongside Cancer and urgent operative needs to minimise any harm to our patients and reduce our overall waiting times for elective surgery.

Ensuring that the theatre capacity we have available is utilised in the most efficient manner will allow for subsequent decisions regarding any residual capacity deficits and new ways of working.

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
60	39	36	32	30	34	43	45	43	37	44	41

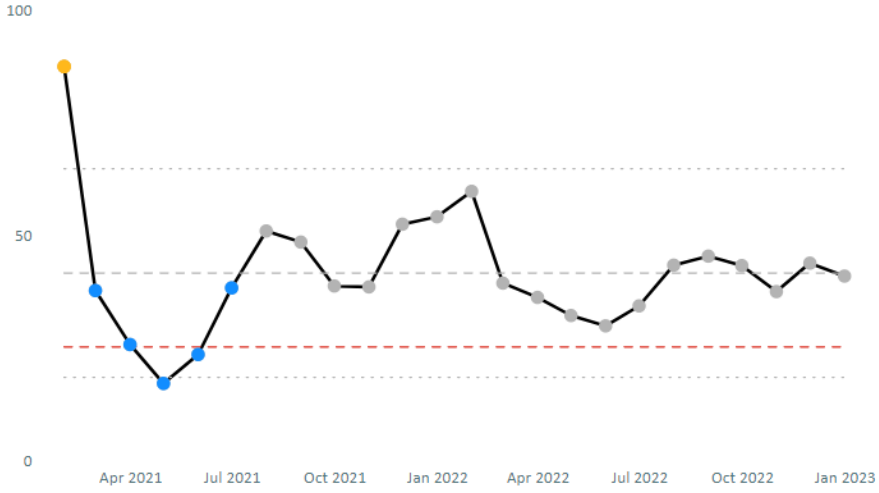
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us
By counting every minute of theatre time not utilised we describe an opportunity for more effective utilisation. In January the potential opportunity decreased to 41 lists, from 44 in the previous month.

Intervention and Planned Impact
- Januarys utilisation was impacted due to site pressure and a phased incremental to EOC recovery up to 30/01/23.
- The number of cases per list in the most recent week has been maintained at 2.3 from an average of 1.9 across the last 20 weeks.
- Ophthalmology saw a reduction in cancelled sessions where they have implement dedicated operational support and pre-assessment
- Further improvement measures that have been implemented are continuously reviewed ensuring shared learning across the Care groups;
- Urology working closely with pre-assessment to reduce UTI on the day cancellations
- All specialities are reviewing where standby patients can enable reduced cancellations on the day by increasing pre assessment pool discussed through the Theatre Optimisation Group
- The Trust is optimising scheduling opportunities with the booking teams with an aim of booking all lists to 95% and increasing actual utilisation to over 85% in February
- Late starts continue to remain a focus for General Surgery where it was identified that delays were due to ITU bed. The action was to add a small case first on the list to enable allowance for ITU capacity
- An improvement day was held for the Elective Orthopaedic Centre in January to further improve patient experience, theatre productivity and reduce length of stay
- The theatre optimisation group continues to meet fortnightly led by the Surgery & Anaesthetic leadership team. This group continues to focus on the development of Standard Operating Procedures regarding theatre utilisation and the analysis of the data regarding early finishes/late starts and cancellations with actions to improve performance. The group has ensured specialities focus on key metrics to analyse themes and trends. We aim improve and maintain actual utilisation to 85% by March 23
- We have continued to successfully appoint theatre staffing across the sites

Risks/Mitigations
- Theatre staff shortages continue mainly at WHH Active recruitment is ongoing with a trajectory to fully recruit by July 24 subject to business case approval.
- Daily review of staffing across all sites to mitigate reduction of lists.
- Theatre Business case (pending CEMG approval) would provide increased substantive staffing levels across all sites & staff the current unfunded theatre sessions.

Our patients

Matt Powls

ED 12h Total Time in Department

There is a nationally proposed new set of Emergency Department Access Standards which will focus on 12 hour Total Time in Department. This measures from arrival to either discharge, transfer or admission.

ED performance has been adversely affected by year on year increases in emergency presentation to our acute sites. The global pandemic has created additional pressures in terms of managing infection and maintaining social distance.

Significant investment has been made into expanding our emergency departments and to recruitment to our nursing teams to provide enhanced patient pathways improving both quality of care and experience and this work is ongoing.

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
9.2%	10.5%	10.4%	8.7%	9.5%	11.2%	12.1%	11.4%	10.5%	9.9%	12.2%	11.8%

F

Variation indicates consistently falling short of the target

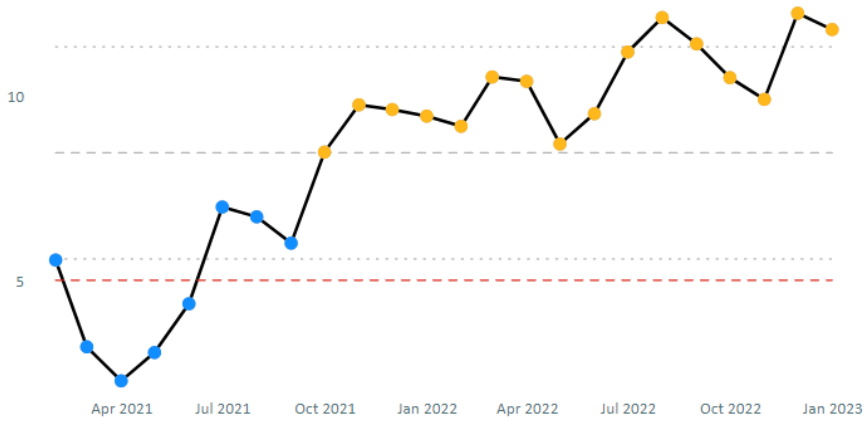
H

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

Flag Description

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

XMR Run Chart



What the chart tells us

In January 11.8% of patients attending ED remained in the department for more than 12 hours. This is a slight improvement on the previous month (12.2% in December). There was a slight improvement for the non-admitted mean time in ED (4.1 v 4.6 in Dec) though the corresponding mean time for admitted patients remains challenged (30.6 v 30.5 in Dec).

The average numbers of patients waiting in ED for an inpatient bed at 08:00hrs increased in January (80.5 v 76.3 in Dec) together with the increasing numbers of patients in acute beds on complex pathways (430 v 364 in Dec) . January reports the highest number declared for this cohort of patients in the last 12 months, impacting on capacity and patient flow out of the ED's.

Intervention and Planned Impact

As part of the plans across the UEC workstreams these interventions are aimed to improve the total wait in ED:

- Introduction of 'Safari rounds in ED to undertake a review of all patients 'admitted overnight' to reduce the need for in-patent beds through access to community pathways, frailty community capacity,
- Working with the system to access the increased nursing home capacity across East Kent,
- Implementation of a new clinical model at the front door (WHH) with a nurse and senior doctor initial assessment to provide earlier interventions at the start of the patient journey and maximise the use of pathways to SDEC, UTCs impacting on the non admitted and admitted times,
- Daily pathway zero meetings with key internal stakeholders to improve discharge planning and mitigate delays,
- System wide MADE event identified opportunities with community and voluntary sector stakeholders to support earlier discharge for patients on pathways 1 and 2,
- The UEC has developed action plans to focus on the 4 hour standard improvement for both paediatric and UTC at WHH . These form part of the wider Front door workstream under the UEC improvement programme,
- The introduction of the discharge 'hubs' commenced at QEQM led by the Integrated Director with WHH.

Risks/Mitigations.

- SECAMB conveyances to the ED's remains the highest nationally. System support to undertake a 'missed opportunity' audit in February to identify use of alternative pathways prior to conveyance to hospital.
- Surgical and Orthopaedic clinical leads working in collaboration with the UEC have agreed direct access pathways mitigating the need to go through the ED's; to be launched end of February.
- Medical SDEC Direct Access Pathways approved and to be launched in February to reduce the footfall through ED impacting positively on the timed pathways.

22/23 breakthrough objective

Same Day Emergency Care (SDEC)

Ensuring patients are seen and treated in the right setting, at the right time and in the right way are key aspects of efficient and effective patient care. A number of patients currently accessing our Emergency Departments can be safely assessed, treated and discharged via a Same Day Emergency Care pathway, such as Emergency Ambulatory Care, Gynaecology, Surgery or Frailty). Access to an SDEC service may be following a direct referral by a GP or via the Emergency Department.

It is anticipated that an average of 2,600 patients each month can be safely seen and treated via a Same Day Emergency Care pathway, this is the ambition for 2022/23.

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
1,940	2,302	1,945	2,076	1,972	2,032	1,793	2,007	1,909	2,080	2,230	2,141

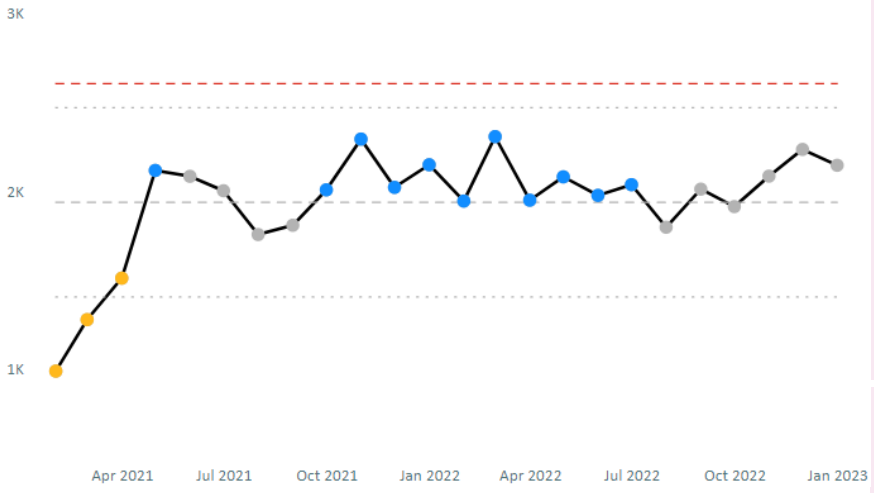
Variation indicates consistently falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The SDEC activity across all services saw a slight decrease in the total numbers of patients accessing Ambulatory services across the trust (2141 v 2230 in Dec) with a decrease in both frailty and children's SDEC activity. The decrease in children's correlates to the overall decrease in paediatric activity (5220 v 7913 in Dec) which was significantly above plan in December possible reflecting the national strep A concerns during that period. The WHH continues with its extended hours of operation with the numbers increasing month on month since commencing in November 2022. However it remains important to note that the SEAU at WHH/QEQM was partially used in January to manage the increased inpatient bed requirements (OPEL4) together with the change to the frailty model at the WHH as part of the use of the dedicated space to support the ED build

Intervention and Planned Impact

- The Direct Access Pathway/SDEC workstream, is working on delivering an extended SDEC model for winter. Patients with long term conditions attending ED require the support of an integrated approach from community clinicians and acute hospital specialists. Virtual Wards for Respiratory conditions are evolving and will provide further integration, these are planned to come on-line in February 23.
- As part of the workstreams within the Emergency Care Delivery Programme, clinical pathways have been developed in collaboration with the surgical, acute medical and orthopaedic leads to increase the cohort of patients accessing the SDEC services. These pathways reduce the demand within the ED, supporting the right place , first time approach and are planned to go live end of February.
- The development of the Medical Day Unit at the KCH site, to release capacity in the medical SDEC services on the QEQM/WHH sites to increase the cohort of patients identified against the Ambulatory Care Conditions
- The use of 'Hot Slots' for referral into SDEC the next day has proven successful reducing some patients waiting overnight to access the service..
- Plans being developed for access to specialty Hot Clinics within the SDEC are being progressed to enable more patients to be seen urgently as an out patient reducing the need for in patient stay.

Risks/Mitigations

- As part of managing phase 2b of the WHH ED build a new clinical model implemented with senior nurse and senior doctor assessors (initial assessment) for walk-ins at the front door. The aim is to progress early plans/interventions for patients and increase the numbers signposted to UTC/SDEC.
- Surgical direct access (DA) pathways developed and approved by the care group to be operationalised mid February which includes access 24/7 at the WHH.
- Pathways completed for Medical SDEC to enable DA at the front door for GPs/Paramedics. These will be launched across the sites, beginning with WHH. Assurance regarding the training , governance , monitoring to be signed off with a communication plan ahead of the launch mid February
- Specialty wide collaboration event to explore the expansion of clinical pathways into speciality SDEC.
- Reducing risk of bedding the SDEC areas to be managed through the Site Triumvirates. QEQM focussed work to release space back to Medical SDEC.

Our patients

Matt Powls

Trust Access Standards: Cancer 62day

The National 62 Day Referral to Treatment requires all patients to receive treatment for Cancer within 62 days from GP referral. The standard exists to ensure patients are seen, diagnosed and treated as soon as possible to promote the best possible outcome for all patients on a cancer pathway.

The Trust is committed to reducing the time to diagnose and treat patients. Throughout the pandemic the Trust has prioritised and maintained access for all cancer patients improving our overall performance.

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
71.0%	74.5%	66.1%	61.7%	73.2%	78.0%	71.7%	65.8%	65.3%	71.5%	71.9%	61.8%

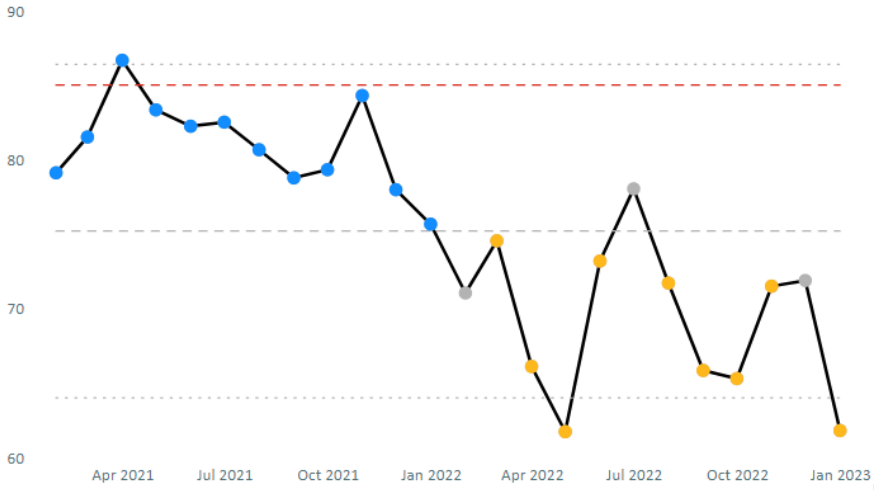
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Astronomical Point

XMR Run Chart



What the chart tells us

Performance has dipped in January and that is due to the increase in breaches within Urology. We are working with Surgery & Anaesthetics Care Group to support improvement in 62 days. The Trust remains in the top 3 performers nationally for 2-week wait access and is still making the biggest contribution to a Cancer Alliance that has the 3rd smallest backlogs for 62 day breaches.

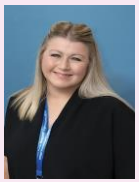
Intervention and Planned Impact

- Engagement with care groups regarding back log of 28 day letters for patients, work in progress, significant improvement in some areas
- Enhanced escalation process put in place for Consultant reviews, Tertiary referrals, surgical dates and diagnostics. New bi weekly multi-professional meetings starting with Urology and Lower to further support.
- CCHH and Clinical Support Services working closely to optimise the radiology diagnostic capacity in the CDC to support faster and early diagnosis. Achieving the 28-day standard will help reduce the number of patients waiting over 62 days.
- Endoscopy Electronic record of recording when a patient can be removed from the pathway is working well
- Lower GI benign letter has been signed off by the consultants and being used which has already had an impact on reducing the backlog and increasing compliance with 28 days.
- PGD now in place, minimising delays and repeat colonoscopies.
- Proactive management of long waiting patients to understand how we can best manage these groups through to treatment. .
- All roles within CCHH Compliance team being reviewed to support improved learning, standardising practice for all teams, to help improve morale, co-design and share best practice.
- There are a number of patients that have a QFIT requested following first OPA that didn't have one done prior to the referral. Operations Director has met with the CQUIN lead to discuss plan to support community colleagues to embed Qfit prior to a 2WW cancer referral.

Risks/Mitigations

- Delays to diagnostics vetting and booking remains a significant risk but pathway mapping and changes with process being implemented to support improvement.
- Histopathological reporting remains a significant contributor to the teams ability to achieving sustainable compliance, again work in progress with CSS to support improved turnaround times.
- Theatre capacity for Specialities within Urology, Head & Neck, Breast and Lower continues to be a risk.
- Tertiary capacity for OPA's, diagnostics and treatments remains challenging, working with the Alliance to support improvements.
- MDM radiology cover Consistency continues to be a significant risk, need to confirm plans for Easte

Our patients



Sarah Shingler

Patient Experience: Inpatient Survey

The National In Patient Survey published in October 21 (surveyed patients discharged in November 2020), completed responses for the trust were received from 515 patients (1,250 invited) with a response rate of 43%. The survey consists of 45 questions and the trust scored below the national trust average on all questions, and in 23 out of the 45 responses the trust scored in the bottom five trusts in the region, and in the bottom five Nationally.

The Trust has chosen ten questions from the National In-Patient survey, and our average for our focused 10 questions is 7.13 compared to 7.65 as a national average.

41 adult in-patient wards will complete 50 surveys per month (2,050) using the tendable app using the 10 questions.

Our ambition is to improve performance against the focussed ten questions to achieve the national average score of 7.65 as a minimum by March 2023.

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
					8.9	8.8	8.9	8.9	9.0	9.0	9.4

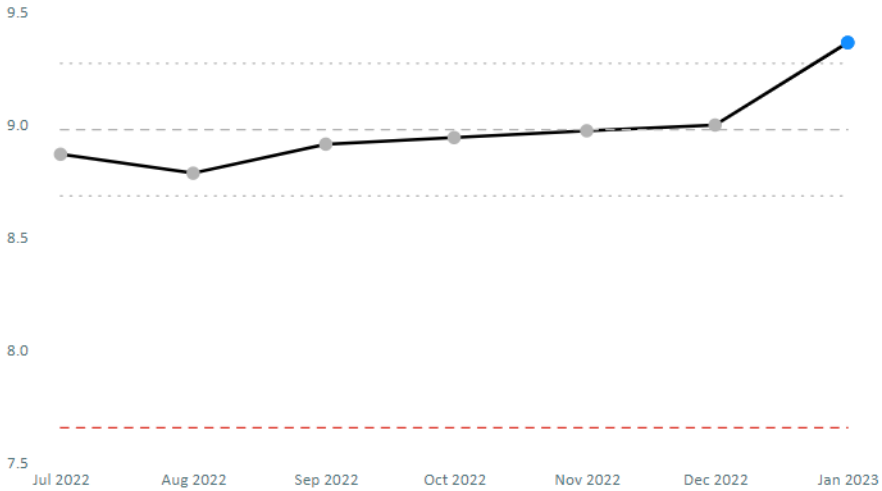
P — Variation indicates consistently passing the target

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

Flag Description

Outside Moving Range Limit
Astronomical Point

XMR Run Chart



What the chart tells us

In January, 2023 Patient Experience Surveys were completed via Tendable across 55 wards. The target of 2050 surveys has been exceeded.

The Trust had an increased overall score of 9.3 (93%), the Trust threshold is 7.7 (77%).

The exception continues to be patients reporting that they had difficulty sleeping at night due to noise. The 'No' response for this specific question is a positive, therefore the January score of 6.7 (67%) is reflecting those patients that had a positive experience.

Intervention and Planned Impact

Patient feedback is that the noise disturbance is not just from other patients but from staff, lights and equipment. The question was changed this month from 'Were you prevented from sleeping at night by noise from other patients' to a more generic 'Were you prevented from sleeping at night by noise'.

Measures to counteract the noise disturbances at night continue to be raised with the frontline teams, including the provision of earplugs and eye masks for patients and sharing of guidelines for night duty staff, particularly in our escalation areas. The Procurement Team are leading on ways to safely reduce the noise from equipment.

Patient volunteers and champions will be able to work with the quality improvement nursing team to support the wards in the completion of the carer and inpatient experience surveys in adult and paediatric areas, particularly those areas that have completed less than the expected 50 surveys per month. The HoNs and DoNs support the wards to complete their surveys and develop actions to address poor responses, reporting monthly to the Nursing, Midwifery and AHP Board. The data is also presented and reviewed at the monthly Fundamentals of Care Committee (FoC).

The Patient Involvement Team continues to review the feedback mechanisms and governance arrangements around how the national Friends and Family Test feedback is shared within Care Groups and across the Trust for ED, Outpatients and Theatres.

Risks/Mitigations

If culture and behaviours do not change and the patients voice continues not to be heard, there is a risk that patient experience does not improve or deteriorates further, placing the Trust at increased risk of CQC regulatory action and reputational damage.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Oct-22	Nov-22	Dec-22	Jan-23
Cancer 62d			Cancer 2ww Performance		93.0%	95.7%	96.9%	95.8%	96.8%
	W4		Cancer 28d Performance		75.0%	70.4%	68.5%	67.7%	52.5%
	W4		Radiology Diags vs Plan		Traj.	18.5K	18.7K	17.1K	18.6K
	W4		Endoscopy vs Plan		Traj.	1,399	1,359	1,087	1,230
RTT - 18 Weeks	W4		RTT 78w Breaches		Traj.	344	306	357	314
	W4		RTT 52w Breaches		Traj.	3,372	3,379	3,299	3,317
	W4		DM01 Compliance		75.0%	65.1%	66.8%	60.6%	57.6%
	W4		RTT OP Booking Breaches		14,000	26.9K	26.9K	28.7K	27.6K
	W4		Elective Admissions vs Plan		Traj.	8,845	9,305	8,037	8,419
ED Compliance	W4		ED Compliance		90.0%	68.8%	69.9%	64.7%	68.4%
	W4		Unplanned Re-attendance ED		10.0%	14.0%	12.3%	12.6%	13.2%
	W4		Super Stranded >21D		107	291	295	287	310
	W4		NEL Admissions vs Plan		Traj.	6,645	6,732	6,708	6,650

Cancer 2ww
Whilst this metric remains compliant with the 93% standard performance has reduced slightly and is now showing 7 data points below the mean of the period resulting in the SPC alert. Performance in February to date is compliant and has improved to around 97%.

RTT 18 Weeks
The impact of winter pressures in December and early January has resulted in an increased number of patients breaching 78 weeks. Recovery plans from mid January have been reset and specialities are focussed on validating and scheduling treatment for patients before the end of March 2023. January has seen a significant focus diverted to validating our pathways, the impact of this has yielded only a marginal change in the 52 week position which is positive despite the activity cancelled.
DM01 compliance, due to reduced routine activity and increasing volumes of urgent/cancer/consultant only demand, has seen performance deteriorate in month. Improvement work across Radiology, Endoscopy and Cardiology continues, with focus on reducing the request to reporting times for patients on our urgent and cancer pathways, and ensuring diagnostic requests can be scheduled at point of referral without delay.

ED Compliance
Compliance with the 4h standard improved in January to 68.4% v 64.7% in December. The improvements in the Emergency Department was mainly seen at WHH and improved for both admitted and non-admitted patients. 4h performance for the UTC's however improved by 6.8% and was over 95% for the first time in 8 months. Again this improvement was seen at WHH with QEQM already performing highly in this area.

Super stranded over 21 days
In response to increased pressure we have introduced patient by patient review with key decision makers and enablers from within the Trust and from our community partners. Numbers increased during January after the reductions seen in December.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Oct-22	Nov-22	Dec-22	Jan-23
FFT	W4		FFT Maternity Response Rate		18.0%	16.6%	17.4%	15.5%	15.6%
	W4		Complaint Response		90.0%	19.6%	39.7%	40.4%	62.3%
	W4		Duty of Candour - Verbal		100.0%	88.5%	90.9%	78.6%	90.9%
	W4		Duty of Candour - Written 15wd		100.0%	93.5%	72.4%	77.8%	80.0%

Duty of Candour

Previous reporting issues have been addressed, and the Deputy Director of Quality Governance has been meeting with care groups to ensure DoC is completed and recorded in Datix. As a result, compliance has improved significantly and remains on track to achieve full compliance by April 2023. There remains a backlog of circa 150 contacts (verbal, written and findings) that require a dedicated resource to clear; previous support was temporary and has now ended.

Complaints

Although a steady increase has been seen in the response times for complaints, overall the time taken to respond is outside of policy, with an average of 59 days taken. This is due to higher turnover of staff in the central complaints team and delays to filling vacancies, and delays in accessing key roles such as care group leadership and the executive team for response approvals. The number of complaints received in January was 80, with returners remaining consistent at 14 in total. Despite the turnover of staff in the complaints team, compliance for responding within 3 days has been achieved for the first time in 7 months. Work to improve the process continues through the Deputy Director of Quality Governance meeting care groups and the Head of service.

Our people


Our patients
Our people
Our future
Our sustainability
Our quality and safety

Our people

Andrea Ashman

Staff Engagement (score)

Staff Engagement levels have remained below the national average throughout the last five years. The Staff Engagement Index itself has been on a downward trend for three years and, as an organisation, we are one of the most challenged in the country, sitting in the bottom 20% nationally. Given the negative implications of reduced staff engagement, it is imperative that levels are significantly and consistently improved.

The National NHS Staff Survey (NSS) is used to give an indication of staff engagement, providing an overall Staff Engagement Index to the Trust. In order to monitor this more regularly, we are also measuring this at quarterly intervals through the National Quarterly Pulse Survey (NQPS). Our aim is to improve our Staff Engagement Index score to 6.8 by March 2023, as demonstrated in the annual staff survey.

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
6.35	6.35	6.26	6.26	6.26	6.33	6.33	6.33	*Under embargo*			

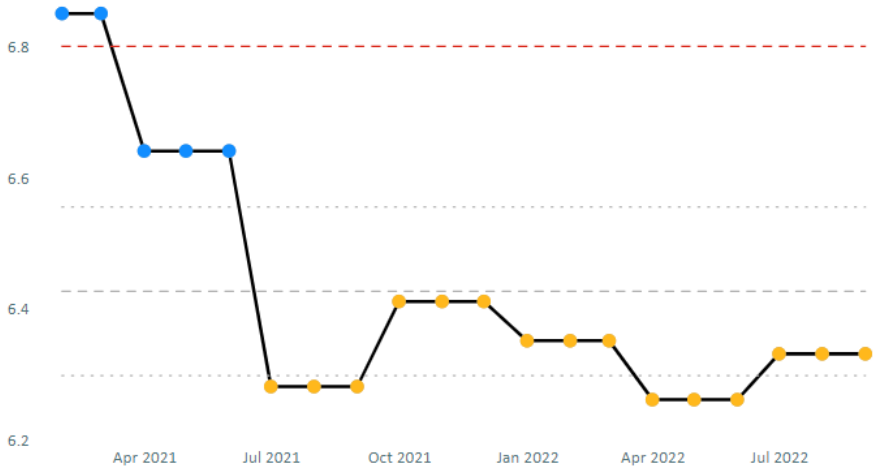
F — Variation indicates consistently falling short of the target

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

Flag Description

Below Mean Run Group Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

Results of the National Staff Survey are now available under a strict national embargo. The data cannot be shared until 9th March, meaning the graph opposite cannot yet be updated.

Staff Engagement has subtly improved quarter-on-quarter. The improvement is attributable to improvements in involvement and motivation, two of the domains of engagement. Further overall improvement is blunted by a significant reduction in advocacy, the extent to which people would recommend our Trust.

Interventions and Planned Impact

An enhanced National Staff Survey dashboard has been published following access to the embargoed NSS 2022 results. This allows for analysis and action at three levels:

Specialty level – with a 'change three things' programme for each specialty, monitored by PCBP's
Corporate level – with targeted interventions in areas with greatest opportunity for improvement
Trust level – identification of areas with the greatest 'gap' from the national standards

Specialties are being provided with a 'specialty guide' to support identification of their three change areas. A project management tool has been implemented with the PCBP's to report this action monthly and support assurance. Overall, the majority of NSS results have remained unchanged. The most significant headlines centre around advocacy (the extent to which people recommend the organisation), confidence around raising concerns and satisfaction with pay.

Risks/Mitigations

Staff engagement has been on a downward trajectory nationally for each of the last four quarters. The Independent Investigation into East Kent Maternity services appears to have had an impact on staff advocacy, which fell following publication. There is a risk that the pending restructure of the organisation has an impact on the level of engagement with NSS-related Action Plans which have previously been led by Care Group Triumvirates.

22/23 breakthrough objective

Staff Involvement Score

EKHUFT's staff involvement score is lower than the national average for acute trusts (6.7). Staff involvement is one of the 3 components that contributes to staff engagement – the We Care People True North. Of the three components, staff involvement is more heavily weighted, it can be tangibly impacted and also influences the other two components - staff motivation and advocacy. Our aim is to improve staff involvement, as a core aspect of improving the overall staff engagement score.

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
6.20	6.20	6.13	6.13	6.13	6.28	6.28	6.28	*Under embargo*			

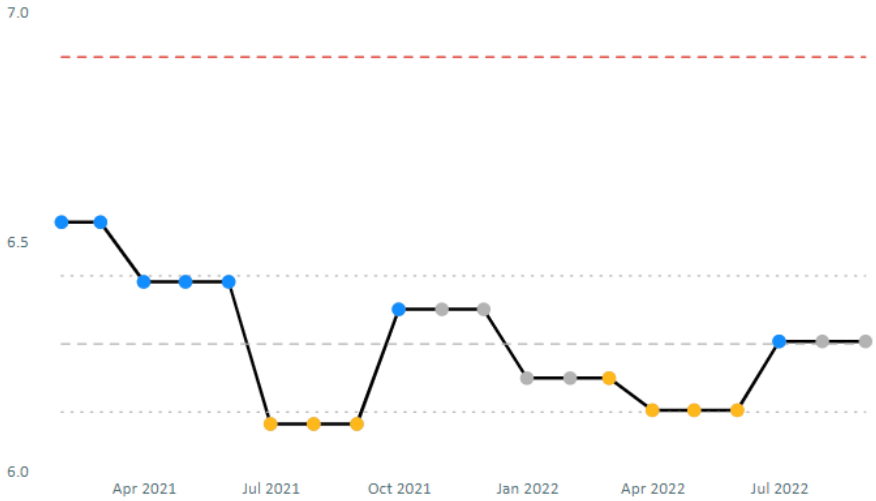
Variation indicates consistently falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

Staff Involvement has improved significantly both quarter-on-quarter (from Q2 to Q3) and year-on-year (from 2021 to 2022). High-performing bright spots have been identified along with more challenged hotspots. Intensive support will be provided to hotspots and learning will be applied from those performing well.

Intervention and Planned Impact

- 45 areas have now been trained as part of the Team Engagement and Development (TED) pilot, including Cardiology and Rheumatology
- The We Care rollout has been extended and will also include Urology and Cardiology
- Two of the priority areas identified as part of the National Staff Survey 2021 data review (those with the lowest scores for involvement) have completed the KENT Fundamentals programme
- The new staff intranet, Interact, has been reviewed and can provide; sentiment analysis, target pulse surveys and an online suggestion area, the effectiveness of which will be piloted
- An 'Involvement Toolkit' is being finalised to provided support at team leader, speciality and Care Group level and will be launched to support work following release of 2022 Staff survey results

Risks/Mitigations

- Nationally, levels of staff involvement in the NHS have been on a downward trend for the last 3-4 years and there has been a pronounced fall in recent quarters
- The Kirkup Report could have a significant impact on staff morale and may have affect the way colleagues respond overall to the National Staff Survey questions
- Rising pressures surrounding the cost of living can raise stress and anxiety levels and lead to reduced overall engagement scores

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Oct-22	Nov-22	Dec-22	Jan-23
Staff Engagement	W4		Appraisals Compliance		80.0%	69.8%	69.9%	68.9%	69.9%
	W4		Statutory Training		91.0%	90.2%	90.1%	90.4%	90.2%
	W4		Safeguarding Adults Training		90.0%	85.0%	84.5%	83.9%	84.1%
	W4		Safeguarding Children Training		90.0%	86.2%	85.5%	84.6%	85.5%
			Staff Turnover: HCA		13.5%	13.9%	13.9%	13.6%	13.5%
			Premature Turnover Rate		25.0%	23.6%	25.4%	25.1%	25.8%
	W4		Medical Job Planning Rate		90.0%	33.3%	33.9%	29.1%	

Appraisal Compliance
Overall appraisal compliance had been on an upward trend from June 22 to November 22. Compliance dropped to 68.9% in December, but returned to 69.9% in January 23. The metric remains below the reviewed alerting threshold of 80%. The compliance by Care Group ranges from 86% for Surgery HNBD to 65% for UEC. Corporate areas are the lowest of the groups at 55%.

Statutory Training
Statutory training compliance remains below the threshold of 91% at 90.2%, and decreased from the previous month of 90.4%. This continues to be an important 'watch' at monthly Care Group Performance Review Meetings, and will be closely monitored to ensure compliance improves. Compliance ranges from 94% for Clinical Support down to 83% for UEC.

Staff Turnover: HCA
Healthcare Support Worker turnover has now reached the desired threshold (**13.5%**). This follows 5 months of improvement following a peak of 14.9% in August 2022. In-month HCSW turnover also remains below the desired threshold and has done for 3 of the last 4 months. The HCSW workforce now stands at 1122 WTE – the highest is has been in East Kent.

HCSW's represent a high flight risk staff group, in the top two leaver groups for turnover and premature turnover. Part of this is due to the lack of professional identity and being undervalued. As a result, the Trust successfully bid for funds through NHSE and will launch the **HCSW Voice Programme** on 27th March.

Premature Turnover Rate
Premature turnover in January stands at **25.81%**. This is slightly above the target threshold (25%) and has risen 0.7% over the last month. The rise is partially a result of improved total turnover (as premature turnover is measured as a % of this smaller turnover pool), but also as premature leavers have increased recently, with 20+ leavers with <12m service across 3 of the last 5 months.

The 'New Starter Experience Survey' launched on 30th January and will begin to give intelligence across five time-points (week one, month one, 100 days, 6 months and 1-year) and help initiate targeted action.

Our sustainability

Our sustainability

Phil Cave

Financial Position (I&E Margin)

Whilst there has been a significant financial deficit over the years up to 2019/20, in the last two financial years a breakeven position or better was delivered. This metric will measure us against our long term aim to maintain a breakeven position.

For 2021/22 the impact of Covid-19 paused the NHS business planning process nationally and had limited the ability of the Trust to hit its cost efficiency targets. In 2022/23 there is a return to a more traditional planning process and an efficiency target of £30m, in additional to Covid spending reductions of £9m and elective recovery fund (ERF) income of £18m. The current plan is for breakeven which improves from the figures quoted last month because of £6m additional inflation funding and £16m non-recurrent ICS funding.

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
1.307	0.076	-3.700	-6.624	-6.604	-7.795	-11.453	-13.015	-15.313	-19.323	-24.520	-28.935

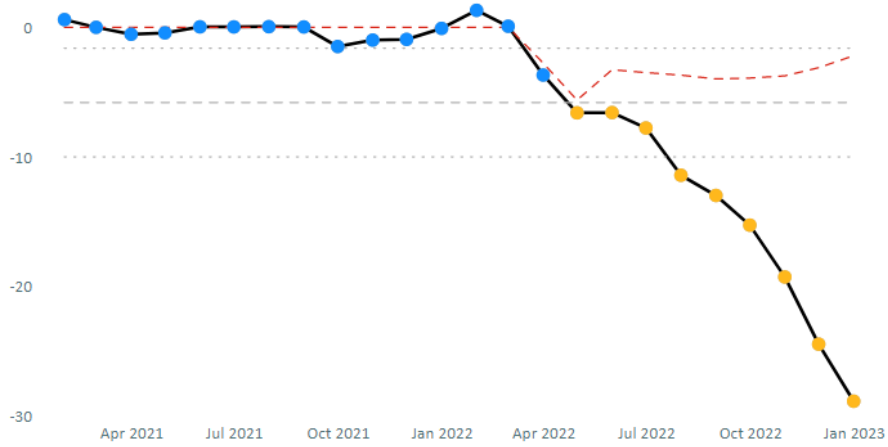
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Below Mean Run Group Astronomical Point Descending Run Group Two ...

XMR Run Chart



What the chart tells us

The first two years of the graph show the monthly financial performance of the organisation which has resulted in both years being breakeven. The final graph point shows position in January which is a £28.9 deficit against a plan of £2.2m deficit. The key drivers behind the deficit are: £6.4m behind plan on CIPs, £7.2m on escalation areas (additional 60 beds), £5.1m on metal health staffing, £3.1m other staffing pressures due to demand, overspends on work permits £1.4m, drugs overspend £1.7m and not charging for parking £1.8m. The Trust is currently reforecasting the position to a £19.3m deficit in year.

Interventions and Planned Impact

The largest interventions for the plan are:

- Delivery of the £30m CIP programme, the largest pillar of this is the reduction of premium pay which is a breakthrough objective. Fortnightly meetings being held with clinical and corporate areas, use of national benchmarking data, plus detailed budget reviews underway.
- CEO/CFO finance deep dive held in December.
- Increased controls on pay/ non-pay introduced.
- System working to minimise overspends on escalation areas.

Risks/Mitigations

For 2022/23 the key risk and mitigations are:

- Increased usage of escalation areas, Trust working with system partners and increased national investment to reduce usage.
- Efficiency target of £30m, PMO team working with care groups and executive directors
- Covid-19 spend reductions £9m, DIPC working with finance to release costs
- Non-pay inflation. Procurement is working closely with NHS England procurement and supply chain to minimise impact.

22/23 breakthrough objective

Premium Pay Spend

Premium pay spend consists of agency (circa £36m per annum), bank (circa £32m per annum) and overtime/ locums (circa £19m per annum) across the Trust. The total value is around £87m per annum (18% of total pay bill). These costs are amongst the most influenceable by the management of the organisation and therefore a good area for a breakthrough objective that will positively impact the finances of the Trust.

The objective is to reduce the spend by 10% or £8.7m in 2022/23 but may be refined once the full project plan is developed.

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
7,403	9,148	7,890	7,497	8,894	8,702	8,809	9,618	9,178	8,577	8,413	9,034

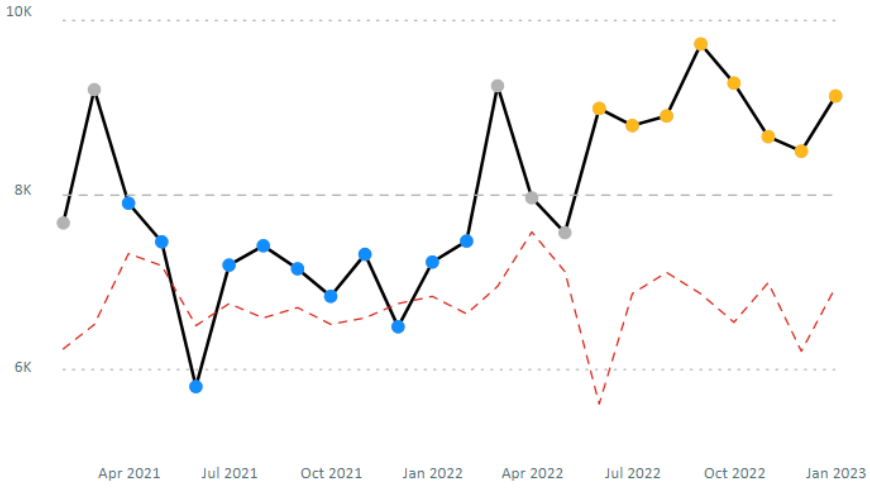
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Above Mean Run Group

XMR Run Chart



What the chart tells us

The chart tracks premium pay spend in £'000 across the last two years. There are two points in March 2021 and March 2022 where a spike is seen above the usual control limits. This is caused by the Trust ensuring all costs in that financial year are captured and include unpaid claims due in year.

This information is the baseline for which we will measure improvement over 2022/23. In January premium pay increased by £600k in relation to increased escalation areas opened.

Intervention and Planned Impact

- The breakthrough objective although having a finance executive lead will be run by senior HR colleagues and will need support of all care groups to help deliver.
- Key Interventions include:
- Detailed focus by care groups on drivers of premium pay..
- Review of bank, agency and overtime rates across all staff groups.
- Ensure improved sign off processes and governance across the Trust.
- Recruitment to key clinical posts to reduce the need for temporary staffing.
- Ensuring exit plans in place for high cost medical agency locums

Risks/Mitigations

- Most Care Groups have identified premium pay as a driver and will need support to align and focus on the biggest opportunities for reduction
- A significant proportion of premium pay is caused by vacancies and will need targeted recruitment support to fill
- The remainder of spend is caused by sickness and operational demand. The former should reduce but work is required to control and reduce the latter.
- The increase in escalation beds and the increased need for specialing patients has increased the need for temporary staff?

Our sustainability

Carbon Footprint (CO2e)

Implementing environmentally sustainable principles and reducing the Trust's greenhouse gas emissions adds value to our patients and reflects the ethics of our staff. The national requirement is for the Trust to be net zero for the emissions it controls by 2040 (80% by 2028 to 2032). Being environmentally sustainable is therefore a key element of our Trust's True North. The Trust's carbon emissions are made up of direct emissions i.e. natural gas; indirect and direct emissions i.e. electricity consumption, waste, water, steam, anaesthetics and inhaler usage. It is these areas we will be focussing on improving over the coming five to ten years. We also plan to add in other measures such medicines waste, NHS fleet and leased vehicles and staff travel, as we develop these metrics in the future. Our aim is to reduce the net emissions controlled by the Trust directly by 50% by 2025/26.

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
7.70	8.03	6.43	6.77	2.48	4.44	4.72	4.14	5.76	6.05	7.49	

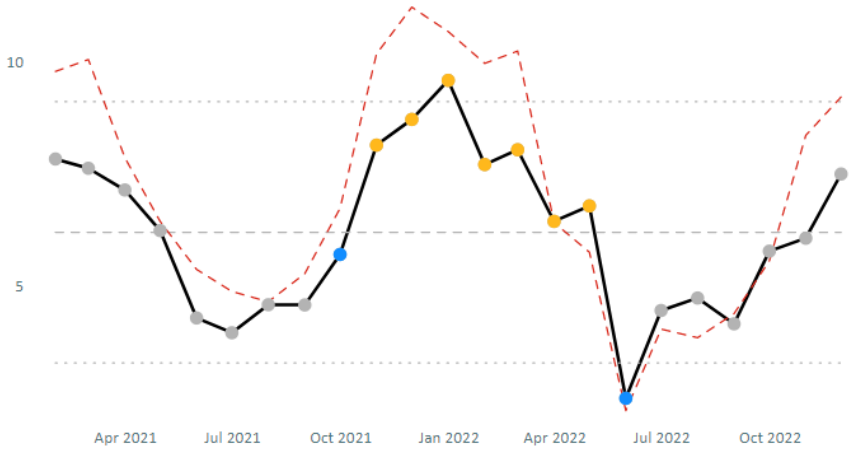
Variation indicates consistently passing the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

There is a clear seasonal effect to the Trust's carbon footprint as demonstrated in the chart. The position is reporting below the monthly trajectory of 9.25 at 7.5kgC02e per m2 and is below the same period last year (which reported at 8.7). The Trust has increased its m2 during 2022 (ie, new Emergency Department expansions at both Queen Elizabeth The Queen Mother Hospital and William Harvey (WHH), and the ITU build at the WHH) and this, plus the installation of combined heating and power (CHP), will have an impact on the Trust's energy usage. CHP in particular will have an impact on the amount of gas used. The annual 10% reduction is a fixed value and the reduction is phased across the year and is based on seasonal phasing and on historic assumptions. While this allows greater tolerance in the winter months, it also increases the potential for missing the trajectory in month, because seasonal predictions can be difficult. We are, however, currently reporting that we will be within the annual 10% reduction for the end of the year. The trajectory now compares performance against historical data to a trajectory of systematic carbon reduction in line with NHSE/I's 'Delivering a Net Zero NHS'. This allows the measurement of carbon used to be proportionate to the size of the Trust's estate. An increase in our site footprint will, as a consequence, increase the use of carbon and therefore the new metric allows for appropriate contextualisation.

Interventions and Planned Impact

Breathe Energy has been working with the Trust and 2gether to identify carbon reduction schemes that could be commissioned in the new financial year. The Trust, with 2gether, produced a business case which identifies the installation of heat pumps on the three acute sites funded via the PSDS 4 Grant. The Trust submitted its bid on 15 October 2022 and, although this successfully passed through to the second stage, we have been notified that we have been unsuccessful for this particular funding round, due to the total value of applications received. A technical review and feedback of our project has been requested against PSDS criteria to ensure we are in a good position to successfully secure funding in any subsequent public sector grants that may become available.

A Joint Carbon Reduction Steering Group is in place which includes representatives from both the Trust and 2gether Support Solutions. Our Green Plan is in the process of being finalised and objectives relate to:

Sustainable Estate (Using energy, water, waste, travel, procurement and buildings efficiently while adapting to climate change); and Sustainable Healthcare (Delivering healthcare that reflects wider corporate, social and environmental issues, including prevention of poor health and developing more environmentally sustainable models of care). The Joint Carbon Reduction Steering Group will drive the strategic improvements required to reduce the carbon footprint, in line with our agreed trajectory.

Risks/Mitigations

- Appropriate funding to trigger significant change is not available.
- Lack of behaviour change & culture in the organisation negates the opportunity to promote carbon reduction.
- Due to the backlog maintenance programme and age of the estates we will have inefficient use of energy.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Oct-22	Nov-22	Dec-22	Jan-23
Financial Position	W4		Total Pay	L	0.0%	-6.9%	-7.2%	-7.4%	-7.8%
	W4		Non Pay		0.0%	-0.4%	-1.4%	-2.4%	-2.6%
	W4		Efficiencies YTD Variance (£M)	L	0.0	-1.3	-2.5	-4.6	-6.4
	W4		Efficiencies FOT Variance (£M)	L	0.0	-3.4	-7.1	-7.7	-8.0
	W4		Efficiencies Green Schemes	H	90.0%	42.6%	49.3%	48.8%	65.7%
	W4		I&E Monthly Variance Trust (£)		0	-2.4M	-4.1M	-5.8M	-5.4M
	W4		I&E YTD Variance (£)	L	0	-11M	-15M	-21M	-26M
	W4		I&E FOT Variance (£)	L	0	-30M	-30M	-30M	-30M

Total Pay

This metric is mainly driven by the expected reduction in premium pay not being achieved. Premium pay reductions are still a focus of care groups as a break through or driver metric. Other key drivers are the opening of escalation beds and a shortfall in CIP.

Efficiencies YTD Variance/ Efficiencies Green Schemes

The Trust has been slower than expected in developing its CIP programme due to operational pressures in Q4 of 21/22. The total CIP plan for the year is £30m for which £23m is identified. The executive team are monitoring progress through PRMs and CEMG. In addition the CFO is meeting with care groups on a fortnightly basis.

I&E Monthly Variance Trust/ I&E YTD Variance

The key drivers behind the deficit are: £6.4m behind plan on CIPs, £7.2m on escalation areas (additional 60 beds), £5.1m on metal health staffing, £3.1m other staffing pressures due to demand, overspends on work permits £1.4m, drugs overspend £1.7m and not charging for parking £1.8m. The Trust is currently reforecasting the position to a £19.3m deficit in year.

Our future


Our patients
Our people
Our future
Our sustainability
Our quality and safety

Our future

Matt Powls

Not fit to reside (patients/day)

We have embedded the recording of criteria to reside (C2R) via daily board rounds through the course of the pandemic, this enables us to identify patients who no longer need to reside in hospital. This allows us to easily identify the ongoing support and care patients need to leave hospital.

Patients are delayed in hospital awaiting a supported discharge which may be a care package, discharge to a Community Hospital for rehabilitation or discharge to a nursing or residential home. There may also be patients delayed for internal reasons, such as a diagnostic test or a change in clinical condition.

The Trust works in partnership with the local health economy (LHE) stakeholders to ensure that external capacity is sufficient to meet the needs of the local population. This includes reviewing the available out of Hospital capacity and ensuring patients are reviewed daily for timely discharge.

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
320.4	336.2	351.1	352.9	354.9	402.6	385.9	358.3	362.2	350.4	354.1	392.3

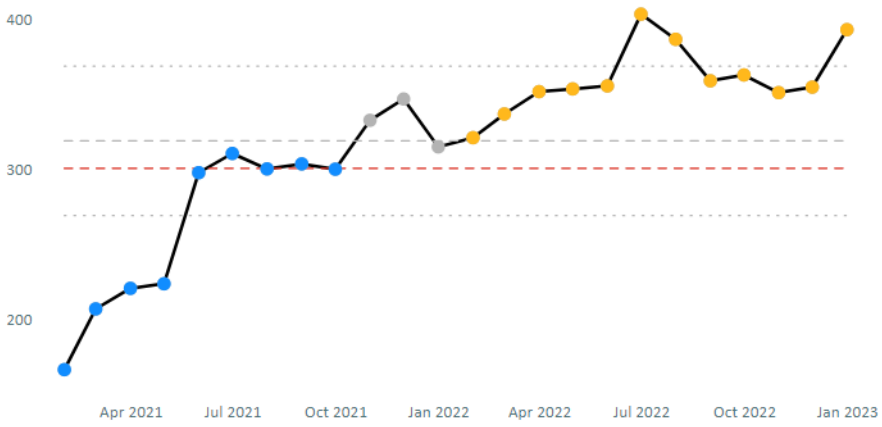
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

There has been a marked up lift in patients that remain in the care of the Trust who no longer require the services of an acute provider. In December the Trust recorded 354 patients who were no longer fit to reside. This has increased to 392 in January 23. Patients who cannot leave hospital and are delayed will, in turn, reduce the available beds for emergency admissions from the Emergency Department.

The Trust is also recording a record high number of patients residing within the care of the Trust for more then 21 days, 310 in January 23. This has been an upward trend since April 21.

Intervention and Planned Impact

In December 22 the East Kent HCP was awarded funding from the Adult Social Care Discharge fund to support the provision of additional enablement ward capacity (up to 30 beds), additional hospice capacity (up to 8 beds) and funding for additional packages of care for the Trust's patients requiring Pathway 1 services.

The RTS team have been supporting the identification of suitable patients to these additional facilities and the Trust continues to consistently discharge patients as capacity becomes available.

Further to this funding stream outline above, the Acute Hospital Discharge Fund was announced by the Government in early January 23. Currently, the HCP is targeting an element of this fund toward Pathway 3 patients with complex needs who have the longest length of stay in acute hospital beds. It is pleasing to report that this approach is having a positive effect, with the first four weeks of the scheme enabling the discharge to care homes of 39 patients who had a total length of stay of over 2100 days in EKHUFT beds. The transfer of these patients from a hospital environment into non-acute facilities has resulted in a vastly improved service user experience and resulted in improved relationships with local care homes.

Whilst these schemes will impact flow to a degree, this additional capacity has come at a time of high demand on the Trust services and will likely only mitigate against the additional demand rather than improve the overall position.

Risks/Mitigations

- Over two-thirds of no longer fit to reside patients required an on-going package of care to leave the Trust.
- Continue the work with colleagues in the community to ensure the Trust fully utilises the additional capacity available and the flow of patients continues through the external facilities.
- QEQM is a pilot site for the Regional Improvement Therapy Hub, with external and internal therapy support provided by the ICB – daily meetings review all Pathway 1 to 3 patients and their on-going care needs.
- Regular pathway 0 meetings held across the acute sites to ensure the Trust is discharging patients who do not require a package of care, in a safe and timely manner.
- Weekly deep dives have just commenced to assess the Trust's long stay Pathway 3 patients. The scope of this meeting is being broadened to incorporate community colleagues.

Our future

Recruitment to Clinical Trials

In order to deliver outstanding care for patients, we need to provide and promote access to clinical trials and innovative practice for all our local population. Research, education and innovation are not yet embedded in our organisation at the heart of everything we do. We need to encourage and enable more multi-professional staff, across all clinical specialities, to engage with research and innovation to deliver excellence. The preferred measurement of success is the number of staff participating actively in research and innovation. However, at present the total number of staff involved in research and innovation is unclear and work is being undertaken to enable this metric to be measured and used going forward. Data does, however, enable us identify the number of patients recruited to trials within the Trust and this metric will be used initially.

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
91	246	129	162	430	82	161	190	120	124	116	127

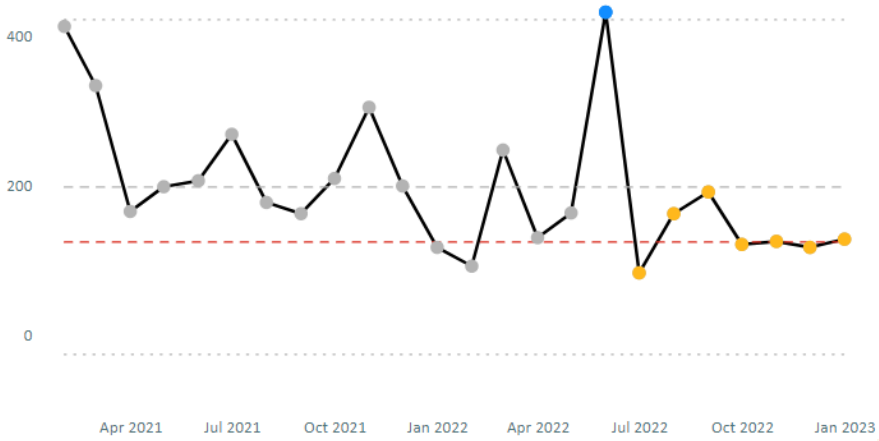
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Below Mean Run Group

XMR Run Chart



What the chart tells us

In 2020/21, 5,132 patients were recruited into trials. This number is significantly higher than usual as it included 3,000 Covid patients. In 2021/22, the Trust recruited 2,285 patients (including 240 Covid patients) across 22 specialities. The January position of 127 participants is above the monthly threshold of 123 (positive). The April – January cumulative position is 1,631 patients recruited to trials, which is 33% above the year to date trajectory of 1,230 (positive). The data reflects the return of staff from Christmas breaks with a higher number of studies being set up in January than in previous months.

The highest recruiting studies in January included TRANSLATE (a prostate cancer biopsy study) and IBD Bioresource (a study that is looking at genetic, environmental and lifestyle factors that may contribute to diagnosis and progression of Irritable Bowel disease).

Intervention and Planned Impact

- There are 27 studies in feasibility stage or set-up, including 12 CTIMP drug trials (Clinical Trial of an Investigational Medicinal Product).
- Collaboration discussions with the Trust partners at Trinetx have been set up with a number of commercial sponsors who are interested in expanding their work with the Trust.
- The Kent Medical school visited the Clinical Trials Unit at QEQM in early December for a tour and to discuss future collaboration opportunities.
- The Trust is in the process of designing its first real-world data project using the Trinetx platform (a collaborative international platform which connects Trusts with sponsors and provides real world data to investigators) with access to 114 million patient records globally. However, progress has been limited over the Christmas period.

Risks/Mitigations

- Space at K&C has been identified as a constraint with the key risk being the impact on the Trust's ability to continue to provide a number of cancer trials. Space requirements are being reviewed urgently.
- Lack of recurrent funding to support the additional research fellow posts. Discussions continue.
- Lack of outpatient space for follow-ups. As trials increase, this will become more challenging
- The delay in the new research database will delay the Trust's ability to move to the original metric.
- Completion of East Kent data integration.

Appendix 1
Non-Alerting Watch Metrics

NHS
East Kent
Hospitals University
NHS Foundation Trust

True North Domain	BR	Flag	KPI	SPC	Thres.	Oct-22	Nov-22	Dec-22	Jan-23
Harm Events	W		Falls	H	Sigma	152	145	177	192
	W		IPC: Klebsiella Infections		6	7	4	3	1
	W		IPC: Pseudomonas Infections		3	2	2	2	5
	W		52w Severe Harm Review		0	0	0	0	0
	W		Reported Medication Errors		Sigma	186	218	207	205
	W		Nutrition Incidents		Sigma	64	44	52	34
	W		Pressure Ulcers: Cat 2		Sigma	40	28	35	41
	W		Pressure Ulcers: Cat 3 & 4		Sigma	1	1	1	2
	W		Pressure Ulcers: DTI		Sigma	7	9	5	6
	W		Pressure Ulcers: Unstageable		Sigma	15	9	12	11
	W		Clinical Incidents		Sigma	2,117	2,205	2,196	2,416
	W		IP Spells with 3+ Ward Moves	L	Sigma	446	400	378	345
	W		Serious Incidents		Sigma	23	20	13	16
	W		Serious Incidents Breached	L	0	16	16	16	0
	W		Never Events		0	0	0	0	1
	W		Maternity Serious Incidents		2	6	1	0	4
Mortality	W		Extended Perinatal Mortality	L	5.93	4.44	4.94	4.64	4.33

True North Domain	BR	Flag	KPI	SPC	Thres.	Oct-22	Nov-22	Dec-22	Jan-23
Staff Engagement	W		Sickness		5.0%	5.6%	4.9%	5.6%	
	W		Staff Turnover Rate		11.5%	10.5%	10.3%	10.2%	10.0%
	W		Vacancy Rate		10.0%	10.9%	9.7%	9.8%	9.1%
	W		Staff Turnover: Nursing	L	10.0%	9.7%	9.5%	9.6%	9.2%

True North Domain	BR	Flag	KPI	SPC	Thres.	Oct-22	Nov-22	Dec-22	Jan-23
Cancer 62d	W		Cancer 31d Performance		96.0%	97.9%	98.1%	98.3%	95.5%
RTT - 18 Weeks	W		RTT 60w Waiters (w/o TCIs)	L	Sigma	1,531	1,502	1,580	1,443
	W		OPA vs Plan		Traj.	75.3K	81.3K	66.3K	75.0K
ED Compliance	W		Clinician First Seen within 1h	H	50.0%	45.3%	47.5%	44.4%	53.5%
	W		A&E Atts vs Plan		Traj.	24.1K	24.3K	25.4K	22.5K
	W		Discharges by Midday		15.0%	12.8%	14.6%	15.1%	14.5%
	W		Pathway 0 Patients >7 Days		Sigma	149	140	125	128
	W		NEL Readmissions	L	15.0%	8.9%	9.1%	10.2%	8.7%
	W		Stroke Ward within 4 Hours		50.0%	63.2%	62.9%	66.7%	74.2%
FFT	W		FFT IP Response Rate	H	15.0%	19.5%	20.1%	18.2%	18.8%
	W		FFT DC Response Rate		27.0%	29.8%	29.6%	28.3%	30.6%
	W		FFT ED Response Rate		12.0%	14.4%	13.7%	14.0%	14.8%
	W		FFT OP Response Rate		17.0%	19.2%	18.9%	18.5%	19.6%
	W		Complaints Number		Sigma	83	81	65	94
	W		Mixed Sex Breaches		Sigma	108	104	101	71
	W		Duty of Candour - Findings		100.0%	100%	100%	100%	75.0%

Appendix 2
Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
Governance of Clinical Guidelines	Tina Ivanov	To have a central repository of for all clinical guidelines	Jan 2022 1st phase complete 2nd phase April 23	• Project meeting with Executive and senior managers of the project to discuss progress to date and next steps in roll-out programme. • Paper prepared for presentation to CEMG. • Transition methodology and key roles further defined to improve awareness of process and responsibilities. • Discussion and analysis of Maternity clinical guidelines on 4policies for transfer to MicroGuide.	• Presentation of project progress to CEMG. • Meet with Infection Prevention & Control to plan their transition to MicroGuide. • Aim to fill vacant CGAG membership positions in preparation for April. • Continue scoping meetings with additional specialties for transition to MicroGuide.
Improving End of Life Care	Sarah Shingler	Deteriorating patients who's death can be recognised in a timely way enabling better care in the right place at the right time this will also improve HSMR, reduce unnecessary use of hospital resource, increase personalised care planning	April 23	**Process / System Workstream** • Formally launch beds at QEQM • Develop WHH plan and on-going project development with - monitor the outcomes of using these beds using plan, do study act (improvement tool) as appropriately. **Education workstream** • Review and consider roll-out plan – delayed due to operational pressures **Culture workstream** • Work with Flix production company to develop learning messages and poster campaign to go alongside film. • EoLC story at Dec Trust board	**Process / System Workstream** • Focus to be on the implementation of QE beds • Proposal going through CEMG in February 2023 • A plan for the WHH is progressing **Education workstream** • Review and consider roll-out plan – continues to be delayed due to operational pressures on the WHH & QE site **Culture workstream** • Continue to work with production company to develop learning messages and poster campaign to go alongside film.
Fractured Neck of Femur	Rebecca Martin	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	April 23	• WHH 37 out of 39 patients got to theatre in time • QEQM figures also improving • WHH team involvement in QEQM hip fracture meeting to discuss orthogeriatric input • Admission to correct ward has been impeded by IPC and operational issues	• Continue to push correct ward with site teams. • Focus on golden patients • Discussions started about aligning orthogeriatric support at QEQM to service provided at WHH • Joint meeting this month to share ideas and support each other

Appendix 2
Completed Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date
CITO Management	TBC	To replace WINDIP with an EDM which will meet the needs of users, support the Trust's Electronic Patient Record objectives and the rollout of Sunrise by providing scanning capability for documentation which has yet to be or cannot be directly captured or integrated into Sunrise EPR	Jan 2022
ITU Expansion	TBC	Expanded 24 bed Critical Care unit operational for patients to be admitted	Feb 2022 - BAU
ED Expansion	TBC	Expansion to current ED footprints to enable provision of 'Emergency Village / Same Day Emergency Care' facilities	Dec 2023 - BAU
Safeguarding	Sarah Shingler	Timely assessment of patients with mental health &/or cognitive impairment risks, to determine the level of support required carried out for 100% of patients. Provision of individualised treatment plan to optimise support and care to maintain safety.	Mar 2022 - BAU
Sepsis Audit tool	Sarah Shingler	Ensure the correct sepsis audit tool is used for the right people at the right time, initial threshold 85% completion	Complete
Hospital Out of Hours	Rebecca Martin	Provision of a Hospital out of Hours Team to ensure timely response & co-ordination to Deteriorating Patients	Complete
Falls on Datix	Sarah Shingler	Improved data quality of reporting of falls on Datix ensure high quality accurate reporting	Complete
Accommodation Strategy	Phil Cave	To enhance the functionality, experience and investment opportunities in the staff and student non-clinical estate at K&C, WHH and QEQM.	Moved to BAU Oct 22
Trust wide Job Planning	Rebecca Martin	To ensure every substantive SAS and Consultant doctor has a signed job plan on the e-job system, that accurately reflects their workload	Moved to BAU Oct 22
National & Local Clinical Audit	Rebecca Martin	An agreed vison, roles & responsibilities of an audit lead. To have 75% of all audits that are effectively managed within each of the Care groups (Must do's - nationally dictated, Local audits requested by local Commissions)	Moved to BAU Oct 22
Safe & Effective Discharge	Rebecca Martin	All patients discharged have an accurate EDN completed and appropriately authorised in a timely fashion	Project to become more targeted within the Trust Emergency Care Delivery Group Nov 22
Maternity Ultrasound Booking	Rebecca Martin	All patients will have an Ultrasonography appointment that is linked to their pathway and consultant. To ensure the capacity and staffing is available to meet the demand of the service.	Moved to BAU Nov 22

Appendix 3: Glossary of Terms

East Kent Hospitals University NHS Foundation Trust

Term	Description
A3 Thinking Tool	Is an approach to thinking through a problem to inform the development of a solution. A3 also refers to the paper size used to set out a full problem-solving cycle. The A3 is a visual and communication tool which consists of (8) steps, each having a list of guiding questions which the user(s) work through (not all questions may be relevant). Staff should feel sure each step is fully explored before moving on to the next. The A3 Thinking Tool tells a story so should be displayed where all staff can see it.
Breakthrough Objectives	3-5 specific goals identified from True North. Breakthrough Objectives are operational in nature and recognised as a clear business problem. Breakthrough Objectives are shared across the organisation. Significant improvement is expected over a 12 month period.
Business Rules	A set of rules used to determine how performance of metrics and projects on a scorecard are discussed in the Care Groups Monthly Performance Review Meetings.
Catchball	A formal open conversation between two or more people (usually managers) held annually to agree the next financial year's objectives and targets. However, a 6 monthly informal conversation to ensure alignment of priorities is encouraged to take place. The aims of a Catchball conversation are to: (1) reach agreement on each item on a Scorecard e.g. driver metrics, watch metrics tolerance levels, corporate/ improvement projects. (2) Agree which projects can be deselected. (3) Set out Business Rules which will govern the process moving forward.
Corporate Projects	Are specific to the organisation and identified by senior leaders as 'no choice priority projects'. They may require the involvement of more than one business unit, are complex and/or require significant capital investment. Corporate Projects are often too big for continuous daily improvement but some aspect(s) of them may be achieved through a local project workstream.
Countermeasure	An action taken to prevent a problem from continuing/occurring in a process.
Countermeasure Summary	A document that summarises an A3 Thinking Tool. It is presented at monthly Performance Review Meetings when the relevant business rules apply.

Appendix 3: Glossary of Terms

NHS
East Kent Hospitals University
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Term	Description
Driver Lane	A visual tool containing specific driver metric information taken from the A3 (e.g. problem statement, data, contributing factors, 3 C's or Action Plan). The driver lane information is discussed every day at the improvement huddle and in more detail at weekly Care Group driver meetings and Monthly Performance Review Meetings. The structure of a driver lane is the same as the structure of a countermeasure summary.
Driver Meetings	Driver Meetings are weekly meetings that inform the Care Group of progress against driver metrics on their scorecard. Having a strong awareness of how driver metrics are progressing is vital for continuous improvement. Driver meetings also enable efficient information flow. They are a way of checking progress to plan.
Driver Metrics	Driver Metrics are closely aligned with True North. They are specific metrics that Care Group's choose to actively work on to "drive" improvement in order to achieve a target (e.g. 'reduce 30 day readmissions by 50%' or 'eliminate all avoidable surgical site infections'). Each Care Group should aim to have no more than 5 Driver Metrics.
Gemba Walk	'Gemba' means 'the actual place'. The purpose of a Gemba Walk is to enable leaders and managers to observe the actual work process, engage with employees, gain knowledge about the work process and explore opportunities for continuous improvement. It is important those carrying out the Gemba Walk respect the workers by asking open ended questions and lead with curiosity.
Huddles (Improvement Huddle) Boards	Huddle or Improvement Boards are a visual display and communication tool. Essentially they are a large white board which has 9 specific sections. The Huddle or Improvement Boards are the daily focal point for improvement meetings where staff have the opportunity to identify, prioritise and action daily improvement ideas linked to organisational priorities (True North). The Huddle or Improvement Board requires its own Standard Work document to ensure it is used effectively. The aims of the Huddle/Improvement board includes: 1. help staff focus on small issues 2. prioritise the action(s) 3. gives staff ownership of the action (improvement)
PDSA Cycle (Plan Do Study Act)	PDSA Cycle is a scientific method of defining problems, developing theories, planning and trying them, observing the results and acting on what is learnt. It typically requires some investigation and can take a few weeks to implement the ongoing cycle of improvement.
Performance Board	Performance boards are a form of visual management that provide focus on the process made. It makes it easy to compare 'expected versus actual performance'. Performance Boards focus on larger issues than a Huddle Board, e.g. patient discharges by 10:00am. They help drive improvement forward and generate conversation e.g.: 1. when action is required because performance has dropped 2. what the top 3 contributing problems might be 3. what is being done to improve performance

Appendix 3: Glossary of Terms

NHS
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Term	Description
Scorecard	The Scorecard is a visual management tool that lists the measures and projects a ward or department is required to achieve. These measures/projects are aligned to True North. The purposes of a Scorecard include: 1. Makes strategy a continual and viable process that everybody engages with 2. focuses on key measurements 3. reflect the organization's mission and strategies 4. provide a quick but comprehensive picture of the organization's health
Standard Work	Standard work is a written document outlining step by step instructions for completing a task or meeting using 'best practice' methods. Standard Work should be shared to ensure staff are trained in performing the task/meeting. The document should also be regularly reviewed and updated.
Strategy Deployment	Strategy Deployment is a planning process which gives long term direction to a complex organisation. It identifies a small number of strategic priorities by using an inch wide mile deep mindset and cascades these priorities through the organisation.
Strategy Deployment Matrix	A resource planning tool. It allows you to see horizontal and vertical resource commitments of your teams which ensures no team is overloaded.
Strategic Initiatives	'Must Do' 'Can't Fail' initiatives for the organisation to drive forward and support delivery of True North. These programmes of work are normally over a 3-5 year delivery time frame. Ideally these should be limited to 2-3. Initiatives are necessary to implement strategy and the way leaders expect to improve True North metrics over time (3-5 years).
Structured Verbal Update	Verbal update that follows Standard Work. It is given at Performance Review Meetings when the relevant business rules apply.
Tolerance Level	These levels are used if a 'Watch Metric' is **red** against the target but the gap between current performance and the target is small or within the metrics process control limits (check SPC chart). A Tolerance Level can be applied against the metric meaning as long as the metrics' performance does not fall below the Tolerance Level the Care Group will continue watching the metric.
True North	True North captures the few selected organisation wide priorities and goals that guide all its improvement work. True North can be developed by the Trust's Executive team in consultation with many stakeholders. The performance of the True North metrics against targets is an indicator of the health of the organisation.
Watch metrics	Watch metrics are measures that are being watched or monitored for adverse trends. There are no specific improvement activities or A3s in progress to improve performance.

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**MONTH 10 FINANCE REPORT**
MEETING DATE:	**9 MARCH 2023**
BOARD SPONSOR:	**CHIEF FINANCE OFFICER (CFO)**
PAPER AUTHOR:	**DIRECTOR OF CONTRACTING, COMMISSIONING AND COSTING**
APPENDICES:	**APPENDIX 1: M10 FINANCE REPORT**

Executive Summary:

Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion

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:

The Group achieved a £4.4m deficit in January, which brought the year-to-date (YTD) position to a £28.9m deficit which is £26.7m adverse to the plan.

The Trust worked with Kent & Medway (K&M) NHS system partners to resubmit a financial plan for 2022/23 at the end of June following a national announcement confirming additional funding to mitigate inflationary pressures. In the resubmitted plan the Trust receives £22m of additional funding, consisting of £6m inflationary funding and £16m of non-recurrent income, bringing our overall plan to a breakeven position.

Delivery of this breakeven 2022/23 financial plan looks extremely challenging as it requires that the Trust:

1) Delivers £30m of efficiency savings.
2) Receives £18m of additional Elective Recovery Funding for treating planned patient activity above a nationally-set threshold.
3) Reduces the average spend on incremental Covid-19 costs by £9m as compared to the previous financial year.
4) Supports delivery of a further £16m of K&M system financial efficiency which does not yet have identified plans.

Group Position

	This Month			Year to Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
EKHUFT Income	70,669	71,204	535	634,882	647,383	12,501
EKHUFT Employee Expenses	(42,596)	(46,458)	(3,862)	(383,969)	(412,316)	(28,347)
EKHUFT Non-Employee Expenses	(27,587)	(30,068)	(2,481)	(255,432)	(260,476)	(5,044)
EKHUFT Financial Position	**486**	**(5,323)**	**(5,809)**	**(4,518)**	**(25,409)**	**(20,890)**
Spencer Performance After Tax	(15)	(79)	(63)	129	158	29
2gether Performance After Tax	100	145	45	897	1,112	215
Rephasing/Sub IFRS16 Adjustment	56	(22)	(78)	305	(34)	(339)
Consolidated I&E Position (pre Technical adjs)	**626**	**(5,278)**	**(5,905)**	**(3,187)**	**(24,172)**	**(20,986)**
Technical Adjustments	6	81	75	57	(348)	(405)
Consolidated I&E Position (incl adjs)	**632**	**(5,197)**	**(5,830)**	**(3,130)**	**(24,520)**	**(21,391)**

The key drivers to the YTD deficit are:

- Escalation Areas opened of around 80 plus beds across the Trust due to patient demand and flow £7.2m (This relates to the nursing costs and does not include the non-pay or increased levels of medical staffing.
- Cost Improvement Programme (CIP) Slippage £6.4m.

East Kent Hospitals University NHS Foundation Trust

	• Drugs £1.7m. • Premium pay around the organisation £3.1m. • 1.1 speciality/mental health £5.1m. • Work permits £1.4m. • Parking income £1.8m. All NHS systems have access to funding in 2022/23 through the Elective Recovery Fund (ERF), subject to meeting the required threshold of 104% of 2019/20 activity levels. We have assumed to receive full ERF funding in April to March as it is expected that activity shortfalls for the full year are underwritten by national funding which has recently been announced. **The Trust has now formally agreed a revised deficit of £19.3m for year end.** The Group cash balance (including subsidiaries) at the end of January was £40.7m maintaining the balance from December and is above plan by £0.5m. Total capital expenditure at the end of January was £25.5m against an £23.5m plan. The capital expenditure overspend is not considered to be an issue and the Trust is working closely with system partners to maximise the available funding to support required investments. The Trust achieved efficiency savings of £1.8m in January which is £1.9m below plan bringing the YTD position to £6.7m below the plan of £22m. Efficiency delivery represents one of the biggest risks to achieving our financial plan in 2022/23 especially as a large proportion are non-recurrent and non-cash releasing.
Key Recommendation(s):	The Board of Directors is asked to review and **NOTE** the financial performance and actions being taken to address issues of concern. To **NOTE** the reforecasting of the financial position to a £19.3 deficit.

Implications:				
Links to 'We Care' Strategic Objectives: **Healthy finances:** Having Healthy Finances by providing better, more effective patient care that makes resources go further.				
Our patients	Our people	Our future	**Our sustainability**	Our quality and safety

Link to the Board Assurance Framework (BAF):	**BAF 38**: Failure to deliver the financial breakeven position of the Trust as requested by NHS England (NHSE).	
Link to the Corporate Risk Register (CRR):	**CRR 137**: There is a risk that the Trust will not be able to meet its 2022/23 efficiencies target equating to £30m. **CRR 136**: Failure to secure planned income due to underperformance against the Elective Recovery Fund baseline.	
Resource:	N	Key financial decisions and actions may be taken on the basis of this report.
Legal and regulatory:	N	
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	None	

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2022/23

January 2023

Chief Finance Officer
Philip Cave

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Month 10 (January) 2022/23

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Month 10 (January) 2022/23

Executive Summary

The group achieved a £4.4m deficit in January, which brought the year-to-date (YTD) position to a £28.9m deficit which is £26.7m adverse to the plan.

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Delivery of this breakeven 2022/23 financial plan was extremely challenging as it requires that the Trust:
Delivers £30m of efficiency savings.
Receives £18m of additional Elective Recovery Funding for treating planned patient activity above a nationally-set threshold.
Reduces the average spend on incremental Covid-19 costs by £9m as compared to the previous financial year.
Supports delivery of a further £16m of K&M system financial efficiency which does not yet have identified plans.

Group Position

	This Month			Year to Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
EKHUFT Income	70,700	71,593	893	705,583	718,977	13,394
EKHUFT Employee Expenses	(42,628)	(47,709)	(5,081)	(426,597)	(460,025)	(33,428)
EKHUFT Non-Employee Expenses	(27,334)	(28,498)	(1,164)	(282,766)	(288,975)	(6,208)
EKHUFT Financial Position	**738**	**(4,614)**	**(5,352)**	**(3,780)**	**(30,023)**	**(26,242)**
Spencer Performance After Tax	25	28	3	155	186	32
2gether Performance After Tax	100	93	(7)	997	1,205	208
Rephasing/Sub IFRS16 Adjustment	56	18	(38)	360	(23)	(383)
Consolidated I&E Position (pre Technical adjs)	**919**	**(4,475)**	**(5,394)**	**(2,269)**	**(28,654)**	**(26,386)**
Technical Adjustments	6	60	54	63	(281)	(344)
Consolidated I&E Position (incl adjs)	**925**	**(4,415)**	**(5,340)**	**(2,206)**	**(28,935)**	**(26,730)**

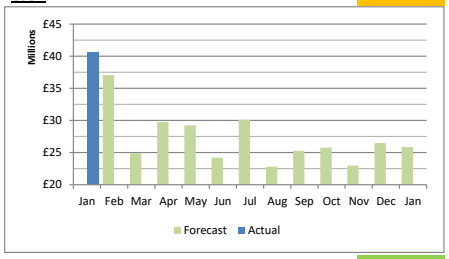
All NHS systems have access to funding in 2022/23 through the Elective Recovery Fund (ERF), subject to meeting the required threshold of 104% of 2019/20 activity levels. We have assumed to receive full ERF funding in April to March as it is expected that activity shortfalls for the full year are underwritten by national funding which has recently been announced.
The Trust is now forecasting a deficit of £19.3m for year end and reforecast in line with national protocol .

Income and Expenditure R

The key drivers to the YTD deficit are:

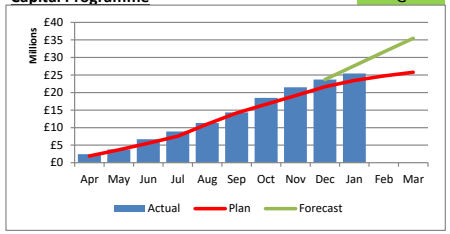
- Escalation Areas opened of around 80 beds across the Trust due to patient demand and flow £7.2m
- CIP Slippage £6.4m
- Drugs £1.7m
- Premium pay around the organisation £3.1m
- 1.1 speciality/mental health £5.1m
- Work permits £1.4m
- Parking income £1.8m

Cash A



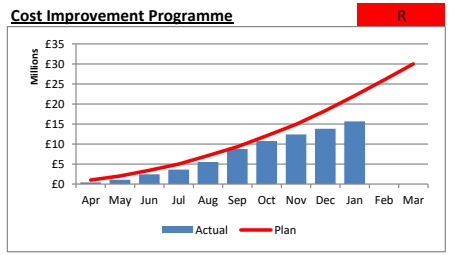
The Group cash balance (including subsidiaries) at the end of January was £40.7m, maintaining the balance from December. Trust cash balances were above plan by £0.5m

Capital Programme G



Total capital expenditure at the end of January was £25.5m against an £23.5m plan. The capital expenditure overspend is not considered to be an issue and the Trust is working closely with system partners to maximise the available funding to support required investments.

Cost Improvement Programme R



The Trust achieved efficiency savings of £1.8m in January which is £1.9m below plan bringing the year-to-date position to £6.4m below the plan of £22m. CIP delivery represents one of the biggest risks to achieving our financial plan in 2022/23 especially as a large proportion are non recurrent and non cash releasing.

Income and Expenditure Summary
Month 10 (January) 2022/23

Unconsolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	9,312	6,782	(2,530)	89,964	81,090	(8,875)
Non-Electives	19,971	17,573	(2,398)	199,947	177,376	(22,571)
Accident and Emergency	3,430	3,727	297	37,965	38,575	610
Outpatients	9,736	9,499	(237)	96,054	88,875	(7,179)
High Cost Drugs	3,869	4,452	583	38,687	43,544	4,857
Private Patients	23	55	31	233	174	(58)
Other NHS Clinical Income	19,256	25,056	5,800	193,119	241,703	48,584
Other Clinical Income	115	122	7	1,146	1,314	169
Total Income from Patient Care Activities	**65,711**	**67,265**	**1,554**	**657,114**	**672,651**	**15,537**
Other Operating Income	4,989	4,329	(661)	48,469	46,326	(2,143)
Total Income	**70,700**	**71,593**	**893**	**705,583**	**718,977**	**13,394**
Expenditure						
Substantive Staff	(38,340)	(40,363)	(2,022)	(377,496)	(391,316)	(13,820)
Bank	(2,079)	(3,805)	(1,725)	(24,384)	(33,008)	(8,624)
Agency	(2,208)	(3,541)	(1,333)	(24,717)	(35,701)	(10,984)
Total Employee Expenses	**(42,628)**	**(47,709)**	**(5,081)**	**(426,597)**	**(460,025)**	**(33,428)**
Other Operating Expenses	(26,519)	(27,780)	(1,261)	(274,028)	(281,122)	(7,094)
Total Operating Expenditure	**(69,147)**	**(75,489)**	**(6,342)**	**(700,624)**	**(741,147)**	**(40,523)**
Non Operating Expenses	(815)	(719)	97	(8,739)	(7,853)	886
Income and Expenditure Surplus/(Deficit)	**738**	**(4,614)**	**(5,352)**	**(3,780)**	**(30,023)**	**(26,242)**

Consolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Income from Patient Care Activities	67,164	68,413	1,249	671,289	685,060	13,771
Other Operating Income	4,539	4,785	246	43,675	44,941	1,266
Total Income	**71,703**	**73,198**	**1,495**	**714,964**	**730,001**	**15,037**
Expenditure						-
Employee Expenses	(45,865)	(51,471)	(5,606)	(458,993)	(497,398)	(38,406)
Other Operating Expenses	(24,073)	(25,434)	(1,361)	(249,188)	(253,128)	(3,940)
Total Expenditure	**(69,938)**	**(76,905)**	**(6,967)**	**(708,181)**	**(750,526)**	**(42,346)**
Non-Operating Expenses	(846)	(767)	79	(9,052)	(8,129)	923
Income and Expenditure Surplus/(Deficit) (pre Technical adjs)	**919**	**(4,475)**	**(5,393)**	**(2,269)**	**(28,654)**	**(26,386)**
Technical Adjustments	6	60	54	63	(281)	(344)
Consolidated I&E Position (incl adjs)	**925**	**(4,415)**	**(5,340)**	**(2,206)**	**(28,935)**	**(26,730)**

Income from Patient Care Activities

In month the Trust saw an overperformance against plan of £1.6m (£15.5m YTD).
Other NHS Clinical Income over performed in month by £5.8m (£48.6m YTD). This is made up of:

- £1.0m of additional funding to cover the cost of the pay award (£10.0m YTD).
- £0.2m under performance due to unfunded service developments inherent in our plan (£1.7m YTD)
- £0.3m over performance on high cost drugs and devices (£4.0m YTD)
- £0.2m additional funding from October for UTC telephone service (£0.9m YTD)
- £4.4m of contract income in excess of the activity performance (£32.0m YTD).

Rechargeable drugs and devices are net neutral with expenditure.

Out of Area patients are now directly funded and set nationally, this has resulted in the Trust receiving block amounts from ICBs which are direct payments. The majority of the annual amount of this income has been collected.
Overseas patients invoicing is higher than planned for generating an overperformance of £0.2m YTD.

As per national guidance, the current income position assumes no clawback for underperformance against the 104% Elective Recovery year-end target.

Other Operating Income and Expenditure

Other operating income is adverse to plan in January by £0.7m and adverse to plan by £2.1m YTD. The main drivers for the variance in month are below plan income for Covid-19 costs and credit notes relating to electricity recharges totalling £0.4m. Below plan car parking income of £0.3m is offset by income for international nurse recruitment of £0.2m. YTD, income relating to parking charges, property rental, including staff accommodation, research and innovation and Covid-19 are below plan by a total of £3.3m. These adverse variances are offset by donated income including Harmonia Village of £0.9m, and above plan income for education and training £0.7m.

Total operating expenditure is adverse to plan in January by £6.3m and by £40.5m YTD.

Employee expenses performance is adverse to plan in January by £5.1m and by £33.4m YTD (7.8%) of which £0.6m and £7.7m respectively relates to the above plan pay award. Indicative direct costs for escalation beds continue to be at least £0.8m in month and £7.2m YTD, and 1:1 specialing costs are at least £0.6m and £5.1m YTD.

Total expenditure on pay in January was £47.7m, an increase of £1.2m when compared to December, with increased costs relating to bank and agency staff of £0.7m. Expenditure on permanent staff increased by £0.6m.

Other operating expenditure is adverse to plan by £1.3m in January and by £7.1m YTD (2.6%). The in-month variance is driven mainly by above plan spend on drugs of £0.9m and the Operated Healthcare Facility which is adverse to plan by £0.9m, inclusive of the subsidiary pay award and unconfirmed CCN baseline uplift assumptions. These overspends are offset by below plan spend on clinical supplies and premises costs totalling £0.5m.

Other operating expenditure was £27.8m in January, a reduction of £1.5m when compared to December. Expenditure on drugs and clinical supplies fell by a total of £0.6m and Operated Healthcare Facility costs fell by £0.2m. Expenditure on gas fell by £0.2m and partial exemption VAT rebates were received totalling £0.3m.

Income and Expenditure Summary
Month 10 (January) 2022/23

Unconsolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
General and Specialist Medicine	3,200	1,093	(2,107)	34,201	24,987	(9,213)
Urgent and Emergency Care	2,084	976	(1,108)	21,836	14,252	(7,585)
Surgery and Anaesthetics	655	(321)	(977)	(25)	(8,195)	(8,170)
Surgery - Head and Neck, Breast Surgery and Dermatology	2,121	2,123	2	18,346	18,073	(273)
Clinical Support Services	(4,670)	(4,340)	331	(49,026)	(51,008)	(1,983)
Cancer Services	629	690	61	8,950	8,491	(459)
Child Health	82	(133)	(215)	(264)	(987)	(722)
Women's Health	716	484	(232)	5,460	4,346	(1,114)
Strategic Development and Capital Planning	(6,124)	(7,454)	(1,330)	(66,319)	(65,439)	880
Corporate	(4,290)	(4,302)	(12)	(43,909)	(45,610)	(1,701)
2gether Support Solutions	100	93	(7)	997	1,205	208
Spencer Private Hospitals	25	28	3	155	186	31

General & Specialist Medicine

Employee Expenses is £1.13m adv in month and £6.8m adv YTD
- Nursing and HCA growth of Staff in Post 188 WTE from April 22 to January 23, and £0.48m increase in monthly premium pay driven by:
- Escalation Beds £0.46m in month and £3.0m YTD
- Continuing high level of 1:1 care including mental health £0.32m in month and £3.27m YTD
- Safer Staffing investment, wards experiencing high level of junior workforce and extended supernumerary period £0.3m in month, financial benefits from IEN recruitment are expected to be realised in 23/24
- Medical premium pay cover for Site pressures, outliers, escalation and weekends £0.23m in month and £1.98m YTD

Other Operating Expenses is £1.00m adv in month and £2.50m adv YTD
- Efficiencies £0.35m adv in month and £1.63m adv YTD due to delays in Endoscopy Independent (IS) reduction. Into 23/24, internal capacity will be maximised, to reduce IS / premium rate activity. Savings are being backfilled non-recurrently through income
- Drugs £0.28m adv in month and £0.85m adv YTD, an estimated £0.16m YTD is escalation beds, the remainder being Renal, Gastro and Neurology
- Clinical consumables £0.2m adv in month and £0.3m adv YTD particularly increase in positive sleep studies requiring treatment

Urgent and Emergency Care

Employee Expenses is £1.7m adverse in month and £5.96m adverse YTD. The key drivers are:
- Escalation beds- an average of 56 extra beds are in use at an estimated cost of £0.5m in month and £3.0m YTD.
- Growth in junior doctor cover to wards - £0.12m in month and £1.2m YTD.
- Growth in mental health agency/bank support - £0.1m in month and £1.0m YTD.
- SDEC extended opening hours- £50k per month and £0.4m YTD.
- Enhanced bank nursing rates to improve staffing levels - The impact of this initiative is being assessed.
- Efficiency shortfalls - £0.18m in month and £1.0m YTD.
- Budget movement in month - £0.65m UTC budget was moved in January and retrospectively from pay to non-pay headings, to align budgets to costs. This has skewed the pay/non-pay in month positions.

Other Operating Expenses is £0.6m favourable in month and £1.63m adverse YTD. The key drivers are:
- Efficiency shortfalls - £0.14m in month and £0.8m YTD.
- Increased drugs, clinical/non-clinical supply overspends associated with patient attendance growth and patients staying longer in the Care Group's departments awaiting admission or undergoing treatment.

Surgery and Anaesthetics

Employee Expenses is £0.9m adv in month and £5.8m adv YTD:
- Additional Theatre staffing £0.17m adv in month, £1.33m YTD to cover vacancies and extra lists.
- Supernumerary Nursing £0.15m adv in month, £1.12m YTD for IENs waiting extended periods for OSCE & PINs.
- 1:1 Specialing Nursing care £0.19m adv in month, £0.95m YTD.
- Premium pay ITU staffing £0.18m adv in month, £0.82m YTD to cover vacancies and junior staffing.
- Escalation beds £0.07m adv in month, £0.48m YTD.
- Medical Staffing premium pay £0.03m adv in month, £0.91m YTD to cover vacancies.

Other Operating Expenses is break-even in month and £2.6m adv YTD:
- Efficiencies £0.37m adv in month, £1.94m YTD.
- Clinical Supplies £0.42m fav in month, £0.29m adv YTD with additional activity and complexity of patients.
- Drugs break-even in month, £0.37m adv YTD with additional activity and complexity.

Surgery - Head and Neck, Breast Surgery and Dermatology

Employee Expenses is £0.1m fav in month and £0.3m fav YTD:
- Medical Staffing premium pay break-even in month, £0.27m adv YTD to cover vacancies.
- Efficiencies £0.09m fav in month, £0.5m fav YTD.

Other Operating Expenses is £0.1m adv in month and £0.6m adv YTD:
- Efficiencies £0.1m adv in month, £0.6m YTD.

Clinical Support Services
- There was a reduction in other operating income this month in relation to lower recharges to Spencer for AMD drugs (£0.1m).
- In addition to this, recharges to other imaging consortium organisations (KMMIC) for the PACs system was reduced in month. • Employee expenses £0.06m Adv/£0.5m Fav YTD. Run rate increased and was overspent in month £0.06m, but retained a favourable position YTD (£0.55m).
- The other operating expenses position improved in month (£0.5m), year to date £2.1 Adv. The improvement was due to a correction of the outsourced radiology reporting accrual in relation to Community diagnostic hubs activity which was previously double counted (impact £0.7m).
- The overspend is a direct result of increased activity supported by the Care Group - specifically increased demand for tests across all Pathology disciplines, direct access and outpatient imaging and ED demand and escalation beds supported by the Therapies teams.

Cancer Services
- Improved position in month £0.06m/£0.45m adv YTD.
- Main overspend and risk is non-rechargeable drugs which have increased in line with activity and demand in Clinical Oncology and Clinical Haematology.
- Forecast outturn remains £0.5m adverse. Efficiency target met YTD (£0.1m Favourable).

Child Health

Employee Expenses is £0.17m adverse in month and £0.5m adverse YTD. The key drivers are:
- Recurrent efficiency shortfalls - £0.12m in month and £0.7m YTD.
- Medical overspends due to the use of premium pay to cover vacancies, sickness and increasing demand - £0.5m YTD.
- Overall activity was 7% above plan in month and is 2% above YTD. The contract adjustment to dampen overperformance is £2.6m.

Other Operating Expenses is £30k adverse in month and £0.1m adverse YTD. The key drivers are:
- Efficiency shortfalls - £0.2m YTD.
- Increased drugs expenditure due to higher activity levels.

Women's Health

Employee Expenses is £0.17m adverse in month and £0.7m adverse YTD. The key drivers are:
- Medical overspends due to the use of premium pay to cover vacancies, sickness, the 'on-call' rota and work to reduce patient waiting times - £0.2m in month and £1.2m YTD.

Other Operating Expenses is £70k adverse in month and £0.5m adverse YTD. The key drivers are:
- Efficiency shortfalls - £0.14m YTD.
- Small scale building/environment improvement work and IT software/equipment - £0.1m YTD.
- Increased drugs expenditure due to changes in prescribing policy to reduce clinical risk - £85k YTD.
- New rental charges for community midwifery clinic space - £40k YTD.

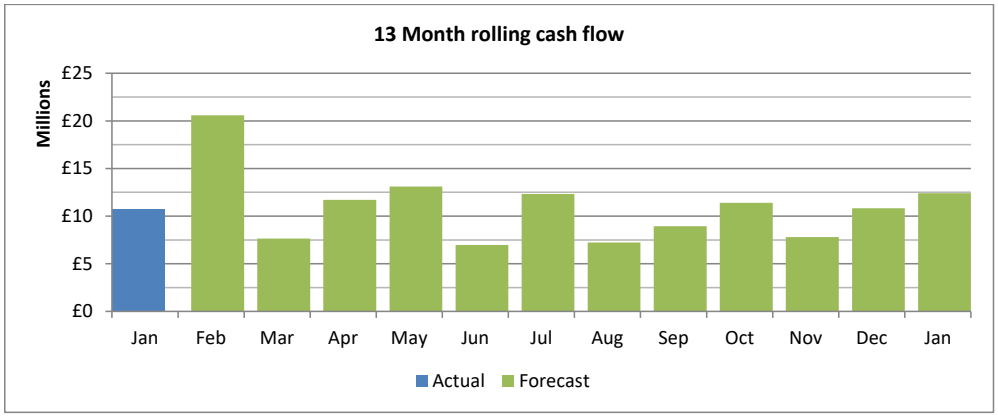
Strategic Development and Capital Planning

The main drivers behind the in month £1.3m adverse position and YTD £0.9m favourable position are detailed below.
- Pay £0.09m favourable in month and £1m favourable YTD 70% of vacancies are within IT
- Operating expenses are adverse £1.25m in month and breakeven YTD. The position in month is mainly due to increases in 2gether true up costs for EME and patient feeding which have yet to be agreed £0.5m, and also utilities £0.3m.
- The YTD operating expenses position of breakeven is due to the 2gether efficiency for the year being actioned in total in a prior period therefore offsetting the adverse variance above.

Corporate

The main drivers behind the position YTD £1.7m adverse position is detailed below.
- Other operating income is £0.3m favourable in month and £0.5m YTD is due to NHSE income for overseas nurse recruitment, this offsets expenditure albeit not fully.
- Other operating expenses are adverse £2.1m YTD, this is predominantly £1.4m on permits and excess overseas recruitment costs £0.6m
- Covid-19 YTD is £0.2m favourable YTD to plan.

Cash Flow
Month 10 (January) 2022/23



Unconsolidated Cash balance was £10.7m at the end of January 2023, £0.5m above plan.

Cash receipts in month totalled £75.7m (£1.0m below plan)
K&M CCG paid £53.9m in December. £0.8m above plan. (plan of £53.9m)
NHS England receipts were over plan by £0.4m. (plan of £11.2m)
VAT reclaim of £6.1m was £2.3m above plan. This was a result of two 2gether OHF invoices being paid to 2gether in December. (Approval of Novembers invoice was slowed down by the reintroduction of additional required authorisations and it was paid in December.)
Other receipts were £0.4m above plan in month (resulting from various receipts from 2gether, EKH Charity and other debtors)

Cash payments in month totalled £76.1m (£3.7m above plan)
Creditor payment runs including Capital payments were £19.7m (£0.5m below plan due to restrictions on creditor payments).

YTD cash receipts total £770.5m (£28.8m above plan - largely driven by block receipts from K&M ICB and additional receipts from NHS England).

YTD cash payments total £787.2m (£27.8m above the plan - mainly driven by creditor payments (£15.6m) and Payroll (£22.4m))

All spare cash received is being used to pay creditors as far as possible.

2022/23 Plan

The revised group plan submitted to NHSE/I in June 2022 shows a breakeven position at the end of 2022/23. A breakeven position eliminated the option of borrowing cash and so all borrowing was removed from the forecast. (The Trust had expected to require additional funds from September 2022).
Additional income from NHS Kent & Medway ICB commenced in July. The cash forecast is showing future receipts spread evenly to the end of the financial year.
Cash shortfalls are being managed by careful control of creditor payments.

Forecast

2023/24 receipts and payments are based on 2022/23 levels. A 1% uplift was assumed for K&M ICB and NHS England block payments as no further information was available.

A monthly borrowing amount has been forecast in 2023/24 to ensure the Trust can continue to pay creditors in a timely manner.

Future year forecasting will be revised when further information is available.

Creditor Management

The Trust moved further away from 30-day creditor terms in Month 10, closing the month at 44 day terms. This is still whilst withholding payment to one key supplier. As at 31st January 2023, £21.7m is overdue for payment to them. A weekly schedule of payments has been agreed with £8m paid to them on the 2nd February. Weekly payments will be made to reduce the outstanding balance further. In addition, payments to some NHS organisations continued to be held throughout Month 10 with the intention to make payments once additional funding is received.

£12m has been received from 2gether Support Solutions in early February. (a £4m dividend and £8m early repayment of loan). In addition to this, £19m revenue funding has been agreed with NHSE/I, to be received in February.

Planned borrowing in March has been replaced by proposed increases in clinical income from discussions with ICB.

At the end of January 2023, the Trust was recording 82 creditor days (Calculated as invoiced creditors at 31st January/ Forecast non-pay expenditure x 365).

Cash Flow

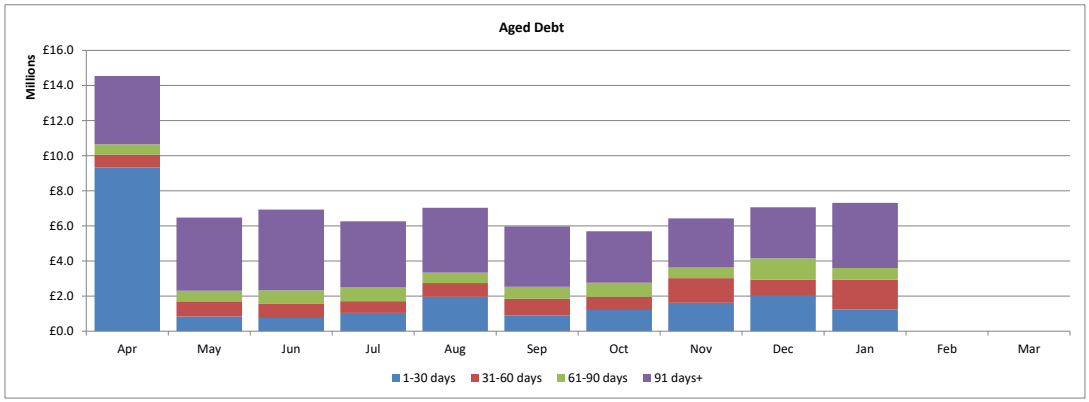
Month 10 (January) 2022/23

	This Month			Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
	Plan	Actual	Variance	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
Opening Cash Balance	9,793	11,126	1,333	11,126	10,718	20,575	7,657	11,701	13,100	6,985	12,340	7,225	8,936	11,394	7,793	10,829
Prior Year Main Contract CCGs																
Kent & Medway CCG Contract	53,880	54,581	700	54,581	51,754	62,754	53,854	53,854	53,854	53,854	53,854	53,854	53,854	53,854	53,854	53,854
Kent & Medway CCG - Other		119	119	119	2,140	2,126	539	539	539	539	539	539	539	539	539	539
NHS England	11,235	11,663	429	11,663	11,255	11,235	11,341	11,341	11,341	11,341	11,341	11,341	11,341	11,341	11,341	11,341
All Other NHS Organisations	6,705	1,198	(5,508)	1,198	1,295	5,644	7,072	1,213	1,213	7,088	1,221	1,205	7,096	1,221	1,197	1,221
Capital Receipts																
All Other Receipts	4,940	8,124	3,184	8,124	16,415	7,663	5,271	5,004	4,904	4,804	4,835	4,872	4,835	4,714	4,810	4,835
Provider Sustainability Fund																
PDC Loans					19,000		5,000	5,000	5,000	5,000	5,000	7,000	3,000	5,000	5,000	5,000
Total Receipts	**76,761**	**75,684**	**(1,076)**	**75,684**	**101,859**	**89,421**	**83,077**	**76,951**	**76,851**	**82,626**	**76,791**	**78,812**	**80,666**	**76,670**	**76,741**	**76,791**
Opening Cash Balance																
Monthly Payroll inc NI & Super	(37,290)	(40,221)	(2,931)	(40,221)	(40,227)	(40,305)	(40,340)	(40,340)	(40,340)	(40,340)	(40,340)	(40,340)	(40,340)	(40,340)	(40,340)	(40,040)
Creditor Payment Run	(39,007)	(35,038)	3,970	(35,038)	(50,216)	(55,703)	(37,446)	(33,966)	(41,068)	(35,685)	(40,008)	(31,514)	(36,621)	(38,372)	(32,119)	(33,933)
Capital Payments		(833)	(833)	(833)	(1,558)	(1,558)	(1,247)	(1,247)	(1,558)	(1,247)	(1,558)	(1,247)	(1,247)	(1,558)	(1,247)	(1,247)
PDC Dividend Payment						(4,773)						(4,000)				
Interest Payments																
Total Payments	**(76,297)**	**(76,092)**	**205**	**(76,092)**	**(92,001)**	**(102,340)**	**(79,033)**	**(75,552)**	**(82,966)**	**(77,271)**	**(81,906)**	**(77,100)**	**(78,208)**	**(80,270)**	**(73,706)**	**(75,219)**
Total Movement In Bank Balance	**464**	**(408)**	**(871)**	**(408)**	**9,857**	**(12,918)**	**4,044**	**1,399**	**(6,115)**	**5,355**	**(5,115)**	**1,711**	**2,458**	**(3,600)**	**3,036**	**1,571**
Closing Bank Balance	**10,256**	**10,718**	**462**	**10,718**	**20,575**	**7,657**	**11,701**	**13,100**	**6,985**	**12,340**	**7,225**	**8,936**	**11,394**	**7,793**	**10,829**	**12,401**
Plan				10,256	9,646	13,893	4,015	16,896	16,218	11,753	17,649	14,420	10,206	14,326	9,176	11,300
Variance				462	10,930	(6,236)	7,686	(3,796)	(9,233)	587	(10,425)	(5,484)	1,187	(6,533)	1,653	1,101
2gether Support Solutions Ltd				28,728	15,080	16,085	16,524	14,346	15,076	15,535	13,365	14,088	11,918	12,648	13,356	11,186
Spencer Private Hospitals Ltd				1,214	1,410	1,144	1,560	1,801	2,143	2,216	2,221	2,262	2,463	2,550	2,286	2,282
Group Closing Balance				**40,660**	**37,065**	**24,886**	**29,785**	**29,248**	**24,205**	**30,091**	**22,811**	**25,286**	**25,775**	**22,991**	**26,471**	**25,869**

Working Capital
Month 10 (January) 2022/23

Top ten debtor balances outstanding as at 31/01/2023

Debtor Name	Current	1+	31+	61+	91+	Total
SPENCER PRIVATE HOSPITALS LIMITED	474	579	493	486	677	2,708
NHS KENT AND MEDWAY ICB	387	161	567	26	9	1,150
KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	385	8	28	30	514	965
MEDWAY NHS FOUNDATION TRUST	16	16	66	1	342	441
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	89	76	55	6	182	408
2GETHER SUPPORT SOLUTIONS LTD	105	40	62		100	307
SRCL LTD	45		264		0	220
DANSAC LIMITED	101	103				204
DARTFORD AND GRAVESHAM NHS TRUST	28	35			119	182
NHS ENGLAND	24	9		7	91	133
Total	**1,565**	**1,026**	**1,536**	**556**	**2,034**	**6,718**



Total invoiced debtors have decreased from the 2022/23 opening position of £16.8m by £7.3m to £9.5m (of which £2.2m is curren t debt)

This decrease is largely driven by an £8.1m decrease in Kent & Medway CCG/ICB debt. Spencer Hospitals debt increased by £1.0m, 2gether Support Solutions debt decreased by £0.3m and Kent Community Health FT debt increased by £0.4m.

At 31st January there were 2 debtors owing over £1m.

- Spencer Private Hospitals owe £2.7m - the Trust will liaise with Spencer to arrange a reciprocal payment once Spencer have sufficient cash and invoices authorised.
- Kent & Medway ICB owes £1.2m, of which £0.5m is less than 30 days old.

Top ten creditor balances outstanding as at 31/01/2023

Supplier Name	Current	1+	31+	61+	91+	Total
NHS Professionals Ltd	4,106	4,845	5,962	4,803	6,095	25,811
Other Creditors	9,226	3,949	647	181	1,471	15,473
Maidstone & Tunbridge Wells NHS Trust (RWF)	343	363	655	18	521	1,900
2gether Support Solutions Ltd		895	666	131	1	1,693
Spencer Private Hospitals Ltd		252	196	213	698	1,359
Medway NHS Foundation Trust (RPA)	216	172	(95)	106	930	1,329
Integrated Care 24 Ltd	849	232		10		1,091
18 Week Support Ltd	3	496	337			835
Quantum Pharmaceutical Ltd	681	63			10	754
Alliance Healthcare (Distribution) Ltd	419	254				674
Total	**15,842**	**11,521**	**8,368**	**5,463**	**9,726**	**50,919**

Better Payment Practice Code	Last Year YTD Number	Last Year YTD £'000	This Year YTD Number	This Year YTD £'000
Non NHS				
Total bills paid in the year	58,294	487,572	56,875	490,117
Total bills paid within target	53,847	442,763	47,288	412,710
Percentage of bills paid within target	**92.4%**	**90.8%**	**83.1%**	**84.2%**
NHS				
Total bills paid in the year	2,273	10,053	1,731	8,444
Total bills paid within target	1,828	8,073	1,108	5,081
Percentage of bills paid within target	**80.4%**	**80.3%**	**64.0%**	**60.2%**
Total				
Total bills paid in the year	60,567	497,625	58,606	498,561
Total bills paid within target	55,675	450,836	48,396	417,791
Percentage of bills paid within target	**91.9%**	**90.6%**	**82.6%**	**83.8%**

Invoiced creditors have increased by £30.1m from the opening position to £50.9m.

31% relates to current invoices with 19% or £9.7m over 90 days. This is up by 6.2m from month 9 and mainly relates to NHSP (5.986m)

NHSP debt has grown significantly during the year from £2.74m to £25.8m. This is due to an increased reliance on premium pay staff to fill vacancies and sickness along with mounting pressures on the Trusts available cash.

Our BBPC figures have dipped below 90% which means we have to explain the reasons for this failure to NHSIE

Income from Patient Care Activities

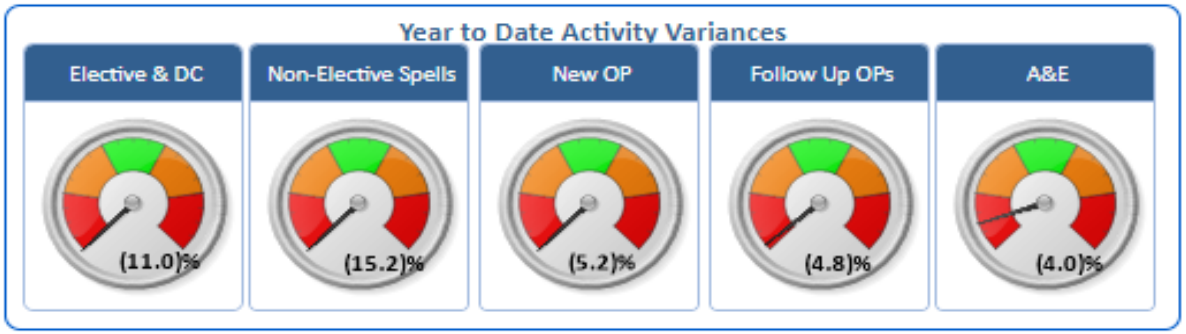
Month 10 (January) 2022/23

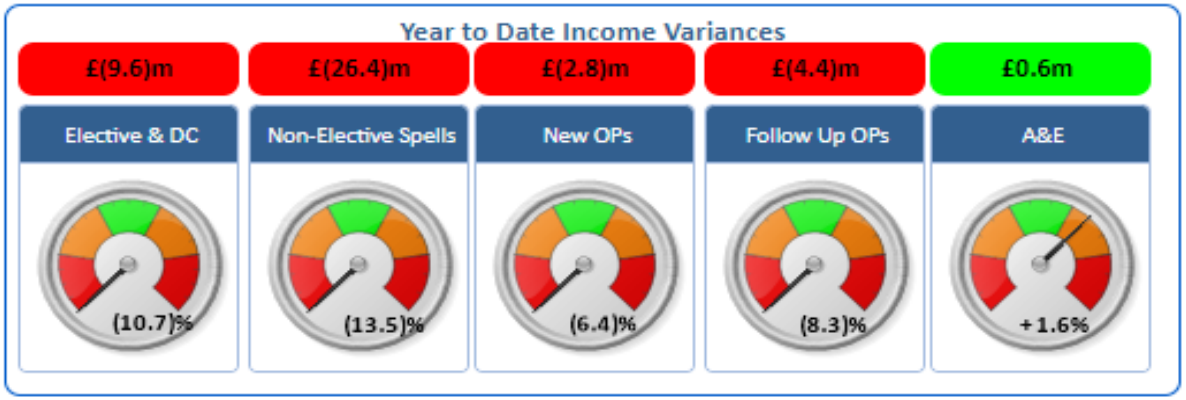
Trust Income Plan	Trust Actual Income	Income Variance
£657.114m	£672.651m	£15.537m

2022/23 - Month 10

East Kent Hospitals University NHS
NHS Foundation Trust

	Year to Date Activity			Year to Date Income £m			Average Tariffs	
Point of Delivery	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual
1a Total Non Elective Spells	74,290	63,034	(11,256)	£196.3 m	£169.9 m	£(26.4)m	£2,643	£2,696
2 Accident & Emergency	245,189	235,336	(9,853)	£38.0 m	£38.6 m	£0.6 m	£155	£164
3a Total Elective Spells	81,664	72,673	(8,991)	£89.6 m	£80.1 m	£(9.6)m	£1,098	£1,102
4a New Outpatient Attendances	220,640	209,160	(11,480)	£42.9 m	£40.2 m	£(2.8)m	£195	£192
4b Outpatient Follow Up Attendances	483,024	459,777	(23,247)	£53.1 m	£48.7 m	£(4.4)m	£110	£106





Actual income by care group is reported as equal to plan due to national guidance not to accrue risk against Elective Services Recovery Fund (ESRF).

Elective spells activity has underperformed by 17% against plan in month, and is showing a 11% underperformance against plan YTD. There is no financial impact in our position as a result of this shortfall.

The outpatient element is 4% under plan in month and 5% under plan YTD. There has continued to be a high number of escalation beds open across the Trust and there continues to be an increase in the number of patients over 24 hours and over 48 hours recorded as an A&E attendance rather than an admission.

The variable element of NHSE High Cost drugs is £4.5m above plan YTD, but are pass through costs and net with expenditure.

Activity

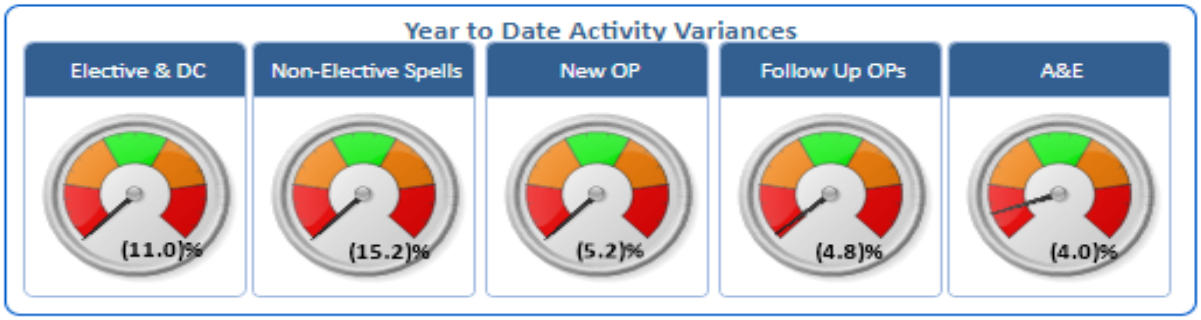
Month 10 (January) 2022/23

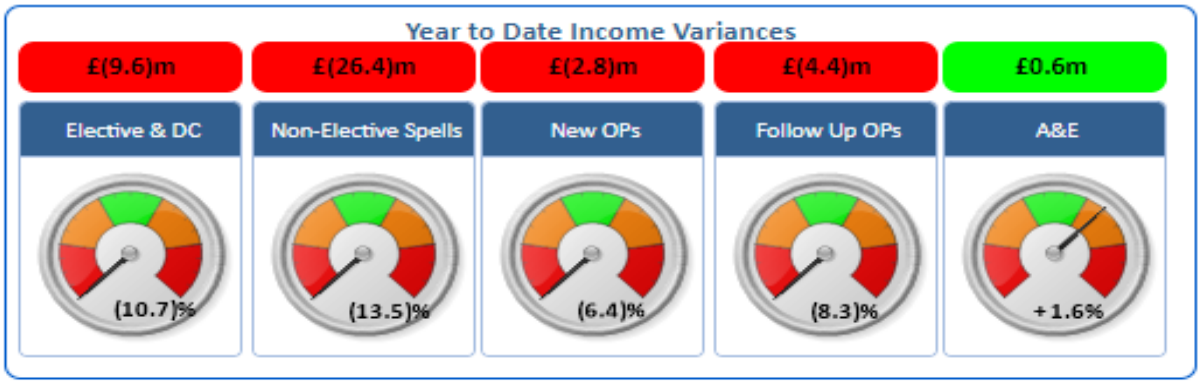
Trust Income Plan	Trust Actual Income	Income Variance
£657.114m	£672.651m	£15.537m

2022/23 - Month 10

East Kent Hospitals University NHS
NHS Foundation Trust

	Year to Date Activity			Year to Date Income £m			Average Tariffs	
Point of Delivery	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual
1a Total Non Elective Spells	74,290	63,034	(11,256)	£196.3 m	£169.9 m	£(26.4)m	£2,643	£2,696
2 Accident & Emergency	245,189	235,336	(9,853)	£38.0 m	£38.6 m	£0.6 m	£155	£164
3a Total Elective Spells	81,664	72,673	(8,991)	£89.6 m	£80.1 m	£(9.6)m	£1,098	£1,102
4a New Outpatient Attendances	220,640	209,160	(11,480)	£42.9 m	£40.2 m	£(2.8)m	£195	£192
4b Outpatient Follow Up Attendances	483,024	459,777	(23,247)	£53.1 m	£48.7 m	£(4.4)m	£110	£106





The Trust has investigated the Non-Elective underperformance against plan compared to the increased pressure the services are under. The Trust is experiencing difficulties with the flow of Non-Elective patients, caused by significant delays to the discharging of medically fit patients. The combination of this and an evolution in the use of observation bays appears to have resulted in a greater proportion of patients seen and treated in A&E with stays >48hrs, resulting in the number of Non-Elective admission being lower. The underlying reason is a lack of capacity of Non-Elective beds, due to the numbers of delayed discharges.

Outpatient activity was 4% under plan in month and 5% under plan YTD.

Daycase and Elective inpatient activity has underperformed by 17% against plan in month, and is showing an 10% underperformance against plan YTD. The financial element of Elective Inpatients and Daycases is under plan by £2.4m in month and £8.6m YTD. T&O is £4.9m below plan YTD and Gastro/Endoscopy are £2.2m below plan YTD, both of which are significant drivers of the ERF under-performance against baseline, which is being reviewed.

The level of A&E attendances is running an overperformance against plan of 1% in month and an underperformance of 4% YTD. The financial variance is over by 10% in month and over by 2% YTD, which reflects a richer case mix of patients now seen and treated in A&E.

ESRF Income

Month 10 (January) 2022/23

Reporting POD	In-Month Income Target (104%) (£m)	In-Month Price Actual (£ m)	In-Month Financial Adjustment @ 75% (£ m)	IncomeTarget (104%) + 1.6% October Inflation (£m)	YTD Price Actual (£m)	YTD Financial Adjustment @ 75% (£m)	YTD Income Performance vs 104% Baseline (£m)	YTD Activity Performance vs 104% Baseline
Daycases	3,748	4,326	433	41,286	42,925	1,229	102%	101%
Elective Inpatients	3,692	2,259	(1,075)	38,071	33,476	(3,446)	101%	100%
Outpatient News	3,827	3,592	(176)	36,052	34,499	(1,165)	101%	100%
Outpatient Follow Ups	4,507	4,078	(322)	40,696	39,240	(1,092)	100%	100%
Outpatient Procedures	1,745	1,820	57	16,568	17,159	443	110%	106%
Chemotherapy	415	548	100	4,099	4,938	629	103%	100%
Reconcile to M6 National Position					(483)	(362)		
M7-10 Reconcilation accrual		(80)	(60)		(322)	(241)		
Grand Total	**17,935**	**16,543**	**(1,044)**	**176,772**	**171,433**	**(4,005)**	**102%**	**101%**

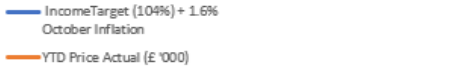
The Trust activity plan has been designed to meet the 104% by financial value Elective Services Recovery Fund (ESRF) target. Due to the expected greater performance in Outpatients compared to Electives the expectation is that activity will need to rise to around 110% of the 2019/20 levels to compensate, which is proving to be very challenging.

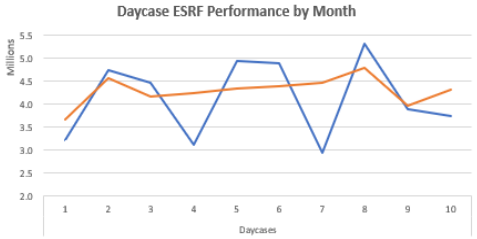
The Trust recently received national monitoring data which shows the value of underperformance against the national target is lower than previously thought at £3.4m to M6, rather than the Trusts previously reported £5.7m. The main difference is a change in the treatment of Outpatient follow ups. The Trust has now excluded them from the calculation. This has generated a reconciliation adjustment of £0.6m YTD.

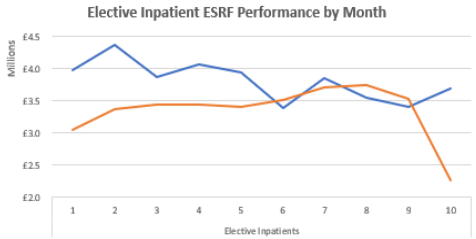
It has been confirmed that there is no requirement to build risk into the position as there is no clawback expected for underperformance at this level, by either the ICB or by NHSEI.

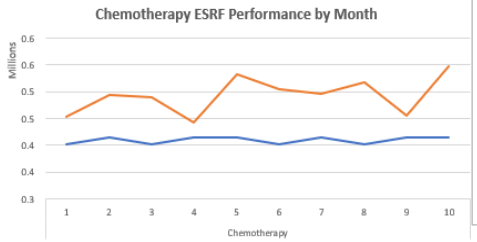
Throughout the year, ESRF has been calculated against a nationally set baseline which is phased differently to the internal activity plans. Therefore, although the Trust underperformed against the internal activity and income plan in month and YTD, when compared against the threshold.

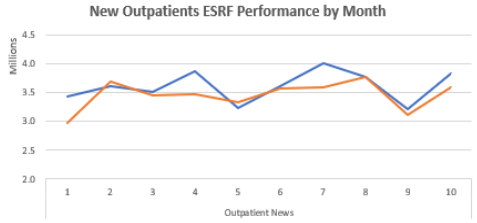
The Elective Inpatients achievement in January is much lower than the baseline, which the Trust is investigating. However, the initial investigations indicate that there has been a significant difficulty with discharging medically fit patients. The Trust has worked hard to mitigate this issue by increasing the amount of Daycase activity and is intending to recover performance in the coming months.

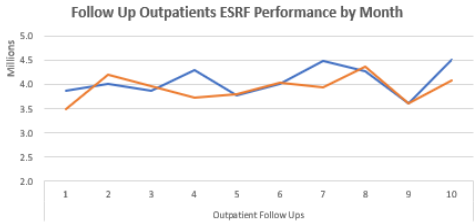


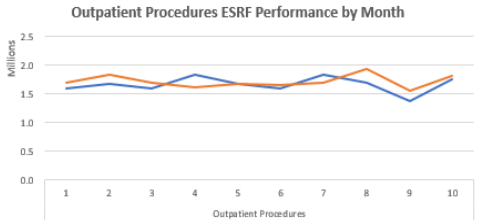


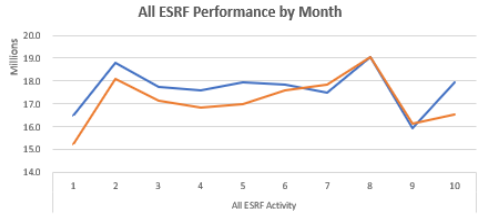






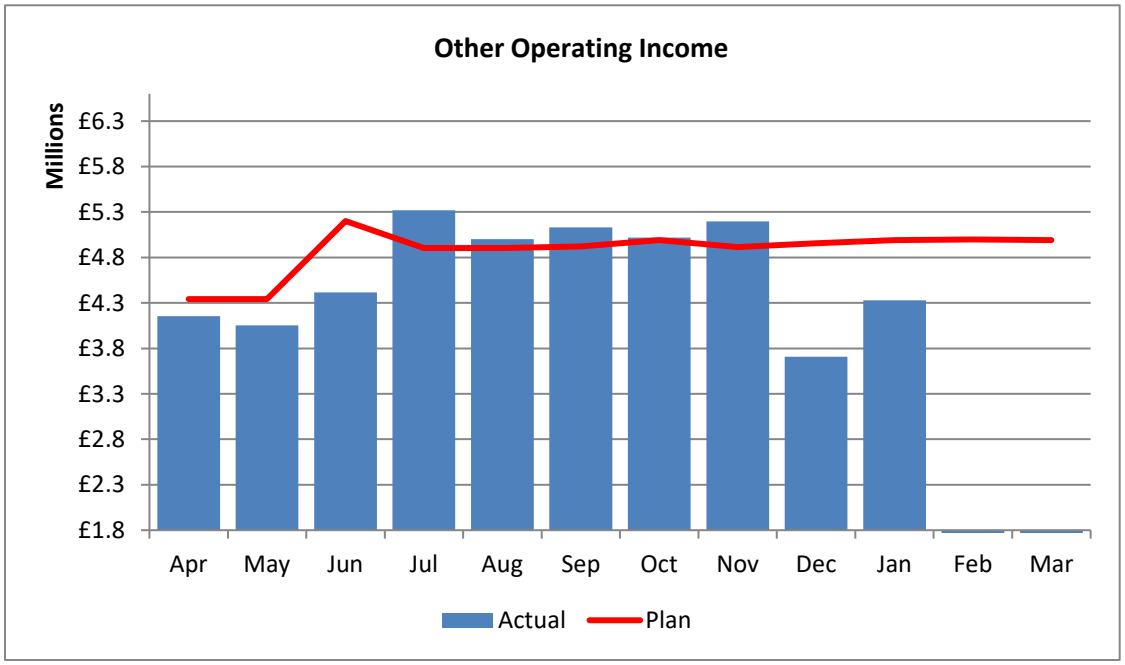






Other Operating Income
Month 10 (January) 2022/23

Other Operating Income	This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Non-patient care services	1,864	2,033	169	18,645	20,718	2,073	22,374
Research and development	219	259	40	2,188	1,990	(199)	2,626
Education and Training	1,522	1,664	141	15,225	15,926	701	18,272
Car Parking income	475	202	(273)	3,326	1,549	(1,777)	4,304
Staff accommodation rental	160	129	(32)	1,604	1,371	(233)	1,922
Property rental (not lease income)	36		(36)	364		(364)	436
Cash donations / grants for the purchase of capital assets	75	69	(6)	750	1,694	944	900
Charitable and other contributions to expenditure	14	20	6	143	133	(10)	171
Other	623	(48)	(670)	6,224	2,946	(3,278)	7,453
Total	**4,989**	**4,329**	**(661)**	**48,469**	**46,326**	**(2,143)**	**58,458**
			-13.25%			-4.42%	
			Adverse			Adverse	



Other operating income is adverse to plan in January by £0.7m and adverse to plan by £2.1m YTD. The main drivers for the variance in month are below plan income for out of envelope Covid-19 costs and credit notes relating to electricity recharges to SRCL totalling £0.4m. Below plan car parking income of £0.3m is offset by income for international nurse recruitment of £0.2m.

YTD, income relating to parking charges, property rental, including staff accommodation, research and innovation and Covid-19 are below plan by a total of £3.3m. These adverse variances are offset by donated income including Harmonia Village of £0.9m and above plan income for education and training £0.7m.

Employee Expenses
Month 10 (January) 2022/23

Employee Expenses	WTE This Month			This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Permanent Staff										
Medical and Dental	1,413	1,338	76	(11,890)	(11,859)	31	(117,832)	(114,620)	3,212	(141,419)
Nurses and Midwives	3,305	2,881	423	(10,923)	(11,825)	(901)	(104,185)	(112,517)	(8,332)	(127,151)
Scientific, Therapeutic and Technical	1,762	1,579	183	(5,743)	(5,946)	(203)	(57,952)	(58,619)	(666)	(69,634)
Admin and Clerical	1,767	1,558	209	(3,369)	(3,955)	(586)	(33,583)	(38,550)	(4,966)	(40,322)
Other Pay	1,814	1,578	236	(5,230)	(5,514)	(284)	(52,134)	(53,707)	(1,572)	(62,595)
Permanent Staff Total	**10,061**	**8,934**	**1,127**	**(37,156)**	**(39,100)**	**(1,944)**	**(365,687)**	**(378,012)**	**(12,325)**	**(441,121)**
Waiting List Payments										
Medical and Dental	0	0	0	(399)	(463)	(65)	(3,975)	(4,701)	(726)	(4,773)
Waiting List Payments Total	**0**	**0**	**0**	**(399)**	**(463)**	**(65)**	**(3,975)**	**(4,701)**	**(726)**	**(4,773)**
Medical Locums/Short Sessions										
Medical and Dental	0	52	(51)	(786)	(799)	(14)	(7,833)	(8,603)	(769)	(9,405)
Medical Locums/Short Sessions Total	**0**	**52**	**(51)**	**(786)**	**(799)**	**(14)**	**(7,833)**	**(8,603)**	**(769)**	**(9,405)**
Substantive	**10,061**	**8,986**	**1,076**	**(38,340)**	**(40,363)**	**(2,022)**	**(377,496)**	**(391,316)**	**(13,820)**	**(455,299)**
Bank										
Medical and Dental	0	40	(40)	(292)	(537)	(245)	(3,424)	(5,268)	(1,844)	(3,962)
Nurses and Midwives	9	359	(350)	(974)	(1,924)	(950)	(11,423)	(15,442)	(4,019)	(13,218)
Scientific, Therapeutic and Technical	0	18	(18)	(50)	(110)	(60)	(583)	(1,202)	(619)	(675)
Admin and Clerical	7	85	(78)	(164)	(285)	(121)	(1,928)	(2,416)	(488)	(2,231)
Other Pay	6	302	(297)	(599)	(949)	(350)	(7,025)	(8,679)	(1,654)	(8,129)
Bank Total	**21**	**804**	**(782)**	**(2,079)**	**(3,805)**	**(1,725)**	**(24,384)**	**(33,008)**	**(8,624)**	**(28,215)**
Agency										
Medical and Dental	2	46	(44)	(618)	(1,004)	(386)	(6,768)	(10,426)	(3,659)	(7,870)
Nurses and Midwives	0	227	(227)	(818)	(1,313)	(495)	(9,357)	(12,256)	(2,899)	(10,667)
Scientific, Therapeutic and Technical	0	4	(4)	(24)	(26)	(3)	(245)	(281)	(36)	(289)
Admin and Clerical	0	7	(7)	(7)	(122)	(115)	(85)	(686)	(601)	(96)
Other Pay	0	59	(59)	(82)	(207)	(125)	(943)	(2,425)	(1,482)	(1,074)
Agency Total	**3**	**343**	**(341)**	**(1,548)**	**(2,672)**	**(1,124)**	**(17,397)**	**(26,074)**	**(8,677)**	**(19,996)**
Direct Engagement - Agency										
Medical and Dental	2	60	(58)	(654)	(865)	(211)	(7,256)	(9,563)	(2,307)	(8,316)
Scientific, Therapeutic and Technical	0	1	(1)	(6)	(3)	2	(64)	(64)	()	(72)
Direct Engagement - Agency Total	**2**	**60**	**(59)**	**(660)**	**(869)**	**(209)**	**(7,320)**	**(9,627)**	**(2,307)**	**(8,388)**
Agency	**4**	**404**	**(399)**	**(2,208)**	**(3,541)**	**(1,333)**	**(24,717)**	**(35,701)**	**(10,984)**	**(28,384)**
Total	**10,087**	**10,193**	**(106)**	**(42,628)**	**(47,709)**	**(5,081)**	**(426,597)**	**(460,025)**	**(33,428)**	**(511,898)**
						-11.92%			-7.84%	
						Adverse			Adverse	

Employee expenses performance is adverse to plan in January by £5.1m and by £33.4m YTD (7.8%) of which £0.6m and £7.7m respectively relates to the above plan pay award. Indicative direct costs for escalation beds continue to be at least £0.8m in month and £7.2m YTD, and 1:1 specialing costs are at least £0.6m and £5.1m YTD.

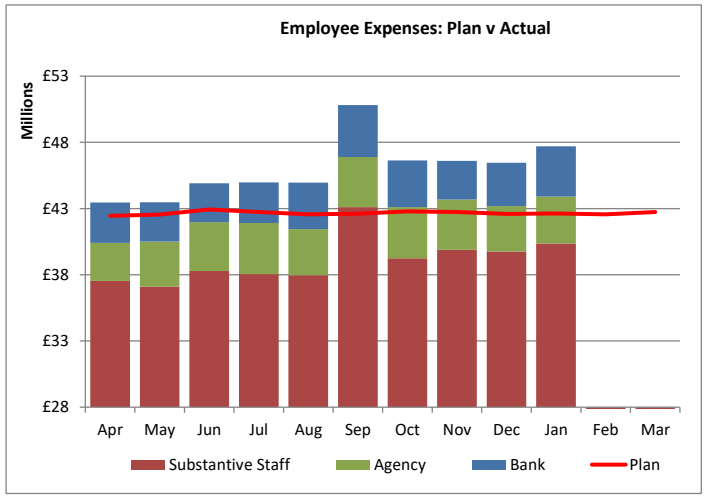
Total expenditure on pay in January was £47.7m, an increase of £1.2m when compared to December, with increased costs relating to bank and agency staff of £0.7m. Expenditure on permanent staff increased by £0.6m.

The increase in spend on permanent staff in January relates mainly to expenditure on medical consultants, qualified nurses and HCAs, which grew by a total of £0.5m including Bank holiday enhancements. Contracted wte increased by a further 84 wte overall.

Expenditure on bank staff Increased by £0.5m, all relating to qualified nurses, with further incentive schemes in UEC costing approximately £0.2m. Expenditure on agency staff grew by £0.1m, again mainly relating to qualified nurses.

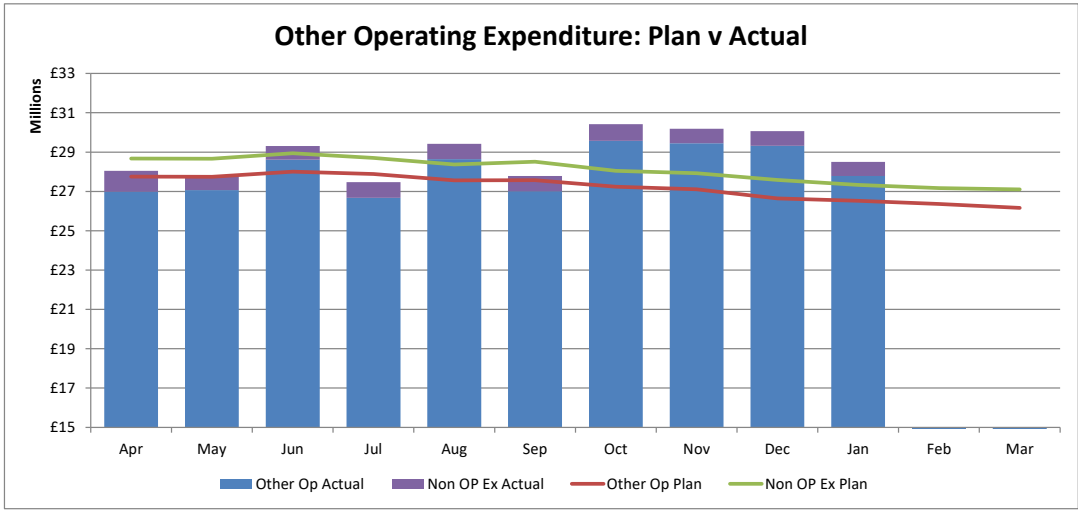
Expenditure on all substantive staff is adverse to plan in January by £2.0m and by £13.8m YTD inclusive of the pay award impact.

Expenditure on bank and agency staff combined is adverse to plan in January by £3.1m and by £19.6m YTD.



Other Operating Expenditure
Month 10 (January) 2022/23

	This Month			Year to Date			Annual
£000	**Plan**	**Actual**	**Var.**	**Plan**	**Actual**	**Var.**	**Plan**
Drugs	(6,613)	(7,506)	(893)	(66,873)	(71,611)	(4,738)	(80,094)
Supplies and Services – Clinical	(3,334)	(3,093)	241	(34,870)	(34,949)	(79)	(41,509)
Supplies and Services - Non-Clinical	(8,821)	(9,821)	(1,000)	(93,546)	(97,062)	(3,517)	(110,939)
Non Executive Directors	(19)	(30)	(11)	(188)	(164)	24	(229)
Purchase of Healthcare	(594)	(523)	71	(7,007)	(5,849)	1,158	(8,059)
Education & Training	(304)	(313)	(9)	(3,044)	(3,084)	(39)	(3,652)
Consultancy	(27)	(22)	5	(270)	(213)	58	(325)
Premises	(1,130)	(893)	238	(11,352)	(7,966)	3,386	(13,615)
Clinical Negligence	(2,210)	(2,139)	71	(22,166)	(21,392)	774	(26,591)
Transport	(226)	(300)	(74)	(2,499)	(2,623)	(124)	(2,935)
Establishment	(341)	(402)	(62)	(3,405)	(4,166)	(761)	(4,081)
Other	(920)	(805)	115	(9,000)	(13,193)	(4,193)	(10,752)
Depreciation & Amortisation-Owned Assets	(1,981)	(1,932)	48	(19,807)	(18,811)	996	(23,769)
Impairment Losses					(39)	(39)	
Total Other Operating Expenditure	**(26,519)**	**(27,780)**	**(1,261)**	**(274,028)**	**(281,122)**	**(7,094)**	**(326,549)**
Profit/Loss on Asset Disposals				(375)	(89)	286	(500)
PDC Dividend	(778)	(778)		(7,990)	(7,829)	161	(9,545)
Interest Receivable	181	271	90	1,809	2,261	452	2,171
Interest Payable	(218)	(212)	7	(2,183)	(2,195)	(12)	(2,619)
Total Non Operating Expenditure	**(815)**	**(719)**	**97**	**(8,739)**	**(7,853)**	**886**	**(10,493)**
Total Expenditure	**(27,334)**	**(28,498)**	**(1,164)**	**(282,766)**	**(288,975)**	**(6,208)**	**(337,043)**



Other operating expenditure is adverse to plan by £1.3m in January and by £7.1m YTD (2.6%).

Drug spend is adverse to plan in January by £0.9m and by £4.7m YTD. Drugs historically classed as rechargeable which includes blood product deliveries and issues to homecare patients are adverse to plan in January by £0.6m and by £3.0m YTD. All other drugs are adverse to plan in month by £0.3m and adverse to plan by £1.7m YTD.

Supplies and services - clinical are favourable to plan in month by £0.2m and marginally adverse to plan by less than £0.1m YTD. Slippage against CIP targets and adverse variances on rechargeable High Cost Devices items totalling £1.3m in month are offset by underspends on radiological reporting services following a review of accruals and medical consumables totalling £1.5m.

Supplies and services - non-clinical are adverse to plan by £1.0m in January and by £3.5m YTD. Variances in month and YTD relate predominantly to the Operated Healthcare Facility contract which is adverse to plan in month by £1.0m and by £4.3m YTD, which is inclusive of the subsidiary pay award and unconfirmed CCN baseline uplift assumptions. Slippage on CIPs is £0.2m in month and £0.3m YTD.

Purchase of healthcare from the independent sector is favourable to plan in month by £0.1m and favourable to plan by £1.2m YTD. This reflects the reduced use of Spencer beds and the transfer of provider invoicing for agreed procedures to the ICB with effect from August.

Premises costs are favourable to plan in month by £0.2m and by £3.4m YTD. In month, favourable variances on business rates, purchase of computer software, licence fees and service contracts total £0.2m. YTD the position is driven mainly by a favourable variance on business rates of £1.8m, inclusive of prior year rebates and overachieved CIPs, and below plan spend on building works totalling £0.6m. Rental of premises, licence fees and service contracts are favourable to plan by a total of £0.6m YTD.

Clinical negligence is favourable to plan in month by £0.1m and by £0.8m YTD, linked to the non-collection of the Maternity Incentive Scheme 2022/23.

Other expenditure is favourable to plan by £0.1m in month and adverse to plan by £4.2m YTD, which is inclusive of the Urgent Treatment Centres (UTC) GP telephony service contract change of £0.2m, offset by Patient Care Income, and partial exemption VAT rebate of £0.3m. The YTD variance is mainly driven by overspends in UTC £0.9m and work permits £1.4m YTD.

Depreciation is slightly better than plan in month and favourable to plan by £1.0m YTD.

Cost Improvement Summary

Month 10 (January) 2022/23

Delivery Summary	This Month			Year to Date			Forecast	
Programme Themes £000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Outturn**	**Variance**
Agency	647	543	(105)	4,115	3,397	(718)	4,558	(1,003)
Bank	-	12	12	-	76	76	106	106
Workforce	81	209	129	412	1,442	1,030	1,722	1,124
Outpatients	-	-	-	-	-	-	-	-
Procurement	236	29	(207)	1,259	262	(997)	569	(1,231)
Medicines Value	162	53	(109)	870	760	(110)	992	(208)
Theatres	390	22	(368)	2,214	246	(1,968)	258	(2,742)
Care Group Schemes *	1,852	891	(961)	11,219	7,255	(3,964)	9,422	(5,761)
Sub-total	**3,368**	**1,758**	**(1,610)**	**20,088**	**13,438**	**(6,651)**	**17,626**	**(9,715)**
Central	326	77	(249)	1,957	2,193	236	4,354	1,695
Grand Total	**3,694**	**1,835**	**(1,859)**	**22,045**	**15,630**	**(6,415)**	**21,980**	**(8,020)**

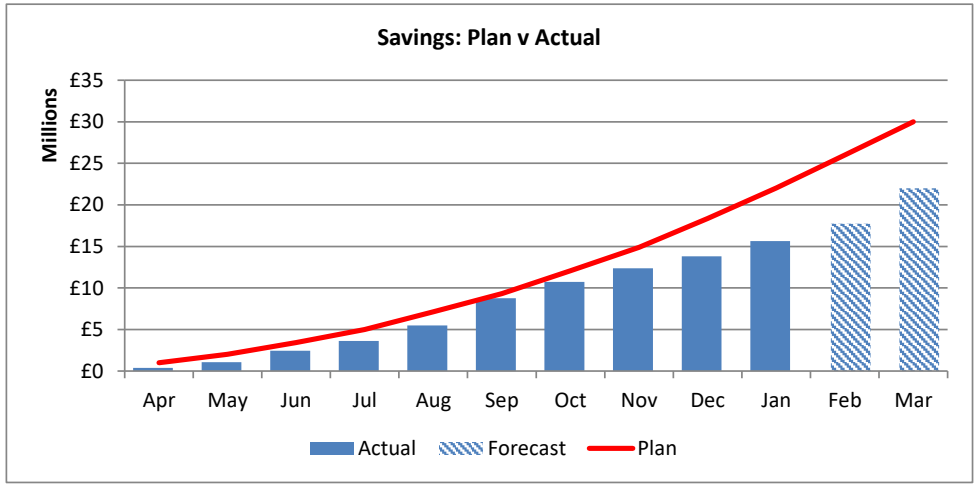
* Smaller divisional schemes not allocated to a work stream

Delivered £000		
Month	**Target**	**Actual**
April	999	391
May	1,023	662
June	1,399	1,375
July	1,562	1,205
August	2,129	1,863
September	2,212	3,270
October	2,733	1,957
November	2,848	1,650
December	3,446	1,422
January	3,694	1,835
February	3,945	
March	4,010	
	30,000	**15,630**

Efficiencies

The submitted Efficiencies plan for 2022/23 is £30m. The Trust achieved savings of £1.8m in January, which is below plan. The in-month performance relates to shortfalls in Care Groups, Agency, Procurement, Theatres & Central, offset by overperformance in Workforce and Bank. YTD underperformance is primarily due to timing of schemes in Theatres, Procurement and Care Groups currently being developed. Recurrent savings in January amounted to £1.0m, with £0.8m being on a non-recurrent basis.

Recurrent savings YTD amount to £7.6m with £8.0m on a non-recurrent basis. We are looking to deliver as much of the forecast, and as recurrently as possible, and is updated and reviewed weekly to accelerate progress. Weekly meetings continue with an increased focus on 2023/24 ideas, which require development.



Capital Expenditure
Month 10 (January) 2022/23

Capital Programme	Annual	Annual	Year to Date		
£000	**Plan**	**Forecast**	**Plan**	**Actual**	**Variance**
ED Expansion WHH & QEQM	11,654	14,592	10,794	12,408	(1,614)
24 Bed ITU Kennington Carpark WHH	350	399	350	399	(49)
Electronic Medical Records	910	2,800	850	1,611	(761)
PEIC - Backlog maintenance/ Patient environment improvement	3,750	4,050	3,189	2,744	445
MDG - Medical equipment replacement (<£250k per item)	1,136	2,126	715	1,145	(430)
IDG - IT hardware/ systems replacement	2,400	1,468	2,300	1,333	967
New Interventional Radiology (IR) suite - K&C	160	203	160	203	(43)
Endovascular theatre (EVT) kit installation - K&C	937	937	937	827	110
Maternity Training		269			
Clinical Trials Unit	1,000	457	815	451	364
Community Diagnostic Hub - BHD	250	279	250	279	(29)
Maternity Estates Review	376	100	376	77	299
Refurbishment of SCBU QEQM and meeting IPC requirements	341	65	341	46	295
Theatre 4&5 - AHU Replacement - KCH	1,200	1,470	1,200	1,470	(270)
Restore and Recovery	250	210	250	207	43
East Kent Transformation Programme	178	178	178	162	16
Donated Assets	900	998	750	732	18
2gether Support Solutions		304		65	(65)
Spencer Private Hospitals		85		8	(8)
Other IFRS16 Assets		1,074		1,074	(1,074)
All Other		(231)		(200)	200
Other IT		1,033		412	(412)
Mechanical Thrombectomy		2,100			
Imaging Diagnostic Equipment		344			
Maternity - Entonox		469			
	25,792	**35,780**	**23,455**	**25,451**	**(1,996)**
Funded By:					
Operational Cash	23,368	22,032			
System Set Underutilisation	(4,168)	0			
Grants and Donations	900	1,914			
Disposals	500	300			
Front Line Digitisation PDC	910	1,820			
Other PDC	4,282	8,214			
Right of Use Asset Liabilities	0	1,300			
	25,792	**35,580**			
Under/(Over) Commitment		**(200)**			

2022/23 Summary Capital Spend position - M10 and Forecast Outturn

The group gross capital year-to-date spend to the end of Month 10 is £25.5m, against an YTD Plan of £23.5m. This represents a £2m overspend against plan, as a result of the overall increase in the 2022/23 Capital Programme.
The estimated forecast for the year as at the end of M10 is £35.8m, representing a £10m increase from the original capital plan submitted in April 2022 of £25.8. The £10m increase in the overall capital programme relates to:

- £4.6m - Mechanical Thrombectomy;
- £1.3m - IFRS16 Assets (net neutral impact on bottom line);
- £1m - Donated Assets (£0.8m related to Harmonia Village and £0.2m to the East Kent Charity);
- £1m - Digital Diagnostics Imaging schemes;
- £0.9m - Additional Frontline Digitisation PDC funding;
- £0.7m - Additional System PDC Funding, approved by the K&M CFO Group on 19.12.22;
- £0.05m - Cyber Security Funding, received in January 2023;

The M10 position reports a £0.2m overcommitment against the available capital funding, as a result of a corresponding reduction in the level of disposals gains assumed at the beginning of the year. However, the K&M ICS approved a further £0.5m CDEL increase (non-cash backed) to EKHUFT on 09/02/2023, following a system re-distribution of capital. This latest allocation will partly be used to offset the current overcommitment and it is expected to be reflected in the forecast as of M11.

Major Capital Schemes Updates:

- The Trust has been informed that the Application to the Public Sector Decarbonisation Scheme, approved by the Trust Board in November 2022, has been unsuccessful, as the total value of applications received prior to EKHUFT's exceeded the scheme's available funding, being therefore heavily oversubscribed. The scheme was expected to secure a £25m government grant to support the Trust in achieving a significantly reduced carbon footprint.

Other risks

- The level of disposal gains is likely to reduce further by the end of the financial year, implying an additional funding reduction risk of circa £0.1 to £0.15m; no provision has been made against this emergent risk and mitigating actions are expected to be explored at the next Capital Group Meeting.

- IFRS16 Leases - Cash Repayments: the previously reported risk around the capital lease repayments remains; the latest estimate as at M10 for our 2022/23 Lease Capital Repayments totals £1.35m, representing a £0.4m risk against our planned provision of £0.95m; however, as at M10, repayments totalling £1.25m were expected to be made, although only £0.9m has actually materialised; this is likely to have been the result of a mixture of late invoicing by the lessors and/or late payme nts of the outstanding invoices by the Trust; this risk carries a significant degree of volatility and it is difficult to ascerta in precisely where the year-end position will land, but if the current trend maintains, the risk exposure is expected to reduce to immaterial levels of circa £0.02m;
The team will continue to monitor the development of this risk and a regular monthly update will be provided in the upcoming reports.

Statement of Financial Position

Month 10 (January) 2022/23

£000	Opening	To Date	Movement	
Non-Current Assets	**419,046**	**423,899**	**4,852**	▲
Current Assets				
Inventories	5,527	7,542	2,015	▲
Trade Receivables	17,933	10,375	(7,558)	▼
Accrued Income and Other Receivables	16,715	20,448	3,732	▲
Assets Held For Sale			-	
Cash and Cash Equivalents	27,372	10,605	(16,767)	▼
Total Current Assets	**67,547**	**48,970**	**(18,578)**	▼
Current Liabilities				
Payables	(33,309)	(66,971)	(33,661)	▲
Accruals and Deferred Income	(54,360)	(42,885)	11,475	▼
Provisions	(5,761)	(5,545)	216	▼
Borrowing	(5,750)	(5,675)	75	▼
Net Current Assets	**(31,633)**	**(72,105)**	**(40,472)**	▼
Non Current Liabilities				
Provisions	(4,417)	(4,304)	113	▼
Long Term Debt	(83,551)	(78,066)	5,484	▼
Total Assets Employed	**299,446**	**269,423**	**(30,023)**	▼
Financed by Taxpayers Equity				
Public Dividend Capital	425,777	425,777	-	
Retained Earnings	(181,901)	(211,802)	(29,901)	▼
Revaluation Reserve	55,569	55,448	(122)	▼
Total Taxpayers' Equity	**299,446**	**269,423**	**(30,023)**	▼

Non-Current asset values reflect in-year additions (including donated assets) less depreciation charges. Non-Current assets also includes the loan and equity that finances 2gether Support Solutions. A “full" revaluation of the Groups estate is underway and will be completed as at 31 March 2023.

Trust closing cash balance was £10.6m (£11.1m December) £0.5m above plan. See cash report for further details.

The Board of 2gether approved the transfer of £12m cash - £4m dividend and £8m early repayment of loan - the cash was received on 2 February (month 11). The year-to-date Month 8 deficit of £19m was applied for to be drawn as PDC in February 2023.

Trade and other receivables have reduced from the 2021/22 opening position by £7.6m (£8.1m reduction in December). Key drivers are detailed on the Cash report

Payables have increased by £33.7m (£22.4m increase in December) See Working Capital sheet for more detail on debtors and creditors.

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

The movement in Retained earnings reflects the year-to-date unadjusted deficit.

Summary Profit & Loss January 2023 and Outturn Forecast

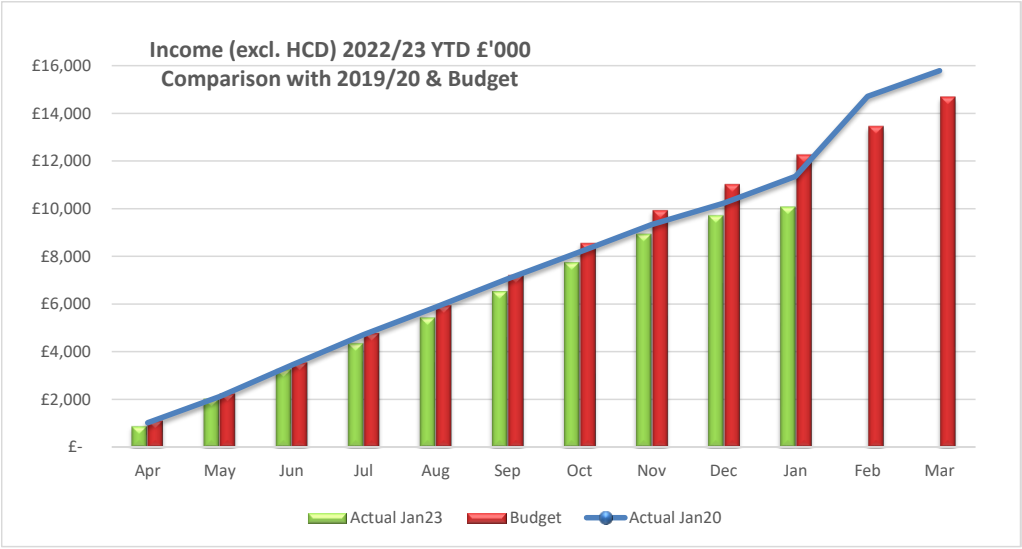
£'000s	Month			YTD			Full Year 2022-23		
	Actual	Budget	Variance	Actual	Budget	Variance	Outturn	Budget	Variance
Income	1,675	1,546	129	15,150	15,332	(182)	19,677	18,344	1,332
Pay	(796)	(752)	(44)	(7,696)	(7,418)	(278)	(10,229)	(8,881)	(1,348)
Non Pay	(638)	(647)	10	(6,153)	(6,343)	189	(7,312)	(7,590)	277
Other Costs	(204)	(112)	(93)	(1,045)	(1,343)	298	(1,803)	(1,571)	(232)
Operating Profit	37	35	2	256	228	28	332	302	30
OP %	*2.2%*	*2.3%*	*1.9%*	*1.7%*	*1.5%*	*-15.3%*	*1.7%*	*1.6%*	*2.3%*
Interest Receivable / Interest Expense	1	(1)	2	4	(13)	17	(10)	(15)	5
Net Profit before Tax	38	34	5	260	215	45	322	287	35
NPBT %	*2.3%*	*2.2%*	*3.6%*	*1.7%*	*1.4%*	*-24.8%*	*1.6%*	*1.6%*	*2.7%*
Tax	(10)	(8)	(2)	(74)	(61)	(13)	(121)	(78)	(42)
Net Profit after Tax	28	25	3	186	155	32	202	209	(7)
NPAT %	*1.7%*	*1.6%*	*2.2%*	*1.2%*	*1.0%*	*-17.5%*	*1.0%*	*1.1%*	*-0.5%*

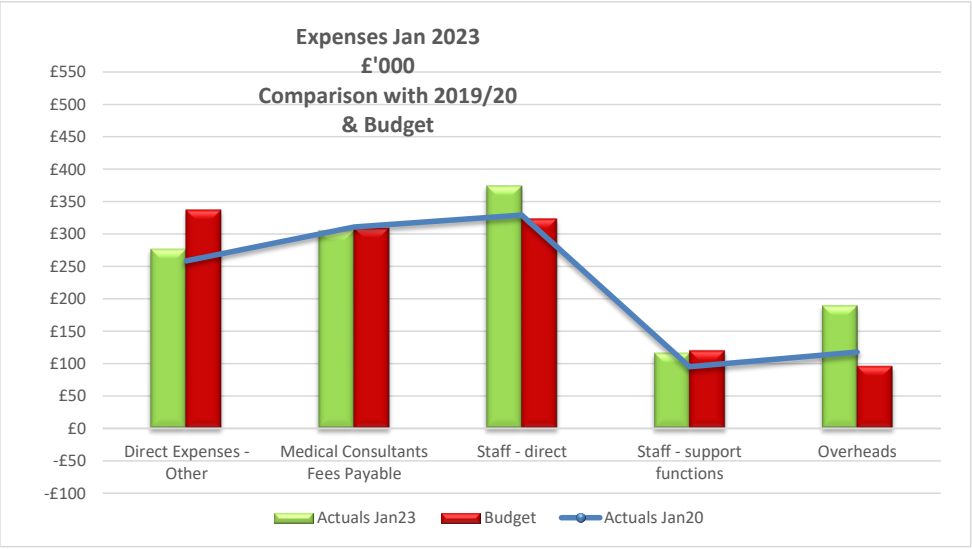
Salient comments on month / YTD results:

A net profit of £0.03m was achieved in January which was slightly above budget for the month.

We continue to incur increased staff costs due to high utilisation of agency nursing and theatre staff despite attempts to recruit into these roles.

Other Costs were significantly above budget this month due to the inclusion of £0.06m unbudgeted costs for new radiators at the Margate site. However, with increased revenues as a result of less restrictions on access to theatres, profit in line with budget has been achieved.





2gether Support Solutions
Month 10 (January) 2022/23

Summary Profit & Loss January 2023

£'000s	Month Actual	Month Budget	Month Variance	YTD Actual	YTD Budget	YTD Variance
Income	11,639	12,009	(370)	118,735	120,089	(1,353)
Costs	(11,508)	(11,885)	378	(117,384)	(118,855)	1,471
Operating Profit/(Loss)	**131**	**123**	**8**	**1,352**	**1,234**	**118**
OP %	*1%*	*1%*	*0%*	*1%*	*1%*	*0%*
Operating Profit/Loss EKHUFT	162	17	146	679	166	513
Operating Profit/Loss Retail	(30)	107	(137)	674	1,068	(394)
Interest Receivable	209	215	(6)	2,165	2,150	15
Interest Receivable (Bank)	52	()	52	217	()	217
Interest Expense	(186)	(180)	(6)	(1,818)	(1,805)	(13)
Net Profit/(Loss) before Tax	205	158	48	1,916	1,579	338
NPBT %	*1.8%*	*1.3%*	*0.5%*	*1.6%*	*1.3%*	*0.3%*
Tax	(113)	(58)	(54)	(711)	(582)	(129)
Net Profit/(Loss) after Tax	**93**	**100**	**(6)**	**1,205**	**997**	**209**
NPAT %	*0.8%*	*0.8%*	*0.0%*	*1.0%*	*0.8%*	*0.2%*

Salient comments
YTD

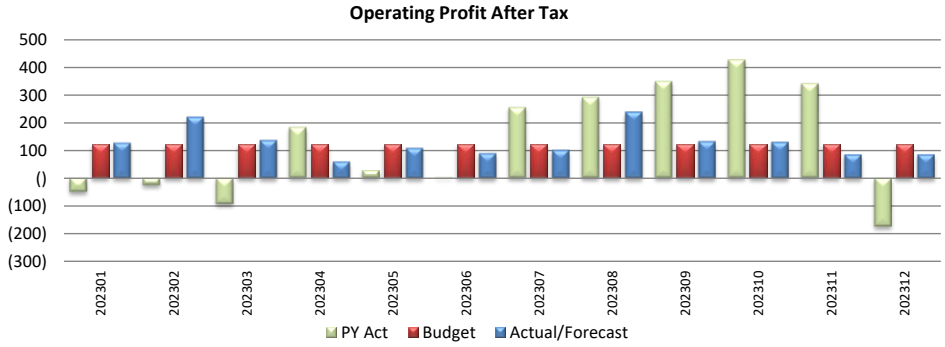
The Operating Profit and Profit after Tax level is a profit of £1.4m and £1.2m respectively.

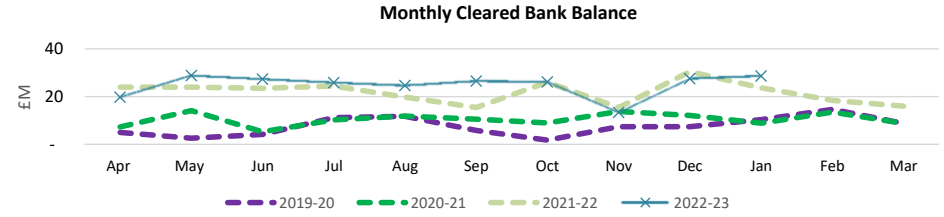
2gether is accruing contract income (and EKHUFT contract costs) relating to: price and volume cost pressures for patient feeding, volume and aged equipment maintenance costs for EME; and, price & volume related costs for IHSS equipment sterilisation.

The Senior Leadership Team are actively managing their pay and non-pay cost base given inflationary, volume and service pressures to ensure that the budgeted profit level is delivered and the high-level forecast outturn remains to achieve this.

Operating Working Capital has increased to £24.5m. Cash is £28.7m. EKHUFT debt is £2.1m. EKHUFT creditor is £7k.

BALANCE SHEET £000's	**Mar-22**	**Jan-23**	**Movement**
Total non-Current Assets	**79,286**	**73,397**	**(5,889)**
Trade and other Receivables	22,868	3,177	(19,691)
Prepayments	2,240	5,134	2,893
Accrued Income	(276)	2,563	2,839
Total Debtors	**24,832**	**10,874**	**(13,958)**
Stocks	**4,824**	**4,824**	0
Creditors and other payables	(11,274)	(8,495)	**2,779**
Accruals	(14,827)	(11,447)	3,380
Deferred Revenue	(130)		130
Total Creditors	**(26,231)**	**(19,942)**	**6,289**
Cash	**15,997**	**28,723**	**12,726**
Operating Working Capital	**19,422**	**24,478**	**5,056**
Borrowings	**(63,801)**	**(61,764)**	**2,037**
Net Assets	**34,907**	**36,112**	**1,205**
Share Capital	30,267	30,267	0
Retained Profit/(Loss) - Prior Year	4,640	5,845	1,205
Shareholders Funds	**34,907**	**36,112**	**1,205**





East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**CHIEF MEDICAL OFFICER'S (CMO'S) REPORT: LEARNING FROM DEATHS – QUARTER 2 AND QUARTER 3 2022/23**				
MEETING DATE:	**9 MARCH 2023**				
BOARD SPONSOR:	**CHIEF MEDICAL OFFICER**				
PAPER AUTHOR:	**CHIEF MEDICAL OFFICER**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	This report provides the Board with Quarter 2 (Q2) and Quarter 3 (Q3) updates on how we are Learning from Deaths (LfD) in line with the National Quality Board recommendations.				
Summary of Key Issues:	The Trust's mortality position continues to improve with a 'statistically low' Hospital Standardised Mortality Ratio (HSMR) as reported in the monthly Integrated Performance Report (IPR) and 'as expected' Summary Hospital-level Mortality Index (SHMI). Mortality data is reviewed monthly at the Mortality Surveillance and Steering Group (MSSG) and deep dives undertaken dependent on data and coding reviews. Learning from deaths is shared via Care Group governance processes including morbidity and mortality meetings, patient safety communications and via the Patient Safety Committee (PSC). The themes highlighted in Q2 and Q3 are recognised, especially the impact of the current pressures in our Emergency Departments (EDs) leading to overcrowding and corridor care. Safety huddles and rounding are in place to support safe care and improvement workstreams to divert patients to most appropriate pathways away from ED are underway. In addition, we are piloting palliative care beds to support end of life (EoL) patients being fast tracked to a more suitable environment with clear care plans. We have noted a rise in deaths in the ED in December 2022. This is only crude data at this stage and a deep dive into the drivers of this is being undertaken. While many specialities are LfD there remain areas that need further embedding, promoting clinical teams to be curious about the outcomes of the care they deliver and drive for continuous improvement. Supporting this will be part of the new Mortality Lead role. We continue to focus on reducing the recurrent clinical themes and monitoring that actions already in place have had their intended impact on clinical care and outcomes for patients, or are adjusted if not. This includes a refocus on our approach to the deteriorating patient.				
Key Recommendation(s):	The Board of Directors is asked to discuss and **NOTE** the LfD Quarter 2 and Quarter 3 2022/23 Report.				

East Kent Hospitals University NHS Foundation Trust

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	Our people	Our future	Our sustainability	**Our quality and safety**

Link to the Board Assurance Framework (BAF):	**Principal Risk – BAF 32** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.	
Link to the Corporate Risk Register (CRR):	**Risk 117 –** Patients may be harmed through poor medicines management due to poor culture towards medicines prescription and administration at ward and department level that may result in patient harm, poor patient experience and increased length of stay (16). **Risk 116** – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate nursing staffing levels and skill mix to meet patient's needs (20). **Risk 123 -** There is a risk of inadequate medical staffing levels and skills mix to meet patients' needs (15). **Risk125 -** There is a risk of failure to meet patients' nutrition and hydration needs (12). **Risk 132 -**There is a failure to demonstrate compliance with national standards for Venous Thromboembolism (VTE) assessment in inpatients using VitalPAC assessment tool (12).	
Resource:	N	
Legal and regulatory:	N	
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	In part by Quality and Safety Committee (updated data)	

East Kent Hospitals University NHS Foundation Trust

Mortality & Learning from Deaths – Q2 and Q3 2022/23

1. Introduction

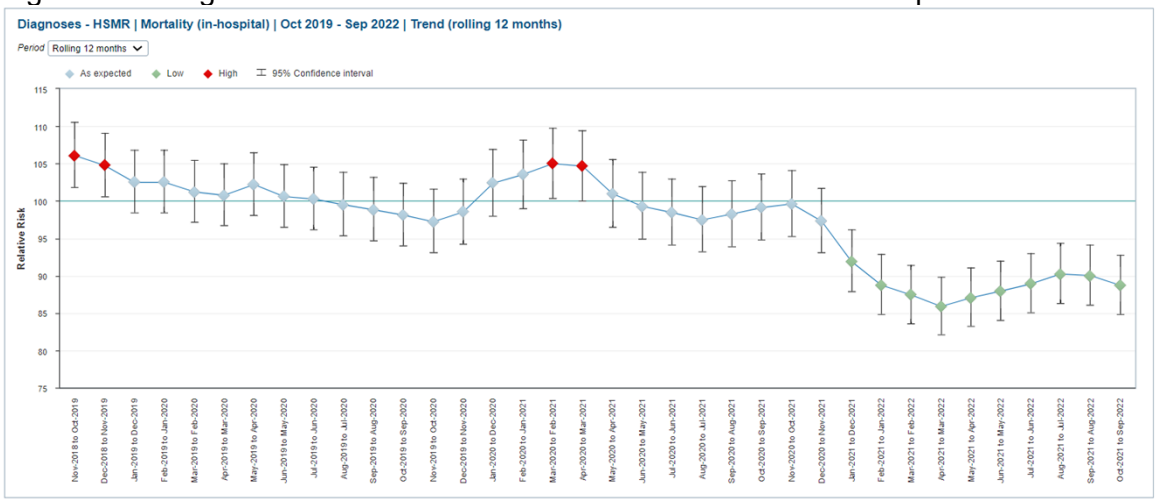
This report highlights the activity undertaken in Q2 and Q3 for Mortality and Learning from Deaths.

1.1 Overview of mortality data

Mortality summary reports from the Telstra Health platform are received and reviewed in depth at the monthly MSSG. These are used to identify positive and negative outlier diagnostic groups and also those at risk through review of confidence limits.

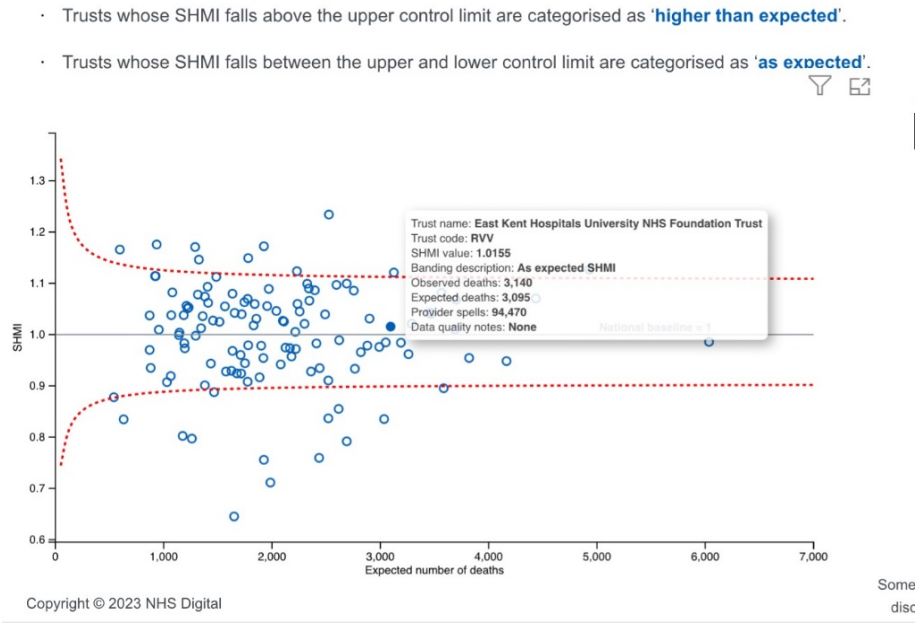
Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect. A score of 100 means that the number of deaths is similar to what you would expect. It was developed to enable a more meaningful comparison of mortality rates between hospitals. The HSMR scoring system works by taking a hospital's crude mortality rate and adjusting it for a variety of factors – population size, age profile, level of poverty, range of treatments and operations provided. The HSMR is the relative risk of in-hospital mortality for patients admitted within the 56 diagnosis groups that account for 80% of in-hospital deaths. Current HSMR performance is reported within the IPR as a True North metric for reduction in mortality. Our last reported position demonstrates a rolling 12 month to October 2022 HSMR is 88.8, statistically 'lower than expected'. This represents an increase in the relative risk of dying with the admission diagnosis, alongside an increase in the number of expected deaths, to last month's position. Our palliative care rate 2.89% is above the national average and peer rates. Key alerts and current position are now reported to the Quality and Safety Committee in the assurance report from MSSG.

Figure 1. Rolling 12-month trend in HSMR over time for East Kent Hospitals



The Summary Hospital-level Mortality Index (SHMI) is the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die, on the basis of average England figures and given the characteristics of the patients treated. Key differences are that SHMI includes deaths up to 30 days following a patient's discharge, includes all diagnostic groups and does not make an adjustment for palliative care. Figure 2 illustrates our SHMI against other providers.

Figure 2. SHMI



From our data review any deep dives into diagnostic categories are commissioned and the results reviewed, including data quality and clinical pathways. Clinical recommendations are reported through to PSC who determine how to embed and monitor effectiveness of actions.

Our crude data shows an increase in mortality in our EDs in December 2022. This data is currently being scrutinised to understand the drivers and will be reported back through to Quality and Safety Committee.

2. Learning from Deaths (LfD)

To learn from deaths there are two main governance processes for the majority of deaths. Deaths are now scrutinised by the Medical Examiner service as an initial screening review. If a patient's death is related to a failing or omission in care then it will be reviewed at the Serious Incident (SI) Declaration Panel and be managed through that process. For those cases that do not meet criteria for SI a proportion will be put forward for Structured Judgement Review (SJR) by trained reviewers. Selection is guided by locally and nationally mandated guidance and local priority is given to those cases identified by the Medical Examiners. There are specific processes in place for perinatal deaths and stillbirths using the Perinatal Mortality Review Tool, for child deaths and for deaths in patients with learning disabilities.

The LfD panel reviews second SJRs which are indicated when the overall care has been judged to be poor or a >50% chance of poor care contributing to the outcome.
In Quarter 2 (Q2) 57 cases and in Quarter 3 (Q3) 57 cases were reviewed through SJRs as illustrated in Figure 3 and 4 respectively. The dashboard requires updating to recognise that screening is now completed by the Medical Examiners. Following the external review of mortality processes we are now aiming to complete reviews on a smaller percentage of deaths but this will include nationally mandated categories and those where the Medical Examiner has identified a learning opportunity. Where there are concerns raised in relation to clinical care these are managed through the SI process.

Figure 3: Overall Completion Q2 2022/23

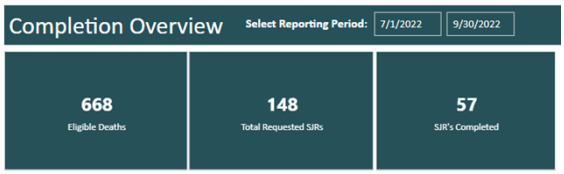
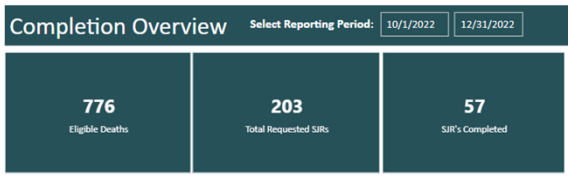


Figure 4: Overall Completion Q3 2022/23



The SJR reviews care across five phases of care as relevant to each patient and overall care. Phase of care scores for Q2 and Q3 are illustrated in Figure 5 and 6.

Figure 5. Phase of Care Scores Q2

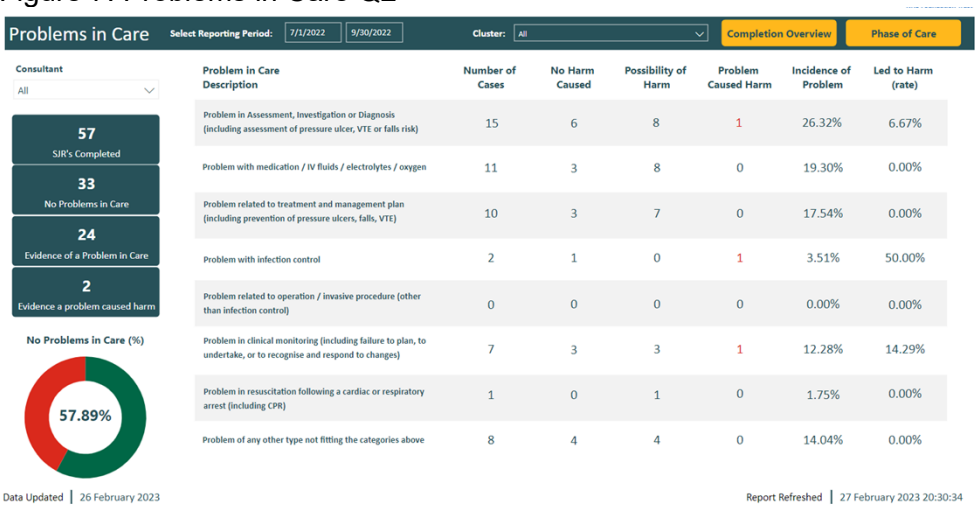
Overall the majority of care is judged to fall within the good category. Poor overall care was identified in 14 cases in Q2 and 12 cases in Q3 in any phase of care. Drilling into the reviewers' comments to identify causes of poor care the following can be identified:

- Delay in being assessed within the ED or being admitted to a ward;
- Inappropriate streaming to Urgent Treatment Centre (UTC);
- Documented senior review and oversight of clinical care with clear plan including ceilings of care.

Figure 6. Phase of Care Scores Q3

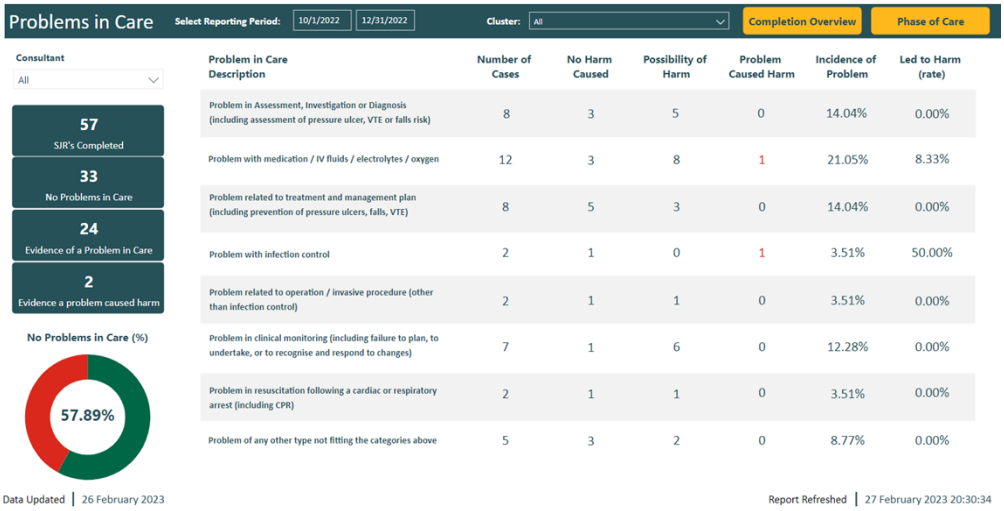
In Quarter 2 (figure 7), there were 24 cases where a problem in care was identified and for two patients the problem caused harm (one patient had two categories of problems leading to harm). One was related to management of an overdose and one Covid-19.

Figure 7: Problems in Care Q2



In Quarter 3 (figure 8), there were 24 cases where a problem in care was identified and for two patients the problem caused harm. One was an anaphylactic reaction in a patient with no known allergies so deemed unavoidable and one with a hospital acquired influenza.

Figure 8. Problems in care Q3



Problem in Care Description	Number of Cases	No Harm Caused	Possibility of Harm	Problem Caused Harm	Incidence of Problem	Led to Harm (rate)
Problem in Assessment, Investigation or Diagnosis (including assessment of pressure ulcer, VTE or falls risk)	8	3	5	0	14.04%	0.00%
Problem with medication / IV fluids / electrolytes / oxygen	12	3	8	1	21.05%	8.33%
Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)	8	5	3	0	14.04%	0.00%
Problem with infection control	2	1	0	1	3.51%	50.00%
Problem related to operation / invasive procedure (other than infection control)	2	1	1	0	3.51%	0.00%
Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)	7	1	6	0	12.28%	0.00%
Problem in resuscitation following a cardiac or respiratory arrest (including CPR)	2	1	1	0	3.51%	0.00%
Problem of any other type not fitting the categories above	5	3	2	0	8.77%	0.00%

Review of specialty level SJRs is part of the agenda for specialty level Morbidity and Mortality meetings and this is supported by attendance of the LfD facilitators, although there remain speciality teams that are not consistently doing this and these gaps are being addressed. To ensure the focus remains on learning we are sharing good practice from the ED where they have introduced scene setting to remind staff of the aims and optimise the outputs from the discussions. Learning is also shared through key messages each month displayed in Education Centres and disseminated electronically. We are currently recruiting to a Trust Mortality Lead to provide additional support to the LfD facilitators and to chair the LfD review panels.

The themes highlighted in Q2 and Q3 are recognised, especially the impact of the current pressures in our EDs with overcrowding and corridor care. Safety huddles and rounding are in place to support safe care and improvement workstreams to divert patients to most appropriate pathways away from ED are underway. We are currently piloting palliative care beds to support timely admission to an inpatient environment for patients admitted as emergencies at EoL.

3. Conclusion

While many specialities are LfD there remain areas that need further embedding, promoting clinical teams to be curious about the outcomes of the care they deliver and drive for continuous improvement. Supporting this will be part of the new Mortality Lead role. This programme offers the opportunity to learn from excellent care as well as where care is not delivered to the standards our patients should expect. There is work in place supported by the LfD facilitators to continue to drive this into all specialities.

We continue to focus on reducing the recurrent clinical themes and monitoring that actions already in place have had their intended impact on clinical care and outcomes for patients, or are adjusted if not.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**CHIEF MEDICAL OFFICER'S (CMO'S) REPORT: CLINICAL ETHICS COMMITTEE (CEC)**				
MEETING DATE:	**9 MARCH 2023**				
BOARD SPONSOR:	**CHIEF MEDICAL OFFICER**				
PAPER AUTHOR:	**CHIEF MEDICAL OFFICER**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	**Decision**	Approval	Information	Assurance	Discussion
Purpose of the Report:	This report provides an update to the Board on the progress of the Clinical Ethics Committee (CEC).				
Summary of Key Issues:	The principles of the CEC are that is does not make decisions, but it assists clinicians and healthcare professionals who are having difficulties in making ethical decisions, provides ethical support and education for staff and inputs to relevant Trust policies and guidelines. • The CEC has met with its fully established multi-professional membership three times; • The CEC has agreed the ethical frameworks that it will use to support discussions, with dummy cases being considered as the Committee establishes; • The referral process to the Committee is being finalised, including the ability to respond to 'hot' cases. The CEC is looking forward to providing a safe space for clinicians to bring ethical dilemmas arising within our work place to the Committee for consideration, with a provisional date in April to start taking referrals from staff.				
Key Recommendation(s):	The Board of Directors is asked to: • **NOTE** the CEC report and the progress of the Committee; • **AGREE** the route of reporting for future CEC reports and consider if this should be through a Committee of the Board.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	Our future	Our sustainability	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	N/A				
Link to the Corporate Risk Register (CRR):	N/A				

East Kent Hospitals University NHS Foundation Trust

Resource:	N	
Legal and regulatory:	N	
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	No	

East Kent Hospitals University NHS Foundation Trust

CLINICAL ETHICS COMMITTEE (CEC)

1. Purpose of the report

This report is to update the Board on the work of the Clinical Ethics Committee (CEC).

2. Background

The CEC was established by the Board initially as a Covid-19 Ethics Committee in early 2020 to support our response to the pandemic. Subsequently the Board agreed to the Chief Medical Officer's recommendation to establish it substantively as a CEC, to address an unmet need by creating a safe space for people to raise and discuss dilemmas around clinical ethics.

The principles of the CEC are that is does not make decisions, but it assists clinicians and healthcare professionals who are having difficulties in making ethical decisions, provide ethical support and education for staff and input to Trust policies and guidelines. The CEC does not address research ethics, this process is well established and embedded within research operating frameworks within the NHS.

CEC currently reports into the Board of Directors and consideration should be given if this should report into a Board Committee, with only summary briefing of cases discussed and not details. Patient related outcome of discussions will be incorporated into their medical records.

The CEC is a member of UK Clinical Ethics Network, which brings additional offers to members around education and development of the CEC work.

3. Membership

The CEC has now established with its multi-professional membership, established after a selection process as significant interest was received. A number of the Committee members have existing ethical committee experience and qualifications. The Committee is supported by a Medical Ethicist. The Committee membership is:

- Chief Medical Officer (Chair)
- Non-Executive Director (NED)
- Deputy Chief Nursing Officer (for Chief Nursing and Midwifery Officer (CNMO))
- Consultant Nurse, Supportive and Palliative Care/Joint Clinical Lead End of Life Care, EKHUFT
- Medical Ethicist - Senior Lecturer, Lead for Medical Ethics (Kent & Medway Medical School (KMMS))
- Deputy Operational Director
- Site Lead Chaplin
- Legal representative
- Consultant Stroke / Health Care of Older People (HCOOP)
- Consultant Renal
- Clinical Director General and Specialist Medicine (GSM)
- Occupational Health Doctor
- Junior Doctor
- Macmillan Support Worker
- Consultant Anaesthetics

- Staff Nurse
- Safeguarding representative

4. The Terms of Reference (ToR)

The ToR are being reviewed to include a core membership with existing experience in the use of ethical frameworks. This will be brought to the next Board for approval.

5. Function of the Committee

The CEC will be advertised throughout the Trust, encouraging staff to present cases for CEC discussion of the dilemma. CEC would be able to provide support around breakdown of communication with families and clinicians in respect of treatment plans as these might not be what was expected for a patient, along with providing sign-posting support.

Cases will be triaged by a CEC member on whether 'hot' or 'cold' case, noting majority could wait to be presented to next CEC meeting to be held. A referral form has been agreed subject to final amendments and will be ratified in March's meeting.

The Chair is being supported by the Communications and Engagement team to set up a page on Staff Zone. This will give details of who the Committee are, the purpose and function and how to refer cases.

6. Ethical Framework

The Committee has reviewed ethical moral values, looking at clinical ethical dilemmas, considering the four principles or four quadrant approach covering medical indications, patients' preferences; contextual factors; and quality of life as well as considering the four cardinal virtues, prudence; justice; temperance and fortitude. These were around good practice. It was noted morale stress was an output and impact for clinicians as a result of the Covid pandemic.

The Committee agreed frameworks for decision-making in Clinical Ethics and agreed its preference to use the Four Quadrant (Jonsen) Approach framework, but until the Committee matured it was noted it would be beneficial to have a clear structured framework and consider using the Ethox Framework.

The Committee has now run two sessions using 'dummy' cases for members to use our chosen ethical framework to support discussions, taking on different positions for the cases. Our Medical Ethicist is additionally providing a workshop for members in April. The intention is after the next meeting to open to live cases.

7. Conclusion

The CEC is progressing with its widened membership and has met three times since fully established. The ethical frameworks have been agreed and are currently being tested through the use of 'dummy' cases. A further workshop is being run in April to support new members. We are looking forward to providing a safe space for clinicians to bring ethical dilemmas from our work place to the Committee for consideration.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**INFECTION PREVENTION AND CONTROL (IPC) QUARTERLY UPDATE**				
MEETING DATE:	**9 MARCH 2023**				
BOARD SPONSOR:	**EXECUTIVE DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC)**				
PAPER AUTHOR:	**EXECUTIVE DIRECTOR OF INFECTION PREVENTION AND CONTROL**				
APPENDICES:	**APPENDIX 1: QUALITY AND SAFETY REPORT** **APPENDIX 2: DRAFT BOARD ASSURANCE FRAMEWORK (DOCUMENTS PROVIDED IN THE READING ROOM FOR BOARD MEMBERS)**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	To apprise the Board of Trust performance against external and internal Key Performance Indicators and any risks and issues arising in the previous quarter.				
Summary of Key Issues:	• Reportable infections: one case of *methicillin-resistant Staphylococcus aureus* (MRSA), a similar level of *Meticillin-Sensitive Staphylococcus. aureus* (MSSA) cases compared with previous year, Cdiff and *E. coli* have exceeded the external thresholds. *Klebsiella species* and *Pseudomonas aeruginosa* on target to achieve external thresholds. • The combination of Covid-19, Influenza, other winter viruses and the extraordinary operational and flow pressures over winter, has been very challenging to optimal IPC practice and patient placement. • Care Quality Commission (CQC) regulatory action in midwifery included aspects of hygiene and IPC practice. IPC is supporting the improvements. • An update to the 2022/23 work plan is given. • A summary of the new 'Code of Practice' and NHS England (NHSE) Board Assurance Framework (BAF) is given and the full draft update is in the reading room. •				
Key Recommendation(s):	The Board of Directors is asked to discuss and **NOTE** the content of the IPC update.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	Our future	Our sustainability	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	BAF 31 – Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements, leading to harm.				
Link to the Corporate Risk Register (CRR):	N/A				
Resource:	Y/N	N			
Legal and regulatory:	Y/N	N			
Subsidiary:	Y/N	N			
Assurance Route:					
Previously Considered by:	N/A				

Trust Board - Infection Control Quarterly Update to end January 2023

1. Nationally reportable infections with and without externally set thresholds

Trust assigned MRSA bacteraemia: one single case in the reporting year to date (no change from previous report).

Trust assigned MSSA bacteraemia (no external trajectory set): 53 cases in the reporting year to date, this is similar to the same period last year (56 cases). Comparisons with the previous year should be made with caution due to activity levels and the impacts of the Covid-19 pandemic.

Trust assigned *Clostridioides difficile* (Cdiff): The trust has exceeded the external threshold, with 108 cases year to date. This reflects a regional and national increase in Cdiff which, at this time, remains not fully understood. Targeted and generic infection prevention and control (IPC) activities have continued and there is no evidence of an outbreak. There is no change from the situation locally, regionally or nationally that has been previously described and IPC activities continue as before.

Trust assigned Gram negative bacteraemias: *E coli* bacteraemias have exceeded the external threshold with 143 cases year to date. The number of cases over the summer months was considerably higher than the same period last year (26 extra cases in July to September) and that trend has continued to a lesser degree since. A deep dive is being undertaken to understand the drivers for the increase in cases to inform any additional control measures. Some of the impact is postulated to be from the extraordinary hot weather in the summer months and from the much higher numbers and higher acuity of emergency pathway patients in this reporting year so far. Both *Klebsiella species* and *Pseudomonas aeruginosa* are on target to be below the external threshold with 56 and 38 cases respectively, year to date.

2. Covid-19 and winter 2022-2023

The winter period has been very challenging with varying surges in Covid-19, rising to peaks of around 80 positive inpatients every four to six weeks approximately. This has been combined with the first significant Influenza season since 2019 and cases of Respiratory Syncytial Virus (RSV), mostly in children. The combination of these respiratory viruses and the enormous pressures on patient flow, including unprecedented numbers of patients attending on the emergency pathway and high numbers of patients awaiting care in other settings, has led to some compromise decisions on patient placement for IPC reasons, in order to balance other risks to patient safety. The IPC team have supported clinical and operational colleagues to make the best possible decisions. There has been a small number of cases of norovirus so far this winter.

3. CQC regulatory action in Midwifery

The Board is aware and has received reporting that the regulatory action by the CQC, following the unannounced inspection in January 2023, included some aspects of environmental hygiene and IPC practice. The response to this action is being led through the office of the Chief Nursing and Midwifery Officer but the IPC aspects are being supported by the IPC team. The details are not given here to avoid duplication.

4. Revised Healthcare Associated Infection Code of Practice and NHSE Board Assurance Framework

A revised Code of Practice on the Prevention and Control of infections (Health and Social Care Act) was published in December 2022 and a revised NHS England Board Assurance Framework (BAF) has been circulated in draft for consultation in February 2023. The revised BAF is based on the 'The Code of Practice' and is expected to be formally published in March 2023. It is unlikely that the consultation will lead to major changes to the new BAF and the IPC team have already created a draft response and action plan to the revised code and BAF. The assessment against the code and the BAF shows that the trust is largely compliant, but there are some areas for action and other areas that would benefit from further in-depth review. The full draft BAF and draft action plan have been placed in the reading room and, once formally published, the full BAF will be presented to the board.

5. Update on the IPC Work Plan 2022/23

Overview
The winter pressures, as described above, limited the capacity of the IPC team for developmental aspects of the work plan. Despite this, the majority of the work plan is on track for completion. The 2023/24 work plan will be informed by the code/BAF review described above.

Priority	Element	Lead	Progress	Notes
Governance and Assurance	Review of committees	DIPC		New committee structure to 'go live' from April 2023 New requirement for a ventilation safety committee to be established by April 2023
	Business continuity plans	DIPC		Delayed due to operational priorities
	Succession Planning	DIPC		Updated as per Trust process
Infection Reduction Priorities	Driver metrics	DIPC		C diff and *E coli* have exceeded external threshold.
	Watch metrics	DIPC		*C difficile* moved to Driver category
Team and Service Development	'Brilliant Teams' event	DIPC		Completed – outputs to inform further team development

	IPC leads Trust Wide portfolios	Deputy DIPC		All leadership roles now filled and portfolios in progress
	LW decontamination lead role	Deputy DIPC		Deputy DIPC taken up role and reviewing all aspects of decontamination
	Kent Fundamentals training	Deputy DIPC		In progress (new staff to complete)
	Poster/publication	DIPC		Two publications completed (but by DIPC, not the rest of the team) Project identified (automated hand hygiene monitoring system evaluation) – delayed by external factors
IPC Education and Link Practice	IPC education review	IPC Site Lead		In progress
	Link practice review	IPC Site Lead		In progress
Surveillance, Audit and Epidemiology	IPC audit programme review	Deputy DIPC		In progress – dependent on 'Tendable' audit implementation
	Surveillance activity	IPC Site Lead		Working with orthopaedics to increase robustness of mandatory surveillance
	Increased epidemiological/analytical capacity	DIPC		No funding available in-year due to financial challenge
	Automated surveillance	DIPC		Exploratory at this stage, in discussions with information colleagues
'Must Do'	Review of compliance with	DIPC		New Code and BAF under review

	the 'Code of Practice			
Antimicrobial Stewardship (AMS)	Improvement activity beyond Business As Usual (BAU) of AMS team and committee	DIPC		Consultant pharmacist in post February 2023 Internal Audit of AMS completed, -partial assurance – actions agreed

Key

	Completed
	In progress - on track
	In progress - off track – mitigations in place/ delays beyond local control
	Off track – mitigation required/ not started

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**HEALTH & SAFETY (H&S) AND STATUTORY COMPLIANCE UPDATE**				
MEETING DATE:	**9 MARCH 2023**				
BOARD SPONSOR:	**CHIEF EXECUTIVE**				
PAPER AUTHOR:	**2GETHER SUPPORT SOLUTIONS (2GETHER), MANAGING DIRECTOR** **2GETHER, ASSISTANT DIRECTOR OF SAFETY** **2GETHER, ASSISTANT DIRECTOR OF ESTATES**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	This report provides an update to the Trust Board of Directors on the Trust's position in relation to the status and management of H&S, and estates statutory compliance.				
Summary of Key Issues:	• The current cumulative Health and Safety Toolkit Audit (HASTA) score is 91% as of January 2023. • Audits commenced in 2022/23 for all Care Group and Corporate areas. Support is provided by 2gether's Safety Team to enable further improved outcomes for this financial year. • Inconsistency in respect to Fire safety management across parts of the estate needs to be addressed. • The statutory compliance assurance level currently sits at c88%. Whilst we have seen a level of regression over the last quarter, mainly due to challenges with contractors and various workflow demands, we now expecting our 2022/23 financial year-end (YE) position to achieve c91 to 93%.				
Key Recommendation(s):	The Board of Directors is asked to **DISCUSS** and **NOTE** the Trust's current position in relation to Health & Safety, and statutory compliance, especially in respect to the prevailing risks.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	Our people	Our future	Our sustainability	Our quality and safety	
Link to the Board Assurance Framework (BAF):	**Strategic Goal 4 - Objective:** Develop a clinical strategy for the Trust that addresses key risks faced in terms of service delivery, workforce and estate condition (backlog and statutory compliance).				
Link to the Corporate Risk Register (CRR):	CRR 34 – Continuing to embed Health & Safety systems within the Care Groups.				

Resource:	Y	The Trust allocated c£4.05m capital for 2022/23, most of which has all been assigned against urgent priority risk items. It should be noted that the funding made available in the budget period is lower than the level required to redress the historic under investment into the critical infrastructure as identified within the ARUP report in 2021. Any additional capital and future funding will be allocated based on output of ARUP Critical Infrastructure Risk Survey and joint risk workshops. 2gether also received an additional total of £2m to meet 95% statutory compliance.
Legal and regulatory:	Y	• Health and Safety Legislation • Estates legislative Statutory Compliance
Subsidiary:	Y	2gether provides health and safety advice and guidance in line with the Service Level Agreement. 2gether also provides the Trust's hard facilities management services.
Assurance Route:		
Previously Considered by:	Strategic Health and Safety Committee has received the HASTA information table and other elements summarised in a report that is consistent with this report. The Strategic Capital Planning and Performance Committee, and Clinical Executive Management Group (CEMG) has received briefings and updates relating to Health and Safety and Statutory Compliance, backlog maintenance status.	

East Kent Hospitals University NHS Foundation Trust

HEALTH AND SAFETY & ESTATES STATUTORY COMPLIANCE UPDATE

1. Background and Executive Summary

1.1. This report updates the Trust Board of Directors on the Trust's position in relation to the ongoing management of Health & Safety, and the estates statutory compliance.

2. Health & Safety

2.1 **HASTA:** Audits are scheduled throughout the year in all clinical and non-clinical wards and departments. In most areas good audit results have been evident for those audits undertaken so far. A steady state from previous years can be seen, with 91% Trust Wide compliance. Work is now ongoing with the Women's Health team to improve their position.

	2020/21 Year end	2021/22 Year end	2022/23*
Cancer Services	90%	97%	92%
Children's Health	99%	97%	99%
Corporate Services	92%	93%	90%
Clinical Support Services	96%	97%	95%
General Specialist Medicine	87%	88%	91%
Surgical & Anaesthetic	87%	85%	88%
Surgery Head & Neck, Breast and Dermatology	93%	90%	98%
UEC (Urgent and Emergency Care)	83%	81%	83%
Women's Health	93%	92%	72%
Trust Wide Totals	**91%**	**91%**	**91%**

**Scores relate only to those departments audited as at 10/1/23. Further audits may affect year end scores*

2.2 **Training**: In Q3 2022/23 there has been ongoing link worker training sessions, a combination of both face to face and WebEx. Other training that has taken place during this quarter includes:

a. First Aid at Work;
b. Institution of Occupational Safety and Health (IOSH) (managing safely);
c. IOSH (working safely);
d. Control of Substances Hazardous to Health (COSHH);
e. Fire Safety, and
f. MAYBO

2.3 In addition, a small number of ad-hoc training sessions have been undertaken in regard to the risk assessment process. These have taken place in the link workers working environment and are usually in the form of a walkthrough / talk through of an actual risk assessment the link worker needs to undertake. These have proved to be popular and well regarded and the H&S team are looking at ways of expanding this work in the future.

2.4 **H&S Team Support:** The Safety Team has been engaged in numerous areas of support across the Trust, in general this has involved accident investigations, assistance and support for risk assessments in areas such as Nitrous Oxide use and Emergency Department (ED) corridor bed usage, as well as involvement in the numerous building projects across the whole of the estate.

2.5 **Trust H&S Leads:** It should be noted that the Trust Health and Safety Leads continue to work well to embed Health and Safety standards in their Care Groups.

2.6 **Working Together:** Both the 2gether and Trust H&S teams continue to work together to ensure continued compliance against the HASTA framework. HASTA outcomes will be monitored via monthly Health and Safety meetings chaired by the Intelligent Client function. Formal quarterly compliance reports are presented to the Strategic Health and Safety Committee.

3. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reports for January 2023

3.1 There were four reports made to the Health and Safety Executive (HSE) by the Trust in January 2023 under RIDDOR. In summary, these were two slips, one trip over cable and one staff injury as a result of patient pushing the staff member over.

4. Fire Safety Update

4.1 **Fire Safety Governance:** The Joint EKHUFT and 2gether Fire Safety Group continues to meet on a monthly basis. The Group monitors and tracks topics including fire safety compliance, the fire safety plan and fire training.

4.2 **Fire Safety Plan:** The joint Fire Safety Plan has seen generally good progress seen in quarter 3, with some areas of improvement required for EKHUFT. Mainly in areas such as completing sufficient fire evacuation drills and the review of localised fire procedures.

4.3 **Fire Risk Assessments and support:** There has been very good compliance with fire risk assessment this quarter, with 100% of all risk assessments completed by 2gether in time. There is active tracking and reporting of risk-based actions that arise from the fire risk assessments. 2gether are currently carrying out a survey of fire doors across the estate. There continues to be professional support and advice for fire safety provided to EKHUFT in areas such as corridor usage, fire safety management and regulatory body findings - currently the lack of storage in parts of the estate is leading to a level of risk being applied to the safe management of evacuation corridors and fire street.

4.4 **Fire Training:** There have been good levels of e-learning fire training in the quarter with levels across the Trust standing at 89%. However, recent engagement has identified inconsistencies across clinical groups in respect to the day to day application of this learning. At this point we would recommend that the existing on-line training course be complimented with a level of face to face support from April 2023.

4.5 **Fire inspections:** There were no formal inspections from Kent Fire and Rescue in the period. There is one scheduled inspection for the Queen Elizabeth the Queen Mother Hospital (QEQM) maternity unit in March 2023. There is a joint group set up to plan and prepare for the inspection.

The following table provides an overview of the current risk, mitigation, and planned activity.

Risk Identified	Current Mitigation	Planned/Scheduled Activity
Patient care in corridors particularly in Emergency Departments at William Harvey Hospital (WHH) and QEQM blocking or restricting fire routes.	Revised escalation plan distributed to EKHUFT managers. Revised procedures produced and communicated. Daily checks by safety team at WHH and QEQM. Formal letter from 2gether issued to Trust outlining concerns. Risk Assessments undertaken.	Plan to reduce corridor care to an absolute minimum. Monitoring of situation within EKHUFT continues at gold calls (three times a week at present).
Lack of fire drills over the last few years (significantly affected by staffing levels and Covid).	Fire training and procedures.	Table top and actual fire drills will be scheduled in the forthcoming year.
Gaps in assurance and support to face to face training (e-learning monitored and completed at present).	Some ad-hoc face to face training has been arranged and delivered, especially where clinical staff need support around understanding of fire safety obligations.	Fire training programme for 2023/24 includes face to face training.

5. Estates Statutory Compliance

5.1 Work continues in respect to improving the overall statutory compliance levels within the estate.

5.2 The overarching statutory compliance assurance level currently sits at c88%, a reduction of c1% in quarter. This reduction has in the main been caused due to challenges with contractors and various workflow demands which have led to the realignment of a number of services with new providers. We are now expecting our 2022/23 YE position to achieve between c91 & c93%.

5.3 The priority for statutory compliance remains water safety, electrical improvements and fire safety maintenance activities. As previously reported the current gaps in the main relates to:

a. fixed wire testing;
b. emergency lighting;
c. fire door inspection/maintenance;
d. fire smoke damper inspection and maintenance; and
e. ductwork inspection and cleaning.
f. Fire alarm systems maintenance.

5.4 Whilst the YE position in now expected to fall below the 95% target level agreed with the Trust, we continue to manage the risk associated with the areas of shortfall; at this juncture we are expecting to hit the 95%+ level sometime between June and September, dependent on specialist works completion and possible ancillary funding requirements.

5.5 Critical Infrastructure: Post the publication of the ARUP Critical Infrastructure Report in 2021 work has been ongoing to try and redress various technical systems shortfall within the estate. Utilising the six-facet survey and initial findings of the ARUP critical infrastructure report, our technical leadership team have reviewed the backlog maintenance priorities for each site. All items have been risk scored. 2gether's also undertook an internal risk assessment with the support of the Hospital Leadership Teams, the Director of Infection Prevention and Control (DIPC), and Deputy to prioritise patient safety. A combination of these processes gives a final risk allocation for use by the Patient Environment and Investment Committee (PEIC). To date the Trust has allocated c£3.5m toward the redress of the existing issues, which in real terms is c50% of the annualised requirement truly required to manage the prevailing risk at this point. Whilst discussions remain ongoing, the Trust is seeking to allocate c£4.6m in the 2023/24 budget period, mainly in support of redressing high-risk fire and electrical systems issues.

6. Risk Management & Mitigation

6.1 The current compliance reporting model is under review as part of a wider piece of work designed to improve the technical assurance levels within the estate. At this point the existing statutory compliance management process is somewhat disjointed and does not fully utilise the Planet CAFM system. Work is ongoing to redress the current management process shortfall. An interim compliance reporting model will be utilised until a suitable resolution can be achieved.

Action Requested

The Trust Board of Directors are requested to review and note the points made in this report.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**PATIENT VOICE AND INVOLVEMENT QUARTERLY REPORT**				
MEETING DATE:	**9 MARCH 2023**				
BOARD SPONSOR:	**CHIEF NURSING AND MIDWIFERY OFFICER (CNMO)/ EXECUTIVE BOARD MATERNITY SAFETY CHAMPION**				
PAPER AUTHOR:	**HEAD OF PATIENT VOICE AND INVOLVEMENT**				
APPENDICES:	**APPENDIX 1: PATIENT VOICE AND INVOLVEMENT QUARTERLY REPORT**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion
Purpose of the Report:	The report provides the Board with an update on how we are implementing the Patient Voice and Involvement Strategy.				
Summary of Key Issues:	The Patient Voice and Involvement team is now in place and is making progress on implementing the strategy. The team have recruited Participation Partners (patients/family members) to get involved in a range of groups. The team have established a Patient Participation and Action Group to hold us to account in implementing the strategy. The team have started to recruit staff as Involvement Champions, and identified services who want to establish a Patient Participation Group (e.g. Rheumatology). The team are working with Care Group leads around patient communications (appointment letters, identifying communication needs). The team are going out to local communities using pop-up stalls and attending local events to recruit Participation Partners and to get feedback. The team are attending groups to meet with people who have used our services (e.g. Stroke groups) or who experience barriers to accessing healthcare (e.g. Deaf people who use British Sign Language (BSL) at Deaf Together Groups). The team are working with partners and stakeholders to begin to address long-standing inequalities of access, experience and outcomes.				
Key Recommendation(s):	The Board of Directors is asked to **NOTE** the Patient Voice and Involvement quarterly report.				

Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	Our people	Our future	Our sustainability	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.				
Link to the Corporate Risk Register (CRR):	**CRR 118**: There is a risk that the underlying organisational culture impacts on improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace. Specifically, there is a requirement for urgent and significant improvement in relation to staff attitudes and behaviours.				
Resource:	Y/N	None.			
Legal and regulatory:	Y/N	Care Quality Commission regulations.			
Subsidiary:	Y/N	Not applicable.			
Assurance Route:					
Previously Considered by:	Not applicable.				

East Kent Hospitals University NHS Foundation Trust

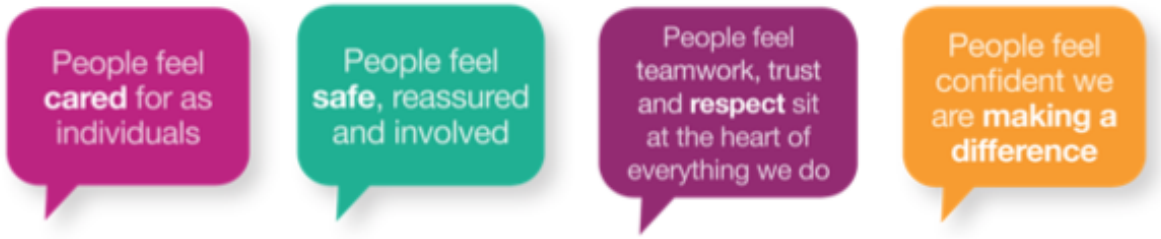
Patient Voice and Involvement Report October to December 2022

1. Introduction

1.1 The Patient Voice and Involvement Strategy was agreed by the Trust Board in March 2022. This included establishing a Patient Voice and Involvement Team. The first team members started in August 2022. The team was fully staffed by January 2023.

1.2 Listening to patients and their families, acting on their feedback and sharing the changes and improvements made are all part of patient experience.

1.3 Patient involvement builds on this to engage with and involve people who use our services and the local communities that we serve. The goal is co-designed services and co-design service improvements. East Kent Hospitals' values directly relate to patient experience and patient involvement:



1.4 The report provides an update on implementing the Trust's Patient Voice and Involvement Strategy.

2. Participation Partners

2.1 We have recruited nine Participation Partners to date, with three others waiting for reference checks. These are people who use our services, their families and people from the wider community. They all are members of our Patient Participation and Action Group (PPAG) (see below). One is also now joining the End of Life Care Committee. We have also been establishing links with people who are part of the Voluntary Community and Social Enterprise (VCSE) sector. We have two representatives on the PPAG one from Hi-Kent and one from Carers Support East Kent and also a Healthwatch Kent representative. We also have a VCSE representative on the Fundamentals of Care Committee from the Kent Multiple sclerosis (MS) Therapy Centre.

3. Patient Participation and Action Group (PPAG)

3.1 The inaugural meeting of our new PPAG held on 21 November. This group is co-chaired by a Participation Partner and the Head of Patient Voice and Involvement, and a Non-Executive Director and Vice-Chair of the Board attends as the Board Champion for Patient Voice.

3.2 Meetings are held every two months, alternating between face to face and online meetings. At each meeting we will focus on a particular service. The January 2023 meeting focused on Maternity services.

3.3 Membership of the group is 50% people who use our services or carers (up to 12 people), 30% voluntary community and social enterprise (VCSE) sector representatives (up to 8 people) and 20% EKHUFT staff.

4. Involvement Champions

4.1 Involvement Champions are staff who volunteer to attend some training on patient involvement and agree to get involved in making changes based on patient feedback.

4.2 Following the briefing sessions held in November 2022, we had planned to hold follow up sessions in February. However, we have not been able to confirm dates due to pressure on the wards, making it hard for staff to be released. We have therefore decided to pause work with the wards and refresh our approach. The Lead for Patient Voice and Involvement started on 16 January, and he will work with the Patient Involvement Officers to plan and deliver Involvement Champion sessions across all sites from March 2023. These will be open to all staff across the Trust, both clinical and non-clinical.

5. Community Engagement

5.1 We now have promotional materials for the team (pull up banners, tablecloths, etc.) and have started a series of pop-up stands in community settings and on our sites. Community settings include children's centres, leisure centres, community centres, shopping centres, Gateways and events aimed at health prevention initiatives, such as Eat Well for Less events.

5.2 We have attended Deaf Together groups in Margate and Ashford to get feedback direct from Deaf people who use BSL. Deaf people experience significant barriers when using health services and as a result experience significant health inequalities. We are therefore looking to identify solutions, including improved access to BSL interpreting and promotion of Interpreters Live which enables BSL users to contact the Trust via a video BSL service. Information about this is on our public website and our intranet (staff zone). We have added a direct link to the BSL video interpreting on to the ZENworks smart desktop, to give staff quick access.

5.2 We have attended several local Stroke groups to get feedback from people who have had a stroke. Key issues raised are poor communication and support after discharge. The team are working with clinical colleagues and with the Senior Participation Manager at Kent Community Health NHS Foundation Trust to look at how we improve people's experience, both in hospital and after they go home.

6. Patient Experience

6.1 We supported the Community Diagnostic Centre (CDC) at Buckland Hospital to get feedback from 32 patients as part of a national survey devised by NHS Elect to get patient feedback. EKHUFT were the only NHS Trust in the South East Region to take part in the survey. Feedback was overwhelmingly positive, but there are actions needed around signage and information explaining what the CDC is and the benefits of travelling there rather than attending one of our main sites.

6.2 We have developed a simple survey form to log feedback from community groups and pop-ups. This is themed to identify aspects of patient experience that we do well in, and areas we need to improve. The Patient Involvement Officers use this to log feedback gathered. The information is anonymous.

6.3 We have worked with our IT department to enable patients and families to have direct access to the Trust's In-patient survey. The survey is already available on the wards and staff go through the 10 questions with patients. We wanted to enable patients to complete the survey independently and this will be available both on patient iPads on wards and via a link on our website shortly.

6.4 We have worked with the Lead Rheumatology Nurse to establish a Patient Participation Group, which includes developing the terms of reference and promotional flyer. The group will hold its inaugural meeting online in March.

7. Friends and Family Test (FFT)

7.1 The Trust receives on average 12,000 responses a month to the FFT. Of these responses over a third relate to services at Kent and Canterbury Hospital outpatients and day surgery. Response rates (surveys sent versus surveys completed) is around 18% per month Trust-wide, with a satisfaction level of between 93% and 95% overall from October to December 2022.

7.2 We are looking at how our Care Groups can provide assurance that all of the comments on FFT surveys are reviewed, shared with services and teams and used to identify learning and improvements. Whilst there is an overview report from each Care Group to the Complaints and Feedback Group, these reports do not currently provide sufficient information on learning and actions from patient feedback.

8. Communication

8.1 Poor communication is one of the recurring themes of patient feedback – whether through patient experience surveys, Care Opinion, FFT, Patient Advice and Liaison Service (PALS) or Complaints.

8.2 There are a number of factors that impact on communication with patients – some are human factors, including how staff (clinical and non-clinical) speak to patients and their families, including tone, clarity and what information is communicated and how well staff listen and respond to questions, and some system (organisation) factors, such as telephone systems, appointment letters, information on the Trust website, access to information in different formats and interpreting.

8.3 It is in our power to address these factors, both organisation wide and as individuals in our daily contact with patients and families. Improving communication needs to be a top priority for the Trust – both to support staff, but also to improve patient experience and to support patient safety. There are challenges in this. In part because it is not always clear who is responsible for organisation-wide systems and for service processes.

8.4 An example of this is appointment letters. The content is down to individual Care Groups and then within Care Groups, services. This makes it harder to improve the quality and accuracy of information, as who has responsibility for it is not always clear. Therefore, when patient feedback suggests we need to change or improve patient information in a specific appointment letter, it's hard to identity who will do this and how we get assurance it's been done.

8.5 To help address this, the Patient Voice and Involvement team have met with Care Group representatives to discuss appointment letter templates. Their feedback highlighted frustrations with the general template letter on All Scripts, including layout errors which have to be manually corrected each time and unhelpful/inaccurate

content. There are also issues with All Scripts logging people out too quickly, requiring them to log in again. It's a continuous issue and takes up time. There is also an issue with patient texts regarding changing an appointment not being automatically sent through to the service, meaning patients were then not offered a new appointment date. Some services are not unaware until the patient phones and chases for a new appointment date. The team will be raising these issues with the Outpatients team through their Outpatients Working Group and with IT Projects / Patient Administration System (PAS). We will also be following up individually with each Care Group. We have also worked with the IT Projects team to review the new template letters for the new Patient Portal. This has included an updated section on how Deaf people who use BSL can contact us.

8.6 Another element of communication is patient information leaflets. During Covid leaflet racks were removed and whilst we have a leaflet library on the public website, this is not accessible to all. Digital exclusion is a very real issue, with people of all ages excluded from digital content due to a range of factors including affordability of technology, data limits, not feeling confident in using technology and lack of accessibility of digital content (e.g. lack of BSL videos, Easy Read, digital content incompatible with screen readers etc). The Patient Information Co-ordinator is working with services to restore printed information in outpatient clinic areas and will be visiting sites during February 2023 to support this work. The Communications team are working on the new public website, with a focus on what patients want to know, rather than what we think they need to know. The Patient Voice Feedback Co-ordinator is a member of the steering group for this work.

9. Accessible Information Standard (AIS)

9.1 The way that our staff communicate with patients and their families is an area that needs more focus. This includes listening to understand (rather than listening simply to respond), speaking clearly, facing people when speaking, checking that the person understands what they have been told, providing written information to back up verbal information, in a format that's accessible to the patient or parent.

9.2 To do this well, staff (both admin and clinical) need to routinely identify patient's communication needs and record, flag, share and meet them.

9.3 This means in practice, staff recording people's communication needs on PAS and other patient record systems, checking and updating details as needed, and then meeting the needs, whether that's in terms of appointment letters, contacting the patient, arranging BSL interpreters. By doing this we will help to reduce Did Not Attends (DNAs), make better use of resources, provide a better patient experience and demonstrate compliance with the Accessible Information Standard.

9.4 Whilst the Accessible Information Steering Group has oversight of this, we continue to hear via a range of feedback that patient's communication needs are often not being met – both in outpatient and in-patient settings.

9.5 To address this, each Care Group and service in it, will need to undertake a review of information held on PAS about their patient's communication needs, including gaps in this information. They then need to agree a plan for how each service will address gaps in information. They also need to encourage staff to do the AIS E-learning to have a better understanding of the importance of identifying, recording and meeting people's communication needs.

10. Conclusion

10.1 The Patient Voice and Involvement team are now all in post. We have made good progress on starting to put the strategy into action. A detailed action plan was presented to the first PPAG in November.

10.2 2023 will see us recruiting more Participation Partners, continuing to reach out to people in communities whose voices are seldom heard, working with colleagues across the Trust to address health inequalities and encouraging staff to become Involvement Champions.