Board of Directors - Open meeting (Thursday 7 September 2023)

Thu 07 September 2023, 12:30 PM - 04:35 PM

Harris Room, Spitfire Ground, Old Dover Road, Canterbury CT1 3NZ / WebEx

East Kent Hospitals University NHS Foundation Trust

Agenda

OPENING/STANDING ITEMS

12:30 PM - 12:40 PM
10 min

23/67
Welcome and Apologies for Absence

To Note *Chairman*

Verbal

12:40 PM - 12:40 PM
0 min

23/68
Confirmation of Quoracy

To Note *Chairman*

Verbal

12:40 PM - 12:40 PM
0 min

23/69
Declaration of Interests

To Note *Chairman*

23-69 - Board of Directors register of interests - July 2023.pdf (3 pages)

12:40 PM - 12:40 PM
0 min

23/70
Minutes of Previous Meeting held on 6 July 2023

Approval *Chairman*

23-70 - Unconfirmed BoD 06.07.23 Open Minutes.pdf (15 pages)

12:40 PM - 12:40 PM
0 min

23/71
Matters Arising from the Minutes on 6 July 2023

Approval *Chairman*

23-71 - Front Sheet Open BoD Action Log.pdf (5 pages)

Patients

12:40 PM - 01:10 PM
30 min

23/72
Patient Story

Information *Interim Chief Nursing & Midwifery Officer (CNMO)*

23-72.1 - Front sheet Patient Story Board Sept 2023.pdf (3 pages)
23-72.2 - Appendix 1 Patient Experience Story Board 7 Sept 2023.pdf (7 pages)

01:10 PM - 01:15 PM
5 min

TEA/COFFEE BREAK 1:10 - 1:15 (5 MINS)

REGULATORY AND GOVERNANCE

01:15 PM - 01:20 PM
5 min

23/73
Chairman's Report

Information *Chairman*

23-73 - FINAL Chairman BoD Report - Sept 2023 07.09.23.pdf (6 pages)

01:20 PM - 01:30 PM
10 min

23/74
Chief Executive's (CE's) Report

Discussion *Chief Executive*

23-74 - CEO Report to Board - September 2023.pdf (7 pages)

Our People

01:30 PM - 02:20 PM
50 min

23/75
Board Committee - Chair Assurance Reports:

Assurance *Board Committee Chairs*

23/75.1
Nominations and Remuneration Committee (NRC) – Chair Assurance Report (10 mins)

Assurance *Chair NRC - Stewart Baird / Chief People Officer (CPO)*

23-75.1 - NRC Board Chair Assurance Report 11.07.23.pdf (3 pages)

23/75.2
People and Culture Committee (P&CC) – Chair Assurance Report (10 mins)

Assurance *Chair P&CC - Stewart Baird / Chief People Officer*

23-75.2 - PCC Board Assurance Report 30.08.2023.pdf (6 pages)

Patients - Quality and Safety

23/75.3
Quality and Safety Committee (Q&SC) - Chair Assurance Report (10 mins)

Assurance *Chair Q&SC - Andrew Catto / Interim Chief Medical Officer (CMO) / Interim Chief Nursing & Midwifery Officer (CNMO)*

23-75.3 - QSC Board Report 290823.pdf (3 pages)

Sustainability - Quality and Safety

23/75.4
Integrated Audit and Governance Committee (IAGC) – Chair Assurance Report (10 mins)

Assurance *Chair IAGC - Olu Olasode / Group Company Secretary (GCS) / Interim Chief Finance Officer (CFO)*

23-75.4 - IAGC Assurance Report to Sept BoD 28.07.23 FINAL.pdf (6 pages)

23/75.5
Finance and Performance (FPC) – Chair Assurance Report (10 mins)

Approval *Chair FPC - Richard Oirschot / Interim Chief Finance Officer (CFO)*

23-75.5 - FPC Assurance Report BoD final.pdf (6 pages)
23-75.5.1 - FPC Committee Assurance Report 290823 FINAL.pdf (5 pages)

02:20 PM - 02:30 PM
10 min

TEA/COFFEE BREAK 2:20 - 2:30 (10 MINS)

02:30 PM - 02:40 PM
10 min

23/76
Transforming our Trust: Our Response to 'Reading the Signals': Maternity and Neonatal Services in East Kent - Update Report

Information *Chief Executive / Chief Strategy & Partnerships Officer (CSPO)*

23-76 - Board report Reading the Signals - Sept.pdf (3 pages)

02:40 PM - 03:05 PM
25 min

23/77
Maternity Incentive Scheme Year 5 Submissions (15 mins)

Approval *Interim CNMO / Director of Midwifery (DoM)*

- **Perinatal Mortality Review Tool (PMRT)**
- **Transitional Care**
- **Saving Babies Lives**
- **Perinatal Quality Surveillance Tool (PQST)**

23-77 - BoD CNST overarching report.pdf (3 pages)

23/77.1
Maternity and Neonatal Improvement Plan (MNIP) (10 mins)

Approval *Interim CNMO / DoM*

23-77.1 - Front Sheet MNIP.pdf (7 pages)
23-77.2 - Appendix 1 MNIP Charters and Workstream 1 Project Plan.pdf (13 pages)

03:05 PM - 03:20 PM
15 min

23/78
Freedom to Speak Up (FTSU) Quarterly Report

Discussion *CPO / FSTU Guardians*

23-78 - FTSU Paper.pdf (6 pages)

03:20 PM - 03:30 PM

23/79

10 min

Patient Voice and Involvement Quarterly Report

Information *Interim CNMO*

- 23-79.1 - Front sheet Patient Voice and Involvement Report Board Sept 2023 FINAL.pdf (3 pages)
- 23-79.2 - App 1 Patient Voice and Involvement Report April to June 2023 FINAL.pdf (6 pages)

03:30 PM - 03:45 PM
15 min

23/80
Integrated Performance Report (IPR)

Discussion *Chief Executive / Executive Directors*

- 23-80.1 - Front Sheet Sept 23 IPR.pdf (3 pages)
- 23-80.2 - Appendix 1 Board IPR_v5.0_Jul 23_FINAL.pdf (59 pages)

23/80.1
Month 4 Finance Report/Financial Position

Information *Interim CFO*

- 23-80.1.1 - M4 Finance Report Front sheet.pdf (4 pages)
- 23-80.1.2 - App 1 M4 Finance Report short version.pdf (8 pages)

03:45 PM - 03:55 PM
10 min

23/81
Integrated Improvement Plan (IIP) Report including metrics

Information *CSPO*

- 23-81.1 - Front Sheet Integrated Improvement Plan Report Final new 07.09.23.pdf (2 pages)
- 23-81.2 - App 1 EKHUFT IIP September Board Report 29.08.23.pdf (16 pages)

03:55 PM - 04:05 PM
10 min

23/82
Board Assurance Framework (BAF) Risk Register

Approval *Interim CNMO*

- 23-82.1 - Board Assurance Framework 11.08.2023 v3.pdf (8 pages)
- 23-82.2 - Appendix 1 BAF 2023-24 11.08.2023.pdf (11 pages)

04:05 PM - 04:15 PM
10 min

23/83
Health and Safety and Statutory Compliance Update

Assurance *Managing Director, 2gether Support Solutions*

- 23-83 - HS Stat Compliance and Critical Infrastructure Report (Sept 2023).pdf (8 pages)

CLOSING MATTERS

04:15 PM - 04:20 PM
5 min

23/84
Any Other Business

Discussion *All*

Verbal

04:20 PM - 04:35 PM
15 min

23/85
Questions from the Public

Discussion *All*

Verbal

Date of Next Meeting: Thursday 5 October 2023

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM JULY 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	Appointed 1 September 2019
BAIRD, STEWART	Vice Chair/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)**	1 June 2021 (First term)
CATTO, ANDREW	Non-Executive Director	Chief Executive Officer, Integrated Care 24 (IC24) **(1)** Member of east Kent Health and Care Partnership (HCP) **(1)**	1 November 2022 (First term)
CORBEN, SIMON	Non-Executive Director	Director and Head of Profession, NHS Estates and Facilities, NHS England **(1)**	1 October 2022 (First term)
DICKSON, JANE	Interim Chief Nursing and Midwifery Officer	Director, Holiday Letting, Scotland (Ltd company) **(1)**	15 May 2023
DICKSON, NIALL	Chair	Senior Counsel, Ovid Consulting Ltd (trading as OVID Health Company) (started November 2020) **(1)** Chair of the East Kent Health and Care Partnership (HCP) Board **(1)**	5 April 2021

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM JULY 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
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)
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)
JONES, DYLAN	Chief Operating Officer	None	Appointed 12 April 2023
MARTIN, REBECCA	Chief Medical Officer	None	Appointed 18 February 2020
OIRSCHOT, RICHARD	Non-Executive Director	Non-Executive Director, Puma Alpha VCT plc (July 2019) **(1)** Director, R Oirschot Limited (August 2010) **(3)** Trustee, Camber Memorial Hall (June 2016) **(4)**	1 March 2023 (First term)
OLASODE, OLU	Senior Independent Director (SID)/Non-Executive Director	Chief Executive Officer, TL First Consulting Group (started 9 May 2000) **(1)** Chairman, ICE Innovation Hub UK (started 11 September 2018) **(1)** Independent Chair, Audit and Governance Committee, London Borough of Croydon (started 1 October 2021) **(1)** Independent Non-Executive Director (Adult Care), Priory Group (Adult Social Care and Mental Health Division) (started 1 June 2022) **(1)**	1 April 2021 (First term)

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM JULY 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
STEVENS, BEN	Chief Strategy and Partnerships Officer	None	1 June 2023 (substantive) (20 March 2023 interim)
STEVENS, MICHELLE	Interim Chief Finance Officer	None	1 April 2023
SYKES, CLAUDIA	Non-Executive Director	Director, Cloudier Skies Ltd **(1)** (started 21 December 2022)	1 March 2023 (First term)
WOOD, MICHAEL	Interim Group Company Secretary	None	April 2023
YOST, NATALIE	Executive Director of Communications and Engagement	None	31 May 2016

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

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

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

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

Categories:

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

UNCONFIRMED MINUTES OF THE ONE HUNDRED AND THIRTY FIRST MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 6 JULY 2023 AT 2.00 PM IN THE CONFERENCE ROOM, EDUCATION CENTRE, KENT AND CANTERBURY HOSPITAL, ETHELBERT ROAD, CANTERBURY, KENT CT1 3NG AND BY WEBEX TELECONFERENCE

PRESENT:

Mr N Dickson	Chairman	ND
Mr R Anakwe	Non-Executive Director (WebEx)	RA
Ms A Ashman	Chief People Officer (CPO)	AA
Mr S Baird	Non-Executive Director (NED)/People and Quality Committee (P&CC) Chair/Nominations and Remuneration Committee (NRC) Chair	SB
Dr A Catto	NED/Quality and Safety Committee (Q&SC) Chair	AC
Mr S Corben	NED/2gether Support Solutions (2gether) NED In-Common	SC
Ms J Dickson	Interim Chief Nursing and Midwifery Officer (CNMO)	JD
Ms T Fletcher	Chief Executive (CE)	TF
Ms L Fulci	NED	LF
Dr R Martin	Chief Medical Officer (CMO)	RM
Mr R Oirschot	NED/Finance and Performance Committee (FPC) Chair	RO
Dr O Olasode	NED/Senior Independent Director (SID)/Integrated Audit and Governance Committee (IAGC) Chair	OO
Mrs M Stevens	Interim Chief Finance Officer (CFO)	MS
Ms C Sykes	NED/Charitable Funds Committee (CFC) Chair/*Reading the Signals* Oversight Group Chair	CS

ATTENDEES:

Ms M Durbridge	Improvement Director, NHS England (NHSE)	MD
Prof C Holland	Associate NED/Dean, Kent & Medway Medical School (KMMS)	CH
Ms A Smith	Deputy Director of Midwifery (DoM)	AS
Ms L White	Deputy Director, Infection Prevention & Control (DIPC)	LW
Mr M Wood	Interim Group Company Secretary	MW
Mrs N Yost	Executive Director of Communications and Engagement (EDC&E)	NY

IN ATTENDANCE:

Miss L Coglan	Council of Governors (CoG) Support Secretary	LC
Mr T Cook	Special Adviser to the Chairman and Deputy GCS	TC
Miss S Robson	Board Support Secretary (Minutes)	SR

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mrs M Bonney	Governor (WebEx)
Ms V Brandon	Member of the Public (WebEx)
Mr R Brittain	Governor (WebEx)
Mr N Daw	Member of Staff (WebEx)
Ms C Heggie	Member of the Public
Mr N Kalli	Business Development Manager, South London, iRhythmtec
Mr G Short	iRhythmtec
Mrs B Mayall	Lead Governor (WebEx)
Ms D Pook	Member of the Public (WebEx)
Mr D Richford	Member of the Public (WebEx)
Mr B Rylands	Governor (WebEx)
Mr J Sullivan	Governor
Mrs L Williams	Member of the Staff (WebEx)

MINUTE NO.		ACTION
23/052	**CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE** The Chairman opened the meeting, welcomed everyone present and noted apologies received from Mr B Stevens, Chief Strategy and Partnerships Officer (CSPO). The Chairman stated a Closed BoD meeting had been held that morning that included discussions about the 2023/24 Plan, Care Quality Commission (CQC) Maternity Report and Unannounced Inspection, and Review of Board meeting papers. The Chairman reported the format of the Board meeting papers was different as these needed to be compliant with Government accessibility guidance requirements. The Chairman reported a Staff Experience Story presentation was due to be presented at this meeting, unfortunately the staff member was unable to attend. It was noted the next meeting in September would receive a Patient Experience Story presentation. The teams going forward would look at having a list of individuals in reservation who could be called upon to attend if those identified were unable to.	
23/053	**CONFIRMATION OF QUORACY** The Chairman **NOTED** and confirmed the meeting was quorate.	
23/054	**DECLARATION OF INTERESTS** There were no new interests declared.	
23/055	**MINUTES OF THE PREVIOUS MEETING HELD ON 1 JUNE 2023** **DECISION:** The Board of Directors **APPROVED** the minutes of the previous meeting held on 1 June 2023 as an accurate record.	
23/056	**MATTERS ARISING FROM THE MINUTES ON 1 JUNE 2023** **B/02/23 - Number of women took decision and went elsewhere to other NHS organisations to access maternity services and not East Kent Hospitals (their local NHS Trust)** The Interim CNMO reported the Trust was awaiting this information. **B/10/23 - Incorporating the national maternity dashboard within the Trust's maternity dashboard for comparison against performance** The Interim CNMO reported the Trust's maternity dashboard resonated with the national maternity dashboard, and there was no plans to make any changes to this alignment. It was agreed to close this action. **B/11/23 – Include in future reports updates on staff learning and training identified from Serious Incidents (SIs)** The Interim CNMO reported learning and training for staff would be incorporated in future SI reports. It was agreed to close this action.	

B/15/23 - Provide a breakdown on the planned projection to reduce premium pay, how this would be done and when, with scenarios on the actions to support this
The CPO reported this would be a main focus by the wider leadership teams within the new organisational structure, working closely with the Finance team, and closely monitored, with progress discussed and challenged at the regular performance meetings held with the Care Groups. It was agreed to close this action.

B/16/23 - Provision of healthy food and drinks across hospital sites during out of hours
The CE reported the 2gether Support Solutions (2gether) team were looking at various options to improve the availability of healthy food and drink for patients, visitors and staff. It was noted 2gether were working in conjunction with the Trust's Hospitals Food and Drink Committee and this continued to be work in progress. It was agreed to close this action.

DECISION: The Board of Directors **NOTED** the action log and updates from the actions from the previous meeting, **NOTED** the actions for future Board meetings and **APPROVED** the three actions recommended for closure and the four actions agreed for closure as noted above.

23/057 **CHAIRMAN'S REPORT**

The Chairman emphasised the Trust continued to remain and operate under significant pressure during the Summer months. The CQC had undertaken a Well Led inspection of the Trust that week (week commencing 3 July) and any learning from this would be taken onboard. Disappointment was expressed that the Trust had not been included in the new hospitals programme investment provision. There was going to be a rolling programme in the future which would have a significant impact for the Trust, in respect of its estate and lack of capital investment in being able to provide appropriate level of care provision and working environment for staff. This would continue to compromise operating services efficiently as well as financial impact and achieving its financial plan.

It was commented that the Trust's current capital programme funding was insufficient to maintain its estate and carry out backlog maintenance requirements of its critical infrastructure, which was unsustainable. A report would be produced detailing the significant risks aligned with the Trust's longer term strategy, which would be shared with the wider system.

The Chairman highlighted the success of the new Community Diagnostic Centre at Buckland Hospital Dover, that had delivered tests to nearly 50,000 patients since it opened in January 2022, with many coming from the most deprived communities. Patients waiting more than 6 weeks for a CT scan at the Centre had reduced from more than 1000 to just 37 in the year up to March.

It was noted the Council of Governors continued to build on its work engaging with members as well as members of the Board, and delivering its membership engagement strategy.

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

23/058 **CHIEF EXECUTIVE'S (CE's) REPORT**

The Chief Executive reported the following key points of development:

- Antenatal scanning service, delays in provision of timely scans and anomaly scans, with ongoing work to understand these delays. Work to increase capacity availability of this service and that women received timely scans;

- Ongoing issue in respect of industrial action and working closely with consultants and junior doctors to ensure provision of patient care during periods of industrial action. Noting the impact on planned elective care and non-emergency care to ensure continued emergency care provision. Support from Care Group team staff in co-ordinating rota cover as well as support across the organisation as a whole. Thanks to all Trust staff for their support;

- In respect of the CQC Well Led inspection (4 and 5 July), vast volume of evidence had been provided as part of this inspection that included interviews with Trust staff involving a number of Board members. Initial verbal feedback had been provided, nothing raised that was unexpected and the formal written report was awaited.

Arising out of discussion, NEDs raised the matter of patient pathways in respect of urgent and emergency care (UEC) and ensuring patients followed the right pathway that met their requirements for care provision; to assess outcomes and the success of these and also learn from what other trusts had in place. It was also enquired about progress to reduce the elective waiting lists. The CE stated a report could be presented to a future Board meeting setting out the various UEC patient pathways to meet the individual needs around ongoing treatment, covering the next six to twelve months period. This would also need to incorporate the collaborative work with the out of hours service and support from the community. The CE further highlighted the impact on elective activity due to increased number of referrals and availability of resources, with ongoing monitoring of demand.

ACTION: Present report to October 2023 Board meeting setting out the various urgent and emergency care (UEC) patient pathways to meet individual patient needs for ongoing treatment, covering the period over the next six to twelve months. To also incorporate the collaborative work with the out of hours service and support from the community. — COO

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

23/059 **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS:**

23/059.1 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

The P&CC Chair highlighted key points:

- Assurance of staff sickness that was 4.3%, stable and below the threshold;
- Assurance on staff turnover, overall at 9.7%, below the threshold and falling;
- Not assured on staff engagement and staff involvement, there had been no material improvements. Progress was being made with 133 Culture Champions appointed across the Trust with ongoing initiatives to support improving this position;

- Not assured about staff appraisals that had further declined to 67.4%, consistently falling below the threshold. This was a key risk that had been escalated for inclusion on the Corporate Risk Register and referred to the IAGC;
- 407 Internationally Educated Nurses (IEN) recruited in 2022, with a further 70 staff being recruited between January and March 2023.

The Board of Directors **NOTED** the 30 June 2023 P&CC Chair Assurance Report.

23/059.2 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

The Q&SC Chair highlighted key points:

- Partial assurance of current performance about nationally reportable infections, Clostridioides difficile remained a significant challenge with cases considerably above the trajectory, noting the national increase. A progress report against the internal audit of Antimicrobial Stewardship arrangements was received and the Committee challenged progress, a further report would be presented to the October 2023 meeting;
- Clinical Audit Symposium held, example of good practice that was well attended;
- Partial assurance from the Safe Staffing Review, pressure from the additional escalation areas, an issue with resuscitation training capacity was raised with ongoing work around external support to strengthen this and an update and details about the associated risks was requested to be provided at the next meeting;
- Assurance from the Human Tissue Authority (HTA) report, the processes in management of the mortuary that would continue to be monitored.

The Interim CNMO reported focus on the Board Assurance Framework and management of risks, challenged with Care Groups that actions were being progressed to reduce risk scores.

The Associate NED raised the importance of looking at theatre utilisation and ensuring the most efficient use of theatres. The COO acknowledged the need to move forward at pace with the improvement plan and support to assist with the work needed.

The Board of Directors **NOTED** the 27 June 2023 Q&SC Chair Assurance Report.

23/059.3 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The FPC Chair highlighted key points:

- Limited assurance against progress of the Cost Improvement Programme (CIP) that remained a challenge, £0.2m efficiencies identified to date against £3.1m, and the year target of £40m. Approximately £11m of ideas identified (£9m in year effect). Care Group recovery meetings being scheduled to be held bi-weekly to challenge and monitor progress of efficiency savings, as well as robust management of expenditure;
- Patients No Longer Fit To Reside (NLFTR) revised target of 119 vs the current 174 as a target number to improve flow;

- Capital plan report with projected capital funding over the next five years of £130m, funding gap of £140m, escalation of short-and medium-term capital shortfall with Integrated Care Board (ICB), NHSE, and regional and national teams;
- Month 2 financial position, achieving £19.7m against the plan of £17.8m, a £1.9m deficit variance to plan;
- FPC approval of the Infusion Pumps and Consumables contract award**;** Orthopaedic Prosthesis – Hips and Knees contract award**;** Endoscopy Capital Bid, and Pathology Collaboration Agreement – Memorandum of Understanding (MOU), all recommended for approval by the BoD.

The NEDs queried Care Group engagement with the CIP and their accountability in supporting achievement of the target. The Interim CFO highlighted the CIP was a challenge, noting Care Groups fully engaged with recovery sessions being held to re-enforce and challenge the need to make significant savings, and maintaining robust management and control on expenditure.

The NEDs highlighted the importance of producing a three year financial plan as soon as possible around having a clear plan of what was needed to improve the Trust's financial position.

DECISION: The Board of Directors:

- **NOTED** the 27 June 2023 FPC Chair Assurance Report;
- **APPROVED** the Infusion Pumps and Consumables contract award**;**
- **APPROVED** the Orthopaedic Prosthesis – Hips and Knees contract award**;**
- **APPROVED** the Endoscopy Capital Bid;
- **APPROVED** the Pathology Collaboration Agreement – Memorandum of Understanding (MOU).

23/059.4 **CHARITABLE FUNDS COMMITTEE (CFC) – CHAIR ASSURANCE REPORT**

The CFC Chair highlighted:

- Charity expenditure plan proposal for Board approval, specifically spending £1.2m of the Charity's assets over the next 12-18 months, on the three main categories of Medical Equipment, Staff Wellbeing, and Estates;
- Updated Charity Strategy for Board approval.

DECISION: The Board of Directors:

- **NOTED** the 20 June 2023 CFC Chair Assurance Report;
- **APPROVED** the:
  - Charity expenditure plan proposal;
  - Charity's updated 3-year Strategy.

23/060 **TRANSFORMING OUR TRUST: OUR RESPONSE TO *READING THE SIGNALS* – UPDATE**

The CE highlighted:

- Implementation of the Culture and Leadership Programme (CLP) with the launch of the change team (approximately 50 staff members in attendance at the first session held that week, and approximately 60 staff members due

to attend the second session the following week), overall aim of a total of 127 staff. Sessions had been very positive with insightful questions raised by staff;
- Meetings of the Oversight Group continued with involvement and engagement from families in attendance, with challenging discussions that supported progress to be made. More work was still needed to take this forward as well as management of the meeting agendas.

The CPO commented on useful information on StaffZone for Trust staff about the CLP. The EDC&E agreed to circulate this information to Board members for information.

ACTION: Circulate to Board members the information published on StaffZone for Trust staff about the CLP. EDC&E

The Board of Directors **NOTED** the *Reading the Signals* update report.

23/061 **MATERNITY GOVERNANCE:**

23/061.1 **MATERNITY DASHBOARD – MATERNITY AND NEONATAL ASSURANCE GROUP (MNAG) REPORT**

The Deputy DoM reported:

- Recording issues were impacting data quality associated with 'fresh eyes' cardiotocograph (CTG) reviews, as manual tools were being used and a digital solution was being explored. The narrative within the dashboard detailed the mitigations and plans, with daily checks and signing off by two signatories;
- Rise in staff turnover at William Harvey Hospital (WHH), there would be a focus reviewing exit interviews with analysis of the reasons for staff leaving and what could be done to reduce the number leaving the organisation. Five midwives recruited due to commence in September 2023, with continued focus on recruitment of more midwives;
- Fall in appraisal rate over the last three months, identified senior midwifery staff to address appraisal gaps, with a trajectory for improvement, and weekly reporting to monitor achievement against the trajectory;
- Meetings had been held with three families to reduce their anxiety about coming into hospital;
- Scanning cancellations by hospital had increased above average for three months, resulting in some Serious Incidents (SIs), impacted by staff sickness, mitigations and interventions in place including bringing obstetric ultrasound team into women's health providing better oversight. It was noted the national shortage of sonographer staff.

The NEDs commented on the benefits of the dashboard and the information presented, noting that a review of the charts to aid understanding of the thresholds and measuring horizontal achievement would be welcome. The Interim CNMO stated following the Making Data Count session at the closed BoD meeting that morning, she and the team would be linking with that lead about how presentation of the maternity data could be improved.

ACTION: Liaise with the NHSE Lead following July Making Data Count session and discuss how improvements could be made to the presentation of maternity data. — Interim CNMO

The NEDs highlighted the importance of learning and that this should be reflected in the report and related action, as well as linking all data including i.e. complaints and SIs to ensure no underlying issues were overlooked. The Deputy DoM commented that a new staff appointment had been made whose remit would include reviewing learning as well as using patient stories as feedback.

The Board of Directors **NOTED** the contents of the Maternity Dashboard – MNAG report and the key issues and plans to tackle and address these.

23/061.2 **PERINATAL QUALITY SURVEILLANCE TOOL (PQST)**

The Deputy DoM reported:

- A new period of CNST reporting had started from May to December 2023;
- Concern remained with standard 8 PRactical Obstetric Multi-Professional Training (PROMPT) due to anaesthetic workforce challenges and availability of obstetric faculty to facilitate Multi-Disciplinary Team (MDT) PROMPT. Training compliance remained below the national standard of 90% and was improving;
- One Healthcare Safety Investigation Branch (HSIB) referral for the month of May;
- Supernumerary status and 1:1 care compliance was not reported at 100%, figures had been validated and records would be updated to confirm 100% 1:1 achieved on both units for May;
- Slight decrease in Friends and Family Test (FFT) response at 10.3, decreased from 11.8 the previous month;
- Plans introducing Walking the Patch capturing live feedback from Women and Birthing people on the post-natal wards, as well as Leave your troubles at our door as a way of addressing any issues prior to leaving the hospital;
- Training compliance was met across all maternity staff groups for fetal monitoring PROMPT and Newborn Life Support (NLS).

The Board of Directors **NOTED** the contents of the PQST report.

23/061.3 **MATERNITY AND NEONATAL IMPROVEMENT PLAN (MNIP)**

The BoD **NOTED** the ongoing development of an MNIP. A We Hear You engagement away day was held, with good attendance and input from Trust staff, as well as attendance from the Local Midwifery System (LMS) Lead, Maternity Improvement Advisor, and service users.

23/061.4 **OBSTETRIC WORKFORCE UPDATE**

The CMO reported:

- Risk with vacancies in consultant workforce at Queen Elizabeth the Queen Mother Hospital (QEQM), with interviews held and recruitment of good candidates due to commence that would have a positive impact on reducing this risk;

- Visit in March to the team by Health Education England (HEE) who spoke to junior doctors across Obstetrics and Gynaecology, following the concerning General Medical Council (GMC) survey, and feedback was positive across both sites that they felt well supported.

The Board of Directors **NOTED** the contents of the obstetric workforce update report.

23/061.5 **BI-ANNUAL MIDWIFERY WORKFORCE OVERSIGHT REPORT COVERING STAFFING/SAFETY ISSUES**

The Deputy DoM reported:

- Last BirthRate Plus review completed in April 2021, more detailed workforce review paper presented to Board in May 2022 including mitigations for the identified workforce shortfalls. An associated business case was approved for additional midwife posts;
- Trust would be working with the LMS to undertake a full workforce review, and the findings would be presented to the Board.

DECISION: The Board of Directors:

- **NOTED** the results of the CNST biannual midwifery workforce report and contents of the action plan in compliance with CNST Safety Action 5 required standard;
- **NOTED** and **APPROVED SIGNING** off of the inclusion of the Midwifery Workforce Action Plan.

23/061.5 **CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) SAFETY ACTION 8 COMPLIANCE PLAN**

The Deputy DoM reported:

- Review of methodology of the facilitation of PROMPT across sites, increase amount of training weeks undertaken when new MDT members (Foundation Year (FY) & Trainees) usually falling in August to ensure compliance and safety was maintained;
- Ensure anaesthetic and obstetric teams understood the provisions needed to facilitate PROMPT.

The Board of Directors **NOTED** the CNST Safety Action 8 Compliance Plan Report.

23/023 **INFECTION PREVENTION AND CONTROL (IPC)**

23/062.1 **IPC QUARTERLY UPDATE**
IPC ANNUAL REPORT 2022-2023

The Deputy DIPC reported as follows:

- Above the threshold for Clostridioides difficile cases that would be a challenge to meet the target. Antimicrobial Stewardship (AMS) in place, specialist support to drive forward the strategy plan to reduce cases of healthcare associated infections (HCAI);
- Implementation of National IPC manual;

- New robust governance structure in place;
- Linking with another trust of similar size that had reduced Clostridioides difficile cases around potential for learning of best practice;
- IPC Annual Report 2022-2023 for BoD approval.

The NEDs raised the matter of co-ordination with specialist teams and the emerging issue within the Emergency Departments (EDs). The Deputy DIPC emphasised that the IPC workplan, strategy, and AMS were in place to support staff in managing IPC, with focus on prescribing support within the EDs. Challenges were highlighted with regard to the estate and environment around cleanliness, it being noted that a robust audit programme was in place. It was reported that the IPC Committee was carrying out robust and regular monitoring of the IPC position, IPC team and IPC Committee working closely with 2gether to address any IPC issues raised.

DECISION: The Board of Directors:

- discussed and **NOTED** the contents of the IPC quarterly update report;
- **APPROVED** the IPC Annual Report 2022-2023.

23/063 **CHIEF MEDICAL OFFICER (CMO) REPORTS:**

23/063.1 **MEDICAL REVALIDATION ANNUAL REPORT**

The CMO highlighted the following key points:

- CMO fulfilled the statutory duty Responsible Officer (RO) role, supported by the Deputy CMO, that had been challenged to deliver all of the planned improvements identified in last year's report had been compromised, when covered gaps in medical leadership roles supporting the QEQM medical director role;
- Since commencing in Autumn 2021 the Appraisal Lead was very committed, working above their hours, and had successfully driven forward improvements in the quality of appraisals. Real benefits were being seen from this intensive support;
- Challenges with appraisal rate compliance, currently overall at 76.8%, for consultants 81.3%; Specialty and Specialist (SAS) doctors 73.1%, and other locally employed doctors 70.5%. Aim to reach >90% compliance during 2023/24;
- Responsible Officers Advisory Group (ROAG) established that would be supported by lay representation;
- NHSE Regional Revalidation Team Quality Visit in September 2022 with positive feedback on good practice, processes and support in place as well as some recommendations to further strengthen these;
- The new medical leadership roles would support to embed and continue improvements.

The NEDs questioned whether sufficient resources were in place to ensure continued compliance. It was also highlighted the need to improve the compliance rate and that this be monitored to ensure these increased, and that there was consideration in respect of Equality, Diversity and Inclusion (EDI) and appraisers and there not being any sub-conscious biases. The CMO reported robust processes and monitoring were in place, as well as addressing areas of non-compliance. It was noted there was good engagement.

The Chairman enquired how the Trust compared with other trusts on its compliance. The CMO reported the Trust was not an outlier and continued to drive forward improvements and increase its compliance rate.

DECISION: The Board of Directors **NOTED** the annual report and progress, and **APPROVED** the Report and Statement of Compliance prior to submission to NHS England Regional Revalidation Team.

23/063.2 **CMO'S REPORT – UPDATE ON MEDICAL WORKFORCE**

The CMO reported:

- Challenging time currently for the medical workforce as well as other staff throughout the NHS, managing industrial action, workload pressures, with primary interventions at local level to improve doctors' working lives and make them feel that they belonged and were valued. This included ensuring provision of hot meals and drinks, facilities for rest breaks and lockers for personal belongings;
- Support to SAS and Locally Employed (LE) Doctors improving working conditions, educational and study leave, and pastoral support to develop their medical careers. Successful away day held, disappointing attendance, the day was valued by those who attended with sessions focussed on EDI and well-being;
- HEE visit in March 2023, with a focus on specialities that contributed to maternity services: Obstetrics and Gynaecology, Paediatrics, Anaesthetics and Operating Department Practitioners. Published report highlighted areas for improvement, and an action plan was in place and being progressed to address the mandated recommendations.

The Associate NED commented on the significant additional funding provision for educational training, and the requirement for trainers to be able to fulfil the provision of this increased training along with additional space to provide this training to staff.

The Board of Directors **NOTED** the medical workforce report and how the local interventions were being addressed through the Culture and Leadership programme and the Integrated Improvement Plan (IIP).

23/064 **INTEGRATED PERFORMANCE REPORT (IPR)**

The Chairman reported work continued to review the IPR and improve its presentation of the data, to enable focussed discussion of the key areas that needed to be improved. He commented the Board received a presentation that morning at its closed meeting from a data expert and how data could be better presented.

Mortality (Hospital Standardised Mortality Ratio (HSMR))

The CMO reported on the aim to reduce mortality and be in the top 20% of all trusts for the lowest mortality rates in 5 to 10 years, against the threshold set for rolling 12 month HSMR to be below 90 by January 2027.

- HSMR was below the threshold target;
- Summary Hospital-level Mortality Indicator (SHMI) was as expected;

- Intelligence used to drive deep dives into pathways to drive forward improvements.

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 (NFTR)

The COO reported:

- Refocus of the action plan to improve theatre capacity and performance;
- Weekly performance meetings held to monitor embedding to increase elective activity;
- Urgent care performance continued to improve, with reduction in the number of patients with a total of 12 hours in the Emergency Department (ED), with access to Urgent Treatment Centres increasing to 72%;
- Cancer 62 day performance continued to remain under pressure, with reduced performance due to endoscopy increased waiting times, along with urology pathway delays due to increased demand and seeking mutual aid from local trusts to support addressing this.

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:

- Staff Involvement had improved slightly to 6.23, up 5 points but considerably below the desired threshold, and appeared to be primarily due to staff feeling less able to make improvements happen in their area of work and showing that changes were happening was vital to ensure improvements.

Financial Position (Income and Expenditure Margin) and Month 2 Finance Report

The Interim CFO highlighted key points:

- At month 2 a £19.7m deficit, of £1.9m variance to plan, the key drivers were £400k for industrial action by junior doctors, and non-delivery against the CIP of £2.9m;
- Key risks to delivery of the 2023/24 financial plan included, increased usage of escalation areas, specialling, additional staffing above establishment, and the standardisation of Waiting List Initiatives (WLI) payments.

Reduce Incidents with Harm

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

- Improvements were being seen around the deteriorating patient improvement work;
- High volume of feedback from patients and families with a key area of focus to reduce disruption and noise at night impacting patients sleep;

- Importance of recognising and celebrating areas of improvement and good practice.

The NEDs commented feedback about noise at night was a repeating theme and the need to be open and honest that all was being done that could be. The Interim CNMO reported learning from others that had co-horted patients living with dementia and understanding the reasons for moving patients at night, to reduce this and the impact of disruption that would be supported by improving patient flow.

The Board of Directors discussed and **NOTED** the:

- True North and Breakthrough Objectives of the Trust;
- Month 2 financial report, financial performance and actions being taken to address issues of concern.

23/064.1 **INTEGRATED IMPROVEMENT PLAN (IIP) UPDATE**

The CE reported key highlights:

- Ongoing work looking at presenting a wider range of metrics providing strengthened data information and assurance on progress, and recognition of trends and themes;
- Delivery oversight and monitoring with presentation of report updates to the Strategic Improvement Committee, discussions of the risks, current position and any slippages to delivery;
- Recognition for improvements at pace, with stretching ambitious timeframes.

NHSE's Improvement Director stated a review of the IIP was required in alignment with the IPR refresh and review. Key areas to enable improvements included identifying where there were blocks and monitoring progress of actions via the Care Group performance review meetings.

The NEDs raised the need for a clear plan to be delivered with identified milestones. NHSE's Improvement Director stated the overall plan was managed by the CSPO, supported by the Programme Management Office (PMO), with Executive Directors leading specific workstreams and monitoring delivery against the milestones.

The Board of Directors discussed and **NOTED** the IIP report and progress of delivery of the IIP to date.

23/064.2 **EMERGENCY DEPARTMENT (ED) BUILDS – UPDATE**

The COO reported the following matters:

- Building works at WHH and QEQM around remodelling front door pathways to mitigate the risks created by these works, completion of work at both sites expected by end of 2023;
- Since commencement of phase 3 works at QEQM had shown early signs of improvement and increased performance;
- Reinforcing alternative pathways to ED by enhancing Urgent Treatment Centre (UTC) co-located utilisation.

The NEDs commented the new ED space and environment was great for both patients and staff.

The Board of Directors **NOTED** the ED Builds update report and the associated progress with front door performance.

23/065 **ANY OTHER BUSINESS**

There were no other items of business raised.

23/066 **QUESTIONS FROM THE PUBLIC**

The Chairman raised a written question that had been submitted from a member of staff, Healthcare Assistant (HCA), in respect of the white uniform colour that was difficult to keep white, considering their roles and nature of work, and whether a different and more suitable colour could be considered. The Interim CNMO agreed to liaise with the staff member direct about looking at specific staff groups and considering a different uniform colour, noting the need for an overall review of uniforms.

ACTION: Liaise with the HCA direct about looking at specific staff groups to consider a different uniform colour. — Interim CNMO

The Chairman apologised to those attending online for the poor sound quality which would be improved for the next meeting.

Mr Rylands (Public Governor) commented on an incident he had been made aware of from a constituent about their experience when attending for surgery and a 'near miss' event. He enquired how often near misses were being reported. The CMO confirmed that the Trust had a well-established system for reporting near misses.

Mr Rylands raised a further issue in respect of a patient being sent home without the provision of community care being in place. The CE commented on the pressures of the number of NFTR patients waiting to be discharged, and the need to work closely with community colleagues to ensure assessments of patients and provision of community/social care support if needed. In respect of another patient who had been discharged with mobility issues, the Interim CNMO agreed to liaise with the Governor outside of the meeting to discuss this specific case.

Mr Brittain (Public Governor) raised an issue related to an Inquest finalised at the end of June 2023 and asked why the Trust had provided a written statement to the media from a spokesperson. In response the EDC&E explained that usually statements were issued from an Executive Director and sincerely apologised that this had not happened on this occasion. The CE stated that she had given statements and interviews previously and it was important going forward that the normal practice of the Trust should be that senior representatives respond to Inquests.

In respect of an antenatal scanning issue, Mr Brittain conveyed thanks to the CE for being open and transparent with Governors in how the matter was being addressed.

Mr Brittain raised a query in respect of recent bids for funding submitted to the ICB and how this was being reported. The CE reinforced the Trust's commitment to being transparent with Governors, working together as a team.

The Chair closed the meeting at 5.40 pm.

Date of next meeting: Thursday 7 September 2023.

Signature _____

Date _____

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Matters Arising from the Minutes on 6 July 2023**

Meeting date: **7 September 2023**

Board sponsor: **Chairman**

Paper Author: **Board Support Secretary**

Appendices:

NONE

Executive summary:

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

Implications:

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

Assurance route:

Previously considered by: None

MATTERS ARISING FROM THE MINUTES ON 6 JULY 2023

1. Purpose of the report

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

2. Background

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

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

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/02/23	Check and confirm the number of women that took the decision and went elsewhere to other NHS organisations to access maternity services and not East Kent Hospitals (their local NHS Trust). Include this information in the next Board report.	~~Jun-23~~/ ~~Jul-23~~/ Sep-23	Interim Chief Nursing and Midwifery Officer (CNMO)	Open	06.07.23 – Trust awaiting this information. Verbal update to be provided at 07.09.23 Board meeting.
B/03/23	Review and reassess the current BAF, its contents and the risks, assessing the risks against achievement of the strategic annual objectives and the IIP over the next 12 month period.	Sep-23	Chief Executive/ Executive Team	Open	Verbal update to be provided at 07.09.23 Board meeting.
B/04/23	Present a report to the Board in November 2023 (12 months following the publication of the Kirkup report) providing a review and evaluation of the changes and improvements implemented, the impact and outcome of these	Nov-23	Interim Chief Nursing and Midwifery Officer (CNMO)	Open	Item for future Board meeting.

	on women, the service and its staff, along with feedback from staff about how they felt working in maternity services and what had changed and whether had made a real difference for them.				
B/06/23	On completion of the ED works review the UEC services, front door patient pathways, management of patients, and patient flow to develop a sustainable Trust strategy.	Feb-24	Chief Operating Officer (COO)	Open	Item for future Board meeting.
B/07/23	Present the revised de-minimis report following its review for Board to have a discussion about the current position of the Trust's infrastructure, the mitigations, and what could be done in the short-term, medium-term, and long-term to ensure sustained future provision of services.	Sep-23	Chief Strategy & Partnerships Officer (CSPO)	To Close	Capital Investment Requirement report presented to Closed Board meeting on 07.09.23. **Action for agreement for closure at 07.09.23 Board meeting.**
B/08/23	Consider when reviewing the Oversight Group later in the year extending invitation to some patient and family representative members to present at a future Board on their experience of this Group and the progress that had been made.	Nov-23	Chief Strategy & Partnerships Officer (CSPO)	Open	Item for future Board meeting.
B/09/23	Look at including in future reports an additional column in the pillars of change update appendix providing a brief overview of the result of the	Jul-23	Chief Strategy & Partnerships Officer (CSPO)	Open	Work in progress and will report at the September 2023 Board meeting.

	actions detailing 'the what, impact and outcomes from these'. Consider and look at using Blue, Red, Amber and Green (BRAG) status definitions rather than RAG currently used.				
B/12/23	Provide in the report presented to the September 2023 Board meeting an update following the review of feedback from staff exit interviews and the reasons for staff turnover, particularly the reasons for the higher turnover rate at WHH.	Sep-23	Interim Chief Nursing and Midwifery Officer (CNMO)	Open	Verbal update to be provided at 07.09.23 Board meeting.
B/13/23	Provide an update in the next report presented following discussion with the Patient Voice and Involvement team and wider CNMO teams about the triangulation of patients, families and communities feedback across the Trust, FFT responses, as well as complaints. This was around ensuring identification of any themes, what changes and improvement action was needed to address issues raised and that action was taken on the feedback received. Consider looking at producing a deep dive report on any themes identified.	Sep-23	Interim Chief Nursing and Midwifery Officer (CNMO)	Open	Verbal update to be provided at 07.09.23 Board meeting.
B/14/23	Include section in the next report presented on feedback of the PLACE audits as well as any themes	Sep-23	Interim Chief Nursing and Midwifery Officer (CNMO)	Open	Verbal update to be provided at 07.09.23 Board meeting.

	identified from complaints.				
B/17/23	Present report to October 2023 Board meeting setting out the various urgent and emergency care (UEC) patient pathways to meet individual patient needs for ongoing treatment, covering the period over the next six to twelve months. To also incorporate the collaborative work with the out of hours service and support from the community.	Oct-23	Chief Operating Officer (COO)	Open	Item for future Board meeting.
B/18/23	Circulate to Board members the information published on StaffZone for Trust staff about the CLP.	Sept-23	Executive Director Communications & Engagement (EDC&E)	To Close	Information circulated to Board members on 01.09.23. **Action for agreement for closure at 07.09.23 Board meeting.**
B/19/23	Liaise with the NHSE Lead following July Making Data Count session and discuss how improvements could be made to the presentation of maternity data.	Sept-23	Interim CNMO	Open	Verbal update to be provided at 07.09.23 Board meeting.
B/20/23	Liaise with the HCA direct about looking at specific staff groups to consider a different uniform colour.	Sept-23	Interim CNMO	Open	Meeting held with Interim CNMO and HCA.

East Kent Hospitals University NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (BoD)

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

Meeting date: **7 September 2023**

Board sponsor: **Interim Chief Nursing and Midwifery Officer**

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

Appendices:

APPENDIX 1: Patient Experience Story

Executive summary:

Action required:	Information
Purpose of the Report:	To hear the stories of local Deaf people who use British Sign Language (BSL) to communicate and have not had positive experiences whilst in our care due to a failure or delay in providing a BSL interpreter.
Summary of key issues:	The report provides information on the experiences of Deaf people using services at East Kent Hospitals, and the wider context of the barriers facing Deaf people and the health inequalities they experience. There are an estimated 300 to 400 Deaf people who use BSL as their only means of communication in East Kent. The video the Board will see is of a Deaf person providing some insight into a local Deaf person's experience. NC works for BSL Community, who are a community interest company that provides support to Deaf people living in Kent. They work closely with Kent County Council (KCC) Sensory Services. They run Deaf Together groups in Ashford and Margate. The patient story in this report relates to a Deaf person with complex health needs, who was admitted to William Harvey Hospital (WHH) in June and then to Queen Elizabeth the Queen Mother Hospital (QEQM) in July. In both cases there were significant delays in arranging BSL interpreters. The Trust's contracted provider said they required 2 weeks' notice for a BSL face to face interpreter. KCC Sensory Services team got involved and provided some initial support until another provider was found to provide the interpreting needed. For both of the admissions an incident was logged on Datix to reflect the delays in getting interpreters and the impact on the patient's safety and wellbeing. The Safeguarding team are aware of this case and are undertaking a deep dive into it, along with one raised in November last year. It is hoped that any lessons learned can be shared widely across the Trust.

We care

East Kent Hospitals University NHS Foundation Trust

	The story in this report and the video the Board will see is typical of Deaf people's experiences. The Patient Voice and Involvement team has been going out to Deaf Together groups in Margate and Ashford since November 2022 to listen to people's experiences and we've heard directly from around 60 Deaf people. We are working with our operational colleagues and other NHS and social care partners to share what we've learnt and to find ways to improve access for Deaf people, as well as their experience and outcomes. We have taken a number of actions at Trust level to improve systems and processes, and ultimately the actions of staff on the wards and in our services will shape the experiences of Deaf patients who need BSL interpreters in order to use our services and experience appropriate and safe care.
Key recommendations:	The Board of Directors are asked to **DISCUSS** the patient stories and support actions being taken to ensuring that: • Our systems and processes support Deaf people to get safe and timely care. • The Trust secures provision of a reliable face to face BSL interpreting service. • The Trust raises staff awareness of the communication needs of Deaf patients and their families and how meeting these needs is a vital element of patients giving informed consent to treatment and understanding any risks. • The Trust works with our partners in East Kent, including GPs, Kent Community, Kent County Council and the wider Integrated Care Board (ICB) to create a co-ordinated approach to interpreting provision for Deaf people, in order to ensure their safety and involvement in their healthcare and to reduce the health inequalities they experience.

Implications:

Links to 'We Care' Strategic Objectives:	• Patients • Quality and safety
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.
Link to the Corporate Risk Register (CRR):	**CRR 159**: Detriment to patients with a disability as we are non-compliant with the mandatory Accessible Information Standards.

East Kent Hospitals University NHS Foundation Trust

Resource:	No
Legal and regulatory:	The Trust must implement the mandatory Accessible Information Standard and the Equality Act 2010, including the Public Sector Equality Duties. We must comply with the Care Quality Commission Regulations.
Subsidiary:	No

Assurance route:

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

East Kent Hospitals University NHS Foundation Trust

PATIENT EXPERIENCE STORY

1. Purpose of the report

1.1 The report provides information on the experiences of Deaf people using services at East Kent Hospitals, the barriers facing Deaf people and the health inequalities they experience.

1.2 The video you will see is about a local Deaf person, Barbara, whose story is told by a Deaf actor, Nicole. It provides some insight into a local Deaf person's experience of healthcare. Nicole works for British Sign Language (BSL) Community, who are a community interest company that provides support to Deaf people living in Kent. They work closely with Kent County Council Sensory Services. They run Deaf Together groups in Ashford and Margate.

1.3 The other story in this report is sadly typical of Deaf people's experiences. If Deaf people who communicate using BSL do not get an interpreter provided at their appointment or when they are an in-patient, there is a risk to their safety and they cannot be properly involved in decisions about their care, or give informed consent. In an emergency situation our staff should always use the BSL video interpreting service if a face to face BSL interpreter is not available, which is usual in emergency situations.

1.4 The Patient Voice and Involvement team has been going out to Deaf Together groups in Ashford and Margate since November 2022 to listen to people's experiences and we've heard directly from around 60 Deaf people. We are working with operational colleagues at the Trust and other NHS and social care partners to share what we've learnt and to find ways to improve access for Deaf people and their experience of using health services.

2. Background

2.1 British Sign Language (BSL) has its own grammatical structure and syntax and as a language it is not dependent on, nor strongly related to, spoken English. BSL is the main language of approximately 145,000 people in the UK. East Kent has a higher than average population of Deaf people who use BSL, with numbers estimated to be 300 to 400 Deaf people, plus family members with hearing who sign.

2.2 Around half of the local Deaf population aged 18 to 65 are known to Kent County Council (KCC) Sensory Services. KCC often get involved in their client's healthcare needs as a number of their staff are able to sign. Most Deaf people's experiences of healthcare are poor because they are not often provided with a BSL interpreter in a timely way, or at all. Many Deaf people who sign are not able to communicate easily in written English. Lip reading requires a good knowledge of spoken English and English is not many Deaf people's first or second language.

2.3 Whilst there is a 999 BSL video service for Deaf people, that ambulance paramedics can use to communicate with the Deaf person when they arrive at their home or whilst in the ambulance, as soon as they leave the patient in our care, this stops. At this point our Emergency Department (ED) staff need to arrange for an interpreter whilst the patient is in ED, or on the Acute Medical Unit (AMU) or in an escalation area, pending admission to a ward.

2.4 The patient story in this report relates to a Deaf person with complex health needs, who was admitted to William Harvey Hospital (WHH) in June and then to Queen Elizabeth the Queen Mother Hospital (QEQM) Hospital in July. In both cases there were significant delays in arranging BSL interpreters. For both the admissions an incident was logged on Datix to reflect the delays in getting an interpreter and the impact this had on the patient's safety and wellbeing. The Safeguarding team are aware of this case and are undertaking a deep dive into what improvements need to made.

2.5 There are some similar issues for people with little or no hearing who have acquired hearing loss, however as they grew up using spoken and written English, the barriers relate to spoken communication more than written communication. The trust offers deaf awareness sessions for staff, hearing loops are available on all wards and in all departments, however communication for people with no hearing is a barrier as they are unable to telephone us and most services do not have an email address that patients can use. There are some exceptions, such as Audiology and Oncology which do offer patients a contact email. 1 in 5 adults in the UK have hearing loss that is substantial enough to impact on their daily lives. This figure is projected to be 1 in 3 adults by 2030.

3. A Deaf patient's story

3.1 The Patient Voice and Involvement team were emailed on the morning of 5 June 2023 by KCC Sensory Services to advise that a person (GL) who is profoundly Deaf and uses BSL to communicate had been admitted in to WHH on the Bank Holiday Monday. KCC were due to visit him in hospital later that day to check on his well-being and ensure that his communication needs and wishes were being met.

3.2 We were advised that GL had complex health issues and would need to have an operation. GL also had sight issues as well as deafness. KCC advised that an informed discussion needed to happen with facilitated sign language support immediately to ensure full information and understanding is in place regarding risk, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), the care plan, consent, mental capacity etc. GL and their partner lived in a social care setting that was appropriate to their cultural, communication and health needs. The Trust was asked to liaise with appropriate health professionals (consultants, surgeons, care manager etc) about GL's needs for communication support at all meetings and consultations. We escalated this request to the then Director of Nursing at WHH and the Deputy Chief Nursing Officer.

3.3 KCC Sensory Services' Assessment and Enablement worker visited GL on the afternoon of 5 June. They emailed after the visit to raise their concerns that GL had received no interpreting support since admission. The consultant had written things down for GL and GL had signed a consent form. GL has not retained or understood any information regarding risks and complications with this procedure. He did not recall a conversation having taken place. In addition, the KCC Assessment and Enablement worker's colleague was concerned about this because GL has sight difficulties as well as limited English skills, and therefore may not have fully understood the written communication to give his consent and what the impact would be on their mobility after the surgery. The Assessment and Enablement worker confirmed that DNACPR, advance care planning, future care had not been discussed with GL. This was confirmed with the doctor who was on the ward that day.

3.4 At the visit by KCC Sensory Services they were advised that the current plan was for GL to continue antibiotics. There would then be a scan in preparation for their operation the following week. GL and the ward staff confirmed they were happy to

engage in a meeting with an interpreter to further discuss GL's care. The doctor and nurse told KCC that many things haven't been discussed with GL as they were not able to communicate and were often guessing GL's basic needs.

3.5 The KCC Assessment and Enablement worker then made some paper flash cards for GL and the staff to use in the interim. It seemed the ward had not used the Hospital Communication Book. They also noted that GL had not been given a large print menu to choose their food. Staff were unsure if this was available. GL had asked the KCC Assessment and Enablement worker to explain why they were so ill. The KCC Assessment and Enablement worker relayed information given by GL's nurse - HB level low 76 - blood transfusion given. Blood glucose level very low at 1.2. GL appreciated this information and said they felt much better knowing this.

3.6 The following day, 6 June, the Director of Nursing at WHH emailed to confirm this patient's case had been picked up and there was an interpreter coming later that day. The ward staff would then assess to see if a capacity assessment is required and if any safeguarding issues need investigating. In response to this email KCC Sensory Services stated they understood that the Trust would be talking to the safeguarding lead regarding the well-being of GL.

3.7 KCC asked the Trust to ensure that we involved Sensory Services and the care facility where GL lives, to provide support to GL and to all hospital staff and to ensure the Trust booked a BSL interpreter to facilitate communication between all those involved and GL in any discussions and any actions/decisions made.

3.8 The ward's Surgical Matron responded to confirm that the ward had booked an interpreter via another provider as the Trust's contracted provider was unable to accept a booking with less than two weeks' notice. The interpreter would support a conversation between the orthopaedic team and GL the following morning. The Matron had also contacted GL's care facility, who would be advising their senior team. KCC's Assessment and Enablement Worker confirmed they would attend this meeting.

3.9 The ward nurse emailed KCC Sensory Services on 9 June to confirm the meeting had gone well that morning. It was attended by the named nurse, two doctors, KCC's Assessment and Enablement worker and the BSL interpreter. The nurse said that the plan had been clearly explained to GL and they were happy to commence therapy, which had been commenced that afternoon and to continue with IV antibiotics and bloods on to monitor. The BSL interpreter reiterated that it is essential for interpreters to be present for management decisions so GL can have a full understanding and be able to take informed decisions. The nurse stated that GL was very happy with the discussion. The ward had booked a BSL interpreter for 1 hour every day until Friday 16/06/23 and for 2 hours on Tuesday 13/06 as they were hoping for a Tissue Viability Nurse to review the therapy whilst a BSL interpreter was present. The interpreting provider advised they would extend all bookings to two hours as it made no difference to the cost (BSL interpreting has a minimum of a two- hour booking).

3.10 In conclusion, whilst the ward had tried to do what was in the best interest for GL, there were initially safeguarding concerns as there were missed opportunities to communicate with GL effectively. It transpired that no BSL interpreter had been provided at GL's pre-assessment appointment. KCC Sensory Services had raised their concerns about this.

3.11 Although the KCC Assessment and Enablement worker was able to communicate with GL, they were not allowed to be used as an interpreter as they are not level 6 BSL trained (medical). As soon as the ward were made aware of this, they contacted

the Trust's contracted Interpreting provider and spoke to one of their representatives who stated that to get a BSL interpreter they would need 2 weeks' notice.

3.12 Due to the lack of effective communication the ward sought further advice from KCC Sensory Services who stated it was the Trust's duty to ensure that the correct method of BSL interpreting was put in place urgently. KCC provided several options for BSL interpreting providers the ward could use. A local BSL Interpreting provider was able to provide the ward with an interpreter the next day and the ward noted the positive change in GL's mood and engagement with the team. GL was less withdrawn and engaged more with all the ward team. The ward found that the local BSL interpreting provider understood the importance of providing the same interpreter as far as possible, in order to support continuity in care and developing a therapeutic working relationship with GL.

3.13 The ward had a discussion with the Safeguarding team and they noted that the ward had rectified any initial concerns, therefore they would be there to support the ward if needed. Subsequently there were no further safeguarding concerns whilst GL was an in-patient at WHH.

4. Interpreting Services

4.1 The Trust has a contract in place for the provision of interpreting service, including non-spoken. This includes BSL, Sign Supported English (SSE), Deaf/Blind interpreting and Makaton. This contract has been in place since June 2022, and the Trust has worked with the provider around the fulfilment rate for bookings for face to face BSL interpreting. However, the national shortage of BSL interpreters and our providers requirement for booking two weeks ahead impacts on our ability to get an interpreter, in particular for unplanned episodes of care.

4.2 The Trust does have a BSL video interpreting service which is available on demand from 8am to 8pm, but this is not always appropriate, especially for patients when we require them to make important decisions or consent to treatment, or when they have additional communication needs, related to a sight impairment or a learning disability.

5. Actions taken

5.1 The Trust has an alternative provider for BSL interpreting to be used on a case by case basis. The Trust has made it easier for staff to access the on demand BSL video service through an icon on the smart desktop. Deaf patients can also access the service free of charge to contact the five hospital sites or our Patient Advice and Liaison Service (PALS) team. We've updated the layout of the page following feedback from local Deaf people, and there is now a BSL video explaining how to use the service at the top of the page, and instructions in plain language. The page can be viewed using this link:
https://www.ekhuft.nhs.uk/information-for-patients/hospital-accessibility/interpreter-services/video-sign-language-interpreter-service/

5.2 We have updated our Accessible Information Stand (AIS) Staff Handbook and included updated information on how staff can book interpreters and use the BSL video interpreting on demand service.

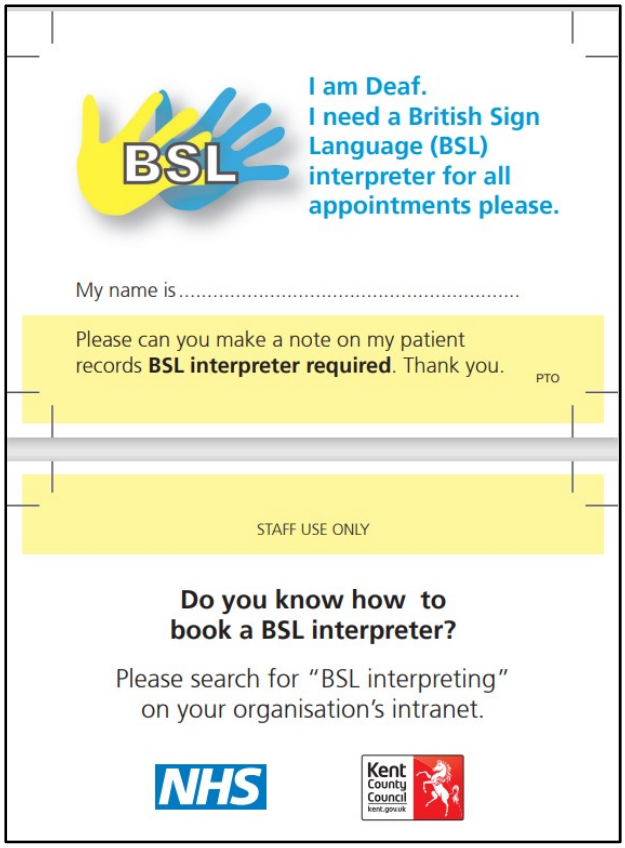
5.3 We held two online sessions in march 2023 for our staff, delivered by KCC Sensory Services Deaf community worker, about Deaf people and the Deaf BSL community, which helped raise staff awareness that BSL is a language in its own right, structured very differently to spoken English, and that simply writing things down or expecting

people to lip-read is not suitable for most Deaf people. It also highlighted the significant health inequalities experienced by Deaf people.

5.4 The Patient Voice and Involvement team has worked with the IT team to update the Accessible Information Standard (AIS) codes on Patient Administration System (PAS) / Sunrise, our electronic patient record system, so that they match the national SNOMED AIS codes. Our staff can now use the correct codes to record, flag, share and meet our patients' communication needs.

5.5 The IT team has added options on the Patient Portal for patients to state their preferred format for appointment letters, including Braille, Large Print, Easy Read and Electronic (by email). The Patient Portal is currently linked to some of our services, but over time will be rolled out widely.

5.6 We have reprinted the BSL card that Deaf people can use to show to staff, which indicates they need a BSL interpreter and how staff can arrange this. We are distributing this card via the local Deaf Together groups.



6. Action planned for the next three to 12 months

6.1 The Patient Voice and Involvement team has worked with the IT team on the next phase of the Patient Portal, which will include options for patients to add their communication needs for when they attend appointments. These updates will then link to their electronic patient record at East Kent Hospitals. This will go live in the next few months.

6.2 The Director of Nursing at QEQM, who manages the Interpreting Contract, is reviewing options for an enhanced BSL video on demand service that will be available 24/7, every day of the year. The current provision is only 8am to 8pm. In addition, the Head of Patient Voice and Involvement is talking to other NHS trusts in Kent and Medway to plan a joined-up approach for BSL video interpreting that will help patients moving between the acute, community and mental health trusts. This is in the early stages of development and subject to current contractual arrangements which run to different timescales at each trust.

6.3 The Trust is currently procuring a new video appointment software system. We have asked for this to include an option for closed captions, however there are some risks related to automated sub-titles in terms of accuracy and information governance. NHS England's Accessible Information Standard team are aware of this, however there is not a simple solution. We can however arrange speech to text reporting for patients unable to hear but who are able to read English.

6.4 The Trust has been asked to get involved in NHS England's pilot of an Accessible Information Standard self-assessment framework. We are meeting with NHS England colleagues later in September to discuss this. The timeline for this work has not yet been confirmed, however it will enable us to assess where we are and identify further actions needed.

7. Conclusion

7.1 The experiences shared give important insight to the barriers Deaf people face in getting healthcare, being involved in decisions about their care and treatment and to being safe in our care. Our engagement with the Deaf community has highlighted that very few people use the NHS App and digital exclusion is a significant issue for many Deaf people. In addition, they are far less likely to give us feedback through the Friends and Family Test (FFT) survey or complaints as these methods are not accessible to many Deaf people. It is therefore important that we continue to proactively engage with the local Deaf community to get their feedback in order to reduce the barriers they experience and give them equity of access, experience and outcomes.

7.2 The improvements we've made to date and the planned changes will provide some assurance to the Board, and our patients, their families and communities. However, the experience of care provided to patients is primarily in the hands of the medical, nursing and support staff in Urgent and Emergency Care and on the wards. Therefore, improving access, experience and outcomes for Deaf patients and their families has to become everyone's business from ward to Board.

7.3 We cannot undo what happened to the Deaf people who relied on us for their care. But we must do everything we can to ensure we learn from their experiences and do everything we can to make sure it does not happen to others.

8. Recommendations

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

- Our systems and processes support Deaf people to get safe and timely care.
- The Trust secures provision of a reliable face to face BSL interpreting service.

- The Trust improves staff awareness of the communication needs of Deaf patients and their families and how meeting these needs is a vital element of patients giving informed consent to treatment and understanding any risks.
- The Trust works with our partners in East Kent, including GPs, Kent Community, Kent County Council and the wider ICB to create a co-ordinated approach to interpreting provision for Deaf people, in order to ensure their safety and involvement in their healthcare and to reduce the health inequalities they experience.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Chairman's Report**

Meeting date: **7 September 2023**

Board sponsor: **Chairman**

Paper Author: **Chairman**

Appendices:

Appendix 1 – Non-Executive Director Commitments

Executive summary:

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

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	N/A

East Kent Hospitals University NHS Foundation Trust

Link to the Corporate Risk Register (CRR):	N/A
Resource:	No
Legal and regulatory:	No
Subsidiary:	No

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

CHAIRMAN'S REPORT

1. Purpose of the report

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

2. Introduction

The lessons to be learned from the crimes committed by the nurse Lucy Letby, will doubtless emerge from the judge-led public enquiry. Nevertheless, even at this stage, the tragedy at the Countess of Chester Hospital is a stark reminder of the importance of, and need for, strong, effective clinical governance together with systems and a culture which support staff in raising concerns. Thankfully, health professionals who turn out to be killers are exceptionally rare, but we work in a safety critical industry where constant vigilance and willingness to learn from each other is essential.

At this Trust we know we have a lot to learn and more to do in this area. The Reading Signals report was our wake-up call but I believe we have begun our journey to transform the culture of this organisation. The newly implemented Culture and Leadership Programme developed by Professor Michael West and others is just one of a number of measures which will help us bring this about. Last week, I was given the opportunity to be interviewed by staff who had volunteered as part of this programme. Although they were interviewing me, their depth of understanding and commitment to bring about change was so uplifting.

The decision at the Board's Development Day in August to work with our staff and our partners to create a new medium to long term strategy for the Trust will be another key part of this transformation programme – absolutely central to this will be staff involvement and engagement in shaping not just the strategy but the vision and values which underpin it.

The development session was an opportunity for the Board, which is still forming, to take time to tackle key issues together. The session covered Maternity Transformation, Equality and Diversity, Clinical Risk, as well as that vital session on our long-term strategy. The future of our Trust depends on the decisions we make today, and as such, we must set ourselves up for success with a clear timeline of what we want to achieve over the coming months, and years.

In addition to those areas, we considered the Trust's financial, and operational, pressures. As Tracey says in her report for this meeting, the Trust has a current year to date deficit of £39m, against a planned target of £30.6m. The external pressure on all Trusts at the moment are very considerable and well documented but we must do better to get control of our spending. The executive team continues to work on control measures including further scrutiny of budgets and controls within Care Groups, but we need to demonstrate we have a grip on this and do much better in the remainder of this financial year.

Alongside this financial pressure, we continue to experience considerable operational pressures across our hospitals. I am glad to say that we have focused on Urgent and Emergency Care, including of course the opening of the new facilities in Ashford and Margate. Work has also continued on managing demand at our front door, with shorter ambulance handovers, and reduced (but still excessive) waiting times in our Emergency Departments. At the same time,

the flow of patients through our hospitals and out into the community remains one of, if not the most, significant challenge we face.

Health and care services continue to struggle to meet demand across east Kent, and as we move into Winter, it will be essential that we work alongside colleagues across the system – we cannot tackle this problem alone.

3. East Kent Health and Care Partnership (H&CP) Board

The East Kent Health and Care Partnership (H&CP) Board which I chair met on the 2 August 2023. The Board agenda and reports show the commitment among the partners to working together and I believe they demonstrate the progress that has been made over the last few months across east Kent. Both Tracey and I believe the partnership will be vital in changing the way services are co-ordinated across our patch and as such we must do everything we can to support, and engage with everyone involved.

NHS Kent and Medway (the Integrated Care Board) has acknowledged the strong engagement and widening development of partnership alongside good clinical engagement in helping to develop safe and effective services.

The Health and Care Delivery Committee of the Partnership provided an update on the development of integrated neighbourhood teams which will form a solid base for joint working within our communities. The aim is to develop a new vision for integrating primary care, improving access, experience and outcomes. Five early adopter proposals are being taken forward using population health data. These will form the blueprint for local integrated working across the whole of east Kent.

The Partnership Board also received an update on the Urgent and Emergency Care work across the patch. The programme focuses on tackling the high demand for acute front door services, and our partners across east Kent are working together on a single improvement programme, to make sure people are able to access the right care at the right time. I am glad to say there is emerging evidence that this coordination of effort is starting to have an effect but we will have to monitor closely how we all manage as Winter approaches.

The Wellbeing and Health Improvement Partnership which is part of the East Kent Partnership provided an update on its seven health inequalities programmes, three of which are progressing well with the rest still under development:

- The homelessness service moving from 2 days a week to 5 from September 2023.
- An implementation plan has been agreed to fund cost of living support and housing delays.
- All three Pillars of work for the Farrow Court Project are progressing well, the focus being on measuring outcomes data around discharge and ensuring parity for those patients with mental health issues.
- The mobile food services benefiting hard to reach communities, delivered in partnership by Folkestone and Hythe District Council and The Rainbow Centre; the funding received has

made it possible to purchase a mobile van to reach communities that cannot easily access existing food banks.

- The partnership is working with the Voluntary, Community and Social Enterprise sector, to plan engagement sessions with the public on the Kent wide Social Prescribing Strategy.

The report from the Voluntary, Community and Social Enterprise Sector Alliance also showed how they are supporting the health and wellbeing of local communities. As with all parts of the health and care sector though they are facing high demand for their services and in addition they face major cuts in their budgets and challenges in recruiting and retaining both staff and volunteers.

4. Council of Governors (CoG)

Since my last report, joint site visits between our Non-Executive Directors and Governors have taken place at Margate and Ashford with a focus on Maternity, and Emergency care. Both visits were positive, and the reports will go to the Council of Governors.

Governors also participated in the volunteer summer tea's at WHH, QEQM which provided an opportunity to showcase the fantastic work of our volunteers in supporting patients and our hospital sites.

Across September we will be holding Membership enrolment days at our main hospital sites in Margate, Ashford and Canterbury. These will provide an opportunity for patients and families who are not members to meet our Governors, understand the work they do, and how they can become a member of the Foundation Trust.

East Kent Hospitals University NHS Foundation Trust

Appendix 1 – Non-Executive Director (NED) Commitments

NEDs July and August 2023 commitments have included:

Non-Executive Directors	Meetings with Chairman Meetings with Executive Directors Extra-ordinary Closed Board of Directors (BoD) meeting BoD Strategy Development Day Finance and Performance Committee (FPC) meeting Quality and Safety Committee (Q&SC) meeting People and Culture Committee (P&CC) meeting Extra-ordinary Integrated Audit and Governance Committee (IAGC) meeting IAGC meeting Nominations and Remuneration Committee (NRC) meeting Clinical Ethics Committee (CEC) meeting Reading the Signals Oversight Group meeting Maternity and Neonatal Assurance Group (MNAG) meeting CoG meeting CoG NRC meeting Governor and NED Joint Site Visit (Maternity at Queen Elizabeth the Queen Mother Hospital) Governor Liaison meeting Spencer Private Hospitals (SPH) Board meeting SPH Audit Committee meeting Strategy Development Interviews Culture and Leadership Programme Interviews NHS Kent & Medway NEDs Forum (Black, Asian and Minority Ethnic (BAME)) Kent & Medway Audit Committee Chairs' meeting

We care

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **7 September 2023**

Board sponsor: **Chief Executive**

Paper Author: **Chief Executive**

Appendices:

NONE

Executive summary:

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

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the 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)

At the meeting on 16 August 2023, the CEMG approved the Ziopatch Business Case to develop a sustainable and timely service model for the delivery of 7-day electrocardiogram (ECG) Monitoring, as piloted in 2021/22.

The Group also provided support to a bid for external funding from the Kent and Medway Cancer Alliance and Macmillan to recruit 18 additional posts, to ensure the Trust meets the National NHS Priorities for 2023/24, while providing significant improvements for patients and additional activity and income.

4. Operations update

4.1 Urgent & Emergency Care Performance (UEC)

The Emergency Care Delivery Group (ECDG) continues to focus on delivery of the clinical models that support the underpinning principle; right patients, right place, first time.

The ECDG workstreams focus on the development of the front door models, with the Queen Elizabeth the Queen Mother Hospital (QEQM) establishing the Medical Assessment Unit (MAU) and short stay function for medical referred patients. This involves planning with clinical leads to ensure the out of hours (OOH) cover arrangements support the MAU function to optimise utilisation, while planning for the Emergency Department (ED) Observation unit to convert to a dedicated ED Clinical Decision Unit is on track for September 2023.

The William Harvey Hospital (WHH) ED build is planned to be complete in early October 2023. The associated plans continue, which include moving the current MAU to its new destination within the existing Acute Medical Unit (AMU), providing additional capacity to manage a higher proportion of the medical intake.

The WHH team have established Paediatric Direct Access Pathways with the Women, Children and Young People Care Group (WCYP CG) with similar pathways to be introduced at the QEQM, subject to agreement. The plan to introduce a Clinical Decision Unit (CDU) at the WHH remains subject to the completion of the ED build and the clinical model sign off.

Training for the Doctor Initial Assessment (DIA) model that is in place at the WHH to be replicated at the QEQM commences August which includes approved clinical

pathways to the new CDU opening September. Work progresses with the UEC team for final sign off at the September ECDG.

Same Day Emergency Care (SDEC) utilisation is increasing with July reporting the highest number of patients accessing / streamed to the services (2329 v 2163 in June) which is due to the improvements to the streaming at the front door, the increase in the number of Direct Access Pathways included together with the increase in hours of operation of the medical SDEC at QEQM and WHH.

In July the reported position for All Types of activity (type 1&3) was 74% which is the best position reported for > 18 months. The July position was above the Tier 1 trajectory for type 1 (51.3%) with the percentage of patients for a total time of 12 hours in the EDs showing improvement for July at 8.9% v 10.2% in June and the best reported position for > 12 months. July also reported a reduction In the total number of reportable 12-hour trolley waits in the ED compared to the previous months 769 v 1136 in May and 929 in June.

Ambulance handover compliance is improving for < 30 minutes with July reported 91.8% v 78.9% 12 months previous.

With the noted improvements to the front door pathways and the schemes of work in place, the Trust has been able to improve the time spent in ED for those patients requiring same day emergency care. However, the flow of patients out of the EDs to speciality wards and the number of available beds for admitted patients remains a constraint contributing to the higher number of 12-hour Trolley Waits.

4.2 Senior Review, Assessment, Flow, Early discharge, Regular review (SAFER) Principles

The Trust-wide roll-out of the national SAFER Bundle continues at the WHH in all adult acute wards and is due to complete by early October 2023. The roll-out at the QEQM will commence in September, with external support focusing on patient flow, which will be monitored through the ECDG.

4.3 Elective

The number of incomplete elective pathways, since the start of the COVID-19 pandemic, has continued to increase with significant weekly growth observed in rapid access referrals to Dermatology, Colorectal Surgery, Urology and Gynaecology since 2019.

Incomplete referrals accelerated rapidly in February 2023 and peaked to their highest volume in July 2023. Due to this pressure and the Trust's ability to reduce long waiting patients, additional oversight of the position continues, with Care Groups, where speciality growth is attributed, investigating and exploring the reason for such growth whilst working to provide more flexibly to their capacity and improve efficiencies within their services.

With the reorganisation of the Care Group structure, it is anticipated that efforts to improve elective performance and address elective activity levels, will be re-focussed, alongside addressing and containing unnecessary spend.

The establishment of clinical networks and options to introduce more innovative operational and digital solutions, to support validation and communication with our patients, are being considered and it is anticipated this will start to form a more

robust and consistent approach to tackling and delivering our ambition of improving elective performance and treating our longest waiting patients.

5. Financial performance and NHSE control measures

At the end of M4 (July) 2023 the Trust has a year to date (YTD) deficit of £39m against the planned year to date deficit of £30.6m. Two elements of the deficit are strike action (£1.1m), unfunded pay award (£0.5m) neither of which were part of the planned £72m deficit. Key drivers of the YTD position include non-delivery of recurrent efficiency savings and pay overspend including increased levels of staffing utilisation due to escalation areas, one to one care and the associated high cost of agency premium.

The Trust is embedding the control measures as set out by NHSE. As the Integrated Care Board (ICB) is financially challenged these are at three and four, the highest controls to be in place. These include workforce reviews for nursing and medical staff, the Trust has widened that scope to also include a full review for administrative posts. The Trust Executive led vacancy control panel, which has been embedded since January 2023, has widened its scope from reviewing administrative posts to also include clinical posts from 8A and above. In addition, an investment oversight panel has been set up to review non-pay spend, that would increase the run rate and has a full year effect of over £10,000 including VAT (not including drugs and clinical supplies).

The Executive team has met with all of the new Care Groups to set out the control measures in place and to review the work being undertaken within the Care Groups on efficiency delivery, workforce reviews and for a first review of the Care Groups projected forecasts. The new financial oversight framework starts in September which will help support the Care Groups to review quality & performance and workforce and finance through a series of monthly recovery and performance review meetings.

6. Care Group Organisational Restructure

The new Care Group structure was implemented with effect from 14 August 2023 following a review process and upon conclusion of the formal consultation process with staff. Formal and informal feedback received throughout the consultation process has been responded to and we will continue to listen to staff and consider their views as we move to the new ways of working that arise from these changes.

To reiterate, the Care Groups are now organised with an emphasis on pathway management predominately at either place-based care or care that operates across the Trust and for some services, the Kent & Medway sector. Each Care Group is led by an accountable Managing Director, supported by a senior leadership team and an appropriate leadership structure, including a Medical Director and Director of Nursing, or equivalent.

We have substantively appointed Managing Directors for the Women, Children and Young People, WHH and Kent and Canterbury Hospital (K&C) Care Groups, while the remaining three Care Groups (Critical Care, Anaesthetics and Specialist Surgery; Diagnostics, Cancer and Buckland; and QEQM) have interim Managing Directors in place, as we continue with the substantive recruitment process, which we hope to appoint to later this month.

Similarly, we are continuing to recruit substantively to the remaining Medical Director positions for the WHH, QEQM Care Groups and also to the Associate Medical Director position for the Women, Children and Young People Care Group.

To date the response from staff has been positive and we will now focus our attention on the second phase, which will include the establishment of clinical networks, where appropriate. We will be discussing with clinical teams as to the best way to establish these networks, whilst we will also consider necessary changes to our corporate teams and administrative functions.

7. Care Quality Commission (CQC) update

Initial feedback from the CQC 'well led' inspection held on 4 to 5 July 2023 reflected that the Trust had been candid and clear about the challenges faced and that we recognised the amount of work required to embed our improvement plans, strengthen risk and governance and to develop our long-term strategy. In August 2023, the inspectors invited clinicians to share examples of innovative practice as part of this inspection, whilst we continue to await receipt of their final report.

During the earlier inspection of the general medicine, UEC and paediatrics service in May 2023, inspectors provided feedback that staff were open and transparent and that they saw good examples of care being delivered. Following the inspection, the CQC wrote to the Trust asking formally that we provide, by mid-September, evidence of how we are managing handover arrangements in the ED; improving medical and nurse staffing, skill mix and training compliance; and have systems and processes to mitigate risk relating to the environment, premises and equipment, cleanliness and infection, prevention and control. These are areas that we are focused on improving and working hard to mitigate any potential impact on patients, whilst we await receipt of their report.

8. CQC's 2022 Urgent and Emergency Care Survey

The Trust has been identified as performing 'much worse than expected' for Type 1 (Accident & Emergency (A&E)) services in the CQC Urgent and Emergency Care Survey conducted in July 2022. This is due to the proportion of respondents who responded negatively to questions asked about their A&E care (30%), being significantly above the national average of 23%.

The Trust's bottom five scores relate to patients being able to get help from staff if they needed attention whilst in A&E, pain control, being able to discuss their fears and anxieties with staff, being given sufficient privacy when examined or treated and overall being treated with dignity and respect. The Trust scored 'much worse than expected' compared to other Trusts in 16 questions, and 'somewhat worse' or 'worse than expected' in 11 other questions, out of a total of 37.

The Trust's top five scores related to health and social care staff having information about patients visits after they left A&E, staff explaining the purpose of medications and transport arrangements and patients were able to get food and drink in A&E. Although these scores were the 'same or slightly above the average' when compared to other Trusts, there is still improvement required in each of these areas.

The ED teams at WHH and QEQM are reviewing the survey results and considering what action they need to take, whilst we will be adding additional questions to the A&E (ED) Friends and Family Test (FFT) survey to measure the lower scoring areas on a more frequent basis.

As you will be aware, the Trust has also invested £30m to improve and expand our EDs at Ashford and Margate, which will include new children's EDs, new treatment areas for adults, dedicated areas for patients with mental health needs and extensive renovations within the existing departments, all of which it is hoped will improve the Trust's A&E position and the care received by patients.

9. Suspension of Postgraduate Dental Training

The Oral and Maxillofacial Surgery Department has been subject to two quality reviews from Health Education England (HEE), Kent, Surrey and Sussex (now NHS England Workforce, Training and Education, Kent, Surrey and Sussex (NHSE WTE KSS)). In the Maxillofacial Team, the postgraduate training doctor post has been suspended, as have the six dental core trainee posts. This does not affect any individuals as there are no trainees currently in post.

In the main, the concerns relate to the culture and learning environment within the department, which has also been evidenced by the Freedom to Speak Up Guardian Team. This is being addressed by the whole team attending the Royal College of Surgeons in Edinburgh non-technical skills for surgeons course in July and they will also be undertaking Civility Saves Lives training.

Other concerns relate to the quality of induction, which is being improved and the lack of an appropriate middle-tier on-call rota, which is now almost completely recruited to.

The Trust is required to evidence action against all requirements and an action plan is in place. The department is using locally employed doctors and locums known to the department to cover all seven posts.

10. Governors Quality Accounts

During the submission of the 2022/23 Quality Accounts, the Council of Governors identified some important omissions. The Trust is committed to addressing the following key areas to ensure that sustained progress is achieved and reported in next year's Accounts:

- Learning Disability, Autism and Neurodiversity.
- Maternity, Culture and lack of staff engagement.
- People & Culture, poor compliance with appraisals and supervision.
- Emergency Department, ensuring that we will achieve the level of benefits that we had planned as some were as a result of the issues within the emergency care pathways.
- Staffing and Engagement, oversees staff issues with accommodation and embedding of health and safety standards and practices.

11. National Joint Registry (NJR) Data Quality Awards – K&C

K&C has been awarded as an NJR Quality Data Provider for 2022/23 recognising the Trust's work to promote patient safety standards through compliance with the mandatory NJR data submission and quality audit processes.

To gain Quality Data Provider (QDP) status for 2022/23, hospitals were required to meet targets for best practice, increase engagement and awareness of the importance of quality data collection and embed the ethos that thorough and accurate data enables the NJR to improve patient outcomes for hip, knee, ankle, elbow and shoulder joint replacement operations.

12. NHS Pastoral Care Quality Award

The Trust has been awarded the NHS Pastoral Care Quality Award recognising work in international recruitment and our commitment to providing high-quality care to internationally educated nurses and midwives during the recruitment process and throughout their employment.

13. Workforce Development, Education and Training - East Kent College Student and Employer Awards

The Trust's Workforce Development Education and Training (WDET) team have been awarded the Outstanding Employers Award 2023 by East Kent College, recognising the development of T level placements for students on the Healthcare T level programme, who are an important part of our future workforce.

These awards are a testament to the WDET teams work to support students and their commitment to embedding all aspects of student training and recruitment across the Trust.

14. Conclusion

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

East Kent Hospitals University NHS Foundation Trust

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

Committee: **Nominations and Remuneration Committee (NRC)**

Meeting date: **11 July 2023**

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

Paper Author: **Board Support Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

No new interests declared

Assurances received at the Committee meeting:

Agenda item	Summary
NRC Decisions outside the Committee	The Committee ratified the decisions taken outside the NRC business cycle and approval of the: • Appointment of Michelle Stevens as Interim Chief Finance Officer (CFO) for at least six to twelve months before re-advertising the position. • Appointment and salary of Ben Stevens as Director of Strategic Development and Partnerships (DSDP). • Appointment and salary of Sarah Hayes as CNMO. • Proposed recruitment process to replace the Chief Medical Officer (CMO).
Executive Directors' End of Year Appraisals and Objective Setting 2023/24	• The Committee received and discussed an appraisal summary report that provided limited assurance, feedback was provided on the Executive Team objectives. • Feedback included the need for a finance objective for each Executive Director, reflecting finance was a collective issue, to have clear objectives for the individual Executive Directors in respect of the Integrated Improvement Plan (IIP), Pillars of Change, and Culture and Leadership Programme (CLP), as well as operational standard targets measurable against outcomes, and the link to 2gether Support Solutions. • As part of the mid-year review all Executive Director objectives to be strengthened and Specific, Measurable, Achievable, Realistic and Time-Bound (SMART) against planned trajectories providing assurance around improvements, as well as showing the vision to take the organisation forward.

Update: Interim Executive Appointments/Substantive Recruitment	• The Committee received a verbal report providing an update and assurance on the current position with recruitment: • Sarah Hayes, substantive CNMO due to start with the Trust on 8 September 2023. • CMO role out to advertisement and interviews scheduled to be held on 4 September 2023. • Michelle Stevens, Interim CFO, for a 12 months interim period.
Succession Planning Update	• The Committee received and discussed an update report on succession planning providing assurance around the process, its effectiveness and sustainability. • The recent appointments to Executive Director roles and the organisational restructure were reflected. • The National framework was expected to be finalised by the end of the year. • The People and Culture team would be working with the appointed leadership to ensure alignment with the framework, and that discussions were taking place with staff around succession planning and developing leaders for the future. • The Committee received assurance that equality, diversity and inclusion (EDI) was being considered as part of the appointments process. • The Committee noted the need to have a range of strengths, leadership skills and personalities creating a diverse leadership team. • The Committee emphasised the importance of the Safeguarding Lead role that was being covered by an Interim and the need to recruit substantively to this role.
Board Self-Assessment	• The Committee received assurance from the proposed Board self-assessment questionnaire and provided input for additional questions, including feedback on the effectiveness of Board Committees, and Board members skills. • The revised questionnaire to be circulated to Board members for completion and a report presented on the outcome and feedback received.
Extension to Non-Executive Director (NED) Contract – Spencer Private Hospitals (SPH)	• The Committee received assurance from the recommendation of SPH's NRC to extend the SPH NED/Senior Independent Director (SID) and Chair of the SPH Audit Committee's contract. • The Committee noted the SPH NED had been in post for seven years, their extensive knowledge, expertise and background, that had provided continuity, and an annual appraisal and Board competency assessment had been undertaken. • The Committee noted best practice and the NHS Constitution allowing a one-year extension on an exceptional basis.

	• The Committee agreed a one year extension on the existing salary, and that SPH's NRC/Board actively recruit a replacement to ensure it was in a position to appoint a replacement at the end of the extended period acknowledging the need for a refresh of SPH's Board.
NEDs term of office for renewal – Spring 2024	• The Committee discussed the term of office due to end in Spring 2024 for four NEDs and received assurance the Trust Chairman would have discussions with the individual NEDs. • An update will be provided at the next Committee meeting about whether individuals wished to be considered to extend their term of office tenure. It was noted any extensions required approval by the Council of Governors (CoG).
Chief Executive – End of Year Review and 2023/24 Objectives	• The Committee received, discussed and agreed the 2023/24 Chief Executive objectives. • The Committee received assurance from the objectives presented and provided feedback on additional focussed elements to provide an overview of finances, long term strategy, Integrated Improvement Plan (IIP), and Culture and Leadership Programme (CLP). • The Committee acknowledged the Chief Executive's commitment, hard work, achievements and progress to date and also the continued challenges and pressures. • The Committee noted the recruitment of a substantive Executive team and the importance of strong leadership showing vision and enthusiasm to aspiring new and upcoming leaders within the new structure to support and shape the organisation. It was noted the significant challenges and improvement work that remained to be achieved.

Other items of business

- The Committee noted the 2023 Annual NRC Work Programme that will be reviewed by the NRC Chair and Chief People Officer (CPO).
- The Committee noted the Board Register of Interests.

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

Item	Purpose	Date
The Committee asks the BoD to receive and note this assurance report.	Assurance	To Board on 7 September 2023

East Kent Hospitals University NHS Foundation Trust

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

Committee: **People and Culture Committee (P&CC)**

Meeting date: **30 August 2023**

Chair: **Stewart Baird, Non-Executive Director**

Paper Author: **Interim Group Company Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

No

Assurances received at the Committee meeting:

Agenda item	Summary
July 2023 Integrated Performance Report (IPR) 'We Care' and 'True North' Objectives	Significant key points for the Board to **note:** • **ASSURED: Sickness** Sickness absence increased to 4.9% in July 2023, but remained just below the threshold of 5%. It was noted that mental health issues now accounted for 12% of all reasons for absence, which had been c.6% in January 2023. The Trust was working on establishing an in-house a psychological support service (previously provided by NHS England (NHSE)). The three national wellbeing awards for which the Trust had been nominated, were highlighted. • **ASSURED: Staff Turnover** Staff turnover remained below the nationally desired standard (10%) at 9.50%, which had been the case for seven consecutive months. This was primarily driven by wider improvements in Healthcare Support Worker (HCSW), nurse and premature retention. • **ASSURED: Vacancy Rate** The overall vacancy rate had improved for the seventh month in succession, falling from 9.8% in December to 7.2% in July. The Trust had now remained below the alerting threshold of 10% for nine months. • **ASSURED: Statutory & Mandatory Training** Statutory training compliance remained stable and was above the threshold of 91% at 91.2%. This continued to be an important 'watch' at monthly Care

	Group Performance Review Meetings, and would be closely monitored to ensure compliance improved. Low compliance across the Medical & Dental workforce continued to negatively affect overall compliance, although there had been an increase (74% in July 2023). • **PARTIALLY ASSURED**: **Staff Engagement and Staff Involvement** Staff Engagement levels had improved by seven points quarter-on-quarter, with equitable improvements across each of the three engagement domains. The overall score of 6.27 represented improved performance, moving towards the national average of 6.50. Staff Involvement levels had improved by six points quarter-on-quarter, and by eleven points across the last six months (to 6.29). Model Health data indicated that staff Involvement (6.3) had moved from being an outlier and was now on a par with partners across the system/Integrated Care Board (ICB) (6.3), Trusts of an equivalent size/clinical output (6.3) and our staff survey benchmarking group (made up of 128 Trusts across the country). • **NOT ASSURED: Premium Pay** In July 2023, premium pay increased by £0.2m and remained high. A premium pay dashboard was now 'live', giving timely information which would be used to target areas of high premium pay usage. • **NOT ASSURED: Appraisals** Overall appraisal compliance inflected sharply upwards to 72.4% (from 66.8%) following a recent 'amnesty' of information which resulted in 350 additional appraisals being added to Electronic Staff Record (ESR). The metric remained below the reviewed alerting threshold of 80% and work was ongoing to identify areas where support was needed for updated ESR training, or where compliance was low.
Vacancy and Recruitment Update – Pipeline Against Establishment to Include Medical Vacancies Review	The Committee was **PARTIALLY ASSURED** in respect of the Vacancy and Recruitment Pipeline against Establishment to Include Medical Vacancies Review. Points of **note** were as follows:- • both band 5 Registered Nurse (RN) and HCSWs were above predicted vacancy targets, with the lowest vacancies rate within twelve months; • RN was currently at 9.3% and HCSWs at 7.82%; • consultant 'hard to fill' posts remained a challenge, with a small decrease in the vacancy rate for the top seven hard to recruit areas falling from 21.5% to 20.8%. Seven new consultants were appointed in July 2023; • the Band 6 Midwifery gap had increased, as a result of some internal promotions;

	• there were thirteen IEMs currently undertaking Objective Structured Clinical Examinations (OSCE) to be signed off and to become Band 6 midwives.
Cultural Development & HR Programme	The Committee was **ASSURED** in respect of the Cultural Development & HR Programme. There were a number of key priority areas of focus that were currently being managed by the team: **1.1** Integrated Improvement Plan, supporting the Trust to demonstrate progress on 'People' to NHSE and the progressive work being carried out to meet the exit criteria. Monthly highlight reports were created detailing progress made and next steps along with associated risks to be highlighted to the programme board. Over the past month, a number of milestones had turned blue, demonstrating both achievement of the milestone and provision of evidence to NHSE. The ongoing aims and objectives were to ensure that we continued to embed these actions into business as usual and continued to progress, and better, the achievements made; **1.2** the Recruitment strategy finalised and would be presented to People and Culture Committee in September 2023; **1.3** Leadership Development programmes (3 levels) had been launched and there had been a good uptake for current and future cohorts; this, alongside the development of the behaviour framework, supported colleagues and leaders in understanding expectations and future development; **1.4** the Medical Programme Plan continued to develop, and a Project Initiation Document (PID) had been developed for medical rostering and was being reviewed by the Interim Chief Medical Officer. Milestones under hard to recruit roles, through both social media/advertising, medical rostering and LOOP implementation continued to progress and were being reviewed monthly. **2. Next steps** **2.1** An updated version of the Strategy was currently in the final stages of editing, linked to the updated NHS Plan and updated Trust Improvement Strategy, and was in a fully accessible format.
'Hot Items'	The Committee was **ASSURED** by the 'Hot Items'. Key points were as follows: • The Chief People Officer advised the Committee of the strike action by consultants which had ensued this month, and the need to recognise there may be further action to come. There had been positive engagement with the Local Negotiating Committee (LNC) and these good relations and dialogue continued, with a renewing of this relationship noted.

	• The Chief People Officer advised on the restructure of the organisation and that Care Groups were in place. Not all posts had been filled, but the majority had; interim arrangements had been made for vacant roles. • The Chief People Officer reinforced that the Board had been asked for Equality, Diversity and Inclusion (EDI) objectives set for individuals but also collectively; this was also being discussed in the wider system. • In addition, the Chief People Officer advised of the Deputy Chief People Officer's departure from the Trust, to undertake a new role at King's College Hospital.
Accommodation Strategy	This item had been deferred to the September 2023 session.
Freedom to Speak Up Guardian's (FTSU) Report – Quarter 1	The Committee was **ASSURED** in respect of the Freedom to Speak Up Guardian's (FTSU) Report – Quarter 1. Key points of **note** included: • the FTSU Team continued to see a steady rise in the number of matters raised with them. The majority of matters raised had an element of worker safety or wellbeing in them; • two Deputy FTSU Guardians had settled in to post and were demonstrating capacity to support the workforce. The roll-out of mandated e-learning modules was being supported by face-to-face training sessions, workshops and forums; • there was evidence to support the positive impact the team were able to make on workers' understanding of FTSU when they received dedicated input on the subject; • future focus would be on understanding the effectiveness of the Trust's speaking up arrangements in response to the low scores in the National Staff Survey (NSS) around the confidence worker and to measure the number of workforce now actively aware and engaged with the FTSU team.
Board Assurance Framework (BAF) and Principal Mitigated People and Culture Risks (CRR)	The Committee was **ASSURED** in respect of the BAF and Corporate Risk Register (CRR) risks. Key highlights were as follows: • two BAF risks and 6 risks on the CRR relating to 'Our People'. Changes to the CRR during this reporting period: • three risks approved for a decrease in risk rating and one risk approved for closure at the Clinical Executive Management Group (CEMG) on 5 July 2023 and one risk approved for addition at the CEMG on 2 August 2023.

	New risk for addition: • **CRR 151** – Failure to comply with appraisal completion and local oversight, personal development and performance. Reduction in risk rating: • **CRR 116** - There is a risk of inadequate nursing staffing levels and skills mix to meet patients' needs; • **CRR 122** - There is a risk of inadequate midwifery staffing levels and skills mix to meet the needs of women and their families; • **CRR 118** - There is risk of failure to address poor organisational culture. Closure from CRR: • **CRR 88** - There is a risk of failure to support staff health and wellbeing. This risk was primarily added during the pandemic and as such had now run its course.
Apprenticeship Service Overview	The Committee was **ASSURED** by the Apprenticeship Service Overview. Key points of **note** included: • a 21.8% increase in Apprenticeship Enrolments over the past six months, which was positive, but with a resulting increase in levy declarations and expiration. By September the Trust would be expiring £248,385,00 and as a result, the issue had been placed on to the Risk Register; • the first five Health T-Level placements had now been successfully completed, with further work being carried out to introduce more placements across the Trust. The Trust had been recognised regionally as an award winner with the local provider, and nationally by the Department for Education, as an employer being involved in the first T- Level Healthcare placements.
EDI Policies	The Committee **APPROVED** both the EDI Policy in respect of Workforce and the EDI Policy for Patient, Carers & Relatives.

Other Items of Business

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

There were no items referred to the BoD or another Committee for approval, decision or action.

East Kent Hospitals University NHS Foundation Trust

The Committee asks the BoD to discuss and **NOTE** this P&CC Chair Assurance Report.	Assurance	7 September 2023

East Kent Hospitals University NHS Foundation Trust

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

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

Meeting date: **29 August 2023**

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

Paper Author: **Interim Group Company Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

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

In attendance: Moira Durbridge, NHS England (NHSE) Improvement Director.

Assurances received at the Committee meeting:

Agenda item	Summary
Integrated Performance Report (IPR) – We Care Breakthrough Objectives & Watch Metrics	**Partial assurance** was received by the Committee in considering a new-style Integrated Performance Report (IPR), which contained high-level metrics. The Committee accepted that the IPR was still in the process of development, and there was a need for clarity with regard to reporting constitutional standards and operational metrics. It was noted that discussion in respect of Board Committee oversight would be considered further by the Board, informed by Executive guidance. It was accepted that with regard to quality data there needed to be a balance between nursing and medical-related metrics. With regard to patient safety, discussion centred on pressure ulcers, mixed sex breaches and the turnaround on complaints and Serious Incident (SI) closures (18 currently open, with no SI breaches in Maternity). Care Group safeguarding training was highlighted as an area of improvement. The Trust compares favourably with other trusts in respect of the Friends & Family Test, but more needs to be done. The Committee welcomed the greater emphasis on accountability as part of the new IPR.
Infection Prevention and	The Committee received **partial assurance** of the current performance about nationally reportable infections noting the following:

Control IPC) Report	– arising out of recent NHSE/Integrated Care Board (ICB) independent IPC visits feedback had generally been positive in respect of the Trust's IPC protocols and procedures; – Clostridioides difficile remains a challenge for the Trust being a key area of focus for the Antimicrobial Stewardship Group; – some improvement in meeting thresholds was reported, working closely with regional colleagues; – improved surgical site infection surveillance measures were now in place; – in respect of the IPC Board Assurance Framework (BAF), the Trust was 60% currently compliant, with 40% of risks forming part of workforce plan priorities.
Care Quality Commission (CQC) Update Report	– The Committee received the latest assurance report on the activities of the Journey to Outstanding Care Programme Steering Group (JTOCPSG). The Committee noted that the Trust was required to respond to CQC in respect of the Section 29a notice by 20 September 2023.
Corporate Principal Mitigated Quality Risks	– The Committee approved proposed changes and updates to the Board Assurance Framework (BAF) and Corporate Risk Register (CRR). It was noted that the Board had reviewed its risk appetite at the Board Strategy Day in August which was included within the BAF.
Patient Safety Committee (PSC) Chair's Report	The Committee considered the assurance report on the activities of the Patient Safety Committee, with discussion on the work being undertaking in respect of the Deteriorating Patient workstream – a key priority for the Trust.
Fundamentals of Care (FoC) Chair's Report	The Committee considered an assurance report on the activities of the Fundamentals of Care Committee, the following key points being noted: - the level of engagement work with stakeholders and examples of positive feedback received; - in respect of Ward Accreditation, it was welcomed that 29 wards had been rated Gold; 21 Silver and 80 Bronze; - the Trust remained below the national average with regard to the National Impatient Survey; - a review of patient test results would be considered by the FoC Committee.
Mortality and Learning from Deaths	The Committee considered an assurance report on the activities of the Mortality Steering and Surveillance Group, it being noted that a report on specific quality metrics and SIs would be presented at a future meeting. It was noted that differentials in structured judgement reviews were being looked at across the Trust, referring to national exemplars.
Maternity and Neonatal Assurance Group	The Committee received an assurance report on the activities of the Maternity and Neonatal Assurance Group and noted the following key matters:

(MNAG) Chair's Report	– a revised improvement programme was considered at the Board Strategy Day in August 2023; – two 'Must Do' requirements in respect of staff training were being addressed as a top priority (67% of anaesthetists had currently been trained); – the regional team midwife had provided some positive feedback on the Trust's improvement plan; – a letter from the Chief Executive Officer (CEO) with contact details was provided to parents in respect of the recent Letby case.
Safeguarding Committee Assurance Report	The Committee noted the assurance report on the activities of the Safeguarding Assurance Committee and agreed that **significant assurance** was continuing to be provided. It was noted that the Risk Register was being updated in respect of Safeguarding matters.
Clinical Audit and Effectiveness Committee (CAEC) – Chair's Report	The Committee received and noted the content of the CAEC Chair's Report, issues of quoracy being highlighted. Positive feedback was received in respect of the Clinical Audit Symposium held in June 2023. It was noted that 54 National Institute for Health and Care Excellence (NICE) guidelines had been issued in recent times and assurance measures were being strengthened to ensure that guidelines were adhered to.
Clinical Ethics Committee	The Committee received a report from the Clinical Ethics Committee, noting that the Committee had recently reviewed its Terms of Reference and membership.
Endoscopy Update	The Committee noted that there was a significant backlog in respect of Endoscopy testing and capacity, largely related to staffing shortages and level of current demand. Mitigations were being put in place by the Care Group to address the immediate situation and to prioritise need against the six-week standard.
Safe Staffing and SI Review	The Interim Chief Nurse outlined how a new clinical governance reporting system would operate in future as part of the Care Group review, which would be considered in further detail by the Committee in terms of what would be escalated to QSC as the system embedded. The Committee received **partial assurance** from the Safe Staffing and SI Review.

Referrals from other Board Committees

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

The Committee asks the BoD to discuss and **NOTE** this Q&SC Chair Assurance Report.	Assurance	7 September 2023

East Kent Hospitals University NHS Foundation Trust

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

Committee: **Integrated Audit and Governance Committee (IAGC)**

Meeting date: **28 July 2023**

Chair: **Dr Olu Olasode, Non-Executive Director**

Paper Author: **Board Support Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

No additional declarations of interest made

Assurances received at the Committee meeting:

Agenda item	Summary
Internal Audit Progress Report and Internal Audit Strategy 2023 – 2026 (including Internal Audit Plan 2023/24)	• The Committee received **limited assurance** from the Internal Audit progress report and the next steps/action plans: • Three audit reports finalised since last meeting: • Risk Management – **Reasonable Assurance**. Recommendations included refining risk management strategy and risk appetite, address challenges and actions having an impact to reduce risk scores, and appropriate escalation of issues; • Safeguarding – **Reasonable Assurance**. Identification of lots of good practice and shared learning across the Trust, gaps in compliance with level 2 and 3 staff training, and the need to focus on ensuring all staff were up to date with their appropriate training; • Cyber Security - **Reasonable Assurance**. Controls identified to enhance, improve and protect the information systems network, and an internal vulnerability scanning tool. • 17 actions implemented on the Risk Management, Infection Control (IC), Job Planning and Rostering reviews. 10 actions categorised as in the process of being implemented but were overdue, relating to reviews of Spencer Private Hospitals (SPH), Financial Systems, Job Planning and IC. One IC action was high priority. 8 actions not yet become due for implementation. Actions overdue escalated to the Executive Directors. • Slow progress to improve safeguarding training rates, staff needed to be compliant and that action be taken forward to address this. Referral to Safeguarding Committee to monitor safeguarding training compliance and provide challenge that staff compliance rate needed to be improved as a matter of priority. • The overdue management action about the Antimicrobial Stewardship Group (ASG) and for action plans from each Care Group to improve

	AS to be returned to the ASG. The revised deadline of 31 March 2024 was an unacceptable delay as this was a high risk, and needed to have a much earlier deadline. The CNMO was asked to take forward and address this issue.
	
	• The Committee received **limited assurance** from the Internal Audit Strategy 2023 – 2026 and approved the Internal Audit Plan for 2023/24:
	  • Plan had been discussed with Executive Directors, included mandated work, areas of risks, and prioritised against the key elements to be undertaken.
	  • The next year's annual plan to reflect and include any areas of focus from each of the Board Committees, and discussions would be held with each of the NED Board Committee Chairs.
	  • The contents of the plan were challenged, recognising the financial challenges of the Trust, and to be considered areas where assurance was provided by other review methods, and focus on mandatory areas to give the required assurance. There will be a review around staff health and wellbeing support and if assurance could be provided by other methods.
	  • Review of Serious Incidents (SI) and Duty of Candour (DoC) areas needed to assess that learning was being embedded throughout the organisation.

Local Counter Fraud Specialist (LCFS) RSM Risk Assurance Services LLP – Progress Report and Reactive Benchmarking Report	• The Committee received **assurance** and noted the LCFS progress report, reactive benchmarking report and the detailed activity. • To monitor appropriate processes to mitigate, reporting identification of potential fraud and Trust compliance with the NHS requirements to meet Government Functional Standard 013 Counter Fraud.
External Audit Grant Thornton (GT): External Audit Progress Report and Annual Accounts 2022/23 Update	• The Committee noted a verbal update report providing **limited assurance** of progress to present unqualified 2022/23 Annual Accounts for approval for the revised submission deadline of 15 September 2023. • Finance team and GT working closely to submit unqualified accounts by the revised submission deadline that must be achieved as well as the requirement for laying before Parliament, for presentation to the Trust's Annual Members Meeting (AMM) by the end of September 2023. • Briefing paper to be produced for circulation with timeline for completion, presentation, and approval of the 2022/23 annual accounts for submission. The final version of accounts to be approved by IAGC and also the Board of Directors (BoD). • A lessons learnt review to be undertaken looking at reasons for the delay in submission, to ensure the necessary processes and procedures in place and that the deadline for the following year's annual accounts will be met. The Trust's Chairman has requested to be involved in this review and learning process.
Executive Risk Assurance Group (ERAG) Chair Reports	• The Committee received **partial assurance** from the ERAG Chair reports from the meetings held on 23 and 12 June 2023.

	• The Committee noted the focussed review, scrutiny and challenge with Care Groups of their risk registers at these meetings, and assurance of monitoring structure and review of risks by the Clinical Executive Management Group (CEMG) then Board Committees. • There will be a BoD Development Strategy Day in August to discuss and review the Trust's Risk Appetite and risk scoring process. • The new midwifery leadership and improvement work expected to have a positive impact on reducing risks within the Women's Health Care Group. Current gaps in midwifery staffing vacancies addressed by moving community midwives to provide cover in the hospital units.
Board Assurance Framework (BAF) and Corporate Risk Registers (CRR)	• The Committee received **partial assurance** from the latest BAF and CRR update report, providing an update on risk activities of the Board Committees. A total of 9 BAF risks and 29 CRR risks. • Continued work to make improvements to the BAF and CRR, risk review process, escalation process and risks being appropriately mitigated and actions were having a positive impact to reduce risk scores. As well as work in progress to refine the risk registers, update the Risk Management Strategy, tightening controls and monitoring oversight, working with staff (looking at provision of staff training) to improve risk descriptions and scores to ensure mature risks are presented in the future. • The Committee acknowledged the Trust's significant financial position and risk of achieving the financial plan that remained a significant risk. • The importance of continued ongoing robust challenge and discussions of risks, risk scores and mitigations to reduce level of risks at Board Committees, and within the Care Groups.
Review of Senior Managers' Risk Management Training Compliance – Annual Report	• The Committee received **assurance** from a verbal report that the annual risk management training compliance report deferred for presentation to IAGC at its October 2023 meeting. • This report needed to be presented through the appropriate governance process prior to presentation to the IAGC. • All Board members were requested to check their training compliance and ensure they were up to date with all their mandatory training requirements.
Risk Management and Governance: The new governance framework	• The Committee received **limited assurance** from the Risk Management and Governance: The new governance framework update report. • Draft Quality Governance Framework presented that still required discussion and input from the Executive Management Team (EMT), CEMG and Care Groups, before coming to IAGC. • The proposed framework did not provide sufficient assurance on the structure for embedding management of risks, appropriate and mature description of risks, governance flow from ward to Board to ensure quality and safety throughout the organisation, as well as accountability and responsibility for the management of risks. • The work needed to be focussed in line with the scope previously received by the Committee. The paper is to be represented having taken account of comments made by IAGC members.

	• The planned independent/external comprehensive governance review needed to be undertaken without delay and the IAGC to have sight of the scope of this that will provide an independent view as well as assurance and feedback on the internal governance review. • Confirmation from the Interim Chief Finance Officer (CFO) that the external review will be funded from Recovery Support Programme (RSP) and not the Trust's deficit. The Committee also requested for scope and costs of current risk management consultancy and planned governance review. Committee noted that some of the governance issues have been consistently raised at IAGC for some time.
Freedom to Speak Up (FTSU)/Raising Concerns Activity Report	• The Committee received **assurance** from the FTSU Activity Report. • Positive indication the FTSU service is working, continued steady rise in the number of concerns handled, with a 269% increase between 2021/22 and 2022/23 financial years. • FTSU team work proactive and reactive, supported by the dedicated team in place. Two new Deputy FTSU Guardians in post at the William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) to support demands. • New FTSU policy published and FTSU e-learning modules made mandatory, and development of a FTSU Strategy. • Staff supported in speaking up, barriers to speaking up addressed, encouraging positive culture of speaking up. Concerns about 'behaviours/leadership' continued to be main theme for 2022/23, followed secondly by concerns about patient safety/experience. • Results from 2022 National Staff Survey (NSS) showed a decrease in workers' confidence to speak up and that concerns raised would be addressed compared to the previous year, 83.9% of respondents felt were encouraged to report errors, near misses and incidents. • Development of a timeframe to respond to staff speaking up. • Regular meetings held with the Chief People Officer (CPO) providing opportunity to escalate any issues, as well as meetings held with the Chief Executive. Improved engagement and involvement throughout the organisation, supported by the collaborative working with the People and Culture team. • The Interim CNMO and Lead FTSUG will meet, to support working together around escalation, action was being taken and issues resolved.

2022/23 Gifts, Hospitality and Conflicts of Interest of Interest Annual Report	• The Committee received **limited assurance** and approved the Gifts, Hospitality and Conflicts of Interest of Annual Report 2022/23.
	• The Committee noted:
	  • New system introduced for declarations to be recorded on Electronic Staff Record (ESR), higher number of responses;
	  • More work was needed to further improve declarations and an action plan for 2023/24 focussing on:
	  • Working with Communications Team ensuring Conflicts of Interest, and Gifts & Hospitality, registers meet accessibility standards to be uploaded to the public website;

	• Creating a communications plan ensuring wider engagement with Trust staff on the need to declare gifts, and the correct governance procedures; • Targeted staff engagement with decision makers, mainly Band 8a+ staff, ensuring submission of annual declarations, including the creation of a mailbox specifically for queries from staff, and personalised reminders to those not submitted a declaration.
Policies – Review of Finance Policies	• The Committee **did not receive assurance** that the revised policies (minimal amendments) had followed the appropriate governance process. These needed to be presented and approved by the Policy Authorisation Group (PAG), then the Finance and Performance Committee (FPC) that provided oversight of these detailed procedural policies. • The Committee agreed the appropriate governance process to be followed for approval of the policies were PAG, who would recommend to FPC for approval of: • Policy on Procuring Non-Core Services (Additional Services) from External Audit; • Overseas Patients Policy; • Cash Collection Policy and Procedure; • Cash Receipting Policy; • Financial Management of Fixed Assets; • Stock Taking Policy.
Cost Improvement Programme (CIP) and Efficiencies Update 2023/24	• The Committee received **partial assurance** from the CIP and efficiencies 2023/24 update report. • The previous processes to recognise CIP schemes was insufficient around the actions required to achieve the current 2023/24 CIP target. There have been changes to the governance and oversight framework, with deep dive meetings held with Care Groups to discuss their financial position. Fortnightly financial and CIP over sight meetings now held with Care Groups to support driving forward improvements. • Movement from focus on multiple small savings schemes to cost cutting schemes, each will have governance process and progress oversight by an Executive Director. Schemes included reducing temporary staffing, looking at productivity and efficiency, and review of non-clinical posts throughout the organisation. • Increased oversight and control of expenditure at Executive and senior leadership level, and recruitment review panel. • To support future sustainability the Programme Management Office (PMO) and We Care teams will work collaboratively towards quality improvement (efficiency) and financial stewardship/sustainability to achieve breakeven position over the years to come. • There needed to be assurance of the current position, the identification of risks and these being managed, and appropriate actions to ensure the achievement of the £40m CIP target. The framework will provide oversight and delivery. A report to be presented for discussion at the BoD with a clear outline of the risks, where there were gaps and the level of savings anticipated from the actions and cost cutting schemes. • The process to look at and identify potential CIP schemes needed to be started much earlier in the year to ensure these could be progressed as early as possible to have a positive impact on achieving savings. To

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	ensure a sufficiently robust CIP plan was in place for the year, and noted the process the next year would be commenced in August/September 2024. • The Committee noted an additional referral from the People and Culture Committee in respect of the risk associated with poor staff appraisal completion rates that would be discussed at the next IAGC meeting.

Other items of business

The Committee noted the 2023/24 IAGC Annual Work Programme and that in the Autumn the items would be reviewed in respect of risk management and governance. This would be around completion of the current review and assurance of alignment with the governance framework structure.

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

Item	Purpose	Date
The Committee noted referral to FPC of the Finance Policies for approval.	Approval	To FPC on 29 August 2023.
The Committee asks the BoD to discuss and note this assurance report from the IAGC.	Assurance	To Board on 7 September 2023.

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

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

Meeting date: **25 July 2023**

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

Paper Author: **Executive Assistant**

Quorate: **Yes**

Appendices: **None**

Declarations of interest made:

None

Assurances received at the Committee meeting:

Agenda item	Summary
Cost Improvement Programme (CIP)	• As at month 3, care groups have recognised £0.5m of CIP efficiencies against a Q1 CIP plan of £5.3m. • There is a £10m CIP pipeline based on care group generated ideas, however, the Trust has transitioned to cross-cutting themes with Executive Director leads (as below). • The overall financial challenge for Financial Year (FY24) includes both a run-rate reduction for care groups to meet the agreed plans for FY24 (approximately £30m) and £40m of required CIP savings: • We are seeking to capture all aspects of both productivity and efficiency improvement across the Trust, however, this pipeline currently only reflects items that are expected to deliver cash releasing CIP savings. • The majority of ideas currently identified through the care group process are less than **£50k** (55%) or less than **£250k** (23%). • The largest increase in the month is from Outpatients Procedures coding – valued prudently at £1m. • There are now 153 schemes being worked on (130 last month), of which 82 (54%) are valued, (73 last month). • The new meeting structure/schedule supported by the Executive team is being rolled out week commencing 17/07/23.

	• Working across the Programme Management Office (PMO), Strategy team, and We Care team to focus on the largest impact cross-cutting themes. • Ongoing work to transition to new structure and support on a matrix basis between themes and new care groups. The Committee discussed and **NOTED** the M3 Savings and Efficiencies Update and **LIMITED ASSURANCE** received of the Trust's progress of the programme against a £40m target.
Patients no longer fitting the criteria to reside	• The Trust has updated the criteria for which the No Longer Fit to Reside (NLFTR) position is reported to reflect those patients who are flagged as "Not Fit to Reside" and "Medically Optimised". The time at which the data is collected has been adjusted, moving from a 5pm collection to a midnight collection to reflect the position once all of the day's discharges have been completed. • Work continues across the Trust to support earlier discharges for those patients requiring an on-going package of care. Whilst there are still recognised limitations with the available packages of care, work internally aims to ensure that patients requiring on-going care are flagged to the Rapid Transfer Service (RTS) at the earliest opportunity. • A 'Discharge and Re-set' event was held at William Harvey Hospital (WHH). The key successes of the event include: The closure of long-term escalation area within the hospital – Singleton Ward; Part reversion of bedded Discharge Lounge to next-day patients; No cancellations to our urgent and cancer lists; Direct #NOF pathway (x2 beds opened) - KC1 Ward; Reduction in PW3 referrals, increase in PW1 - Home first approach; Reduction in medical outliers (41-->22); Increase to front door discharges via Temporary Alternative Discharge Destination (TADD); Optimal flow from Emergency Department (ED). • The volume of escalation beds in use has declined since January of this year. The bed reconfiguration clinical forum is in progress at WHH and will commence at the Queen Elizabeth the Queen Mother Hospital (QEQM) in August 2023 reviewing the proportional allocation of bed space by specialty with a view to reduce escalation bed use and reduce outlying patients. • A full de-escalation paper will be developed over the course of the next month and reported to Financial Improvement Oversight Group (FIOG) at the request of the Chief Strategy & Partnerships Officer and will include the running order of the closure plans in place for the escalation beds, key milestones to achieve this, and the considered financial impact as we reduce escalation beds.

	• An internal audit is in progress to reset the 'core' bed base within our data collection systems. With the long-term use of some escalation beds over time the status of the beds has been re-set to core for some wards. This audit seeks to address this position and improve reporting accuracy. • New national guidance has been received (20/7/23) for the reporting of escalation beds. The impact of this guidance is being considered and will be reported at the next FPC. The Committee discussed and **APPROVED** the Patients No Longer Fitting the Criteria To Reside.
Month 3: **• Finance Report** **• Cash Position** **• Month 3 efficiencies**	The Group achieved an in month position of £9.2m against a plan of £7.4m resulting in a deficit variance of £1.8m. The Groups Year to Date (YTD) position is £28.9m against a plan of £25.2m giving a YTD variance to plan of £3.7m. The key drivers to the Trusts YTD deficit are: • Strike action £0.7m; • £0.4m of non-funded pay award; • Non-delivery of efficiency savings £4.8m YTD of which £3.2m has been allocated to Pay and £1.6m to non-pay; • Pay overspent by £3.3m due to non-delivery of CIP, increased levels of staffing utilisation, mainly in nursing (c174 Whole Time Equivalent (WTE)) & Medical & Dental (c127 WTE) and high cost of agency premium; • Non-Pay overspend £1.1m driven by underspend on drugs of £0.9m, overspend on clinical supplies & services £0.9m and premises costs of £0.3m.
Board Assurance Framework (BAF) and Principal Mitigated Financial and Performance Risks	**Headlines**: There are 3 BAF risks and 8 risks on the Corporate Risk Register (CRR) relating to 'Our Future' and 'Our Sustainability'. **Changes to the CRR during this reporting period**: There were two new risks approved for addition; one risk approved for a decrease in risk rating and two risks approved for closure at the Clinical Executive Management Group (CEMG) on 5 July 2023. **New risks for addition:** CRR 148 - Failure to deliver the financial plan of the Trust as requested by NHS England (NHSE) for 2023/24; CRR 149 - Inability to implement improvements in the Estate across the Trust due to the financial constraint on capital funding, backlog of work and volume and extent of work required. **Reduction in risk rating:** CRR 145 – There is a risk that the Trust will not be able to meet its 2023/24 efficiencies target, and therefore miss the agreed control total deficit, potentially further losing financial autonomy, and jeopardising the Financial Recovery Plan. **De-escalation to local risk register:** CRR 34 – Failure to sustain and improve health and safety standards across the Trust will result in an increase in incidents affecting staff, patients and visitors and could lead to prosecution and fines.

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	Closure from Corporate Risk Register: CRR 124 – There is a risk of failure to manage supply chain delays that may cause patient harm. **Other key changes**: There has been no movement on the BAF risk register during this reporting period. Other changes to the risk records are included in the risk registers at Appendices 1 and 2. **Quarterly performance**: Quarter one performance data and related commentary is available for the Committee to review on pages 3-5. **Tracker report**: The tracker report is presented to the Committee on pages 6-7 to enable the Committee to have oversight of risk movement over the past year. The Committee discussed and did **NOT APPROVE** the Board Assurance Framework and Corporate Risk Register. Specifically, the recommendation to reduce the rating of CRR 145 and CR 34 in regards to the 2023/24 Efficiencies target and the failure to sustain and improve health and safety standards.
Business Cases: Review **Patient Voice and Involvement Strategy Update/Review** **WHH & QEQM Emergency Department Build Update/Review**	The Committee members discussed and noted the Patient Voice and Involvement Strategy Update/Review. The Committee members discussed and noted the WHH and QEQM Emergency Department Build Update/Review.
We Care Integrated Performance Report (IPR) (M2): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee members discussed and noted the We Care IPR with partial assurance received of the performance against key metrics for 2023/24 including the Breakthrough objectives: Improving theatre capacity, Actual utilisation, Elective Orthopaedic Centre (EOC) utilisation, Same Day Emergency Care admissions, Emergency Care Delivery Programme, Direct Access Pathways, Phase 3 WHH ED build, Use of Hot Slots, Hot Clinics, Staff involvement, National Staff Survey, Team Engagement and Development (TE) pilot, We Care Rollout and Premium Pay Costs.
Contract Awards **1. Orthopaedic Prosthesis – Trauma**	**1. Orthopaedic Prosthesis – Trauma** The Committee discussed and **APPROVED** the **Orthopaedic Prosthesis – Trauma contract award.**
2023/24 Internationally Educated Nurse	Paper not submitted. Due to be submitted at August FPC meeting.

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(IEN) Recruitment – Business case	
Strategic Capital Planning and Performance Committee	The Committee members discussed and noted the Strategic Capital Planning and Performance Committee paper.
Cash Report	Closing Group cash position at Month 3 was £39.4m. Closing Trust cash position at Month 3 was £28.7m. As a result of the Trusts financial position, creditor payment terms were stretched to 37 days in May and have remained at that level to date. In addition, payments to NHS Professionals (NHSP) and NHS creditors are being reviewed on a weekly basis. £18.4m revenue support was received in Q1 and a further £22.4m has been agreed for Q2. Quarter 2 funding has been agreed with 2 additional conditions to be met: • Creation and submission of a format report on the implementation of controls; • Submission of a recovery plan for CIP. The Committee members discussed and noted the Cash report.
Strategic Investment Group (SIG)	The Committee received an assurance report on the activities of SIG on 18 May 2023.
Financial Improvement Oversight Group (FIOG)	The Committee received an assurance report on the activities of the FIOG on 20 June 2023.

Other items of business

Supply of Sleep Therapy Devices and Accessories

The Committee discussed and **APPROVED** the **Supply of Sleep Therapy Devices and Accessories contract award.**

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

Item	Purpose	Date

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The BoD is asked to receive and **NOTE** this FPC Assurance Report.	Assurance	7 September 2023

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

Committee:	**Finance and Performance Committee (FPC)**
Meeting date:	**29 August 2023**
Chair:	**Richard Oirschot, Non-Executive Director**
Paper Author:	**Executive Assistant to Interim Chief Finance Officer (CFO)/Interim Group Company Secretary**
Quorate:	**Yes**

Declarations of interest made:

None

Assurances received at the Committee meeting:

Agenda item	Summary
Cost Improvement Programme (CIP)	• As at Month 4, Care Groups recognised £0.8m of Cost Improvement Programme (CIP) efficiencies Year to Date (YTD) against a plan of £8.8m. In addition to the £40m CIP requirement, the Trust is required to improve run-rate by £30m to deliver the 2023/24 plan; • for transparency purposes, only Care Group level CIPs have been reported which are on or ahead of plan. A number of specific areas of overspend (e.g. escalation areas, 1:1 specialising) are being offset by underspends and one-off corporate items. To reflect a clearer CIP position at a Trust-wide level, it is proposed to move to reporting non-recurrent CIPs from M5; • currently, approximately £14.4m of (CIP saving) ideas have been identified (£11.3m in-year effect) which represents a £3.6m improvement over the previous month. A further £2.8m schemes are being evaluated. The key focus is on five high impact areas (domains) which have been selected by the Executive; • recent enhancements to drive savings include: an administrative/ clerical vacancy review; deep dive reviews by the Chief Nurse of all nursing agency; greater controls being rolled out by the Interim CFO; rapid review meetings for all new Care Groups with the Executive Management Team (EMT) to drive CIPs and to discuss controls and forward forecasts for Financial Year (FY) FY24. The Committee discussed and **NOTED** the M4 Savings and Efficiencies Update showed a disappointing position and **LIMITED ASSURANCE** received of the Trust's progress of the programme against a £40m target.

Patients no longer fitting the criteria to reside	• **Decline in No Longer Fit to Reside Patients**: The Trust's reported count of patients categorised as No Longer Fit to Reside (midnight occupancy) has shown a consistent decline since January 2023. Currently, the count stands at 192, marking the lowest position recorded since July 2022; • **Positive Trends in Longer Stay Cohorts**: positive trends observed in longer-stay cohorts. Both patients staying for 7+ days and 21+ days have exhibited a decline in numbers since January 2023; • **Steady Enhancements in Emergency Department (ED) Efficiency**: notable improvements in the total time spent in ED over 12 hours have progressed since April 2023, now reaching a reported position of 8.9%; • **Consistently Meeting the 4-Hour Standard**: performance against the 4-hour Standard has consistently outpaced the projected trajectory for the past four months. Amendments made to ED pathways have facilitated smoother flow for same-day emergency care patients in alignment with the 4-hour standard; • **Reduced Time for Admitted ED Patients**: positive developments observed for patients admitted from the Trust's EDs. In February 2023, the mean time for admitted patients in ED peaked at 30.9 hours, which has gradually decreased to 14.0 hours; • **De-Escalation Report and Workstream Update**: to be considered at the next meeting; • **Internal Audit Progress on Bed Base:** first stage of the internal audit work, aimed at establishing a ward-by-ward position of the funded and unfunded bed base, completed and shared with senior operational team in order to re-set internal reporting systems; • **Escalation bed reporting and financial monitoring:** this work will serve two key purposes: a) internal requirement to monitor utilisation of funded and unfunded beds; b) alignment of reporting systems to the revised criteria for reporting escalation beds externally. The Committee discussed and **NOTED** the report.
Month 4: **• Finance Report** **• Cash Position** **• Month 4 efficiencies**	The Group reported an in-month deficit of £10m against a plan of £5.4m resulting in a variance of £4.7m for M4. The Group's YTD position is £39m against a plan of £30.6m giving a YTD variance to plan of £8.4m. The agreed financial plan for the year of 2023/24 is a £72m deficit. Key drivers to the Trust's YTD deficit were highlighted and include: • strike action costs of £1.1m;

	• £0.5m of non-funded pay award; • non-delivery of recurrent efficiency savings £8.3m YTD of which £5.2m has been allocated to Pay and £3m to non-pay; • pay overspent by £7.4m due to non-delivery of CIP, increased levels of staffing utilisation and high cost of agency premium to cover escalation areas still open above plan, increased levels of 121 nursing care and delayed Internationally Educated Nurse (IEN) supernumerary cover; • non-Pay overspent by £4.4m predominantly driven by non-delivery of efficiencies and the Laboratory Information Management System (LIMS) pathology contract which has now commenced and increased non-pay by £0.5m although this is offset against a corresponding increase in income. The Group cash balance (including subsidiaries) at the end of July was £28.8m. The Trust drew £3.5m of working capital (Public Dividend Capital (PDC)) in the month, making a YTD total of £21.9m. Work is underway with the Integrated Care Board (ICB) and Regional team reviewing the next steps alongside the National protocol. Total capital expenditure at end of July 2023 was broadly on target with a £6.3m spend against a plan of £6.4m plan. The Trust has achieved very little recurrent efficiency savings so far this year against the £8.8m plan. Non-recurrent efficiencies will be reported from Month 5.
Board Assurance Framework (BAF) and Principal Mitigated Financial and Performance Risks	**Headlines**: There are 3 BAF risks and 8 risks on the Corporate Risk Register (CRR) relating to 'Our Future' and 'Our Sustainability'. **Changes to the BAF**: There have been no changes to the BAF during this reporting period. **Changes to the CRR**: There have been no changes to the CRR during this reporting period. **Other changes**: Other changes to the risk records are included in the risk register summaries on pages 5 - 13. **Tracker report**: The tracker report, as presented to the Committee on page 4, enables the Committee to have oversight of risk over the past year. The Committee discussed and did **NOT APPROVE** the Board Assurance Framework and Corporate Risk Register. Specifically, with regard to the previous recommendation not to reduce the ratings of Risks 41 and 145. Consideration was given also to the potential shortfall of capital funding of £140m which could substantially impact those risks further.
We Care Integrated Performance Report (IPR) (M4): National Constitutional	The Committee discussed and noted the 'We Care Integrated Performance Report' (IPR) with **partial assurance** being received with regard to performance against key metrics for 2023/24, including Breakthrough Objectives: Improving theatre capacity, Actual utilisation,

Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	Elective Orthopaedic Centre (EOC) utilisation, Same Day Emergency Care admissions, Emergency Care Delivery Programme, Direct Access Pathways, Phase 3 William Harvey Hospital (WHH) ED build, Use of Hot Slots, Hot Clinics, Staff involvement, National Staff Survey, Team Engagement and Development (TE) pilot, We Care Rollout and Premium Pay Costs.
Workforce Quarterly Report – Q1	The Committee noted that premium pay spend was above target, with a small increase in spend of approximately £200k during Q1 2023/24 when compared to Q4 2022/23. The adverse position was as a result of vacancies and operational pressures, including doctors' strikes. Actions being taken to address the key contributory factors include: • on-going 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; • ensuring that best practice and policy are applied to temporary staffing for escalation and specialising; • ensuring exit plans are in place for all long-term medical agency locums. The Committee discussed and **NOTED** the Q1 Workforce Report.
2023/24 IEN Recruitment Business case	Recruitment of IENs has supported the reduction in the Band 5 vacancy rate. NHS England (NHSE) have confirmed there are no plan for financial support/bids in 2024 for IEN recruitment. The estimated cost of recruitment and supernumerary work per nurse is £33,825, after NHSE's contribution of £28,825. Total cost for 112 IENs £3,228,400. The Committee noted with concern that some 50 IENs had been recruited before the business case had been formally approved by FPC or Trust Board. However, after discussion, the business case was **APPROVED** for recommendation to the Board for approval.
Ziopatch Contract Award	The Committee discussed and **APPROVED** the Ziopatch Contract Award.
Capital Investment Group (CIG)Terms of Reference	The Committee discussed and **APPROVED** the Capital Investment Group (CIG) Terms of Reference.
Business Case Scrutiny Group(BCSG) Terms of Reference	The Committee discussed and **APPROVED** the Business Case Scrutiny Group (BCSG)Terms of Reference.

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Strategic Investment Group (SIG)	The Committee received an assurance report on the activities of SIG as at 15 June 2023.
Financial Improvement Oversight Group (FIOG)	The Committee received an assurance report on the activities of the FIOG as at 18 July 2023.

Other items of Business

None

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

Item	Purpose	Date
The BoD is asked to receive and **NOTE** this FPC Assurance Report.	Assurance	7 September 2023
The BoD is asked to **APPROVE** the 2023/24 IEN Recruitment Business case.	Approval	7 September 2023

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REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Transforming our Trust: Our Response to *"Reading the Signals: Maternity and Neonatal Services in East Kent"* – Update Report**

Meeting date: **7 September 2023**

Board sponsor: **Chief Strategy and Partnerships Officer (CSPO)**

Paper Author: **Executive Director Communications and Engagement**

Appendices:
NONE

Executive summary:

Action required:	**Information**
Purpose of the Report:	To update the Board on progress on the Trust's 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 the Reading the Signals Report to provide safer care and improved staff engagement.
Key recommendations:	The Board of Directors are asked to **NOTE** the report for information.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and safety • Patients • Our people • Partnerships • Sustainability
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: N/A

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

2. The Pillars of Change

2.1. The Pillars of Change summarise the Trust's response to the key areas for action included in *Reading the signals* and cover work within Maternity and Neonatal services as well as actions applicable to the whole Trust. They are:

- Reducing harm and delivering safe services
- Patient, family and community voices
- Care and compassion
- Engagement, listening and leadership
- Organisational development

2.2. The Pillars of Change cover the practical steps the Trust has already begun to put into place and include the further work to be delivered over the next three years. The Pillars link to the areas in the Independent Investigation Report and to the Trust values that people should feel cared for, safe, respected and confident we are making a difference.

2.3. They have been adopted as part of the Trust's strategic objectives and are included in the Trust's Improvement plan and the Maternity and Neonatal Improvement Programme.

3. Culture and Leadership Programme (CLP)

3.1. Significant progress has been made in the recruitment of change champions to support the Trust-wide programme of cultural change. Following a recruitment campaign more than 100 staff have been recruited and trained. We have been sharing the stories of our change champions and what motivated them to get involved, in staff communications.

3.2. They are leading the discovery phase of the culture programme, which is seeing them running staff focus groups and interviewing members of the Board.

3.3. The next stage of the programme, diagnosing our culture, includes running a Leadership and Behaviours survey which will run in September. It will be open to all Trust colleagues, as well as external partners.

4. The Reading the Signals Oversight Group

4.1. The *Reading the signals* Oversight Group meets in public and is responsible and directly accountable to the Board of Directors. It provides 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.

4.2. The group includes a range of representatives from patients and families as well as our Council of Governors.

4.3. The fourth meeting of the Group was held on 8 August 2023. The Group received the maternity dashboard and the draft charters which form the Maternity and Neonatal Improvement Programme and discussed the level of information that would be helpful for the group to receive at future meetings.

4.4. Members of the group have been involved in the charters and in supporting the revision of the Trust's Communications and Engagement Strategy which has been refreshed and is published on the Trust website.
4.5. A future engagement event Maternity and Neonatal services was discussed and a progress report detailing one year on from the publication of *Reading the signals.*
4.6. The Group remains committed to be flexible in its approach to family representation and if other families come forward wishing to join membership of the Group this should be facilitated.
4.7. The next meeting of the Oversight Group will be held on 19 September 2023.

5. The Independent Case Review Process

5.1. We have established an Independent Case Review process. Families who have concerns about the maternity or neonatal care they received from the Trust 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.
5.2. We have been addressing enquiries from 18 families and expect to conduct 13 reviews. Key Lines of Enquiry (KLOES) are agreed with the families. The first case review has been completed. Three more reports are expected to be completed shortly.

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REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Maternity Incentive Scheme Year 5 Submissions**

Meeting date: **7 September 2023**

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

Paper Author: **Director of Midwifery**

Appendices:

APPENDICES PROVIDED IN READING ROOM (DOCUMENTS FOR INFORMATION)
APPENDIX 1: Perinatal Mortality Review Tool (PMRT)
APPENDIX 2: Transitional Care
APPENDIX 3: Saving Babies Lives
APPENDIX 4: Perinatal Quality Surveillance Tool (PQST) – July 2023
APPENDIX 5: PQST – August 2023

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The Maternity Incentive Scheme applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). The scheme incentivises ten maternity safety actions which if achieved enables Trusts to recover an element of the contribution to CNST. Within the majority of the 10 safety actions there is a requirement for reports to be presented to the Board for information and oversight. Alongside this report there are detailed reports which correspond to the relevant Safety Actions that have been presented to the Maternity and Neonatal Assurance Group (MNAG) for detailed review and discussion.
Summary of key issues:	For Quarter 1 of 2023/24 the following reports have been presented to MNAG and are brought to the Board in compliance with the following CNST requirements. **Safety Action 1**: **National Perinatal Mortality Review Tool (PMRT)**: A report that includes a review of all eligible deaths, themes identified and actions taken in line with the PMRT should be received by the Board each quarter. The paper is shared for information and oversight. **Safety Action 3: Demonstration that there are transitional care services in place to minimise separation of mothers and their babies**. The requirement within this safety action is that the Trust's transitional care

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	guideline has been embedded fully and that a process is in place to ensure auditing of all admissions to identify whether separation could have been avoided. There is an audit programme supervised by the Trust audit lead midwife and an action plan has been developed further to these reviews. The Board is asked to approve the action plan. **Safety Action 6:** The service is required to provide assurance to the Trust Board that it is on track to fully implement all elements of the Saving Babies Lives v3 tool by March 2024. Whilst the report provided demonstrates an initial gap analysis against the standard, compliance will be calculated using the national implementation tool that was published at the end of June 2023 by October 2023. **Safety Action 9**: This report is brought to the Board in compliance with Safety Action 9, which aims to ensure that discussions regarding safety intelligence including incidents, staff and user feedback, staffing and training compliance takes place at Board level monthly and that this is reflected in Board minutes. Given that there was no Board meeting in the month of August reports for July and August are included. These reports have both been presented at the MNAG.
Key recommendations:	The Board of Directors is asked to: **Safety Action 1**: National Perinatal Mortality Review Tool: The Board to receive **ASSURANCE** that a Quarterly Perinatal Mortality Review Tool paper has been received for Q1 2023/24 demonstrating full compliance in line with CNST standard requirements four areas of evidential requirement. **Safety Action 3**: Avoiding Term Admissions into Neonatal Units (ATAIN) There is room to improve the data capture of babies being admitted to transitional care facilities at William Harvey Hospital (WHH). However, an action plan has been developed which addresses the findings of the reviews undertaken to minimise separation of mothers and babies born equal to or greater than 37 weeks. The Board is required to **APPROVE** the action plan and provide a formal agreement that the Transitional Care and ATAIN reviews and action plan findings can also be shared with the Local Maternity and Neonatal System (LMNS), Integrated Care Board (ICB) and Integrated Care System (ICS) quality surveillance meeting. **Safety Action 6**: The report that was presented to MNAG provided an initial gap analysis against the revised Safety Action and care bundle. Many of the required interventions have already been implemented at EKHUFT. However, there is a substantial amount of work required to achieve implementation of elements within the revised care bundle. In order to assess whether the service will achieve compliance in relation to this Safety Action it must now undertake an assessment utilising the recently released national

	implementation tool. On completion of the gap analysis the service will share findings with the Board and the ICB. **Safety Action 9**: The PQST report dated June 2023 was presented to MNAG in July and the July report presented to MNAG in August 2023 **June PQST** • Anaesthetic training compliance for PRactical Obstetric Multi-Professional Training (PROMPT) has improved to 83% but remains below the national standard of 90%. • There were 3 Healthcare Safety Investigation Branch (HSIB) referrals for the month of June. **July PQST** • 1 HSIB referral for the month of July. • 2 Serious Incidents (SIs) reported. • 1:1 care in labour 100% compliant. • Friends and Family (FFT) received 252 responses which is a 12.3% response rate – the national best is 18%.The responses show 94.6% extremely likely or likely to recommend which is an increase from last month.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	N/A
Link to the Corporate Risk Register (CRR):	N/A
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: MNAG – 8 August 2023

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: MATERNITY AND NEONATAL IMPROVEMENT PROGRAMME (MNIP)

Meeting date: 7 SEPTEMBER 2023

Board sponsor: CHIEF NURSING & MIDWIFERY OFFICER

Paper Author: DIRECTOR OF MIDWIFERY

Appendices:

APPENDIX 1: SIX WORKSTREAM CHARTERS

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The paper is brought to the Board for approval of the amended Maternity and Neonatal Improvement Programme.
Summary of key issues:	• A Maternity Transformation Programme (MTP) was developed in March 2023 following the publication of the *Reading the Signals* report in October 2022 and the Care Quality Commission (CQC) inspection in January 2023. • It was aligned to the 5 pillars of change outlined by the Trust in its response to *Reading the Signals*. • Some Quality Improvement (QI) projects were non-negotiable as linked to the Integrated Improvement Plan (IIP) and Trust exit strategy. • The programme included 6 workstreams with designated Executive leads. • In May 2023 the Single Delivery Plan – a 3-year plan that sets out how the NHS will make maternity and neonatal care safer, more personalised and more equitable was published. • 'We hear you' engagement day 28 June 2023 (internal and external stakeholders including Maternity and Neonatal Voices Partnership (MNVP)/families). • The name of the programme (The Maternity and Neonatal Improvement Programme (MNIP)) and the vision was co-produced with all stakeholders. The 6 Workstream charters have been amended to include feedback received from all stakeholders. • The amended workstream charters have been reviewed by the Maternity Improvement Advisor, shared with the Integrated Care Board (ICB), Regional Midwifery lead and MNVP chair for feedback on 28 July 2023. • The workstream charters shared with the Reading the Signals Oversight Group on 8 August 2023. • The amended MNIP was presented to the Maternity and Neonatal Assurance Group (MNAG) on 8 August 2023.

We care

East Kent Hospitals University NHS Foundation Trust

Key recommendations:	The Board of Directors is asked to **APPROVE** the amended charters and programme for delivery.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients • Our people • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	N/A
Link to the Corporate Risk Register (CRR):	N/A
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: MNAG – 8 August 2023, and Reading the Signals Oversight Group – 8 August 2023.

East Kent Hospitals University NHS Foundation Trust

Maternity and Neonatal Improvement Programme

1. Purpose of the report

The paper is brought to the Board for approval of the amended Maternity and Neonatal Improvement Programme (MNIP).

2. Background

Following the publication of Dr Kirkup's report into maternity and neonatal care in East Kent between 2009 and 2020, *Reading the Signals* in October 2022 and the CQC inspection in January 2023, a Maternity Transformation Programme (MTP) was developed.

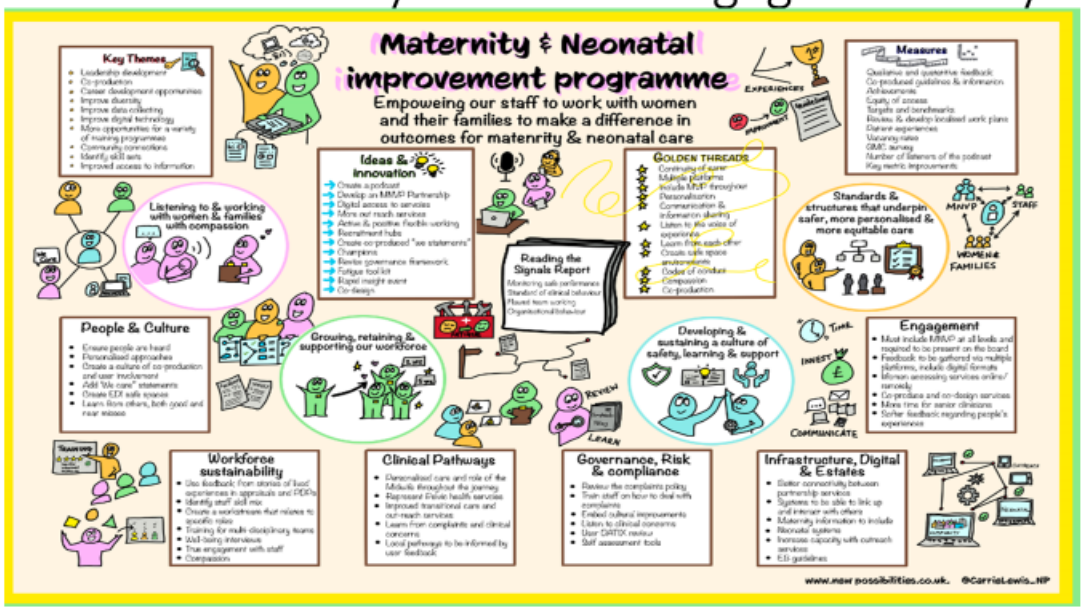
The MTP was aligned to the 5 pillars of change outlined within the Trust's response to *Reading the Signals*. Some quality improvement projects were non-negotiable as linked to the IIP and Trust exit strategy.

The programme included 6 workstreams with designated Executive leads as Senior Responsible Officers (SROs).

- People and Culture - Chief People Officer
- Workforce - CNMO
- Clinical Pathways – Chief Medical Officer
- Governance - CNMO
- Engagement - CNMO
- Infrastructure and digital – Chief Strategy & Partnerships Officer

In May 2023 the Single Delivery Plan – a 3-year plan that sets out how the NHS will make maternity and neonatal care safer, more personalised and more equitable was published. The incoming leadership team facilitated an engagement day for internal and external stakeholders including the MNVP/families.

MNIP - Visual Synthesis of engagement day



The name of the local programme and the vision was co-produced with all stakeholders and is now referred to as **the Maternity and Neonatal Improvement Programme (MNIP)**.

The 6 Workstream charters have been amended to include feedback received from all stakeholders. The elements of the workstream charters relevant to the Reading the Signals (RTS) recommendations were also shared at the Reading the Signals Oversight Group.

3. Summary of Workstream Charters

The MNIP comprises of the following 6 workstreams that are aligned to the Trust's Pillars of change and the Single Delivery Plan. The project timescales have also been aligned to the Trust Integrated Improvement Plan, the Single Delivery Plan and the Maternity Safety Support Programme (MSSP) milestones. The action plans aligned to each workstream set out clear responsibilities and measures of success across the service.

1. **Developing a positive culture (leadership)**

   The need for a positive culture and leadership of services was highlighted in the *Reading the Signals* report and other high-profile failings within Maternity Services across the UK. Workstream 1 sets out actions in relation to developing and sustaining a positive culture through empowering the team to work with kindness, professionalism and compassion at both Trust and departmental levels.

2. **Developing and sustaining a culture of safety, learning and support**

   Whilst workstreams 1 & 2 are interlinked in relation to safety culture, workstream 2 focusses on actions that will be taken in relation to monitoring safety performance articulated in the *Reading the Signals* report as 'finding signals among noise'. This also includes understanding

national data in the context of the local demographics and how this impacts on local women and families using the service.

3. **Clinical Pathways that underpin safe care**

   Dr Kirkup's investigation identified that clinical care was poor, additionally, other national reports found that despite advances in clinical practice many women were not offered care in line with best clinical practice.

   This workstream sets out the Clinical pathways that are to be embedded incorporating nationally defined best practice. The ambition being to consistently implement best practice in order to reduce variation.

4. **Listening to and working with women and families with compassion**

   It is well known that listening and responding to women and families is an important element of safe care within maternity services. The *Reading the Signals* report highlighted the need to re-establish listening to patients as a vital part of clinical practice.

   This workstream sets out actions aligned to listening to families and working with service users, in order to achieve personalised care and improve equity.

5. **Growing retaining and supporting our workforce**

   There is national recognition that for maternity services to achieve the ambition of safer, more personalised and equitable care there must be a commitment to ensuring that care is provided by skilled teams with sufficient capacity and capability.

   This workstream sets out the actions required to achieve this ambition and is also aligned to recommendations within the NHS Long Term Plan and the NHS People Plan.

6. **Infrastructure and digital**

   The *Reading the Signals* report highlighted the detrimental effect that sub-optimal estates have on the provision and experience of care.

   This workstreams sets out the actions that are required to address these issues to both enable women and service users to have access to the information they need and ensure safe and personalised care.

4. Support, oversight and measuring success

Each of the six workstreams will have a supporting project plan and identify:

- Responsible project/workstream leads at Executive, care group, management and action level
- Milestones taken from the Charters
- Supporting tasks required to achieve each milestone
- Associated costs
- Evidence log

- Progress against completion vs assurance
- Key Performance Indicators (KPIs)

A dashboard containing all metrics from each of the workstreams will be developed to support monitoring and oversight of the programme's implementation. Each MNIP Workstream will have a nominated Executive Senior Responsible Officer and there will be a robust quality assurance process to review and approve evidence in support of achievement of each milestone within each plan.

The table below is a draft of the proposed Women's Health Governance Reporting Structure to oversee delivery of improvement alongside business as usual activity; this is being progressed as part of the development of the revised Women's Health Quality and Safety Framework (QSF):

<table>
<tr><td colspan="8">Trust Board</td></tr>
<tr><td colspan="2">Quality + Safety Committee
Performance Management Board</td><td colspan="6">Maternity + Neonatal Assurance Group</td></tr>
<tr><td colspan="8">Women's Health Care Group Integrated Assurance Meeting
Chairs: DOM/CD/ADOP/DDoM</td></tr>
<tr><td>Operational Performance Group
Chairs: Ops Site Leads</td><td>Transformation and Improvement Group
Chair: Transformation Lead/HoMs</td><td colspan="3">Patient Safety Group
Chair: DDOM/Obs Governance Leads</td><td colspan="2">Experience and Engagement Group
Chair: TBC</td></tr>
<tr><td colspan="8">Reporting Groups</td></tr>
<tr><td>Workforce meeting Inc. professional standards</td><td>MNIP Programme Management</td><td>Clinical Groups*</td><td colspan="2">Governance Groups</td><td>Women/Birthing People</td><td>Workforce</td></tr>
<tr><td rowspan="2">Efficiency</td><td rowspan="3">MNIP Operational Workstream Meetings
1. Positive Culture
2. Safety Culture
3. Clinical Pathways
4. Listening
5. Workforce
6. Infrastructure (Inc. Digital)</td><td rowspan="2">Antenatal Pathway Forum (future)</td><td>Monthly</td><td>Weekly</td><td>MVP (PPAG)</td><td>Staff Side meeting</td></tr>
<tr><td>Risk Meeting</td><td>Local incident meetings</td><td rowspan="2">Partners Group</td><td rowspan="2">PMA Meetings</td></tr>
<tr><td>Estates, Equipment and Procurement</td><td>Antenatal Screening Forum</td><td>PMRT Group</td><td>SI tracker</td></tr>
<tr><td rowspan="4"></td><td>Integrated Improvement Plan (IIP)</td><td>Intrapartum (labour ward) group</td><td>M+M Group</td><td>Rapid Review</td><td>YVH (PPAG)</td><td>Women's Group</td></tr>
<tr><td>Reading the Signals</td><td>Postnatal pathway/ATAIN forum (future)</td><td>Guideline & PILs Group</td><td rowspan="3"></td><td>Pt. Info Group</td><td>Consultant Meeting</td></tr>
<tr><td>We Care Metrics</td><td>CQC</td><td>Audit Group</td><td>FFT (PPAG)</td><td>Band 7 meetings</td></tr>
<tr><td></td><td></td><td>Education and Learning Faculty</td><td colspan="2">Patient Voices Model will report into a local PPAG forum, that reports through this structure into Trust-level PPAG</td></tr>
</table>

*Business as usual forums; improvement elements have oversight via MNIP under 'Transformation and Improvement Group'

The 'Transformation and Improvement Group' within the above draft structure is supported by this proposed MNIP Governance Reporting schedule that sets out review dates at operational, care group, and Trust level:

East Kent Hospitals University NHS Foundation Trust

Maternity and Neonatal Improvement Programme (MNIP) Planner 2023/24

Overview

	MNIP Project Groups							Care Group Reporting				Trust-level Reporting			
	Culture	Workforce	Clinical Pathways	Safety Culture (Governance)	Infrastructure	Listening	No. Meetings	WH Improvement & Transformation Group	WH Integrated Assurance Group	MTP Board (Project Board) MNAG?	No. Meetings	MNAG	Strategic Improvement Committee (SIC)	Trust Board	No. Meetings
Chair	Clinical Director	Director of Midwifery	Director of Operations	Dep. Director of Midwifery	Director of Operations	Director of Midwifery		Service Development Programme Lead	Head of Governance	Chief Nursing & Midwifery Officer (CNMO)		Chief Nursing & Midwifery Officer (CNMO)	Chief Executive Officer (CEO)	Trust Chairman	
Frequency & Forum	Monthly Snr MW Mtg 3rd Thursday of each month	Monthly Snr MW Mtg 3rd Thursday of each month	Monthly Cross-Site Mgmt Mtg 3rd Friday of each month	Monthly WH Governance Mtg 2nd Thursday of each month	Monthly Cross-Site Mgmt Mtg 2nd Friday of each month	Monthly Snr MW Mtg 2nd Friday of each month		Monthly - TBA	Monthly - TBA	Monthly - TBA		Monthly - 2nd Tuesday of each month	Monthly - 	Monthly Trust Board 1st Thursday of each month	
Oct 2023	07-Sep-23	07-Sep-23	15-Sep-23	07-Sep-23	08-Sep-23	08-Sep-23	6	22-Sep-23	29-Sep-23	03-Oct-23	3	10-Oct-23	TBA	02-Nov-23	3
Nov 2023	05-Oct-23	05-Oct-23	20-Oct-23	12-Oct-23	13-Oct-23	13-Oct-23	6	27-Oct-23	03-Nov-23	07-Nov-23	3	14-Nov-23	TBA	07-Dec-23	3
Dec 2023	02-Nov-23	02-Nov-23	17-Nov-23	09-Nov-23	10-Nov-23	10-Nov-23	6	24-Nov-23	01-Dec-23	05-Dec-23	3	12-Dec-23	TBA	TBC	3
Jan 2024	28-Dec-23	28-Dec-23	15-Dec-23	07-Dec-23	08-Dec-23	08-Dec-23	6	22-Dec-23	29-Dec-23	02-Jan-24	3	09-Jan-24	TBA	TBC	3
Feb 2024	25-Jan-24	25-Jan-24	19-Jan-24	11-Jan-24	12-Jan-24	12-Jan-24	6	26-Jan-24	02-Feb-24	06-Feb-24	3	13-Feb-24	TBA	TBC	3
Mar 2024	22-Feb-24	22-Feb-24	16-Feb-24	08-Feb-24	09-Feb-24	09-Feb-24	6	23-Feb-24	01-Mar-24	05-Mar-24	3	12-Mar-24	TBA	TBC	3

5. Conclusion

The paper provides an overview of the six workstreams within the Maternity and Neonatal Improvement plan which will be implemented in response to Dr Kirkup's investigation, other high-profile maternity reports, the local CQC review and recommendations contained within the Single Delivery Plan.

The workstreams have been developed with internal and external stakeholders including women and families.

We care

Workstream 1: Developing a Positive Culture

Objective: To build an inclusive culture where staff feel safe, valued, listened to and supported to deliver kind and compassionate, person-centred care

Executive Senior Responsible Officer (SRO): Chief People Officer

Maternity and Neonatal Improvement Programme

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

Associated Document: Reading the Signals, October 2022 – Dr Bill Kirkup CBE

High-level Milestones What?	**Timeframes** When?	**Outcomes (objectives/improvements)** Why?	**Outputs (deliverables)** How?	**Measurable Benefits (results)** Our achievements will show through…
❖ Delivery of NHSI Culture and Leadership Programme (CLP) ❖ Delivery of Trust-level leadership development programme for those recruited into leadership posts	March 2025 *(Aligned to Trust Pillars of Change and timeframes)*	The workforce provides care with professionalism, kindness, compassion and respect whilst feeling listened to by an inclusive leadership team There are opportunities for routine welfare checks across the workforce to support and maintain a culture of consideration of others, and their mental wellbeing Service users feel they receive professional, kind, compassionate, inclusive, personalised care and support The workforce and managers alike are in receipt of, and provide, personalised leadership that consistently exhibits the Trust values and behaviours	A programme based on nationally recognised workforce culture assessment tools / frameworks e.g. NHSI CLP Perinatal Quality Leadership Programme for Care Group Quad Alignment to Royal College of Obstetricians & Gynaecologists (RCOG) Leadership and Management Framework Use of acquired skills and learning to demonstrate compassionate leadership and nourish a safe working environment Improved capacity of resources to deliver services due to improved workforce morale Implementation of the Trust-level Leadership Behaviours Framework once published linked to a re-launch of the Trust values Wider workforce opportunities through statutory and mandatory training programme to include values and behaviours of leaders across the service Embedded process and practice for managing behaviours that do not meet Trust values	• Register of Change Managers appointed through NHSI Culture and Leadership Programme (CLP) and outputs from their programme of work • Perinatal Quality Leadership Programme completion • Yearly upward trends in NHS Staff Survey / Quarterly Pulse Survey results • CQC Maternity Survey results for patient experience aligned to national scores • Downward trend in complaints/concerns about poor staff attitude, communication, and people not feeling listened to • 85% service users feel listened to and their questions answered • 85% completion of the B7 Connected training by the midwifery leadership/management workforce • 85% attendance of the senior medical workforce or doctors in leadership roles on the Trust Leadership Development Programme • NHS Staff survey re: Bullying and Harassment, and poor behaviours

❖ Implementation of Inclusion and Respect Charter	August 2024	There are clearly defined standards of behaviours that set out expectations for all interactions throughout the maternity journey and neonatal care	Cohesive team working and safe spaces based on common goals, and a shared understanding of the individual and unique contribution of each team member
			
			Alignment to Trust-level Inclusion and Respect Charter once published
			
			Values-based recruitment and achievement reviews inclusive of requirements for demonstrable adherence to Trust Values
				• Improved trajectory for NHS Staff Survey:
				  • People Promise 1 – we are compassionate and inclusive
				  • People Promise 3 – we have a voice that counts

❖ Structured escalation processes for raising concerns for the workforce and service users outside of clinical situations* *Clinical escalation in Workstream3	March 2025	There are development opportunities for the multi-professional workforce to be involved with and support a culture of safety Service users increasingly feel that their concerns will be heard and acted upon Listening to and acting upon issues raised by staff or service users through complaints, MNVP or FTSU	Freedom to Speak Up (FTSU) Guardians listen to, act upon and respond openly and effectively to concerns Workforce access to FTSU training Clear, available and accessible processes of escalation for the workforce and service users Visible leadership and presence in the clinical setting Evidence of 'you said, we did' in relation to staff concerns and patient concerns	• Your Voice is Heard (YVIH): 90% women feel listened to • FTSU report routinely presented to Maternity and Neonatal Assurance Group (MNAG): case figures, themes, escalation and resolution • FTSU training completion rates • Full implementation of Maternity Safety Champions
❖ Completion of the SCORE survey	May 2024	A clear understanding of the current culture in the maternity service	Identified areas for quality improvement through gap analysis of SCORE results	• SCORE Survey Results • Identified improvements against previous survey

Workstream 2: Developing and sustaining a culture of safety, learning and support

Objective: To embed robust governance structures that underpin continuous improvement and delivery of high quality, person-centred care

Maternity and Neonatal Improvement Programme

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

Executive Senior Responsible Officer (SRO): Chief People Officer

Associated Document: Reading the Signals, October 2022 – Dr Bill Kirkup CBE

High-level Milestones What?	**Timeframes** When?	**Outcomes (objectives/improvements)** Why?	**Outputs (deliverables)** How?	**Measurable Benefits (results)** Our achievements will show through…
❖ Clear patient-safety related backlogs	December 2023	Incidents, Serious Incidents (SIs), complaints, guidelines, and patient information leaflets reflect current regulatory requirements and best practice	There is a clear process for review of patient-safety related activity and documentation to ensure that documents and processes are updated prior to deadlines and expiry dates becoming overdue	• No. overdue 'open' incidents • No. overdue 'open' serious incidents • No. overdue 'open' complaints responses • No. expired guidelines • No. expired patient information leaflets
❖ Achievement of local safety measures to support national maternity safety ambition to halve rates of perinatal mortality from 2010, by 2025	March 2025	Improved safety for service users, the workforce, and regional / national standards of maternity and neonatal care	Implementation of Saving Babies Lives Care Bundle (SBLCB) v3 through Workstream 3 – Clinical Pathways Implementation of Maternity and Neonatal Safety Champions as a point of contact to raise concerns, with established governance processes for sharing learning/escalation of concerns	• 50% reduction in incidents of avoidable harm with adverse outcomes benchmarked against 2010 data • Compliance with the process and outcome indicators defined within Saving Babies Lives Care Bundle (SBLCB) v3 – dashboard metrics to be developed and reviewed with oversight and support of a structured governance process • Progress against areas of concern raised through Maternity and Neonatal Safety Champions
❖ Compliance with 15 x Immediate and Essential Actions (IEAs) of Ockenden (Final) – March 2022	March 2025	Meaningful and sustained changes will be made to the quality and safety of services to prevent future avoidable adverse outcomes for service users and their families	Gap analysis of 15 x IEAs with current Trust performance to identify remaining areas for improvement to be included in supporting project plan Sustained delivery of the 15 x Immediate and Essential Actions (IEAs)	• Compliance with Ockenden IEAs
❖ Compliance with 10 x Safety Actions within Clinical Negligence Scheme for Trusts (CNST) Year 5	January 2024 *Submission by 01 Feb 2024*	Supporting continuous improvement to patient safety through alignment to the NHS Maternity Safety Strategy, which sets out the Department of Health and Social Care's ambition to reward those who have acted to improve maternity safety Improved patient outcomes Improved service user and workforce experience	Gap analysis of CNST Year 5 with current Trust performance against ten safety actions to identify areas for improvement Development of local guidance and a project plan to successfully implement and achieve compliance with CNST supported by clearly defined roles and responsibilities for each of the ten safety actions Monthly local and regional CNST reporting using the Perinatal Quality Surveillance Tool (PQST) to demonstrate month-on-month progress against the ten safety actions within the CNST framework Shared knowledge and awareness of Maternity Services Data Set (MSDS) with monthly results and trends used to compliment identified areas for improvement	• Compliance with CNST Year 5 • Benchmarked results of MSDS data with EKHUFT producing comparable outcomes (within middle 50%) to national trends

❖ Implement Maternity and Neonatal Quality and Safety Framework v3 (to replace current Risk Management Strategy v2)	September 2023	Good systems of control underpin safer care through a governance model that sets out robust monitoring and reporting structures, patient safety processes and methods for identifying and sharing lessons learned to improve services, patient experience processes, clinical effectiveness, and clear roles and responsibilities	Embedded governance structure with clear reporting lines from ward to Board (includes representation of Maternity at Trust Board) with supporting terms of reference that define purpose and membership, and a suite of template documents for professional presentation, consistency and standardisation Standardised processes for managing patient safety activities (including escalation and/or referral criteria), patient experience, and clinical effectiveness activities Alignment of local guidelines to the Trust-level 'Development and Management of Trust Policies' with a clear governance process for derogation from national guidelines Implementation of agreed annual clinical audit plan Alignment to 3-Year Single Delivery Plan for Maternity and Neonatal Services Theme 3: Developing and sustaining a culture of safety, learning, and support	• 75% attendance of members at meetings within the governance reporting structure • Governance report templates for all forums • 95% Serious Incident (SI) investigations complete within 'X days (monitored via SI tracker) • 95% of families involved in a serious incident have been offered to be involved in the investigation • 75% of families involved in the investigation process felt listened to, involved, and had their needs met with the support of an ISA • 30% reduction in complaints/concerns being returned for the reason of questions not being fully answered • Ethnicity to be included in compliance monitoring • Confirmed exit from National Oversight Framework level 4 to National Oversight Framework level 3
❖ Implementation of NHS Patient Safety Incident Review Framework (PSIRF)	March 2024	Embedded and effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety	Alignment to Trust-level preparations and plans in readiness for the roll-out of PSIRF, including plans for engaging and involving patients, families and staff following a patient safety incident Refresh of Datix incident reporting system – aligned to Trust-level Datix upgrade work - to align to future case management, monitoring and reporting requirements Implementation of Independent Safety Advisor (ISA) role to support learning, and service improvements "Finding signals among noise" and taking learning from data to inform areas for improvement, that contribute to the Training Needs Analysis (TNA) Specialist training for roles involved with delivery, engagement, and oversight of PSIRF A proactive and coproduced culture of learning using recognised PSIRF Learning Tools Lessons are learned, identified and shared to inform a cycle of continuous improvement through the Trust's 'We Care' quality improvement framework; underpinned by an Appreciative Inquiry approach	• 100% compliance with PSIRF Standards, including policy, plan and oversight standards • Attendance/completion of PSIRF-specific training by role, as identified in the PSIRF training guidance • Compliance audits and trends of outcomes from changes in practice following use of PSIRF Learning Resource Tools • 'We Care' outcomes
❖ Publication of updated Maternity Dashboard with agreed performance and outcome measures	December 2023	A generation of measures that are meaningful, risk adjustable, available and timely and are analysed and presented using a statistical-based approach to identify random variation versus significant trends and outliers to improve the monitoring and identification of clinical outcomes	Collaboration with NHSE 'Making Data Count' team Alignment to the national requirement for the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use	• Agreed maternity dashboard with performance and outcome measures presented in Statistical Process Chart (SPC) format that identify outliers and trends
❖ Sustained compliance with environmental daily checks	March 2024	An improved environment to support and meet health and wellbeing needs of servicer users and the workforce	Collaborative working with Infection Prevention Control (IPC), and Estates teams to complete quality checks and arrange remedial and/or repair/replacement works 'Stop the clock' assurance process of daily, weekly and monthly environmental safety checks	• 95% compliance Monthly Infection Prevention Control (IPC) Led Environmental Audits • 90% compliance Hand Hygiene (HH), Personal Protective Equipment (PPE) • 95% compliance Weekly Environmental Audit • 100% Daily Environmental Checks • 100% compliance accessible fire routes • Progress against minor works log • Downward trend of patient safety incidents relating to poor estate / infrastructure (Inc. equipment)

❖ Care Quality Commission (CQC) 'Good' rating	March 2025	Safe: People are protected from avoidable harm and abuse, and legal requirements are met Effective: People have good outcomes because they receive effective care and treatment that meets their needs Caring: People are supported, treated with dignity and respect, and are involved as partners in their care Responsive: People's needs are met through the way services are organised and delivered Well-led: The leadership, governance and culture promote the delivery of high-quality person-centred care	Programme of local quality assurance checks and ongoing monitoring based on the CQC assessment framework Joint working with corporate services to implement and escalate necessary improvements including (but not excluded to) Pharmacy, Safeguarding, Infection Prevention Control, Medical Devices, and Estates Delivery of all must and should do requirements identified through the CQC inspection of EKHUFT Maternity Services in January 2023 Routine completion and benchmarking against the Maternity Self-Assessment Tool Compliance with 'Well-led' and 'Safe' CQC domains to meet requirements of the Maternity Safety Support Programme (MSSP) Regulatory compliance reporting through governance forums including (but not excluded to) Women's Health Care Group Governance meeting, CQC Oversight and Assurance Group, Maternity and Neonatal Assurance Group (MNAG)	• 'Good' ratings for CQC self-assessment compliance against the regulatory framework • Compliance with Maternity Self-Assessment Tool • Exit from the Maternity Safety Support Programme • 'Good' rating from future CQC inspection
❖ Coproduction of Maternity and Neonatal guidelines, and patient information	March 2024	Improved involvement of development of information that recognises the workforce and service users as experts in their own right with valuable experiences and knowledge that contribute to service improvement	Establishment and use of stakeholder engagement and involvement forums to gain feedback, thoughts and ideas for guideline and patient information development	• Response rate from stakeholder consultation for guideline development • Response rate from stakeholder consultation for development of patient information

Workstream 3: Clinical Pathways that underpin safe care

Objective: To progress evidence-based clinical care pathways to consistently deliver equitable, high quality, safe care and treatment

Maternity and Neonatal Improvement Programme

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

Executive Senior Responsible Owner (SRO): Chief Medical Officer

Associated Document: Reading the Signals, October 2022 – Dr Bill Kirkup CBE

High-level Milestones What?	**Timeframes** When?	**Outcomes (objectives/improvements)** Why?	**Outputs (deliverables)** How?	**Measurable Benefits (results)** Our achievements will show through…
❖ Compliance with Saving Babies Lives Care Bundle (SBLCB) v3	March 2025	Delivery of the six elements of care within SBLCB v3 supports the national maternity safety ambition to halve rates of perinatal mortality from 2010, by 2025 Improved patient outcomes Improved service user and workforce experience	Gap analysis of SBLCBv3 with current Trust performance against defined process and outcomes measures to identify areas for improvement Development of local guidance and a project plan to successfully implement and achieve compliance with SBLCBv3 supported by clearly defined roles and responsibilities for each element of the care bundle Monthly local and regional SBLCBv3 reporting to demonstrate month-on-month progress against the six elements of the framework	• Compliance with the process and outcome indicators defined within Saving Babies Lives Care Bundle (SBLCB) v3 – dashboard metrics to be developed and reviewed with oversight and support of a structured governance process • Routine use of the Perinatal Mortality Review Tool (PMRT) with escalation reporting to local, Trust and regional governance forums
❖ Implementation of Maternal Early Warning Score (MEWS) 2 and Newborn Early Warning Track and Trigger (NEWTT) 2	March 2025	Identification of abnormal physiological parameters and early intervention may prevent further deterioration and reduce maternal and newborn morbidity and mortality	Embedded use of MEWS tool to help identify women and birthing people at risk of deterioration Alignment to, and implementation of, MEWS2 following completion of the national pilot Embedded use of NEWTT2 tool to detect subtle deterioration in clinical conditions that can lead to early medical review, which in turn reduces morbidity	• Upward trend in MEWS compliance audit results • Upward trend in NEWTT2 compliance audit results • Reduced trend in serious incidents resulting from failure to recognise and act on the deteriorating woman, birthing person, and/or baby
❖ Development of clinical care pathways, including: • Sonography • Triage • Diabetes • Perinatal Mental Health • Recognition of Deteriorating Woman (HDU) • Antenatal Systems and Processes • Postnatal Care Pathway • Antenatal Newborn Screening • Multiple Pregnancy • Transitional Care / ATAIN • Fetal Medicine Unit • Midwifery-led Care • Fundamentals of Care • Removal of Virtual Appointments • Clinical Practice Standards • Bereavement Care • Discharge Processes	July 2023 – March 2026	Consistency in the application of 'best practice' care through the adoption of Integrated Care System (ICS) shared standards and guidelines to be part of an NHS service with joint initiatives that respond to local and regional maternity and neonatal care needs Service users will have timely access to the right care, in the right place, at the right time from the right person	Benchmarking against, and alignment to, evidence-based best practice and national guidelines with a clear governance process for derogation Use of national and local clinical outcome data, incidents, compliments and complaints to inform areas for improvement and shape ways of working Implementation of the Maternity and Neonatal Improvement Programme (MNIP) for development through care pathway project plans delivered by pathway Leads and multidisciplinary teams Alignment to 3-Year Single Delivery Plan for Maternity and Neonatal Services Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care	• Improved perception of service user choice for place of birth CQC Maternity Survey results • Delivery of Key Performance Indicators (KPIs) within project plans for clinical pathway development – dashboard metrics to be developed and reviewed with oversight and support of a structured governance process • MSDS Benchmarking with EKHUFT producing results within 5% of national comparator group • Compliance with Perinatal Quality Surveillance Model (PQSM) reported monthly through local and regional governance structures using the Trust Perinatal Quality Surveillance Tool (PQST) • Downward trend in complaints/concerns and incidents results from poor quality of care • Benchmarked results of national clinical audits with EKHUFT producing comparable outcomes (within middle 50%) to national trends

❖ Achievement of UNICEF Baby Friendly Initiative (BFI) accreditation for infant feeding	March 2027* (national timeframe goes beyond the duration of this programme)	A workforce supported to provide sensitive and effective care so that service users can make informed choices about feeding, and overcoming challenges to enable successful breastfeeding when this is the preferred option	Alignment to the UNICEF BFI guides and standards and implementation of tools, forms and eLearning Promotion of the infant feeding specialist teams across maternity and neonatal services, and development of a project plan to prepare the service for implementation	• Maternity and neonatal service accreditation with UNICEF BFI • Infant feeding dashboard metrics

❖ Implementation of escalation pathways for service users and members of the workforce to raise patient safety concerns	December 2023	Clear pathways for clinical escalation identify roles and responsibilities and actions to take based on the need / acuity of emerging emergency situations
		
		Service users and the workforce are empowered to, and are cared for/work within the right culture, behaviours and conditions that enable effective clinical escalation when they identify concerns, deterioration or a potential mistake
		
		Service users are witness to respectful and conducive conversations that provide reassurance and better understandings of their own situation
			Embedded use of the Maternity Escalation Policy and use of MOPEL action cards
			
			Implementation of structured escalation framework e.g. Each Baby Counts: Learn and Support Escalation Toolkit
			
			Standardise a daily cross-site multi-professional safety huddle every day to identify any concerns/issues anticipated that day
			
			Staff and service users report feeling listened to
				• Introduction of scheduled 'Escalation surveys':
				  • Do you know everyone on your shift today?
				  • Do you know who you're going to escalate concerns to during the shift?
				  • Have you said thank you to a colleague?
				  • Have you celebrated your successes together?
				  • Have you made sure your colleagues are okay at the beginning and end of each shift?
				• Reduced adverse outcomes from serious incidents
				• Alignment to NHS Staff Survey national average scores for:
				  • People Promise 3 – we have a voice that counts (5.6 v 6.6)
				• 85% YVIH metric services users 'felt listened to'
				• Compliance checks against SITREP template

❖ Implementation of NHS South East Clinical Delivery and Networks Maternity and Neonatal Co-Production Resource Pack		Embedded coproduction into the culture and practice of maternity services to ensure that pathways and patient information are robustly developed to reflect and be responsive to local need	Use of NHS South East Co-production tool(s) when mapping out clinical pathway development needs to inform the content of supporting project plans	• Use of the coproduction tool as part of clinical pathway development approach/plans within the Maternity and Neonatal Improvement Programme (MNIP)
				• Improved service user feedback re: involvement in local redesign of maternity and neonatal services e.g.
				  • Maternity and Neonatal Voices Partnership (MNVP) Feedback Log
				  • Formal compliments
				  • MNIP Feedback processes

Workstream 4: Listening to and working with women and families with compassion

Objective: To listen to our birthing people and our workforce to design coproduced, personalised and equitable Maternity & Neonatal Services

Maternity and Neonatal Improvement Programme

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

Executive Senior Responsible Owner (SRO): Chief Nursing and Midwifery Officer

Associated Document: Reading the Signals, October 2022 – Dr Bill Kirkup CBE

High-level Milestones What?	**Timeframes** When?	**Outcomes (objectives/improvements)** Why?	**Outputs (deliverables)** How?	**Measurable Benefits (results)** Our achievements will show through…
❖ Implementation of Personalised Care and Support Plans (PCSPs), aligned to the Core20PLUS5 Framework	December 2023	People are empowered and have choice and control over the way their care is planned and received based on 'what matters' to them and their individual needs and preferences without repetition Core20PLUS5 is an Integrated Care System (ICS) framework to target clinical areas requiring accelerated improvement based on; - 20% of the national population as identified by the Index of Multiple Deprivation (IMD) - ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes - Five clinical areas of focus which require accelerated improvement; one of these being **Maternity**	Sharing of PCSP Information with, and completion of Personalised Care Institute training by, the maternity workforce Implementation of the NHSE Personalised care and support planning guidance With their midwife or obstetrician, service users will consider and discuss their life, family situation, health and wellbeing, and preferences, so that their care reflects their needs and wishes Through the eLearning for healthcare (eLfH) Cultural Competence programme the workforce responds to the needs of our diverse population through an understanding of the key issues relating to culture and how this may influence the uptake of health care and treatment options 'Intentional rounding' ensures regular checks that fundamental care needs of service users are met, as recorded in their PCSP (pain, placement, personal needs, positioning) Care outside guidance pathway	• Benchmarked PCSP completion rates against registered pregnancies to identify compliance • Intentional Rounding compliance audit results • Improved CQC Maternity Survey results
❖ Improved results of indicators from the CQC Maternity Survey	March 2024	CQC Maternity Survey 2023 demonstrates improved service user experience of antenatal, intrapartum and postnatal care including support services e.g. infant feeding	Delivery of local CQC Maternity Survey action plan to address results from 2022, focused on identified areas for improvement	• Progress against local CQC Maternity Survey 2022 action plan • Improved CQC Maternity Survey 2023 Results
❖ Ensuring the availability of bereavement services 7 days a week for families who sadly experience loss	March 2024	Bereaved families receive compassionate high-quality care including appropriate accommodation	Implementation of a 7-day bereavement service	• Evidence of required workforce, dedicated bereavement accommodation and facilities across sites • Rotas demonstrate availability of a 7-day service
❖ Implementation of Maternity and Neonatal Engagement Framework	March 2024	Coproduction of services with the workforce and service users garners valuable feedback about how healthcare services work in practice, considers what works well and brings about ideas for improvement. Participation helps to improve health inequalities experienced by protected characteristic groups	Collaborative development of an Engagement Framework including, but not exclusive to: - Maternity and Neonatal Voices Partnership (MNVP) - Local Maternity and Neonatal System (LMNS) - Integrated Care System (ICS) - EKHUFT Patient Participation and Action Group (PPAG) - EKHUFT Maternity service user feedback - EKHUFT Maternity workforce feedback	• Progress against Engagement Framework development plan

❖ The workforce and service users feel involved in the improvement of Maternity and Neonatal services through coproduction	March 2024		Collaborative working with local and regional stakeholder groups opens opportunities for sharing learning from service user experiences, and for involvement with service redesign
			
			Support and promotion of opportunities for engagement with service developments are provided through multiple platforms including the Professional Midwifery Advocate (PMA) team
				• Improved trajectory of NHS Staff Survey for:
				  • Staff Engagement
				  • Morale
				  • People Promise 3 – We have a voice that counts
				• Progress against the MNVP Feedback Log
				• Progress against the MNVP Work Plan

❖ Improved equity and equality in maternity and neonatal care	March 2024	All service users achieve good health outcomes by responding to each person's unique health and social situation, with increasing support as health inequalities increase, so that care is safe and personalised for all	Alignment to the NHSE Equity and Equality guidance for local maternity systems Equitable access to perinatal mental health services Equitable access to perinatal pelvic health services Alignment to NHS Accessible Information Standard (AIS) ensures information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss are met Increased diversity of the East Kent Maternity and Neonatal Voices Partnership (MNVP) to reflect the local community	• MBRRACE-UK Perinatal mortality metrics for stillbirths and neonatal mortality for Black and Asian babies divided by the rate for White babies in the UK, expressed as a ratio • Office for National Statistics (ONS) Perinatal mortality metrics for stillbirths and neonatal mortality for the most and least deprived communities in England, measured using the slope index of inequality • AIS Guideline compliance • Evidence of AIS needs recorded in patient record systems e.g. Euroking, PAS, Sunrise • Case numbers accessing perinatal mental health / pelvic health services by ethnicity and Index of Multiple Deprivation (IMD) • NHS Mental Health Dashboard metrics • Maternity dashboard metrics are available by ethnicity and Index of Multiple Deprivation (IMD) • MNVP demographic data
❖ Embedded communications plan and Patient Voices Model to improve service user and workforce engagement, feedback and experience	March 2024	Good experience of care, treatment and support underpins excellent maternity and neonatal services, alongside clinical effectiveness and safety, and helps to shape service improvement	Consistent, structured and timely information is shared and received between maternity and neonatal services, its workforce, service users and regional partners though an agreed communications plan, which includes multiple formats such as: - Patient stories - Newsletters - Surveys - Infographics Platforms for sharing messages include: - Workshops - Meetings / forums - Social media - Email - Videos / podcasts - Patient information screens Maternity Patient Voices Model collates feedback from all formal sources into a central point for analysis of response rates, satisfaction measures, themes and trends. Learning is shared through the communications plan and identifies areas for improvement; areas for improvement are collated into a central point for oversight and triangulation 'Little Voices are Heard' local initiative for children and young people to raise concerns in a safe space to a trusted person	• Friends and Family Test (FFT) results • Your Voice is Heard metrics • Compliance with CNST Safety Action 7 • Themes and tone of qualitative service user feedback from all sources • Feedback results from the Patient Voices Model

Workstream 5: Growing, retaining and supporting our workforce

Objective: To embed a process of continuous review and planning that produces and retains a competent, supported and sustainable workforce

Executive Senior Responsible Officer (SRO): Chief Nursing and Midwifery Officer

Associated Document: Reading the Signals, October 2022 – Dr Bill Kirkup CBE

Maternity and Neonatal Improvement Programme

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

High-level Milestones What?	**Timeframes** When?	**Outcomes (objectives/improvements)** Why?	**Outputs (deliverables)** How?	**Measurable Benefits (results)** Our achievements will show through…
❖ Implementation of a structured framework for supporting the local workforce	March 2024	Improved quality and confidence across the multi-professional workforce through a structured framework of support, reflection and learning that harnesses personal and professional development.	Implementation of a medical clinical supervision model aligned to Royal College of Obstetricians and Gynaecologists (RCOG), and British Association of Perinatal Medicine (BAPM) guidance A dedicated Professional Midwifery Advocate (PMA) team to support local needs and priorities through restorative clinical supervision, aligned to a formalised clinical supervision model such as A-EQUIP Thematic lessons learned from reflective practice and clinical supervision activities	• Live register of clinical supervisors with assigned supervisees across all grades/functions • Evaluation and feedback on the clinical supervision programmes and supervisor(s) • Improved trajectory for NHS Staff Survey for: • People Promise 5 – We are always learning
❖ Agreed Maternity and Neonatal Succession Plan using a recognised NHS talent management toolkit,	March 2025	Workforce planning supports current and future, local, national and international resource requirements with clearly defined career pathways to meet and adapt to service needs	Alignment to the NHS People Plan Medical job plans reflective of demand and capacity Maternity and Neonatal workforce, recruitment and retention plan(s) Clearly defined local and regional career pathways to provide guidance and options to the workforce when making career choices	• Progress against the Succession Plan • Improved trajectory for NHS Staff Survey for • People Promise 2 – We are recognised and rewarded • 85% Appraisal rate
❖ Implementation of 3-year Training Needs Analysis (TNA), and Annual Training Plan (ATP)	March 2024	Teams that work together, train together across all pre- and post-registration training for all professions, to understand and respect each other's skills and perspectives. Supported to complete local, regional and national training requirements the multi-professional workforce is knowledgeable of, and works to, current statutory and mandatory standards A highly competent workforce uses skills and knowledge gained through a dedicated learning environment with specialist resources and learning tools to provide personalised, high-quality care. These skills are aligned to a formalised competency framework, include a focus on professional behaviour and compassionate care, and provide opportunities to progress in-line with an inclusive succession plan Staff feel valued when they are supported to develop	Training Needs Analysis (TNA) identifies annual and 3-yearly statutory and mandatory training requirements by grade and clinical / non-clinical roles, including Internationally Educated Midwives (IEMs) and preceptors/preceptees The TNA, in line with clinical competency framework, also includes thematic learning from patient-safety related activities and feedback from the workforce and service users where improvements for knowledge and skills are identified A funded programme of training and education is collated into an Annual Training Plan (ATP) with opportunities including Continued Professional Development (CPD) shared through a Maternity and Neonatal prospectus Competency frameworks that underpin each role across Maternity and Neonatal services	• 85% compliance with annual statutory and mandatory training completion rates • Benchmarked General Medical Council (GMC) National Training Survey (NTS) results with EKHUFT showing comparable outcomes to national trends (upwards trend in 'green' ratings) • Progress / compliance of delivery of the TNA/ATP • Monitoring and review of the training budget/spend • Compliance with the Competency Framework, by staff grade, benchmarked against national requirements

❖ An effective 'Safe Staffing' model to meet local and regional service needs	March 2025	Workforce (safe staffing) planning tools are used and monitored to ensure sufficient skill mix requirements are provided on each shift / clinic to enable teams to maximise the ability for high-quality patient-centred care
		
		Reduced absence and improved workplace satisfaction resulting from improved and safer working conditions enables people to have more positive experiences whilst caring for service users, and each other's wellbeing at work.
		
		Clarity around expectations and acceptance of personal duties, including the authority of clinical leaders, that are provided to the highest of standards - aligned to the respective scope of practice - by each member of the multidisciplinary team
		
		Staff feel valued at al stages of their career
			Embedded use of an activity/acuity-based workforce assessment and planning tool to identify daily and long-term establishment needs, such as Birthrate Plus (BR+)
			
			Implementation of a process for RCOG Certificate of Eligibility for short-term locums providing middle-grade cover
			
			Alignment to 3-Year Single Delivery Plan for Maternity and Neonatal Services Theme 2: Growing, retaining and supporting our workforce
			
			Rotas that reflect and provide the appropriate skill mix required for each shift, including e.g. anaesthetics, neonatal services, sonography
				• Improved trajectory for NHS Staff Survey:
				  • People Promise 4 – We are safe and healthy
				  • People Promise 6 – We work flexibly
				  • Morale
				• Improved People & Culture (HR) related rates:
				  • 11.5% Turnover Rate
				  • 5% sickness absence
				  • 10% Vacancy
				  • 85% Appraisals
				• Rota fill rate / compliance
				• Reduction in Premium Pay (PP) costs
				• Compliance with CNST SA4 & 5

❖ Sustained levels of improved staff satisfaction	December 2024	People work effectively as a diverse team with varied but equally weighted skills and experience that drives an inclusive culture and sense of belonging that supports equal opportunities for personal and professional development	Access to a full suite of wellbeing support, which includes mental health services, and return to work meetings to support people coming back into the workplace following a period of absence
			
			'Check in / Check out' opportunities at the beginning and end of each shift support safe spaces to have conversations about any personal worries or concerns
			
			Promotion of, and equal opportunities for, flexible working
			
			Routine stay / exit interviews to understand the reasons that people remain in post / leave the EKHUFT Maternity Service to enable identification of the what could be improved or done more consistently well to retain the workforce
				• Reduced sickness absence rate due to work-related mental wellbeing
				• 11.5% Turnover rate
				• Improved Royal College of Midwifery (RCM) survey results
				• Improved trajectory of NHS Staff Survey for
				  • People Promise 6 – We work flexibly
				  • People Promise 7 – We are a team
				• Friends and Family Test results aligned to national average for Maternity and Neonatal services
				• CQC Maternity Survey results aligned to national average scores

❖ Improved provisions for student development	March 2024	Undergraduate and postgraduate medical students are trained to deliver high-quality, safe patient care with good outcomes through joint working with partner medical schools and within the requirement of regulatory and educational frameworks All trainees including apprentices, student midwives, and medical students will be supported through their programme of education by EKHUFT Maternity and Neonatal services to learn local and regional policies and procedures (based on national guidance) for the delivery of good quality maternity and neonatal care Maternity and Neonatal clinical educators work to secure the future workforce, retain existing employees through, and maximise productivity through education and training to optimise capability and confidence at every level (NHS Educator Workforce Strategy)	Reintegration of student midwives into EKHUFT A multi-professional 'student plan' will form part of the over-arching recruitment / workforce plan for Maternity and Neonatal Services, at local and regional levels Recruitment hubs will promote new opportunities across Maternity and Neonatal services, including international recruitment, and a suite of unique selling points (USPs) will set EKHUFT apart from, but remain complimentary to and considerate of, national peers, to establish the Trust as a preferred choice of employment Students will spend the necessary time for their education programme in clinical practice with direct contact with service users. This could be at home, in the community, on midwifery-led units, in specialist clinics, and in other hospital-based settings supported by a team of qualified practice education facilitators Learning resources, time and spaces will ensure compliance with regulatory and educational frameworks	• Progress against Student Plan • Defined set of Unique Selling Points (USPs) • Improved trajectory of NHS Staff Survey for • People Promise 5 – We are always learning • Completion rates for student education modules • Student Qualification rates • Benchmarked General Medical Council (GMC) National Training Survey (NTS) results with EKHUFT showing comparable outcomes to national trends (upwards trend in 'green' ratings) • Compliance with requirements of Health Education England (HEE) Quality Interventions Review Report requirements – June 2023 • 'Student to employee' conversion rates • Compliance audits of job plans / rotas for members of the education faculty

❖ A workforce reflective of the service demographic	March 2025	An understanding of local and regional cultural needs from the sharing and learning of cultural experiences from maternity and neonatal involvement at local, regional and national equality and diversity networks
		
		A support network for colleagues, including internationally educated midwives, from black, Asian and minority ethnic backgrounds to have a voice that speaks clearly to leadership, about their unique experiences within the healthcare system
			Established Maternity and Neonatal Equality, Diversity and Inclusion (EDI) network
			
			Representation of Maternity and Neonatal services at the Trust's Ethnic Diversity Engagement Network (EDEN)
			
			Alignment to NHS People Plan, recruitment and retention hubs supported by targeted and accessible recruitment campaigns with diverse recruitment panels
				• Membership and attendance at EKHUFT EDI network meetings
				• Membership and attendance at EKHUFT EDEN meetings
				• Benchmarked Workforce Equality Data Standards
				  • Workforce Race Equality Standards (WRES) data
				  • Workforce Disability Equality Standards (WDES) Data

Workstream 6: Infrastructure and Digital

Objective: To establish an environment with enhanced digital systems to ensure the workforce and service users have access to the information and facilities they need, when they need it

Executive Senior Responsible Officer (SRO): Director of Strategic Development and Partnerships

Associated Document: Reading the Signals, October 2022 – Dr Bill Kirkup CBE

Maternity and Neonatal Improvement Programme

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

High-level Milestones What?	**Timeframes** When?	**Outcomes (objectives/improvements)** Why?	**Outputs (deliverables)** How?	**Measurable Benefits (results)** Our achievements will show through…
❖ Implementation of Maternity and Neonatal Digital Strategy ❖ Implementation of regional Maternity and Neonatal Information System	March 2025	Digital ways of working and innovation through technology are used to improve access to healthcare and information, quality of services and safer service provision, and effective integration between services and the wider healthcare system Frontline electronic patient record management system(s) enable secure and timely access to relevant clinical information at the point of care by the appropriate person to support clinical decision-making and clinical management for the best clinical outcome(s)	Coproduction with internal and external stakeholders will ensure that objectives within the Digital Strategy are realistic and achievable and consider the needs of people using digital systems for accessing, recording, assessing, monitoring and managing information Engagement with the WGLL Hub and Integrated Care System (ICS) for support regarding digital health information and good practice examples of technology-enabled healthcare, standards, guides and policies, useful tools and templates and networking information The multi-professional workforce is able to access electronic patient records at the point of care throughout each stage of the maternity and neonatal journey to improve timeliness and effectiveness of clinical assessment, decision-making, and management Service users are able to access their digital records, patient information leaflets and Personalised Care and Support Plans (PCSPs) through the Patient Portal	• Periodic (six-monthly) completion and review of digital maturity assessment • Progress against the MNIP Infrastructure Project Plan and specific digital requirements (e.g. connectivity in the Community, Euroking Developments) • End-to-end electronic patient record system across maternity and neonatal services • Pending standards through WGLL page • Patient Portal registration vs pregnancy rates
❖ Compliance with Health Buildings Note (HBN) 09-02: Maternity care facilities – aligned to Trust-level Estates Plans	March 2026	Alignment to best practice guidance on the design and planning of adaptation/extension of existing facilities across all maternity settings to provide safe care of service users in a comfortable, relaxing environment that facilitates what is a normal physiological process, enabling self-management in privacy whenever possible, and enhances the family's enjoyment of an important life event	Coproduction with service users to understand preferences for room design to enable choice and control over their labour and birth Collaboration with key interfaces to ensure appropriate facilities are available for intervention when complications occur Provision of dedicated training spaces	• Compliance with 'key recommendations' within HBN 09-02 guidance • Compliance with Health Education England (HEE) Quality Framework relating to learning environment • Downgrading of Estates risk (CR144) on Corporate Risk Register • Relocation of Bereavement Suite (WHH) • 30% Reduction in the number of complaints relating to Estates and Facilities
❖ Sustained compliance with Planned Preventative Maintenance (PPM) schedule, and equipment management	December 2023	Embedded systematic approach to the acquisition, deployment, maintenance (preventive maintenance and performance assurance), repair and disposal of medical devices to ensure delivery of safe, efficient, high-quality services	Alignment to national Managing Medical Devices guidance Effective processes and collaborative working to undertake routine equipment safety checks with agreed arrangements for service, repair and replacement Escalation process for 'failed' medical devices 'Stop the clock' assurance process of daily equipment safety checks	• 90% compliance with Planned Preventative Maintenance (PPM) schedule • 100% compliance Daily Equipment Safety Checks (all settings)

MNIP Workstream 1 - Developing a positive culture

Today's Date: 16/08/2023

Highlights (work completed this reporting period)

- ✓ Development of draft project plan to reflect requirements of Workstream 1 Charter
- ✓ Commencement of Perinatal Culture Leadership Programme for Care Group Quad (Leaders)
- ✓ Initial discussions with NHSI to plan for launch of SCORE survey in October 2023
- ✓ Launch of 'We Hear You' escalation process for the workforce
- ✓ Leave your troubles at the door' and Maternity & Neonatal Safety Champion posters shared with Maternity ward

Project SRO	Chief People Officer	**Project Care Group Senior Lead**	Director of Midwifery
Project Lead	Care Group Head of People and Culture	**Project Start Date**	01/04/2023
Project Support	MNIP Project Manager	**Project End Date**	31/03/2025

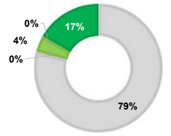
Maternity and Neonatal Improvement Programme

PROJECT Progress Bar

17%

No. Actions	24	Status (%)
Not scheduled to start	19	79%
Off track	0	0%
At risk	0	0%
On track	1	4%
Complete	4	17%
	24	**100%**

ACTION COMPLETION STATUS (%)



PROJECT Cost

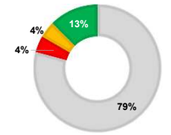
£0.00

PROJECT Delivery Status

15%

Level of Assurance	24	Status (%)
Not scheduled to start	19	79%
Not yet delivered	1	4%
Delivered, not evidenced	1	4%
Evidenced and assured	3	13%
	24	**100%**

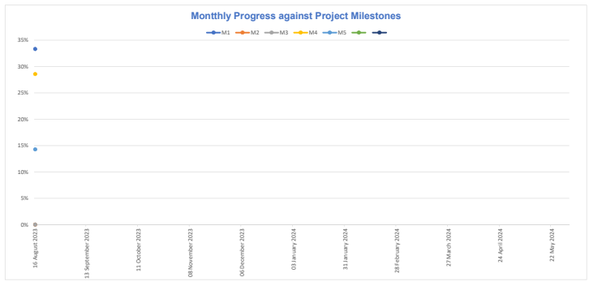
ACTION ASSURANCE STATUS (%)



No DAYS left

593

Montthly Progress against Project Milestones



Monthly Progress against Project Milestones

Milestone Ref	16 August 2023	13 September 2023	11 October 2023	08 November 2023	06 December 2023	03 January 2024	31 January 2024	28 February 2024	27 March 2024	24 April 2024	22 May 2024
M1	33%										
M2	0%										
M3	0%										
M4	29%										
M5	14%										

Status	Summary of At Risk / Overdue Actions	Action Ref.	No. Days Overdue
OT	None	N/a	N/a
AR	None	N/a	N/a

< 30 Days of completion date

> 30 Days of completion date

	Key Risks to Delivery	Mitigations
1	Misalignment with Trust-level programmes of work and timelines	All MNIP workstreams have been coproduced and triangulated with known Trust-level programmes of work for example, with the Executive Integrated Improvement Plan (IIP) in response to 'Reading the Signals' (Oct 2022)
2	Missed deadlines resulting from lack of clarity regarding roles and responsibilities	There are clearly defined owners at Executive, Care Group, Management and Project levels. Work has been ongoing to develop relationships with key interfaces / teams required for successful delivery of the full programme of work. All tasks will be shared with task owners, and each owner will be a member of the project group to attend monthly progress review meetings and attendance will be monitored and shared through the MNIP governance reporting structure
3	Implementation of initiatives and improvements are not sustained	Some initiatives and improvements may be superseded by further enhanced ways of working either organically, through a cycle of PDSA (Plan, Do, See, Act) or because outcomes have proved them to be ineffective. However, effective changes will be underpinned by the the NHSI Sustainability framework and championed by service leaders / ambassadors; they will also be monitored by project leads for a six-month period following completion of the project plan before being reviewed for approval to become 'business as usual' ways of working

Maternity and Neonatal Improvement Programme - Project Plan		Project Title	Workstream 1 - Developing a positive culture	Executive Sponsor	Chief People Officer
Care Group Senior Lead	Director of Midwifery	Project Lead	Care Group Head of People and Culture	Project Manager	MNIP Project Manager
MNIP Vision	**Empowering our staff to work with women and their families to make a difference in outcomes for maternity and neonatal care**				

Maternity and Neonatal Improvement Programme

	Project Milestones		Project Outputs	Project Qualitative and Quantitative Measures		Cost	
1	Delivery of NHSI Culture and Leadership Programme (CLP)	31/03/2025	• A programme based on nationally recognised workforce culture assessment tools / frameworks e.g. NHSI CLP • Perinatal Quality Leadership Programme for Care Group Quad • Alignment to Royal College of Obstetricians & Gynaecologists (RCOG) Leadership and Management Framework • Use of acquired skills and learning to demonstrate compassionate leadership and nourish a safe working environment • Improved capacity of resources to deliver services due to improved workforce morale • Implementation of the Trust-level Leadership Behaviours Framework once published linked to a re-launch of the Trust values	1	• Register of Change Managers appointed through NHSI Culture and Leadership Programme (CLP) and outputs from their programme of work • Perinatal Quality Leadership Programme completion • Yearly upward trends in NHS Staff Survey / Quarterly Pulse Survey results • CQC Maternity Survey results for patient experience aligned to national scores • Downward trend in complaints/concerns about poor staff attitude, communication, and people not feeling listened to • 85% service users feel listened to and their questions answered • 85% completion of the B7 Connected training by the midwifery leadership/management workforce • 85% attendance of the senior medical workforce or doctors in leadership roles on the Trust Leadership Development Programme • Downward trends in NHS Staff survey re: Bullying, harassment, and poor behaviours	1	£0.00
2	Delivery of Trust-level leadership development programme for those recruited into leadership posts	31/03/2025	• Wider workforce opportunities through statutory and mandatory training programme to include values and behaviours of leaders across the service • Embedded process and practice for managing behaviours that do not meet Trust values	2		2	£0.00
3	Implementation of Inclusion and Respect Charter	31/08/2024	• Cohesive team working and safe spaces based on common goals, and a shared understanding of the individual and unique contribution of each team member • Alignment to Trust-level Inclusion and Respect Charter once published • Values-based recruitment and achievement reviews inclusive of requirements for demonstrable adherence to Trust Values	3	• Improved trajectory for NHS Staff Survey: - People Promise 1 – we are compassionate and inclusive - People Promise 3 – we have a voice that counts	3	£0.00
4	Structured escalation processes for raising concerns for the workforce and service users outside of clinical situations* (*Clinical escalation in Workstream 3)	31/03/2025	• Freedom to Speak Up (FTSU) Guardians listen to, act upon and respond openly and effectively to concerns • Workforce access to FTSU training • Clear, available and accessible processes of escalation for the workforce and service users • Visible leadership and presence in the clinical setting • Evidence of 'you said, we did' in relation to staff concerns and patient concerns	4	• Your Voice is Heard (YVIH): 90% women feel listened to • FTSU report routinely presented to Maternity and Neonatal Assurance Group (MNAG): case figures, themes, escalation and resolution • FTSU training completion rates • Full implementation of Maternity Safety Champions	4	£0.00
5	Completion of the SCORE survey	31/05/2024	Identified areas for quality improvement through gap analysis of SCORE results	5	• SCORE Survey Results • Identified improvements against previous survey	5	£0.00

Project Start Date	01/04/2023
Project End Date	31/03/2025
Total No. Days	730
Days Left	593

Objective (Milestone) 1 — Delivery of NHSI Culture and Leadership Programme (CLP)

Milestone Completion Date: 31/03/2025 | Milestone Status (RAG): Not scheduled to start | Milestone Progress: 33% | Milestone Delivery: 33% | Milestone Costs: £0.00

Action Ref.	Action	Owner (Role)	Start Date	Due Date	No. days	Action Status (RAG)	Progress Bar	Completion Date	No. Days Overdue	Cost (£)	Progress notes	Level of Assurance	Delivery Progress	Evidence Log (to demonstrate output)
1.1	As part of Phase 1 of the Perinatal Culture and Leadership Programme (PCLP) share care group Quad delegate details with NHSI for registration and enrolment	*To be agreed*	01/04/2023	31/08/2023	152	Complete	100%		0	£0.00	16.08.23 - Care group Quad for this programme are: DoM (MC) / Ass. Medical Director (ZW) / Head of Ops (CK) / Neonatal Clinical Lead (SM)	Evidenced and assured	100%	1.1 01 PCLP Welcome Document 1.1 02 PCLP Programe Timeline
1.2	Care Group Quad to complete 8 x development days over a six-month period (mix of virtual, and face-to-face) that will be hosted by an external provider ('Safe and Reliable')	Women, Children and Young People Care Group (WCYP CG) Quad	01/04/2023	30/09/2023	182	Not scheduled to start	0%		-45	£0.00	16.08.23 - Pending copy of Phase 1 dates for evidence folder	Not scheduled to start	0%	
1.3	Following completion of Phase 2 (milestone 5 - SCORE Survey), Care Group Quad to engage with, and deliver, Phase 3 of the PCLP	Women, Children and Young People Care Group (WCYP CG) Quad	01/03/2024	31/05/2024	91	Not scheduled to start	0%		-289	£0.00	16.08.23 - Dependent on successful delivery of Phases 1 and 2	Not scheduled to start	0%	

Objective (Milestone) 2 — Delivery of Trust-level leadership development programme for those recruited into leadership posts

Milestone Completion Date: 31/03/2025 | Milestone Status (RAG): Not scheduled to start | Milestone Progress: 0% | Milestone Delivery: 0% | Milestone Costs: £0.00

Action Ref.	Action	Owner (Role)	Start Date	Due Date	No. Days	Action Status (BRAG)	Completion Date	No. Days Overdue	Cost (£)	Progress notes	Level of Assurance		Evidence Log (to demonstrate output)
2.1	Identify medical leadership requirements aligned to Royal College of Obstetricians & Gynaecologists (RCOG) Leadership and Management Framework and work with Medical Education to produce a plan for implementation across the medical workforce	Zoe Woodward, Associate Medical Director for Women's Health	01/09/2023	31/03/2025	577	Not scheduled to start	0%		-593	£0.00		Not scheduled to start	0%	
2.2	Embed the B7 Connected (Leadership) training for all new appointments to midwifery leadership/management roles	Jess O'Reilly, Quality and Education Matron	01/09/2023	31/03/2025	577	Not scheduled to start	0%		-593	£0.00		Not scheduled to start	0%	
2.3	Implement the Trust-level Leadership Behaviours Framework once published (linked to a re-launch of the Trust values)	Claire Everley, Organisation Development Business Manager	01/09/2023	31/03/2025	577	Not scheduled to start	0%		-593	£0.00		Not scheduled to start	0%	
2.4	Embed Trust processes and practice for managing behaviours that do not meet Trust values	To be agreed	01/09/2023	31/03/2025	577	Not scheduled to start	0%		-593	£0.00		Not scheduled to start	0%	

Objective (Milestone) 3 — Implementation of Inclusion and Respect Charter

Milestone Completion Date: 31/08/2024 | Milestone Status (RAG): Not scheduled to start | Milestone Progress: 0% | Milestone Delivery: 0% | Milestone Costs: £0.00

Action Ref.	Action	Owner (Role)	Start Date	Due Date	No. Days	Action Status (BRAG)	Completion Date	No. Days Overdue	Cost (£)	Progress notes	Level of Assurance		Evidence Log (to demonstrate output)
3.1	Share the Trust's current version of the Inclusion and Respect Charter across the Women, Children and Young People Care Group (WCYP CG) with an introductory biography to the role of Head of Equality, Diversity and Inclusion	Parveen Kumi, Head of Equality, Diversity & Inclusion (EDI)	01/09/2023	30/09/2023	29	Not scheduled to start	0%		-45	£0.00		Not scheduled to start	0%	
3.2	Implement values-based recruitment and achievement reviews (appraisals) inclusive of requirements for demonstrable adherence to Trust Values	Karl Woods, Head of People and Culture for Women, Children and Young People Care Group (WCYP)	01/09/2023	31/08/2024	365	Not scheduled to start	0%		-381	£0.00		Not scheduled to start	0%	
3.3	*Work to be agreed*	*To be agreed*	01/09/2023	31/08/2024	365	Not scheduled to start	0%		-381	£0.00		Not scheduled to start	0%	

Objective (Milestone) 4 — Structured escalation processes for raising concerns for the workforce and service users outside of clinical situations* (*Clinical escalation in Workstream 3)

Milestone Completion Date: 31/03/2025 | Milestone Status (RAG): Not scheduled to start | Milestone Progress: 39% | Milestone Delivery: 29% | Milestone Costs: £0.00

Action Ref.	Action	Owner (Role)	Start Date	Due Date	No. Days	Action Status (BRAG)	Completion Date	No. Days Overdue	Cost (£)	Progress notes	Level of Assurance		Evidence Log (to demonstrate output)
4.1	Embed 'We Hear You' service and promote across the care group, including email contact address and posters for display around the units / in community	George Bennett, Patient Safety Midwife	01/05/2023	30/06/2023	60	Complete	100%		0	£0.00	31.05.23 - We Hear You poster templates shared by Patient Safety Midwife for comment	Evidenced and assured	100%	
4.2	Launch 'Leave your troubles at the door' support for the workforce as well as families	Adaline Smith, Deputy Director of Midwifery	01/07/2023	31/08/2023	61	Complete	100%		0	£0.00	08.08.23 - Posters produced and shared with local midwifery management teams for displaying on the wards at WHH and QEQM 16.08.23 - Further work potentially needed to share the purpose and intention of this service, and to increase awareness amongst the workforce	Delivered, not evidenced	67%	4.2 01 Maternity Posters - 08 Aug 2023
4.3	Freedom to Speak Up Guardian (FTSUG) to routinely report into MNAG with anonymised caseload figures and high-level themes for shared awareness, learning and triangulating with other workstreams e.g. Patient Safety / People and Culture themes, MNIP workstreams	Katie Clark, Maternity Freedom to Speak Up Guardian	01/08/2023	31/03/2024	243	On track	75%		-228	£0.00	16.08.23 - Agreed at MNAG in August for FTSU report to be a standing agenda item and scheduling to be arranged between MNAG administrator and Maternity FTSUG	Not yet delivered	33%	
4.4	FTSU training to be made available across the care group with monitoring of completion rates	Katie Clark, Maternity Freedom to Speak Up Guardian	01/09/2023	31/03/2025	577	Not scheduled to start	0%		-593	£0.00	16.08.23 - Training opportunities to be scoped out, discussed and agreed with FTSUG and Education team for events to be planned and shared	Not scheduled to start	0%	
4.4	Embed 'You said, We did' in response to themes of escalated concerns from the workforce	Adaline Smith, Deputy Director of Midwifery	01/09/2023	31/03/2024	212	Not scheduled to start	0%		-228	£0.00		Not scheduled to start	0%	
4.5	Promote and embed awareness of Maternity and Neonatal Safety Champions across the service; themes of concerns shared with Safety Champions to continue to be reported to MNAG and Trust Board	Michelle Cudjoe. Director of Midwifery	01/09/2023	31/03/2024	212	Not scheduled to start	0%		-228	£0.00		Not scheduled to start	0%	
4.6	*Work to be agreed*	*To be agreed*	01/09/2023	31/03/2025	577	Not scheduled to start	0%		-593	£0.00		Not scheduled to start	0%	

Objective (Milestone) 5 — Completion of the SCORE survey

Milestone Completion Date: 31/05/2024 | Milestone Status (RAG): Not scheduled to start | Milestone Progress: 14% | Milestone Delivery: 14% | Milestone Costs: £0.00

Action Ref.	Action	Owner (Role)	Start Date	Due Date	No. Days	Action Status (BRAG)	Completion Date	No. Days Overdue	Cost (£)	Progress notes	Level of Assurance		Evidence Log (to demonstrate output)
5.1	Meet with NHSI Perinatal Culture and Leadership (CLP) team to understand local arrangements needed for the publication of the staff SCORE survey	Leane Jeffrey, Service Development Programme Lead	01/08/2023	31/08/2023	30	Complete	100%		0	£0.00	16.08.23 - Discussed with NHSI Lead and timeline received for all three phases of the perinatal CLP, including requirements for the planning and delivery of Phase 2 - SCORE survey. Pending receipt of SCORE mapping template from NHSI to complete and return by 15/09/2023	Evidenced and assured	100%	5.1 01 Email re NHSI SCORE Meeting - 16 Aug 2023 5.1 02 PCLP Welcome Document - 16 Aug 2023 5.1 03 PCLP Timeline - 16 Aug 2023
5.2	Facilitate completions of the SCORE mapping document with MDT senior management team and return to NHSI to support the structural requirements of the survey based on service specific information e.g. locations, headcount by location	Leane Jeffrey, Service Development Programme Lead	21/08/2023	15/09/2023	25	Not scheduled to start	0%		-30	£0.00	16.08.23 - Pending receipt of the mapping template from NHSI	Not scheduled to start	0%	
5.3	Work with local and corporate Communications teams / channels to share resources to promote the SCORE survey to maximise completion rates (min. required response rate is 40%, ideal rate is <60%)	Leane Jeffrey, Service Development Programme Lead	01/09/2023	10/12/2023	100	Not scheduled to start	0%		-116	£0.00	16.08.23 - Survey will lauch 17 Oct 2023 and available for 7 weeks	Not scheduled to start	0%	
5.4	Launch and share the link for completion of the staff SCORE survey	Leane Jeffrey, Service Development Programme Lead	17/10/2023	10/12/2023	54	Not scheduled to start	0%		-116	£0.00	16.08.23 - Pending receipt of the link / QR code from NHSI once the survey has been built and is ready to publish	Not scheduled to start	0%	
5.5	Once results received, the care group Quad to work with Culture Coach from 'Safe and Reliable' to understand survey results, understand benchmarking against national themes, identify what's working well to replicate wider across the service and identify areas for improvement	Michelle Cudjoe. Director of Midwifery	01/01/2024	28/02/2024	58	Not scheduled to start	0%		-196	£0.00	16.08.23 - Schedule of Culture Coach sessions to be confirmed	Not scheduled to start	0%	
5.6	Care group Quad to present outcomes and plans for sustainable change to Trust Board	Michelle Cudjoe. Director of Midwifery	01/03/2024	30/04/2024	60	Not scheduled to start	0%		-258	£0.00	16.08.23 - Pending results of SCORE Survey by 28/02/2023	Not scheduled to start	0%	
5.7	Change agents to be trained by NHSI to support ongoing culture conversations for continous improvement, and shadow Culture Coach from 'Safe and Reliable' provider	Karl Woods, Head of People and Culture for Women, Children and Young People Care Group (WCYP)	01/03/2024	30/04/2024	60	Not scheduled to start	0%		-258	£0.00	16.08.23 - Dependent on completion of previous actions within this milestone, then register of Change Agents / Managers to be developed and shared across the service	Not scheduled to start	0%	

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Freedom to Speak Up (FTSU) Quarterly Report**

Meeting date: **7 September 2023**

Board sponsor: **Chief People Officer**

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

Appendices:

None

Executive summary:

Action required:	Discussion
Purpose of the Report:	This paper gives an update on the activity of the FTSU Guardians in Q1 (April - June 2023), as well as an update on the Trust's performance against the new national standards.
Summary of key issues:	• The FTSU Team continue to see a steady rise in the number of matters raised with them. • The majority of matters raised have an element of worker safety or wellbeing in them. • Two Deputy FTSU Guardians are settled in post and demonstrating their capacity to support the workforce. • The roll-out of mandated e-learning modules is being supported by face-to-face training sessions, workshop and forums. • We now have evidence to support the positive impact the team makes on worker's understanding of FTSU when they receive dedicated input on the subject. • The future focus will be on understanding the effectiveness of our speaking up arrangements in response to the low scores in the National Staff Survey (NSS) around the confidence workers have in the Trust taking action when concerns are raised.
Key recommendations:	The Board of Directors is asked to **NOTE** the FTSU report and: • The Trust would benefit from pro-actively seeking feedback on workers' experiences of speaking up from numerous routes.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability

Link to the Board Assurance Framework (BAF):	**CRR Risk 71, 77, 110 and 36:** 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. **CRR Risk 76:** 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):	SRR 2 and 8. Failure to maintain standards of high quality care and to recruit and retain high calibre staff.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: None

East Kent Hospitals University NHS Foundation Trust

Freedom to Speak Up (FTSU) Quarterly Report

1. Purpose of the report

This paper gives an update on the activity of the Freedom to Speak Up Guardians in Q1 (April - June 2023) as well as an update on the Trust's performance against the new national standards.

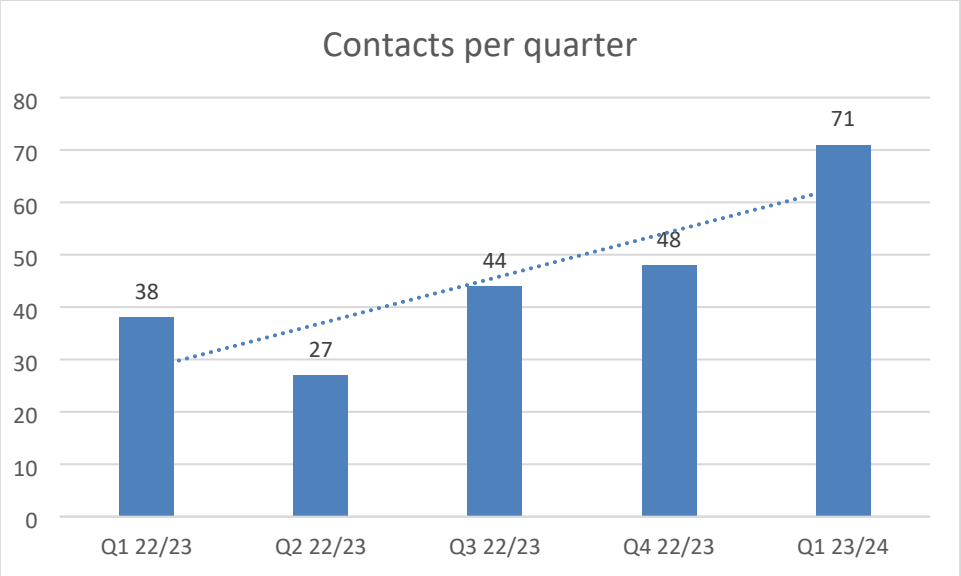
2. Freedom to Speak Up activity

The work of the FTSU team can be broadly categorised as 'reactive' and 'proactive'.

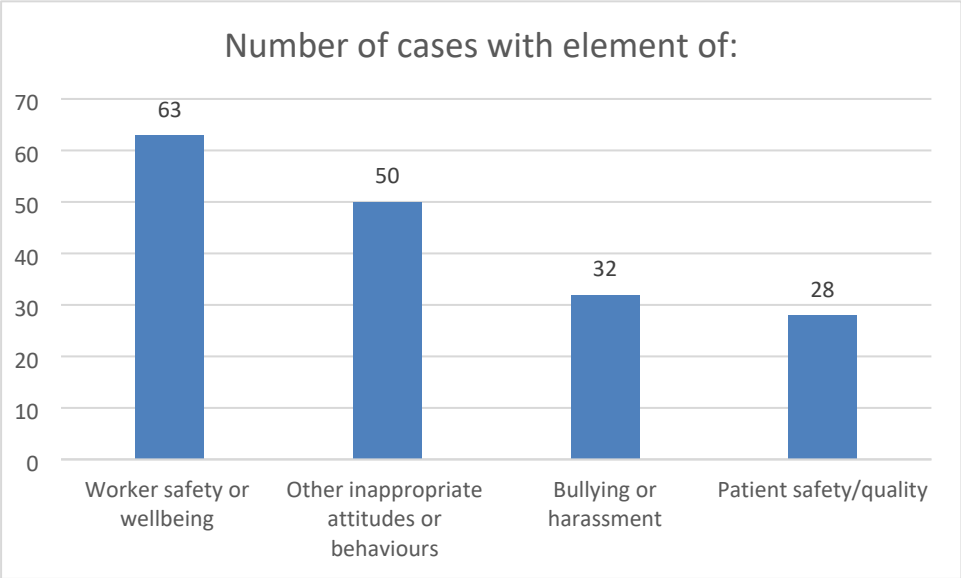
Reactive work

2.1 The Freedom to Speak Up Team were contacted a total of 71 times in Q4 2023/2024.

Graph 1:



Graph 2:



Graph 1 reflects the rise in the number of contacts the FTSU team have had. There has been a 48% increase in the number of contacts made between Q4 (22/23) and Q1 (23/24). This is reflective of the capacity within the FTSU team now that the two new Deputies have settled in to their new roles. Of note, in Q1 (23/24) the FTSU Team experienced long-term staff absence; with a full complement, it is believed that the number of people speaking up to the team would have been higher.

Graph 2 highlights the numbers of contacts with the team which include elements of:

- Worker safety of wellbeing
- Other inappropriate attitudes or behaviours
- Bullying or harassment
- Patient safety / quality

The majority of matters spoken up about contained concerns and/or suggestions for improvement around the safety or wellbeing of our workers.

Proactive work:

Expansion of the FTSU Team

2.2 The two Deputy FTSU Guardians have been in post for approximately seven months. For Q1 (23/24) the deputies have supported with 56% of matters raised with the team.

Connectors

2.3 The FTSU Team are working collaboratively with other People & Culture teams to nurture and develop the Connector network. Starting in September, a monthly meeting will take place where Connectors can come together to offer peer support, give updates and feedback on how their role is being utilised across the Trust.

FTSU e-learning support

2.4 The FTSU e-learning modules are mandatory. To support compliance, complement and enhance the learners' experience, the team are providing the following opportunities:

- Face to face sessions
  - Attendees will work through the e-learning modules in a group session, with discussion facilitated by a FTSU Guardian.
- Workshop
  - A face-to-face workshop with interactive exercises that bring to 'life' the speaking up process from start to finish.
- Online forum
  - Virtual spaces for workers to come together to explore what speaking up means to them as well as offering feedback on what improvements can be made to speaking up process.

Compliance rates will be reported in the next report.

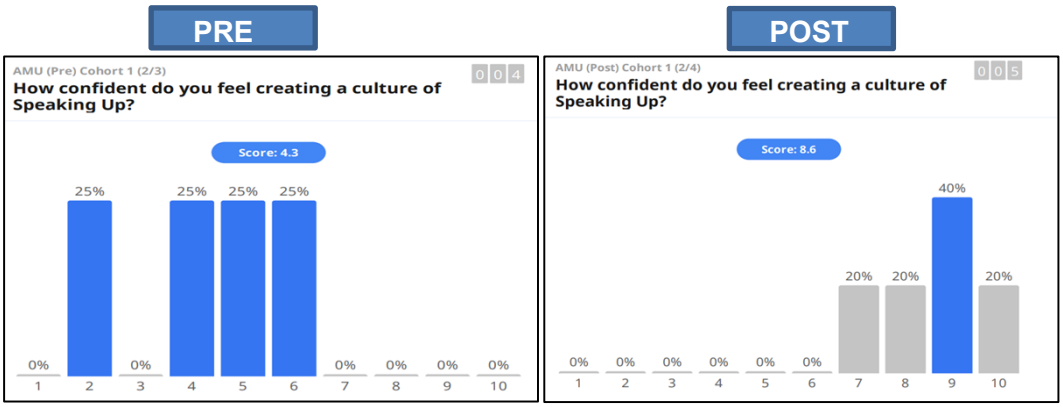
Raising awareness of speaking up

2.5 The importance of speaking up continues to be championed across the Trust in the following ways:

- Input from the FTSU Team at all Trust Welcome Days, during the induction period for all Internationally Educated Nurses and Midwives and during development sessions for Healthcare Assistants.
- Delivery of talks to Newly Qualified Midwives and students.
- Engagement with Staff Networks, Equality, Diversity and Inclusion (EDI) steering group and Staff Committee meetings.
- Board level endorsement.
- Posters, screensaver messages, Trust news articles and social media posts.

Working together

2.6 Concerns for the wellbeing of workers features in the majority of cases heard by the team. As a result of this, the FTSU Team and the Wellbeing Team work closely to support workers in need. We have also co-delivered training sessions to enhance a team's understanding of both subjects and how they are interlinked. Feedback from the sessions has shown that raising awareness of the subjects has a positive impact on worker's confidence to speak up.



3. Future activity by the FTSU Team.

3.1 The Trust has just launched it's restructure and there will be a period of transition as people to settle in to their new roles. The team will continue to function in its current format:

- Deputy FTSU Guardian – Covering the Queen Elizabeth the Queen Mother site.
- Deputy FTSU Guardian – Covering the William Harvey Hospital site.
- Maternity FTSU Guardian – Covering maternity and Child Health teams.
- Lead FTSU Guardian – Covering the Kent and Canterbury Hospital, Buckland Hospital and Royal Victoria Hospital.

3.2 The newly established People & Culture Multi Disciplinary Team (MDT) continues to meet to explore ways in which the directorate can listen, respond to and influence good practice in speaking up. This model of working is strengthening relationships and will support the newly restructured People and Culture teams.

3.3 The primary focus of the team has been on promoting the importance of speaking up as well as how to do so. Feedback from the National Staff Survey (NSS) tells us that workers feel less confident that action and change will come about following speaking up. Therefore, the primary focus for the team will now be on understanding more about the effectiveness of our speaking up arrangements.

3.4 The FTSU team has reflected in previous reports that, as an organisation, we are weakest in the area of 'completing the loop'. The FTSU team will be exploring the concept of contracting agreed timeframes with leaders across the Trust to ensure that feedback is expected where concerns have been raised.

4. Conclusion

4.1 The FTSU Team continues to be contacted by high numbers of workers wishing to raise concerns. The demand outweighs the team's capacity and so the team are managing the workload by ensuring that workers are signposted to the correct internal mechanism for raising concerns in the first instance.

4.2 Mandating the FTSU e-learning modules is supporting the team and wider organisation to deliver a consistent message around the responsibilities of our workers to speak up, listen up and follow up. This will support leaders to recognise and address where they may have their own challenges around speaking up.

4.3 The Trust would benefit from pro-actively seeking feedback from workers who speak up via a variety of routes. This would demonstrate a willingness and ability to better support the needs of our workers. It will also allow us to establish if we are truly making change as a result of speaking up.

East Kent Hospitals University NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (BoD)

Report title: **Patient Voice and Involvement Quarterly Report**

Meeting date: **7 September 2023**

Board sponsor: **Interim Chief Nursing and Midwifery Officer**

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

Appendices:

APPENDIX 1: Report for April to June 2023

Executive summary:

Action required:	**Information**
Purpose of the Report:	To provide an update on Patient Voice and Involvement work and implementation of the Patient Voice and Involvement Strategy.
Summary of key issues:	**Patient Voice and Involvement:** <u>Engagement and involvement work</u> During April to June 2023 the team carried out a wide range of engagement work with external stakeholders and partners. This included communities in socially deprived areas, community groups supporting specific communities such as trans people and people of ethnic backgrounds, groups supporting people with mental health diagnosis, and groups supporting people with particular long-term conditions. Positive themes were care given, quality of treatment, positive staff attitude. Negative themes included inaccessibility of our systems to Deaf people who use British Sign Language (BSL), lack of awareness of hospital staff about some patient's long-term conditions or the health inequalities they experience, and poor communication. <u>Work with Healthwatch Kent</u> We worked with Healthwatch Kent to agree a schedule of visits to our three main sites in May to gather feedback direct from patients and carers. These visits resulted in a lot of positive feedback on the care and compassion of staff and the quality of treatment. They also highlighted the need for better sign-posting, accessible waste bins in the accessible toilets, the need to keep patients updated whilst waiting in the clinic for their appointment, and the need for staff to make patients aware that they can request appointment letters in other formats, such as large print, Easy Read or Braille. <u>Carers</u> We have had feedback that carers and families continue to not be listened to. We will be developing ways to better involve carers. To support this work we set up a Carers Task and Finish Group, involving both clinical leads and local

	carers organisations, which held its first meeting in July. We will build on the work started as part of the Dementia Strategy, including a carers passport and flexible visiting times for the patient's primary carer. Communication Poor communication, including difficulties in getting through to services by telephone, inaccurate appointment letters and unclear information are recurrent themes of patient feedback. The lack of service email addresses has also been raised. We are hoping that the work on appointment letters and the new Patient Portal will resolve some of these long-standing issues. Patients will be able to request appointment letters in a range of formats. Friends and Family Test (FFT) surveys The Trust received 52,000 responses to the Friends and Family Test (FFT) from April to June 2023. The response rate (surveys sent versus surveys completed) is just under 18% Trust-wide, with an overall satisfaction level of just over **93%** from April to June 2023. This is consistent with previous quarters. Nationally the figures for satisfaction levels for in-patient and day cases are 95%, for outpatients they are 94% and Urgent and Emergency care they are 80%. Across Kent and Medway satisfaction levels for Urgent and Emergency care range from 71% at Dartford and Gravesham, 73% at Medway, 82% at EKHUFT and 93% at Maidstone and Tunbridge Wells. For in-patients, satisfaction levels range from 89% at Dartford and Gravesham and Medway, 90% at EKHUFT and 97% at Maidstone and Tunbridge Wells. For out-patients satisfaction levels range from 91% for Medway, 95% for EKHUFT and Maidstone and Tunbridge Wells, and 97% for Dartford and Gravesham. (data: February 2023, the most recent national figures available). Deep dive into FFT comments for three inpatient services: Paediatric Medicine, Rheumatology and Ear, Nose and Throat (ENT) Each month we focus on an out-patient service. This may relate to providing further insight to a service we are developing work with, such as Rheumatology, an area our Patient Participation Partners have asked we look into (Paediatrics) or where we are aware of some negative feedback (ENT).There are common themes across these services. The positive themes are the care and kindness of staff and the quality of treatment. The negative themes relate to communication and information. This includes unclear appointment letters, patients having difficulties getting in touch with the service, not being updated on waiting times in the clinic and poor signage around the sites. Theming Patient Experience Theming Patient Tracker (PTL) for Friends and Family (FFT) Survey free text comments The Information team and Patient Voice and Involvement team have developed a PTL, which gathers all the free text comments from the FFT surveys and enables these to be themed by the service, by subject and

East Kent Hospitals University NHS Foundation Trust

	whether they are positive or negative. We launched this in July 2023. It will make it easier for services to identify themes and for us to track the themes Trust-wide.
Key recommendations:	The Board of Directors is asked to **NOTE** the report.

Implications:

Links to 'We Care' Strategic Objectives:	• Patients • 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:	No
Legal and regulatory:	Yes - The Trust must implement the statutory guidance on Working with People and Communities, July 2022 and the Equality Act 2010, including the Public Sector Equality Duties
Subsidiary:	No

Assurance route:

Previously considered by: Monthly Patient Voice and Involvement reports go to the Fundamentals of Care Committee. This quarterly report is a summary of these.

East Kent Hospitals University NHS Foundation Trust

Patient Voice and Involvement Report April to June 2023

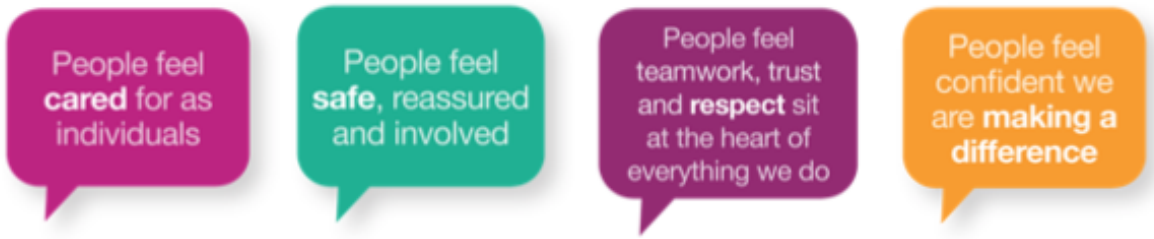
1. Introduction

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.

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 ultimate goal is co-designed services and co-design service improvements.

1.4 East Kent Hospitals' values directly relate to patient experience and patient involvement:



1.5 The report provides an update on implementing the Trust's Patient Voice and Involvement Strategy.

2. Participation Partners

2.1 A key element of the strategy is to ensure that patients, families and communities have a voice, and this includes being part of groups and committees where decisions are made and progress on implementing the strategy is reviewed.

2.2 We have recruited 14 Participation Partners to date, with two others waiting for reference checks. These are people who use our services, their families and people from the wider community. They are all members of our Patient Participation and Action Group (PPAG) (see below). Two have now joined the End of Life Care Committee, two have joined the Food and Drink Committee, two have joined the Ethics Committee and one has joined the East Kent Health and Care Partnership Quality Forum.

2.3 Participation Partners have been involved in reviewing the draft Quality Account for 2022/23, where the need for less jargon and clearer images / graphs was highlighted. They have also given feedback on the wording of patient experience survey questions, given feedback on the Trust's new website and on the design of hospital maps.

2.4 We have continued to establish links with people who are part of the voluntary, community and social enterprise (VCSE) sector. We have two representatives on

the Patient Participation and Action Group (PPAG) from Hi-Kent and 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 MS Therapy Centre.

3. Patient Participation and Action Group (PPAG)

3.1 The **Patient Participation and Action Group (PPAG)** has now met four times up to the end of June. This group holds us to account for implementing the Patient Voice and Involvement Strategy.

3.2 The May meeting focused on Child Health and Dermatology Services. Child Health gave a presentation on their services, patient feedback and actions taken to improve patient experience. Dermatology discussed a potential relocation of services based at Kent and Canterbury to a purpose built, accessible and larger facility in Canterbury. The group receive a regular update on implementation of the strategy including achievement of milestones.

3.3 The group is co-chaired by a Participation Partner and the Head of Patient Voice and Involvement, and a Non-Executive Director attends as the Board Champion for Patient Voice. Membership of the group is 50% people who use our services or are carers or family members (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 participate in a bespoke training session on patient involvement and agree to get involved in making changes based on patient feedback.

4.2 From March we've delivered a monthly session for Health Care Support Workers (HCSWs) focused on 'Seeing the Person'. Approximately 80 HCSWs have participated to date, with feedback being very positive about how they can understand the vital role they play in making every patient's experience positive.

4.3 We have been co-designing a patient involvement toolkit for staff to support this work. This will shortly be piloted with some colleagues.

5. Community Engagement

5.1 During April to June, the team has had contact with a range of community groups and attended both online and face to face events. We have carried out some targeted engagement with the Canterbury and Herne Bay Trans groups to involve them in developing a policy to support gender diverse patients. We visited Beyond the Page in Thanet, who are a group supporting women born outside of the UK to become confident, active citizens in their local communities. The team has continued to support the Community and Family Voice work for the Reading the Signals Oversight Group. We have focused on reaching out to people who don't always have their voices heard, including Ukranian mothers. Feedback from this engagement is shared with the relevant services and shapes what we focus on in terms of encouraging the service to make improvements. This can take time, especially when services are focusing on other priorities.

5.3 We worked with Healthwatch Kent to agree a schedule of visits to our three main sites in May to gather feedback direct from patients and carers. These visits resulted in a lot of positive feedback on the care and compassion of staff and the quality of

treatment. They also highlighted the need for better sign-posting, accessible waste bins in the accessible toilets, the need to keep patients updated whilst waiting in the clinic for their appointment, and the need for staff to make patients aware that they can request appointment letters in other formats, such as large print, Easy Read or Braille. The team acted as a point of contact to get responses to these issues from the services and then share these with Healthwatch. Healthwatch carried out another round of visits in July.

6. Patient Experience

6.1 Rheumatology:
We continue to work with the Lead Rheumatology Nurse to support the Rheumatology Patient Action Group. The group has now held two meetings. Group membership is small, but growing. We alternate between face to face and online meetings. Feedback includes difficulties caused to patients when appointments are issued only two weeks in advance. The service is unable to change this due to clinic room allocations at some sites.

6.2 Communication
Poor communication, including difficulties in getting through to services by telephone, inaccurate appointment letters and unclear information are recurrent themes of patient feedback. The lack of service email addresses has also been raised. We are hoping that the work on appointment letter templates of which the engagement phase is now complete and the new Patient Portal will resolve some of these long-standing issues. Patients will be able to request appointment letters in a range of formats.

6.3 Two of the team supported the Communications team to check ward and clinic phone numbers at the three main sites in the run up to the new website going live. Many of the phone numbers on the old website were out of date and when some numbers were phoned no-one answered, so the team went in person to check ward's phone numbers on each site.

6.4 Accessible Information Standard
The team now lead on the continued implementation of the Accessible Information Standard (AIS). We have worked with IT colleagues to update the AIS codes on Patient Administration System (PAS) / Sunrise (our electronic patient record systems) so they reflect the national SNOMED codes and to get a new guide for staff on adding AIS codes on PAS. We have also worked with the IT Projects team on linking options on the Patient Portal to the AIS codes. A report on AIS was discussed at the Clinical Executive Management Group (CEMG) on 3 May. The Executive supported the need to raise staff awareness of AIS and embed AIS into every day practice, both on wards and clinics. It also committed to ensuring that IT work with the Patient Voice and Involvement team on further developing the Patient Portal, so that patients can tell us what adjustments they need when attending hospital appointments and diagnostic tests.

The AIS Staff Handbook has been updated to assist staff. We attended an AIS session for trainee doctors at Kent and Medway Medical School in May to share how we are implementing AIS at EKHUFT. As a result of this we have recently been asked by NHS England to pilot the new AIS self-assessment framework. An update on this work will be provided in the next quarterly report.

6.5 Carers
We have picked up feedback that carers and families continue to not be listened to. We will be looking at whether the trust would benefit from adopting the Triangle of

Care as part of developing ways to better involve carers. To support this work we set up a Carers Task and Finish Group, involving both clinical leads and local carers organisations, which held its first meeting in July. We will build on the work started as part of the Dementia Strategy, including a carers passport and flexible visiting times for patient's primary carer.

7. Friends and Family Test (FFT)

7.1 The Trust received 52,000 responses to the Friends and Family Test (FFT) from April to June 2023. The response rate (surveys sent versus surveys completed) is just under 18% Trust-wide, with an overall satisfaction level of just over **93%** from April to June 2023. This is consistent with previous quarters.

7.2 Nationally the figures for satisfaction levels for in-patient and day cases are 95%, for outpatients they are 94% and Urgent and Emergency care they are 80%. Across Kent and Medway satisfaction levels for Urgent and Emergency care range from 71% at Dartford and Gravesham, 73% at Medway, 82% at EKHUFT and 93% at Maidstone and Tunbridge Wells.

7.3 For in-patients, satisfaction levels range from 89% at Dartford and Gravesham and Medway, 90% at EKHUFT and 97% at Maidstone and Tunbridge Wells.

7.4 For out-patients satisfaction levels range from 91% for Medway, 95% for EKHUFT and Maidstone and Tunbridge Wells, and 97% for Dartford and Gravesham. (data: February 2023, the most recent national figures available).

7.5 No national data on response rates is available, however the figures indicate we are getting the highest response numbers in Kent and Medway for out-patients, second highest for Urgent and Emergency Care, but lower numbers for in-patient responses compared to two of the three other acute trusts.

7.6 The Information team has developed a Patient Experience Theming Tracker (PTL), which gathers all the thousands of free text comments from **Friends and Family Test (FFT) surveys** and enables these to be themed by the service, by subject and whether they are positive or negative. The Theming PTL and dashboard has been demonstrated to some services who have started to use it. An update on themes will be included in the next quarterly report.

7.7 Working with colleagues in IT, the Information team and Quality Improvement, we've finalised a Standard Operating Procedure (SOP) for Patient Experience Surveys. This has been approved at the Fundamentals of Care Committee. It will enable us to have a consistent approach to developing patient experience surveys, including adding additional optional questions to the **FFT surveys**. We will ensure patients are involved in checking the wording of questions, to ensure they use plain language.

7.8 Each month the team reviews **FFT surveys** and comments from a specific out-patient service across all sites. We select the service based on whether we've noticed a number of negative comments coming through, or we are working with the service an some additional insight is needed, or our Patient Participation and Action Group are interested in a closer look at a service's patient feedback. The results are shared in a report to the Fundamentals of Care Committee. These deep dive reports are summarised below.

8. Deep dive into out-patient FFT survey comments

8.1 Paediatric Medicine

We reviewed April's FFT comments for Paediatric Medicine across the five sites – Buckland, Estuary View, Kent and Canterbury Hospital (K&C), Queen Elizabeth the Queen Mother Hospital (QEQM) and William Harvey Hospital (WHH). There were 132 responses. The feedback is overwhelmingly positive, with parents consistently highlighting the care, compassion and patience of both doctors and nurses, as well as being listened to and being given helpful information. There were a few negative comments, mostly at K&C and QEQM concerning lost test results, staff not being gentle when taking a baby's blood, waiting time in a clinic being difficult with an autistic child, delays in being seen for the first appointment, seeing a different doctor each time, seeing a doctor to be told the GP should follow up and a doctor being rude to the parent.

8.2 Rheumatology

We reviewed May's FFT comments for Rheumatology across the six sites – Buckland, Estuary View, K&C, QEQM, Royal Victoria and WHH. There were 240 responses. The feedback is overwhelmingly positive, with patients feeling listened to by both the consultants and nurses and reassured and not rushed. Feedback was particularly positive at our smaller clinics at Buckland Hospital, Estuary View and the Royal Victoria Hospital in Folkestone. There were some negative comments about clinics running late, the attitude of a consultant, an appointment letter not being received and only realising they had an appointment when they got a text reminder. Several patients mentioned the lack of signage at K&C and the reception there not having the clinic list.

8.3 Ear, Nose and Throat (ENT) - Adult and Paediatric

We reviewed June's FFT comments for ENT across the four sites – Buckland, Kent and Canterbury, QEQM, and WHH. There were 519 responses for adult ENT and 38 for paediatric ENT. Please note that adult ENT includes general ENT, Otology, Rhinology, Thyroid, and nurse led clinics. The feedback is overwhelmingly positive, including staff being caring, taking time to explain things and reassure patients and the quality of care. Negative comments related to feeling rushed, not getting the correct information about the appointment / or getting conflicting information, not having an issue resolved and having to travel for the appointment rather than go to their nearest hospital.

8.4 There are common themes across services. The positive themes are the care and kindness of staff and the quality of treatment. The negative themes relate to communication and information. This includes unclear appointment letters, patients having difficulties getting in touch with the service, not being updated on waiting times in the clinic and poor signage around the sites. Some of these issues can be addressed more easily than others. The impact of administrative vacancies, staff turnover and limited funds to invest in our estate and infrastructure does have a direct impact on patients. This, along with backlogs post Covid, means patients have a poorer experience related to delayed diagnosis and access to timely treatment. The experience of patients when they get any treatment is overwhelmingly positive

9. Conclusion

9.1 The Patient Voice and Involvement team continue to make good progress on implementing the strategy. A key part of this is ensuring that the patient and family voice is present and heard – both at a strategic level and at service level, with patient and family feedback being reviewed and acted on.

9.2 We need to use patient experience feedback to drive quality improvements, in particular to systems and processes. Good patient experience is not simply just about the treatment received, it's the whole patient journey. Creating more effective and efficient ways to theme feedback, provides us invaluable insight into what we need to improve. Then we need our services to work with patients and their families to co-design solutions, to ensure we improve on the areas that matter most to our patients.

August 2023

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **7 September 2023**

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

Paper Author: **CSPO**

Appendices:

APPENDIX 1: July 2023 IPR

Executive summary:

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

East Kent Hospitals University NHS Foundation Trust

	Key performance points (July Reported Month): **Patients** • All type Emergency Department (ED) performance is ahead of plan at 74.3%. • Type 1 ED performance is under plan at 50.5%. • Cancer 28 Faster Diagnosis Standard (FDS) has slightly improved. • Diagnostics performance has deteriorated with key issues in CT and endoscopy. **Quality & Safety** • 11 Serious Incidents (SIs) declared in the month. • 1 never event reported in July. • The number of overdue incidents has decreased by 543. • Hospital Standardised Mortality Ratio (HSMR) remains below 100 although has an increasing trend. **People** • Sickness rates better than target at 4.9% although an increase on the prior month. • Vacancy rate has fallen for the 7th consecutive month. • Staff turnover rate has fallen for the 4th consecutive month. • Staff engagement score improved from the prior month but remains below the target threshold. • Completed medical job plans has continued to improve but remains below the target at 58.7%. • Appraisal rates improved by 5.6% from the prior month. **Sustainability** • The financial position is adverse to plan by £8.4million Year to Date (YTD). • Cost Improvement Programme (CIP) delivery is significantly below the plan for month 4. • An additional £3.6million of pipeline schemes has been added to the CIP programme since the prior month. • Premium pay remains high with drivers that include escalation beds, and additional 1:1 care needs. **Maternity** • 5 SIs declared in the month of July in women's health. • Complaint response times are below the target threshold. • Perinatal mortality has decreased further since the prior month. • FFT recommend rate has increased by 5.9% to 95.3%. • Staff engagement score has improved on the prior month.
Key recommendations:	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the metrics reported in the Integrated Performance Report.

Implications:

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

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

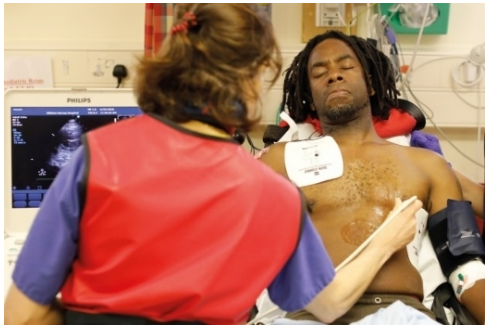
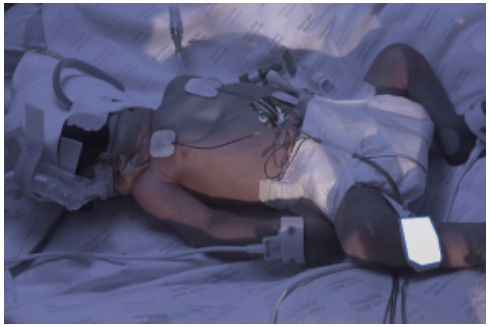
Integrated Performance Report

July 2023







Patients

Operational Performance

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
Operational Perfomance	ED Compliance	73.0%	Jul-23	74.3%			65	70	74	Special cause of improving nature or lower pressure due to higher values
	Type 1 Compliance 4hrs	55.0%	Jul-23	50.5%			38	45	52	Common cause (no significant change)
	Ambulance Handovers within 30m	95.0%	Jul-23	91.8%			75	83	91	Special cause of improving nature or lower pressure due to higher values
	12Hr Trolley Waits (MTD unvalidated)	0	Jul-23	769			380	688	996	Special cause of concerning nature or higher pressure due to higher values
	Super Stranded >21D	107	Jul-23	246			197	231	265	Special cause of improving nature or lower pressure due to lower values
	Not Fit to Reside (pats/day)	300.0	Jul-23	192.3			153	183	214	Special cause of concerning nature or higher pressure due to higher values
	Cancer 28d Performance	75.0%	Jul-23	63.1%			57	66	75	Special cause of concerning nature or higher pressure due to lower values
	Cancer Over 62d on PTL	67	Jul-23	386			153	251	349	Special cause of concerning nature or higher pressure due to higher values
	Cancer Over 104d on PTL	0	Jul-23	73			17	38	58	Special cause of concerning nature or higher pressure due to higher values
	DM01 Compliance	75.0%	Jul-23	55.9%			57	65	72	Special cause of concerning nature or higher pressure due to lower values
	RTT 52w Breaches	Traj.	Jul-23	4,575			3,339	3,796	4,254	Special cause of concerning nature or higher pressure due to higher values
	RTT 65w Breaches	0	Jul-23	1,148			1,183	1,509	1,835	Special cause of improving nature or lower pressure due to lower values

July Performance Summary

Emergency Department: The type 1 and all types (type 1 & 3) continue to improve month on month since March '23 . The Emergency Care Delivery Group (ECDG) workstreams continue to focus on delivery of the new clinical models to reduce the number of patients in the Emergency Department (ED) with Direct Access Pathways and the implementation of Medical Assessment Units. July all type performance is the best reported position for 24 months with type 1 showing month on month improvement following the changes to reporting of type 1 in March '23. Ambulance handover compliance against the 30 min standard shows steady improved performance at 91.8% v 78.9% 12 months ago. The % of patients seen by a senior doctor within 1 hour shows a positive upward trend (54.3% in July '23 v 42.0% in Aug '22) following the introduction of the Dr Initial Assessment at the front door at the WHH, with plans to replicate at the QEQM September '23. There is a correlating improvement in the reported total time in ED (12 hour), July performance is 8.9%, which is the best position for 24 months.

Cancer: 28D FDS; Slight improvement from May, key learning and actions in place, new 2ww transformation work underway to support sustainable compliance going forward. Cancer 62 and 104 day breaches remain extremely high, highest contributing factors are with the Lower GI and Urology Cancer Pathway. Breach reports, Datix, harm reviews and learning documented and actions built into improvements needed.

Diagnostics: Diagnostic performance has deteriorated in July, whilst positive improvement is noted within a small volume of modalities the scale of breaches in excess of 6 weeks in July have increased across CT and Endoscopy in month and MRI breaches increased in June and have remained static in month.

Referral to Treatment Waiting Times: 52 week breaches continue to grow and exceed trajectory. The impact of referral growth, waiting longer for first out patient appointments and diagnostic tests means our ability to reduce 52 week breaches are challenging, compounded by Industrial Action since April 2023.

Type 1 ED 4h Compliance

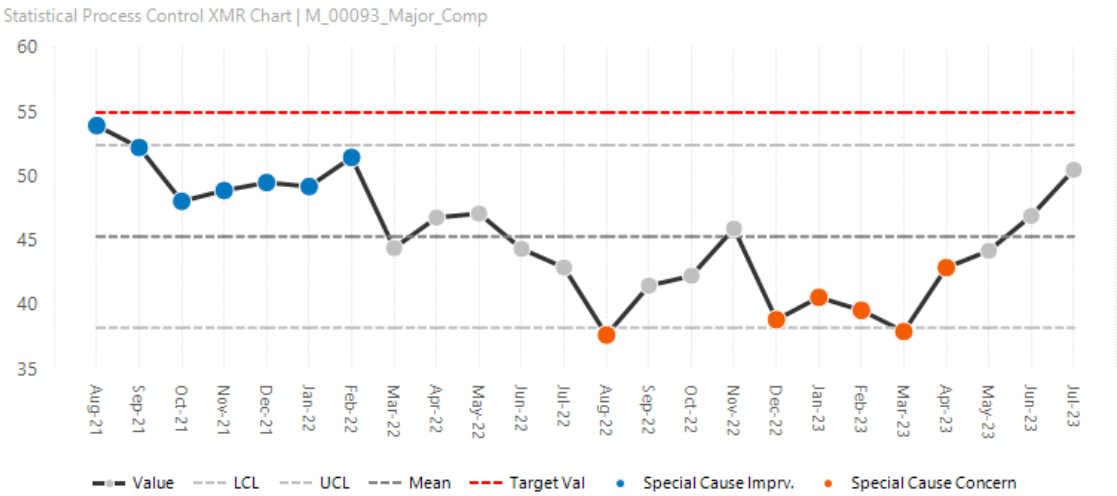
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Type 1 Compliance 4hrs

Month	Value
Aug-22	37.7%
Sep-22	41.5%
Oct-22	42.3%
Nov-22	46.0%
Dec-22	38.9%
Jan-23	40.6%
Feb-23	39.6%
Mar-23	38.0%
Apr-23	42.9%
May-23	44.2%
Jun-23	47.0%
Jul-23	50.5%



Understand the most recent data point

Variation Type

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

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
ED Single point of access for all patients requiring urgent and emergency care	• Direct Access Pathways (DAPs) implemented since March '23 and include pathways to SDEC/SEAU/Majors Assessment/CAU • Training to be progressed for the Medical staff at QEQM	• SC/DS/HT/RL • WK/SC/JW/DB	• On going monitoring in place via daily ED review meetings • September	• Work to progress the DAPs ahead of the opening of the CAU end Sep. • Review of the DAP to MAU in readiness for the opening of the new MAU • Training packs in place | Clinical lead will provide the training package over 2 weeks
Internal processes not fully aligned to operational delivery	• Implementation of internal escalation processes	• SC/RL/DB/DS/ WK/JW/CS	• Sep 2023	• Internal plans development | in progress at WHH, work commencing at QEQM
Whole Hospital Response Establishing CDUs at WHH/QEQM	• Trust wide development of IPS. GIRFT recommendation • CDU Models agreed for QEQM • CDU Model being explored at WHH to go live Oct 23. Requires phase 3b of the build to be completed	• SC.DCMO/Clinical leads/Ops Leads • Clinical leads MDs DoN	• Dec 2023 • Sep 2023 (QEQM) • Oct 2023	• Work with support form the GIRFT team to support IPS implementation • Internal training planned for September • Daily meetings to support the work required to create the space required for the CDU

Emergency Attendance 4h Compliance

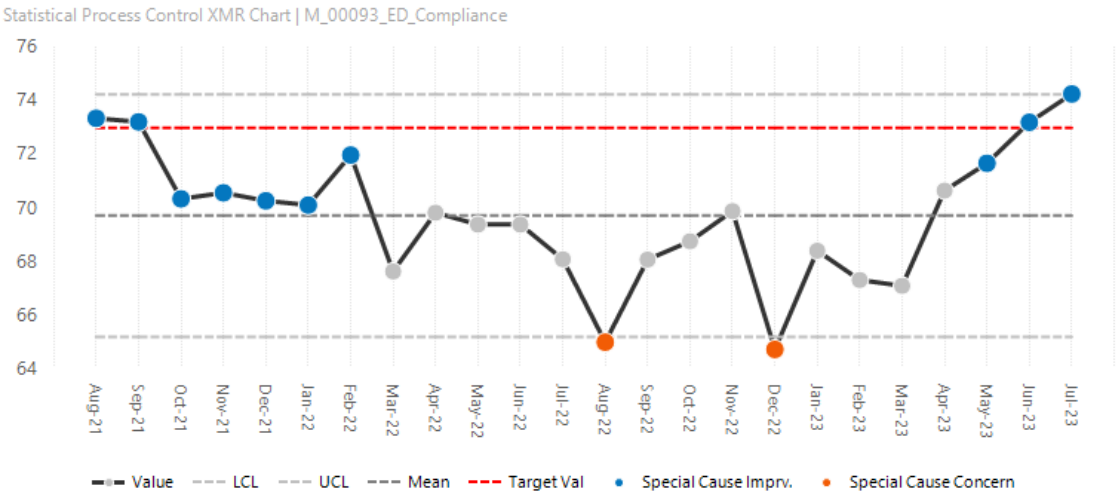
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

ED Compliance

Month	Value
Aug-22	65.0%
Sep-22	68.1%
Oct-22	68.8%
Nov-22	69.9%
Dec-22	64.7%
Jan-23	68.4%
Feb-23	67.3%
Mar-23	67.1%
Apr-23	70.7%
May-23	71.7%
Jun-23	73.2%
Jul-23	74.3%



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to higher values(| | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Lack of timely UTC pathways and direct access from the front door. Requirement for direct access pathways GP/Secamb.	• Review of the UTC pathways supported by the ICB Clinical Lead • Further work progressing to increase activity and cohort into the UTC	• Clinical ED leads /UTC leads/ Head of Ops	• Aug 2023	• Agreement with the UTC Leads to increase portfolio and criteria of patients QEQM • Progress monitored via the ECDG and the daily meetings Managing Directors
Same Day Emergency Care (SDEC) capacity and utilisation. Includes development work with Children's for DAP to CAU to reduce numbers waiting in Paediatric ED.	• Review SDEC criteria using the Ambulatory Care Condition Directory. Limitations at QEQM due to the number of Acute Medics • Expansion of hours to be established across both sites	• Clinical Leads /MDs /Head of Ops/BI Lead	• Sep 2023 2 month plan	• July reported the highest number of patients seen in the SDECs. • CAU pathway development to be progressed at QEQM
Capacity available in Medical and Surgical Assessment units at QEQM/WHH	• Pilot units in place; restricted due to ED build. • Move the services to dedicated space October • Introduce DAP pathways for GP/Secamb and ED	• Clinical Leads/MDs /Head of Ops/BI Lead	• July 2023 3 month plan	• Work commenced Jan '23 | WHH pilot in place since Mar '23 • QEQM commenced Jul '23

Ambulance Handovers within 30m

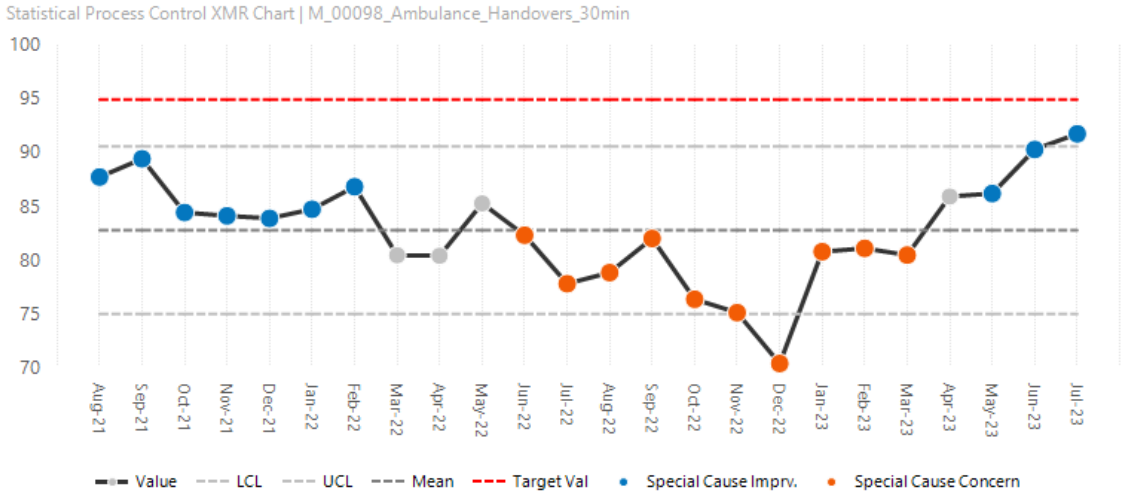
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Ambulance Handovers within 30m

Month	Value
Aug-22	78.9%
Sep-22	82.1%
Oct-22	76.4%
Nov-22	75.1%
Dec-22	70.4%
Jan-23	80.8%
Feb-23	81.1%
Mar-23	80.5%
Apr-23	86.0%
May-23	86.2%
Jun-23	90.4%
Jul-23	91.8%



Understand the most recent data point

Variation Type	
H	Special cause of improving nature or lower pressure due to higher values(| | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)
F	Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
High numbers of ambulance conveyances to the Emergency Departments at QEQM/WHH (national outlier)	• Working with the HCP and SECAMB partners . Implementation the Alt-ED model • Support from GIRFT – one of the key recommendations following the review in July	• HCP/Hospital Site teams /Secamb	• Sep 2023; 3 month plan	• Establishing the HCP action plan to support the Alt-ED roll-out and the GIRFT action plan to support UCR pathways
Review of process for accepting and transferring of patients at the front door	• Introduction of front door streaming and RAT to support early handover of patients. Early ED triggers in place to reduce risk for off-loading . • Streaming in place to support direct access to SDEC/MAU/SAEU/CAU/UTCs against patient criteria	• Clinical lead ED and Head of Ops	• In place	• ED reviewing their internal plans to ensure early triggers resolve potential issues with off loads /Over capacity EDs
Time to Dr Initial Assessment	• Introduction of the Dr Initial Assessment(WHH) to support timely reviews and assessment of pts arriving on ambulances • To develop model at QEQM	• Clinical lead ED and Head of Ops	• In place and on-going • September	• To implement the model at QEQM • Tracing to commence September to include all DAP s and early assessment and patient plans

12h In Department

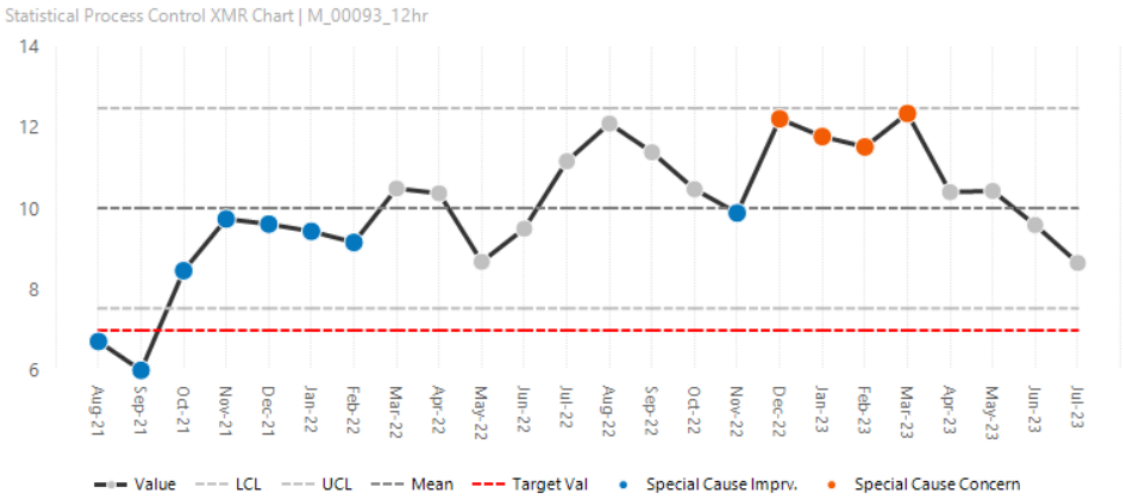
Integrated Improvement Plan

NHS
East Kent Hospitals University
NHS Foundation Trust

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

12 Hr Total Time in Department

Month	Value
Aug-22	12.1%
Sep-22	11.4%
Oct-22	10.5%
Nov-22	9.9%
Dec-22	12.2%
Jan-23	11.8%
Feb-23	11.5%
Mar-23	12.4%
Apr-23	10.4%
May-23	10.5%
Jun-23	9.6%
Jul-23	8.7%



Understand the most recent data point

Variation Type

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

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Number of patients waiting for a bed (admitted cohort)	Implementation of; • Daily pathway zero meeting • Specialty in-reach to the front door • Frailty units established • Clinical forums to right size bed base and ensure appropriate configuration	• Clinical leads /MDs /Head of Ops		• Creation of integrated hubs at the front door with access to domiciliary care to reduce admissions | On track • SAFER Bundle roll-out | Commenced WHH • Focussed work to improve patient flow at QEQM | External support tbc
Use of corridor to manage high numbers of pts in ED	• Implement SAFER Bundles • Protection of the DAP pathways and assessment units • Increase UTC/SDEC activity • Review of internal triggers aligned to the new OPEL Framework (live from Oct 23) and work with HCP to align system wide response requirements	• Clinical leads /MDs /Head of Ops • HCP/MDs	• On going • Sep 2023	• Internal triggers and access and use of escalation areas completed WHH pending approval. QEQM – in development • HCP Event September to agree system plans to support OPEL framework ahead of live date
High number of Mental Health (MH) patients in ED. Long waits due to lack of inpatient MH facilities	• Daily external escalation processes to be approved by the HCP to support oversight and planning • External ICB support to EKMHT to manage capacity access OOA	• DoNs/MDs /MDs/COO /CNO/HCP leads	• On-going • Oct/Nov 2023	• ED internal processes in place to support patients in ED • Plans in place with HCP/MH to put in 24/7 LPS to the sites/ Safehavens to be co-located at QEQM

Super Stranded Patients (>21d LoS)

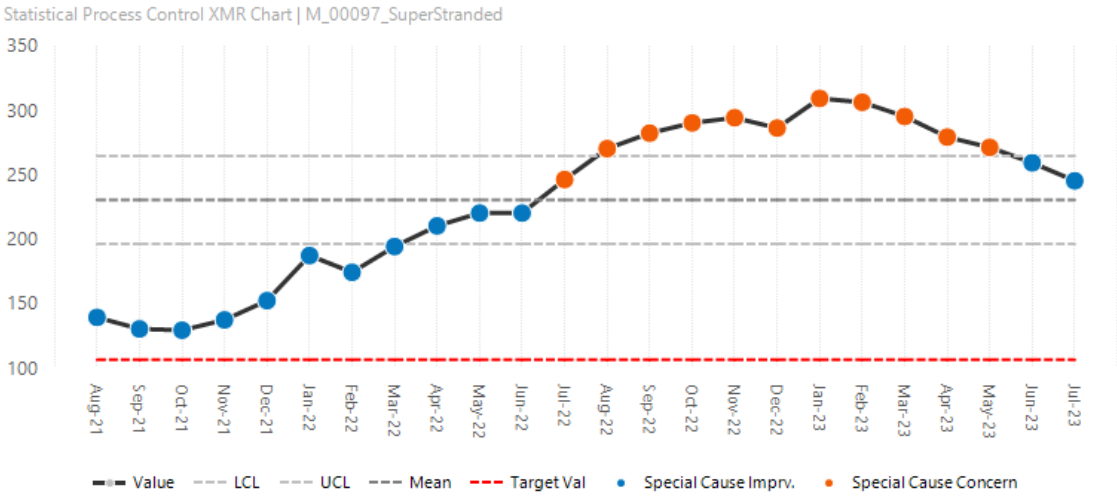
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Super Stranded >21D

Month	Value
Aug-22	271
Sep-22	283
Oct-22	291
Nov-22	295
Dec-22	287
Jan-23	310
Feb-23	307
Mar-23	296
Apr-23	280
May-23	272
Jun-23	260
Jul-23	246



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to lower values(Above Mean Run Group | | | | | Descending Run Group | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Long Stay Patients	• Roll out of SAFER bundle. Under the 'R' – 'Regular Review' principle patients with a LoS of more than 14 days will be reviewed at a weekly Super Stranded MDT	• Site MDs	• End October	• SAFER Board Round Bundle launched at WHH w/c 21st August. The programme will run from August to October 2023. QEQM dates to be set. • Ongoing patient/staff feedback being captured throughout the programme
Access to community capacity	• East Kent Health and Care Partnership Urgent and Emergency Care Plan for 23/24 is structured with 5 priority areas of work: Increasing urgent and emergency care capacity, Making it easier to access the right care, Improving discharge, Expanding pro-active care outside of hospital, Increase workforce size and flexibility.	• HCP/COO	• 23/24 Year End	• 8 additional stroke beds commissioned by KCHFT to open from 17th July. Will extend to 15 beds in Sept 23. • Home First Support Worker - Recruitment process underway. Aim to recruit 25 staff ASAP. Will reduce unnecessary readmissions and community P1 waits. • Implementation of P2 Transformation Programme: Aim to increase KCC bed occupancy up to 80% from 60%, reduce NLFTR for P2 to <10% by Winter via clearly defined pathways for rehabilitation, enablement and recovery

Not Fit to Reside

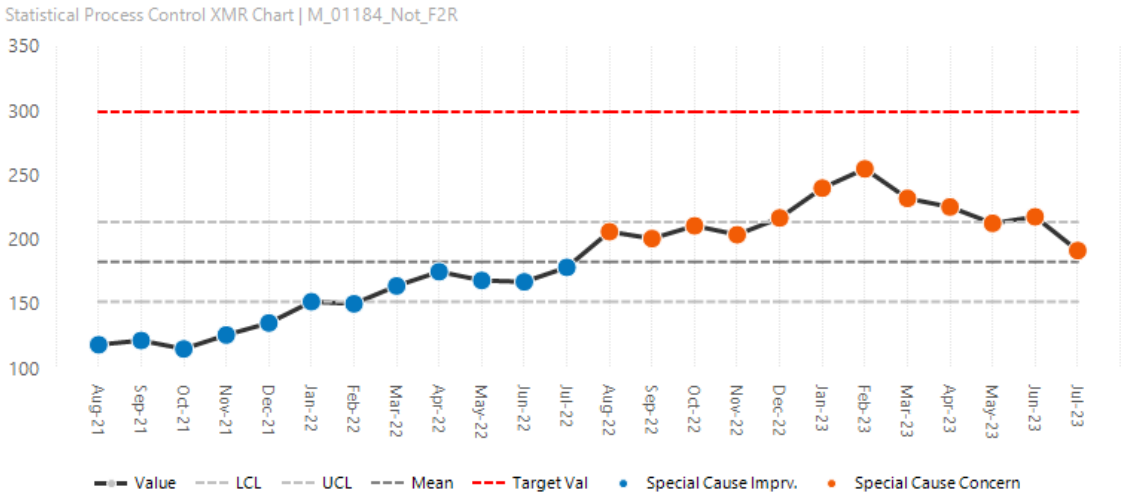
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Not Fit to Reside (pats/day)

Month	Value
Aug-22	206.9
Sep-22	201.6
Oct-22	211.5
Nov-22	204.5
Dec-22	217.6
Jan-23	240.7
Feb-23	255.7
Mar-23	232.8
Apr-23	226.1
May-23	213.4
Jun-23	218.5
Jul-23	192.3



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to higher values(Above Mean Run Group | | | | | |Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently passing the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Access to community capacity	• East Kent Health and Care Partnership Urgent and Emergency Care Plan for 23/24 is structured with 5 priority areas of work: Increasing urgent and emergency care capacity, Making it easier to access the right care, Improving discharge, Expanding pro-active care outside of hospital, Increase workforce size and flexibility.	• HCP/COO	• 23/24 Year End	• 8 additional stroke beds commissioned by KCHFT to open from 17th July. Will extend to 15 beds in Sept 23. • Home First Support Worker - Recruitment process underway. Aim to recruit 25 staff ASAP. Will reduce unnecessary readmissions and community P1 waits. • Implementation of P2 Transformation Programme: Aim to increase KCC bed occupancy up to 80% from 60%, reduce NLFTR for P2 to <10% by Winter via clearly defined pathways for rehabilitation, enablement and recovery
Long Stay Patients	• Roll out of SAFER bundle. Under the 'R' – 'Regular Review' principle patients with a LoS of more than 14 days will be reviewed at a weekly Super Stranded MDT	• Site MDs	• End October	• SAFER Board Round Bundle launched at WHH w/c 21st August. The programme will run from August to October 2023. QEQM dates to be set. • Ongoing patient/staff feedback being captured throughout the programme
Ward/RTS comms.	• PTL improvements provide the ward and RTS with a traffic light system highlighting the patient status on the RTS caseload. Alert system rolled out to provide two-way communication between ward and RTS for patient reviews.	• GS and Gastro DHoN	• End October	• Alert system rolled out and accessible by the wards and RTS in August 23. Training ongoing for the Red, Amber, Green patient status update. • Work continues to consolidate the RTS and Ward Discharge planning PTLs to further improve live information feeds and communication

Cancer 28d Faster Diagnosis

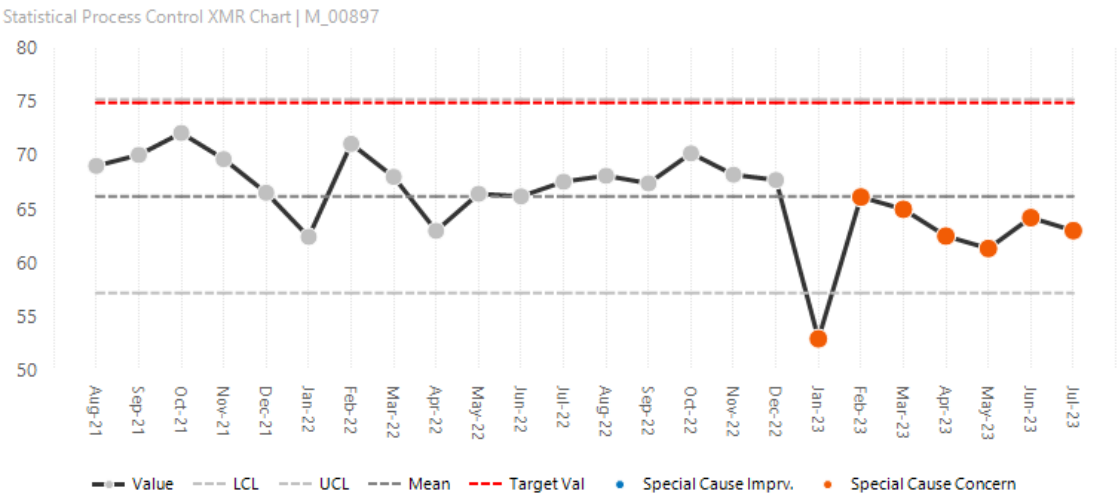
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Cancer 28d Performance

Month	Value
Aug-22	68.2%
Sep-22	67.5%
Oct-22	70.3%
Nov-22	68.3%
Dec-22	67.8%
Jan-23	53.0%
Feb-23	66.2%
Mar-23	65.1%
Apr-23	62.6%
May-23	61.4%
Jun-23	64.3%
Jul-23	63.1%



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to lower values(| Below Mean Run Group | | | | |)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Diagnostic reporting for CT's & MRI's (current reporting time is 2 weeks for CT's and 6 weeks for MRI's) Ref to exam - CT- 2-3 days if bloods done, if not 14 days. MRI 11 days.	Reduce referral to reporting to 10 days for CT and MRI	• Radiology • Cancer Trackers • Phlebotomy	• End Oct 2023	• Improved escalation process being piloted for bloods, vetting, booking and reporting
Qfit process not consistently applied and current waiting time for endoscopy booking is 4 weeks.	Qfit process to be consistently applied and sustained. To reduce waiting time to Scope to 10 days for 2ww and screening patients	• Endoscopy • Qfit Facilitator • AMD Surgery	• Dec 2023	• Insourcing agreed to the end of September- working every weekend on all sites. September onwards is currently being reviewed. STT implemented for Lower. SOP for Qfit drafted to be implemented by end of August 2023
Waits for typing of cancer patient clinic letters , typing for Urology, Upper and Lower GI. Averaging 8-12 weeks.	Typing of letters for those tumour sites to be completed within 7 days.	• Care Group Lead Medical Secs	• End Oct 2023	• Benign letters agreed to support improvement, while waiting time improved for comprehensive letter • Updates on progress circulated to teams 3 times a week to support improvement

Cancer Patients >62d on PTL

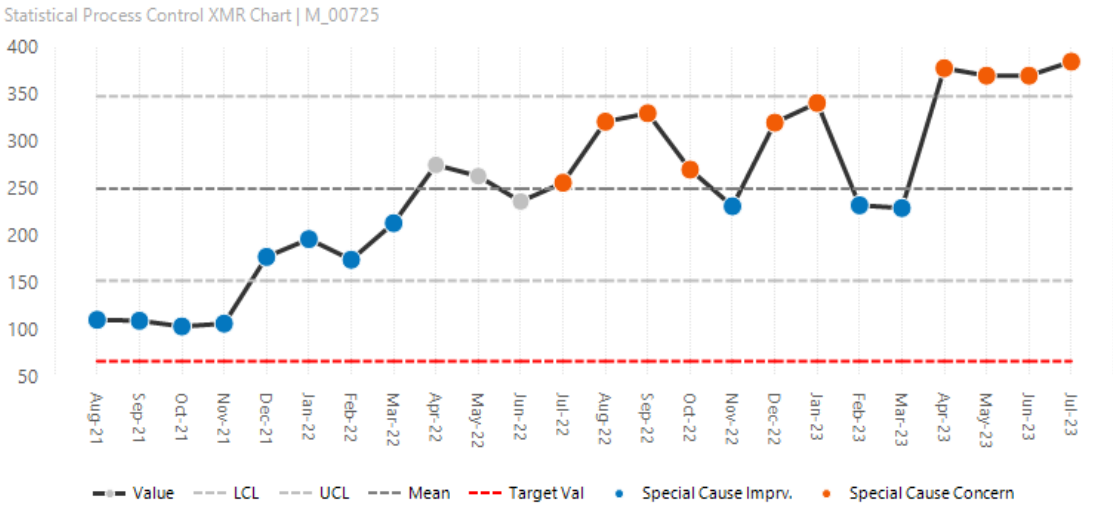
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Cancer Over 62d on PTL

Month	Value
Aug-22	322
Sep-22	331
Oct-22	271
Nov-22	232
Dec-22	321
Jan-23	342
Feb-23	233
Mar-23	230
Apr-23	379
May-23	371
Jun-23	371
Jul-23	386



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to higher values(| | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Diagnostic waiting time for U/S Guided Biopsies. Average wait time 4-5 weeks	Reduce wait time to diagnostic to 7-10 days.	• Radiology	• Oct 2023	• Radiology Improvement plan in place • Options for dedicated lists on the K&C site being explored • Options within the Alliance being explored to support the teams involved
Inadequate capacity within out-patients for F2F appointments post MDM to discuss treatment options post MDM	• Increase Outpatient capacity for decision to treat (DTT) OPA's. OPA to be available within 5 days following the MDM. • Provide Increased straight to test (STT) capacity to release medical time for F2F OPA's etc.	• FDS Lead Clinician • Out-patient Lead	• Oct 2023	• 2ww Transformation Working Group established • STT for lower expanding capacity in September • STT prostate funding agreed posts due to be advertised • STT Lung and Upper in place, under review for additional learning/improvement following patients feedback

Cancer Patients >104d on PTL

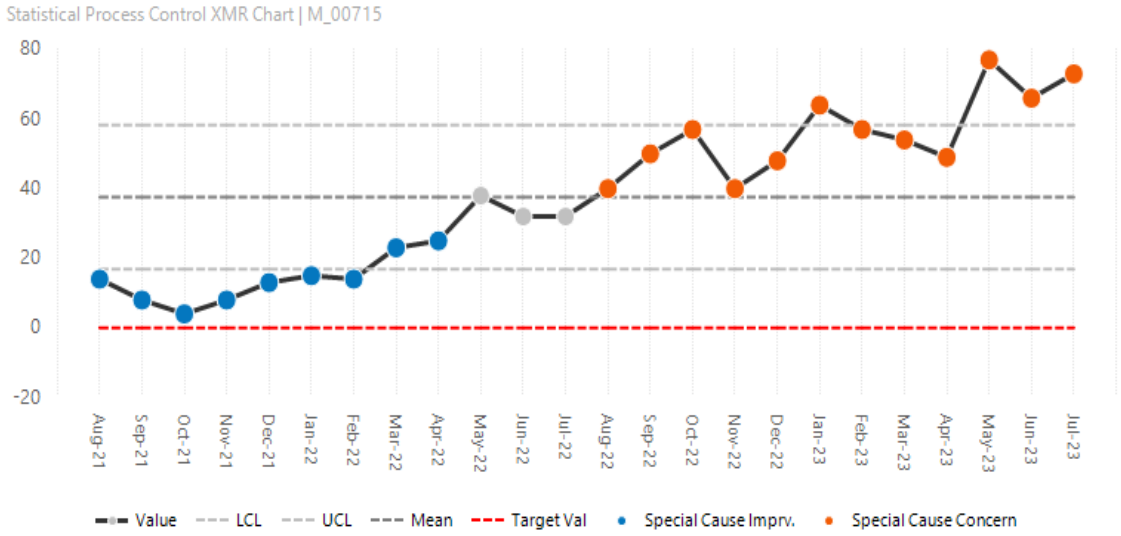
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Cancer Over 104d on PTL

Month	Value
Aug-22	40
Sep-22	50
Oct-22	57
Nov-22	40
Dec-22	48
Jan-23	64
Feb-23	57
Mar-23	54
Apr-23	49
May-23	77
Jun-23	66
Jul-23	73



Understand the most recent data point

Variation Type

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

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Urology Surgical capacity	Increase surgical capacity by exploring mutual aid options with MFT for RALP and Alliance for Cystectomy	• MD • AMD and MD K&C • MDT Lead for Urology	• Sep 2023	• Pathway agreed with MFT, awaiting financial detail • K&M Cancer Alliance meeting being arranged
Tertiary referral – delays with receiving communication back from tertiary centres.	Improved collaboration between EKHUFT and tertiary centres.	• Senior Service Managers EKHUFT • Tertiary Centres • EKHUFT Compliance Managers	• Sep 2023	• Established weekly PTL meetings for UGI with our London colleagues. • Meetings with Kings took place on 1st and 14th August to review IPT transfers, and correct completion of documents. Established the main contacts for help in escalating issues.
Patient engagement throughout pathways, multiple cancellations/DNA's	Ensure GP's are informing the patients they are being referred on a cancer pathway and not all investigations will be at the hospital nearest to them.	• Care Group Leads/ CNS's • GP's/Support Workers/Patient Engagement Officer Kent & Medway Cancer Alliance	• Oct 2023	• 2ww Transformation Working Group. • Working with our GP Cancer Lead to ensure patients are being told they are on a cancer pathway at referral • STT implementation • Early escalation to Cancer CNS's to support patients • Development of 2ww information of Trust web page to support patients and their relatives/carers on a cancer pathway, being designed

Diagnostic Waiting Times: DM01

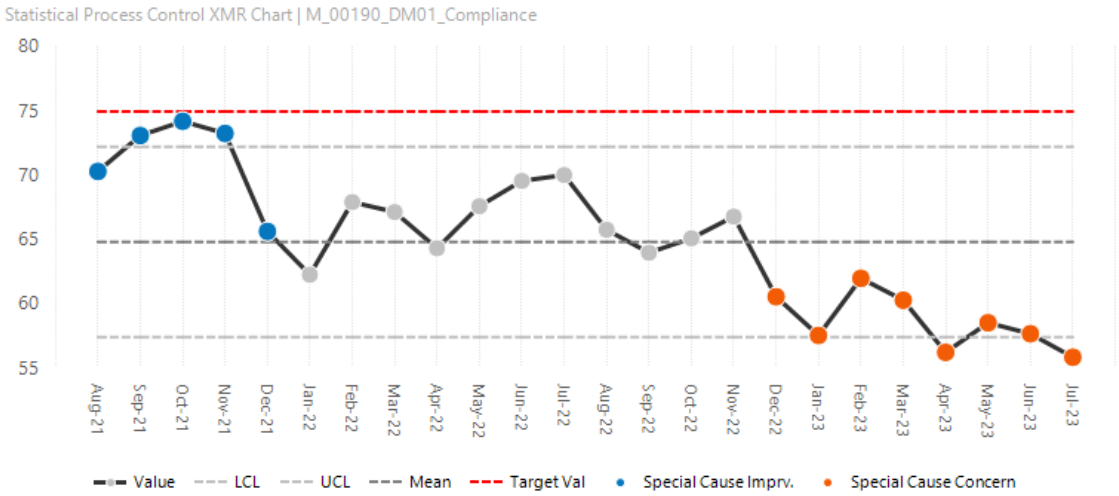
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

DM01 Compliance

Month	Value
Aug-22	65.8%
Sep-22	64.0%
Oct-22	65.1%
Nov-22	66.8%
Dec-22	60.6%
Jan-23	57.6%
Feb-23	62.0%
Mar-23	60.3%
Apr-23	56.3%
May-23	58.6%
Jun-23	57.7%
Jul-23	55.9%



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to lower values(| Below Mean Run Group | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE(S)	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
CT issues; • CT Cardiac • CT Vetting • Ranzac protocol	• Cardiac | awaiting review of external funding • Vetting | training plan for Junior Dr's • Ranzac | agree protocol	• DCOO • Rad: Clinical Lead • Rad: Clinical Lead	• tbc • Start Sep 24 • Start mid Sep 24	• Awaiting financial approval • Awaiting training to start • Awaiting stage one of protocol signoff
MRI scanning capacity	Additional MRI scanners X2 to meeting 19/20 plan of 120%. Trust agreed 100%	• Trust	• No agreement or timescale. To be reviewed at Business Planning	• 2 MRI's would achieve DM01 compliance in 6 months + reduced backlog position
Endoscopy Capacity | Demand outstrips capacity	Procurement underway to insource 1,000 scopes per month for 12 months, STW in place whilst procurement concludes to deliver an additional 50 lists per month in the interim	• TS	• Award Aug 2023 • Implementation Sep-Oct 2023 dependent on governance/sign off	• 21.08.23 | Bids evaluated, clarification questions sent back to bidders to complete

Referral to Treatment Waiting Times: 65w Waits

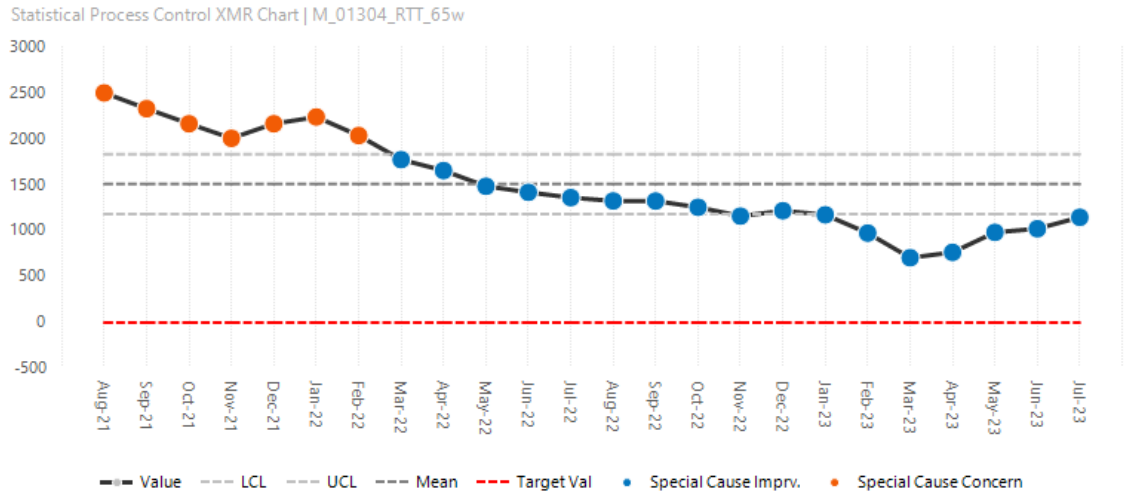
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

RTT 65w Breaches

Month	Value
Aug-22	1,326
Sep-22	1,325
Oct-22	1,257
Nov-22	1,161
Dec-22	1,219
Jan-23	1,175
Feb-23	976
Mar-23	707
Apr-23	766
May-23	984
Jun-23	1,023
Jul-23	1,148



Understand the most recent data point

Variation Type

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

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Non-admitted pathway delays impacting ability to reduce breaches	• Out Patient Transformation re-set internally aligned to revised Kent and Medway Out Patient Transformation	• COO	• Sep 2023	• K&M relaunched OP meeting • EKHUFT to redesign OP meeting in line with new restructure
Sickness absence has significantly impacted ability to recover longest waiting patients in ENT	• Local and regional (Inc. London) capacity options exhausted | 78ww trajectory to recover otology breaches remains (Jan 2024)	• COO	• Jan 2024	• Continue to validate patient pathways • Maximise internal theatre capacity • Theatre workforce competency training underway to release more otology lists in Oct 2023
Diagnostic delays – demand in cancer impacting ability to scan/scope routine (longer waiting RTT patients)	• Endoscopy Insourcing tender process underway to secure additional capacity for cancer demand, routine and surveillance patients	• COO	• Sep 2023	• Scoring completed • Internal financial governance to be completed • Modelling impact on cancer/RTT position

Referral to Treatment Waiting Times: 52w Waits

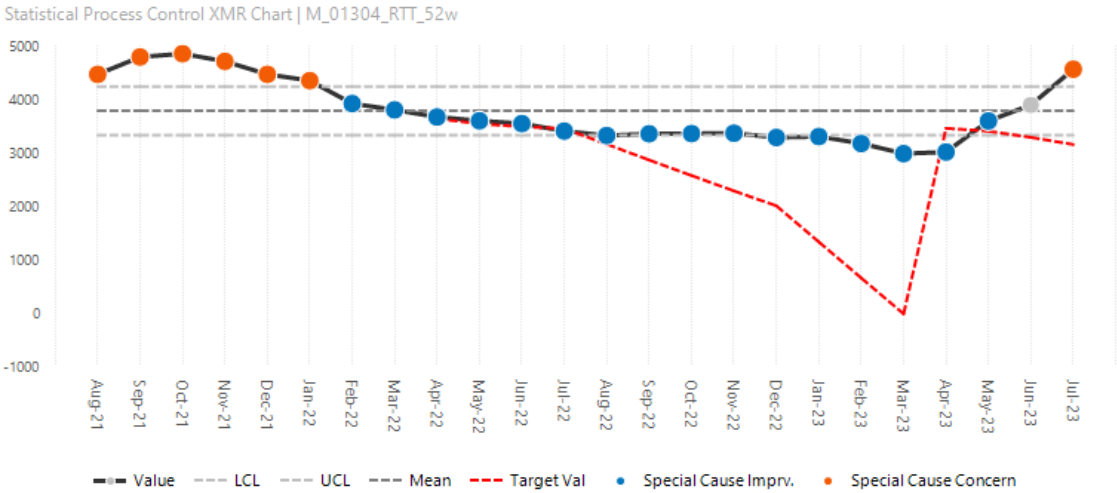
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

RTT 52w Breaches

Month	Value
Aug-22	3,336
Sep-22	3,368
Oct-22	3,372
Nov-22	3,379
Dec-22	3,299
Jan-23	3,317
Feb-23	3,187
Mar-23	2,997
Apr-23	3,027
May-23	3,608
Jun-23	3,907
Jul-23	4,575



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to higher values(| | Outside Moving Range Limit | Astronomical Point | | |)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Industrial Action – accumulated impact of cancelled patients and lost capacity (due to not booking patients)	• Specialities reviewing theatre opportunity to develop tangible plans to increase elective activity and where possible increase beyond plan (within budget)	• Managing Directors	• Sep 2023	• Speciality proposals being developed which articulate activity volumes and timeframes • Review current Theatre meetings to ensure they align with new structure reporting arrangements
Non-admitted validation - in ability to maintain 12 weekly validation targets for every patient	• Implement two way text messaging for all non-admitted patients to support requirement to validate and ensure compliance against the validation standard	• Elective Recovery Director	• Sep 2023	• Trail completed in two admitted specialities • Approve logic for all admitted pathways and roll out • Test two specialities in non-admitted and roll out
Elective capacity to meet demand	• Review stretch targets set for business planning 23/24 with COO/Exec Team	• BI and Elective Director	• Sep 2023	• Paediatric capacity increase planned from Oct 23 with longer term plan required • Specialities quantifying actions and timeframes to increase theatre cases

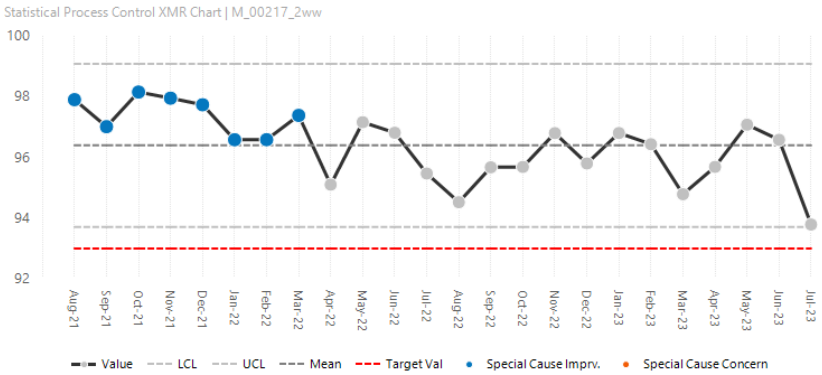
Cancer Performance

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

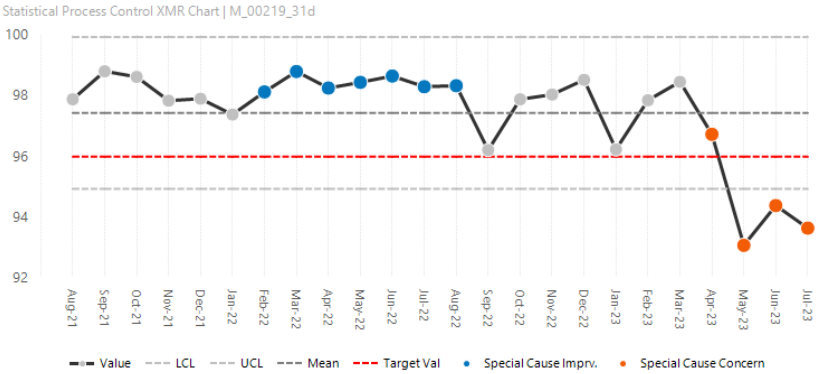
Cancer 2ww Performance

Month	Value
Aug-22	94.5%
Sep-22	95.7%
Oct-22	95.7%
Nov-22	96.8%
Dec-22	95.8%
Jan-23	96.8%
Feb-23	96.4%
Mar-23	94.8%
Apr-23	95.7%
May-23	97.1%
Jun-23	96.6%
Jul-23	93.8%



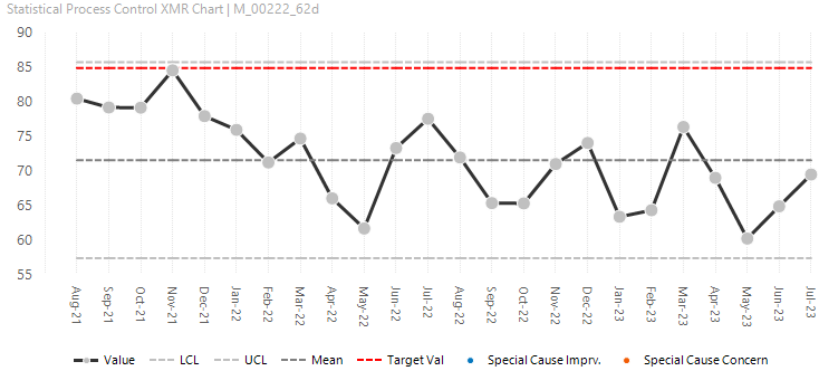
Cancer 31d Performance

Month	Value
Aug-22	98.3%
Sep-22	96.2%
Oct-22	97.9%
Nov-22	98.1%
Dec-22	98.5%
Jan-23	96.2%
Feb-23	97.9%
Mar-23	98.5%
Apr-23	96.7%
May-23	93.1%
Jun-23	94.4%
Jul-23	93.6%



Cancer 62d Performance

Month	Value
Aug-22	72.0%
Sep-22	65.4%
Oct-22	65.4%
Nov-22	71.1%
Dec-22	74.1%
Jan-23	63.4%
Feb-23	64.4%
Mar-23	76.4%
Apr-23	69.1%
May-23	60.3%
Jun-23	64.9%
[illegible]	69.6%



PERFORMANCE UPDATE

The dip in 2ww performance is due to the care groups beginning to clear the backlog of letters. Waits within endoscopy significantly increased during this time and there were delays with biopsy and diagnostic booking and reporting.

31 Day Performance reduced due to reduced capacity for skin procedures. In the summer there is always an increase in referrals which impacts on capacity. June saw an increase in referrals of 325 compared to last years referrals.

Slight increase in 62d performance. Improvements actions include;

- Straight to Test (STT) pathways for Lung, Lower GI, Upper GI and Haematuria
- Enhanced escalation process in place for Consultant reviews, tertiary referrals, surgical dates and diagnostics to reduce the number of days on the pathway
- Engagement with Care Groups to support booking of patients
- Improving access to blood tests for cancer patients so that diagnostics can be booked earlier

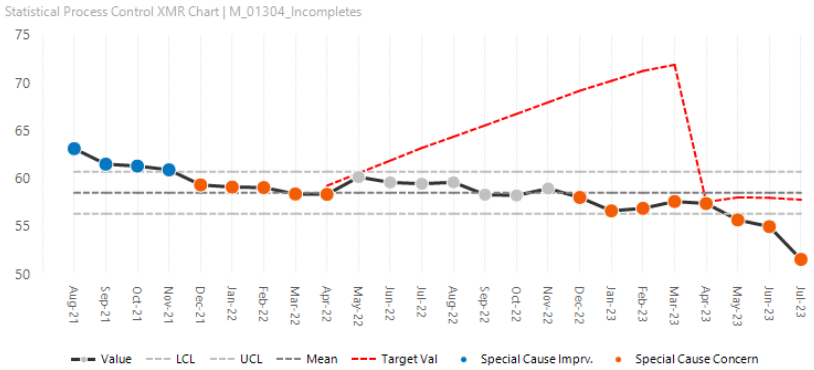
RTT Performance

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

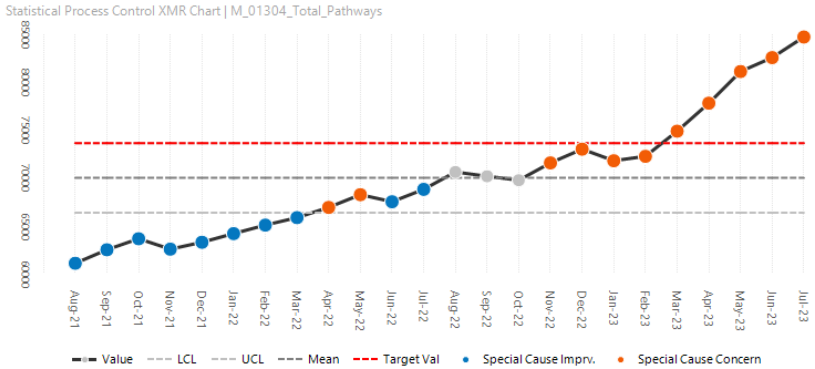
RTT Incomplete Performance

Month	Value
Aug-22	59.7%
Sep-22	58.4%
Oct-22	58.3%
Nov-22	59.0%
Dec-22	58.1%
Jan-23	56.7%
Feb-23	56.9%
Mar-23	57.7%
Apr-23	57.5%
May-23	55.7%
Jun-23	55.0%
Jul-23	51.6%



RTT Total Incomplete Pathways

Month	Value
Aug-22	70.7K
Sep-22	70.3K
Oct-22	69.9K
Nov-22	71.7K
Dec-22	73.1K
Jan-23	71.9K
Feb-23	72.4K
Mar-23	75.0K
Apr-23	77.9K
May-23	81.2K
Jun-23	82.7K
Jul-23	84.8K



PERFORMANCE UPDATE

Performance has been deteriorating monthly due to our inability to increase capacity significantly beyond plan for patients waiting beyond 18 weeks for first definitive treatment.

The volume of total incomplete pathways is growing rapidly each week – a proportion of the referrals can be attributed to referral growth from primary care but a growing volume of out of area patients are being referred via non-primary care pathways to our clinicians.

Weekly more patient RTT pathways are being started (clock start) compared to those being ended (clock stop).

Elongated pathway waits in first, follow up and diagnostics are contributing to our ability to treat and end pathways before 78 weeks. Specialities have been asked to work to stretch targets for 23/24 but are hindered by workforce and capacity constraints.

Validation has been a key focus for speciality teams since last year, approximately 50% of the total RTT PTL is validated. The plan to roll out a digital solution, to support teams validating, is progressing. Furthermore the option to utilise the patient portal to support this programme of work is being reviewed and considered.

DM01 performance is impacting waiting times – an improvement plan to support recovery in the most challenged diagnostic modalities is underway.

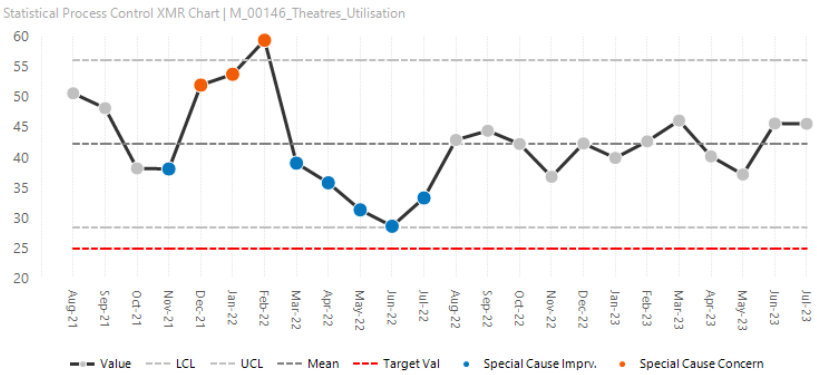
Efficiency Metrics

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

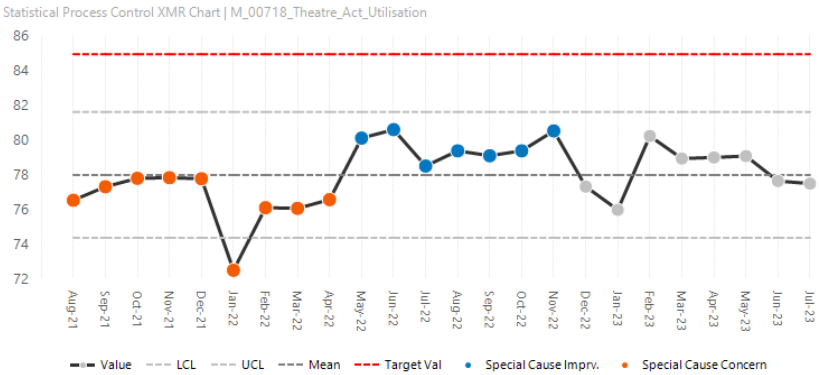
Theatre Session Opp.

Month	Value
Aug-22	43
Sep-22	45
Oct-22	42
Nov-22	37
Dec-22	42
Jan-23	40
Feb-23	43
Mar-23	46
Apr-23	40
May-23	37
Jun-23	46
Jul-23	46



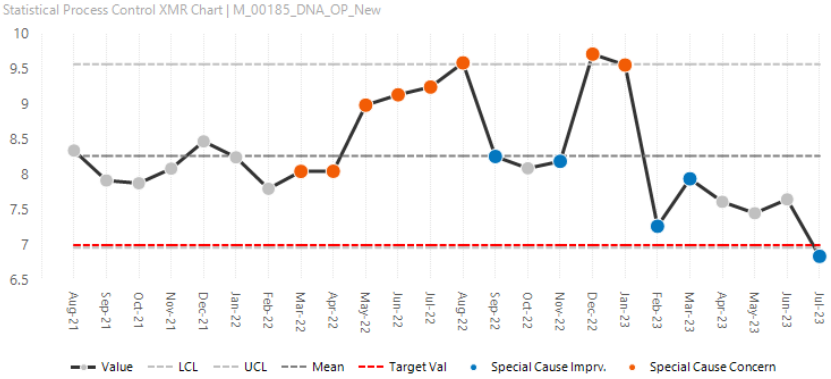
Theatre Actual Utilisation

Month	Value
Aug-22	79.4%
Sep-22	79.1%
Oct-22	79.4%
Nov-22	80.6%
Dec-22	77.4%
Jan-23	76.0%
Feb-23	80.3%
Mar-23	79.0%
Apr-23	79.0%
May-23	79.1%
Jun-23	77.7%
Jul-23	77.5%



DNA Rate OP New

Month	Value
Aug-22	9.6%
Sep-22	8.3%
Oct-22	8.1%
Nov-22	8.2%
Dec-22	9.7%
Jan-23	9.6%
Feb-23	7.3%
Mar-23	7.9%
Apr-23	7.6%
May-23	7.5%
Jun-23	7.7%
Jul-23	6.8%



PERFORMANCE UPDATE

Theatre session opportunity remains within normal variation showing no significant change over the last 12 months. The biggest opportunity remains in relation to cancelled sessions, with more than 50% of the 46 session opportunity linked to this.

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

The theatre efficiency programme will be reviewed in line with new operational changes and specialty plans to improve theatre performance will be evaluated to ensure they are quantified and deliverable in line with theatre capacity and workforce.

DNA rates are showing signs of an improving nature with rates in July of 6.8%, below the Trust aim of 7%. Increasing numbers of patients now have the ability to choose their appointment date as specialties are moving back to the electronic referral service which appears to be having a positive impact and decreasing capacity lost due to DNA.

Quality & Safety

Quality & Safety

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
Quality	Serious Incidents	Sigma	Jul-23	11			1	19	37	Common cause (no significant change)
	Overdue Incidents	0	Jul-23	2,395			4,129	5,221	6,313	Special cause of improving nature or lower pressure due to lower values
	Incidents - Moderate / Severe	Sigma	Jul-23	41			9	34	58	Common cause (no significant change)
	HSMR	96.0	Mar-23	93.5			87	91	96	Special cause of concerning nature or higher pressure due to higher values
	Pressure Ulcers	Sigma	Jul-23	106			74	107	141	Common cause (no significant change)

July Performance Summary

Incident Reporting: There were 2,184 patient incidents reported in July, of which 11 were declared as serious incidents at the Serious Incident Declaration Panel, which is chaired by the Chief Nursing and Midwifery Officer, the Chief Medical Officer or the Director of Quality Governance. This compares with 2,353 overall incidents reported in June, 2,448 in May and 2,173 in April. There was one Never Event reported in July compared with two in June, one in May and none in April. Each of the never events occurred at the QEQM hospital, one in the Day Case Theatre Unit (low harm), one in the Emergency Department (low harm) and two in main theatres (both low harm). These are currently being investigated. The CNMO and CMO will be holding a quality meeting with the care group triumvirate to consider any underlying cultural, safety and risk issues. Overdue incidents at 2,395 has reduced in month, the narrative for this can be found at slide 22.

Mortality: The current HSMR performance remains below 100, which demonstrates a statistically lower than expected mortality. From October 2022 to March 2023, the HSMR has been trending upwards with the most significant contributors to this being Acute Myocardial Infarction, Viral Infection, and Rest of Miscellaneous Operations, all of which have currently higher than expected mortality (above 100). Analysis by the Mortality Surveillance Steering Group is ongoing to understand the upward trend of HSMR and to identify the countermeasures required to address it if it continues to rise.

Harm Events: The number of harm events shows an upward trend from April-29, May-32 and June-29, with a subsequent increase in cases taken to the Serious Incident Investigation Panel, although not all cases presented resulted in an SI being declared. There has been improved clinician presence at this panel and following in-depth discussion the number of cases deemed to reach SI thresholds has not increased.

Serious Incidents

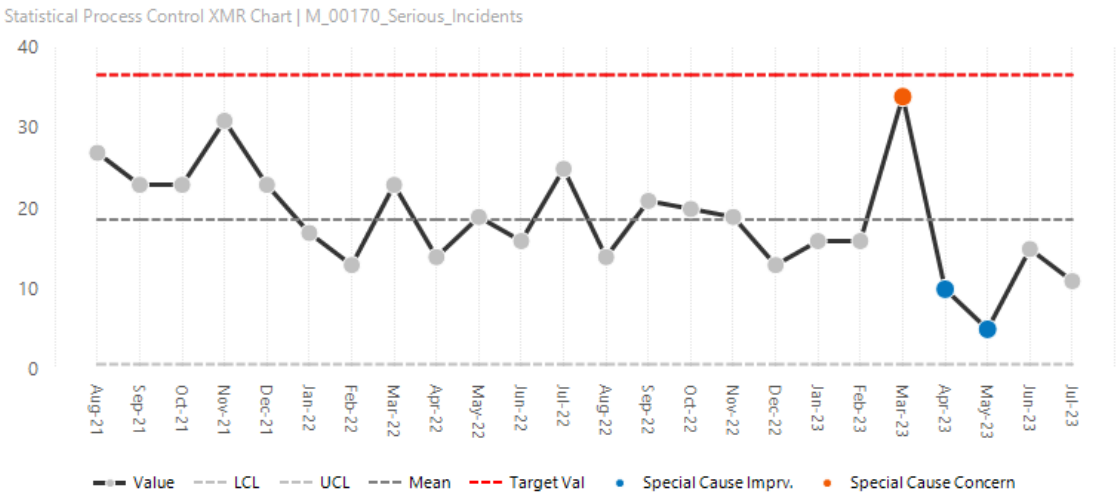
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Serious Incidents

Month	Value
Aug-22	14
Sep-22	21
Oct-22	20
Nov-22	19
Dec-22	13
Jan-23	16
Feb-23	16
Mar-23	34
Apr-23	10
May-23	5
Jun-23	15
Jul-23	11



Understand the most recent data point

Variation Type

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

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
The Never Event was reported as Wrong Site Surgery for an intrauterine device which was not consented for. It was removed whilst the patient was in Theatres' Recovery.	• Immediate reflection by the Consultant and Junior Doctor. Theatre Leads have been working closely with staff around escalation prompts and WHO Safety Checks. Simulation exercises are planned. The CNMO & CMO are to hold a Quality Meeting with the Care Group Triumvirate to better understand underlying factors.	• Theatre Matron • Clinical Director	• Immediate remedial actions completed. Simulation to be completed by end of September 2023	• Reflection completed. • Simulation planned. • Investigation is ongoing.
There has been a cluster of surgical site infections within T&O at the QEQM and WHH, 13 identified. 4 declared as SIs due to patient deaths but not yet confirmed that the root cause/ cause of death was SSI, QEQM (3) and WHH (1).	• CNMO held an urgent review meeting. Immediate actions included review of theatre air handing and cleanliness. • Gap against national best practice identified immediate actions about patient washing prior to theatre • Detailed investigation underway as well as review of NOF pathway	• Head of Nursing • Clinical Director	• End of August	• Action re requirement for washing prior to theatre communicated • Review of pathway underway • DOC Completed • Follow up meetings to track progress with CNMO weekly

Overdue Incidents

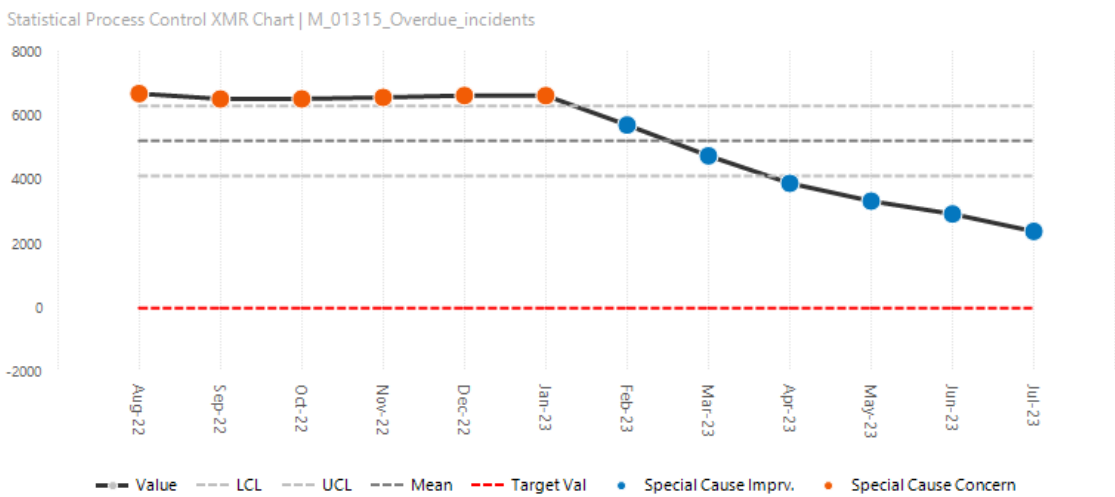
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Overdue Incidents

Month	Value
Aug-22	6,698
Sep-22	6,531
Oct-22	6,532
Nov-22	6,579
Dec-22	6,637
Jan-23	6,635
Feb-23	5,716
Mar-23	4,755
Apr-23	3,897
May-23	3,340
Jun-23	2,938
Jul-23	2,395



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to lower values(| | | Astronomical Point | | Descending Run Group | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
There was a target set to have closed all overdue incidents by the end of August. Despite good progress, we are unlikely to make the deadline in two care groups (Women's Health and General Specialist Medicine).	• The focus remains on closing these incidents and a regular update is given by the Governance Matrons during weekly meetings with the Deputy Director of Quality Governance.	• Director of Quality Governance	• 31 August 2023	• Significant improvement has been seen across all care groups as seen in this huge reduction. Specific support and focus is now being given to Women's Health and GSM care groups, who report the largest numbers and therefor require the greatest resource. • RSP monies are being utilised to bring in additional resource for Women's Health to manage this
The Women's Health Care Group has a large proportion of overdue incidents (630)	• Additional help is being given by the Corporate Governance Team to help the handlers' with the bulk of these cases to close them.	• Director of Quality Governance	• 4 months (to end Dec 23)	

Incidents Causing Harm

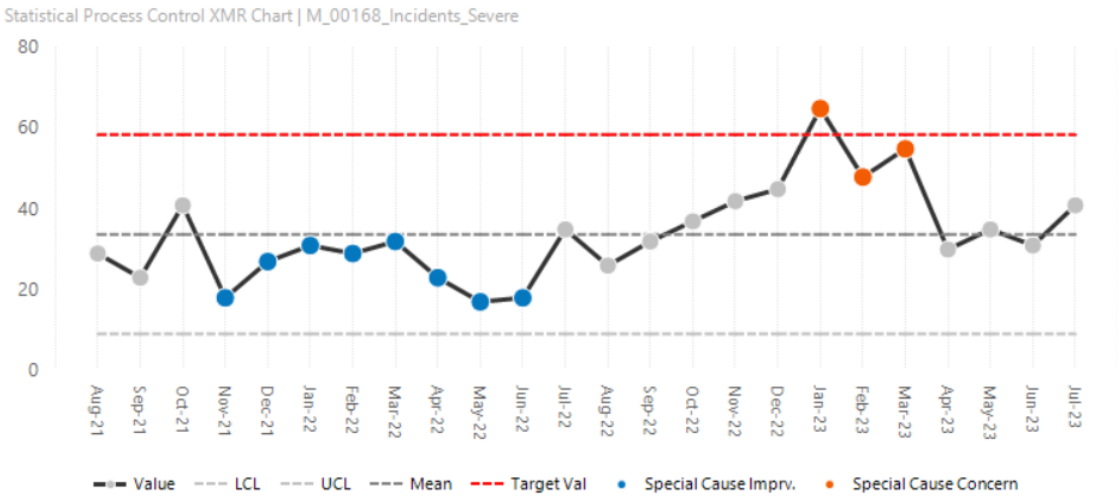
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Incidents - Moderate / Severe

Month	Value
Aug-22	26
Sep-22	32
Oct-22	37
Nov-22	42
Dec-22	45
Jan-23	65
Feb-23	48
Mar-23	55
Apr-23	30
May-23	35
Jun-23	31
Jul-23	41



Understand the most recent data point

Variation Type
Common cause (no significant change)(No Special Cause Flags)
Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Unwitnessed patient fall with head injury.	The Trust has a clear plan to ensure all staff, have received the appropriate training and education to prevent and manage patient falls. • FallStop, virtual and Face to Face • Ready to Care programme • Fundamentals of Care • International Nurses / OSCE Training • Preceptorship • FallStop Champions	• Falls Nurse Specialist	• Full plan should have been completed by June 2023 but continues to be progressed	• Trust-Wide Plan has on-going elements which are in the process of being rolled out. • 51% complete • 22% is on schedule to complete • 16% in progress and overdue • 11% not started
Category 4 pressure ulcer sustained on the ward.	The Pressure Ulcer Trust Wide Improvement plan includes the following focus points: • Leadership and culture • Early identification and intervention • Learning and Prevention • Education and training • Equipment • Clinical Pathways • System wide working to develop system wide community of practice.	• Tissue Viability Nurse	• Full plan on-going	• Trust-wide action plan: • 52% complete • 13% on schedule to complete • 24% in progress and overdue • 11% not started.

Hospital Standardised Mortality Ratio (HSMR)

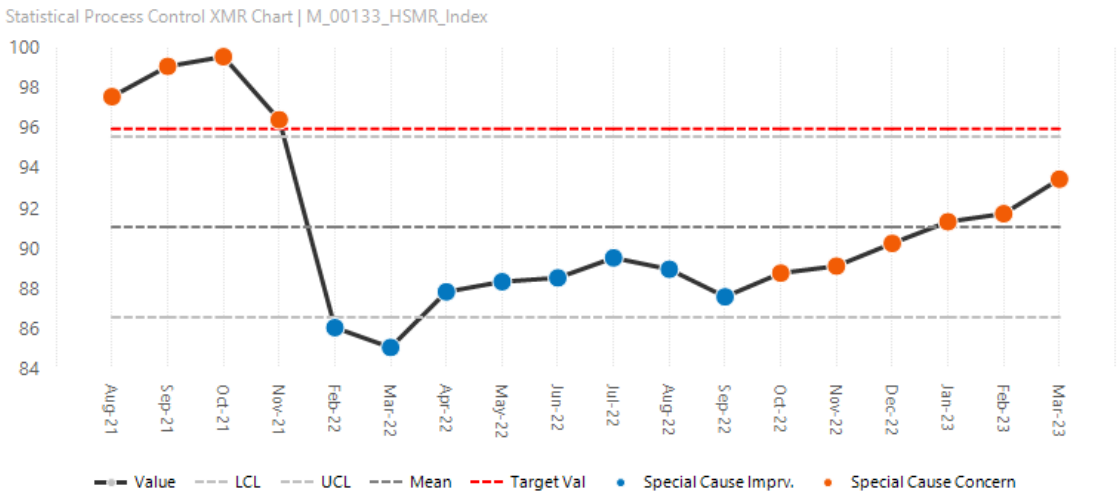
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

HSMR

Month	Value
Apr-22	87.9
May-22	88.4
Jun-22	88.6
Jul-22	89.6
Aug-22	89.0
Sep-22	87.6
Oct-22	88.8
Nov-22	89.1
Dec-22	90.3
Jan-23	91.4
Feb-23	91.8
Mar-23	93.5



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to higher values(| | | | Ascending Run Group | |)

Variation indicates consistently passing the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
To agree, develop and implement a Trust-wide Fractured Neck of Femur Pathway that will address and improve the eight Key Performance Indicators on the National Hip fracture database	• Analyse the recent increase to relative risk reported on Telstra Health UK via MSSG • Confirm remaining comments from WHH regarding fast track process • Launch ring fencing/fast track pilot on Seabathing and Kings C1	• KCVH CG	• Ongoing	• Ongoing work to understand and mitigate risks of recent rise in mortality and identification of surgical site infection.
Emergency Weekend Mortality is higher at the WHH site (specifically on Saturday) than national expected performance	• Review and analyse data in MSSG • Link and compare data through Telstra and integrate with the fractured neck of femur improvement plan • Review impact of higher than average patient complexity (Charlson Comorbidity) score.	• CMO	• Ongoing	• Identified at previous MSSG meeting for further investigation analysis.
"Rest of Miscellaneous Operations", "Viral Infection", and "Acute Myocardial Infarction" all have a higher than expected mortality rate	• Review and analyse data in MSSG • Identify any areas of concern and develop countermeasures for this to address relative risk above 100.	• CMO	• Sep 2023	• Analysis ongoing

Pressure Ulcers

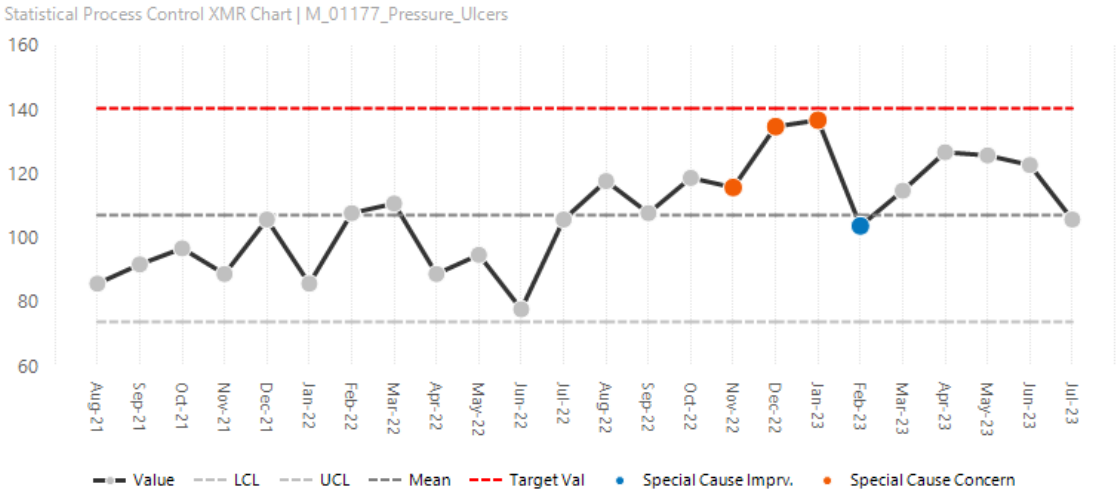
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Pressure Ulcers

Month	Value
Aug-22	118
Sep-22	108
Oct-22	119
Nov-22	116
Dec-22	135
Jan-23	137
Feb-23	104
Mar-23	115
Apr-23	127
May-23	126
Jun-23	123
Jul-23	106



Understand the most recent data point

Variation Type

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

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Inaccurate Waterlow Risk assessment score resulting in delays or inappropriate pressure ulcer (PU) prevention interventions	• To rollout PURPOSE T risk assessment to replace Waterlow trust wide.	• Fran King	• Trust wide Rollout Jan 2024	• Due to delays on risk assessments being available of Sunrise the funding was sought for paper copies of the risk assessment. These have been ordered. Rollout is starting with the ED's, Maternity then ward areas. Training has started to familiarise all staff with the tool.
Increase in Shear damage form lack of or inappropriate Slide sheet use.	• Targeted training for high reporting areas. The moving and handling team continue to perform ward audits and spot checks.	• Sharon Rindsland	• Jan 2024	• High volumes of shear damage reported to Manual Handling Team monthly. Ward based teaching arranged followed by assessment of these areas. • Latest audit data demonstrates increased availability on most wards.
Prolonged length of stay in ED on a trolley increasing Patient harm from Hospital Acquired Pressure Ulcers Trust wide.	• Increased Tissue Viability presence in ED ensuring appropriate risk assessment and equipment is in place in a timely manner. Improved equipment programme, more team presence, targeted education. Trial of a stretcher trolley for ED including a high-risk mattress to improve patient comfort and enhance PU prevention.	• Fran King • Sharon Rindsland	• Mar 2024	• Tissue Viability team are visiting the ED when on site ensuring that the appropriate equipment is in place. T proposed trolley was not x-ray compatible, which might cause issues with the quantity of x-rays • Another meeting will be held to look at the next steps.

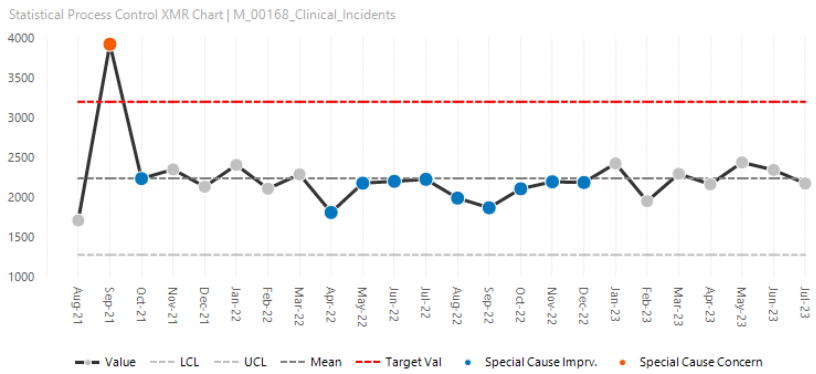
Incident Reporting

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

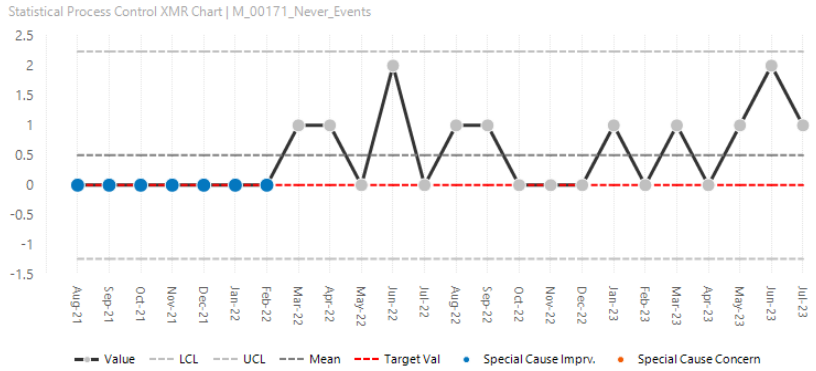
Clinical Incidents

Month	Value
Aug-22	2,000
Sep-22	1,879
Oct-22	2,117
Nov-22	2,205
Dec-22	2,196
Jan-23	2,436
Feb-23	1,961
Mar-23	2,305
Apr-23	2,173
May-23	2,448
Jun-23	2,353
Jul-23	2,184



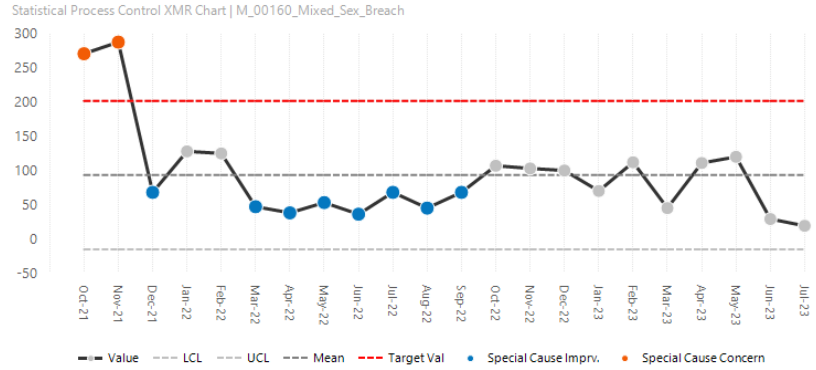
Never Events

Month	Value
Aug-22	1
Sep-22	1
Oct-22	0
Nov-22	0
Dec-22	0
Jan-23	1
Feb-23	0
Mar-23	1
Apr-23	0
May-23	1
Jun-23	2
Jul-23	1



Mixed Sex Breaches

Month	Value
Aug-22	46
Sep-22	69
Oct-22	108
Nov-22	104
Dec-22	101
Jan-23	71
Feb-23	113
Mar-23	46
Apr-23	112
May-23	121
Jun-23	30
Jul-23	20



PERFORMANCE UPDATE

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

Never Event incidents have been described earlier in the report with one being declared in July.

Mixed sex breaches: The graph shows us incidences of unjustifiable Mixed Sex Accommodation breaches due to non clinical reasons. The key objective is to achieve zero Mixed sex accommodation breaches. In March 23 it was agreed with the ICB that SEAU would change to Surgical SDEC and therefore out of scope for national reporting, resulting in consistency across Kent and Medway. In July 23 a further agreement has been reached with the ICB that MAU breaches are those sharing mixed sex accommodation for greater than 4 hours, with a decision to admit, but that the breach declared will be for the individual patient and not the unit as a whole.
No complaints have been received about mixed sex accommodation from patients during the last 3 months.

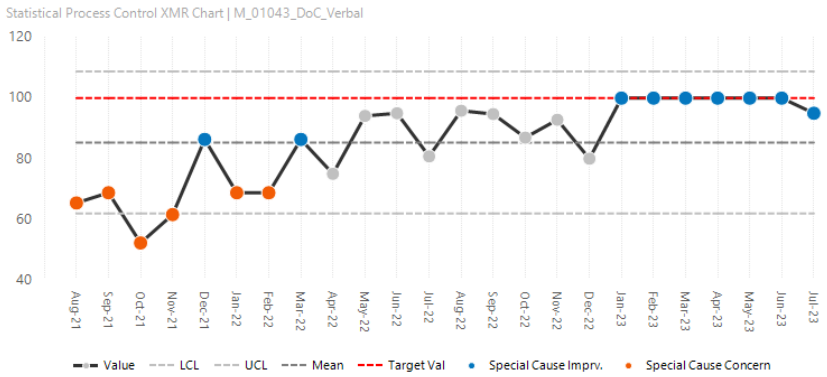
Duty of Candour

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

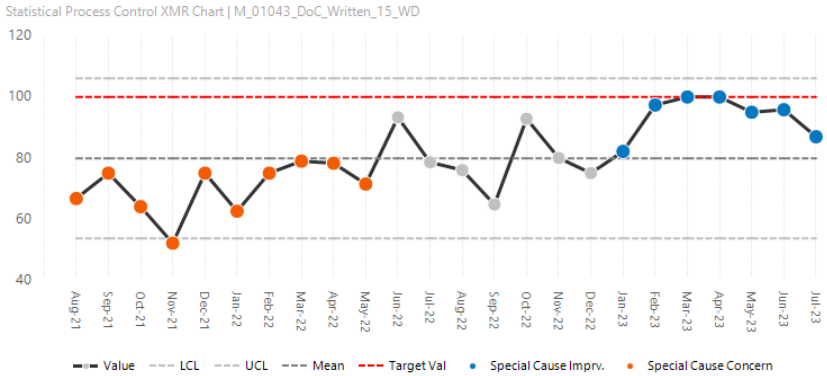
Duty of Candour - Verbal

Month	Value
Aug-22	95.8%
Sep-22	94.7%
Oct-22	87.0%
Nov-22	92.9%
Dec-22	80.0%
Jan-23	100%
Feb-23	100%
Mar-23	100%
Apr-23	100%
May-23	100%
Jun-23	100%
Jul-23	95.0%



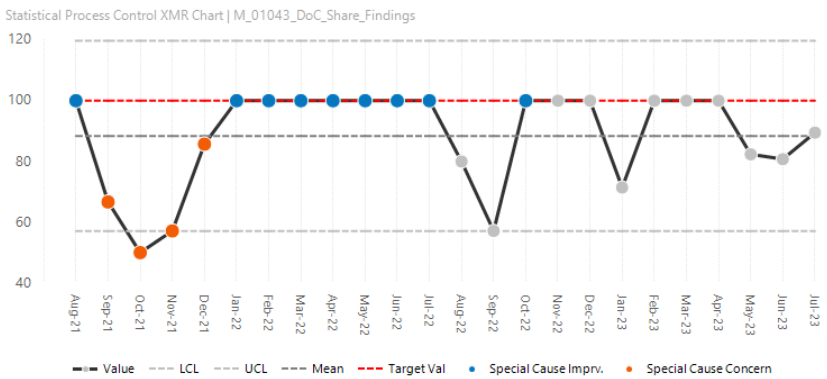
Duty of Candour - Written 15wd

Month	Value
Aug-22	76.0%
Sep-22	64.7%
Oct-22	92.9%
Nov-22	80.0%
Dec-22	75.0%
Jan-23	82.1%
Feb-23	97.4%
Mar-23	100%
Apr-23	100%
May-23	95.0%
Jun-23	95.8%
Jul-23	87.0%



Duty of Candour - Findings

Month	Value
Aug-22	80.0%
Sep-22	57.1%
Oct-22	100%
Nov-22	100%
Dec-22	100%
Jan-23	71.4%
Feb-23	100%
Mar-23	100%
Apr-23	100%
May-23	82.4%
Jun-23	80.8%
Jul-23	89.5%



PERFORMANCE UPDATE

Duty of Candour (DoC) metrics have been upheld since January 2023 but the data for July has a slight discrepancy. There were 19 cases requiring verbal DoC and 19 were completed within 10 working days.

First written DoC was achieved in 21 out of 22 cases.

Findings were shared via second DoC in 19 out of 19 cases within 20 working days. (17 within 10 working days).

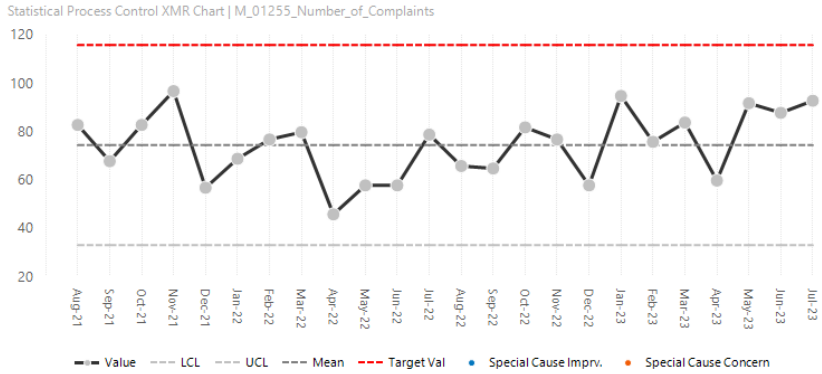
Complaints

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

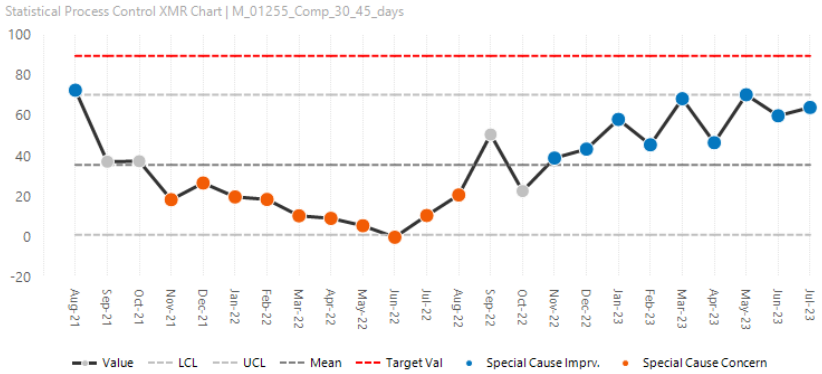
Complaints Number

Month	Value
Aug-22	66
Sep-22	65
Oct-22	82
Nov-22	77
Dec-22	58
Jan-23	95
Feb-23	76
Mar-23	84
Apr-23	60
May-23	92
Jun-23	88
Jul-23	93



Complaint Response

Month	Value
Aug-22	21.0%
Sep-22	51.0%
Oct-22	22.9%
Nov-22	39.3%
Dec-22	43.8%
Jan-23	58.5%
Feb-23	45.9%
Mar-23	68.8%
Apr-23	46.9%
May-23	70.7%
Jun-23	60.3%
Jul-23	64.4%



PERFORMANCE UPDATE

July 2023 saw 962 contacts to the department resulting in 93 new formal complaints and 434 new PALS contacts being taken forward.

10% of contacts in July 2023 were taken forward as new formal complaints. As a seasonal comparison to July 2022 there were 82 complaints and 628 PALS – a 13.5% increase in formal complaints and a 31% decrease in the number of PALS. The DQG is actively working with the PALS team to increase their visibility and access for patients and their families to improve this performance as there should be higher PALS contacts and fewer complaints. The highest number of contacts are in relation to gastroenterology and cardiology. The DQG is currently arranging to meet with the operational teams to determine what needs to be done to reduce the number of contacts.

88% of the new complaints were acknowledged within three working days, this is below the target of 90%. The drop in performance is due to team depletion in the central complaints team. The vacant post is being considered by the VCP.

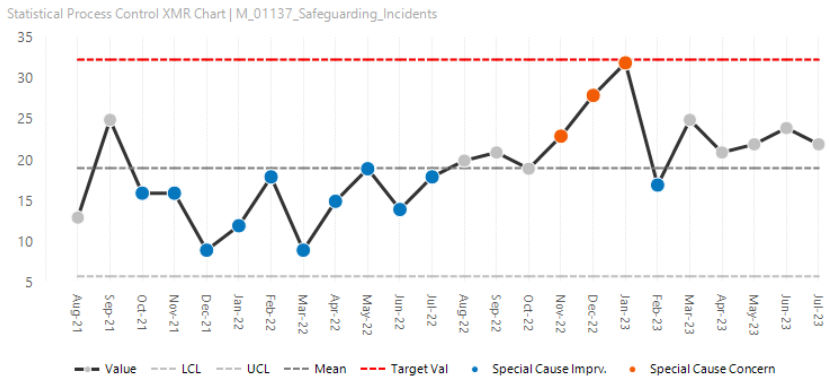
In addition, work to improve complaint response timescales, both initial and completion, is continuing. July 2023 saw a slight increase in performance of responses within timescales to 64% from 62% in June 2023, this is an improving picture when compared to July 2022, responses within timescales was 9%. The increased number of new complaints continues to affect response performance, however as stated above, by improving PALS visibility and access, this should support a reduction in complaints. A thematic review of the last 6 months of complaints is underway which will identify key areas to target for improvement.

Safeguarding
Statutory Metrics

NHS
East Kent Hospitals University
NHS Foundation Trust

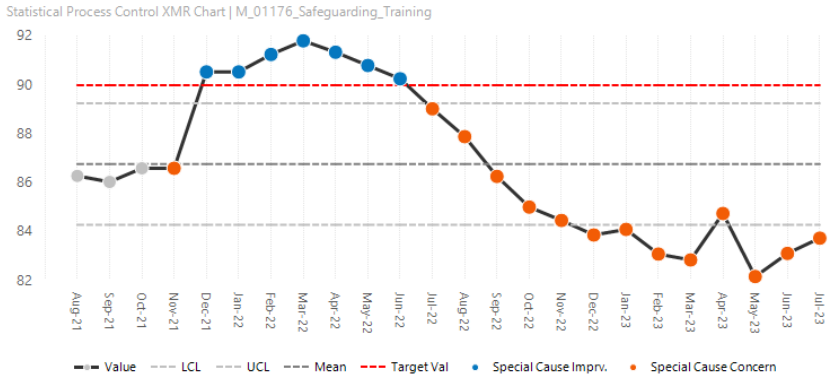
Safeguarding Incidents

Month	Value
Aug-22	20
Sep-22	21
Oct-22	19
Nov-22	23
Dec-22	28
Jan-23	32
Feb-23	17
Mar-23	25
Apr-23	21
May-23	22
Jun-23	24
Jul-23	22



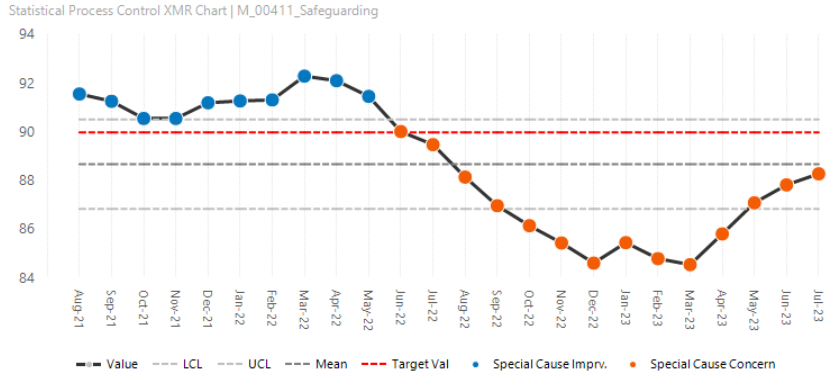
Safeguarding Adults Training

Month	Value
Aug-22	87.9%
Sep-22	86.3%
Oct-22	85.0%
Nov-22	84.5%
Dec-22	83.9%
Jan-23	84.1%
Feb-23	83.1%
Mar-23	82.9%
Apr-23	84.8%
May-23	82.2%
Jun-23	83.1%
Jul-23	83.7%



Safeguarding Children Training

Month	Value
Aug-22	88.2%
Sep-22	87.0%
Oct-22	86.2%
Nov-22	85.5%
Dec-22	84.6%
Jan-23	85.5%
Feb-23	84.8%
Mar-23	84.6%
Apr-23	85.8%
May-23	87.1%
Jun-23	87.8%
Jul-23	88.3%



PERFROMANCE UPDATE

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

Open section 42 is **17**
Overdue is **17**

With regards to training - there remains a shortfall in training compliance at level 2 (children and adults) and 3 (children and adults) across the Care Groups at the agreed local level of **85% in line with national level** (end of June compliance).

There is a trajectory plan in place from all Care Groups were they have indicated that they will be complaint by December 2023.

1. Cancer: Plan in place – achieve by December 2023 – L2C – **81%,** L3C – **92%,** L2A – **86%** and L3A – **41%.**
2. Child health: Plan in place – achieve by November 2023 - L2C – **80%,** L3C – **90%,** L2A and **86%**
3. SHNB&D: Plan in place – achieve by November 2023 - L2C – **87%,** L3C – **83%,** L2A – **83%** and L3A – **72%.**
4. S&A: plan in place – achieve by October 2023 - L2C – **84%,** L3C – **86%,** L2A – **83%** and L3A – **61%.**
5. GSM: plan in place to monitor – achieve by November 2023 - L2C – **78%,** L3C – **75%,** L2A – **81%** and L3A – **61%.**
6. Women's Health: achieve by November 2023 - L2C – **68%,** L3C – **75%,** L2A – **86%** and L3A – **41%.**
7. UEC: plan provided – achieve by September 2023 - L2C – **65%,** L3C – **88%,** L2A – **67%** and L3A – **71%.**
8. CSS - L2C – **88%,** L3C – **82%,** L2A – **83%** and L3A – **52%.**
9. Corporate - L2C – **68%,** L3C – **92%,** L2A – **80%** and L3A – **55%.**

The safeguarding team continue to provide more sessions and support, however, the DNA remains high. This is being addressed by the Deputy Chief Nurse and the Care Groups Governance.
This is also being addressed through the NHSE and ICB Safeguarding Oversight Meetings, ICB PQM through schedule 4 requirements and the CQC must do requirements relating to safeguarding training.

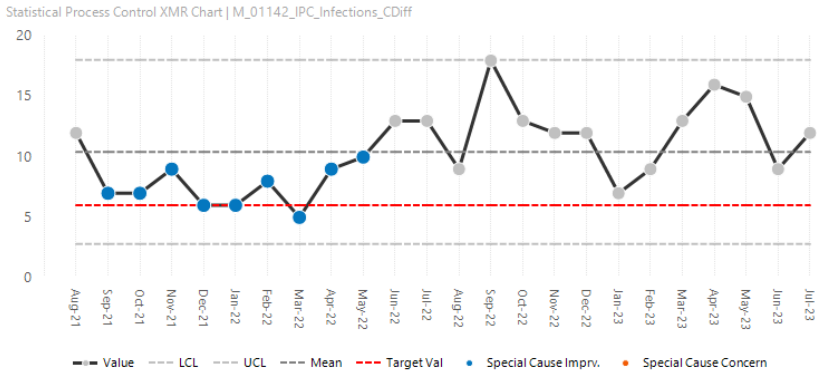
Infection Prevention Control

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

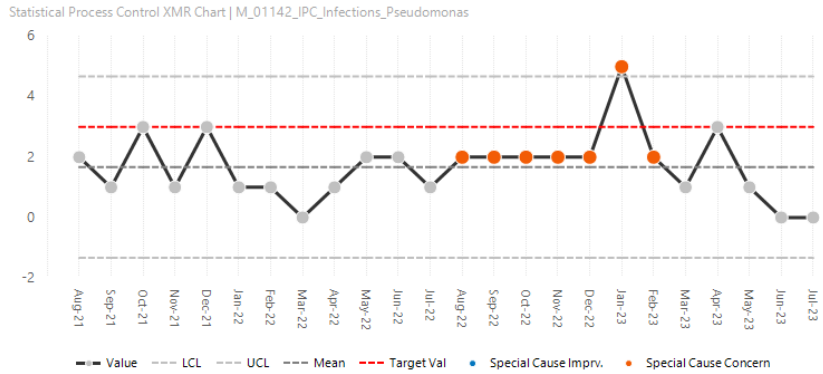
IPC: CDiff Infections

Month	Value
Aug-22	9
Sep-22	18
Oct-22	13
Nov-22	12
Dec-22	12
Jan-23	7
Feb-23	9
Mar-23	13
Apr-23	16
May-23	15
Jun-23	9
Jul-23	12



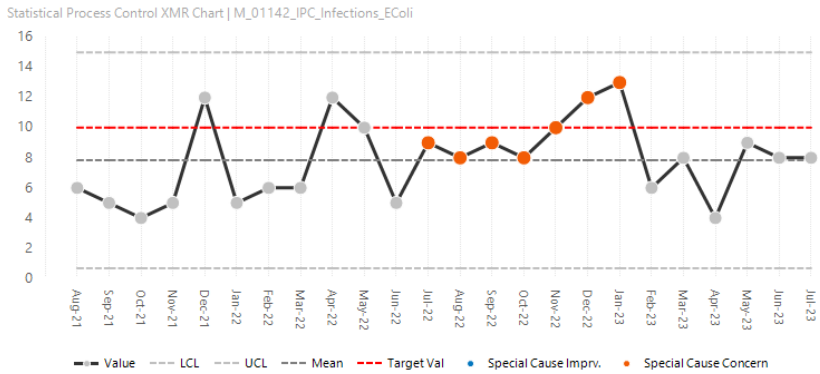
IPC: Pseudomonas Infections

Month	Value
Aug-22	2
Sep-22	2
Oct-22	2
Nov-22	2
Dec-22	2
Jan-23	5
Feb-23	2
Mar-23	1
Apr-23	3
May-23	1
Jun-23	0
Jul-23	0



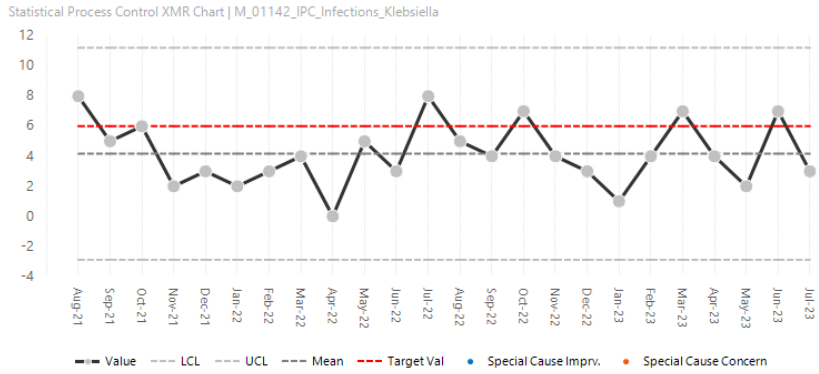
IPC: EColi Infections

Month	Value
Aug-22	8
Sep-22	9
Oct-22	8
Nov-22	10
Dec-22	12
Jan-23	13
Feb-23	6
Mar-23	8
Apr-23	4
May-23	9
Jun-23	8
Jul-23	8



IPC: Klebsiella Infections

Month	Value
Aug-22	5
Sep-22	4
Oct-22	7
Nov-22	4
Dec-22	3
Jan-23	1
Feb-23	4
Mar-23	7
Apr-23	4
May-23	2
Jun-23	7
Jul-23	3



PERFORMANCE UPDATE

Performance against trajectories for the gram negative bacteraemias remains on target, with ongoing monitoring and local actions underway where incidences occur. The C-dif trajectory remains one of concern, and it is not likely that the Trust will meet the planned threshold this year. All cases are reviewed for learning, and the main focusses remain antimicrobial stewardship, timely specimen collection and treatment, and a review of Functional ratings for cleaning standards within departments. Cases have decreased overall since the commencement of the year, however have not yet reached the threshold for monthly reporting. This is a regional concern, and the trust are active participants in the regional c-dif reduction group, lead by the ICB.

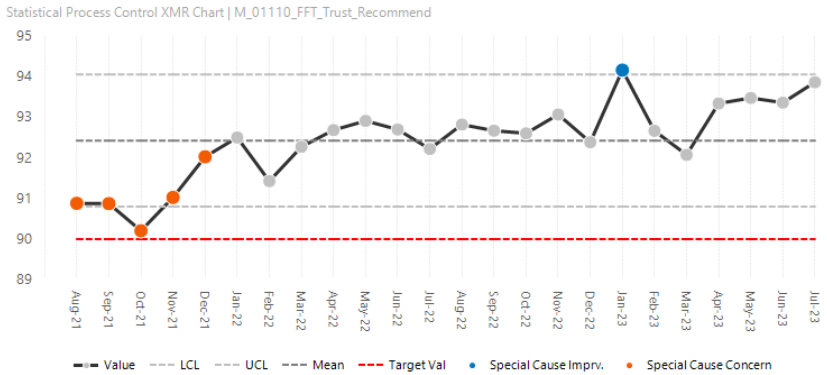
Friends & Family Test

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

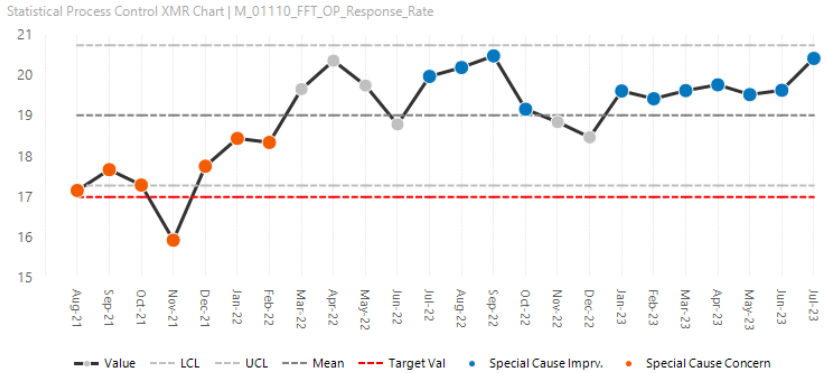
FFT Trust Recommend

Month	Value
Aug-22	92.8%
Sep-22	92.7%
Oct-22	92.6%
Nov-22	93.1%
Dec-22	92.4%
Jan-23	94.2%
Feb-23	92.7%
Mar-23	92.1%
Apr-23	93.4%
May-23	93.5%
Jun-23	93.4%
Jul-23	93.9%



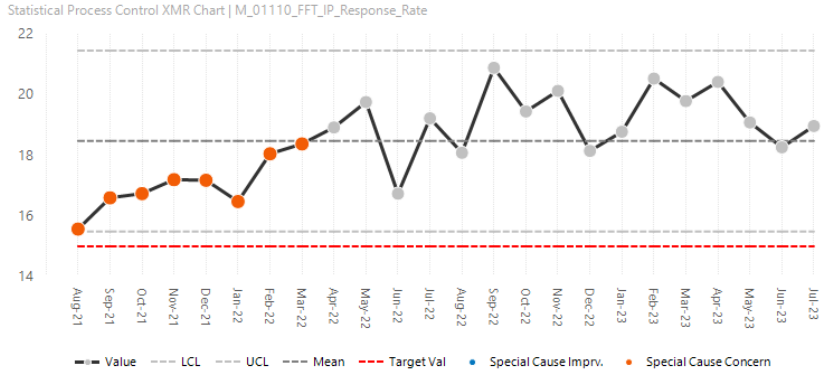
FFT OP Response Rate

Month	Value
Aug-22	20.2%
Sep-22	20.5%
Oct-22	19.2%
Nov-22	18.9%
Dec-22	18.5%
Jan-23	19.6%
Feb-23	19.4%
Mar-23	19.6%
Apr-23	19.8%
May-23	19.5%
Jun-23	19.6%
Jul-23	20.4%



FFT IP Response Rate

Month	Value
Aug-22	18.1%
Sep-22	20.9%
Oct-22	19.5%
Nov-22	20.1%
Dec-22	18.2%
Jan-23	18.8%
Feb-23	20.5%
Mar-23	19.8%
Apr-23	20.4%
May-23	19.1%
Jun-23	18.3%
Jul-23	19.0%



PERFORMANCE UPDATE

The percentage of patients who would recommend EKHUFT is now referred to nationally as the satisfaction level. The trust's satisfaction level has remained over our target level of 90% for the past two years, and has been between 92.1% and 94.2% from August 2022 to July 2023.

Our Friends and Family Test (FFT) response rate for outpatients has been over our 17% target for all but one month over the past two years. It has been between 18.5% and 20.5% from August 2022 to July 2023.

Our FFT response rate for in-patients has been over our 15% target for the past two years. It has been between 18.1% and 20.9% from August 2022 to July 2023.

How we compare with national data:
The most recent national data available is from February 2023. For in-patient care the national satisfaction level is 94% and for outpatient care it is 93%. Therefore our satisfaction level is lower for in-patients and higher for outpatients. There is no longer a national target for response rates.

How we compare with other acute (hospital) trusts in Kent and Medway:
In-patient: We scored 90%, Dartford and Gravesham scored 89%, Maidstone and Tunbridge Wells scored 97% and Medway 89%. Comparing response numbers we received 749 responses, Dartford and Gravesham received 454 responses, Maidstone and Tunbridge Wells received 1,409 responses and Medway received 678 responses.

Out-patient: We scored 95%, Dartford and Gravesham scored 97%, Maidstone and Tunbridge Wells scored 95% and Medway 91%. Comparing response numbers we received 10,690 responses, Dartford and Gravesham received 544 responses, Maidstone and Tunbridge Wells received 2,648 responses and Medway received 1,860 responses.

People

People, Leadership & Culture

Integrated Improvement Plan

NHS
East Kent Hospitals University
NHS Foundation Trust

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
People	Sickness	5.0%	Jul-23	4.9%			4	5	7	Common cause (no significant change)
	Vacancy Rate	10.0%	Jul-23	7.2%			8	10	12	Special cause of improving nature or lower pressure due to lower values
	Staff Turnover Rate	10.0%	Jul-23	9.5%			10	10	11	Special cause of improving nature or lower pressure due to lower values
	Premature Turnover Rate	25.0%	Jul-23	13.8%			15	16	16	Special cause of improving nature or lower pressure due to lower values
	Staff Engagement Score	6.80	Jul-23	6.27			6	6	6	Special cause of concerning nature or higher pressure due to lower values
	Statutory Training	91.0%	Jul-23	91.2%			90	91	92	Common cause (no significant change)
	Medical Job Planning Rate	90.0%	Jul-23	58.7%			26	38	50	Special cause of improving nature or lower pressure due to higher values
Leadership & Culture	Staff Advocacy Score	6.70	Jul-23	5.83			6	6	6	Special cause of concerning nature or higher pressure due to lower values

July Performance Summary

People Metrics: Sickness absence remains below the desired threshold at 4.9% but inflected upwards in July. The vacancy rate has improved further to 7.2%, below the desired threshold and on a positive, downward trend. Staff turnover has reduced further to 9.5% and has sat below the national standard (10%) for seven consecutive months. Premature turnover remains stable and is improving incrementally – it currently sits at 13.8%, below the proposed new threshold of 15%. Statutory training remained at 91.2%, marginally above the threshold, although compliance across the medical staff group remains an issue.

Engagement Metrics: The latest NQPS (Q2) concluded with a credible 2,485 respondents and 25% response rate, 4% ahead of the national average (21%). Staff Engagement (6.27) is up 7 points against Q1 and is now in the second quartile nationally, against a revised national standard of 6.50. Motivation is up 8 points to 6.69 (from 6.61 in Q1) and involvement is up 6 points to 6.29 (from 6.23 in Q1). Both motivation and involvement are now within 0.1 of the national average.
Priorities identified through the National Staff Survey have been acted on throughout the year, with a wide variety of actions initiated. Examples include; the introduction of a brand-new benefits platform to tackle satisfaction with pay (which has seen 4,573 staff sign up), a brand new EAP with a comprehensive range of health and wellbeing support to take more positive action on health and wellbeing, and the We Care rollout being extended after demonstrating a tangible ability to improve advocacy. Further actions have been shared at CEMG and will be socialised during the National Staff Survey fieldwork which begins on Monday 18th September.

Leadership Metrics: Staff Advocacy (5.83) is up 7 points to 5.83 (from 5.76 in Q1) but remains in the lowest quartile nationally. It represents the domain of engagement which is furthest (0.6 away) from the national standard (6.4) and is the primary contributor to reduced staff engagement levels across the organisation. Recent evidence has demonstrated advocacy levels are considerably higher (up to 62 points) in We Care areas than their non-We Care counterparts (see Appendix 1). Given this represents one of the areas the Trust is furthest from the national average, and where closing this gap has been placed as an urgent organisational priority, consideration ought to be given to how We Care can be used as a tool to enhance this alongside wider reputational improvements.

Staff Sickness

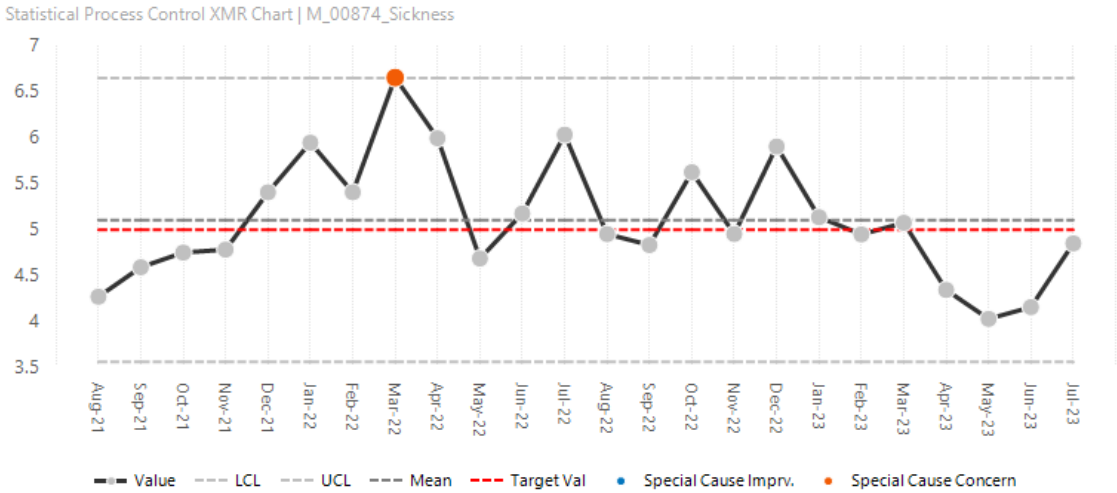
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Sickness

Month	Value
Aug-22	5.0%
Sep-22	4.8%
Oct-22	5.6%
Nov-22	5.0%
Dec-22	5.9%
Jan-23	5.1%
Feb-23	4.9%
Mar-23	5.1%
Apr-23	4.3%
May-23	4.0%
Jun-23	4.2%
Jul-23	4.9%



Understand the most recent data point

Variation Type

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

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining **sickness absence** below 5%, and improved against our fellow Trusts in the ICB	• Working with NHSEI on the Absence Tool Kit to review current sickness management processes and develop actions for improvement.	• Heads of P&C, P&CBPs	• End Sept 23	• Toolkit completed, and Absence Actions plan developed. P&CBP working across P&C team to implement actions.
Keeping Anxiety & Stress related absence to a minimum, and below 15% of all absences.	• Support from Health & Wellbeing Team and Occ Health to focus on areas of high stress related sickness. Improved Return To Work interviews to support intervention.	• Head of Staff Experience, Heads of P&C, P&CBPs, OH	• Ongoing	• Anxiety/Stress related sickness absence approximately half of what it was 2 years ago, and maintaining around 15% of all absences.
Improved pro-active absence management	• New P&C Care Group Teams to focus on absences through a Care Group deep dive, and P&C support.	• P&C Care Group Teams	• End Sept 23	• Deep Dive absence review taking place during September to identify areas with low absence management and high sickness

Vacancy Rate

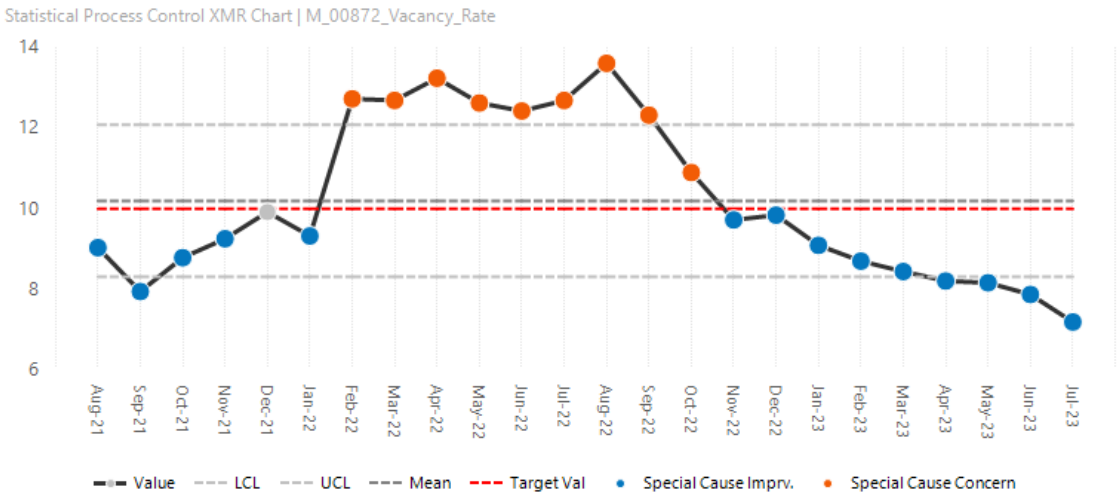
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Vacancy Rate

Month	Value
Aug-22	13.6%
Sep-22	12.3%
Oct-22	10.9%
Nov-22	9.7%
Dec-22	9.8%
Jan-23	9.1%
Feb-23	8.7%
Mar-23	8.4%
Apr-23	8.2%
May-23	8.2%
Jun-23	7.9%
Jul-23	7.2%



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to lower values(| Below Mean Run Group | | Astronomical Point | | Descending Run Group | Two Out Of Three Beyond Two Sigma Group)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring vacancy rate remains below the Trust threshold of 10%.	• Monthly monitoring of vacancies across Care Groups, ensuring that active recruitment is taking place.	• Heads of P&C • P&CBPs	• Ongoing	• New P&C Teams to focus on vacancies as part of Exec Efficiency Meetings and PRMs, supported by Care Group leads meetings.
Reduction in Premium Pay by focusing on hard to recruit roles.	• Workforce Strategies developed for care Groups, focusing on those areas with hard to recruit posts, and a plan to address this.	• Strategic Workforce Lead • Heads of P&C • P&CBPs	• End Sept 23	• First draft Workforce Strategies in place, to be reviewed regularly with Care Groups and Resourcing • Top 7 Hard to Recruit Consultant roles vacancy rate decreased from 21.5% to 20.8% in July 23.
Minimising risk of turnover by improving retention and reducing time to hire.	• Focus on time to hire, with Dashboard set up to monitor.	• Head of Resourcing	• Ongoing	• Time to hire 9.1 weeks. • Band 5 Nursing vacancy rate down to 9.3% • HCSW vacancy rate down o 7.82%

Staff Turnover Rate

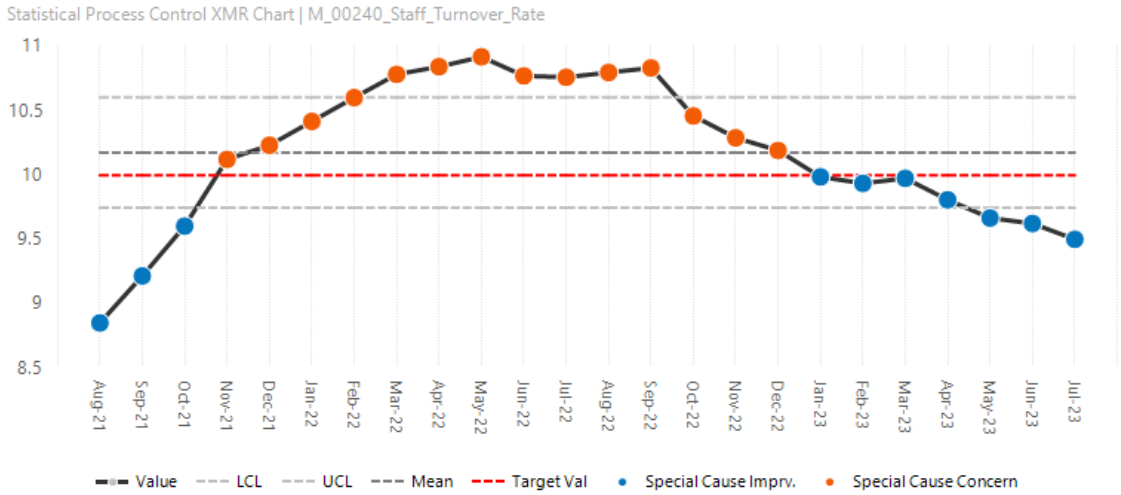
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Staff Turnover Rate

Month	Value
Aug-22	10.8%
Sep-22	10.8%
Oct-22	10.5%
Nov-22	10.3%
Dec-22	10.2%
Jan-23	10.0%
Feb-23	9.9%
Mar-23	10.0%
Apr-23	9.8%
May-23	9.7%
Jun-23	9.6%
Jul-23	9.5%



Understand the most recent data point

Variation Type

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

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining **Staff Turnover** against a gold standard of 10%	• Improving HCSW, Nurse & Premature retention which are the main contributors to overall turnover	• Head of Staff Experience	• Ongoing	• Staff Turnover has been below the desired threshold for 7 consecutive months & stands at **9.50%**
Maintaining **Nurse Turnover** against a gold standard of 10%	• Implementation of actions against the Nursing Workforce Retention Action plan	• Associate Director of Nursing	• Ongoing	• Nurse Turnover has been below the desired threshold for 17 consecutive months & stands at **8.25%**
Reducing **Healthcare Support Worker** Turnover below 13.5%	• Introduction of the HCSW Voice Programme and continued delivery of the Ready to Care programme	• Matron for Recruitment & Career Dev.	• Ongoing	• HCSW Turnover has been below the desired threshold for 7 consecutive months & stands at **11.9%**

Premature Turnover Rate

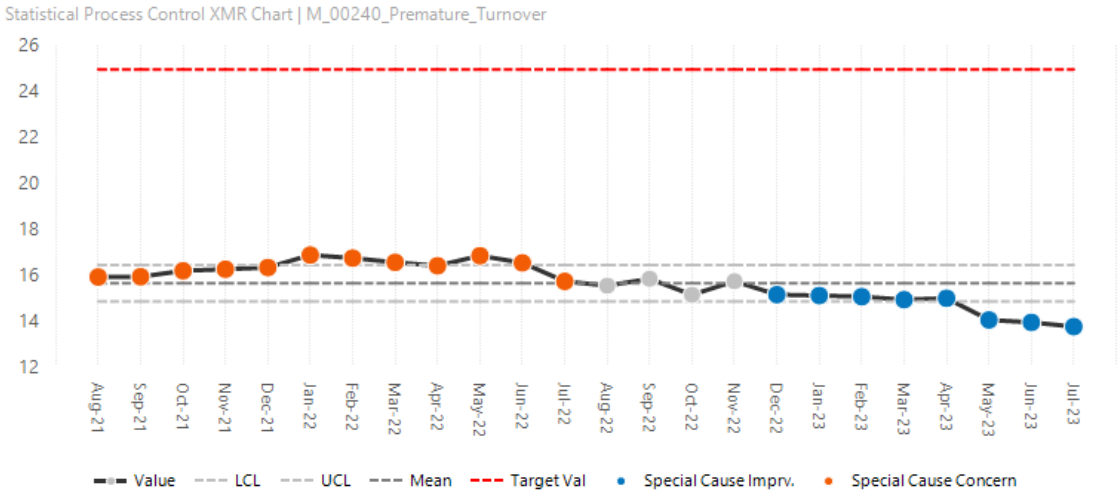
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Premature Turnover Rate

Month	Value
Aug-22	15.6%
Sep-22	15.9%
Oct-22	15.2%
Nov-22	15.8%
Dec-22	15.2%
Jan-23	15.1%
Feb-23	15.1%
Mar-23	15.0%
Apr-23	15.0%
May-23	14.1%
Jun-23	14.0%
Jul-23	13.8%



Understand the most recent data point

Variation Type

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

Variation indicates consistently passing the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Update calculation used to denote premature turnover as acutely sensitive to improvements in total turnover	• New method of calculation agreed bringing PT in-line with other methods of measure & reducing sensitivity to wider improvements	• Head of Staff Experience	• Complete	• Premature turnover (**13.74%**) has been below the suggested new threshold (15%) for 3 consecutive months and on a positive downward trend
Reduction in **Premature Turnover** below desired threshold of 15%	• Efforts to improve the new starter experience through onboarding and induction	• Head of Staff Experience	• Ongoing	• Premature turnover improved by 3% across 18-months
Improvement in the **New Starter Experience** (as denoted by the Kent & Medway NSES)	• Efforts to improve the new starter experience through onboarding and induction	• Head of Staff Experience	• End Jan 24	• Overall net engagement score for new starters (74%) 15% ahead of the K&M average (59%)

Staff Engagement Score

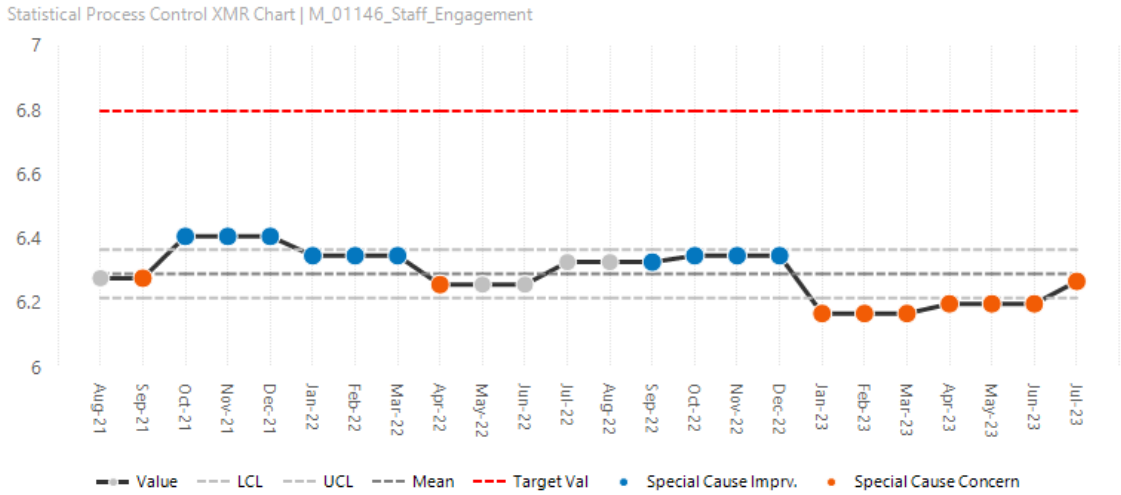
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Staff Engagement Score

Month	Value
Aug-22	6.33
Sep-22	6.33
Oct-22	6.35
Nov-22	6.35
Dec-22	6.35
Jan-23	6.17
Feb-23	6.17
Mar-23	6.17
Apr-23	6.20
May-23	6.20
Jun-23	6.20
Jul-23	6.27



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to lower values(| Below Mean Run Group | | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Engagement levels (6.3) are below the national average (6.5)	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated	• Head of Staff Experience	• Next results available Jan/ Feb 24 (post-NSS)	• Staff Engagement levels have improved by 7 points quarter on quarter, with equitable improvements across each of the three domains of engagement
Actions/ interventions initiated to improve staff engagement	• Examples include; the introduction of a brand-new benefits platform to tackle satisfaction with pay, and a brand-new EAP to take more positive action on HWB	• Head of Staff Experience	• Ongoing	• Overall SE: 6.27 (up 7 points vs. Q1) • Motivation: 6.69 (up 8 points vs. Q1) • Involvement: 6.29 (up 6 points vs. Q1) • Advocacy: 5.83 (up 7 points vs. Q1)
National Staff Survey 2023	• Driving response rates across the 2023 NSS is key to improving engagement and the credibility of associated results	• Head of Staff Experience	• Sept 23 – Nov 23	• A comprehensive, 12-week Comm's Plan has been developed which focuses on actions taken to-date and the impact of key influential leaders

Statutory Training

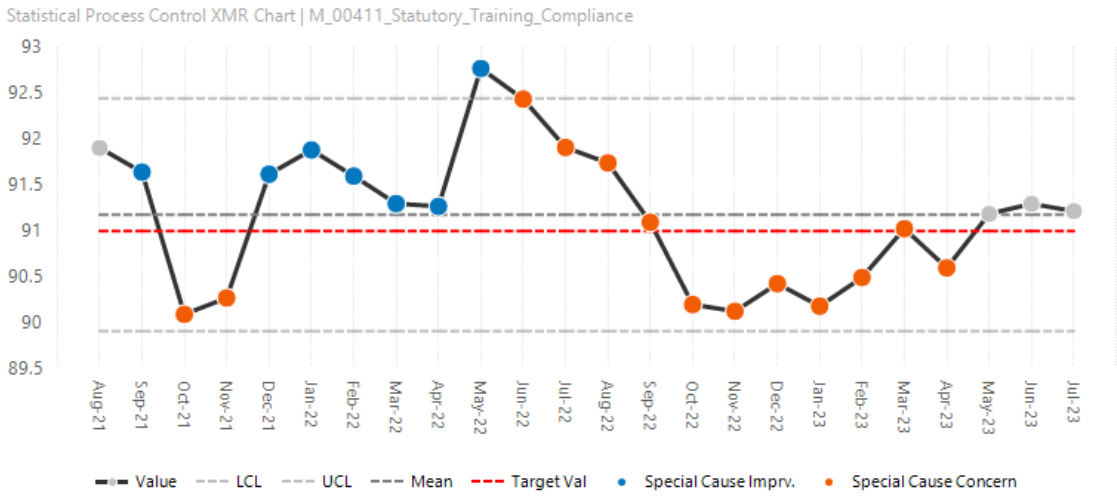
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Statutory Training

Month	Value
Aug-22	91.7%
Sep-22	91.1%
Oct-22	90.2%
Nov-22	90.1%
Dec-22	90.4%
Jan-23	90.2%
Feb-23	90.5%
Mar-23	91.0%
Apr-23	90.6%
May-23	91.2%
Jun-23	91.3%
Jul-23	91.2%



Understand the most recent data point

Variation Type

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

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Medical staff levels of compliance are consistently low at an average of 75%. Has been below 80% for 4 years.	• Identifying those staff who are not compliant, and working with GMs and Clinical Leads to address compliance.	• Head of L&D • Heads of P&C • P&CBPs • CMO	• End Oct 23	• Paper written to identify areas of lowest compliance. Issue not helped by new policy removing ability to stop study leave if non-compliant.
Capacity within face to face statutory learning, particularly Resus.	• Resus team currently at 50% capacity due to vacancies and sickness absence. Being addressed through the Corporate Team	• Deputy Chief Nurse • Resus Team	• End Nov 23	• Care Groups ensuring that the most essential, non-compliant staff are booked on Resus training first.
Low compliance with Trainee Drs, as they do not complete this on arrival, and no agreement to who chases this especially after rotation.	• P&C Leads to work with Med Ed on supporting improvements with this, particularly focusing on induction and rotation.	• DME • Head of L&D • P&C Senior Team	• End Nov 23	• Head of P&C to work with Care Groups to seek support from Med Ed management team.

Medical Job Planning Rate

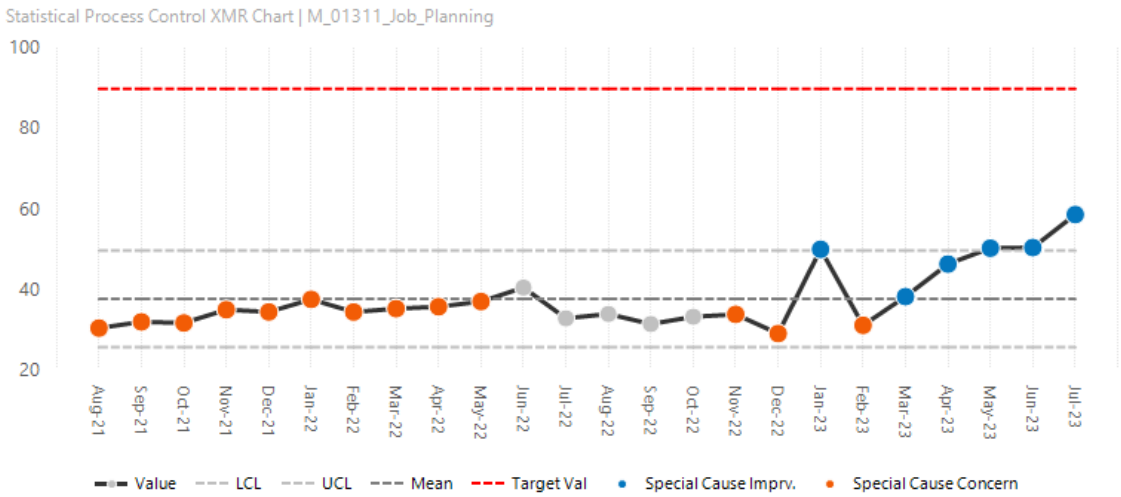
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Medical Job Planning Rate

Month	Value
Aug-22	34.0%
Sep-22	31.5%
Oct-22	33.3%
Nov-22	33.9%
Dec-22	29.1%
Jan-23	50.1%
Feb-23	31.2%
Mar-23	38.3%
Apr-23	46.4%
May-23	50.4%
Jun-23	50.5%
Jul-23	58.7%



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to higher values(| | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
While job planning compliance has improved across most of the specialities, Emergency Medicine and Acute Medicine continue to have the lowest compliance.	• Job planning project manager to meet with speciality leads/general managers to provide bespoke training and support, and to establish drop-in clinics to capture issues and support the sign-off of job plans. Develop welcome packs for new starters to include advice and guidance on job planning. Job planning project manager to work with clinical leads to design template job plans for vacant posts.	• CMO	• End Dec 23	• Meeting dates set up with specialities • ESR/e-JobPlan reconciliation completed
The hierarchies for specialities and sign-off on e-JobPlan do not align to the new structure.	• CMO operational support team to prepare Allocate for the switch over. Activate new structure on e-JobPlan. Transfer existing users into the correct Care Groups/specialities	• CMO	• End Aug 23	• Updates discussed with Allocate. • Adjustments to be made once speciality leads (1st Sign-off) have been identified for the new structure.
The previous process for managing LCEA's did not effectively encourage uptake of job planning	• New LCEA policy to be approved for use. • LCEA applications to only be accepted if suitable engagement with the job planning process is evident, establishing a baseline with which to judge excellence.	• CMO	• Sept 23	• Draft policy with the LNC for consultation

Staff Advocacy Score

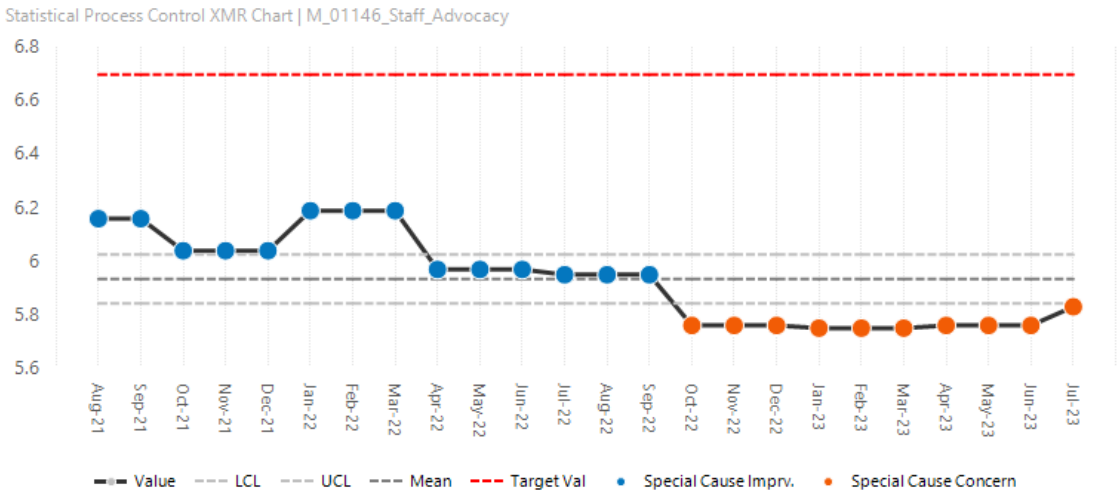
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Staff Advocacy Score

Month	Value
Aug-22	5.95
Sep-22	5.95
Oct-22	5.76
Nov-22	5.76
Dec-22	5.76
Jan-23	5.75
Feb-23	5.75
Mar-23	5.75
Apr-23	5.76
May-23	5.76
Jun-23	5.76
Jul-23	5.83



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to lower values(| Below Mean Run Group | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Advocacy levels (5.8) are significantly below the national standard (6.4)	• Continued action is required to improve the reputation of the organisation & the extent to which staff would recommend as a place to work and be treated	• Executive Team	• End Aug 24 (post Q2 NQPS)	• Staff Advocacy improved by 7 points quarter-on-quarter, from 5.76 (Q1) to 5.83 (Q2), but remain in quartile 1 when benchmarked nationally
Staff Advocacy levels remain in Quartile 1 when benchmarked nationally	• Increased rollout of We Care as a programme to drive staff engagement levels	• Head of Transformation	• Ongoing	• Staff Advocacy levels are 62 points higher in We Care areas than non-We Care counterparts (see Appendix 1)
The extent to which staff would recommend the Trust as a place to work or be treated	• A behavioural framework has been drafted which, alongside We Care, Appraisals, TED & CLP should serve to shift culture	• Head of Organisational Development	• End Aug 23	• First proof created and socialised at CEMG. Visual to describe how it fits alongside We Care strategic objectives & other programmes socialised 16/08

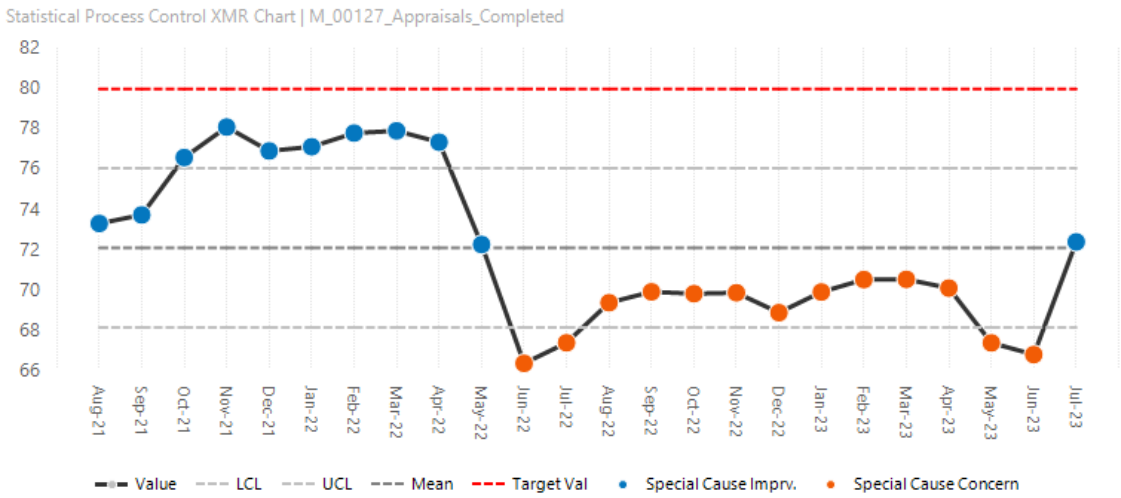
Appraisal Rates

Statutory Metrics

NHS
East Kent Hospitals University
NHS Foundation Trust

Appraisals Compliance

Month	Value
Aug-22	69.4%
Sep-22	69.9%
Oct-22	69.8%
Nov-22	69.9%
Dec-22	68.9%
Jan-23	69.9%
Feb-23	70.5%
Mar-23	70.5%
Apr-23	70.1%
May-23	67.4%
Jun-23	66.8%
Jul-23	72.4%



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to higher values(| | Outside Moving Range Limit | | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Managers not uploading completion dates to ESR	• Recent "amnesty" of information resulted in 350 additional dates added to ESR that hadn't yet been uploaded.	• Heads of P&C • PCBPs	• End Sept 23	• 350 names added to ESR that had previously not been updated • Identifying areas where support needed for updated ESR training
Admin & Clerical appraisal rates remain below threshold, with 642 outstanding appraisals.	• Focus within the new Care Groups on improving A&C appraisal rates, and ensuring they are uploaded to ESR.	• Care Group MDs • Heads of P&C • PCBPs	• End Oct 23	• New P&C Care Group teams to work locally with targeting areas of low A^C appraisal compliance
Quality of appraisal remains low, according to staff survey	• Identify lowest 10 areas of compliance in each Care Group, triangulated with sickness absence and turnover rates, to support positive intervention.	• P&CPs • Heads of P&C	• Mid Sept 23	• P&CBPs working on their lowest 10 areas to present to Heads of P&C and Care Group MDs

Sustainability

Financial Sustainability

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
Finance	I&E Monthly Variance Group (£M)	Traj.	Jul-23	-38.976			-21	-12	-2	Special cause of concerning nature or higher pressure due to lower values
	Efficiencies Green Schemes (£M)	40	Jul-23	3			2	10	19	Special cause of concerning nature or higher pressure due to lower values
	Efficiencies YTD Variance (£M)	0.0	Jul-23	-8.0			-8	-4	1	Common cause (no significant change)
	Premium Pay	Traj.	Jul-23	9,687			6,839	8,392	9,945	Special cause of concerning nature or higher pressure due to higher values

July Performance Summary

Financial Position: The financial position YTD is £8.4m away from plan. The main drivers are due to the industrial action £1.1m, non funded pay award £0.5m with costs above plan for escalation beds, 121 care and IEN increased level of supernumerary usage. In addition non achieved CIP. Executive led sessions have been had with all care groups to review each of the care groups forecasts as well as the plans to support the Admin reviews. The nursing bi-weekly meetings are embedding and should demonstrate a slowing in nursing utilisation from month 6. Work is continuing on the transformation of the reporting to match the new care group structures and a hybrid reporting model will be adopted for month 6. The national requirement of level 4 grip and controls are embedding through the Trust.

Efficiencies: As at Month 4, The Trust has recognised £0.8m of CIP Efficiencies against a plan of £8.8m. As well as the £40m CIP requirement, the run rate is required to improve significantly to deliver the 23/24 budgets.
Currently, approximately £14.4m of (CIP saving) ideas have been identified (£11.3m in year effect) which is a £3.6m improvement on last month. The focus is now on five high impact areas (domains) selected by Executive Directors and each with an Executive sponsor, and within this the Trust will look at challenging decisions that need to be taken.
Recent enhancements to drive savings include: an admin and clerical vacancy and over-establishment review to save c£2m, the Chief Nurse undertaking deep dive reviews of all agency nursing expected to result in multi-million pound savings, greater controls being rolled out by the CFO, and roll out of rapid review meetings for all new Care Groups with the Executive Management Team to drive CIPs and to discuss controls and forward forecasts for FY24.

I&E Monthly Variance Group (£m)

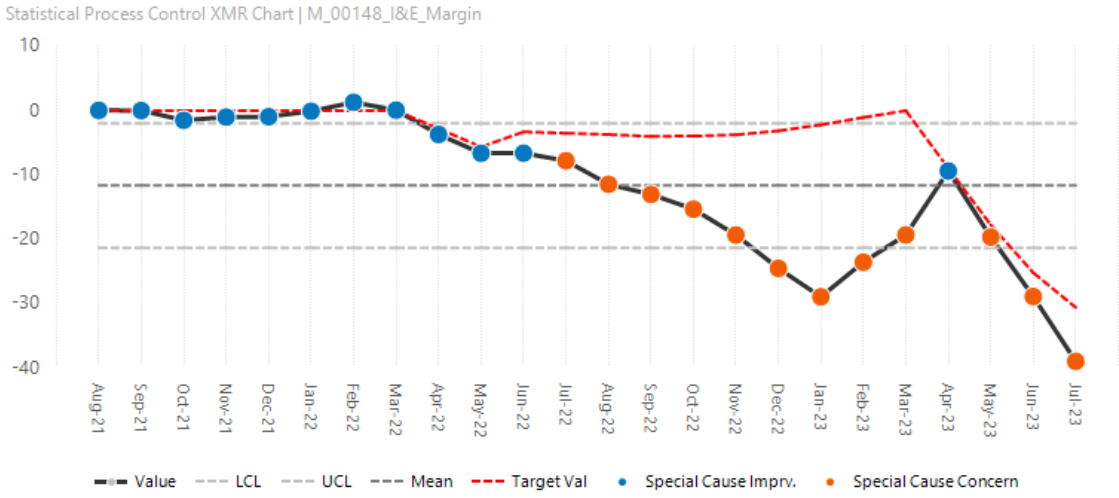
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The I&E Margin (£M) is the difference between the Group technically adjusted Income & Expenditure result for each month. If the number is positive the Group is making a surplus.

I&E Monthly Variance Group (£M)

Month	Value
Aug-22	-11.453
Sep-22	-13.015
Oct-22	-15.313
Nov-22	-19.323
Dec-22	-24.520
Jan-23	-28.935
Feb-23	-23.555
Mar-23	-19.317
Apr-23	-9.379
May-23	-19.651
Jun-23	-28.895
Jul-23	-38.976



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to lower values(| | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently passing the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensure national grip and control level 4's are embededd into the Trust for pay & non pay areas	• All level 4 grip and controls are being rolled out to the wider Trust for both pay and non pay.	• CFO	• On-Going	• Vacancy panel for clinical posts is embedding led by CPO. Nursing workforce review embedding led by CNMO. Investment panel being implemented led by CFO
Run rate continues to be above plan due to utilisation in excess of establishment	• Workforce plans included in the level 4 grip & controls are being embedded to review medical and nursing workforce arrangements	• CNMO & CMO	• On-going	• Nursing PMO reviewing bi-weekly the ward areas for shift compliance, escalation areas, 121 care and IEN supernumerary usage
Non delivery of CIP to date and non achievement of a robust in year CIP plan.	• Increased levels of plans needed to close the CIP plan. Non recurrent CIP's to be externally reported	• Care group MD's • PMO • Exec Team	• End October -23	• Key themes are in progress to deliver the CIP plan. Work is on going on the project plans and outline expected target

Efficiencies: Green Rated Schemes

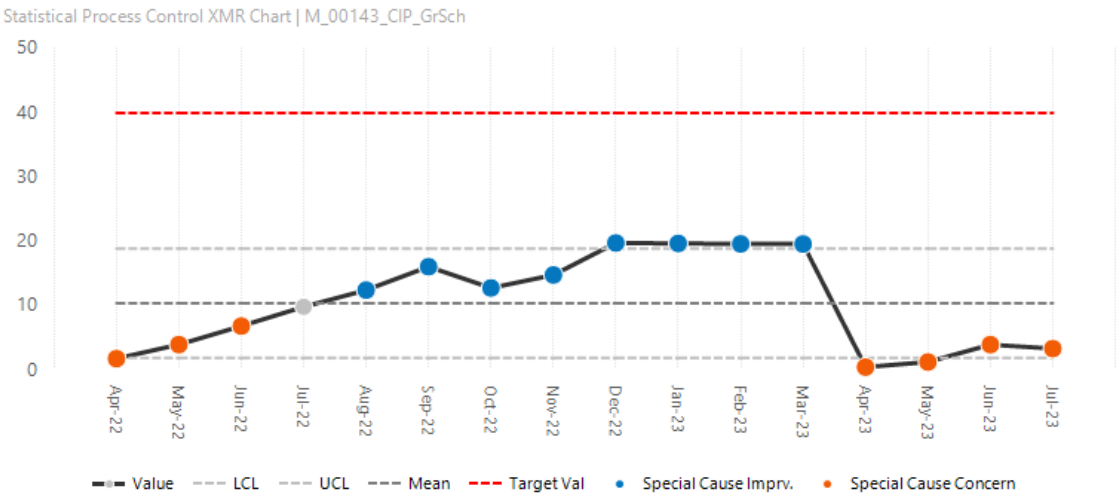
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Efficiencies Green Schemes (£M)

Month	Value
Aug-22	12
Sep-22	16
Oct-22	13
Nov-22	15
Dec-22	20
Jan-23	20
Feb-23	20
Mar-23	20
Apr-23	0
May-23	1
Jun-23	4
Jul-23	3



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to lower values(| | | | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining organisational focus during restructure	• EMT led efficiency meetings with all new care groups; • Move to 3 part Executive led PRMs from September (Wk1 Activity & Productivity, Wk3 Finance & workforce, Wk4 Performance management); • Continue CEO and CFO messaging to organisation on finance and efficiency; • Re-organise PMO to support new care groups and cross cutting themes.	EMT EMT CEO/CFO/ADFI ADFI	23/08/23 01/09/23 Ongoing 31/08/23	• Being held 23/08/23. • Current being set up, existing fortnightly efficiency meetings now include EMT. • CFO released enhanced controls 08/08. • PMO briefed 24/08/23;
Pace of scheme development	• EMT led efficiency meetings with all care groups (as above); • CFO/CSPO led admin and clerical vacancy review; • CNO led deep dives on nursing agency spend rolled out with care groups; • Weekly meetings between CFO/CPSO and FID/ADFI on progress and rapid improvement opportunities;	EMT CFO/CSPO CNO CFO/CSPO	23/08/23 31/08/23 Underway Underway	• Underway, new PRMs from 1st Sept. • Care groups given data/review deadline. • £1m benefit from reducing pool nurses. • Approximately £3m of new schemes added vs previous month
Identification of opportunities sufficient to reach the required £40m	• EMT agreed 5 cross cutting themes for focus with Exec leads; • EMT led efficiency meetings with care groups as above (including the identification of hard to achieve areas); • CFO rolling out enhanced controls to drive organisational change;	EMT/ADFI EMT CFO	Ongoing 23/08/23 08/08/23	• Theme values being developed. • Underway, new PRMs from 1st Sept. • CFO released enhanced controls 08/08.

Efficiencies YTD Variance

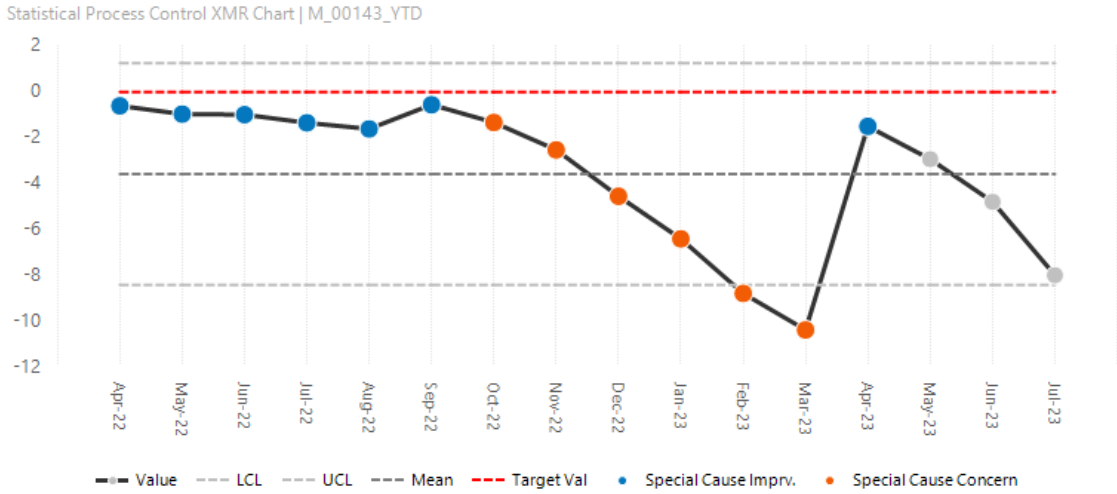
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Efficiencies YTD Variance (£M)

Month	Value
Aug-22	-1.6
Sep-22	-0.6
Oct-22	-1.3
Nov-22	-2.5
Dec-22	-4.6
Jan-23	-6.4
Feb-23	-8.8
Mar-23	-10.4
Apr-23	-1.5
May-23	-2.9
Jun-23	-4.8
Jul-23	-8.0



Understand the most recent data point

Variation Type

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

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring finance and CIP transparency while reflecting underlying organisational improvement	To ensure transparency in CIP & financial reporting, we have only been reporting CIPs at a care group level where they are also on or ahead of plan. As we reach M5, we have identified that there are a number of specific areas of overspend (e.g. escalation areas, 1:1 specialling) that are being offset by underspends and one-off corporate items elsewhere in the Trust. • To ensure continued transparency, and also reflect a clearer CIP position at a corporate level we are proposing to move to reporting both the overspends and non-recurrent CIPs ay Mth 5 at a corporate level only (amounting to c.£5.8m non-recurrent CIP YTD at Mth 4).	• CFO	29/08/23	• Methodology and calculation developed as at Mth 4 to be taken to FPC for discussion, with a view to booking additional non-recurrent CIPs in Mth 5.
Agency usage and cost at a similar level to this time last year	Mental health nurse agency spend increase offset lower BAU use. • CNO & CFO to meet KPMT equivalents to discuss options to resolve. • CNO & FID meet to ensure joined up approach to addressing. High cost medical agency (HCMA) use remains high, ongoing issue. • FID/PMO working with care groups to review HCMA value add.	• CNO/CFO • CNO/FID • FID/PMO	• 17/08/23 • TBC • Sept/Oct 23	• Initial discussions held, meeting TBA. • Initial discussions held, meeting TBA. • To feed work into Finance & w/f PRMs.

Premium Pay

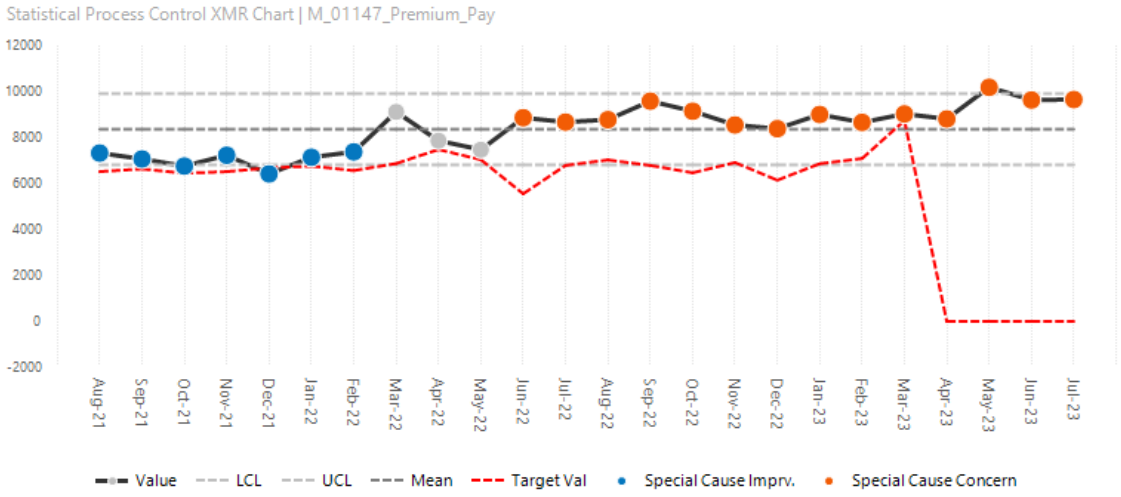
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Premium Pay

Month	Value
Aug-22	8,809
Sep-22	9,618
Oct-22	9,178
Nov-22	8,577
Dec-22	8,413
Jan-23	9,034
Feb-23	8,689
Mar-23	9,058
Apr-23	8,839
May-23	10.2K
Jun-23	9,666
Jul-23	9,687



Understand the most recent data point

Variation Type

Special cause of concerning nature or higher pressure due to higher values(Above Mean Run Group | | | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Timely information that can be used to target areas of high premium pay usage.	• Premium Pay Dashboard now live, and updated regularly.	• Information Lead • Strategic Workforce Lead • Heads of P&C	• End Sept 23	• Heads of P&C and P&CBPs to use this Dashboard and information to support Care Grp Exec Efficiency meetings.
Reduction in Premium Pay by focusing on hard to recruit roles.	• Workforce Strategies developed for care Groups, focusing on those areas with hard to recruit posts, and a plan to address this.	• Strategic Workforce Lead, Heads of P&C, P&CBPs	• End Sept 23	• First draft Workforce Strategies in place, to be reviewed regularly with Care Groups and Resourcing

Maternity

Maternity

Integrated Improvement Plan

NHS
East Kent
Hospitals University
NHS Foundation Trust

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
Maternity	Serious Incidents Maternity	Sigma	Jul-23	5			-3	3	9	Common cause (no significant change)
	Maternity Incidents Moderate / Sev...	Sigma	Jul-23	1			-3	3	9	Common cause (no significant change)
	Maternity Complaints	Sigma	Jul-23	6			-3	6	15	Common cause (no significant change)
	Maternity Complaint Response	90.0%	Jul-23	45.5%			-36	33	101	Common cause (no significant change)
	Extended Perinatal Mortality	5.87	Jul-23	3.40			4	5	6	Special cause of improving nature or lower pressure due to lower values
	FFT Maternity Response Rate	5.0%	Jul-23	11.4%			6	11	15	Common cause (no significant change)
	FFT Maternity Recommended	90.0%	Jul-23	95.3%			84	91	98	Common cause (no significant change)
	FFT Maternity (IP) Recommended	90.0%	Jul-23	97.5%			84	93	102	Common cause (no significant change)
	Maternity Engagement Score	6.90	Jul-23	6.15			6	6	6	Special cause of improving nature or lower pressure due to higher values

July Performance Summary

Incidents: There were 5 serious incidents reported in July for Women's Health; 2 for Maternity and 3 for Gynaecology.
The 2 maternity incidents involve:

1. Unanticipated admission to SCBU – term baby received therapeutic cooling. This meets HSIB and ENS criteria and is an automatic SI.
2. Adult protection / safeguarding of adults – failure to follow mental health pathway.

At month end there are no SI breaches.

Complaints: 6 Stage 1 complaints received in July 2023 for Maternity. At month end there were 26 open complaints of which 7 had breached.

Patient Involvement: FFT Response rate 11.4% - 296 comments made in total. 94.6% extremely likely or likely to recommend

Staff Engagement: Score 6.15 – increase in month

Serious Incidents

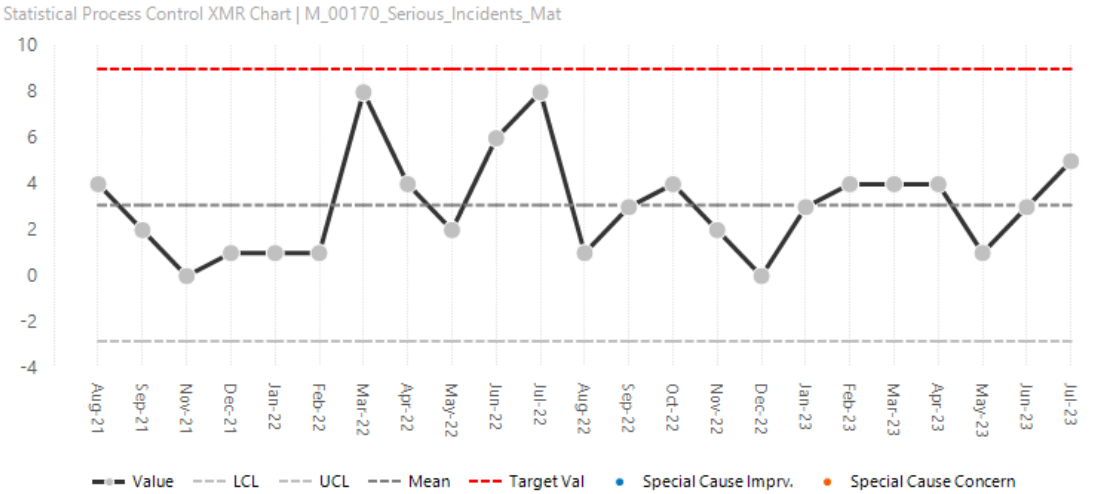
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Serious Incidents Maternity

Month	Value
Aug-22	1
Sep-22	3
Oct-22	4
Nov-22	2
Dec-22	0
Jan-23	3
Feb-23	4
Mar-23	4
Apr-23	4
May-23	1
Jun-23	3
Jul-23	5



Understand the most recent data point

Variation Type

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

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
There were 5 serious incidents reported in July for Women's Health – 2 for Maternity and 3 for Gynaecology.	The Maternity SI's refer to: 1. Unanticipated admission to SCBU – term baby received therapeutic cooling. 2. Adult protection / safeguarding of adults – failure to follow mental health pathway.	• Interim Head of Governance	• 05/01/24 • 12/10/23	1. This meets HSIB and ENS criteria and is an automatic SI. HSIB investigation in progress – automatic extension 2. RCA in progress
At month end there are 18 open SI's in women's Health – 13 for maternity and 5 for gynaecology.	For all SI investigations to be completed within agreed timeframes.	• Interim Head of Governance	• Monthly - ongoing	• At month end there are no SI breaches within Women's Health or Maternity. All open SI's under investigation are within agreed timeframes.
Closure of actions from SI's on the datix actions module.	• Focussed work to close open actions on datix module with action owners • Weekly progress reporting of backlog and current position	• Interim Head of Governance	• 31/08/2023	• The number of overdue actions from the backlog has reduced from 345 to 249 at 14/08. However, the overall current overdue actions has increased due to action plans being added to the module. Progress on closing these actions have been impacted in July and August with the high annual leave period, vacancies and the Patient Safety Team supporting clinical staffing.

Incidents Causing Harm

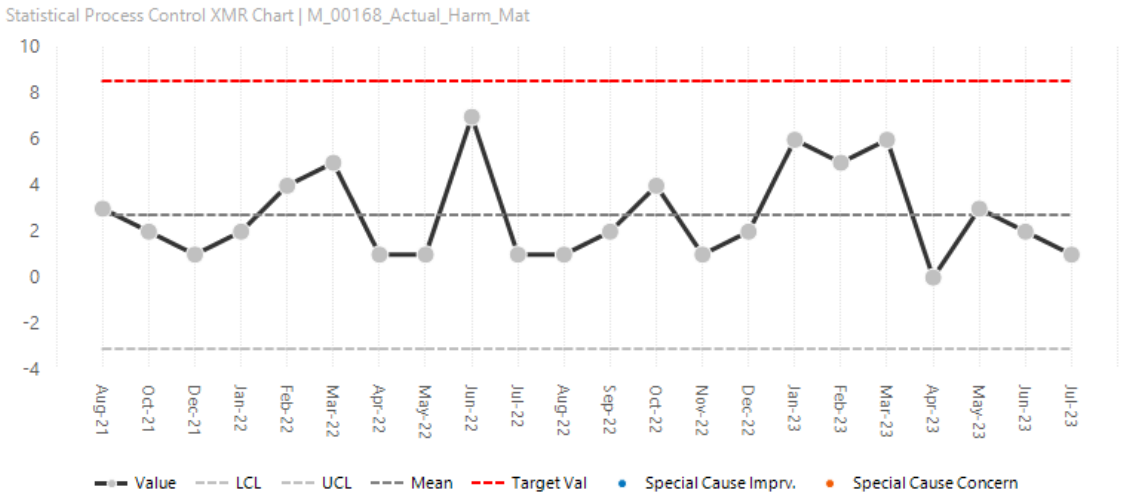
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Maternity Incidents Moderate / Severe

Month	Value
Aug-22	1
Sep-22	2
Oct-22	4
Nov-22	1
Dec-22	2
Jan-23	6
Feb-23	5
Mar-23	6
Apr-23	0
May-23	3
Jun-23	2
Jul-23	1



Understand the most recent data point

Variation Type

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

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Rapid review of moderate incidents and other incidents on maternity trigger list.	• Rapid review process reviewed • MDT attendance • Learning identified	• Interim Head of Governance	• Monthly - ongoing	• MDT attendance affected by strikes/annual leave/vacancy on some days in July but cases reviewed in a timely manner. Themes and learning identified from rapid reviews disseminated via Message of the Week, Safety Threads, Lunch and Learn.
Closure of datix open more than 6 weeks	• Focussed work to close open actions on datix module with action owners • Weekly progress reporting of backlog and current position	• Interim Head of Governance	• 31/08/2023	• The number of open datix from the backlog for Women's Health has reduced from 762 to 217 at 14.08.2023. For maternity, the backlog has reduced from 686 to 187. However, the overall current overdue datix has plateaued. Progress on closing these incidents has been impacted in July and August with the high annual leave period, vacancies and the Patient Safety Team supporting clinical staffing.

Maternity Complaints

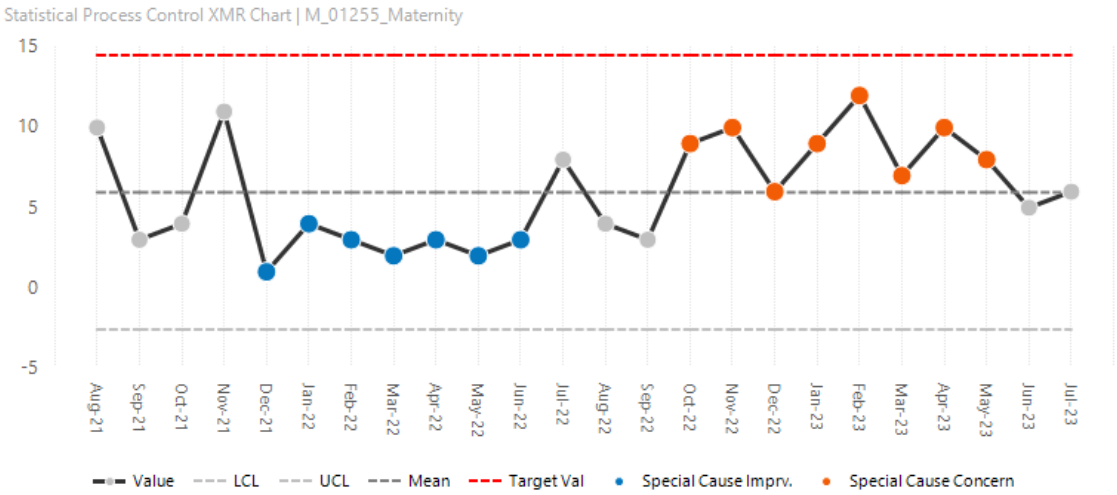
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Maternity Complaints

Month	Value
Aug-22	4
Sep-22	3
Oct-22	9
Nov-22	10
Dec-22	6
Jan-23	9
Feb-23	12
Mar-23	7
Apr-23	10
May-23	8
Jun-23	5
Jul-23	6



Understand the most recent data point

Variation Type
Common cause (no significant change)(No Special Cause Flags)
Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
6 Stage 1 complaints received in July 2023 for Maternity	Themes : • Delay in receiving diagnosis • Delays in receiving treatment • Doctor communication issues • Problems with department appointment • Problems with doctor's attitude • Unexpected outcome / post op complications	• Patient Experience and Complaints Coordinator	• Monthly reporting	• Sent to HOMs and Clinical Lead, as well as other Care Groups for comments – some awaiting leads to be assigned.

Maternity Complaints Response Rate

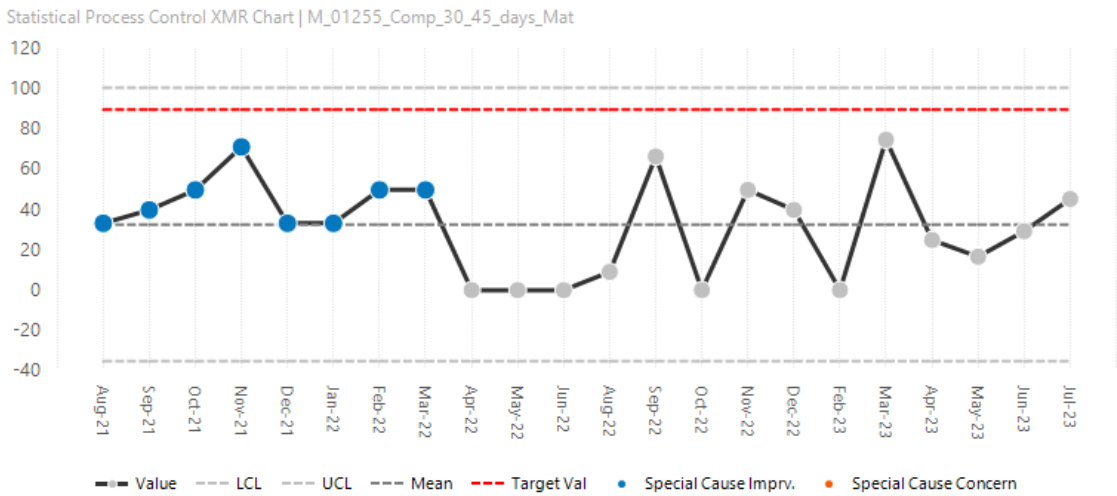
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Maternity Complaint Response

Month	Value
Jun-22	0.0%
Aug-22	9.1%
Sep-22	66.7%
Oct-22	0.0%
Nov-22	50.0%
Dec-22	40.0%
Feb-23	0.0%
Mar-23	75.0%
Apr-23	25.0%
May-23	16.7%
Jun-23	29.4%
Jul-23	45.5%



Understand the most recent data point

Variation Type

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

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Competing priorities of clinical staff cause delays in case reviews and providing the Complaint Coordinator with comments for content	• Complaint Coordinator has set up weekly 'huddle' meetings with HOMs and newly appointed Clinical Lead to try and spotlight urgent cases .	• Patient Experience and Complaints Coordinator	• Weekly and • Bi-Weekly meetings	• At month end there were 26 open complaints of which 7 had breached.
Maternity complaints can span a 10+ month period of care in Maternity & comments needed from lots of teams (EPU, Infant feeding, Community, Maternity Triage, USS, Neonates, Midwifery, Consultant etc.) Paper notes cannot be in more than one place at a time.	• Complaint Coordinator has sought approval for a process to have notes collected and scanned at 'triage' stage to make electronic shared simultaneous access to patient notes. This is to help suit the different availabilities of staff and reduce time waiting for notes to be taken between sites.	• Patient • Experience and Complaints • Coordinator	• Ongoing	• Process in place

Extended Perinatal Mortality

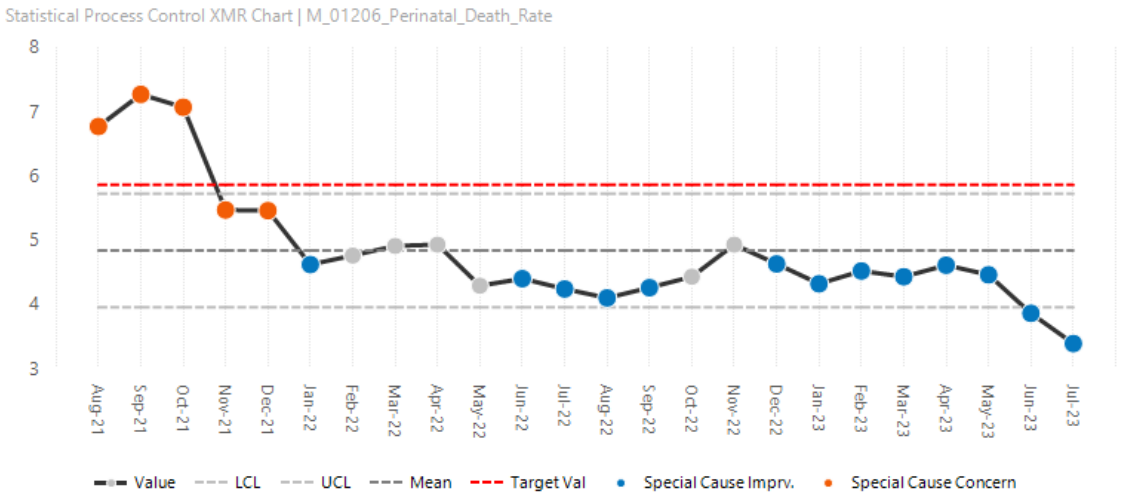
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Extended Perinatal Mortality

Month	Value
Aug-22	4.11
Sep-22	4.27
Oct-22	4.44
Nov-22	4.94
Dec-22	4.64
Jan-23	4.33
Feb-23	4.53
Mar-23	4.44
Apr-23	4.62
May-23	4.47
Jun-23	3.87
Jul-23	3.40



Understand the most recent data point

Variation Type

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

Variation indicates consistently passing the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
In July there were 0 stillbirths reportable to MBRRACE	• The rolling 12 month rate for stillbirths remains below the lower confidence limit at 2.55 stillbirths per 1,000 births. In the 12 month rolling period, there have been 15 stillbirths reportable to MBRRACE. The expected number of deaths based on the group average and our current birthrate would be 23.			
In July there were 0 neonatal deaths reportable to MBRRACE, and 1 neonatal death which is not included under the MBRRACE methodology (baby born at 20+2 weeks)	• The rolling 12 month rate for neonatal deaths remains lower than both the threshold and average at 0.85 neonatal deaths per 1,000 livebirths, and has been so for 15 consecutive periods. In the 12 month rolling period, there have been 5 neonatal deaths reportable to MBRRACE. The expected number of deaths based on the group average and our current birthrate would be 12			
Perinatal Mortality Review Tool	• All neonatal deaths and stillbirths are reviewed through the Perinatal Mortality Review Tool by a multidisciplinary panel and external attendees.	• Emma Parkin	• Monthly	• PMRT Lead Midwife in post from mid June. 100% of perinatal mortality reviews include an external reviewer

Friends & Family Test: Response Rate

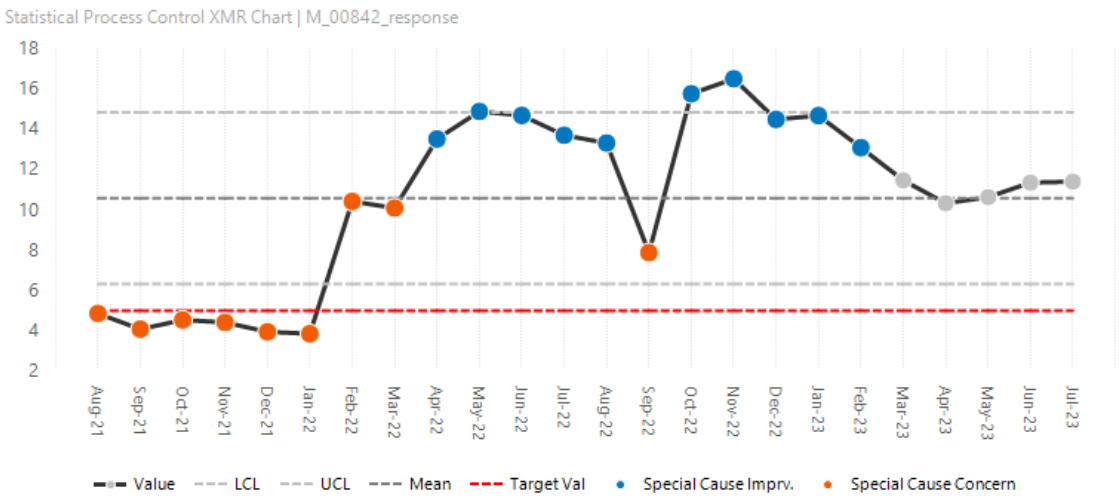
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

FFT Maternity Response Rate

Month	Value
Aug-22	13.3%
Sep-22	7.9%
Oct-22	15.8%
Nov-22	16.5%
Dec-22	14.5%
Jan-23	14.7%
Feb-23	13.1%
Mar-23	11.5%
Apr-23	10.3%
May-23	10.6%
Jun-23	11.4%
Jul-23	11.4%



Understand the most recent data point

Variation Type

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

Variation indicates consistently passing the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Response rate 11.4% 296 comments made in total.	• 252 positive comments= 85.1% an increase from 80.8% last month.	• Patient Experience Midwives	• Monthly	• There is a new PTL for FFT- the aim that FFT feedback is themed in a standardised way and is comparable.
Response rates are typically low for FFT therefore only reflect a minority of women, birthing people and their families, and their experiences	• Embedded communications plan and Patient Voices Model to improve service user and workforce engagement, feedback and experience	• Patient Experience Midwives	• March 2024	• This is a milestone within the Maternity and Neonatal Improvement Plan due to be presented to Trust Board for approval in September 2023

Friends & Family Test: Recommended

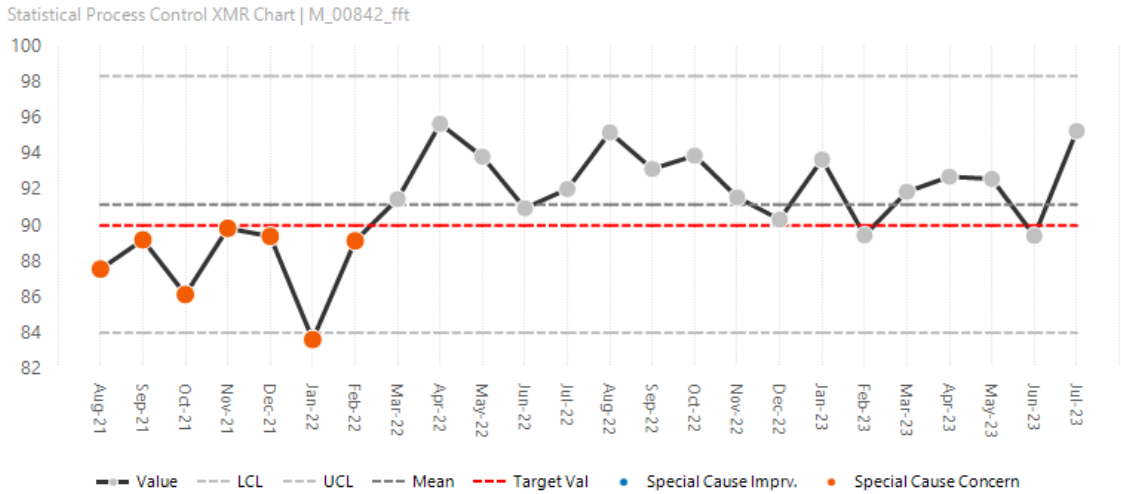
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

FFT Maternity Recommended

Month	Value
Aug-22	95.2%
Sep-22	93.2%
Oct-22	93.9%
Nov-22	91.6%
Dec-22	90.3%
Jan-23	93.7%
Feb-23	89.4%
Mar-23	91.9%
Apr-23	92.7%
May-23	92.6%
Jun-23	89.4%
Jul-23	95.3%



Understand the most recent data point

Variation Type

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

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
The responses show 94.6% extremely likely or likely to recommend which is an increase from June 91.7%	• Positive feedback to staff	• PEM	• Monthly	
Negative comments include: • Staff attitude - rude/not confident • Communication and information • Delayed analgesia • Building and facilities • Delayed discharge • Long wait to be seen	• Escalate concerns at monthly meeting with Matrons/HOMS/Ward Leads- Next meeting 28/8/23 • Pain Assessment and Management in Maternity Bi-Monthly meetings ongoing • Limitations due to estates. PEM have put forward some suggestions from feedback received about the estates and awaiting estate plans to be agreed and actioned. • Discharge Group set up to look at the processes and identify potential Quality Improvements. Also, discussions around managing expectations and information around discharge.			

Friends & Family Test: Inpatient Recommended

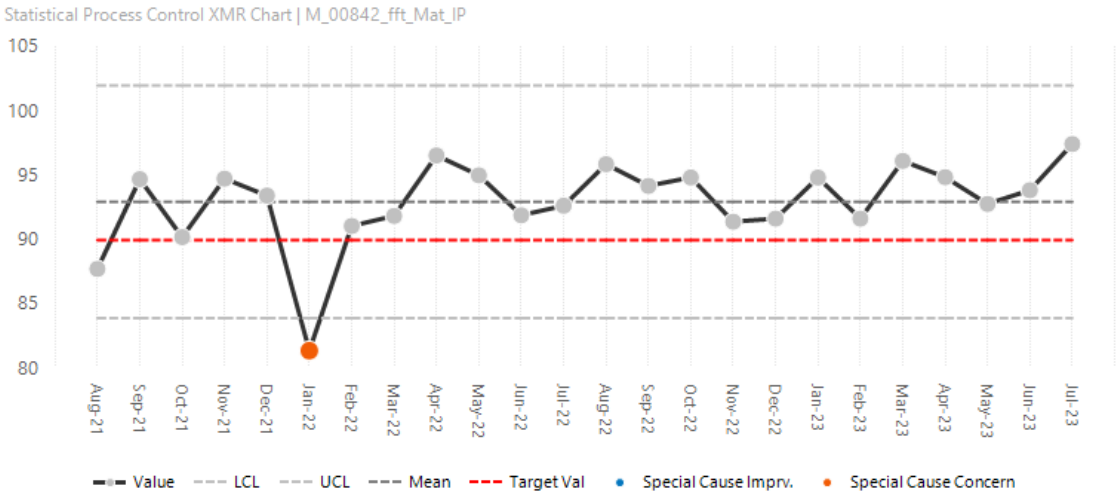
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

FFT Maternity (IP) Recommended

Month	Value
Aug-22	95.9%
Sep-22	94.2%
Oct-22	94.9%
Nov-22	91.4%
Dec-22	91.7%
Jan-23	94.9%
Feb-23	91.7%
Mar-23	96.2%
Apr-23	94.9%
May-23	92.8%
Jun-23	93.9%
Jul-23	97.5%



Understand the most recent data point

Variation Type

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

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Response rates are typically low for FFT therefore only reflect a minority of women, birthing people and their families, and their experiences	• Embedding in discharge process with the introduction of the new post natal discharge process . • Increase awareness via Maternity Voice Partnership • Include in Walking the Patch and standard work for the Discharge coordinators • Explore use of link to QR code	• Liane Ashley	• December 23	• This is a milestone within the Maternity and Neonatal Improvement Plan due to be presented to Trust Board for approval in September 2023

Staff Engagement Score

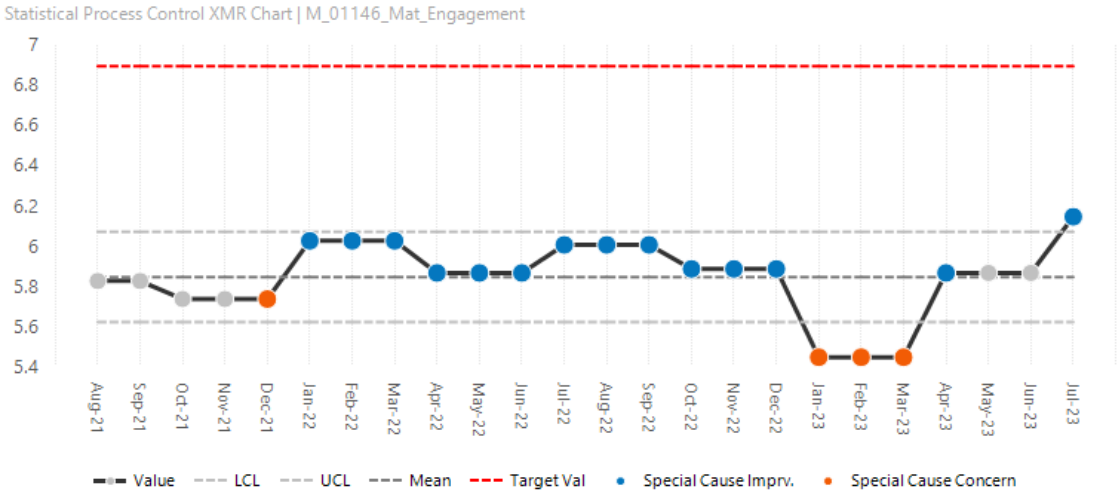
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Maternity Engagement Score

Month	Value
Aug-22	6.01
Sep-22	6.01
Oct-22	5.89
Nov-22	5.89
Dec-22	5.89
Jan-23	5.45
Feb-23	5.45
Mar-23	5.45
Apr-23	5.87
May-23	5.87
Jun-23	5.87
Jul-23	6.15



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to higher values(| | Outside Moving Range Limit | Astronomical Point | | |)

Variation indicates consistently falling short of the target

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

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: MONTH 4 FINANCE REPORT

Meeting date: 7 SEPTEMBER 2023

Board sponsor: INTERIM CHIEF FINANCE OFFICER

Paper Author: INTERIM CHIEF FINANCE OFFICER (CFO)

Appendices:

APPENDIX 1: M4 FINANCE REPORT

Executive summary:

Action required:	Information
Purpose of the Report:	The report is to update the Trust Board on the current financial performance and actions being taken to address issues of concern.
Summary of key issues:	The Group achieved an in month position of £10m against a plan of £5.4m resulting in a deficit variance of £4.7m. The Group's Year to Date (YTD) position is £39m against a plan of £30.6m giving a YTD variance to plan of £8.4m. The agreed financial plan for the year of 2023/24 is £72m. Delivery of the 2023/24 financial plan is based upon some extremely challenging assumptions as it requires that the Trust: 1) Delivers £40m of efficiency savings on a cash releasing efficiency basis. 2) Delivers a stretch activity target. 3) Reduces not medically fit to reside patients. 4) Eliminates 65-week breeches. 5) No additional unknown cost pressures are presented without mitigation in year. 6) Non-elective pressures are within planning tolerances. 7) Full control measures are reintroduced.

We care

East Kent Hospitals University NHS Foundation Trust

Group Position

£'000	This Month Plan	This Month Actual	This Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance
EKHUFT Income	71,620	72,615	995	282,704	285,695	2,992
EKHUFT Employee Expenses	(47,711)	(50,591)	(2,880)	(194,649)	(202,038)	(7,388)
EKHUFT Non-Employee Expenses	(29,507)	(32,965)	(3,458)	(119,391)	(123,833)	(4,442)
EKHUFT Financial Position	**(5,598)**	**(10,941)**	**(5,343)**	**(31,337)**	**(40,175)**	**(8,838)**
Spencer Performance After Tax	(0)	(20)	(20)	163	11	(152)
2gether Performance After Tax	59	152	92	236	363	127
Rephasing/Consolidation Adjustments	78	402	324	123	396	273
Consolidated I&E Position (pre Technical adjs)	**(5,461)**	**(10,407)**	**(4,946)**	**(30,815)**	**(39,405)**	**(8,590)**
Technical Adjustments	63	326	263	221	429	208
Consolidated I&E Position (incl adjs)	**(5,398)**	**(10,081)**	**(4,683)**	**(30,594)**	**(38,976)**	**(8,382)**

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

- Strike action £1.1m.
- £0.5m of non-funded pay award.
- Non-delivery of recurrent efficiency savings £8.3m YTD of which £5.2m has been allocated to Pay and £3m to non-pay.
- Pay overspent by £7.4m due to non-delivery of Cost Improvement Programme (CIP), increased levels of staffing utilisation, mainly in nursing (c174 Whole Time Equivalent (WTE)) & Medical & Dental (c127 WTE) and high cost of agency premium to cover escalation areas still open above plan £0.4m, increased levels of 121 nursing care £2.6m and delayed Internationally Educated Nurse (IEN) supernumerary cover £1.5m.
- Non-recurrent pay efficiencies have been achieved of c£6.1m when taking into consideration the known overspends in pay. Work is underway to understand if these non-recurrent efficiencies are able to be turned into recurrent efficiencies.
- Non-Pay overspent by £4.4m driven by non-delivery of efficiencies, however, the Laboratory Information Management System (LIMS) pathology contract has now commenced and increased non pay by £0.5m this offset against an increase in income. The Trust suffered with a breakdown of its combined heat and power which required the Trust to go back on grid for more expensive electrical supply of £0.2m. Underspend on drugs of £0.9m, overspend on clinical supplies & services £0.9m and premises costs of £0.3m.

Income is above plan YTD by £3m mainly due to additional allocation from the Integrated Care Board (ICB) for Health and Care Partnership (HCP) East Kent projects £0.8m, Pathology LIMS £0.5m and high cost drugs and devices £1.4m and non-recurrent CIP of £0.3m.

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. The Trust has submitted a plan to achieve 106% of 2019/20 baseline. YTD the Trust is behind its activity plan by £1.8m due to

	cancelled activity as a result of the doctor's strike, however, the current ERF guidance is Trusts are paid to plan not to activity levels. Further guidance around changes to ERF have now been received, however, not enacted for month 4 as per national guidance, the finance team are reviewing any financial impact we will have for month 5. The Group cash balance (including subsidiaries) at the end of July was £28.8m. Elective and Day case Inpatient spells activity has underperformed by 11% against plan in month, and is now showing a 5% underperformance against plan YTD. New Outpatient activity was 20% under plan in month and 14% under plan YTD. The level of Accident & Emergency (A&E) attendances were 10% lower than plan in month resulting in a YTD underperformance of 9%. The rechargeable element of NHS England (NHSE) High Cost drugs is £1.3m over plan YTD. As these are pass through costs, there is a corresponding increase in drugs expenditure. Pay is over spent by £7.4m and over utilising establishment by c280 WTE most notable in nursing c170 WTE and Medical and Dental c120 WTE. Nursing PMO's are now in place to review the numbers of nursing staff on the ward, the levels of cover for the escalation areas as well as a review of the IEN's and 121 specialling cover. Work is underway with Kent and Medway NHS and Social Care Partnership Trust (KMPT) with regards to the 121 specialling requirements for the Trust. Total capital expenditure at the end of July was broadly on plan with a £6.3m spend against a plan of £6.4m plan. The Trust has achieved very little recurrent efficiency savings so far this year against the £8.8m plan. The non-recurrent efficiencies are c£6.0m. This will be reported from month 5. The Trust drew £3.5m of working capital (Public Dividend Capital (PDC)) in the month, making a YTD total of £21.9m.
Key recommendations:	The Board of Directors is asked to: • Review and **NOTE** the financial performance and actions being taken to address issues of concern: • **NOTE** the reforecasting of the financial position to a £19.3m deficit.

Implications:

Links to Strategic Theme:	**Healthy finances:** Having Healthy Finances by providing better, more effective patient care that makes resources go further

East Kent Hospitals University NHS Foundation Trust

Link to the Board Assurance Framework (BAF):	**BAF 38**: Failure to deliver the financial breakeven position of the Trust as requested by NHSE.
Link to the Corporate Risk Register (CRR):	**CRR 137**: There is a risk that the Trust will not be able to meet its 23/24 efficiencies target equating to £40m.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: Finance and Performance Committee - 29 August 2023

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2023/24

July 2023

Interim Chief Finance Officer
Michelle Stevens

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Month 04 (July) 2023/24

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Executive Summary
Month 04 (July) 2023/24

Executive Summary

In month the group achieved a £4.7m deficit adverse variance against plan, £8.4m YTD.

From the 1st of April electives and outpatients (apart from follow ups) have been reinstated to payment by results, however current guidance states that Trusts need to report on full delivery of the activity plan due to timings of data collection.

The Trust worked with Kent & Medway NHS system partners to resubmit a financial plan for 2023/24 at the beginning of May. The plan is a deficit position of £72m post a small inflationary allocation. The rest of the ICB need to deliver a breakeven position to achieve the ICB target of £48m deficit. The Trust has now had approval for the £72m deficit position and confirmation that 2023/24 is the first year of the three year trajectory to achieve financial balance.

Delivery of this deficit plan for 2023/24 is a stretch for the Trust as it's based on a higher level of activity than 2022/23 and requires £40m of efficiency savings on a CRES basis and full adherence to cost control measures.

Group Position

	This Month			Year to Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
EKHUFT Income	71,620	72,615	995	282,704	285,695	2,992
EKHUFT Employee Expenses	(47,711)	(50,591)	(2,880)	(194,649)	(202,038)	(7,388)
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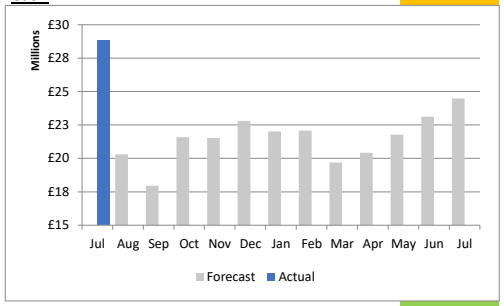
Consolidated I&E Position (incl adjs)	**(5,398)**	**(10,081)**	**(4,683)**	**(30,594)**	**(38,976)**	**(8,382)**

All NHS systems have access to funding in 2023/24 through the Elective Recovery Fund (ERF). The Trust has received funding to meet a threshold of 104% of 2019/20 activity levels for ICB activity, the Trust has submitted a plan that delivers 106% of the 2019/20 baseline. YTD the Trust is behind its activity plan by £1.8m due to cancelled activity as a result of the doctors strike. The guidance for ERF for month 4 is to report as per plan.

Income and Expenditure R

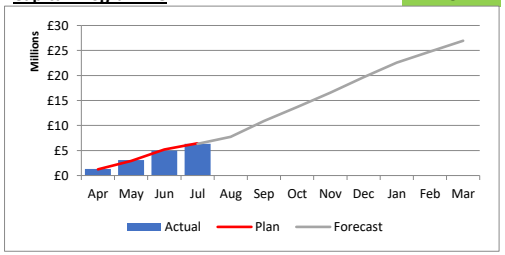
The key drivers behind the deficit are: Strike action £1.1m by the junior doctors, Non-delivery of efficiency savings £8.3m YTD of which £5.2m has been allocated to Pay and £3.0m to non pay, Pay overspent by £7.4m due to non delivery of CIP and increased levels of staffing utilisation mainly in nursing (c172 WTE) & Medical & Dental (c127 WTE) and high cost of agency premium. Total non-Pay overspend of £4.7m, driven by clinical supplies & services (£1.3m), premises costs (0.4m), non-delivery of CIP (£3.0m).

Cash A



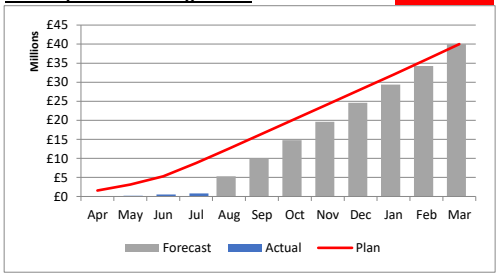
The Group cash balance (including subsidiaries) at the end of July was £28.8m.
The Trust drew £3.5m of working capital (PDC) in the month, making a YTD total of £21.9m.

Capital Programme G



Total capital expenditure at the end of July was broadly on plan with a £6.3m spend against a plan of £6.4m plan.

Cost Improvement Programme R



The Trust has achieved very little efficiency savings so far this year against the £8.8m plan.

This has contributed to the Group not meeting it's planned year to date deficit of £30.6m in July.

Income and Expenditure Summary
Month 04 (July) 2023/24

Unconsolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	8,841	8,032	(809)	32,932	31,267	(1,666)
Non-Electives	21,861	19,146	(2,716)	87,940	73,811	(14,129)
Accident and Emergency	4,293	3,870	(424)	16,847	15,557	(1,291)
Outpatients	9,787	10,000	213	37,132	38,899	1,767
High Cost Drugs	4,070	4,319	249	16,279	17,579	1,300
Private Patients	14	33	19	57	121	64
Other NHS Clinical Income	18,229	22,878	4,649	73,452	90,476	17,024
Other Clinical Income	133	83	(50)	532	482	(51)
Total Income from Patient Care Activities	**67,228**	**68,360**	**1,132**	**265,174**	**268,192**	**3,019**
Other Operating Income	4,392	4,255	(137)	17,530	17,503	(27)
Total Income	**71,620**	**72,615**	**995**	**282,704**	**285,695**	**2,992**
Expenditure						
Substantive Staff	(41,240)	(42,959)	(1,719)	(168,144)	(171,621)	(3,477)
Bank	(3,514)	(3,777)	(263)	(13,843)	(14,560)	(717)
Agency	(2,956)	(3,854)	(898)	(12,663)	(15,857)	(3,194)
Total Employee Expenses	**(47,711)**	**(50,591)**	**(2,880)**	**(194,649)**	**(202,038)**	**(7,388)**
Other Operating Expenses	(28,644)	(32,161)	(3,517)	(115,933)	(120,642)	(4,708)
Total Operating Expenditure	**(76,355)**	**(82,752)**	**(6,397)**	**(310,583)**	**(322,680)**	**(12,097)**
Non Operating Expenses	(863)	(804)	59	(3,458)	(3,191)	267
Income and Expenditure Surplus/(Deficit)	**(5,598)**	**(10,941)**	**(5,343)**	**(31,337)**	**(40,175)**	**(8,838)**

Consolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Income from Patient Care Activities	67,829	69,850	2,021	271,498	273,794	2,296
Other Operating Income	4,517	3,810	(707)	18,030	16,466	(1,564)
Total Income	**72,346**	**73,660**	**1,314**	**289,528**	**290,260**	**732**
Expenditure						-
Employee Expenses	(50,536)	(54,883)	(4,347)	(211,901)	(218,534)	(6,633)
Other Operating Expenses	(26,340)	(28,384)	(2,044)	(104,719)	(107,904)	(3,185)
Total Expenditure	**(76,876)**	**(83,267)**	**(6,391)**	**(316,620)**	**(326,438)**	**(9,818)**
Non-Operating Expenses	(931)	(800)	131	(3,723)	(3,227)	496
Income and Expenditure Surplus/(Deficit) (pre Technical adjs)	**(5,461)**	**(10,407)**	**(4,946)**	**(30,815)**	**(39,405)**	**(8,590)**
Technical Adjustments	63	326	263	221	429	208
Consolidated I&E Position (incl adjs)	**(5,398)**	**(10,081)**	**(4,683)**	**(30,594)**	**(38,976)**	**(8,382)**

Income from Patient Care Activities

In month the Trust saw an overperformance against plan of £1.1m (over performance £3.0m YTD).

The largest in month variance relates to the funding of the Pathology LIMS service of £0.5m which is offset by expenditure. Additional income (£0.8m YTD) has been accrued for EK HCP funded projects - SDEC, discharge reconfiguration and MDU in addition to £0.3m for prior year drugs not included in our plan.

The remaining YTD overperformance is due to high cost drugs which has an overperformance of £1.3m YTD (£0.2m in month) whereas high cost devices is showing a small overperformance of £0.1m YTD. Both these two recharges are pass through costs and are mirrored in expenditure.

Following national guidance, no variance has been accrued against ERF performance at Month 4, but any emerging risk will be evaluated and included in future months' positions if required.

The material under performance on Non-Elective activity is due to continuing high levels of patients in escalation beds in ED who are not admitted due to the lack of ward capacity caused by the high number of non-fit to reside patients in the hospital. The plan for non-electives assumed that we would improve flow through the hospital and thereby see an increase in the number of admissions to wards and a reduction in average length of stay.

Other Operating Income and Expenditure

Other operating income is adverse to plan in July by £0.1m and marginally adverse to plan by less than £0.1m YTD. The in month variance mainly relates to reduction in donated income reported in previous months and below plan staff accommodation rental income totalling £0.3m. This is offset by above plan income for non patient care services, education and training and car parking totalling £0.1m.

Total operating expenditure is adverse to plan in July by £6.4m and by £12.1m YTD, including CIPs which are reported as adverse in month £3.3m and £8.2m YTD.

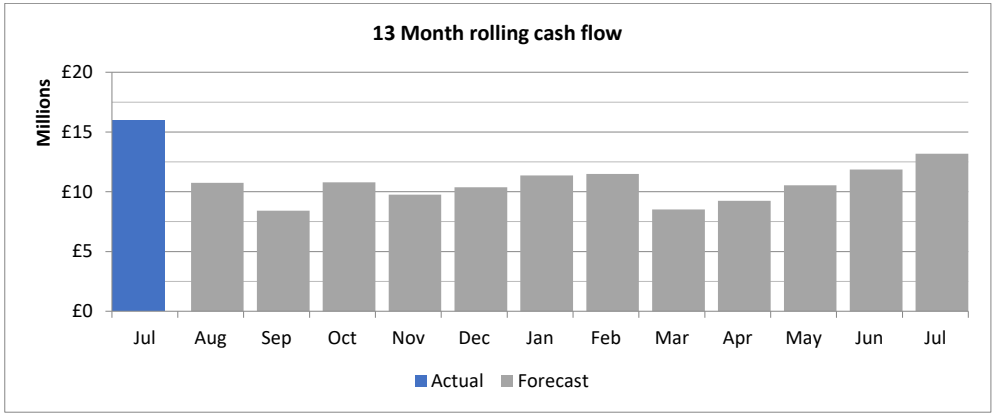
Employee expenses performance is adverse to plan in July by £2.9m and by £7.4m YTD. CIP schemes relating to all pay headings are adverse to plan in June by £2.0m and by £5.2m YTD. This also reflects the impact of cover during strike action by Junior Doctors in July, which is estimated at £0.4m and £1.1m YTD. Shortfalls relating to the implementation of AfC pay awards are estimated at £0.1m and £0.5m YTD. Wte over-utilisation fell marginally by 2 in month to 300, which links to the spend incurred on escalation beds of £1.5m in July and £5.6m ytd, and 1:1 specialing of £0.8m and £3.1m ytd.

Total expenditure on pay in July was £50.6m, a reduction of £0.5m when compared to June. Expenditure on all substantive staff reduced by £0.5m, reflecting bank holiday payments paid in June and a reduced apprenticeship levy payment paid in July. Expenditure on bank staff increased by £0.4m, predominantly relating to nurses and HCAs offset by reduced agency staff spend of £0.4m, mainly for qualified nurses and HCAs and medical consultants.

Other operating expenditure is adverse to plan by £3.5m in July and by £4.7m YTD. CIP schemes relating to all other operating expenditure headings are adverse to plan by £1.3m in July and by £3.0m YTD. The main drivers for the overspend in month are higher than planned spend on OHF and EMS contracts of £1.2m, and overspends on drugs including rechargeables and supplies and services - clinical totalling £0.8m. Hosting charges for the LIMS Clinisys system of £0.5m incurred in July are funded by the ICB via patient care income.

Other operating expenditure increased month on month by £0.5m, predominantly relating to LIMS project Clinisys hosting charges of £0.5m referred to above.

Cash Flow
Month 04 (July) 2023/24



Unconsolidated Cash balance was £16.0m at the end of July 23, £1.9m above plan.

Cash receipts in month totalled £82.4m (£3.7m below plan)
K&M ICB paid £55.2m in July. £1.8m below plan.
NHS England paid £18.3m in July, £0.8m above plan
Other NHS receipts totalled £1.4m (£0.1m above plan)
Non NHS Receipts totalled £4.1m (£0.8m below plan largely due to low VAT reclaim)
Revenue Support is £2.0m below plan in month.

Cash payments in month totalled £95.1m (£16.1m above plan)
Creditor payment runs including Capital payments were £27.7m (£6.1m above plan)
Payments to 2gether were £0.2m above plan.
Payroll was £9.8m above plan (PAYE and NI paid in month includes Junes Pay Award)

YTD cash receipts total £340.4m (£21.9m above plan - largely driven by receipts from NHS England over plan (£19.5m), VAT reclaims under plan (£7.0m), revenue support above plan by £9.7m)

YTD cash payments total £343.0m (£20.0m above the plan - driven by payments to 2gether below plan (£9.1m) and Payroll over plan (£21.6m) and creditor payments over plan (£7.5m))

2023/24 Plan

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

Forecast

Monthly payments on account (£57m YTD) continue to be made to 2gether Support Solutions in lieu of invoices being paid whilst charges are being reviewed. As a result, VAT reclaims are significantly reduced from plan. This will continue to be the case until charges are confirmed. Forecast has been amended to begin clearing invoices in August with the relating VAT reclaim being received in September. The VAT reclaim received will enable further invoices to be cleared in October.

Revenue Support for Quarter 2 has been agreed by DHSC at £22.4m. £3.5m was received in July, £10.8m due in August and £8.1m requested in September. The process for requesting Q3 revenue support will begin in August.

Creditor Management

The Trust moved to 43 day creditor terms in Month 04 (moving out further in early August).

In prior months, payments to one key supplier were being held and invoices cleared only if the funds were available. To avoid late payment charges being levied, it has been agreed to clear their balance by the end of October at a rate of £2m per week. As at 31st July 23, £5.7m was overdue for payment to them, and a further £4.3m of current invoices. This is a significant weekly payment which impacts on the Trusts ability to pay other creditors.

At the end of July 2023, the Trust was recording 61 creditor days (Calculated as invoiced creditors at 31st June/ Forecast non-pay expenditure x 365).

Cost Improvement Summary

Month 04 (July) 2023/24

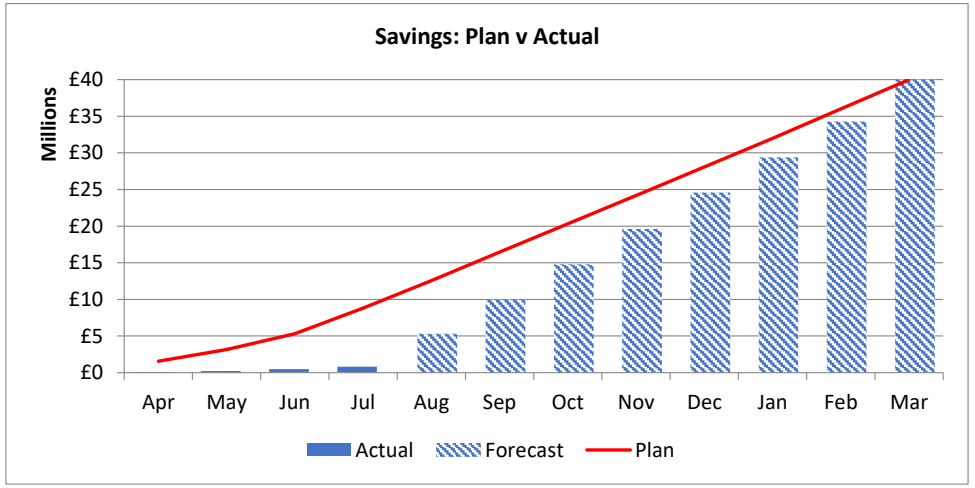
Delivery Summary	This Month			Year to Date			Forecast	
Programme Themes £000	Plan	Actual	Variance	Plan	Actual	Variance	Outturn	Variance
Agency	899	-	(899)	2,259	-	(2,259)	9,153	(141)
Bank	-	-	-	-	-	-	9	9
Workforce	267	26	(241)	901	76	(826)	3,094	10
Outpatients	25	-	(25)	80	-	(80)	275	(69)
Procurement	137	21	(116)	408	233	(175)	1,892	264
Medicines Value	60	153	93	204	181	(23)	977	(23)
Theatres	230	-	(230)	518	-	(518)	2,725	(275)
Care Group Schemes *	1,196	111	(1,084)	2,622	318	(2,304)	13,916	(553)
Sub-total	**2,814**	**311**	**(2,503)**	**6,992**	**808**	**(6,184)**	**32,040**	**(779)**
Central	700	-	(700)	1,815	-	(1,815)	7,960	779
Grand Total	**3,514**	**311**	**(3,203)**	**8,807**	**808**	**(7,999)**	**40,000**	**-**

* Smaller divisional schemes not allocated to a work stream

Delivered £000		
Month	Target	Actual
April	1,563	58
May	1,581	149
June	2,149	290
July	3,514	311
August	3,749	
September	3,890	
October	3,873	
November	3,874	
December	3,874	
January	3,929	
February	3,989	
March	4,015	
	40,000	**808**

Efficiencies

The submitted Efficiencies plan for 2023/24 is £40m. The Trust achieved savings of £0.3m in July, which is below Plan. The in-month performance relates to shortfalls across all areas. YTD underperformance is primarily due to timing of schemes in Theatres, Procurement and Care Groups currently being developed. Achievement of Run Rate reductions are a prerequisite before CRES can be reported. Recurrent savings in June amounted to £0.22m, with £0.09m being on a non-recurrent basis. Recurrent savings YTD amount to £0.52m with £0.28m on a non-recurrent basis. Fortnightly Care Group meetings continue with an increased focus on determining values for 2023/24 ideas, and seeking further opportunities to develop savings plans.



Capital Expenditure
Month 04 (July) 2023/24

Capital Programme	Annual	Annual	Year to Date		
£000	Plan	Forecast	Plan	Actual	Variance
Emergency Department Expansions	4,271	4,271	2,609	3,361	(752)
Community Diagnostics Centre	2,845	2,845	0	16	(16)
Mechanical Thrombectomy	2,608	2,608	0	20	(20)
Diagnostics Clinical Equipment	2,550	2,550	0	0	0
Information Development Group	2,000	2,000	910	686	224
Medical Devices Group	1,666	1,666	552	255	297
Electronic Medical Records	1,545	1,545	595	575	20
Stroke HASU	1,463	1,463	67	691	(624)
Diagnostics Imaging Capacity	1,433	1,383	183	()	183
Patient Environment Investment Committee	3,771	3,771	290	45	245
Charity Donations	900	900	244	83	161
Other Build	736	736	686	32	654
Subsidiaries	519	519	52	0	52
Other IT	375	375	0	375	(375)
Other Medical Equipment	259	259	259	30	229
Trust IFRS16 Acquisitions	0	172	0	0	0
Lease Cars	0	8	0	8	(8)
All Other	0	0	0	155	(155)
	26,941	**27,071**	**6,447**	**6,332**	**115**
Funded By:					
Operational Cash	21,515	21,593			
System Set Underutilisation	(2,850)	(2,981)			
Donations	900	900			
Disposals	250	250			
System Capital PDC	1,463	1,463			
PDC	5,663	5,613			
Carried Forward PDC	0	131			
New Lease Loans	0	180			
New Lease Repayments	0	(78)			
	26,941	**27,071**			
Under/(Over) Commitment		**0**			

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

The latest forecast for the year, as at M4, is £27.07m, representing a £0.13m net increase from the original plan; this is due to New Lease Loans taken in-year totalling £0.18m, offset by a £0.05m reduction in the Diagnostic Imaging Capacity PDC funding assumed (and associated spend plans), to align it to the final funding figure provided in the MOU.

Capital Spend Position - as at M4

The group's gross capital year-to-date spend to the end of Month 4 was £6.3m, against a YTD plan of £6.4m. This represents a £0.1m net underspend, as a result of:

- Underspends totalling £2.1m (including £0.9m on PEIC and Other Build projects, £0.7m on MDG, Diagnostics Imaging and Other Medical Equipment and £0.5m on IDG schemes, Charity and Subsidiaries);
- Overspends totalling £2m (including £0.8m on the ED Expansion programme, £0.6m on Stroke HASU, £0.4m on Other IT schemes and £0.2m overall on other small overspend items);

The Trust is currently holding circa £3.6m worth of unfunded cost pressures, including:

• £1.55m on the WHH Fire Alarm PA Upgrade, which was approved by the Trust Board on 1st June 2023;
• £1.06m on the ED Expansion Programme, as presented to the Executive Team at the Capital Prioritisation event that took place on 31st May 2023;
• £0.9m related to the enabling works required for the installation of the QEQM MRI, the procurement of the device being funded externally;
• £0.14m for completing the Maternity Entonox remedial works at WHH, as a result of higher than expected costs, following the tender process;

These are yet to be reflected in the year-end forecast position, pending identification of suitable mitigating actions. There are ongoing conversations with the K&M ICB regarding the funding of these cost pressures and an update will be provided in the upcoming reports.

Statement of Financial Position
Month 04 (July) 2023/24

£000	Opening	To Date	Movement	
Non-Current Assets	**402,107**	**400,269**	**(1,838)**	▼
Current Assets				
Inventories	6,749	7,629	880	▲
Trade Receivables	11,677	10,210	(1,467)	▼
Accrued Income and Other Receivables	29,981	24,391	(5,590)	▼
Assets Held For Sale			-	
Cash and Cash Equivalents	18,618	15,968	(2,650)	▼
Total Current Assets	**67,025**	**58,198**	**(8,827)**	▼
Current Liabilities				
Payables	(41,537)	(60,856)	(19,319)	▲
Accruals and Deferred Income	(46,653)	(38,063)	8,590	▼
Provisions	(2,887)	(2,809)	78	▼
Borrowing	(4,838)	(3,029)	1,809	▼
Net Current Assets	**(28,892)**	**(46,559)**	**(17,668)**	▼
Non Current Liabilities				
Provisions	(3,405)	(3,365)	41	▼
Long Term Debt	(77,371)	(76,186)	1,186	▼
Total Assets Employed	**292,439**	**274,160**	**(18,279)**	▼
Financed by Taxpayers Equity				
Public Dividend Capital	454,994	476,890	21,896	▲
Retained Earnings	(217,590)	(257,765)	(40,175)	▼
Revaluation Reserve	55,035	55,035	-	
Total Taxpayers' Equity	**292,439**	**274,160**	**(18,279)**	▼

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

Trust closing cash balance was £1.9m (£16m in June) £4.5m above plan. See cash report for further details. Cash has been supported in year by £21.9m of PDC working capital.

The Trust's application for Q2 borrowing for month 5 in the form of working capital PDC was approved - this will be drawn in August to the level of £10.8m. The Trust will not be able to apply for additional cash over the original deficit unless or until the forecast is changed for the year.

The Trust utilised its cash balance from June (£28.7m) to reduce the payable balance.

Trade and other receivables have reduced from the 2023/24 opening position by £5.6m (£1.1m reduction in June). Key drivers are detailed on the Cash report

Payables have increased by £19.3m (£30.3m increase in June). 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.

PDC increased in month by Working Capital (£3.5m).

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Integrated Improvement Plan (IIP) Report Including Metrics**

Meeting date: **7 September 2023**

Board sponsor: **Chief Executive**

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

Appendices:

APPENDIX 1: **Progress Update on Delivery of the IIP since last month and agreed metric reporting**

Executive summary:

Action required:	Information
Purpose of the Report:	To update the Board on progress of delivery of the Integrated Improvement Plan, performance against the agreed metrics and to provide oversight of key risks to delivery.
Summary of key issues:	The IIP update report includes an update on progress against the programme milestones and a summary of performance against the Q1 targets. Quality of Care, Maternity and Leadership and Governance have met the majority of the Q1 milestones set. The exception is maternity Care Quality Commission (CQC) must do actions which have not yet all been actioned and checked. Of 17 10 are complete and 7 remain in progress with partial assurance. Whilst progress continues in a number of the programmes The biggest areas of risk to delivery, against the agreed milestones and exit criteria, are in the finance programme and elements of the operational performance programme, particularly the diagnostics pathway. Both the finance and operational performance programmes are currently RAG rated red.
Key recommendations:	Trust Board members are invited to discuss the report and progress of delivery of the Integrated Improvement Plan to date.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients • People • Partnerships • Sustainability

East Kent Hospitals University NHS Foundation Trust

Link to the Board Assurance Framework (BAF):	**BAF 32** – There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered. **BAF 34** – There is a risk that our constitutional standards are not met. **BAF 38** – Failure to deliver the financial plan of the Trust as requested by NHS England (NHSE).
Link to the Corporate Risk Register (CRR):	N/A
Resource:	Yes - Discussions with National team regarding the use of available resources.
Legal and regulatory:	Yes – regulatory impact.
Subsidiary:	Yes – in the overall provision of services within the resources available to the Trust.

Assurance route:

Previously considered by: Oversight and Assurance is provided through the Strategic Improvement Committee

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

Journey to Exit NOF4
September 2023

29 August 2023

Purpose of Report

East Kent Hospitals University NHS Foundation Trust

This report has been established to update the Board on progress of delivery of the Integrated Improvement Plan. It is also intended to give the Board oversight of key risks to delivery; and to update on key evidence that has been added to the evidence repository to support exit from the Recovery Support Programme (RSP).

Delivery of the Integrated Improvement Plan is overseen by the EKHUFT Strategic Improvement Committee (SiC) which is chaired by the Chief Executive.

The Board will receive an update on the IIP on a monthly basis focusing on successes, challenges and actions to mitigate any key risks to delivery. We will also provide a quarterly deep dive to demonstrate impact and progress against the overall programme objectives.

High-level Summary on Programme Delivery

	Priority area of focus in IIP	Summary update
Leadership & Governance	Leadership Development	• Chief Medical Office interviews scheduled for the 4th September2023. • The new Chief Nurse commences in post on the 18th September 2023. • NHSE finance support to commence End of August/beginning of September. • Scope agreed for board effectiveness work to be undertaken with an external company. • The new Care Group structure came into effect on 14th August 23.
	Governance Framework	• Progress has continued with the refreshed organisational governance framework. The draft framework has been to CEMG, IAGC and will be reviewed at board. The original timescale for completion was June 23 but this will now be September 23 to ensure the approval framework is followed.
Maternity	Maternity Transformation	• Following the maternity engagement day in June the Maternity and Neonatal Improvement Programme charters have been revised and shared. • The implementation of an improved discharge process has been completed. • Quarterly multidisciplinary training sessions are now in place with the ambulance service focused on escalation of emergencies in the homebirth setting.
Operational Performance	UEC Patient Pathways	• New front door models have been embedded at the QEQM emergency department. • The learning from the WHH discharge reset programme is now being applied at QEQM. • Progress has been made on the reimplementation of Clinical Decision Units at both WHH and QEQM. • All type performance has continued to improve.
Quality & Safety	The Deteriorating Patient	• Deteriorating patient education programme complete, Inaugural Deterioration Patient Safety meeting was be held to agree TORs, monthly meetings now in diary
	Ward Accreditation	• Progress made with a full review and reset of the Fundamentals of Care work streams/Ward Accreditation programme with a new set of refreshed milestones as set out under the Quality & Safety programme.
People & Culture	Culture & Leadership	• Continued progress is being made with the Culture and Leadership Programme with launch events for the change team held in July. • The recruitment plan continues for the next cohort of IEN's. • Absence audit and associated action plan has been completed.
Finance	Workforce Plan	• Finance remains one of the biggest areas of risk in terms of IIP delivery. • A range of additional control measures have been implemented including a focus on temporary staff usage and spend control particularly on nursing and midwifery.
Overarching Delivery Milestones	Integrated Improvement Plan	The Strategic Improvement Committee with support from the NHSE Intensive Support Team, have undertaken a thorough review of the required 23/24 overarching delivery improvement milestones as directed by the NHSE Regional Director. Work will progress to align these delivery improvement milestones entirely with the previously agreed IIP to ensure our programmes of work are initiating, enhancing or continuing to progress milestones required to make measurable improvements. In addition, this IIP board report has been refreshed to include specific reporting against these milestones to ensure reporting of assurance and risk is improved. Reporting of the IIP will continue to the Trust Board on a monthly basis, at regional monthly oversight meetings and quarterly RSP meetings with the national RSP team. Funding has also been finalised from the IST team and will be used to support delivery of the IIP.

Analysis and progress against the Q1 23/24 Overarching Delivery Improvement Milestones & IIP

East Kent Hospitals University NHS Foundation Trust

Leadership & Governance:

Q1 Milestone	Progress
Executive Development Plan in place and relevant recruitment plans enacted	• The development plan has been produced and commences in August 2023. • The substantive Chief Nurse commences in post on 18 September 2023. • The CMO interviews are scheduled for 4 September 2023.

Operational Performance:

Q1 Milestone	Progress
4 Hour Performance – 71%	• June performance – 73%
Type 1 Performance – 50% by the end of Q1	• June performance – 48% • The June performance was behind plan but was the third consecutive month of improvement. Further improvement has been delivered in July with performance of 51.6%. Performance is on track to deliver the Q2 milestone of 55%.
Diagnostics Performance – To attain 40%	• June performance – 39%

Financial Governance:

Q1 Milestone	Progress
Financial Governance – FRP Updated	• Draft plan for the timelines for FRP development have been submitted to the board in addition to the lessons learned from the previous FRP.
Temp Staff Expend - £10.28 million	• Q1 total temp staff spend - £13.061 million • Vacancy control panel now established for clinical posts at exec level escalated from the care groups. Non-clinical vacancy panel established since January 23. Additional oversight for nursing agency has commenced at CMNO level.
Efficiency Delivery - £5.293 million	• Current confirmed recurrent delivery is significantly behind plan at £0.5 million. Non recurrent delivery is c£2.2m in addition to the recurrent achievement. • Further work is being undertaken to assess the areas which can be converted to recurrent as well as the development of the recurrent efficiencies. • The total value of identified recurrent schemes to date is £10 million FYE and £9 million PYE.

Analysis and progress against the Q1 23/24 Overarching Delivery Improvement Milestones & IIP continued:

East Kent Hospitals University NHS Foundation Trust

Quality of Care:

Q1 Milestone	Progress
Serious Incidents - Evidence of SI and NE training delivered in induction for new staff	• Incident process awareness training is part of the induction day 2 for all clinical staff. • The Trust are exploring moving this to day 1 which includes all non-clinical and clinical new starters.
Serious Incidents - Reduced time between identification and reporting of an SI.	• The number of overdue incidents has reduced from 13 to 6 in June. Of the 6 overdue incidents 3 are awaiting a decision from the ICB to declassify as SI's based on the investigation findings.
Safeguarding - Up to date safeguarding policies in place.	• All safeguarding policies have been updated in line with the NHSE Safeguarding Accountability and Assurance Framework (SAAF) and implemented.

Maternity:

Q1 Milestone	Progress
Induction of new maternity leadership	• The new Director of Midwifery and Deputy Director of Midwifery are in place and have been having ongoing induction. • The culture and leadership plan has been developed as part of the Maternity and Neonatal Improvement Programme (MNIP)
Quarterly audits supporting appropriate clinical escalation showing improvement	• New leadership team in place and baseline audit completed in Q1 shows 61% compliance with escalation of MEWS • EKUFT is early adopter of new national early warning score in maternity to be implemented in Qtr 2
No overdue SI's HSIB	• The July position was Zero overdue SI's/HSIB's investigations.
Maternity CQC must do's actioned and checked	• Of 17 must do's 10 have been completed and 7 are in progress with partial assurance.

For further detailed metrics aligned to the IIP please see the 'Integrated Performance Report' in the Trust Board papers.

Integrated Improvement Programme – RAG Reported Progress

Progress Summary by Programme:

Progress Summary by Individual Project:

The Quality Governance, Financial Improvement, Maternity Governance & Patient Safety, Elective Recovery (including diagnostics), Cancer and Medical Workforce projects are reported as **off track** in this period, with a further eight projects are rated as **having issues**. The remaining 8 projects are all **on track**.

Executive Leadership Team	Governance	Communications & Engagement	Transformation Programme	
Quality Governance	Safeguarding	Fundamentals of Care	The Deteriorating Patient	
Financial Governance	Financial Improvement	Financial Consciousness		
Team Working	Clinical Escalation & Handover	Clinical Assessment & Care Pathways	Governance & Patient Safety	Engagement, Listening & Leadership
UEC and Whole System Interface	Elective Recovery (incl Diagnostics)	Cancer		
Attract & Retain	Culture & Leadership Development	Medical Workforce		

Programme:	Leadership & Governance

Key progress in programme during last period
• Advertised CMO position with interviews scheduled for 4th September. • Executive Leadership development plan commenced i.e.; Safeguarding, Deloitte, Risk Tolerance / Risk Appetite, Culture & Leadership via Michael West, Collider Scope session on strategy vision & values. • NHSE senior finance support secured from end August 23. • New organisational structure has gone live with majority of senior positions recruited to and gaps out to national advert. • Session with KPMG has taken place for strategy development, draft plan to be discussed at future Executive meeting and approved through CEMG. • Scope agreed with Good Governance Institute to undertake external diagnostic on Board effectiveness. Start date to be agreed. • Good progress with Comms & Engagement workstreams please see slide 13 for full detail.

Key Project Risks	Residual Score
Unable to appoint CFO substantively.	1
Loss of focus on operational delivery due to the ongoing effect of the restructure.	6

Milestones off track	Target Date	What are we doing about it?
1.201: Review and refresh Governance Model to ensure it is aligned with the organisation restructure	Jun-23	A framework document to describe quality governance and accountability from ward to board has been developed also including three-tiered structure committee charts. Draft documents have been to execs & to IAGC on 28th July for discussion & CEMG on 2nd August. Comments from CEMG will be gathered in August with a plan to send to Trust Board in September for approval. This milestone was on target to define & describe framework however, due to approval framework required milestone now off track.
1.403: Continue the Cultural and Leadership Programme focus in maternity and review effectiveness	May-23	Confirmation of leadership and culture session from Frontier Leadership (Army Leadership model in the NHS) - booked for WH Quality Board on 19 Sept 2023.
1.404: Develop the Leadership Behavioural Framework	Jun-23	Due to ratification process discuss accepting delay to target date or amendment of milestone target date to monitor effectiveness of framework. This will be further discussed at the Strategic Improvement Committee (SiC) in September 23. Plan for Behavioural Framework to be published electronically and piloted in specific areas to test interventions.
1.405: Develop and adopt the Behavioural Code in Maternity	Jun-23	This will align with Trust wide process and will be a continuation of the previous cultural work already completed. The team will work in partnership with the Trust wide leads. Work has already commenced, supported by OD in terms of identifying local ''Connector '' roles.

What will be the impact of action? / Are we are assured?
There is assurance that the mitigating action for the off track milestones will deliver the milestones within revised timescales.

Programme: Quality & Safety

Key progress in programme during last period

- Review of levels of harm reported as a result of incidents completed and benchmarked against other Kent acute Trusts and against other large Trusts. Report shared at CEMG and Patient Safety Committee.
- Quality & Governance Structure Framework drafted and circulated to the relevant governance approval framework.
- 35 SIs reported in Q1 of those due to be submitted, 100% was submitted in the 60-day deadline. Previous reporting year (22/23) only 7% was submitted within target highlighting improvements in SI management.
- Quality & Governance Structure Framework presented to IAGC 28th July.
- Completed Risk Management session at Board Development day 1st August 23.
- ICB reviewed and agreed the proposed model for staffing roles and responsibilities meets the requirements for SAAF.
- Advert for Head of Safeguarding has been authorised and is out for advert w/c 31/7.
- ToRs for Task & Finish group approved at SOG.
- Safeguarding workforce business case to be progressed and signed off.
- Head of Safeguarding delivered training session at August Board Development day.
- First thematic review drafted and action plan in place, with some actions completed.
- External safeguarding review undertaken and indicates that the Trust has an effective system for responding and investigating safeguarding concerns.
- New safeguarding adult supervision guidance has been implemented within the safeguarding team.
- Confirmation of thematic SI target completion date to be confirmed by patient safety team and actions issued
- Continue to work with Care Groups to strengthen safeguarding discussion and monitoring.
- The Tissue Viability Team awarded the Quality Improvement Award for Nursing and AHPs at the clinical audit symposium for the use of clinical audit in practice.
- Clinical Lead for Nutrition had been advising and involved in development of NHSE guidance for paediatric restrictive practices during nasogastric feeding - this has now been published as national guidance.
- Deteriorating patient education programme complete, Inaugural Deterioration Patient Safety meeting was be held to agree TORs, monthly meetings now in diary.

Key Project Risks	Residual Score
Delay to PSIRF Implementation	16
Capacity in Ward Accreditation Team	16
Capacity in BI team to support deteriorating patient dashboard	12
Head of Nursing for FoC & Quality on an interim arrangement until end September 23	12

Milestones off track	Target Date	What are we doing about it?
4.101a: Define and describe a quality governance structure and framework for senior leaders to work within	Jul-23	Draft documents have been to execs & to IAGC in July 23 for discussion & CEMG on 2nd August 23. Comments from CEMG will be gathered in August with a plan to send to Trust Board in September 23 for approval.
4.104: Commence transitioning across to the new PSIRF	Aug-23	Learning framework to support the transition will be sent to CEMG and Patient Safety Committee in September for comment and approval in October. Thereafter will commence transition.
4.303: Review current FOC workstreams	Jun-23	FoC governance framework is planned to be published in September, dependent on the organisations governance framework being published.
4.305: Publish FOC framework and KPIs	Jul-23	Unable to publish FoC Governance framework until milestone 4.303 & 4.304 is complete.
4.306: Develop trajectory for further reduction in FoC incidents resulting in moderate harm and above	Jul-23	Nursing leads producing trajectory proposals to be presented initially to FOC Lead Nurse and FOC committee by September 23.
4.401: Agree with ICB the required funding for Patient safety specialist role	Mar-23	A decision has not been made for Patient safety specialist role and is currently covered by secondment.
4.406: Launch NEWS2 e-learning module	Apr-23	Awaiting formal confirmation if approved at Training Steering Group for this training to become mandatory.

What will be the impact of action? / Are we are assured?

There is assurance that the mitigating action for the off track milestones will deliver the milestones within revised timescales.

Programme: Finance

Key progress in programme during last period

- Launched enhanced controls in line with national guidance into care groups and corporate areas, this include review of workforce for Medical and Nursing posts. Investment committee for additional non pay spend excluding drugs and clinical supplies above £10k including VAT.
- Executive led vacancy panel established for all clinical posts 8A and above which is building on the vacancy panel for non clinical staff which was embedded in January 2023.
- Nursing PMO's set up on a bi-weekly basis reviewing all nursing usage to understand fill rates and ensure maintaining the safer staffing review under taken by the Trust
- Additional care group sessions held with all executive colleagues and the managing directors of the new care groups to review admin, nursing and medical workforce. Review of the actions and progress following from the half day sessions undertaken in May and June which reviewed activity, workforce and finance from 2019/20 to 2022/23
- Admin review underway to understand vacant posts which are unfilled, next steps will be to undertake a admin review across the newly formed care groups and the corporate departments
- Work has commenced across the Trust in conjunction with KMPT to review the utilisation of nursing staff to support patients with 121 care needs for mental health.

Milestones off track	Target Date	What are we doing about it?
6.102: Effective Care Group oversight approach in place	Jun-23	Recovery oversight meetings are now in the diary up until Mar 2024. Initial meetings to commenced based on current care group structures. Once restructure is complete, these meetings will be realigned with appropriate representation. Financial control messages are very evident throughout the Trust.
6.103: Embed monthly finance reviews with Care Groups	Jun-23	Effectiveness of these meetings to be initially reviewed in October 2023 following the review of the previous efficiency meetings which have been superseded with exec led oversight meetings
6.105: Meeting structure and review of TOR	Jul-23	Work to be progressed with involvement of executive colleagues.
6.203: Model years one and two of FRP	Jun-23	Draft FRP document submitted to July 2023 Trust board. Further work to finalise required via engagement with key stakeholders. Awaiting national guidance.
6.204: Update FRP document	Jun-23	This links to milestone 6.203 – update as above.
6.205: Fully develop FY24 efficiencies	Jul-23	Trust Board approved additional resource to drive efficiency programmes, however this will take time to recruit and establish the programme.
6.206: Identify and prioritize development of “harder to achieve” improvements	Jul-23	Further work to drive these conversations at the monthly Care Group oversight meetings commenced w/c 17th July.
6.207: Develop multi-year productivity and efficiencies approach covering pathway improvement and GIRFT	Jul-23	Focus required on 23/24 key themes initially, prior to 24/25 being considered.

Key Project Risks	Residual Score
There are currently no project leads within the IIP finance workstream	16
Additional support needed with the updating of the Financial Recovery Programme	16
Risk to the delivery of the Trusts 2023/24 Efficiency Plan	16
Identify and prioritize development of “harder to achieve” improvements	16

What will be the impact of action? / Are we are assured?

The finance programme remains the highest risk in terms of delivery of the milestones and exit criteria and therefore assurance is limited.

Programme:	Maternity

Key progress in programme during last period
• An agreed model for improved discharge processes and implementation of the revised discharge pathway have been completed. • In response to feedback from the engagement day on 28th June, MNIP charters have been revised (these include clinical care pathways). • In response to historic SIs, there are now quarterly MDT training sessions with SECAMB re: escalation of emerging emergency homebirth situations. • Dedicated training spaces are now available within the MLUs on both hospital sites. • Work underway with medical education team to provide a response to the Obs & Gynae HEE quality intervention review that was published June 23. Full response due for submission 1st September 23. • Agreed approach (via MNIP Governance Project Group) to benchmarking learning and improvements from thematic analysis. • Agreement for the establishment of a patient participation group to support the development of patient information leaflets, supported by the corporate patient involvement team. • Pilot of Personalise Care Support Plans (PCSPs) complete. • Fortnightly Maternity/IT MDT meetings reinstated to progress digital improvements, including the onboarding of Maternity to PAS (to maximise functionality of the PAS system).

Milestones off track	Target Date	What are we doing about it?
2.301: Centralisation of telephone triage	Jul-23	A planning meeting was held to redefine the scope of work to be completed to enable centralisation of the telephone Triage service; weekly meetings to be reformed to facilitate the revised model. Much of this work was complete through delivery of the original plan, and other elements are underway e.g. Triage PTL boards This will appear as an agenda item on the next Women's Health Care Group Governance meeting for agreement of the way forward, with an agreed revised date for completion.
2.401: No overdue (breached) SIs / HSIB investigations	May-23	While there are no overdue SIs/HSIB investigations (as reported in slide 5) and good progress made for open incidents and complaints, the current backlogs that we have are predicted to fall behind against the trajectory due to a management vacancy in the Governance team (Pt. Safety Matron). This milestone requires extending as part of the IIP review to reflect all maternity governance related performance indicators.

Key Project Risks	Residual Score
Revised model for telephone triage system not yet finalised	15
Revised Quality & Safety Framework not yet produced	12

What will be the impact of action? / Are we are assured?
There is good progress with the maternity programme and there is assurance that the mitigating action for the off track milestones will deliver the milestones within revised timescales.

Programme:	Operational Performance

Key progress in programme during last period
• Embedded the new front-door models at QEQM. • Learning from discharge re-set programme running at WHH to improve daily discharge numbers and close escalation beds applied to QEQM. • GIRFT UEC review (at the request of the Trust) commenced on 18th July. • SAFER discharge bundle rolled out at WHH. • Scoping completed with regards to implementing CDUs at WHH and QEQM to aid 12-hour performance. • Commencement of new hospital leadership arrangements at WHH and QEQM from 31st July. • Work with partners to refine the integrated hubs at WHH and QEQM to improve the discharge management of Pathway 1 and 3 patients. • Concluded discussions with regard to further Tier 1 related support. • Discharge re-set programme ran at WHH from July 10th until July 19th to refresh the approach to discharge management, improve daily discharge numbers and close escalation beds. Learning will be applied to QEQM. • 78-week trajectory for Otology remains as January 2024 – system meeting held 1 August 2023 (no alternate options identified to support recovery before January 2024). • Interim DCOO has commenced in post - key objectives of the post to review diagnostic delivery plans and support the cancer workstreams. • Patients are being transferred (via Inter Provider Transfer arrangement) to Independent Sector Provider following confirmation the ICB will fully fund the transfer of activity – commenced and will continue until financial year end. • Discussion with the system have taken place on urology mutual aid. • New process agreed for vetting diagnostic referrals RANZAC protocol has been discussed within CSS and awaiting formal ratification to go live.

Milestones off track / due in next 2 months	Target Date	What are we doing about it?
3.111: Established pathways to the MDU at KCH (nurse led)	Jun-23	Pathways established. Confirmation received from ICB to fund majority of project, recruitment in early stages, which is delaying milestone completion.
3.113: WHH End of Life Model implemented	Jun-23	Work in progress. The model of care has been agreed. The medical cover impacted by staffing constraints.
3.205: Validation plan agreed and implemented for all diagnostic modalities utilising digital transformation available within the Trust	Jul-23	Process will be shared once finalised and approved. Set to Amber for July. Further work continue through to late August.
3.302: Internal improvements in place to meet 62-day compliance	Aug-23	509 breaches at the time of writing (15/08/23) this is an unvalidated figure.

Key Project Risks	Residual Score
Diagnostic delays in cancer pathways due to increased activity	15
Inability to comply with 2023/24 activity plan	12
NLFTR position to support emergency flow and 12 hour breach reduction	9
78 week elimination due to inability to secure additional endoscopy and otology capacity	TBC
Inability to fully validate patients at 12 week wait as per Board assurance letter	TBC

What will be the impact of action? / Are we are assured?
Whilst some progress is being made with operational performance sustainable improvement is not yet in evidence therefore there is partial assurance for this programme.

Programme:	People & Culture

Key progress in programme during last period
• Pastoral Care award completed and awarded. • Detailed absence audit completed. • Completed action plan based on outcomes of absence audit. • Updated Nursing Pipeline plan with changes to approach in IENs. • Launch events for change team held on the 3rd July and 10th July with positive response and acknowledgement there is work to do to embed and deliver long term culture change and leadership. • EDI strategy and policy completed and prepared for sign off late July. • Exec risk matrix developed. • Medical attraction plan and detailed social media plan being followed • Development of PID and paper for rostering

Milestones off track	Target Date	What are we doing about it?
5.102: Workforce specialty developed plans linked to clinical adjacencies	Jun-23	Plans complete, awaiting sign off internally. Action plans will then become BAU.
5.103: Workforce strategy inclusive of recruitment strategy developed and communicated	Jun-23	Strategy finalised and is now going through approval process, once approved by P&C committee this will be communicated across the organisation.
5.106: Nursing pipeline plan developed 3-5 years	Jul-23	Plan developed - updates received and revised version to be submitted to Head of P&C Programmes to review initially.
5.108: Appraisal quality reviews	Jul-23	Limited responses received to date, milestone has gone off track in this period. Further discussions to be progressed to agree next actions required to improve milestone progression.
5.209: Culture & Leadership Development rolled out Trust wide	Jul-23	Diagnostic phase 2 required and commenced in July 2023 and due to complete by December 23 (discovery phase).
5.210: Define EDI Strategy & Plan	Jul-23	EDI Policy for Workforce requires approval at Staff Committee before approval at PAG.
5.303: Dashboard for medical attraction and trends built	Jun-23	Working group in place and working towards target date of end of Sept to have a skeleton dashboard.

Key Project Risks	Residual Score
RSP funding 'at risk' to provide People & Culture programme	9
Capacity to scale up delivery of the Leadership Development Programme	16
Culture and Leadership Programme currently not aligned with wider IIP programmes	9
Funding required to undertake practical arrangements for Culture and Leadership Programme trustwide	9
Lack of senior medical leadership, resource in information team, changes in personnel in care groups	16

What will be the impact of action? / Are we are assured?
There is assurance that the mitigating action for the off track milestones will deliver the milestones within revised timescales.

Integrated Improvement Plan Communications and Engagement Update: August

Key progress during last period:

- 'Meet your change team' campaign begun, sharing CLP change team members' stories in weekly Trust newsletter and Staff Facebook page, including video messages
- Promotion of Freedom to Speak Up training which is now mandatory for all staff
- Feedback to all staff on savings ideas submitted so far through the financial consciousness campaign, front-page Trust News about financial controls, Team brief: restructure/finance
- Filming staff-led values video with colleagues across Trust to build engagement and pride
- Internal and external comms celebrating staff and patient stories, including Pastoral Care Award featured on ITV Meridian and cardiology patient and clinicians on BBC Radio Kent
- Supported SAFER roll-out at WHH, communications assets/coverage in weekly newsletter
- To build on 'East Kent Conversation', we have added staff suggestion boxes as another way for staff to give feedback, these have been produced and being distributed across sites
- Monthly round-up of stories about wards/teams using 'We care' in Trust News
- Restructure consultation outcome published
- 'Your hospitals' patient and public magazine printed, content includes patient stories and an update on maternity/Reading the Signals progress
- Trust Comms & Engagement Strategy refreshed with RTS Oversight Group
- Monthly stakeholder bulletin included maternity, ED improvement, compassion video

Limitations to delivery of Comms & Engagement plan:

- Number and pace of initiatives for staff to be aware of/engaged in. Mitigation for this; 'joining the dots' in the narrative to describe how each supports our improvement journey; a monthly focus on one key theme.

Plan for next month:

- Implement CLP leadership survey communications campaign and publication of assets to describe what the CLP journey will look like
- EKHUFT Improvement Journey Week staff campaign w/c 18 September
- 'Check in' face-to-face staff engagement initiative launches, with Chairman Niall Dickson at QEQM emergency department 20 Sept
- Campaign to launch annual NHS Staff Survey
- See ME first Equality, Diversity and Inclusion campaign to launch during National Inclusion Week w/c 25 September
- Continue to link patient and staff stories to improvement plan and use campaign approach to engage all staff in individual projects
- Team brief to be formalised with attendance register for new care groups
- Development of Lobbying plan linked to Capital Estates Requirement
- Annual Members' Meeting 28 September.

Evidence of impact of actions undertaken:

- 85 senior staff attended August's team brief, sent to 270 senior staff to use
- 40 staff submitted financial saving suggestions in August, taking total to 145
- Combined maternity social media following now 6k with addition of new Maternity-specific Twitter/X account.

High Level IIP Programme Risk Summary

Definitions

Movement in month – Key:

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

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Key risks to delivery in this period:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Mitigating Actions	Date of Last Review	Residual Risk Score	Risk Trend
3.3.01	14.06.23	Operational Performance	Dylan Jones	Diagnostic delays in cancer pathways due to increase in activity.	20	a) Radiology improvement meeting weekly b) Radiology reports waiting longer than 15 days post diagnostic are prioritised and cleared. c) All diagnostics are aimed to be booked within 5-10 days of receiving referral. d) Specific focus required on Endoscopy and Urology pathways and capacity. e) Heavy sedation capacity for Endoscopy to be agreed. f) Mutual Aid plan for urology to be agreed.	23.08.23	16	⬌
4.1.01	14.06.23	Quality & Safety	Jane Dickson/ Rebecca Martin	Not upgrading our system to the most up to date version (as with all Trusts using Datix) will delay the PSIRF transition. The Trust has been supported in this work with an agency Datix Project Lead. This post was initially funded by NHSE for 6 months until March 23. As there is not the specialist capability within the Trust to continue managing the Datix upgrade without this support. This specialist remains in post supporting the Trust, however in doing so is incurring a financial overspend.	20	a) This has been escalated to a Director at Datix for their intervention. It is unlikely that we will meet the deadline for September 23 (as with all Trusts using Datix). b) Full cost of overspend being costed for the agency Datix Project Lead. c) A business case is being developed to secure an alternative system, which will be aligned to other Kent and Medway Trusts.	23.08.23	16	⬌
5.2.04	14.06.23	People & Culture	Andrea Ashman	Capacity is limited (only 3.6wte available) in order to scale up delivery of the Leadership Development Programmes at each of the levels required (Leading Others, First Line Leader, Mid-level Leader) as planned. Each of these 5-day programmes are scheduled to run 3x per annum and to do so will require more facilitators. The team are also holding a vacancy due to the required financial efficiencies.	16	a) People and Culture team currently in consultation phase with potential to realign posts to support delivery of Leadership Programme. b) Consultation to conclude 14th July with implementation to follow.	23.08.23	16	⬌
2.3.01	29.06.23	Maternity	Jane Dickson	The original model for this service has been revised by the incoming substantive Director of Midwifery (DoM) meaning that systems which underpin this service need to be reconsidered and revised. Until agreed and implemented, the current triage system remains in place.	15	a) Existing telephone triage system remains operational with supporting guideline in place. b) A planning meeting was held 06/07 to redefine the scope of work to be completed to enable centralisation. c) Weekly meetings to be reformed to facilitate revised model with much of the work completed through delivery of the original plan and other elements are underway i.e. triage PTL boards. d) This will appear as an agenda item on the next Women's Health Care Group Governance meeting on 28th July for agreement of way forward with a revised date for completion.	23.08.23	15	⬌
3.4.01	23.08.23	Operational Performance	Dylan Jones	Delays to eliminate 78 week waits due to inability to secure additional endoscopy and otology capacity immediately before January 2024.	15	a) No immediate mitigation to reduce 78 week breaches before January 2024. Work continues to explore.	23.08.23	15	★

High Level IIP Programme Risk Summary

East Kent Hospitals University NHS Foundation Trust

Opened risks in this period:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Mitigating Actions	Date of Last Review	Residual Risk Score
5.2.05	09.08.23	People & Culture	Andrea Ashman	No CMO in place to provide senior medical leadership for some of the workstreams. Staffing/ resourcing in information team dedicated to workforce will impact on development of dashboards. Trustwide reorganisation will impact on delivery of requested dashboards – additional work in information (additionally reorganisation of P&C teams will cause some delay. Also management teams in Care Groups will have changed and now new people to engage with. Engagement/ appetite for e-rostering is mixed amongst medical colleagues – previous attempts have not been successful coupled with lack of CMO in post.	16	a) Continuation of development of basic plans to suggest to key stakeholders - agreement required from SIC on who takes on SRO in absence of CMO. b) Engagement with an interim CMO and DCMO on programmes of work and suggested way forward. "	23.08.23	TBC Need Andrea to confirm
6.1.03	07.08.23	Finance	Michelle Stevens	Risk to the delivery of the Trusts 2023/24 Efficiency Plan.	16	a) Enhanced Controls measures have been issued to all care groups to ensure adherence to the national controls required for a level 4 organisation	23.08.23	12
6.1.04	07.08.23	Finance	Michelle Stevens	Risk of identifying and prioritising the development of "harder to achieve" improvements from Care Groups.	16	a) Conversations are on going with care groups to fully understand areas which could be explored to reduce spend but with a clear understanding of the clinical impact on the decisions.	23.08.23	12
4.3.02	09.08.23	Quality & Safety	Jane Dickson	Head of Nursing for FoC & Quality (who is also clinical Lead for Nutrition) is currently recruited on an interim arrangement until end September 23 with no clear plan for extension to temporary arrangements or if position is required substantively. Post holder is chair of key quality strategic meetings, project lead for IIP FoC, line manager of specialist nurses, coach & mentor to nursing teams. Risk of instability to lead on FoC workstreams if future of post is not agreed promptly.	16	a) Corporate team restructure is currently being reviewed.	23.08.23	12
3.4.01	23.08.23	Operational Performance	Dylan Jones	Delays to eliminate 78 week waits due to inability to secure additional endoscopy and otology capacity immediately before January 2024.	15	a) No immediate mitigation to reduce 78-week breaches before January 2024. Work continues to explore.	23.08.23	15
3.5.01	23.08.23	Operational Performance	Dylan Jones	Inability to fully validate all patients from 12 weeks wait as per Board Assurance letter received 4 August due to lack of capacity.	8	a) System wide challenge acknowledged at Planned Care Board 22nd August 23. b) Proceed with two-way text message roll out. c) Review of EKHUFT Access Governance/Validation workforce compared to MFT/MTW/DGHd) Progress patient portal opportunities with IT to consider role in validation.	23.08.23	6

High Level IIP Programme Risk Summary

East Kent Hospitals University NHS Foundation Trust

Closed risks in this period:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Update	Date of Last Review	Residual Risk Score	Risk Trend
2.3.02	29.06.23	Maternity	Jane Dickson	Postnatal guideline was not reviewed as planned by the WH guideline group on 16 June 2023. This poses a threat to the milestone date of July and until the service will continue to operate the current discharge model.	15	Postnatal guideline has since been updated, ratified through appropriate governance and published on 4th August 23 which sets out the improved model for the discharge pathway.	23.08.23	9	↓

Summary

- At the beginning of the reporting period 17 risks were recorded on the IIP risk register.
- 2 new potential risks were discussed in the last reporting period however, through further investigation these are deemed as duplications and agreed not to add to the risk register separately including; endoscopy cancer pathways being booked to 6wks+, this is covered within risk 3.3.01 and lack of flow in UEC pathways is recorded on the Trusts corporate risk register.
- 6 new risks have been added during this reporting period – see slide 22.
- In total 23 key areas of risk discussed in this period relating to delivery against the IIP with 1 risk closed relating to postnatal guidance as the guideline has since been ratified and published setting out the improved model for the discharge pathway in maternity (as above).
- There has been no movement in month with risk scores.
- 22 risks remain open on the IIP risk register, summary per programme is as follows; 4 Finance (increase of 2), 2 Leadership & Governance, 2 Maternity (decrease of 1), 5 Operational Performance (increase of 2), 4 People & Culture (increase of 1), 4 Quality & Safety risks (increase of 1).
- Work continues to strengthen risk monitoring within the IIP with particular focus on ‘confirm & challenge’.
- Please see Appendix A for a full detailed IIP Risk Register.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Board Assurance Framework Risk Register**

Meeting date: **7 September 2023**

Board sponsor: **Interim Chief Nursing and Midwifery Officer**

Paper Author: **Risk Manager**

Appendices:

Appendix 1: Board Assurance Framework 11.08.2023

Executive summary:

Action required:	**Approval**
Purpose of the Report:	This report provides the BoD with update on and changes to risks on the Board Assurance Framework (BAF) as at 11 August 2023. It also includes an update on Board Committee risk activity during this reporting period including the Board Development Strategy Day held on 1 August 2023.
Summary of key issues:	**Headlines**: There a total of nine risks on the BAF. **New risks**: There have been no new risks added to the BAF in this reporting period. There has been one risk closed and four decreases in risk scores. **Other changes**: Other changes to the risk records are included in the BAF risk register at Appendix 1. **Quarter One Performance**: The full quarter one performance data (i.e. April to June) and related commentary is shown on Page 4. **Board Committees risk activity**: Risk activity summaries for meetings held in quarter one are included on pages 5-7. This includes the Board Strategy Development Day held on 1 August 2023. **Risk Appetite Statement**: At the Strategy Development Day on 1 August 2023 the Board set the risk appetite levels using the Good Governance Institute risk appetite matrix. The risk appetite statement is set out on page 7 for approval.
Key recommendations:	The BoD is asked to **APPROVE** the latest update on the BAF and discuss whether: • The correct risks are identified on the BAF; • Any reports or assurances received in the work of the Board and its Committees impact on the assurance levels in the BAF; • Controls, assurance, gaps and actions are appropriate; • Any further controls may be required to mitigate the risks identified; • It is **assured** that risks on the BAF are being appropriately mitigated. The BoD is asked to **APPROVE** the revised risk appetite statements.

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Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	This paper provides an update on the BAF.
Link to the Corporate Risk Register (CRR):	This paper provides an update on the CRR.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: Executive Risk Assurance Group; Board Committees – People and Culture Committee, Finance and Performance Committee, Quality and Safety Committee, Integrated Audit and Governance Committee

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Board Assurance Framework Risk Register

1. Purpose of the report

1.1 This report provides the BoD with an update on and changes to risks on the Board Assurance Framework (BAF) as at 11 August 2023. It also includes an update on Board Committee risk activity during this reporting period.

2. Board Assurance Framework

2.1 The BAF contains the principal risks for the Board corporately to assure itself after successful delivery of the organisation's strategic objectives.

2.2 Since the last report to the BoD, there have been five key changes to the BAF risk register. Other key changes to the risk record during this reporting period have been highlighted in red font in Appendix 1.

2.3 Key changes – Decrease in risk rating 'Our Quality and Safety'

2.3.1 **Executive Risk Owner: Chief Medical Officer**

BAF 32 – There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered.

This risk was approved for reduction by the Quality and Safety Committee following recommendation by the Chief Medical Officer as the likelihood of a catastrophic impact (5) occurring has reduced from likely (4) to possible (3). This will reduce the overall risk from an extreme (20) to a high (15).

2.4 Key changes – Decrease in risk rating 'Our Sustainability'

2.4.1 **Executive Risk Owner: Chief Finance Officer**

BAF 41 – Failure to deliver the financial plan of the Trust as requested by NHSE for 2023/24

This risk was approved for reduction by the Finance and Performance Committee following recommendation by the Chief Finance Officer. The impact has reduced from catastrophic (5) to significant (4) and the likelihood has reduced from almost certain (5) to likely (4). This reduces the risk from an extreme (25) to a high (16).

2.5 Key changes – Decrease in risk rating 'Our People'

2.5.1 **Executive Risk Owner: Chief People Officer**

BAF 40 – There is a risk of failure to address inequality, lack of diversity and injustice for staff working at East Kent Hospitals

This risk was approved for reduction by the People and Culture Committee following recommendation by the Chief People Officer. The impact has reduced from significant (4) to moderate (3). An engagement framework has been developed and a refreshed EDI strategy is due to be published in July. This will reduce the overall risk from a moderate (12) to a moderate (9).

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2.5.2 **Executive Risk Owner: Chief People Officer**
BAF 35 – There is a risk of failure to recruit and retain high calibre staff
This risk was approved for reduction by the People and Culture Committee following recommendation by the Chief People Officer. The impact has reduced from catastrophic (5) to significant (4). A significant number of nursing staff have been recruited. An area of outstanding risk is hard to recruit medical specialties the risk of which is managed in its own right on the Corporate Risk Register.

2.6 Key changes – Closure of risk 'Our Quality and Safety'

2.6.1 **Executive Risk Owner: Executive Director of Infection Prevention and Control**
BAF 31 – Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements
This risk was approved for closure by the Quality and Safety Committee following review by the Executive Director of Infection Prevention and Control. The risk as is on the Board Assurance Framework is not reflective of the Trust's strategic objectives and the ability to mitigate the risk to the target level is limited. An additional risk has been added to the Corporate Risk Register which addresses outstanding actions from this risk.

2.7 Quarterly Performance: The Trust's risk management framework links risks to the Trust's strategic objectives. The BAF will be reported to the Board and its Committees alongside the Integrated Performance Report (IPR) on a quarterly basis.

2.7.1 The IPR forms the summary view of organisational performance against the strategic objectives and looking at the BAF risks in parallel will support the Board in determining whether the risks are appropriately managed, whether the risk appetite is set at the right level and whether further resources are required to control the risk.

2.7.2 The table below provides an aggregated overview of the performance against the True Norths as at quarter one.

True Norths		**Q1 Performance**	**Related BAF Risk and Risk Movement**	**Risk Appetite and Risk Appetite status in bracket**	**Overall Assurance**
Our Patients	Over 12 Hour Wait	Red	BAF 34 (High) =	High (within appetite)	Limited
	18 Weeks	Red			
	Cancer 62 day	Red			
Our People	Staff Engagement	Red	BAF 35 (High) =	Significant (within appetite)	Limited
Our Future	No related True Norths	N/A	BAF 36 (Extreme) =	Significant (within appetite)	Limited

East Kent Hospitals University NHS Foundation Trust

True Norths		Q1 Performance	Related BAF Risk and Risk Movement	Risk Appetite and Risk Appetite status in bracket	Overall Assurance
Our Sustainability	I&E Margin	Red	BAF 41 (High) ↓	High (within appetite)	Limited
Our Quality and Safety	Actual Harm	Red	BAF 32 (High) =	High (within appetite)	Limited

3. Board Assurance Framework Movement Tracker

BAF ref.	Risk Title	Movement of the current risk rating within the year												Target risk rating
		A	S	O	N	D	J	F	M	A	M	J	J	
36	Failure to implement the strategic change required to address the service delivery, workforce and estate condition identified in the Pre-Consultation Business Case (PCBC)	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	5
39	There is a risk that women and their families will not have confidence in east Kent maternity services if the Trust does not respond effectively to the recommended themes of 'Reading the Signals' report		20 N	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	15
41	Failure to deliver the financial plan of the Trust as requested by NHSE for 2023/24								25 N	25 =	25 =	16 ↓	16 =	12
34	There is a risk that our constitutional standards are not met	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	8
32	There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered.	15 =	15 =	15 =	15 =	15 =	15 =	15 =	20 ↑	20 =	20 =	15 ↓	15 =	5
35	There is a risk of failure to recruit and retain high calibre staff	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	12 ↓	8
30	Failure to deliver the full benefits of the We Care Improvement System	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	4
33	There is a risk of failure to adequately resource, implement and embed effective governance processes throughout the Trust.	10 =	10 =	10 =	10 =	10 =	10 =	10 =	10 =	10 =	10 =	10 =	10 =	5
40	There is a risk of failure to address inequality, lack of diversity and injustice for staff working at East Kent Hospitals	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	9 ↓	6

4. Board Committee Risk Activity

4.1 Quality and Safety Committee (Q&SC)

4.1.1 At the meeting on 25 April 2023, the Committee sought assurance that progress had been made on the revision of the Corporate Risk Register (CRR) and highlighted that the risk score had not changed for the last 12 months.

4.1.2 The Chair informed the Committee that the Chairman requested to discuss a revised approach to risk management within the Trust, which will include Non-Executive Directors (NEDs). This would be based on best practice from other organisations and expert opinion. This work would be led by the Interim Chief Nursing and Midwifery Officer (CNMO) and interim Director of Quality Governance.

4.1.3 At the meeting on 23 May 2023, the Committee received and noted the content of the report highlighting that revision of the Corporate Risk Register (CRR) was progressing.

4.1.4 At the meeting on 27 June 2023, the Committee approved the changes and updates of the BAF and CRR.

4.1.5 The Committee sought assurance that the revision of the CRR was on track and issues and risks would be separated. The Committee also queried if the assessment of acceptable risk would be made. The Interim Director of Quality Governance assured the Committee that the risks and issues were being separated and the risk appetite would be discussed at the Board Development Day in August 2023.

4.2 Finance and Performance Committee (FPC)

4.2.1 At the meeting on 25 April 2023, the FPC discussed and approved the Board Assurance Framework and Principal Mitigated Financial and Performance Risks.

4.2.2 The Committee requested that two additional risks be reviewed for submission to the risk register

4.2.2.1 Failure to secure sufficient capital;

4.2.2.2 Failure to deliver the reduction of not fit to reside patients to 178.

4.2.3 At the meeting on 23 May 2023, the FPC did not fully discuss the BAF and Principal Mitigated Financial and Performance Risks (as no Executive/Risk Manager present at meeting).

4.2.4 At the meeting on 27 June 2023, the Committee discussed and approved the Board Assurance Framework and Corporate Risk Register.

4.3 People and Culture Committee (P&CC)

4.3.1 At the meeting on 26 April 2023, the P&CC received assurance that the risks relating to 'Our People' are being appropriately mitigated with no new risks added to the BAF or CRR in the reporting period.

4.3.2 At the meeting on 24 May 2023, the P&CC received partial assurance that the risks relating to 'Our People' are being appropriately mitigated with no new risks added to the BAF or CRR in the reporting period.

4.3.3 The Committee asked the Trust Risk Team to review the key risks and risk rating with the Executive Team and report back to the Committee at the next full meeting.

4.3.4 At the meeting on 30 June 2023, the P&CC received assurance that the risks relating to 'Our People' are being appropriately mitigated with no new risks added to the BAF or CRR in the reporting period.

4.3.5 The key highlights were

4.3.5.1 BAF 40 – Risk of failure to address equality, lack of diversity and injustice – rating changed from significant to moderate, reflecting the work now in place with the Equality, Diversity and Inclusion (EDI) team and NHS England's (NHSE's) 'gold' rating of our EDI strategy.

4.3.5.2 BAF 35 – Risk to recruit and retain high calibre staff – rating reduced from catastrophic to significant, reflecting the significant work undertaken to increase headcount and improve staff retention.

4.3.5.3 CRR 118 – address poor organisational structure – rating reduced from 16 to 12 – reflecting the new structure being implemented.

4.3.5.4 CRR 88 – risk of failing to support staff wellbeing – rating reduced from 16 to 9 – reflecting the lowering sickness and turnover.

4.3.5.5 CRR 116 – sufficient nursing – rating reduced from 20 to 16, reflect the significant recruitment work undertaken.

4.3.5.6 CRR 122 – sufficient midwifery staff – reduced from 20 to 16 (pending further review).

4.3.5.7 New risk – appraisals now escalated to the CRR as referred to above.

4.4 Integrated Audit and Governance Committee (IAGC)

4.4.1 At the meeting on 28 July 2023, the IAGC received partial assurance from the latest BAF and CRR update report.

4.4.2 Continued work to make improvements to the BAF and CRR, risk review process, escalation process and risks being appropriately mitigated and actions were having a positive impact to reduce risk scores. As well as work in progress to refine the risk registers, update the Risk Management Strategy, tightening controls and monitoring oversight, working with staff (looking at provision of staff training) to improve risk descriptions and scores to ensure mature risks are presented in the future.

4.4.3 The Committee acknowledged the Trust's significant financial position and risk of achieving the financial plan that remained a significant risk.

4.4.4 The importance of continued ongoing robust challenge and discussions of risks, risk scores and mitigations to reduce level of risks at Board Committees, and within the Care Groups.

4.5 Board of Directors Strategy Development Day

4.5.1 At the Strategy Development Day on 1 August 2023 the Board set the risk appetite levels using the Good Governance Institute risk appetite matric. The risk appetite statement is set out below for approval.

4.5.2 Risk appetite is the level of risk that an organisation is prepared to accept in relation to an event/situation, after balancing the potential opportunities and threats that situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings.

- We have a **CAUTIOUS** appetite for **FINANCIAL** risks. We are prepared to accept the possibility of limited financial risk. However, value for is our primary concern.
- We have a **MINIMAL** appetite for **REGULATORY** risks. We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.
- We have a **CAUTIOUS** appetite for **QUALITY** risks. Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.

- We have an **OPEN** appetite for **REPUTATIONAL** risks. We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.
- We have an **OPEN** appetite for **PEOPLE** risks. We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.

East Kent Hospitals University NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK (BAF) (as at 11 August 2023)

QUARTER 1 – 2023/2024

STRATEGIC GOAL: 1) Our Quality & Safety:
Strategic Objective: The True North target is to achieve zero patient safety incidents of moderate and avoidable harm within 5 years. 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.

Executive Owner: Chief Medical Officer (CMO)
Responsible Committee: Quality and Safety Committee

Date last reviewed: July 2023
Next review scheduled: August 2023
Date risk identified: May 2021

Principal Risk – BAF 32
There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered.

Effect: Poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers, financial impact

Risk Appetite
The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L3 x S5 = 15

Movement of the current risk rating within the year												Projected for 23/24			
J	A	S	O	N	D	J	F	M	A	M	J	Q1	Q2	Q3	Q4
15	15	15	15	15	15	15	15	20	20	20	15				
=	=	=	=	=	=	=	=	↑	=	=	↓				

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 31 March 2025

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities

Aligned BAF Risks
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)
Aligned Corporate Risks
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)
77 – Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services (15)
110 – Children may receive sub-optimal quality of care and poor patient experience within our children's services (15)
36 – Patient outcome, experience and safety may be compromised as a consequence of failure to 1. Identify patients with additional vulnerabilities (adult and children) 2. Assess their needs 3. Plan appropriate care, including relevant safeguarding legislation and local safeguarding policies 4. Mitigate any risks 5. Work in line with relevant legislation (including Children Act, Care Act, Mental Capacity Act, Equalities Act, Mental Health Act) (12)
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)
122 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate midwifery staffing levels and skill mix to meet patient's needs (20)
123 - 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 (15)
78 – There is a risk of overcrowding in ED due to a lack of capacity in the system and increased local demand
139 – Trust fails to adequately investigate clinical incidents in a timely manner and identify themes in order to action change and avoid future repetition

Emergent Risks/Issues
- Change in focus of We Care objectives
- Use of escalation areas across the Trust
- We Care objectives need to be redefined in view of current priorities
- Identification and response to the deteriorating adult and child
- Capacity of staff to deliver focused improvements
- Timely access and response to diagnostics
- Learning from serious incidents, complaints, mortality, incidents and claims

Future Opportunities
- Realisation of Safer Staffing Business Case
- We Care Improvement Programme – In Year Breakthrough Objectives
- RSP exit

Risk and Scoring Commentary

Rationale for Current risk score
The current risk score is rated as a high (15) risk. The severity of the risk is scored as extreme (5), due to the number of patients affected by the risk; potential for multiple permanent injuries; non-compliance with national standards with significant risk to patients if unresolved; sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.
The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.

Latest Commentary
Governance review being undertaken, due to report to the IAGC in July 2023 then CEMG in August for consultation. The inaugural meeting of the Clinical Guidelines Authorisation Group took place in April. Mortality lead appointed, action closed. Deteriorating patient workstream incorporated into Integrated Improvement Plan with lead identified, assurance will be provided through the Strategic Improvement Committee. Quality priorities agreed as part of Quality Account. Mortality metrics are all as expected or lower than expected.

Actions (Planned)

Action required and date
1) Outcome of governance review to define and agree governance and reporting by subsidiaries **Chief Executive Jul 23**
2) Roll-out of MicroGuide across specialties **Director of Quality Governance Mar 25**
3) Work to address deteriorating patient incorporated in Integrated Improvement Plan **CMO Dec 23**
4) Agree Quality Improvement workstreams through We Care **Executive Director of Strategic Development and Partnerships Jun 23**

Controls in place (Existing)

1) The Quality Strategy (2022-2026), approved at Board of Directors (BoD), Sep 22
2) Three-year improvement plan developed
3) Reduction in harm and reduction in mortality are True North objectives agreed by the Executive team and progress monitored monthly at Executive management Team meetings and reported in the Board Integrated Performance Report (IPR)
4) NHSE led Governance review supported restructure and revised terms of reference for the Q&SC
5) Breakthrough Objectives aligned to True North are monitored at monthly Executive management Team meetings and reported in the Board IPR

Assurances

Internal
1) Mortality metrics reported in the Integrated Performance Report to Board of Directors. The metrics show that we are better or as expected.
2) Approval and monitoring of the Trust Quality Strategy through SLT, Q&SC and BoD.
3) Approval and monitoring of the Trust Quality Strategy, We Care objectives and Trust priority improvement projects through SLT, Q&SC and BoD
4) Integrated Improvement Plan monitored through Strategic Improvement Committee, monitoring deteriorating patient workstream and learning from serious incidents.

Gaps in controls and assurance

1) Improve oversight of health and safety governance that impacts on patient safety

6) Monthly performance Review Meetings established to ensure Care Group accountability against the delivery of quality and safety priorities, and to escalate new concerns to driver metric status through Catchball when identified	**External** 1) CQC reports monitored by the BoD and action plans developed and monitored by CQC and NHSE	2) Improve clinical outcomes through internal review, effective use of data and implementation of recommendations from national clinical audits and outcomes, NICE recommendations and Getting it Right First Time (GIRFT)
7) CQC Improvement meeting established under the Chair of CNO to monitor regulatory requirements to deliver safe care		3) Embedding of morbidity and mortality and outcome reviews
8) Systematic processes in place to review mortality		

STRATEGIC GOAL: 2) Our Patients:
Strategic Objective: There is no specific strategic objective, this risk is an enabler. A risk that has an impact on the achievement of our strategy but does not have a primary link to the metrics.

Executive Owners: Group Company Secretary (CoSec)
Responsible Committee: Quality and Safety Committee

Date last reviewed: June 2023
Next review scheduled: July 2023
Date risk identified: May 2021

Principal Risk – BAF 33
There is a risk of failure to adequately resource, implement and embed effective governance processes throughout the Trust.

Effect: Poor delivery and quality and safety of services; failure to meet statutory and regulatory requirements resulting in damage to reputation, regulatory action, harm patients, legal challenge.

Risk Appetite
The Trust has a **HIGH** appetite for risks to improve the quality and experience of the care we offer, so patients are treated in a timely way and access the best care at all times. We will be willing to consider all delivery options that provide acceptable levels of patient related outcomes. However, we will prefer not to take risks with compliance to external performance standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L2 x S5 = 10
Current Risk Rating: L2 x S5 = 10

Movement of the current risk rating with the year												Projected for 23/24			
J	J	A	S	O	N	D	J	F	M	A	M	Q1	Q2	Q3	Q4
10	10	10	10	10	10	10	10	10	10	10	10				
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 31 December 2022

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities

Aligned BAF Risks
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)
Aligned Corporate Risks
None

Emergent Risks/ Issues
- Strategies/policies not consistently followed and are not embedded
- Staffing structures may not be adequate to deliver the governance agenda.
- Knowledge and skills gaps identified

Future Opportunities
- CQC Well led review recognising improvements in governance.
- Trust evidencing improvements in the Leadership and Governance domain as part of the exit criteria of the Recovery Support Programme.

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a moderate (10) risk. The severity of the risk is scored as extreme (5), due to the potential for patient experience to be unsatisfactory; breaches of statutory duty and subsequent prosecution; adverse publicity undermining public confidence in organisation; inquest/ombudsman inquiry.
The likelihood of the risk is scored as unlikely (2), due to the expectation that the risk is not expected to crystallise due to the controls in place however it is possible it may do so.

Latest Commentary
The governance framework has been identified as a priority area of focus in the Integrated Improvement Plan. A clinical lead has been identified to review and refresh the governance model. The next step will be to implement and embed the clear framework for governance oversight within and through the Care Groups, ensuring that all staff are clear on their responsibilities for the management and learning from risks, incidents and complaints.

Actions (Planned)

Action required and date
1) Communicate/train and embed strategies/policies in relation to the governance framework **CoSec/EDQG Jul 22**
2) Ensure the knowledge, qualification and skills in the Care Group governance job descriptions are fit for purpose **COO Jul 22**
3) Recovery Support Programme Action plan to be delivered **Chief Finance Officer (CFO)** ~~**Dec 22**~~ **Mar 23**
4) Develop specific risk management training and roll out across the Trust **Corporate Governance and Risk Consultant** ~~**Jul Dec 22**~~ **Mar 23**
5) Develop integrated governance document to support understanding **CoSec** ~~**Jul**~~ **Oct 22**

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) Suite of governance policies in place	**Internal** 1) Policies are presented to PAG and BoD (if required) for ratification. Robust sign off process for policies including via groups and PAG 2) Challenge of BAF and CRR at Board and Board Committees 3) We Care meetings to provide evidence against progress for each metric 4) Calibration and challenge of risks on Care Group, Corporate and Board Assurance Framework (BAF) risk registers at ERAG **External** 1) RSM independent audit program (Risk management planned) 2) Regional oversight committees 3) Well-led governance review (NHSE)	1) Strategies/policies not consistently followed and are not embedded
2) Additional Executive post created, and portfolios split to provide more capacity and expertise. Director of Quality Governance appointed and joined the Trust May 21		2) Possible gaps in understanding of the breadth of both the clinical and corporate governance agenda
3) Organisational structure in place below Executive Level to support the governance agenda		
4) Governance Review Action plan in place and agreed with NHSE		
5) Terms of reference for various committees and groups approved		3) Deliver and embed the actions from the Governance Review action plan and agree how outcomes will be measured
6) Risk registers in place, BAF, CRR and Care Group level		4) Gaps in knowledge due to a lack of specific training in risk and governance, for all levels and roles
7) Incident Management, Complaints Management and Clinical Audit process in place		5) A lack of integrated governance document for the Trust to support understanding
8) Statutory training in place that includes elements of risk management		
9) Other training including incident investigation		

STRATEGIC GOAL: 2) Our Patients:
Strategic Objective: The National 62 Day Referral to Treatment requires all patients to receive treatment for Cancer within 62 days from GP referral. The new national standard is for no more than 2% of patients to spend longer than a total of 12 hours in the emergency department, from arrival until being admitted, transferred or discharged. The National RTT Standard is to achieve a maximum of 18 weeks wait from GP referral to 1st definitive treatment for every patient.

Executive Owners: Chief Operating Officer
Responsible Committee: Quality and Safety Committee

Date last reviewed: June 2023
Next review scheduled: July 2023
Date risk identified: May 2021

Principal Risk – BAF 34
There is a risk that our constitutional standards are not met

Effect:
Demand of patients who are requiring discharge from hospital on complex pathways for example if a nursing or residential placement is exceeding capacity. Patient experience in the ED is impacted as ED becomes more congested. This is driven by the restricted availability of an inpatient bed or assessment area. Impact of failing to deliver an elective recovery programme to the level of 19/20 pre-Covid activity. The Trust may remain in RSP and underperformance on the financial targets for 23/24 if agreed thresholds for improvement aren't reached these include the reduction of very long waiting patients and deliver 107% activity. The ability for Cancer to meet 52-day targets is impacted by the elongated diagnostic pathways due to increased demand and reduced capacity.

Risk Appetite
The Trust has a **HIGH** appetite for risks to improve the quality and experience of the care we offer, so patients are treated in a timely way and access the best care at all times. We will be willing to consider all delivery options that provide acceptable levels of patient related outcomes. However, we will prefer not to take risks with compliance to external performance standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S4 = 16
Current Risk Rating: L4 x S4 = 16

Movement of the current risk rating within the year												Projected for 23/24			
J	J	A	S	O	N	D	J	F	M	A	M	Q1	Q2	Q3	Q4
16	16	16	16	16	16	16	16	16	16	16	16	16	16	12	12
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L2 x S4 = 8
Projected Target Date: ~~31 December 2022~~ 31 March 2024

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities

Aligned Corporate Risks
CRR 78 – Risk of overcrowding in ED compromising patient safety and patient experience due to a lack of capacity in the system and increased local demand

Emergent Risks/ Issues
- Failure to manage the balance of demand and capacity and risk across the health and social care system
- With patients delayed in the hospital setting and the priority to off-load ambulances, care and treatment of patients is taking place outside an established inpatient and treatment area (escalation areas)
- Continued pressure on emergency department for both admitted and non0admitted patients
- The risk of a combined presence of covid-19 and influenza impacts on both restricted capacity and staff absence
- Cost of living crisis impacts on the health and well-being of vulnerable groups
- Industrial action in key health and care support services will have a cumulative impact
- Winter may impact on elective capacity and staff as emergency pressures build
- Capacity of the centralised booking team
- Capacity of key diagnostic services supporting cancer and elective pathways
- Increased referral demand exceeding outpatient capacity

Future Opportunities
- Structure services on cold and hot site scenario – allow us to have a clearer direct access pathway for patients
- Continued focus on length of stay, NLFTR status of patients and the information flow across the Trust. New models of care i.e. virtual wards
- Manage demand more effectively across the health and social care system to balance risk – cognisant and focused on quality issues around waiting list
- HCP recurrent funding allocations to support expansion of services at East Kent Hospitals for Extended SDEC, improved discharge lounges and increased staffing, increased MDU capacity, extended frailty service

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a high (16) risk. The severity of the risk is scored as significant (4), due to the number of patients affected by the risk; potential for increased length of hospital stay; non-compliance with national standards with significant risk to patients if unresolved; sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.
The likelihood of the risk is scored as likely (4), the severity will probably happen or recur but is not a persisting issue.

Latest Commentary
Due to the changeover in COO a further update to this risk is required with a view to reviewing key risks across all operational functions: business information, EPRR, Elective, Cancer and UEC.

Actions (Planned)

Action required and date
1) Monitor of progress and implementation of the actions across the five key workstreams under pinning the Emergency Care Delivery Group – ED Builds, Patient Flow, Front Door, Simple discharges, SDEC/Direct Access **UEC Lead, Mar 24**
2) Review of NLFTR, Medically Optimised patients and the RTS caseload to ensure improved communication supporting improved discharge processes for patients requiring on-going care needs. Additional resource being secured to support enhanced discharging COO Programme Manager, Deputy Head of Nursing (HoN) for General Surgery, Urology and Surgery and Anaesthetics Sep 23
3) SAFER roll-out planned July across sites **UEC Lead Jul 23**
4) ENT system meeting 22 June 2023 chaired by Planned Care Lead (CEO Medway) to consider hub/spoke model and short-term recovery actions to reduce breaches before January 2024 **Interim Director for Elective Care, Mar 23**
5) Development of Trust Winter Plan 23/24 **COO Lead, Sep 23**
6) Refresh theatre improvement programme including inputting of additional resource and capacity **Interim Director of Elective Care, Sep 23**
7) Implement additional PTL meetings across specialties where 78-week trajectory is at risk of not delivery **Interim Director for Elective Care Sep 23**
8) Refresh outpatient transformation actions and approve at Planned Care Transformation Group 15 June 2023 **Interim Director for Elective Care Sep 23**
9) Agree further roll out for STT in Lower GI **Cancer Ops Director Sep 23**
10) Agree interventions to reduce Endoscopy waiting times and therefore prolonged colorectal pathways **Cancer Ops Director Sep 23**
11) Urgently review the Urology pathway to mitigate capacity and efficiency risks Cancer Ops Director Sep 23
12) Implementation of the key priority work areas identified in the EK HCP Urgent Care Plan for 23/24 – Supporting workstreams are focussed on Increasing Urgent and Emergency Care Capacity, Making it easier to access the right care, Improving discharge, and expanding outside of hospital. Progress against agreed actions is being monitored

Controls in place (Existing)

1) Kent and Medway System Elective Care Programme Board and A&E Delivery Board provides system wide strategic direction attended by the COO. The A&E Delivery Board is chaired by the Trust CEO. The EK Planned Care Improvement Group is chaired by the Trust COO

2) The Kent and Medway ICS have engaged a Winter Director who will report to the Trust CEO and attend the A&E Delivery Board.

3) The Trust has established a Planned care board that meets monthly and covers a range of workstreams, short- and medium-term actions including theatre utilisation; diagnostic support cancer services and RTT position

Assurances

Internal
1) We Care Breakthrough Objective 'Improving theatre capacity' monitored monthly through the Integrated Performance Report presented to the BoD

External
1) Kent and Medway System Elective Care Programme Board reports to the ICS Partnership Board

Gaps in controls and assurance

1) Delivery of 25% of all patient appointments and 60% of all follow ups to be conducted virtually

2) Optimisation of additional capacity via ICB

3) Number of same day cancellations reducing theatre utilisation

4) Weekly monitoring at the PTL meeting is chaired by the COO. The Trust has weekly monitoring by a touch point meeting covering all RTT waiting list cohorts. It also monitors cancer and diagnostic performance.	4) Waiting list patients exceeding 104 weeks
5) Clinical and administrative validation of patients needing procedures to ensure the demand for specialty services can be appropriately managed	
6) Activity business planning targets set to meet two primary objectives: Hold the waiting list position throughout 23/24; ensure no patient is waiting longer than 65 weeks for treatment by March 24.	

STRATEGIC GOAL: 2) Our Patients:
Strategic Objective: There is no specific strategic objective, this risk is an enabler. A risk that has an impact on the achievement of our strategy but does not have a primary link to the metrics.

Executive Owners: Chief Nursing and Midwifery Officer (CNMO)
Responsible Committee: Quality and Safety Committee

Date last reviewed: July 2023
Next review scheduled: August 2023
Date risk identified: August 2022

Principal Risk – BAF 39
There is a risk that women and their families will not have confidence in east Kent maternity services if the Trust does not respond effectively to the recommended themes of 'Reading the Signals' report

Effect:

Risk Appetite
The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L4 x S5 = 20

Movement of the current risk rating within the year											Projected for 23/24			
J	J	A	S	O	N	D	J	F	M	A	M	Q1	Q2	Q3	Q4
			20	20	20	20	20	20	20	20	20				
			N	=	=	=	=	=	=	=	=				

Target Risk Rating: L3 x S5 = 15
Projected Target Date:

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities

Aligned BAF Risks
32 - There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered
Aligned Corporate Risks

Emergent Risks/ Issues
•

Future Opportunities
•

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as an extreme (20) risk. The severity of the risk is scored as significant (4), due to the Trust facing major difficulties which are likely to undermine its ability to deliver quality services.
The likelihood of the risk is scored as almost certain (5), the severity is more likely to occur than not with the current controls in place.

Latest Commentary
Risk reviewed with Interim Chief Nursing and Midwifery Officer. Consideration to be given to reducing the likelihood of the risk to a 3 (possible) which will reduce the overall risk rating to a high (15) at Quality and Safety Committee.

Actions (Planned)

Action required and date
1) Maternity Care Review Group continues with external specialists reviewing cases. Group to be handed over to CNMO by end July 2023.
2) Integrated Improvement plan incorporates the Pillars of Change delivery plan
3) Internal audit of effectiveness of MNAG
4) Monthly reporting to CQC following inspecting in January 2023
5) Delivery of must do and should do's identified in CQC inspection report **Sep 23**

Controls in place (Existing)

1) Regular open forums for staff with the Care Group and Executive Leadership
2) Regular walk arounds by the Maternity Safety Champions
3) Your Voice Is Heard – 6 week follow up calls after birth
4) Continued representation and reporting from Director of Midwifery and Clinical Director to Trust Board
5) Monthly safety summits for patient facing staff to speak directly with CNMO and NED maternity safety champion
6) Appointment of substantive Director of Midwifery and Deputy Director of Midwifery
7) Maternity Transformation Plan reviewed and codesigned with system partners and users

Assurances

Internal
1) Maternity Improvement Plan monitored by Maternity and Neonatal Assurance Group and reported to the Board of Directors
2) Maternity Dashboard in place
3) Your Voice Is Heard reported to MNAG
4) Volume of positive feedback from users based on Your Voice Is Heard
5) Reduction in type of reporting CQC has required following recent submissions in response to January inspections

External
1) Maternity and Neonatal Assurance Group has external Maternity Voices Partnership representation, NHSE Improvement Director, Local Maternity and Neonatal System representation
2) Integrated Improvement Plan monitored by NHSE
3) ICB Performance and Quality meeting

Gaps in controls and assurance

1) CQC inspection undertaken in January 2023 which highlighted areas for improvement and rated services as inadequate

STRATEGIC GOAL: 3) Our People:
Strategic Objective: Our aim is to improve our Staff Engagement Index score to 6.8 by March 2023, as demonstrated in the annual staff survey.

Executive Owner: Chief People Officer (CPO)
Responsible Committee: People and Culture Committee

Date last reviewed: July 2023
Next review scheduled: August 2023
Date risk identified: February 2016

Principal Risk – BAF 35
There is a risk of failure to recruit and retain high calibre staff

Effect: Negative patient outcomes, reputational damage, ability to deliver services, financial, patient harm, regulatory impact, staff wellbeing

Risk Appetite
The Trust has a **SIGNIFICANT** appetite for risks to making the Trust a great place to work. We will be innovative in taking risks in relation to workforce/staff engagement that will offer potential higher benefits to staff, patients and the organisation.
Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L3 x S4 = 9

Movement of the current risk rating within the year												Projected for 23/24			
J	A	S	O	N	D	J	F	M	A	M	J	Q1	Q2	Q3	Q4
15	15	15	15	15	15	15	15	15	15	15	12				
=	=	=	=	=	=	=	=	=	=	=	↓				

Target Risk Rating: L2 x S4 = 8
Projected Target Date: 30 April 2024

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities

Aligned BAF Risks
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)
Aligned Corporate Risks
CRR 115 – Staff health and wellbeing is compromised due to the sustained level of work created by Covid-19 pandemic
CRR 118 – There is a risk that the underlying organisational culture impacts on the improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace
CRR 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
CRR 122 – Inadequate midwifery staffing levels may result in women receiving sub-optimal care during labour
CRR 123 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate medical staffing levels and skill mix to meet patients' needs

Emergent Risks/ Issues
- Do not have the right establishment
- Accommodation
- Agenda for change pay scales for lower banded staff
- Delay in TNP digital solution affecting domestic recruitment numbers in pipeline

Future Opportunities
-

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a moderate (12) risk.
The severity of the risk is scored as significant (4), due to the uncertainty of delivery of key services due to lack of staff or ongoing unsafe staffing levels
The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.

Latest Commentary
International and domestic nurse and midwifery recruitment pipeline utilisation on target, reviewing the number of nurses required. Active involvement in east Kent HCP recruitment and retention strategy, this is being reviewed as there is a new approach around east Kent place-based partnership. Recruitment strategy has been updated and is being communicated.

Actions (Planned)

Action required and date
1a) Development of collaborative medical bank approach across the system **Deputy Chief People Officer Apr 23**
1b) International and domestic nurse and midwifery recruitment pipeline utilisation with cohorts planned throughout 2023 to achieve 150 additional nurses by Mar 2024 **Deputy Chief People Officer Mar 24**
2a) Links with HCP and newly formed Kent and Medway Medical School (KMMS) to develop rotational and joint posts to support medical staff recruitment **Chief Medical Officer Mar 23**
2b) Active involvement in east Kent HCP recruitment and retention strategy **Deputy Chief People Officer ~~ongoing,~~ 30 Apr 2023**
3) Delivery of actions in Rural and Remote Strategy **Associate Medical Director Mar 24**
4) Revamping recruitment strategy focusing on organisational brand and targeted recruitment campaigns **Deputy Chief People Officer ~~Feb~~ Apr 23**

Controls in place (Existing)

1) A five-year People Strategy – People at the Heart 2020-2025 has been approved by Trust Board and is monitored via the People and Culture Committee (PCC).
2) Engagement of staff scores are True North measures which are reported and monitored monthly via We Care and Staff Committee
3) A Recruitment and Retention Strategy with associated plans has been signed off and is monitored via the PCC
4) A Rural and Coastal Strategy led by the Associate Medical Director has been developed and agreed at Trust Board and is monitored via the PCC
5) The Director of HR and OD attends ICP workforce groups to align plans and develop other system side opportunities and agendas
6) A Diversity and Inclusion action plan has been developed and published as part of Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and is monitored via the Equality, Diversity and Inclusion (EDI) Steering Group, Staff Committee and reported to PCC
7) Medical recruitment toolkit launched on 24 September 2021
8) Developing a positive culture strategic initiative
9) Refreshed EDI strategy
10) Launch of cultural programme

Assurances

Internal
1) Approval and monitoring of the agreed HR KPIs (inc vacancy rate and engagement scores) are monitored via We Care and PRMs and reported at PCC.
2) The People Dashboard has been developed with the aim of demonstrating progress against the key objectives identified in the People Strategy. The Dashboard brings together information in an accessible and co-ordinated format that is reviewed as part of our regular People team processes each month and reported through the People and Culture Committee.
3) Workstreams and project work is monitored via the HR Senior Leads meeting, We Care and reported through PCC to BoD.

External
1) Review of EKHUFT's People Strategy via NHSE. Benchmarking and links with national People Team.
2) Director of HR and OD part of Future of NHS and OD national programme
3) Trust involvement in Kent and Medway Health and Wellbeing Board and Kent and Medway Recruitment and Retention Board

Gaps in controls and assurance

1) Lack of supply of professional qualified staff including AHPs is a national issue
2) Hard to recruit areas such as Nursing and Consultants have been identified

11) Revised People Strategy		
12) Ready to Care Programme in place		
13) Centralised booking team in place		

STRATEGIC GOAL: 3) Our People:
Strategic Objective: Our aim is to improve our Staff Engagement Index score to 6.8 by March 2023, as demonstrated in the annual staff survey.

Executive Owner: Chief People Officer (CPO)
Responsible Committee: People and Culture Committee

Date last reviewed: June 2023
Next review scheduled: July 2023
Date risk identified: August 2022

Principal Risk – BAF 40
There is a risk of failure to address inequality, lack of diversity and injustice for staff working at East Kent Hospitals.

Effect: Staff feel disengaged, discriminated against and excluded in the workplace resulting in a lack of opportunity to progress and meet their full potential; ultimately impacting negatively on patient care

Risk Appetite
The Trust has a **SIGNIFICANT** appetite for risks to making the Trust a great place to work. We will be innovative in taking risks in relation to workforce/staff engagement that will offer potential higher benefits to staff, patients and the organisation.
Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S4 = 16
Current Risk Rating: L3 x S3 = 9

Movement of the current risk rating within the year												Projected for 23/24			
J	A	S	O	N	D	J	F	M	A	M	J	Q1	Q2	Q3	Q4
	12	12	12	12	12	12	12	12	12	12	9				
	N	=	=	=	=	=	=	=	=	=	↓				

Target Risk Rating: L2 x S3 = 6
Projected Target Date: 31 March 2023

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned Corporate Risks CRR 118 – Failure to address poor organisational culture CRR 88 – Failure to support staff health & wellbeing	**Rationale for current risk score** The current risk score is rated as a moderate (9) risk. The severity of the risk is scored as moderate (3), due to the potential for low staff morale to affect 25-50% of staff. The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.	**Latest Commentary** Engagement framework developed. Refreshed recruitment strategy and refreshed EDI strategy to be published in July. Equality, diversity and inclusion training being undertaken at the Board development day in August. Proposal to reduce the risk rating to go to Executive Risk Assurance Group in June 2023.	**Action required and date** 1a) Programme for aspiring new leaders **Assistant Director of Organisational Development ~~Mar~~ Dec 23** 1b) Introduce reciprocal mentoring for Exec team **Chief People Officer ~~Dec 22 Mar 23~~ Aug 23** 2) Review and update Reasonable Adjustments policy **Head of Occupational Health ~~Dec 22 Jun~~ Aug 23** 3) Update Recruitment Strategy – ensuring EDI focus **Deputy Chief People Officer ~~Mar~~ Jun 23** 4) Equality, Diversity and Inclusion training to be delivered at Board Development Day **Chief People Officer Aug 23**
Emergent Risks/ Issues • Lack of appreciation and understanding of the experiences of BAME, other under-represented groups and those with a protected characteristic • Lack of opportunity to fulfil potential • Lack of equality of opportunity through selection processes • The Trust's management does not represent the diversity of the workforce			
Future Opportunities •			

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) New senior Head of EDI leading a small EDI team within P&C function working on project work	**Internal** 1) WRES and WDES reviewed and monitored via the EDI Steering Group, Staff Committee and reported to People and Culture Committee **External** 1)	1) Lack of EDI awareness in leadership/management population
2) Equality, Diversity and Inclusion Policy, Strategy & action plan in place		2) Staff Survey (2021) – staff with Long Term conditions report lack of adjustments in the workplace
3) Equality, Diversity and Inclusion mandatory training renewed three yearly		3) WRES and WDES data analysis shows BAME and disabled staff less likely to be appointed via a recruitment process
4) Staff networks in place for BAME, LGBTQ+, Disabilities and Women		4) Lack of EDI involvement in decision-making in the Trust
5) Culture and Leadership programme – focus on Equity & Inclusion		
6) External review in 2021 by Jagtar Singh Associates – informed approved EDI strategy		
7) Part of regional programme to de-bias recruitment		
8) Established P&C policy group to renew all staff policies to make them accessible for all, with thorough Equality Impact Assessments		
9) Exec and NED sponsors for all staff network groups		
10) Leadership programme has a focus and 'golden thread' of equality, diversity and inclusion		
11) Inclusion and Respect Charter		

STRATEGIC GOAL: 4) Our Future:
Strategic 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).**

Executive Owner: Interim Executive Director of Strategic Development and Partnerships
Responsible Committee: Finance and Performance Committee

Date last reviewed: May 2023
Next review scheduled: June 2023
Date risk identified: April 2021

Principal Risk – BAF 36
Failure to implement the strategic change required to address the service delivery, workforce and estate condition identified in the Pre-Consultation Business Case (PCBC)

Effect: Result in lapses in core clinical standards and patient safety issues, and may affect adherence to estate statutory compliance, increased estate backlog risks this could result in further emergency service moves/restrictions and impact on the Trust's reputation

Risk Appetite
The Trust has a SIGNIFICANT appetite for risks to transforming the way we provide services across east Kent. We will pursue innovation and challenge current working practices. We will use new technologies as a key enabler of operational delivery and devolve authority across the Trust to enable us to offer excellent integrated services.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L4 x S5 = 20

Movement of the current risk rating within the year												Projected for 23/24			
J	J	A	S	O	N	D	J	F	M	A	M	Q1	Q2	Q3	Q4
20	20	20	20	20	20	20	20	20	20	20	20				
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 31 Mar 2032

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities

Aligned Corporate Risks
CRR 127 – Failure to allocate and/or attract significant revenue and additional capital will inhibit the Trust's ability to adhere to statutory compliance, as well as the ability to rectify the identified backlog maintenance
CRR 115 – Staff health and wellbeing is compromised due to the sustained level of work created by Covid-19 pandemic
CRR 118 – There is a risk that the underlying organisational culture impacts on the improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace
CRR 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
CRR 122 – Inadequate midwifery staffing levels may result in women receiving sub-optimal care during labour
CRR 123 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate medical staffing levels and skill mix to meet patients' needs

Emergent Risks/ Issues
- Reliance on locums
- Risks are increasing due to retirement and covid

Future Opportunities
- Recruitment strategy (BAF 35)
- New hospital programme
- Emergency capital
- Robotic strategy
- Development of medical school

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as an extreme (20) risk. The severity of the risk is scored as catastrophic (5), due to the potential for permanent loss of core services, disruption to facility leading to significant 'knock-on' effect across local health economy and extended service closure.
The likelihood of the risk is scored as likely (4), the severity will probably happen or recur occasionally with the current controls in place.

Latest Commentary
No notification received as yet by the Trust regarding the new hospital improvement programme.

Actions (Planned)

Action required and date
1a) Trust has put in an expression of interest to join the new hospital improvement programme. Due to be finalised by Autumn 22. **EDSDP ~~Sep Oct Dec 22 Jan 23 Mar~~ Jun 23**
1b) Continue to lobby key stakeholders to maximise success of EOI **EDSDP ~~Sep Oct Dec 22 Jan 23 Mar~~ Jun 23**
1c) Clear lines of accountability and responsibility for the sign off, of the East Kent Transformation (including the PCBC) is identified in the east Kent HCP/ICB Partnership Board Strategic Priorities **CEO ~~Sep 22 Mar~~ Jun 23**
1d) Continue lobbying NHSE if expression of interest for new hospital improvement programme is not successful **EDSDP ~~Mar~~ Jun 23**
2a) Implement annual investment plan for statutory compliance and monitor in year improvements against the agreed trajectory for 22/23 **EDSDP Mar 23**
2b) Prioritise through SIG the investments for backlog maintenance as part of the PEIC capital investment programme. This will be informed by the Six Facet Survey, the work undertaken by NHSE on reducing the backlog position and the ARUP report. Investment will be monitored through FPC and BoD **EDSDP Mar 23**

Controls in place (Existing)
1) The Chairman and CEO confirm that the Sustainability and Transformation Partnership (STP)/ICS Partnership Board prioritises and signs off the East Kent Transformation for agreement with NHSE.
2) The Executive Director of Strategic Development and Partnerships ensure that the PCBC is signed off by the Trust's FPC and BoD.
3) The Executive Director of Strategic Development and Partnerships ensures that the implementation of the clinical strategy receives oversight from the Joint Development Board, SCP&PC and FPC
4) The Trust's position in terms of statutory compliance is published, reported and reviewed six-monthly by CEMG and the BoD
5) The Trust's investment programme in statutory compliance is approved by CEMG, FPC and BoD
6) The Trust wide backlog maintenance plan is approved and reviewed by SIG, CEMG, FPC and BoD
7) Rural and Coastal Recruitment Strategy

Assurances

Internal
1) Approval and monitoring of the Trust framework proposals and workstreams through Strategic Investment Group (SIG), CEMG, JDB, SCP&PC, Q&SC, FPC and BoD (Controls 2 and 3)
2) Minutes of JDB, CEMG, FPC, SIG, SCP&PC Q&SC and BoD (Controls 4,5 and 6)

External
1) Sign off by HCP, ICB and NHSE (Control 1)
2) Stage 2 assurance process passed awaiting allocation of capital (Control 1)

Gaps in controls and assurance
1) Final sign off and approval of capital investment is outstanding from NHSE
2) Gaps and risks relating to backlog and statutory compliance have been identified
3) Unable to consult
4) Risk appetite reduced by regulators. Derogation required from regulators to maintain services
5) Interim capital required to meet the compliance of estate and equipment risks

STRATEGIC GOAL: 4) Our Future:
Strategic Objective: There is no specific strategic objective, this risk is an enabler. A risk that has an impact on the achievement of our strategy but does not have a primary link to the metrics

Executive Owner: Chief Executive Officer
Responsible Committee: Finance and Performance Committee

Date last reviewed: March 2023
Next review scheduled: April 2023
Date risk identified: May 2020

Principal Risk – BAF 30
Failure to deliver the full benefits of the We Care Improvement system

Effect: Improvement plan will fail to deliver, sub-optimal implementation, financial impact, HR impact, reputational risk

Risk Appetite
The Trust has a SIGNIFICANT appetite for risks to transforming the way we provide services across east Kent. We will pursue innovation and challenge current working practices. We will use new technologies as a key enabler of operational delivery and devolve authority across the Trust to enable us to offer excellent integrated services.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S4 = 16
Current Risk Rating: L3 x S4 = 12

Movement of the current risk rating within the year												Projected for 23/24			
J	J	A	S	O	N	D	J	F	M	A	M	Q1	Q2	Q3	Q4
12	12	12	12	12	12	12	12	12	12	12	12				
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L1 x S4 = 4
Projected Target Date: 31 March 2026 (due to the four-year delivery plan of the change system)

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities

Aligned Corporate Risks
None

Emergent Risks/ Issues
- Change of executive directors

Future Opportunities
-

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a moderate (12) risk. The severity of the risk is scored as significant (4), due to the potential for the Trust to face some major difficulties which are likely to undermine its ability to deliver quality services on a daily basis and / or its long-term strategy. The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.

Latest Commentary
Risk reviewed with Site Director, QEQM. Business case for expansion of team is on hold due to changes in organisational structure. Additional action added.

Actions (Planned)

Action required and date
1) Business case to be developed to extend team to meet demand **Head of Transformation ~~Jun Sep 22~~ Jun 23**
2) Review of We Care following delivery of winter plan and how this will change with new care organisations **Head of Transformation Jun 23**

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) We Care Improvement Strategy approved by BoDs and implemented across the Trust. 2) SLT leads monthly cycle of the OMS and reports and update progress on implementation 3) Executive led workstreams in place (strategic deployment; OMS Frontline / Management; Leadership behaviours; Transformation and Step Change; Centre of Excellence; and Communications) reporting into SLT. 4) IPR linked into We Care and reports monthly to sub Board Committees and BoDs 5) Monthly PRMs with Care Groups wired in to We Care 6) Intensive Support process agreed for implementation as and when required.	**Internal** 1) Coaching and mentoring in place for Executive Team; Care Groups; and Frontline Teams. 2) Skills matrix agreed for internal Improvement Team, which links to personal objectives **External** 1) System has been implemented and proven to work in international healthcare systems (USA, Canada, Iceland) and in similarly complex NHS organisations. 2) VFM review undertaken by NHSE with positive findings reported. 3) Endorsement for the change model from the National Director for Lean Transformation	1) The system may not be sustained due to the size of the organisation and capacity of the transformation team to support

STRATEGIC GOAL: 5) Our Sustainability:
Strategic Objective: Our long term aim is to maintain a breakeven position

Executive Owner: Chief Finance Officer (CFO)
Responsible Committee: Finance and Performance Committee

Date last reviewed: July 2023
Next review scheduled: August 2023
Date risk identified: February 2023

Principal Risk – BAF 41
Failure to deliver the financial plan of the Trust as requested by NHSE for 2023/24

Effect: not having adequate cash to continue adequate operations of the organisation, potentially make poor financial decisions which will result in reputational damage and non-compliance with regulators.

Risk Appetite
The Trust has a HIGH appetite for taking financial risks within a context of clear and reliable financial controls. We are prepared to invest for return and minimise the possibility of financial loss by managing risks to a tolerable level. Value and benefits will be considered, not just the cheapest price. Resources will be allocated in order to capitalise on opportunities and provide better, more effective patient care.

Risk Appetite Status: Within appetite

Initial Risk Rating: L5 x S5 = 25
Current Risk Rating: L4 x S4 = 16

Movement of the current risk rating within the year												Projected for 23/24			
J	A	S	O	N	D	J	F	M	A	M	J	Q1	Q2	Q3	Q4
								25	25	25	16				
								N	=	=	↓				

Target Risk Rating: L3 x S4 = 12
Projected Target Date: 31 Mar 2024

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned Corporate Risks • Efficiencies delivery • Elective recovery fund delivery **Emergent Risks/ Issues** • Efficiencies delivery • Elective recovery fund delivery • Corporate memory/changing leadership **Future Opportunities** •	**Rationale for current risk score** The current risk score is rated as a high (16) risk. The severity of the risk is scored as significant (4), due to the financial impact. The likelihood of the risk is scored as likely (4), the severity will probably happen or recur occasionally with the current controls in place.	**Latest Commentary** Risk reviewed with Interim Chief Finance Officer.	**Action required and date** 1) Develop medium-term and long-term financial plans in conjunction with NHSE and Kent and Medway ICB **CFO** ~~**Jun Jul 23**~~ **Jan 24**

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) The Chief Finance Officer is the lead for this risk, and it is managed through the Finance and Performance Committee, Clinical Executive Management Group, Finance and Investment Oversight Group, Performance Meetings with Care Groups and Directors 2) Individual finance reports go to Care Groups on a monthly basis. Finance is monitored through the monthly IPR plus Finance report which goes to Finance and Performance Committee and Trust Board on a monthly basis 3) Other controls in place; annual business planning process, annual cost improvement programme developed, fortnightly financial control meeting in place. 4) Financial turnaround specialist in place for six months	**Internal** 1) Monthly performance meetings are held with Care Groups 2) The financial plan and monthly performance are monitored and minuted at the Finance and Performance Committee and the Trust Board monthly **External** 1) The financial performance of the Trust is monitored by NHSE through a monthly return. This is approved by the Chief Finance Officer. 2) The Trust has a monthly oversight meeting with the regional NHSE team to discuss financial performance (amongst other agenda items).	1) The Trust is likely to remain in Recovery Support Programme (NOF4) until a balanced longer-term plan is developed

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Health & Safety and Statutory Compliance Update**

Meeting date: **7 September 2023**

Board sponsor: **Chief Strategy & Partnerships Officer**

Paper Author: **2gether Support Solutions (2gether) - Managing Director**
2gether - Associate Director of Safety
2gether - Associate Director of Estates

Appendices:

NONE

Executive summary:

Action required:	**Assurance**
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 91.8%, an increase of c1.8% since May 2023. • Audits continue across all Care Group and Corporate areas. Support being provided to care groups to enable improved outcomes for this financial and future years. • Plans remain in play to redress with Kent Fire and Rescue issues raised by the CQC around deficiencies in QEQM Maternity services. Progression being monitored at the Fire Safety Group. • Estate statutory compliance assurance level currently sits at c92.3%. Still working to achieve c95% as soon as practicably possible. • Fire Doors – Post the completion of a full review of all fire doors it has been identified that major investment is required to ensure the Trust remains compliant to current fire legislation. It has been identified that c£2.1m of high-risk repairs and/or replacements are urgently required in the 2023/24 budget period.
Key recommendations:	The Board of Directors is asked to **NOTE** and discuss the Trust's current position in relation to Health & Safety, and statutory compliance, especially in respect to the prevailing risks.

Implications:

Links to Strategic Theme:	• 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 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.
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 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 (H&S), 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. As agreed in the Strategic Health & Safety Committee the "Red Button" (the ability to postpone an audit at short notice) has been reserved for eventualities deemed to be "force majeure" and must be agreed by the Care Group lead for the ward/department and the Health and Safety Manager. So far in the 2023/24 period this has not been implemented.

Overall, all but 1 care group has increased their score. It should be remembered, however, that this is still early in the audit cycle and scores can go up and down throughout the year.

Table 1: HASTA Score Card

HASTA Score-Card	2021	2022	2023
Cancer Services	96.1%	90.5%	100.0% ↑
Children's Health	96.5%	97.4%	99.2% ↑
Corporate Services	90.8%	88.1%	97.7% ↑
Clinical Support Services	96.1%	95.4%	96.0% ↑
General Specialist Medicine	87.2%	89.7%	87.3% ↓
Surgical & Anaesthetic	84.4%	86.8%	87.8% ↑
Surgery Head & Neck, Breast and Dermatology	88.3%	98.1%	99.0% ↑
UEC (Urgent and Emergency Care)	80.4%	84.1%	84.8% ↑
Women's Health	91.9%	81.9%	99.6% ↑
Trust Wide Totals	**90.2%**	**90.2%**	**91.8% ↑**

**Scores adjusted slightly due to new questions added regarding ligature and Covid Risk Assessment for the new financial year. This has affected previous scores due to the system administration adding the question sets to the previous year's scores also. There is a variance of 1-2% drop on scores previously reported.*

2.2 **Training**: In Q1 2023/24 the partnership has remained focused on delivering link worker training. Other training that has taken place during this quarter includes:

a. First Aid at Work;
b. IOSH (managing safely);
c. IOSH (working safely);
d. Control of Substances Hazardous to Health (COSHH);
e. Fire Safety;
f. Risk Assessment Awareness.

2.3 A new provider is delivering Control of Substances Hazardous to Health (COSHH) training. The Health & Safety team and Learning and Development are also exploring the possibility of the provider undertaking additional training for areas that use more extensive and volatile substances i.e. laboratory areas.

2.4 **H&S Team Support:** The Safety Team has been involved in a number of activities to support the Trust's activities both proactively (focused training) and reactively (incident investigations. In addition, the team has continued to be involved, where possible, in supporting the numerous construction projects across the estate.

2.5 **Trust H&S Leads:** As previously noted the Trust Health and Safety Leads continue to work well to embed Health and Safety standards in their Care Groups. There are still two gaps in the H&S leads, Cancer and Urgent & Emergency Care for Kent & Canterbury Hospital (K&C) and Buckland Hospital Dover (BHD).

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. Formal quarterly compliance reports are presented to the Strategic Health and Safety Committee.

3. RIDDOR reports 2023

3.1 During Qtr1 2023/24 budget period, the Trust raised 7 RIDDOR events with the Health and Safety Executive (HSE).

3.1.1 April – 2 events: two assaults on staff by a patient.
3.1.2 May – 3 events; 1 exposure to blood and bodily fluids, 1 manual handling (moving a patient) and 1 slip, trip or fall.
3.1.3 June – 2 events; both manual handling involving patient movement.

3.2 The Safety team continue to support teams with their reporting and to try and improve these timescales with awareness and training.

4. Fire Safety Update

4.1 **Fire Safety Governance:** Considering the nature of both the risks and the estate portfolio it was agreed in the last Fire Safety Group (FSG) that greater representation from the wards/departments would be needed within the FSG so as to ensure updates and escalation against actions can be made in regard to Trust management issues. In addition, and so as to ensure executive oversight the FSG will also report into the Strategic Health & Safety Committee (SHSC).

4.2 **Fire Safety Plan:** The joint Fire Safety Plan continues to see progress against actions and is monitored by the membership of the FSG and SHSC.

4.3 **Fire Risk Assessments and support:** Table 2 (below) sets the number and type of outstanding actions identified through the risk assessment process. The actions are being redressed on a risk basis and reported on at each FSG.

Table 2: Outstanding Fire Safety Actions

As of May, 2023		Action Risk Level				
FRA Risk Level		High	Medium	Low	Advisory	Total Actions
Intolerable	0	0	0	0	0	0
Substantial Risk	2	11	7	0	0	18
Significant Risk	1	1	3	0	0	4
Moderate Risk	73	199	542	109	45	895
Tolerable Risk	277	280	1215	316	99	1910
Trivial Risk	8	3	45	3	2	53
Total FRA's	361					2880

4.4 **Fire Training:** The FSG discussed making the fire safety element of induction training mandatory before starting employment to ensure the number of did not attend (DNA) is reduced. It was noted that the information regarding the number and distribution of fire wardens within the trust was incomplete and unreliable. The H&S team were requested to assist (through the H&S Link Workers) to gather the necessary information to make this information both complete and reliable. A full database will be issued at the next FSG.

4.5 **Regulatory Interaction:** The fire safety manager briefed the FSG following the audit undertaken by Kent Fire and Rescue Service (KFRS). Actions are progressing as planned and no issues noted.

4.6 The fire safety manager and associate director of safety met with the Care Quality Commission (CQC) as part of a planned visit to discuss fire safety and more specifically fire safety governance. The fire safety manager will report back to the FSG on the outcomes of this meeting at the next meeting.

4.7 **Appointments:** 2 Fire Safety Advisors have been appointed with 1 in post as of 24 July and the other to start 28 August 2023.

5 Risk & Mitigation

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 Queen Elizabeth the Queen Mother Hospital (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. 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. New Fire Advisors to support with delivery.
Lack of Annual Audit by Authorising Engineer (fire)	Fire Safety Group monitoring issues on a monthly basis	Authorising Engineer should be appointed by June and an audit / gap analysis to be instructed and carried out in quarter 3
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 plans for face to face training. Two new Fire Safety Advisors recruited to support team to deliver training by quarter 3
Proximity of scanners to existing building less than revised KFRS guidance	Review of all sites underway and revised positions being reviewed	Once the final positions agreed with all parties on each site, risk assessments and consultations with KFRS to commence lead by Fire Safety Manager

5.0 Estates Statutory Compliance

5.1 Work continues to improve the overall statutory compliance levels within the estate. We continue to develop our compliance reporting platform existing infrastructure. All statutory compliance figures captured within this report cover inspection and test only, not remediation status.

5.2 The overarching statutory compliance assurance level stood at c92.3% at the end of July 2023. We continue to work towards achieving a compliance level of c95% by September 2023.

The following table provides a compliance overview by site.

Statutory Compliance - Jun 23 (Inspection only)									
	KCH		WHH		QEQM		Total	Actual	23-24 Target
Compliant	115	93.50%	119	91.53%	112	91.05%	346	92.27%	95.00%
Non Compliant	7	5.69%	10	7.70%	9	8.14%	26	6.93%	5.00%
Part Compliant	1	0.81%	1	0.77%	1	0.81%	3	0.80%	0.00%
Total	123		130		122		375		

5.3 The priority for statutory compliance inspections remains

a. (6) ALL– Fire Alarm Annual Testing & Inspection and Cause & Effect testing - Compliance level has dropped as the annual period has lapsed from the last inspection, however, TFS are presenting monthly progress reports and are on target to complete by November 2023 with a weekly presence on sites testing and repairing equipment.
b. (6) ALL – Fire damper inspections - Strategy to be agreed for the fire damper survey and inspection programme following initial survey and report at WHH from Oakleaf (2019/20 - 6 Facet instruction placed on hold during COVID).
c. (4) QEQM & WHH – PSSR (pressure) insurance inspections for Boilers & Calorifiers. A number of repairs have been completed, improving the overall compliance level. Ongoing programme to repair during the summer period taking essential Heating equipment offline.
d. (2) WHH & K&C– Pressure testing underground oil lines (10 yrly) - The oil line pressure testing surveys to be completed and works completed by end of Q2.
e. (3) ALL - AE Audit Pressure – To be completed in Q2 following contract tender award.
f. (2) ALL– Electrical EICR programme - The fixed wire testing tender pack is being collated and plan to be awarded by Q2 for all sites to complete 25% in 2023/24.
g. (3) K&C & WHH - 5-year Electrical HV lightning conductor earthing (part of the HV major service) - UKPN confirmation received to complete outside of existing inspection schedule. Forecast to be completed by end of Q2 for all 3 sites.
h. (3) ALL – COSHH - New registers and records to be completed (training required).

5.4 We continue to work to manage the risk associated with the areas of shortfall; at this juncture we are still expecting to hit the c95% level by September; dependent on specialist works completion and possible ancillary funding requirements.

6.0 Critical Infrastructure/Backlog Maintenance

6.1 Post the publication of the ARUP Critical Infrastructure Report in 2021 work has continued to try and redress various technical systems shortfall that remain prevalent within the estate. Our technical leadership continue to review backlog maintenance priorities for each site; all items have been risk scored in conjunction 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).

6.2 To date the Trust continues to allocate funding below the level required to redress the historic backlog of critical works – we continue to receive funding at c50% of the

required levels. Whilst 2gether continue to manage the risks associated to any critical life safety systems, the Trust is starting to run the risk of future building closures due to potential estate non-compliance issues.

6.3 WHH Fire Alarm Annunciation System - post the completion of a formal tender exercise, on-site work has now commenced. These works are planned to run until the end of the 2023 calendar year. We continue to hold progress engagements with Kent Fire & Rescue over the project.

6.4 Fire Doors – one of the main critical infrastructure risks revolves around fire doors. Post the CQC audits of the maternity wards earlier in the year, the decision was taken to undertake a full review of all doors across the estate – c5,000 units. This review has recently completed, with the support of a third-party specialist. It was identified that c45% (2,269 doors) require a level of repair, with c54% (2,710 doors) require replacement to ensure compliance to legislation – total value of works identified is projected at c£16.5m. After risk-assessing the findings, it has identified that these works can be conducted over the next 5-years.

7.0 Risk Management & Mitigation

7.1 The current compliance reporting model remains under development 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 remains inconsistent, mainly due to the fact that the current Planet CAFM system is not fully utilised. Work remains 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.