Board of Directors Meeting - Open (Thursday 10 March 2022)

Thu 10 March 2022, 01:00 PM - 04:50 PM

WebEx

East Kent Hospitals University NHS Foundation Trust

Agenda

OPENING/STANDING ITEMS

01:00 PM - 01:15 PM
15 min

21/131
Welcome and Apologies for Absence (1:00) 15 mins

To Note *Chairman*

Verbal

01:15 PM - 01:15 PM
0 min

21/132
Confirmation of Quoracy

To Note *Chairman*

Verbal

01:15 PM - 01:15 PM
0 min

21/133
Declaration of Interests

To Note *Chairman*

21-133 - REGISTER 2021-22 V47 - from March 2022.pdf (5 pages)

01:15 PM - 01:15 PM
0 min

21/134
Minutes of Previous meeting held on 3 February 2022

Approval *Chairman*

21-134 - Unconfirmed BoD 03.02.22 Public Minutes.pdf (11 pages)

01:15 PM - 01:15 PM
0 min

21/135
Matters Arising from the Minutes on 3 February 2022

Approval *Chairman*

21-135.1 - Front Sheet Public BoD Action Log.pdf (2 pages)
21-135.2 - Appendix 1 Public Board of Directors Action Log.pdf (1 pages)
21-135.3 - B-19-21 Appendix 4 We Care roll out V2.pdf (2 pages)

01:15 PM - 01:20 PM
5 min

21/136
Chairman's Report (1:15) 5 mins

Information *Chairman*

21-136.1 - Chairman Report March 2022 Board FINAL 03.03.22.pdf (3 pages)
21-136.2 - Appendix 1 Chairman Report NEDs commitments Final 03.03.22.pdf (1 pages)

01:20 PM - 01:30 PM
10 min

21/137
Chief Executive Officer's (CEO's) Report (1:20) 10 mins

Discussion *CEO*

21-137 - CEO Report to March Board (003).pdf (5 pages)

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

01:30 PM - 02:00 PM
30 min

21/138
Integrated Performance Report (IPR) (1:30) 30 mins

Discussion *CEO/Executive Team*

21-138.1 - IPR Front sheet BoD 10.03.22.pdf (2 pages)
21-138.2 - Appendix 1 IPR_v4.3_Jan22_FINAL.pdf (38 pages)

02:00 PM - 02:05 PM
5 min

21/139
Finance Report (2:00) 5 mins

Information *Director of Finance and Performance*

- **Month 10 Finance Report**

21-139.1 - Front Sheet M10 Finance Report March Board.pdf (2 pages)
21-139.2 - Appendix 1 M10 Finance Report.pdf (27 pages)

02:05 PM - 02:15 PM
10 min

21/140
Board Assurance Framework (BAF) and Corporate Risk Registers (CRR) (2:05) 10 mins

Discussion *Group Company Secretary*

21-140 - Corporate-BAF Risk Register BoD 28.02.22 v2.pdf (20 pages)

02:15 PM - 02:20 PM
5 min

21/141
Infection Prevention and Control (IPC) Board Assurance Framework (BAF) (2:15) 5 mins

Assurance *Deputy Director of IPC*

21-141.1 - Front Sheet IPC BAF 01_03_2022.pdf (2 pages)

21-141.2 - Appendix 1 IPC BAF review_V2_01_03_2022.pdf (17 pages)

02:20 PM - 02:30 PM
10 min

TEA/COFFEE BREAK 2.20 (10 mins)

OUR PATIENTS OUR QUALITY AND SAFETY

02:30 PM - 02:45 PM
15 min

21/142
Maternity Regulatory Compliance Framework: (2:30) 15 mins

21/142.1
Ockenden Review of Maternity Services - One Year on Progress Report

Decision *Chief Nursing and Midwifery Officer (CNMO)*

21-142.1 - OCKENDEN REVIEW OF MATERNITY SERVICES-ONE-YEAR ON FINAL.pdf (64 pages)

02:45 PM - 02:50 PM
5 min

21/143
Maternity Services: (2:45) 5 mins

- **Clinical Negligence Scheme for Trusts (CNST)**

21/143.1
Safety Action 6: Saving Babies Lives Care Bundle Report

Information *CNMO / Clinical Director for Women's Health / Interim Director of Midwifery & Gynaecology*

21-143.1 - February 2022 SBLCB Quarterly Report Paper FINAL SS CHANGES.pdf (20 pages)

02:50 PM - 03:00 PM
10 min

21/144
Chief Nursing and Midwifery Officer (CNMO) - Nursing and Allied Health Professionals (AHP) Workforce update (2:50) 10 mins

Assurance *CNMO*

21-144 - CNMO Quarterly Nursing AHP Staffing update March 22 FINAL.pdf (10 pages)

03:00 PM - 03:10 PM
10 min

21/145
Chief Medical Officer's Report (3:00) 10 mins

Discussion *Chief Medical Officer (CMO)*

21-145.1 - CMO report for BoD 10 March.pdf (5 pages)
21-145.2 - Appendix 1 Clinical Directors Clinical Leads Externally facing roles.pdf (1 pages)

21/145.1
Learning from Deaths - Quarter 3 2021/22

Assurance *CMO*

21-145.1.1 - CMO Mortality Report BoD March 2022 Q3.pdf (8 pages)

REGULATORY AND GOVERNANCE

03:10 PM - 03:15 PM
5 min

21/146
Policies, Guidance and Code of Conduct Review - Council of Governors' Recommendations (3:10) 5 Mins

Approval *Chairman*

21-146 - Policies Guidance and Code of Coduct review Front Sheet - BoD Mar 2022.pdf (6 pages)

03:15 PM - 03:25 PM
10 min

21/147
Health and Safety and Estates Statutory Compliance Update (3:15) 10 mins

Discussion *Director of Strategic Development and Capital Planning*

21-147.1 - FRONT SHEET Estates and Safety Trust Board March 2022.pdf (12 pages)
21-147.2 - APPENDIX ONE STATUTORY COMPLIANCE PRIORITIES.pdf (1 pages)

03:25 PM - 03:35 PM
10 min

21/148
People and Culture Committee (P&CC) - Chair Assurance Report (3:25) 10 mins

Information *Chair People and Culture Committee - Stewart Baird*

21-148.1 - PCC Chair Assurance Report BoD March 2022 final.pdf (5 pages)

03:35 PM - 03:45 PM
10 min

21/149
Finance and Performance Committee (FPC) - Chair Assurance Report (3:35) 10 mins

Approval *Chair Finance and Performance Committee - Nigel Mansley*

21-149.1 - FPC Chair Assurance Report BoD Public Mar 2022 final.pdf (5 pages)

21/149.1
Discharge Process and Criteria to Reside

Information *Chief Operating Officer*

21-149.1.1 - Patient Discharge Process Board Paper 100322 Final.pdf (9 pages)

21/149.2
Waiting List Overview in consideration of NHS England/NHS Improvement 2022/23 Operational and Planning Guidance

Information *Chief Operating Officer*

21-149.2.1 - Waiting List Board Paper 100322.pdf (6 pages)
21-149.2-2 - Appendix 1 RTT January data 2022.pdf (13 pages)

03:45 PM - 03:55 PM
10 min

21/150
Quality and Safety Committee (Q&SC) - Chair Assurance Report (3:45) 10 mins

Assurance *Chair Quality & Safety Committee - Sarah Dunnett*

21-150 - QSC Assurance Report BoD March 2022 v2.pdf (5 pages)

03:55 PM - 04:05 PM
10 min

21/151
Integrated Audit and Governance Committee (IAGC) - Chair Assurance Report (3:55) 10 mins

Approval *Chair Integrated Audit and Governance Committee - Olu Olasode*

- **Gifts, Hospitality and Conflicts of Interest Policy**

21-151.1 - IAGC Chair Board Assurance Report (February 2022) FINAL.pdf (4 pages)
21-151.2 - App 1 Gifts Hospitality CoI Policy V5.4 draft.pdf (26 pages)

04:05 PM - 04:15 PM
10 min

21/152
Nominations and Remuneration Committee (NRC) - Chair Assurance Report (4:05) 10 mins

Assurance *Chair Nominations and Remuneration Committee - Jane Ollis*

21-152 - NRC Chair Board Assurance Report (08.03.22) FINAL.pdf (3 pages)

04:15 PM - 04:25 PM
10 min

21/153
Charitable Funds Committee (CFC) - Chair Assurance Report (4:15) 10 mins

Assurance *Chair Charitable Funds Committee - Jane Ollis*

21-153 - CFC Chair Board Assurance Report (08.03.22) FINAL.pdf (3 pages)

CLOSING MATTERS

04:25 PM - 04:35 PM
10 min

21/154
Any Other Business (4:25) 10 mins

Discussion *All*

Verbal

04:35 PM - 04:45 PM
10 min

21/155
Questions from the Public (4:35) 10 mins

Discussion *All*

Verbal

Date of Next Meeting: Thursday 7 April 2022 at the The Spitfire Ground - Canterbury Cricket Ground

The public will be excluded from the remainder of the meeting due to the confidential nature of the business to be discussed.

REGISTER OF DIRECTOR INTERESTS – 2021/22 FROM MARCH 2022

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ACOTT, SUSAN	Chief Executive	Advisory Council of The Staff College (leadership development body for the NHS/Military) (started 16 October 2017) **(4)**	Appointed 1 April 2018
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	Director of HR and Organisational Development	None **Closed interest** MY Trust (started 11 November 2014/finished 20 July 2020) **(4)**	Appointed 1 September 2019
BAIRD, STEWART	Non-Executive Director	Stone Venture Partners Ltd (started 23 September 2010) **(1)** Stone VP (No 1) Ltd (started 15 August 2017) **(1)** Stone VP (No 2) Ltd (started 1 December 2015) **(1)** Stone VP (No 3) Ltd (started 20 November 2017) **(1)** Hidden Travel Holdings Ltd (started 16 May 2014) **(1)** Hidden Travel Group Ltd (started 15 October 2015) **(1)** Qunifi Holdings Ltd (started 30 November 2017) **(1)** Qunifi Ltd (started 13 February 2015) **(1)** Trustee of Kent Search and Rescue (Lowland) (started 2013) **(4)** **Companies Non-Trading interests** Tempco 0819 Ltd **(1)** Solution Telecom Holdings Ltd **(1)** Qdos Communications Ltd **(1)** Solution Builders Ltd **(1)** Hidden Travel (Flights) Ltd **(1)** Unicus Travel Ventures Ltd **(1)** Pebble Holidays Holdings Ltd **(1)**	1 June 2021 (First term)

REGISTER OF DIRECTOR INTERESTS – 2021/22 FROM MARCH 2022

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
CAVE, PHILIP	Director of Finance and Performance	Wife works as Head of Contracts for Kent and Medway Clinical Commissioning Group (CCG) (started 1 April 2021) **(5)** Interim Managing Director for 2gether Support Solutions **(1)** (started 21 December 2021) **Closed interests** Wife worked as a Senior Manager for Optum, who run the Commissioning Support Unit (CSU) in Kent, which supports the Clinical Commissioning Groups (CCGs) (started 9 October 2017/finished 31 March 2021)	Appointed 9 October 2017
CARLTON, REBECCA	Chief Operating Officer	None	Appointed 16 July 2021
DICKSON, NIALL	Chair	Director, Leeds Castle Enterprises (started 31 May 2012) **(1)** Senior Counsel, Ovid Consulting Ltd (trading as OVID Health Company) (started November 2020) **(1)**	5 April 2021
DUNNETT, SARAH	Non-Executive Director/Senior Independent Director (SID)	Director of Catalyst (London) Ltd **(1)**	1 June 2021 (First term)
FOX, ALISON	Group Company Secretary	Company Secretary, Grabba Enterprises Limited (started 1 December 2020) **(1)** Director, MinervaPro Limited (started 28 November 2021) **(1)**	Appointed 11 November 2013
FULCI, LUISA	Non-Executive Director	Director of Digital, Customer and Commercial Services, Dudley Council (started 6 April 2021) **(1)**	1 April 2021 (First term)

REGISTER OF DIRECTOR INTERESTS – 2021/22 FROM MARCH 2022

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
HOLLAND, CHRISTOPHER	Associate Non-Executive Director	Director of South London Critical Care Ltd **(1)** Shareholder in South London Critical Care Ltd **(2)** Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University and the University of Kent **(4)** South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services **(5)**	Appointed 13 December 2019
IVANOV, TINA	Director of Quality Governance	None	10 May 2021
MANSLEY, NIGEL	Non-Executive Director	None **Closed interests** Jeris Associates Ltd (started 1 July 2017/finished 26 January 2021) **(1) (2) (3)** Chair, Diocesan Board of Finance (Diocese of Canterbury) (started 22 January 2018/finished 14 July 2021) **(1)**	1 July 2017 (Second term)
MARTIN, REBECCA	Chief Medical Officer	None	Appointed 18 February 2020
OLASODE, OLU	Non-Executive Director	Chief Executive Officer, TL First Consulting (started 9 May 2000) **(1)** Chairman, Integrated Management Group (started 16 March 2001) **(1)** Managing Partner, TL First Accountants Ltd (started 4 January 2006) **(1)** Chairman, ICE Innovation Hub UK (started 11 September 2018) **(1)** Independent Chair, General Purposes and Audit Committee, London Borough of Croydon (started 1 October 2021) **(1)**	1 April 2021 (First term)

REGISTER OF DIRECTOR INTERESTS – 2021/22 FROM MARCH 2022

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
OLLIS, JANE	Non-Executive Director	The Heating Hub (started 8 May 2017) **(1)** Non-Executive Director of the Kent Surrey Sussex Academic Health Science Network (AHSN) (started 1 July 2018) **(1)** Founder of MindSpire (started 30 October 2018) **(1)** Non-Executive Director of Community Energy South (started 30 October 2018) **(1)** Vice President of the British Red Cross in Kent (started November 2018) **(4)** Non-Executive Director of 2gether Support Solutions (started 22 May 2019) **(1)** Non-Executive Director of Riding Sunbeams (started February 2020) **(1)**	8 May 2017 (Second term)
SHINGLER, SARAH	Chief Nursing Officer	None	Appointed 7 June 2021
SHUTLER, LIZ	Director of Strategic Development and Capital Planning/Deputy Chief Executive	None	Appointed January 2004
WIGGLESWORTH, NEIL	Director of Infection Prevention and Control	Chair and Director of the International Federation of Infection Control (started 1 January 2018) **(1)** Trustee of the International Federation of Infection Control (started 1 January 2018) **(4)**	15 March 2021
YOST, NATALIE	Director of Communications and Engagement	None	31 May 2016

REGISTER OF DIRECTOR INTERESTS – 2021/22 FROM MARCH 2022

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:
Philip Cave, Nominated Director
Jane Ollis – Non-Executive Director in common/Interim Chair (1 March 2022 to 30 April 2022)
Alison Fox – Nominated Company Secretary

Spencer Private Hospitals:
Stewart Baird – Non-Executive Director in common
Nic Goodger – Nominated Director
Elizabeth Coles – Nominated Director
Alison Fox – Nominated Company Secretary

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 & SIXTEENTH MEETING OF THE BOARD OF DIRECTORS THURSDAY 3 FEBRUARY 2022 AT 4.00 PM AS A WEBEX TELECONFERENCE

PRESENT:

Mr N Dickson	Chairman	ND
Ms S Acott	Chief Executive Officer (CEO)	SAc
Mr R Anakwe	Non-Executive Director (NED) (by WebEx)	RA
Mrs A Ashman	Director of Human Resources & Organisational Development (DoHR&OD)	AA
Mr S Baird	NED/People & Culture Committee (P&CC) Chair	SB
Ms R Carlton	Chief Operating Officer (COO)	RC
Mr P Cave	Interim Managing Director (MD), 2gether Support Solutions (2gether)/ Director of Finance and Performance (DoF&P)	PC
Mr G Dentith	Acting Director of Finance and Performance	GD
Ms S Dunnett	NED/Quality & Safety Committee (Q&SC) Chair	SD
Ms L Fulci	NED	LF
Mr N Mansley	NED/Finance and Performance Committee (FPC) Chair (by WebEx)	NM
Dr R Martin	Chief Medical Officer (CMO)	RM
Dr O Olasode	NED/Integrated Audit and Governance Committee (IAGC) Chair (left at 5.00 pm)	OO
Mrs J Ollis	NED/Deputy Chairman/Nominations and Remuneration Committee (NRC) Chair/Charitable Funds Committee (CFC) Chair	JO
Mrs S Shingler	Chief Nursing Officer (CNO)	SSh
Ms L Shutler	Director of Strategic Development and Capital Planning (DSD&CP) /Deputy CEO	LS

ATTENDEES:

Mrs C Drummond	Interim Director of Midwifery (DoM)	CDr
Ms T Fletcher	Incoming Chief Executive Officer	TF
Mrs A Fox	Group Company Secretary	AF
Professor C Holland	Associate Non-Executive Director	CH
Dr T Ivanov	Director of Quality Governance (DoQG)	TI
Mr J Seaton	Clinical Director (CD) for Women's Health (WH)	JS
Dr N Wigglesworth	Director of Infection Prevention and Control (DIPC)	NW
Mrs N Yost	Director of Communications and Engagement (DoC&E)	NY

IN ATTENDANCE:

Ms S Hayward-Browne	Business Manager to the Chairman	SH-B
Miss S Robson	Board Support Secretary (Minutes)	SR

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Ms F Abdelhak	Member of the Public
Ms S Gradwell	Interim Deputy Director of Governance
Ms A Moore	Member of the Public
Mrs S Pettifer	Staff Governor
Mrs P Pyer	Member of the Public
Mrs M Smith	Member of the Public
Mrs M Warburton	Member of the Public
Ms S Wells	NHS England/NHS Improvement

MINUTE NO.		ACTION
21/112	**WELCOME AND APOLOGIES FOR ABSENCE** The Chairman welcomed those in attendance. He reported this was an additional open Board meeting outside of its meeting cycle following a Board Development	

Day, to address the gap since the last meeting held to discuss key performance and operational issues. It was noted Informal Board meetings had been held enabling decisions to be made and provide briefings on operational pressures.

The Chairman welcomed AF, GCS, who had returned from secondment. He thanked Dorothy Otite for her support and hard work providing covering as Interim GCS, who would remain with the Trust providing Corporate governance support.

The Chairman welcomed the incoming CEO, Tracey Fletcher, to the meeting who would be starting with the Trust at the beginning of April 2022.

The Board **NOTED** there were no apologies for absence received.

21/113 **CONFIRMATION OF QUORACY**

The Board **NOTED** and confirmed the meeting was quorate.

21/114 **DECLARATION OF INTERESTS**

The Board **NOTED** there were no new declarations of interest.

21/115 **MINUTES OF THE PREVIOUS MEETING HELD ON 2 DECEMBER 2021**

The NEDs enquired when it was expected the Patient Voice and Involvement Team business case (minute 21/100) would be presented for approval, as this was a key priority for the Trust. The CNO confirmed this was being progressed through the appropriate internal governance structure and would be presented in March 2022 to the Board.

DECISION: The Board of Directors **APPROVED** the minutes of the previous meeting held on 2 December 2021 as an accurate record.

21/116 **MATTERS ARISING FROM THE MINUTES ON 2 DECEMBER 2021**

Action B/11/21 – Matrix Management
The CEO agreed to circulate the finalised matrix management document to Board members outside the meeting.

Action B/22/21 – University Hospital Association membership
The CMO requested feedback once applications were re-opened whether it was felt this was a priority for the Trust to review the criteria requirements and pursue its application. She enquired whether this should be reported to the Board or the People & Culture Committee (P&CC).

DECISION: The Board **AGREED** to refer this action to the P&CC for consideration at a future Committee meeting.

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

21/117 **CHAIRMAN'S REPORT**

The Chairman reported the volume of Board papers had been reduced and work would continue to ensure these were concise and streamlined.

The Chairman thanked staff for their continued exceptional work and support over the last particularly challenging couple of months, as well as the strong leadership

support. He highlighted the operational pressures and managing activity demand around winter, Omicron pandemic, Nightingale hub, and releasing capacity to manage these demands by adhering to the reducing the burden of reporting guidance.

The NEDs queried about the levelling up agenda and if this would impact on the Integrated Care System (ICS), its partners and the benefits for the Trust optimising this partnership. The Chairman commented discussions would be held at the East Kent Health and Care Partnership around capital funding and he would consider an appropriate date for a future Board meeting discussion to reflect on this issue. The CEO reported she had met with a number of local MPs about this issue to highlight the significant needs, issues and investment requirements within the coastal areas for system wide discussions.

DECISION: The Board of Directors **NOTED** the contents of the Chairman's report and **APPROVED** the decisions made at the informal Board meeting on the 6 January 2022, and the virtual approval of the East Kent Hospitals Charity Annual Report and Accounts 2020/2

21/118 **CHIEF EXECUTIVE'S REPORT**

The CEO highlighted key elements:

- Five business cases detailed in the report had been approved, with the exception of the Dermatology relocation to Estuary House and service expansion presented to the Finance and Performance Committee who had requested further information;
- Cases of Omicron had plateaued but were currently increasing, with approximately 130 Covid positive inpatients currently;
- Colorectal cancer surgery had been moved to Kent & Canterbury Hospital (K&C) to ensure activity was maintained and effectively manage Covid positive inpatients. This service would be returned to its original hospital sites and orthopaedic surgery would return to K&C. Thanks to staff for their support, hard work and flexibility across the hospital sites in managing these service changes ensuring patients requiring urgent treatment was received;
- Streamlined governance arrangements for meetings and decision-making that had successfully reduced the burden of reporting freeing resources to address key priorities. As pressures reduced it would be considered returning to normal governance arrangements;
- Trust had a high staff vaccination rate and was working closely with unvaccinated staff offering access to vaccinations, and holding discussions with staff who intended not to take up vaccination to understand their reasons. Noting the Government's decision to step down from the vaccination as a condition of deployment legislation;
- Damien Green, MP, would be visiting the new 24 bed Intensive Therapy Unit (ITU) facility at William Harvey Hospital (WHH) prior to its opening;
- British Citizens awards event held that week at K&C, around 43 staff received their medals, certificates would be issued to staff, and was a great opportunity to honour, recognise and commend staff.

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

21/119 **INTEGRATED PERFORMANCE REPORT (IPR)**

The Board noted the format of the IPR was being revised and discussions about this had been held at the Board Development Day that morning.

The DoF&P highlighted:

- A number of Executive Directors and NEDs were working collaboratively to review and improve the presentation format of the IPR focussing on the actions taken to improve the position;
- As the IPR was further developed the need to also identify trajectories;
- The True Norths key strategic objective targets would be reset in the next few months and as a result of the discussions at the Board Development.

The NEDs raised the reducing falls breakthrough objective and disappointment that the targeted intervention had not had positive results and concern that numbers remained high. It was enquired whether in future a breakdown of data for men and women as there were differently contributing factors for each that would be beneficial if these could be monitored separately. The CNO reported the falls reduction performance had been impacted by the recent staffing challenges and observing and maintaining patients safety. She emphasised the on-going work to attract and recruit additional staff as well as utilising incentives, with continued support and measures for staff to manage complex acuity of patients and minimise risks of falls. The Chairman requested an update on current performance from the ward that had implemented We Care focussing on this objective, who had provision of training and whether a reduction in falls was being maintained.

ACTION: Explore the feasibility of producing a breakdown of data separately for men and women within the IPR. — DoF&P

ACTION: Provide an update on the ward that had implemented We Care focussing on the reducing falls breakthrough objective and whether a reduction in falls was being maintained. — CNO

The NEDs commended the Executive Directors on improving the IPR and the provision of the one page summary of what was needed that provided an overview of statistics, interpretation of the data and clear action plan with timescales. The DoF&P confirmed the aim to have the refreshed improved IPR format presented at the next Board meeting in March 2022.

The Board of Directors **CONSIDERED** and **DISCUSSED** the:

- True North and Breakthrough Objectives of the Trust; and
- Revised IPR draft format.

21/120 **FINANCE REPORT**

- **MONTHS 8 AND 9 FINANCE REPORTS**

The Acting DoF&P noted key points:

- Income and Expenditure (I&E) as at December 2021 was £0.3m behind plan, £0.8m cumulative deficit year to date (YTD), mainly due to additional Covid costs above the plan against Omicron and reduction in treating elective patients due to capacity and Covid constraints. These would be addressed utilising central allocated funding;
- Reporting a planned forecast breakeven position by year-end (YE), continued system partner working and support from NHSE/I ensuring the Trust accessed available funding;
- £24m capital funding had been spent by the end of December, £5m behind the internal plan, the programme was being closely monitored weekly by the Deputy CEO and it was expected to return on plan by YE;
- Review of the planning guidance for the next financial year, working with system partners to ensure delivery of a breakeven plan. This would be

challenging with an increased efficiency requirement that had already been reviewed by the Executive Directors and discussion about potential efficiency savings. A draft annual plan would be presented to the next Board Closed meeting in March.

The Board of Directors discussed and **NOTED** Months 8 and 9 Finance Reports, financial performance and actions being taken to address issues of concern.

21/121 **INFECTION PREVENTION AND CONTROL (IPC) BOARD ASSURANCE FRAMEWORK (BAF)**

The DIPC reported:

- An increase in the number of Covid-19 positive inpatients than the 108 noted in the report with approximately 130 currently, increase as expected and anticipated this level would continue for a few months;
- Many cases of the Omicron variant had been incidental findings in persons presenting for unrelated health reasons and this had increased to 50% nationally from the 40% noted in the report. This variant was highly transmissible but caused less severe illness, and severity further mitigated by vaccination;
- Continued adherence with guidelines of testing of patients;
- The IPC BAF presented was a fully revised version following the reissued BAF in December 2021, this was more concise and included mitigating actions. There was an audit trail of previous iterations of the IPC BAF.

The NEDs enquired about progress to review We Care IPC breakthrough objectives and produce new objectives. The DIPC commented this was included within the IPC work programme for targeted work focussing on reducing bacteraemia cases (e-coli, pseudomonas) against the trajectories, this was currently being developed, which would be presented to the Board once completed.

ACTION: Present the IPC work programme to the Board for information once completed. DIPC

The Board of Directors discussed and received **ASSURANCE** from the contents of the IPC BAF report.

21/122 **MATERNITY SERVICES: CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) AND MATERNITY NEONATAL ASSURANCE GROUP (MNAG)/MATERNITY BOARD SAFETY CHAMPION REPORT**

21/122.1 **PERINATAL MORTALITY REVIEW TOOL (PMRT) QUARTERLY REPORT – QUARTER 3**

The Women's Health CD highlighted key elements:

- Each individual death was reviewed and assessed identifying whether different management would have resulted in a different outcome, this was externally validated;
- Quarterly reports would be presented to the Board in line with CNST requirements around learning and improvements;
- Provides assurance of reporting of the use of this tool to the required standard and that these were being met. Data reporting within one month and reviews within four or six months if an external investigation was required;
- Monthly PMRT meetings with dedicated PRMT discussions and review of

cases.

The Board of Directors:

- **DISCUSSED** the contents of the PMRT report; and
- Received **ASSURANCE** and **NOTED** the Quarter 3 report demonstrating full compliance in line with CNST standard requirements.

21/122.2 **MATERNITY AND NEONATAL ASSURANCE GROUP (MNAG) – QUARTERLY REPORT**

The CNO highlighted the key elements:

- MNAG commenced in September 2021 its function to ensure the Trust meets all regulatory responsibilities in relation to providing maternity care and driving forward its quality improvement programme, taking over from the Maternity Improvement Committee;
- Provides an update on progress of the work in relation to:
  - CNST;
  - Quality improvement programme;
  - Ockenden;
  - Care Quality Commission action plans;
  - Actions from Oversight meetings with National and Regional teams.
- Improvements in training compliance;
- Quarterly reports would be presented to the Board.

The Board of Directors:

- Discussed and **NOTED** the content of the MNAG report;
- Received **ASSURANCE** MNAG was strengthening Trust level oversight of maternity services and ensuring adherence to national regulatory requirements and delivery of the maternity improvement plan; and
- **APPROVED** the revised MNAG ToR, with the addition of the Director of Workforce and Director of Communications to the membership.

21/122.3 **MATERNITY SAFETY CHAMPIONS REPORT**

The CNO noted:

- Provided an overview of the feedback the Maternity Patient Safety Champions received from staff in maternity services, all of whom were members of MNAG providing a voice to all maternity staff and ensuring their involvement in the improvement work;
- CNO and Interim DoM each week spent one day on each of the maternity units, providing senior leadership visibility and also the opportunity for staff to have discussions about the improvement work and raise any concerns or risks.

The NEDs enquired about feedback from front line staff over the last few months. The Interim DoM reported it had been challenging for staff in managing the pandemic and the continued external scrutiny of maternity services. Staff were engaging and asking questions about the improvement work, supported by the unit walkarounds and forums actively seeking staff feedback linking the ward to Board pathway. Following feedback from students, a project to improve the environment for women on a labour ward was being led by students.

The NEDs highlighted the benefits of case studies looking at the experience of women at the present time and how this would be changed with the new model, identifying the positive impact for women. The CNO reported an antenatal pathway review event held attended by over 40 women and stakeholders about their experiences and how this could be improved. The maternity patient involvement model had also been reviewed and the Board would be kept updated on taking this forward around patient feedback.

The NEDs raised the Governor maternity patient experience story presented at a previous Closed Board meeting and that the areas of concern highlighted were being followed up. As well as the listening element in feeding back to the Governor and the Board of the work being done. The CNO reported the Board would receive a presentation at its Closed meeting in March about progress, meetings had been held with a number of the families.

The NEDs enquired what action plans were being developed for the community midwives and how feedback would be obtained from the Maternity Voices Partnership (MVP). The CNO confirmed the Trust was working closely with MVP who were engaged, an event had been held to strengthen the patient voice and involvement strategy for maternity attended by the MVP Chair and Governors. Action plans for community midwifery services were being developed. A positive National and Regional team visit took place on 10 December, who received a presentation from the Executive team and focus groups with staff providing feedback on the developments and engagement improvements with the leadership teams.

The Board of Directors:

- Discussed and **NOTED** the content of the Maternity Safety Champions report; and
- Received **ASSURANCE** the Trust was currently demonstrating compliance with CNST safety action 9.

21/122.4 **IMPLEMENTATION OF MIDWIFERY CONTINUITY OF CARER (MCoC) PLAN**

The Interim DoM reported:

- MCoC that each woman had a named midwife responsible for co-ordinating their care including labour care;
- A CoC team had been in place at EKHUFT that had not been sustainable. The maternity improvement programme and the recruitment programme would be key to its implementation and sustainability with increasing the workforce but was dependent on being able to recruit additional staff;
- Outlined timeline and implementation of the plan, with the aim to start in March 2023 that would initially focus on vulnerable patients and groups;
- Staff training was also a key element with a lot of work undertaken to improve training compliance;
- Engagement was a key area and work had progressed with the Local Maternity and Neonatal System (LMNS) and users of maternity services, acknowledging a great deal of work needed around engaging with staff in developing the Trust's engagement model;
- Estates continued to be a challenge in the community with the development of plans to address these.

The NEDs commented on the unpredictability of women being in labour and admitted, and their named midwife not being able to be present (i.e. due to annual leave) and how this would be managed. The Interim DoM commented on

successful models with teams of no more than six, where each midwife had a buddy ensuring women met the buddy. An alternative model was staff not being on a shift based working pattern and working flexibly around their patient caseload enabling care delivery. She acknowledged the importance of engaging with staff on the model to be implemented in East Kent.

The NEDs raised the challenge in recruiting staff to the funded posts and enquired whether this would have a positive impact on improving staff retention, as well as the feasibility of having the workforce in place by the implementation date. The Interim DoM commented good progress had been made with recruiting additional midwives, it was optimistic that the 100% workforce fill rate would be achieved, a key element that needed to be addressed was the level of sickness absence and working collaboratively with staff on the best model that would not negatively impact staff retention. This would include learning from other organisations that had successfully implemented MCoC as well as ensuring hospital and community midwifery staff were supported around training and governance structure.

DECISION: The Board of Directors:

- Discussed and **NOTED** the contents of the MCoC report;
- **APPROVED** the implementation plan and **APPROVED** to share with the LMNS for inclusion within system plans; and
- **AGREED** to receive an update against delivery of the plan on a quarterly basis in line with National guidance.

21/123 **PEOPLE AND CULTURE COMMITTEE (P&CC) (PREVIOUSLY NAMED STRATEGIC WORKFORCE COMMITTEE (SWC) – CHAIR ASSURANCE REPORT**

The P&CC Chair noted:

- Staff turnover was above the 10% threshold with 12-month rolling average of 12.6%, noting nursing turnover was well below, although an issue had been identified with turnover of Healthcare Assistants that was being looked into;
- Online exit interview system launched and an analysis report was expected to be presented at the next Committee meeting;
- Sickness absence levels remained below the threshold of 5%;
- Preliminary report of the National annual staff survey discussed and a full report was expected at the end of the following month. Results had identified a slight improvement with staff engagement, although overall the results remained disappointing;
- The March Committee meeting would receive a detailed scoping report about the Trust-wide culture change programme;
- The Staff Health and Wellbeing Strategy.

DECISION: The Board of Directors:

- **NOTED** the December 2021 SWC and January 2022 P&CC Chair Assurance reports;
- **APPROVED** the Staff Health and Wellbeing Strategy.

21/124 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

- **NATIONAL CLEANING STANDARDS BUSINESS CASE**

The FPC Chair highlighted key points:

- Development of the Trust's Financial Recovery Plan (FRP) to progress towards exiting the financial element of the Recovery Support Programme (RSP), with support from NHSE/I;
- Three business cases approved:
  - NHS Cleaning Standards recommended for Board approval;
  - Expansion of Renal Dialysis – Phase 1; and
  - Costs for establishing and provision of soft and hard facilities services to the 24 bed critical unit.
- Two business cases not approved:
  - Dermatology relocation to Estuary House and Service Expansion, further work was requested to be done on the strategic location and certainty of source(s) of funding for reporting at the next Committee meeting;
  - Perioperative Care of Older people Undergoing Surgery (POPS) at K&C, requested more work to be done on benefits realisation and report back at the next Committee meeting.

DECISION: The Board of Directors:

- **NOTED** the FPC Chair Assurance report;
- **APPROVED** the NHS Cleaning Standards Business Case.

21/125 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

The Q&SC Chair highlighted key points:

- In line with reducing the burden, Care Groups were not present at the January 2022 Committee meeting, although it remained a full agenda of items discussed;
- The Trust was commended by the NHSE/NHSI Improvement Director on its progress made in IPC;
- Update received on cancer pathway identified from a Serious Incident, and the actions in relation to downgrading of prioritisation of imaging requests for patients with cancer. The actions would close the gaps and ensure timely diagnosis and referral;
- Referral of an action to the P&CC to review the local induction process for agency and bank staff to ensure the Q&SC took assurance that these staff, those new to working with the Trust, and those assigned to an area they normally did not work in received adequate guidance and training provision prior to working in patient facing roles;
- The revised Terms of Reference (ToR) of the Maternity Neonatal Assurance Group (MNAG).

The DoHR&OD reported the local induction process for locums, agency and bank staff had been reviewed, changes made to the checklists, and was appropriate for this to be reviewed by the P&CC. The NEDs raised the importance of receiving feedback from these staff that the provision of support they received was appropriate and sufficient for them to fulfil their roles.

The CNO emphasised the work undertaken strengthening the onboarding processes of qualified and overseas nurses, with positive feedback from overseas

nurses.

DECISION: The Board of Directors:

- **NOTED** the January 2022 Q&SC Chair Assurance report;
- **APPROVED** the Revised ToR of the MNAG.

21/126 **NOMINATIONS AND REMUNERATION COMMITTEE (NRC) – CHAIR ASSURANCE REPORT**

The NRC Chair reported:

- The Managing Director (MD) appointed to 2gether Support Solutions had withdrawn, the other preferred candidate had accepted the role and a report for virtual decision approving this appointment by NRC was currently being considered and the outcome of which would be presented to the next Committee meeting. Interim cover arrangements were in place until the substantive MD was due to commence in April.

The Board of Directors **NOTED** the December 2021 NRC Chair Assurance report.

21/127 **CHARITABLE FUNDS COMMITTEE (CFC) – CHAIR ASSURANCE REPORT**

The Board of Directors **NOTED** the December 2021 CFC Chair Assurance report.

21/128 **BOARD ASSURANCE FRAMEWORK (BAF) AND CORPORATE RISK REGISTERS (CRR)**

The GCS highlighted:

- Two new risks added to the CRR;
- Good movement in reducing risk scores within the CRR and BAF;
- The new proposed template format;
- Board would receive the full BAF and CRR on a quarterly basis.

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

- the risks identified in the BAF and CRR;
- controls, assurance, gaps and actions were appropriate to mitigate the risks identified.

21/129 **ANY OTHER BUSINESS**

There were no other items of business raised for discussion.

21/130 **QUESTIONS FROM THE PUBLIC**

Mrs Warburton raised the transfer of colorectal surgery to K&C and concern about a cancer patient experience who had been booked to receive cancer treatment at Queen Elizabeth the Queen Mother Hospital (QEQM). At their consultation they were informed this would be undertaken at K&C in the next two weeks. The day after their pre-op assessment were informed their surgery would moved back to QEQM with a delay of two weeks. This was a concern for this individual and potentially for others that might have had a similar experience. The COO reported the planned move to K&C of colorectal surgery during the Covid-19 surge to ensure the continued treatment of cancer and urgent patients as a priority. She had not been made aware of any negative impact for patients and services would resume

on the host hospital sites on 7 February. She apologised for the poor patient experience and agreed to liaise with Mrs Warburton outside this meeting to investigate this case and whether there was any wider implication for other patients with the movement of these services.

Mrs Pryer acknowledged the sad news of the death of Dr James Appleyard the previous week, who joined East Kent in 1971 as a paediatrician, recognising his support and work to children, families and staff.

Mrs Pryer raised the two upcoming public consultations about the two options for future hospital care in East Kent and Vascular services, she enquired when these would be out for consultation, and which would be first. She also asked where overseas nurses were being recruited from and what provision was in place with accommodation for these staff. She had details of a Community Interest Company (CIC) that provided affordable accommodation for overseas staff particularly those working in the health service. The DoSD&CP confirmed the Vascular services consultation commenced that month about the provision of services at K&C, with public meetings being held over the next few weeks. The DoHR&OD welcomed any information about CIC organisations. She reported a Trust Accommodation Strategy Group was looking at wider accommodation issues to ensure sufficient provision for nurses as well as all staffing groups on joining the Trust. Provision of Trust accommodation was for an initial three month period, with the opportunity of this being extended that was reviewed on a case by case basis. Along with supporting staff at the point their wished to move into their own accommodation. 2gether were also supporting with looking at private accommodation provision within the community. The CNO commented a Pastoral Officer was in post to support nurses, as part of the Trust's retention programme.

The Chairman thanked everyone for their attendance and support, as well as the continued commitment and dedication of the Trust staff, recognising the benefits of a staff award scheme on the individuals and the positive impact this had on their teams.

The Chairman closed the meeting at 5.15 pm.

Date of next meeting in public: Thursday 10 March 2022 at the Canterbury Cricket Ground.

Signature _____

Date _____

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**MATTERS ARISING FROM THE MINUTES ON 3 FEBRUARY 2022**				
MEETING DATE:	**10 MARCH 2022**				
BOARD SPONSOR:	**CHAIRMAN**				
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**				
APPENDICES:	**APPENDIX 1: ACTIONS TABLE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	**Approval**	Information	Assurance	Discussion
Purpose of the Report:	The Board is required to be updated on progress of open actions and to approve the closing of implemented actions.				
Summary of Key Issues:	An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales. The Board is asked to consider and note the progress updates in the attached action log (Appendix 1).				
Key Recommendation(s):	The Board of Directors is asked to discuss and **NOTE** the progress updates on the actions from the previous meeting, those for a future meeting, and **APPROVE** the actions recommended for closure.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	None				
Link to the Corporate Risk Register (CRR):	None				
Resource:	Y/N	N			
Legal and regulatory:	Y/N	N			
Subsidiary:	Y/N	N			
Assurance Route:					
Previously Considered by:	N/A				

East Kent Hospitals University NHS Foundation Trust

MATTERS ARISING FROM THE MINUTES ON 3 FEBRUARY 2022

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 consider and note the progress updates in the attached action log (Appendix 1).

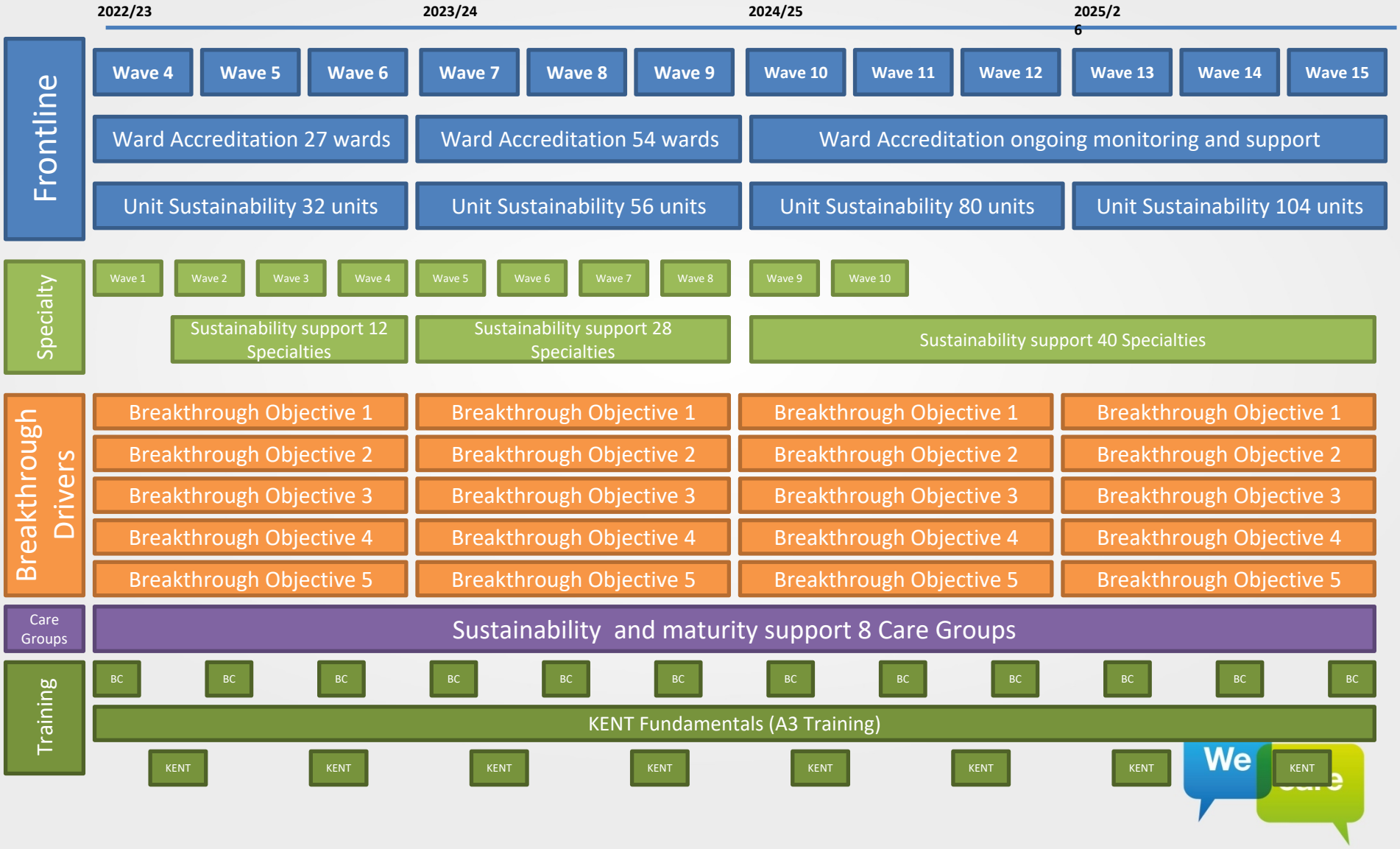
2.3. The Board is asked to consider and approve the actions noted below for closure:

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/19/21	Provide an overview of the rollout of the We Care programme to be appended to the actions table.	~~Dec-21~~/ Mar-22	Director of Strategic Development and Capital Planning (DoSD&CP)	to Close	Overview appended to actions log (Appendix 4). **Action for agreement for closure at 10.03.22 Board meeting**.
B/20/21	Include a list of the Clinical Directors and Clinical Leads with externally facing roles in a future CMO report to the Board.	Mar-22	Chief Medical Officer (CMO)	to Close	Provided as an appendix to the CMO report presented to the 10.03.22 Board. **Action for agreement for closure at 10.03.22 Board meeting**.
B/24/21	Explore the feasibility of producing a breakdown of data separately for men and women within the IPR.	Mar-22	Director of Finance and Performance (DoF&P)	to Close	Currently whilst we capture information on gender it is not a national requirement, however, as part of the latest planning guidance there is a requirement to start exploring health inequalities especially regarding deprivation and ethnicity. As this work evolves further feedback will be given to the Board. **Action for agreement for closure at 10.03.22 Board meeting**.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST - PUBLIC BOARD								
Action No.	**Date of Meeting**	**Min No.**	**Item**	**Action**	**Target date**	**Action owner**	**Status**	**Progress Note (to include the date of the meeting the action was closed)**
B/19/21	28.10.21	21/81.1	Integrated Performance Report (IPR)	Provide an overview of the rollout of the We Care programme to be appended to the actions table.	~~Dec-21~~/ Mar-22	DoSD&CP	to Close	Overview appended to actions log (Appendix 4). **Action for agreement for closure at 10.03.22 Board meeting.**
B/20/21	28.10.21	21/82	Chief Medical Officer's (CMO) Report	Include a list of the Clinical Directors and Clinical Leads with externally facing roles in a future CMO report to the Board.	Mar-22	CMO	to Close	Provided as an appendix to the CMO report presented to the 10.03.22 Board. **Action for agreement for closure at 10.03.22 Board meeting.**
B/24/21	03.02.22	21/119	Integrated Performance Report (IPR)	Explore the feasibility of producing a breakdown of data separately for men and women within the IPR.	Mar-22	DoF&P	to Close	Currently whilst we capture information on gender it is not a national requirement, however, as part of the latest planning guidance there is a requirement to start exploring health inequalities especially regarding deprivation and ethnicity. As this work evolves further feedback will be given to the Board. **Action for agreement for closure at 10.03.22 Board meeting.**
B/25/21	03.02.22	21/119	Integrated Performance Report (IPR)	Provide an update on the ward that had implemented We Care focussing on the reducing falls breakthrough objective and whether a reduction in falls was being maintained.	Mar-22	CNO	Open	Verbal update will be provided to the Board.
B/26/21	03.02.22	21/121	Infection Prevention and Control (IPC) Board Assurance Framework (BAF)	Present the IPC work programme to the Board for information once completed.	Apr-22	DIPC	Open	IPC work programme will be presented to the April 2022 Board meeting, as part of the IPC BAF report.

We Care roll out plan for all aspects of system

NHS
East Kent Hospitals University
NHS Foundation Trust



We Care Roll out

Frontline:

Front line roll out will consist of waves of up to 8 units, each wave takes 4 months, meaning up to 24 units a year. There is a significant time commitment for this approach, meaning more than 8 units per wave would require investment in the Centre of Excellence (CoE) and organisational commitment to release extra staff. Not all areas will be covered in the next 4 years (Western have been undertaking the approach for 9 years and has not fully rolled out across the Trust), however a tipping point will be reached in year two / three as a large number of clinical areas will have been covered by this point. We will need to consider an alternative roll out for smaller areas or commit to a longer roll out plan (c. 2 years more)

Ward Accreditation will focus initially on IP ward areas and will roll out to the 54 ward areas over the next two years and will closely align with the frontline roll out. Once an area has been audited depending on its score, it will continue to be monitored and supported. All wards will be in monitoring and support by 2024.

Unit Sustainability will start this year to support those units that we have completed the first 4 months to ensure the routines, rhythms and tools are embedded to ensure a continuous improvement culture.

Specialty roll out will be in waves of up to 4 specialties and each wave takes 3 months (rapid roll out model developed by Trust CoE) meaning 12 specialties a year (1st wave starts 31 March). All specialties will have the performance management resources by 2024

Specialty Sustainability will start as soon as the first wave have been completed. This will comprise support from C0E to embed and mature the toolkit similar to the Care Groups ongoing support.

- **Care Group** – Roll out to 8 Care Groups (Complete). Ongoing maturity training and coaching to move all care groups to at least silver this year
- **Drivers** – 5 driver meetings linked to the annual breakthrough objectives that have c. 6 units/specialties at a time trained in A3 thinking and working on common problems. This will continue year on year.
- **Training** – Deliver 3 boot camps a year, at least 12 KENT fundamentals and 2 KENT Project management training courses a year. This will mean at least 450 staff a year will be trained in improvement tools and applying them after (including staff to be trained in frontline and specialty).

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**CHAIRMAN'S REPORT**				
MEETING DATE:	**10 MARCH 2022**				
BOARD SPONSOR:	**CHAIRMAN**				
PAPER AUTHOR:	**CHAIRMAN**				
APPENDICES:	**APPENDIX 1: NON-EXECUTIVE DIRECTORS' (NEDs) COMMITMENTS**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion
Purpose of the Report:	The purpose of this report is to: • Report any decisions taken by the BoD outside of its meeting cycle; • Update the Board on the activities of the Council of Governors (CoG); and • Bring any other significant items of note to the Board's attention.				
Summary of Key Issues:	Update the Board on: • Current Updates; • Update from Closed Board; • Integration White Paper; • Activity of the CoG; • Consultant Appointments.				
Key Recommendation(s):	The BoD is requested to **NOTE** the contents of this Chairman's report.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	N/A				
Link to the Corporate Risk Register (CRR):	N/A				
Resource:	~~Y~~/N	N			
Legal and regulatory:	~~Y~~/N	N			
Subsidiary:	~~Y~~/N	N			
Assurance Route:					
Previously Considered by:	N/A				

East Kent Hospitals University NHS Foundation Trust

CHAIRMAN'S REPORT

1. Purpose of the report

To report any decisions taken by the BoD 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

We had a short formal meeting last month alongside an important development day including a useful training session for Board members run by the Healthcare Safety Investigation Branch (HSIB).

I wanted to express the thanks and appreciation of the Board to all our staff who worked so hard to set up the Nightingale Hub alongside having to cope with very extensive other pressures and succeeding in doing so in an amazingly short time period. The fact that it was not required is an obvious source of relief but we have not only learned lessons from the experience but have now developed systems and processes which should give us a road map to undertake similar emergency building projects if they are required in future.

The pandemic may be receding but it is still with us and we are now having to adjust to a new phase in which we learn to live with it alongside other infectious diseases. It will be another highly challenging period not least because of the significant backlog of patients needing treatment.

This will be Susan's last meeting and I wish to record here our thanks and appreciation for all she has done for the Trust during her 4 years at the helm. Her commitment and dedication have been outstanding and she has led this organisation through the most difficult period in its history. Many challenges remain but we have made so many improvements under her leadership for which we are very grateful.

3. Closed Board Meeting Items

At today's Private Board Session, a Transition Plan is due to be presented, to provide assurance of a smooth transition to the incoming Chief Executive Officer (CEO), Tracey Fletcher, who joins us on 4 April.

Sarah Shingler, Chief Nursing and Midwifery Officer, and Nick Hulme, Governor, are attending the Closed Board meeting to provide an update on progress in maternity services in response to issues raised by Governors and to update the Board on the work underway.

4. The Integration White Paper

The Government has produced an integration white paper which focuses on the new arrangements at 'place' level - in our case that means East Kent and the East Kent Health and Care Partnership. The Government's aim and that of the partnership is to achieve better integration across primary care, community health, adult social care, acute, mental health, public health, housing and the voluntary and community sector. All these elements are represented on the Health and Care Partnership Board which I chair. The new Integrated Care Board (ICB) for Kent and Medway is still considering how it will devolve and delegate

services to local level and both the East Kent Partnership and the Trust will be working closely with the ICB leadership to develop the new relationships.

5. Council of Governors (CoG)

The Council had a successful meeting with the Board of the Trust on 10 February, where the Governors heard reports from Non-Executive Directors (NEDs) and Executive Directors and were able to engage with Directors on a range of topics. Governors have been invited to join the meetings with Trust partners to develop our Strategic Initiatives for 2022/23.

We will start site visits between the NEDs and the Governors again next month - the first will be at William Harvey Hospital (WHH) on 14 March and a plan for future visits in 2022/23 is being prepared.

Council is working on a Membership and Engagement Strategy to develop better communication with members and to encourage greater involvement with participation from our membership.

We have two Governor vacancies for Swale with the search for candidates on-going.

Council has been briefed on the Care Quality Commission's (CQC's) 2021 Maternity Survey report by the Chief Nursing and Midwifery Officer, Sarah Shingler. The report underlines the continuing need to improve the experience of mothers and their babies who receive our services.

6. Consultant Appointments

NED members of the Board are responsible for chairing Advisory Appointment Committees (AACs) for new substantive Consultant posts. The following panel was chaired:

- Consultant Emergency General Surgeon with an Upper GI Interest

East Kent Hospitals University NHS Foundation Trust

Non-Executive Directors' (NEDs) Commitments

NEDs February 2022/March 2022 commitments have included:

Chairman	Chaired meeting of NEDs Meetings with individual NEDs Meetings with Executive Directors Meetings with incoming Chief Executive Officer Meeting with Independent Investigation into East Kent Maternity Services (IIEKMS) panel Chaired NEDs/Council of Governors (CoG) joint meeting Meetings with Lead Governor Chaired meetings with Governors Governor Nominations and Remuneration Committee meeting Meeting with Chairman, Spencer Private Hospitals (SPH) Meetings with Consultants, Doctors, Front Line Staff and visits to clinical areas Meeting with Lead Freedom to Speak Up Guardian Meetings with NHS England/NHS Improvement (NHSE/I) Improvement Director Meeting with Care Quality Commission (CQC) Chief Inspector of Hospitals NHSE/I South East Regional Focus meeting (visit to EKHUFT) Addressed British Citizen Award Ceremony for Trust staff East Kent Strategic Initiative workshop Chaired East Kent Health and Care Partnership (HCP) Board meeting Kent & Medway Chairs meetings Chaired interview panel for Chair of 2gether Support Solutions Kent and Medway Medical School event Meeting with NHSE/I Chief Operating Officer and NHSE/I Regional Director for the South East

Non-Executive Directors	Meetings with Chairman Meetings with Executive Directors Integrated Audit and Governance Committee meeting Finance and Performance Committee meeting Quality and Safety Committee meeting People and Culture Committee meeting Maternity and Neonatal Assurance Group meeting Organ Donation Committee meeting Safeguarding Assurance Committee meeting Cultural Change meeting NEDs/CoG joint meeting Governors briefing East Kent Strategic Initiative workshop Meeting with East Kent Hospitals Charity team Meeting with Spencer Private Hospitals Kent & Medway Integrated Care System (ICS) Partnership Board meeting 2gether Support Solutions Board meeting NHS Providers NED Network event

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**CHIEF EXECUTIVE'S REPORT**				
MEETING DATE:	**10 MARCH 2022**				
BOARD SPONSOR:	**CHIEF EXECUTIVE**				
PAPER AUTHOR:	**CHIEF EXECUTIVE**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	The Chief Executive provides a monthly report to the Board of Directors providing key updates from within the organisation, NHS Improvement (NHSI), NHS England (NHSE), Department of Health and other key stakeholders.				
Summary of Key Issues:	This report will include a summary of the Clinical Executive Management Group (CEMG) as well as other key activities.				
Key Recommendation(s):	The Board of Directors is requested to **DISCUSS** and **NOTE** the Chief Executive's report.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	The report links to the corporate and strategic risk registers.				
Link to the Corporate Risk Register (CRR):	The report links to the corporate and strategic risk registers.				
Resource:	~~Y~~/N	No			
Legal and regulatory:	~~Y~~/N	No			
Subsidiary:	~~Y~~/N	No			
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 Improvement (NHSI), 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

3.1 Business cases approved or recommended at the 9 February 2022 meeting of the CEMG included:

- Development of Medical Physics;
- Restructure of Chief Medical Officer (CMO) Team;
- Medical Thrombectomy.

4. Operational Update

4.1 Despite the recent changes in law associated with the removal of all Covid-19 restrictions, the UK remains at a Covid Level 4 National Incident. Covid admissions peaked for the Trust in mid-January however, inpatient numbers remain high (c.130) across the Trust, with acute sites across Kent and Medway continuing to be under significant pressure. There is a notable rise in the number of patients who are delayed in hospital when their on-going needs could be met at home, with support or in residential care; this number is now at 314 compared to 166 back in February 2021.

Throughout the peak of the Omicron wave, Trusts were asked to continue, where possible, with elective care, but to focus on the highest clinical priority patients such as cancer and long waiting patients. As part of our preparations for this wave, the Trust transferred high priority surgery across to Kent and Canterbury Hospital. This remained in place until 7 February 2022, at which time Colorectal cancer surgery and ENT Otology surgery returned to their original sites. This allowed the continuation of important surgical services, as the acute hospital sites balanced Covid-19 and winter surge demand.

4.2 Nightingale Update

On 11 February 2022, EKHUFT received notification from NHSE/I, that the national team have now stepped down the Nightingale Surge for William Harvey Hospital (WHH), which had been in a slow-down phase as the Covid-19 risk abated. The decommissioning process commenced on 21 February 2022 and works will continue until 11 March 2022 (subject to any weather-related delays).

The collaboration and efforts of senior staff to support the Nightingale Programme throughout late December and early January was significant. The culmination of the work undertaken has ensured that EKHUFT has a fully developed clinical and operating policy and clear understanding of the requirements to facilitate a Nightingale Hub on site at the William Harvey Hospital. Should such a contingency ever be needed again for any reason, all of the necessary work is prepared. My thanks to the Execs and hospital leadership team, as well as colleagues in 2gether Support Solutions (2gether), for their excellent team work.

4.3 Elective Update

The 2022/23 Priorities and Operational Planning Guidance were published on 24 December 2021. Key highlights for elective are to deliver significantly more elective care, reduce long waits and improve performance against the cancer waiting times standard. In response to the latest Omicron wave, a further update to the operational planning guidance was issued in early February. The key update extended the period of time to eliminate waits of over 104 weeks from January 2022 to July 2022; the guidance provided a clear target for eliminating waits of over 78 weeks by April 2023 and outlined the ambition to ensure no patients wait over 52 weeks by March 2025.

In response to the updated guidance, Care Groups are in the process of working through their detailed activity planning for 2022/23 to ensure the Trust is able to meet the targets for this year and those set for subsequent years. A task and finish group meets weekly to review those patients currently waiting over 104 weeks and is sighted on those potentially tipping into this bracket in forthcoming months. There is confidence that the Trust will meet the first significant target of eliminating those patients waiting over 104 weeks, by July 2022.

5. Finance Update

5.1 The Trust has delivered a deficit of £0.1m to the end of January. It is expected we will breakeven for the 2021/22 financial year, consistent with plan. The Trust continues to work closely with Kent and Medway system partners to develop our operational plan for 2022/23.

6. Covid 19 Update

6.1 At the time of writing (1 March 2022), the numbers of inpatients with Covid-19 are rising a little. We currently have around 130 patients and the Board will note the numbers are fluctuating. A verbal update will be given at the Board meeting.

6.2 Vaccination continues to be encouraged for all of our staff.

7. People and Culture

7.1 On 24 February 2022, the Trust received the formal outputs of the National Staff Survey (NSS). The information is embargoed until 30 March 2022 and therefore will be shared at the next People and Culture Committee and onto the Board.

7.2 Our People Strategy has been refreshed and the Cultural Change Programme scoped, ready for discussion with the People and Culture Committee. This will incorporate early findings and our response to the NSS and the recent review of Equality Diversity and Inclusion that has now been finalised.

8. Strategic Update – Focussed Visit – 25 February 2022

8.1 A Regional Focus Meeting (RFM) was held with regional and national colleagues regarding key priorities for both the East Kent system, as well as the Trust, on 25 February 2022. This included demonstrating the crucial need for capital allocations (£461m) from the New Hospitals Programme for the reconfiguration of acute services within East Kent, explaining the health needs of the population and our key risks and issues. The meeting took place at the Queen Elizabeth the Queen Mother Hospital (QEQM) and we were grateful that national and regional colleagues took time to visit us locally to gain a better understanding of our case. Colleagues visited Emergency Department (ED) to see the progress of the new build; maternity and Special Care Baby Unit (SCBU) to understand the estate and facilities challenges; Deal ward to understand the ward configuration issues. Our staff were positive, confident and purposeful and above all, pleased to show off their services to our visitors.

9. Catalyst 'Dragon's Den'

9.1 I was delighted to be involved in the Research and Innovation Catalyst 'Dragon's Den', which took place on 10 February 2022. It was fantastic to see the encouragement for research activity and the excellent competitive process for research bidders to pitch for several thousand pounds' worth of investment to supercharge their research projects. The projects were wide ranging but also enabled me to see the clinical depth and talent in the organisation.

10. New Intensive Care Unit – Visit from Damian Green

10.1 On 4 February 2022, we welcomed Damian Green, MP, to visit the new Intensive Care Unit (ITU) at WHH. He took the opportunity to tour the area and compare and contrast what a modern ITU will look like compared to that which has been serving patients since the 1970s.

11. Farewell

11.1 This is my last Board meeting and inevitably I'd like to reflect on a few things. Firstly, taking national colleagues to some of our departments on 25 February was so very enjoyable. This was entirely due to the enthusiasm, professionalism and positivity of the staff who were proud to confidently present their services. This included seeing the progress of the building developments in ED. I have been pleased we have made the case for substantial additional investment in our hospitals which will see patients, families and our staff benefit for years to come. Observation wards, Cardiac extension, ED expansion, ITU developments, the Elective Orthopaedic Centre. This has been an extensive capital programme but of course we need more.

Kings College colleagues came to assess the medical student educational and pastoral experience last week too. Again, this was an incredibly positive visit. I have been pleased and proud to practically support the Director of Medical Education (DME) and her staff and there is no doubt the educational offer here is excellent. I was encouraged with their ability to manage the requirements of the partner medical schools including the Kent and Medway Medical School. As a long-term supporter of this development I'm delighted that this medical school went ahead and is flourishing. Its really good news that we have the Dean on our Board and our relationship with our local universities is excellent.

I mentioned the research dragons earlier and it has been a privilege to support such a strong research base and such well regarded research leads in Tim Dalton and now Jess Evans. East Kent contributes greatly to the Kent Surrey Sussex (KSS) Clinical Research Network (CRN). The value of research moved from the academic and distant to the immediate and personal during the Covid waves but it has a long standing regional structured governance too which is well embedded. Research is a necessary responsibility we should contribute to, even more so with the arrival of the medical school.

Being distant from a metropolitan centre and surrounded by water, East Kent has to meet the needs of all of its population. This is a challenge but does lead to the provision of a very broad range of services not normally provided in a local Trust – the Primary Percutaneous Coronary Intervention (PCI) centre; full head and neck provision; renal dialysis, children's and adult haemophilia services; robotics; vascular, and neuro rehab to name some of these. This broad range of provision needs support and I have been proud to see all of these services grow and attract quality clinicians to them.

The last two years have been the greatest challenge for the NHS, our staff and our citizens. Our staff, our clinical leaders and their teams, and our management community have all risen to the challenge; shown great resilience, bravery and ingenuity. Hard work and great collaboration has all been required to meet some epic challenges.

I'd like to thank the Board, my Executive Team, the Care Group and Hospital Teams and so many staff who I will see personally in the next few weeks. I'm proud of what we have achieved together and would wish you success on the ongoing development and improvement of this Trust.

12. National Updates

12.1 Latest national updates are as follows:-

Coronavirus » Delivery plan for tackling the COVID-19 backlog of elective care (england.nhs.uk)

13. Conclusion

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

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**INTEGRATED PERFORMANCE REPORT (IPR)**
MEETING DATE:	**10 MARCH 2022**
BOARD SPONSOR:	**DIRECTOR OF FINANCE AND PERFORMANCE**
PAPER AUTHOR:	**DIRECTOR OF FINANCE AND PERFORMANCE**
APPENDICES:	**APPENDIX 1: JANUARY 2022 IPR**

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	The Trust has been engaged with a new quality improvement programme called "We Care". The premise is that the Trust will focus on fewer metrics but in return will expect to see a greater improvement (inch wide, mile deep).				
Summary of Key Issues:	The attached IPR is now ordered into the following: **True Norths-** These are the Trust wide key strategic objectives which it aims to have significant improvements on over the next 5 years, as these are challenging targets over a number of years it may be that the targets are not met immediately and it is important to look at longer term trajectories. The areas are: • our **quality and safety.** The two metrics the Trust has chosen to measure against is total harms and mortality rate. • our **patients.** The four metrics being measured are the Cancer 62-day target, the Accident & Emergency (A&E) 4-hour performance target, the Referral to Treatment (RTT) 18-week target and the Friends and Family recommended %. • our **people.** The two metrics chosen are staff turnover and staff engagement. • our **sustainability.** The two metrics chosen to improve are the Trust's financial position and carbon footprint. • our **future.** The two metrics chosen are the medically fit for discharge % and virtual outpatients usage. **Breakthrough objectives-** These are objectives that we are driving over the next year and are looking for rapid improvement. The key areas are: • **Reducing falls**. The target is to have no more than 100 falls per month, this month there was 147. • **Reducing deaths from sepsis**. The latest reportable figure of October 2021 shows an improvement in the sepsis/ respiratory Hospital Standardised Mortality Ratio (HSMR) figures of 112.4 this is below our target of 117. • **Reducing patient time in Emergency Department (ED) once there has been a decision to admit.** Total				

East Kent Hospitals University NHS Foundation Trust

	aggregated delays of 864 hours in our ED remains a significant focus and is higher than our 95-hour target. • **Improving theatre capacity.** The lost theatre opportunities in month was 52 which is worse than the 45 target. **Watch Metrics-** these are metrics we are keeping an eye on to ensure they don't deteriorate.
Key Recommendation(s):	To **CONSIDER** and **DISCUSS** the True North and Breakthrough Objectives of the Trust.

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

Link to the Board Assurance Framework (BAF):	BAF30: Benefits of We Care BAF29: Positive Culture	
Link to the Corporate Risk Register (CRR):	CRR47: Infection Prevention Control (IPC) CRR68: Constitutional Standards CRR77: Maternity Services CRR84: Deteriorating Patient CRR87: Hospital	
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:	None	

East Kent Hospitals University NHS Foundation Trust

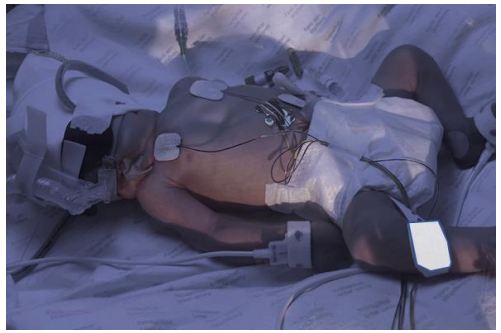
Integrated Performance Report

January 2022







Our vision, mission and values

We care' is how we're working to give great care to every patient, every day. It's about being clear about what we want to focus on and why and supporting staff to make real improvements, by training and coaching everyone to use one standard method to make positive changes.

We know that frontline staff are best placed to know what needs to change. We've seen real success through initiatives like 'Listening into Action', 'We said, we did', and 'I can'.

'We care' is a bigger version of this – it's the new philosophy and new way of working for East Kent Hospitals. It's about empowering frontline staff to lead improvements day-to-day.

It's a key part of our improvement journey – it's how we're going to achieve our vision of great healthcare from great people for every patient, every time.

For 'We care' to be effective, we need to be clear about what we are going to focus on – too many projects will dilute our efforts.

For the next five years, our focus centres on five "True North" themes. These are the Trust-wide key strategic objectives which it aims to significantly improve over the next 5 years:

- our **patients**
- our **people**
- our **future**
- our **sustainability**
- our **quality and safety**

True North metrics, once achieved, indicate a high performing organisation.

What is the Integrated Performance Report (IPR)?

To turn these strategic themes into real improvements, we're focusing on five key objectives that contribute to these themes for the next year. These are the "breakthrough" objectives that we are driving over the next year and are looking for rapid improvement.

- Reducing falls
- Reducing healthcare acquired infections
- Reducing deaths from sepsis/respiratory failure
- Improving theatre capacity
- Reducing patient time in ED once there has been a decision to admit.

We have chosen these five objectives using data to see where focusing our efforts will make the biggest improvement. We'll use data to measure how much we're making a difference.

Frontline teams will lead improvements supported by our Improvement Office, which will provide the training and tools they need. Our Executive Directors will set the priorities and coach leaders in how to support change. Our corporate teams will work with frontline teams to tackle organisation-wide improvements.

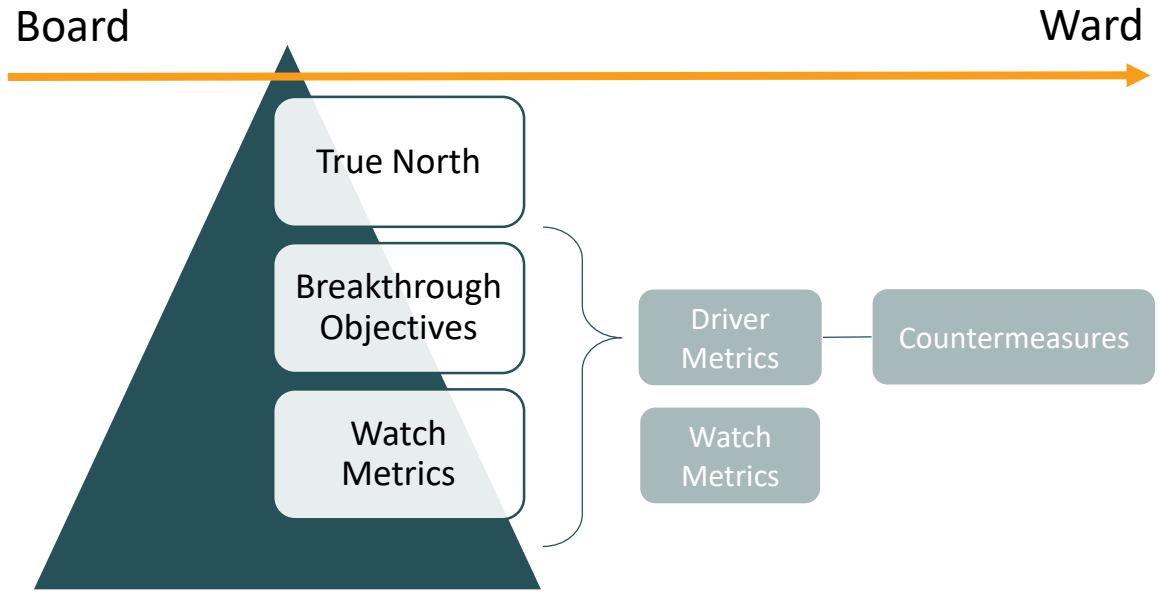
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our improvement journey.

Integrated Performance Report

IPR

Performance Review Meetings

PRM



The IPR forms the summary view of Organisational Performance against these five overarching themes and the five objectives we have chosen to focus on in 2020/21. It is a blended approach of business rules and statistical tests to ensure key indicators known as driver and watch metrics, continue to be appropriately monitored.

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

The 'We Care' methodology incorporates the use of SPC Charts alongside the use of Business Rules to identify common cause and special cause variations and uses **NHS Improvement** SPC icons to provide an aggregated view of how each KPI is performing with statistical rigor.

The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

A minimum of 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels.

If data point falls outside these levels, an investigation would be triggered.

It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Where to find them

What are the Business Rules?

East Kent Hospitals University NHS Foundation Trust

Breakthrough objectives will drive us to achieve our "True North" (strategic) goals, and are our focus for this year.
These metrics have a challenging improvement target and the scorecard will show as red until the final goal is achieved when it then turns green. Once achieved a further more stretching target may be set to drive further improvement, turning the metric back to red, or a different metric is chosen.

Metrics that are not included in the above are placed on a watch list, where a threshold is set by the organisation and monitored. More of these metrics should appear green and remain so. Watch Metrics are metrics we are keeping an eye on to ensure they don't deteriorate.

Business rules work in conjunction with SPC alerts to provide a prompt to take a specific action.

This approach allows the organisation to take a measured response to natural variation and aims to avoid investigation into every metric every month, supporting the inch wide mile deep philosophy.

The IPR will provide a summary view across all True North metrics, detailed performance, actions and risks for Breakthrough Objectives (driver) and a summary explanation for any alerting watch metrics using the business rules as shown here as a trigger.

#	Rule	Suggested rule
1	**Driver** is **green** for reporting period	Share success and move on
2	**Driver** is **green** for six reporting periods	Discussion: 1. Switch to watch metric 2. Increase target
3	**Driver** is **red** for 1 reporting periods (e.g. 1 month)	Share top contributing reason, and the amount this contributor impacts the metric
4	**Driver** is **red** for 2 reporting periods	Produce Countermeasure summary
5	**Watch** is **red** for 4 months	Discussion: 1. Switch to driver metric (replace driver metric into watch metric) 2. Reduce threshold
6	**Watch** is out of control limit for 1 month	Share top contributing reason (e.g. special / significant event)

Our quality and safety

Our quality and safety

Rebecca Martin

Mortality (HSMR)

Mortality metrics are complex but monitored and reported nationally as one of many quality indicators of hospital performance. While they should not be taken in isolation they can be a signal that attention is needed for some areas of care and this can be used to focus improvement in patient pathways.

Our aim is to reduce mortality and be in the top 20% of all Trusts for the lowest mortality rates in 5 to 10 years. We have set our threshold for our rolling 12 month HSMR to be below 90 by January 2027 to demonstrate achievement of our ambition.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
101.6	100.9	97.3	95.8	94.1	94.3	94.8	95.4	97.6			

F

Variation indicates consistently falling short of the target

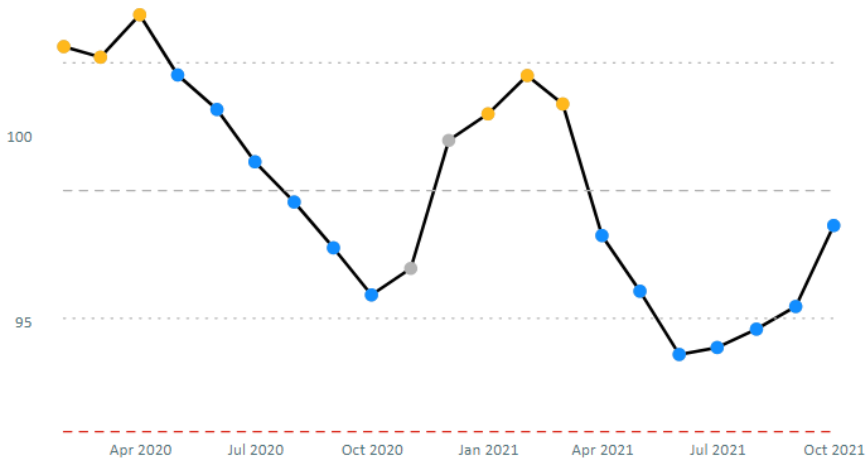
L

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

Flag Description

Below Mean Run Group Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

The Trust HSMR has been improving since the end of the second Covid-19 wave in March 2021 falling below the lower control limit of the SPC chart since June 2021. Quarter two performance is showing an upward trend and currently lies within control limits.
The metric demonstrates a 12 month rolling position.

Intervention and Planned Impact

Interventions planned to drive our improvement are:

- Breakthrough Objective focussed on improving outcome for patients admitted to our hospitals with sepsis or respiratory failure as their admission diagnosis. This has reached its target and is detailed on slide 8. Due to the challenge of tracking this metric against specific interventions it is being reviewed for 2022/23.
- The fracture Neck of Femur pathway is being revised to improve outcomes for this group of patients and this is reported as a driver metric for Surgery and Anaesthetic Care group. We are analysing the impact of reducing our current HSMR for fractured neck of femur from 118 to 100 on the overarching metric to give us an reduction of 2 points on overarching HSMR.
- The Trust has commissioned a desktop review of our mortality review processes through the NHSIE Better Tomorrow team. This will allow us to recognise good current practice and implement recommendations so our Learning from Deaths programme delivers improvements in patient pathways that deliver improved outcomes. The expected impact will be quantified when the outcome of the review is received (due Feb 2022).
- A focussed review of patients with healthcare associated Covid-19 is being undertaken to identify any additional learning

Risks/Mitigations

The impact of Covid-19 on national mortality surveillance is a risk as yet unquantified.

20/21 breakthrough objective

Sepsis & Respiratory Failure (Composite HSMR)

Sepsis and respiratory failure have consistently triggered as primary diagnostic categories making the greatest contribution to the Trust's HSMR over the last few years. We believe that understanding and acting on the drivers behind this performance will help us provide a safer service for our patients.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
134.2	128.7	122.2	114.7	112.8	112.8	110.7	111.3	112.4			

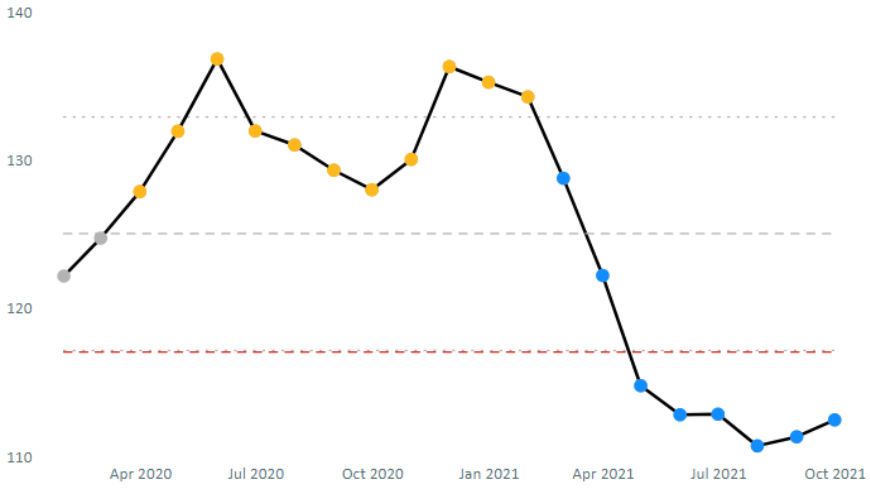
Variation indicates consistently falling short of the target

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

Flag Description

Below Mean Run Group Astronomical Point Two Out Of Three Beyond Tw...

XMR Run Chart



What the chart tells us

The Trust composite HSMR began to rise at the beginning of the global C-19 pandemic peaking around June '20. The rolling 12 month position dropped slightly following the first wave, peaking again following the second wave in early '21. Since then the rolling 12 month performance has consistently improved, achieving threshold in May '21. Performance has been sustained below threshold up to and including the most recent data point in October '21.

Intervention and Planned Impact

The improvement tool used to investigate this breakthrough objective has focused on 3 areas with a 4th being identified via a national mortality alert in November 2020; Recognition, escalation and response to the deteriorating patient, Advance care planning, Learning from deaths and harm & Excess mortality in hip fracture patients.

Interventions over the last 30 days;

- Clinicians engaged NHSE/I support (Better Tomorrow) with review of Trust process in Mortality and Learning from deaths; initial analysis completed; feedback awaited with recommendations.
- Clinical teams introduced to new advance care planning tool (ReSPECT) due to be implemented across Kent & Medway in April 2022; clinical working group assembled.

Interventions planned for the next 30 days

- Confirm the digital methodology to operationalise Sepsis compliance audit from Sunrise system
- Engage Care Groups in updates through Learning from Deaths roadshow
- Re-establish Seabathing ward as nominated hip fracture ward (compromised by the latest Omicron wave of pandemic)

Risks/Mitigations

There are currently no considered risks with this breakthrough objective.

Our quality and safety

Sarah Shingler

The True North target is to achieve zero avoidable harm within 5-10 years. Our calculation includes incidents with harm or those that have the potential to lead to harm and aggregates the following;

- Falls, Pressure Ulcers, C Difficile (in-hospital), E.Coli (in-hospital), Covid Infections (in-hospital), Nutrition Incidents, Medication Errors

The effects of patient safety incidents go beyond the impact of the physical injury itself. Patients and their families can feel let down by those they trusted, and the incident may also lead to further unnecessary pain and additional therapy, or operative procedures and additional time in hospital or under community care.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
482	471	381	431	453	490	436	445	442	459	497	643

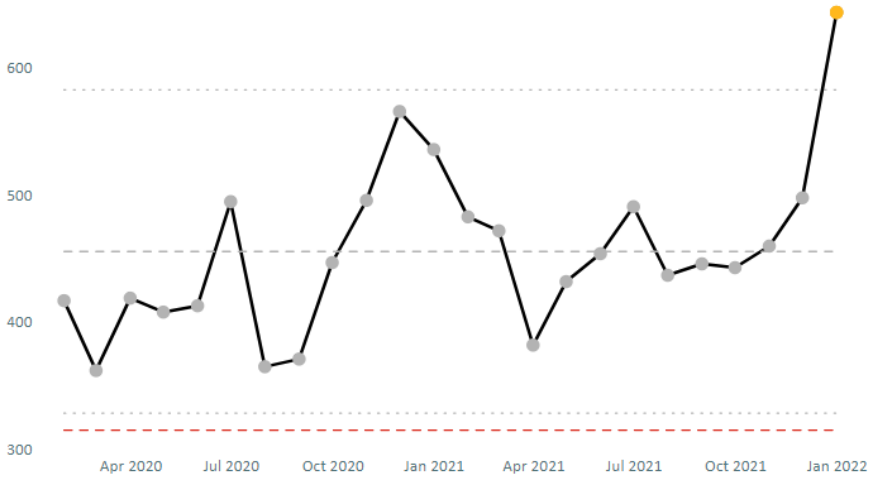
F — Variation indicates consistently falling short of the target

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

Flag Description

Astronomical Point

XMR Run Chart



What the chart tells us

The number of total harms has been fluctuating around the mean and within normal variation for the period since February 2020.

The most recent month's data point has breached the upper control limit on the SPC chart, this increase is driven by the number of C-19 HCAI infections in January '22.

Intervention and Planned Impact

Safe staffing is a major factor contributing to patient harms, we are now beginning to see a direct correlation between low staffing levels and harm. A business case has been approved and recruitment pipeline in place. We expect to see a demonstrable change in staffing levels from May '22 onwards, being fully established by December '22.

Terms of Reference and membership have recently been refreshed for the pressure ulcer and falls multi disciplinary team (MDT) steering groups, both chaired by the Site Director of Nursing. Oversight of progress is reported through the Fundamentals of Care Committee with exception reporting into Quality & Safety Committee (QSC).

An improvement plan is in place for nutrition, falls and pressure ulcer care.

Risks/Mitigations

- Fundamentals of Care training and We Care meetings recommencing.
- Temporary staffing strategies in place to support QEQM ED and AMUs and other wards where staffing is significantly compromised and where enhanced care is required.
- Ward leaders and Matrons out on the floor supporting ward teams, increasing oversight that risk assessment and falls/pressure strategies are being used.

20/21 breakthrough objective

Falls

Analysis shows that falls are currently the greatest contributor to harm events. Currently 45% of falls are reported as not resulting in harm and 54% of falls are reported as resulting in low harm. The assessment of falls is not currently standardised across the Trust.

Any fall can leave patients and their families feeling let down by those they trusted, with the potential need for further therapy, pain, operative procedures or additional time under community care or in hospital. All can impact long term outcome.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
131	112	102	104	132	140	132	146	146	134	148	165

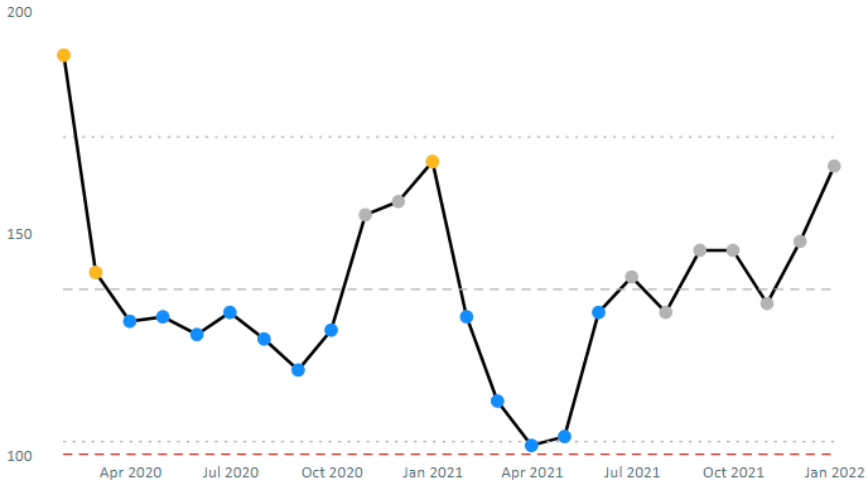
Variation indicates consistently falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The number of falls in January across the Trust was 165. The number had plateaued between June to Nov '21 during a period of intensive focus on harm reduction from falls, by wards/care groups and driver meetings. In Dec/ Jan operational pressures around hospital flow have increased, with additional escalation areas opened and attendance at the driver meetings reduced to allow that focus.

Harm reported in Jan 22: 2 severe, 59 low and 102 low harm events.

Areas of high numbers of falls include UEC areas and Harbledown; hyperacute stroke ward.

Intervention and Planned Impact

- The Dec/Jan driver meetings have been utilised to support the corporate Falls leads in bringing the 'Falls Yellow Kits' into use in the UEC care group. These have now been successfully procured and rolled out at WHH and QEQM. The pilot predicts the impact of the roll out will be greater identification and visibility of patients at high risk of falls, with a significant reduction in falls across UEC (up to 20 fewer falls per month) which continues into the ward admission.
- Harbledown ward currently have the highest numbers of falls across the Trust (10 falls). All of these were either no harm (8 falls) or low harm (2 falls), 8 were unwitnessed. As a hyperacute stroke ward, higher numbers of falls would be expected as a consequence of mobilisation during rehabilitation. The goal is to minimise harm from these through: falls focus at daily handovers, focus on lying/standing BPs, tag 1-1 handovers via yellow arm bands, refocus on falls training. Work is ongoing around enhanced observation training, with weekly (Monday) falls specialist nurse updates.

Risks/Mitigations

Harbledown Ward;

- Out of hours mobility assessments with reduced provision of walking aids. Mitigated by reviewing assess to Yellow Frames on the ward and their placement in the proximity of the nursing station/ bathroom.
- Issues around ward call bells: HoN is reviewing the current arrangements.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	Type	BO	KPI	Thres.	Oct-21	Nov-21	Dec-21	Jan-22
Harm Events	W4		Covid-19 HCAI	1	14	15	36	178
	W4		VTE Assessment Compliance	90.0%	89.2%	89.6%	90.0%	88.3%
	W4		Serious Incidents	18	24	35	24	21

Covid-19 HCAI

The Omicron variant surge presented new and complex challenges, with increased transmissibility compared with Delta (circa X3) and the original Covid-19 virus (circa X10). In common with other trusts locally and nationally there have been a number of outbreaks and clusters of HCAI cases. A second smaller surge in February will see lower but still significant numbers of HCAI cases. Conversely mortality and morbidity appear to be very much reduced in all cases; many cases are incidental findings in patients presenting for other reasons.

VTE Assessment Compliance

The stratified data showing underperformance being driven by number of spells across GSM specialties, general surgery and trauma and orthopaedics without VTE risk assessment. The relevant care group clinical directors are leading on focussed improvement work in their respective areas and are updating the impact via their quality governance reports.

Serious Incidents

The number of SI's remain consistent, with the main themes continuing to be delays in care, falls and pressure ulcers. This reporting period also included 4 Covid-19 outbreaks, and 2 historical maternity cases that are being re-opened.

Our patients

Our patients

Rebecca Carlton

Trust Access Standards: 18wk Referral to Treatment

The National RTT Standard is to achieve a maximum of 18 weeks wait from GP referral to 1st definitive treatment for every patient. It is a priority to ensure patients have access to timely care whilst also reflecting patient choice regarding timing and place of treatment.

Performance has been adversely affected by the global pandemic and as we enter our recovery phase we are committed to improving our elective waiting times moving towards delivery of the constitutional standard. As part of the 'sustaining access' Strategic Initiative early work has commenced with system partners regarding demand management, pathway design, and an early focus on waiting times for 1st Outpatient Appointment.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
61.0%	59.3%	59.7%	62.7%	64.3%	64.5%	63.6%	62.0%	61.4%	61.3%	59.8%	59.6%

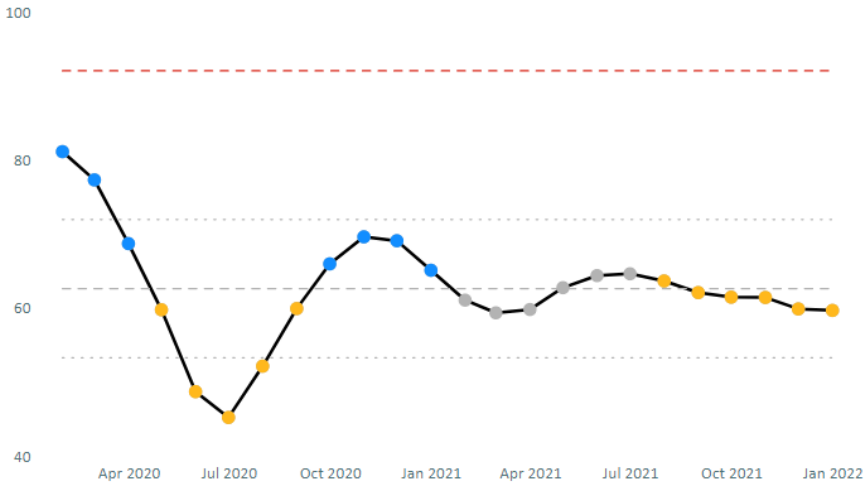
F — Variation indicates consistently falling short of the target

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

Flag Description

Descending Run Group

XMR Run Chart



What the chart tells us

Performance reduced rapidly at the beginning of the pandemic with the lowest performance occurring in July 2020. During the initial elective recovery phase in spring/summer 2020 performance improved, dipping to a lesser extent during waves two and three. Performance is demonstrating a special cause variation of a decreasing nature over the last 6 months with performance now below the mean for the period.

Intervention and Planned Impact

- Breakthrough Objective focussed on improving theatre utilisation and reducing opportunity i.e. "lost capacity" to ensure that we treat as many patients as possible and reduce waiting times. The current opportunity for January is 51 sessions.
- Continue to use the Independent Sector in both East and West Kent to treat long waiting patients.
- Following the planned cessation of routine elective work during C-19 wave three we will ensure that theatre capacity is aligned to specialties who have urgent, cancer and long waiting patients to facilitate treating long waiting patients internally.
- Align green bed capacity at the QEQM and WHH to ensure that we can treat long waiting, routine patients.
- Continue with clinical and administrative validation to ensure waiting lists continue to be prioritised in order of clinical need. Optimise the preoperative assessment pool from 19% to 25% of the elective waiting list.

Risks/Mitigations

- Varying case mix creates challenges in balancing the available bed allocation between emergency, Covid-19 and elective streams. Work is being undertaken with site teams to agree plans moving forward into our next recovery phase.
- Loss of theatre capacity at K&C due to essential theatre works which had been deferred during the pandemic is being managed using the Vanguard theatre at K&C and any available capacity at the acute sites to minimise disruption.

20/21 breakthrough objective

Theatre Session Opportunity

Efficient use of our theatre complex is key to maximising the throughput of routine elective care.
It is imperative that elective surgery deferred during the global pandemic is prioritised alongside Cancer and urgent operative needs to minimise any harm to our patients and reduce our overall waiting times for elective surgery.

Ensuring that the theatre capacity we have available is utilised in the most efficient manner will allow for subsequent decisions regarding any residual capacity deficits and new ways of working.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
87	38	26	17	23	39	51	48	39	38	53	51

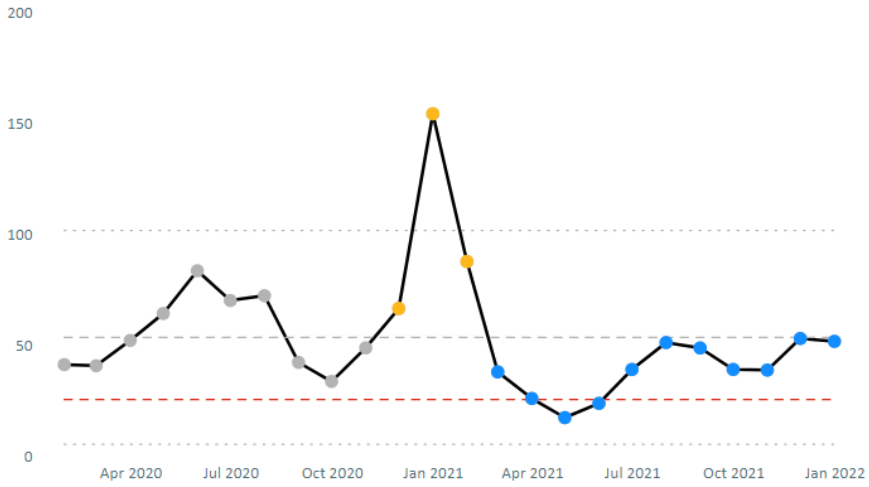
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Below Mean Run Group

XMR Run Chart



What the chart tells us

Current performance shows the equivalent of 51 sessions unused i.e. opportunity for January 2022. This has been compounded by the Covid surge and limited availability of green beds at the WHH and QEQM. Colorectal Surgery was relocated to K&C which led to the cancellation of orthopaedic sessions to accommodate the temporary move. Cancellations remain an area of focus.

Intervention and Planned Impact

- Ensuring our waiting lists are validated and patients are fit and ready for surgery therefore reducing the volume of clinical and non-clinical cancellations on the day
- Develop improvement trajectory to increase the pre operative pool which will improve opportunity to re-schedule patients at short notice
- Allocation of theatres aligned to treating cancer/urgent/longest waiting patients to reduce waiting times of our longest waiting patients (risk areas are ENT Otology, Paediatric ENT, Orthopaedics and General Surgery)
- Revise the 6-4-2 theatre scheduling process to improve 6 and 4 week scheduling enhancing the opportunity for other specialities to backfill under utilised lists in advance
- Care Groups to adopt a more flexible approach covering theatre sessions within their specialities to minimise dropped sessions due to availability of workforce

Risks/Mitigations

- Winter pressures remain a challenge impacting on availability of green beds.
- Short notice patient cancellations due to Covid-19 impacting ability to fully utilise theatre lists.
- Theatre staff recruitment remains a significant risk, this includes anaesthetic staffing – there is a national shortage due to increased demand.
- Increasing the pre operative pool of patients to mitigate short notice cancellations
- Any revision to the national IPC recommendations would increase the opportunity from short notice cancellations

Our patients

Rebecca Carlton

Trust Access Standards: ED Compliance

The National 4 Hour Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at the Emergency Department where clinically appropriate.

Performance has been adversely affected by year on year increases in emergency presentation to our acute sites. The global pandemic has created additional pressures in terms of managing infection and maintaining social distance.

Significant investment has been made into expanding our emergency departments and to recruitment to our nursing teams to provide enhanced patient pathways improving both quality of care and experience and this work is ongoing.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
80.2%	83.6%	83.6%	83.1%	79.2%	75.5%	75.7%	75.4%	73.8%	73.9%	73.5%	73.8%

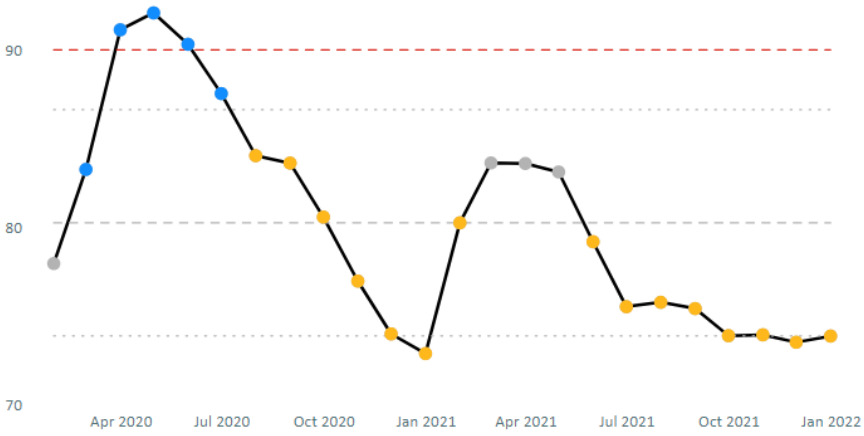
F — Variation indicates consistently falling short of the target

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

Flag Description

Below Mean Run Group
Astronomical Point
Two Out Of Three Beyond Tw...

XMR Run Chart



What the chart tells us

ED performance has remained static at approx. 73.8% since Oct '21. Performance improved during Wave 1 of the pandemic due to the reduced number of attendances, it then slowly deteriorated throughout 2020 as demand increased. Performance improved in early 2021 until Wave 3 began and brought with it the increased IPC challenges of managing patient contacts, together with Covid-19 positive, non Covid-19 and 'Green' pathway elective patients.

Intervention and Planned Impact

- ED Improvement plan has been in place since Oct '21 and now includes an ED Restart programme to focus on achieving 80% performance against the 4 hour standard by the end of February 2022.
- ECIST support the review and increasing the number of patients streamed directly to Same Day Emergency Care (SDEC) pathways. Current performance is 18% and driving improvement to 30%.
- ECIST are also supporting the Trust to review and implement the principles of the Modern Board Round and Criteria to Reside, which will improve patient flow for emergency admissions.
- Reducing the length of stay on the Acute Medical Unit to < 48 hours.
- In February a 7 day working pilot was implemented at WHH and QEQMH for 3 weekends with the aim of achieving consistency for discharges and to assess the impact on length of stay.
- In February the WHH SDEC service was transferred to the Paula Carr Unit for a weekend to test whether there would be a positive impact on patient flow in ED by protecting space for speciality treatment services.

Risks/Mitigations

- Nursing vacancy, particularly at QEQMH – mitigated via senior nurses being rostered to direct clinical care.
- Increasing number of patients with a LOS of >21 days due to insufficient PW1 (domiciliary care) and PW3 (residential/nursing home care) awaiting supported discharge. – mitigation via whole system working to escalate issues and commission appropriate capacity.

20/21 breakthrough objective

ED Aggregated Patient Delay

Long waits across our Emergency Departments (ED) have been a challenge to the organisation for several years, extending length of stay in ED is often a consequence of reduced bed availability for specialist ward areas and admissions.

It is recognised that extended stays in ED can have an impact on patient outcomes. It is a priority for the organisation to reduce time between the decision to admit a patient in ED and the transfer of the patient to a ward environment. We are making this an area of clinical and operational focus to drive down the wait times, improve flow and the standard of care for our patients.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
460	385	311	353	475	644	664	647	797	873	875	897

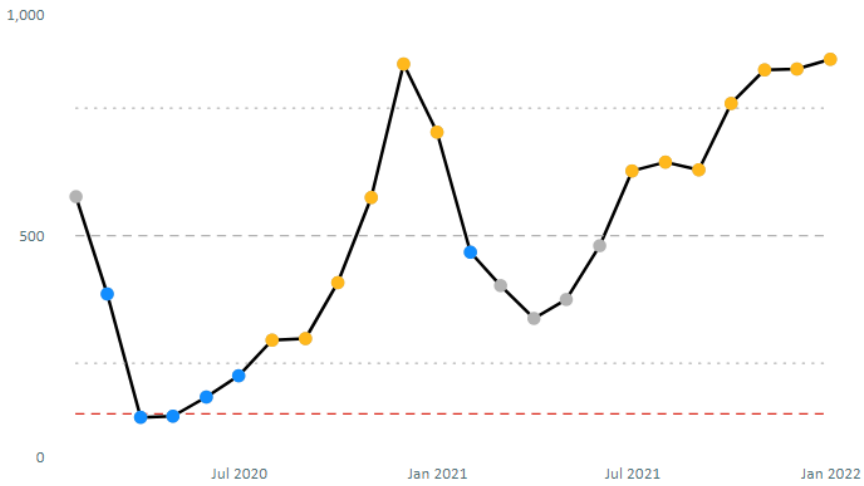
F — Variation indicates consistently falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

At the beginning of the pandemic when attendances reduced, the aggregated patient delay for patients requiring a bed was low and achieved target. Since then as demand has returned to normal performance has deteriorated. Similarly to the 4hr performance the 3 Covid-19 waves have affected the delivery of this standard. This metric is heavily influenced by bed availability on main wards which has been a consistent challenge throughout the pandemic. Performance has recently breached the upper control limit for the period.

Intervention and Planned Impact

- To increase the number of patients discharged by midday each day to 30% of total discharges. Current performance is 14.1% at WHH and 15.5% at QEQMH.
- Senior ED management team have implemented a weekend and evening rota to improve patient flow and timely transfers to wards.
- Achieve a maximum 48 hour LOS on Acute Medical Unit (AMU) which will enable patients to be transferred from ED for assessment.
- Increase the number of patients streamed to SDEC pathways, including direct access for SECAMB.
- Implemented 08:30 speciality in-reach into the AMU to review patients with an agreed speciality condition and agree transfer to a speciality ward or discharge.
- Senior decision makers are rostered to work out of hours, particularly at weekends and to 22:00 when sites are in OPEL 4.
- Working with LHE to escalate >21 day delays for PW1 and PW3. Chief Operating Officer is involved in daily meetings to escalate operational delays and monthly meetings to engage with LHE re commissioning appropriate capacity for local population.

Risks/Mitigations

- Acute Physician vacancy impacts on ability to provide extended working day rota – posts are out to advert, including overseas recruitment.
- LOS on AMU will be >48 hours due to lack of timely bed capacity on wards – mitigation to implement 'Modern Ward Round' to maximise morning discharge and reduce LOS.

Our patients

Rebecca Carlton

Trust Access Standards: Cancer 62day

The National 62 Day Referral to Treatment requires all patients to receive treatment for Cancer within 62 days from GP referral. The standard exists to ensure patient are seen, diagnosed and treated as soon as possible to promote the best possible outcome for all patients on a cancer pathway.

The Trust is committed to reducing the time to diagnose and treat patients. Throughout the pandemic the Trust has prioritised and maintained access for all cancer patients improving our overall performance.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
79.1%	81.5%	86.7%	83.3%	82.2%	82.5%	80.7%	78.8%	79.3%	84.3%	78.7%	75.3%

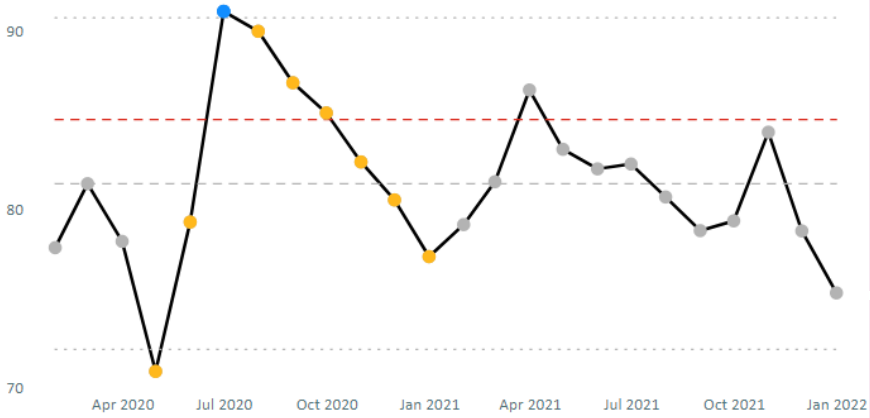
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

Performance increased significantly following the prioritisation of Cancer pathways at the beginning of the pandemic achieving the standard for four consecutive months. With the exception of May 2020 all data points fall within control limits. Performance began to dip during the first recovery phase as demand into the Trust began to resume normal levels. The target has been met 5 times in the last 20 months and was narrowly missed, post validation, in November 21.

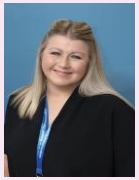
Intervention and Planned Impact

- Using the patient tracking list (PTL), review each pathway for every patient ensuring an optimal plan is in place to improve patient experience.
- All surgical patients escalated at point of known surgical intervention request. Processes to highlight all breach dates to the relevant teams to ensure patients are booked within breach. This will strengthen working relationships between the Cancer Care Groups and other Clinical Care Groups leading to an improvement in tumour site performance.
- Continue to work closely with lead CNS's to reduce waiting times for patients
- Restore face to face out-patient appointments where appropriate and continue reviews of current clinic capacity and support provision to ensure consistency on each site where appropriate

Risks/Mitigations

One of the biggest risks to delivery of the cancer standards is the availability of ring-fenced capacity for MRI and CT scans impacting the cancer pathway. This is being mitigated with support from the Clinical Support Services Care Group who are working up a plan to reduce diagnostic wait times.

Our patients



Sarah Shingler

Patient Experience (FFT)

The Family and Friends Test is a national measure which confirms how likely patients are to recommend the Trust as a place for treatment. This data collection incorporates a scale for quantitative analysis and an area for free text comments and is gathered on a monthly basis.

The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall recommended score together, we have therefore added completion rates as watch metrics to our overall scorecard.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
93.8%	93.3%	91.7%	90.8%	90.5%	91.2%	91.8%	91.8%	91.4%	91.8%	92.7%	93.3%

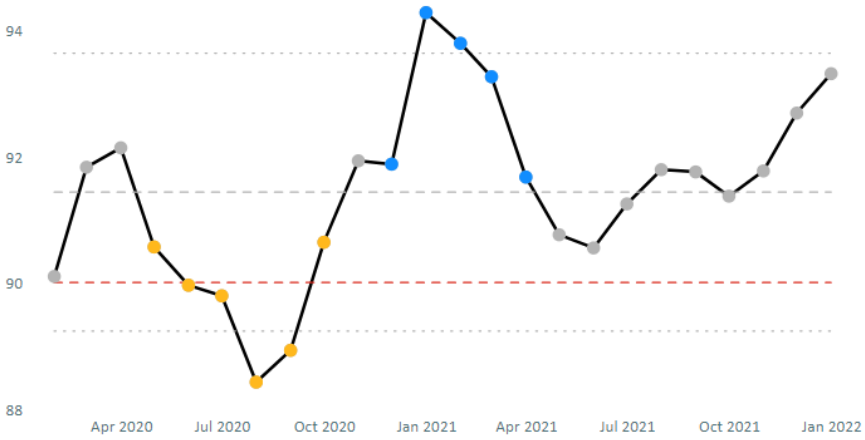
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The Trust has achieved the threshold target of 90% consistently since October '20 for patients who would recommend the Trust as a place for treatment. Performance peaked in Jan/Feb '21 outperforming the upper control limit for the period. Recent performance appears to be showing an upward trajectory but it is too early to say whether this will be statistically significant or natural variation.

Intervention and Planned Impact

The True North for Our Patients has been recently reviewed; moving forwards in addition to FFT the breakthrough objective will focus on ten questions from the in-patient experience survey. Alongside this the ward accreditation project commences roll out in April '21. All in-patient adult wards will complete 50 in-patient surveys per month, with ward leaders and matrons having responsibility and oversight for addressing concerns and driving improvements. This will link into the We Care improvement work.

The Patient Voice and Involvement Strategy has been approved. A business case to resource the Patient Voice team is currently going through approvals process.

Risks/Mitigations

If culture and behaviours do not change there is a risk that patient experience does not improve or deteriorates further, impacting on patients, increasing the risk of CQC regulatory action and reputational damage.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	Type	BO	KPI	Thres.	Oct-21	Nov-21	Dec-21	Jan-22
Cancer 62d	W4		Cancer 28d Performance	75.0%	72.2%	69.8%	66.6%	62.3%
	W4		Radiology Diags vs Plan	Traj.	16,432	16,239	14,957	15,774
RTT - 18 Weeks	W4		DM01 Compliance	75.0%	74.2%	73.3%	65.7%	62.3%
	W4		RTT 35w Undated	8,500	9,434	8,894	9,315	9,826
	W4		RTT 1st OPA Booking Breaches	14,000	17,779	17,976	19,440	19,193
ED Compliance	W4		Clinical Assessment within 1hr	50.0%	34.7%	38.6%	39.0%	38.4%
	W4		Time in Dept over 12 hrs	6.0%	8.3%	9.5%	9.5%	9.2%
	W4		Super Stranded >21D	75	127	139	151	186
	W4		Discharges by Midday	15.0%	11.4%	10.7%	12.4%	13.2%
	W4		NEL Admissions vs Plan	Traj.	6,533	6,548	6,264	6,475
FFT	W4		FFT DC Response Rate	27.0%	24.9%	25.9%	26.3%	20.4%
			FFT ED Response Rate	12.0%	12.5%	12.6%	12.7%	10.0%
	W4		FFT Maternity Response Rate	18.0%	4.2%	4.3%	3.9%	2.6%
	W4		Complaint Response	90.0%	34.6%	23.9%	28.1%	21.9%

Cancer

28And 62 day performance has deteriorated in month due to delays in diagnostics, particularly radiology. Actions include Medical Director engagement with Radiology leads to identify ring fenced capacity to reduce waiting times. This will positively impact on 28 and 62 day compliance.

RTT 18 Weeks

The number of 35wk patients undated has increased due to the planned reduction in operating capacity in January to mitigate Wave 3 of Covid-19. Elective surgery will restart in February which will improve performance.

ED Compliance

Clinical Assessment within 1hr is an improving metric. This is a driver for the UEC Care Group in order to improve patient experience and ensure compliance with the 12 hour total time in ED metric.

Super stranded patients are being actively managed via regular calls with the local health economy however, of note, the winter plan modelling was based on a maximum number of 130 long stay patients. This is an external capacity issue in the main.

FFT

Maternity; The appropriate touch point times when the FFT questions will be asked during pregnancy have been agreed and the numerator and denominator has been adjusted to reflect the agreement. This was put in place mid February therefore improvement is expected in next round of reporting.

EDs: both EDs were extremely challenged throughout December and January, with overcrowding and long waits. FFT data triangulates with PALS concerns and formal complaints received during this period.

Our people


Our patients
Our people
Our future
Our sustainability
Our quality and safety

Our people

Andrea
Ashman

Staff Turnover (rate)

The annual turnover rate provides us with a high-level overview of Trust health. Workforce retention is a top priority across the NHS. High turnover rates are typically associated with increased recruitment and training costs, low morale and reduced performance levels.

Our Aim is to achieve and maintain a 10% staff turnover rate.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
9.5%	9.3%	9.6%	10.1%	10.5%	10.8%	10.9%	11.2%	11.6%	12.0%	12.2%	12.3%

F

Variation indicates consistently falling short of the target

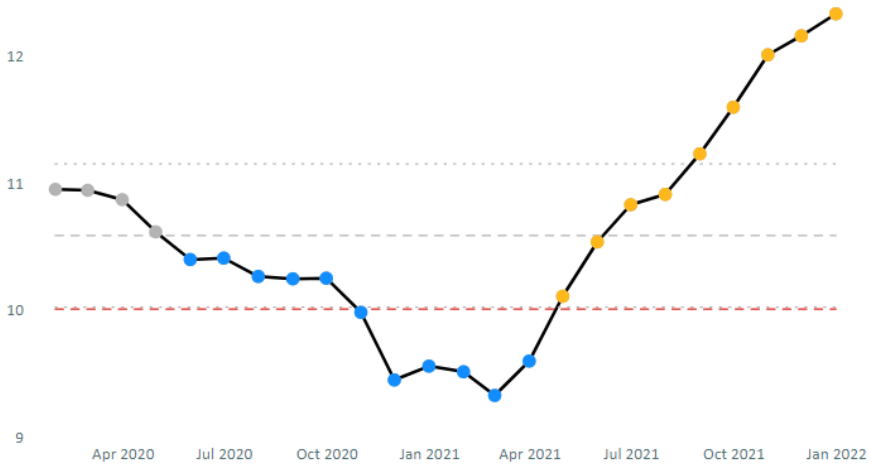
H

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

Flag Description

Above Mean Run Group
Astronomical Point
Ascending Run Group
Two Out Of Three Beyond Tw...

XMR Run Chart



What the chart tells us

The overall staff turnover rate is displayed as a rolling average percentage over the last 12 months. The figure demonstrates voluntary turnover so does not include doctors in training, fixed term contract completion, employee transfers or dismissal. Total turnover has risen for a tenth month in succession and remains above the True North target (10%) at 12.3% (Jan '22). In context, the Trust has recruited 1,264 new staff and lost 803 this financial year, an increase of 460 staff in 10 months. Premature recruitment turnover has risen slightly which correlates with an increase in recruitment.

Interventions and Planned Impact

Five top turnover areas have been identified: Theatres, KCH, Critical Care, WHH, Pharmacy Clinical Services, Pharmacy Operational Services. Targeted interventions are in place to support each area including extensive wellbeing support in theatres and critical care. Care group leads and HR Business Partners are working to understand the challenges in Pharmacy Clinical and Operational Services. Staff nurses are a continual focus with emphasis on the general wellbeing of our nursing workforce.

Premature turnover remains below the gold standard which is positive, but is benefitting from the development of a new starter platform introduction of onboarding champion roles and system wide onboarding communications. An online exit survey has been launched (fully automated upon generation of notification of resignation) and stay conversations introduced to support staff through their lever process with the aim of encouraging withdrawal of the resignation in some situations.

Risks/Mitigations

The drive for increased recruitment will address staffing shortfalls however there is a strong correlations between high volume recruitment and turnover. Especially premature turnover. Additional resources are proposed to support the onboarding process and have been factored into the nursing and recruitment business cases recently approved by the board.

Our people

Andrea Ashman

Staff Engagement (score)

Staff satisfaction levels are amongst the bottom 20% across the country, which can lead to difficulty in recruitment and retention. The annual national staff survey is used to give an indication of staff engagement. We will be monitoring this at quarterly intervals throughout the year via the staff friends and family test.

Our aim is to improve our staff engagement score as demonstrated in the annual staff survey.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
6.9	6.9	6.6	6.6	6.6	6.3	6.3	6.3	6.4	6.4	6.4	

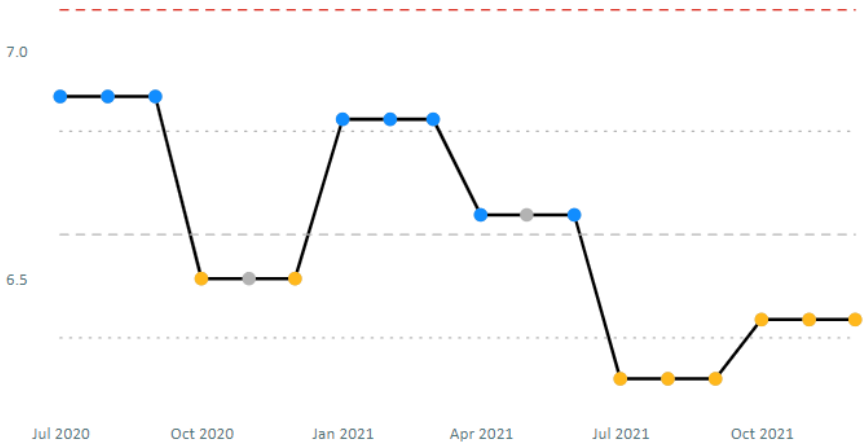
F — Variation indicates consistently falling short of the target

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

Flag Description

Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

Since July 2020 the data has broadly been following a downward trend with quarter two 21/22 data falling below the lower control limit of the SPC chart.

The most recent data returns just within control limits but remains well below mean performance and is consistently missing the desired threshold.

Interventions and Planned Impact

Work is underway to develop a dashboard to display the National Staff Survey results in a more discoverable and accessible way. This will, using the latest data and information, help drive concerted and consistent action at-pace providing greater confidence that the organisation is able to both identify areas of best-practice and to act in a timely manner on concerns raised. Once complete, this will be shared with the People and Culture committee.

Since the Staff Engagement results were made available, work has taken place to identify the areas of best practice and high challenge. The top and bottom ten performing areas have been established and the key domain driving this result identified. A programme of work is being proposed including the **establishment of 'Involvement' as a breakthrough objective under Staff Engagement.**

Work is also underway with our Chief Medical Officer as we begin to commission a 5-year plan around Medical Engagement, specifically aligned with the Medical Engagement Scale. Initial conversations have taken place and local questions are being developed based on respective need for local intelligence. A provider recommended by NHSE/I is being considered and timescales for implementation, to drive a 5 year plan of sustained improvement.

Risks/Mitigations

The National Quarterly Pulse Survey data for Q4 is expected this month. True North for engagement to be supported by breakthrough objective on Involvement.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	Type	BO	KPI	Thres.	Oct-21	Nov-21	Dec-21	Jan-22
Staff Turnover Rate			Staff Turnover: HCA	13.5%	12.9%	13.6%	13.5%	14.3%
	W4		Staff Turnover: Nursing	10.0%	11.7%	12.0%	11.7%	11.7%

Staff Turnover

Total turnover measured in-month (12.76%) has **risen for the first time since September 2021** despite following a promising downward trend for three consecutive months. This appears to be driven primarily by premature and nurse turnover.

The inflection in turnover this month **correlates very strongly with an almost trebling in recruitment** from 78 joiners in December to 194 joiners in January

Nurse turnover remains **above the alerting threshold** (10%) and although there have been promising signs of improvement throughout the last 5 months, this has risen in January following the turnover of almost 20 nurses.

There is recognition that Staff Nurses continue to represent our primary leaver group (154 leavers this year)

Healthcare Assistant turnover remains stable at just under 15%. Substantial growth has been seen nationally as colleagues were able to seek alternative employment, but this continues to be blunted locally by continued support activity in the form of the 'Ready to Care' programme.

Our sustainability

Our sustainability

Phil Cave

Financial Position (I&E Margin)

Whilst there has been a significant financial deficit over the last 3 years at the Trust, in the current year a breakeven position was delivered. This metric will measure us against our long term aim to maintain a breakeven position. The impact of Covid-19 has paused the NHS business planning process nationally and has limited the ability of the Trust to hit its cost efficiency targets.

Our aim is to achieve and sustain a break even financial position.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
0.588	-0.007	-0.548	-0.438	0.030	0.024	0.042	0.021	-1.494	-0.996	-0.941	-0.090

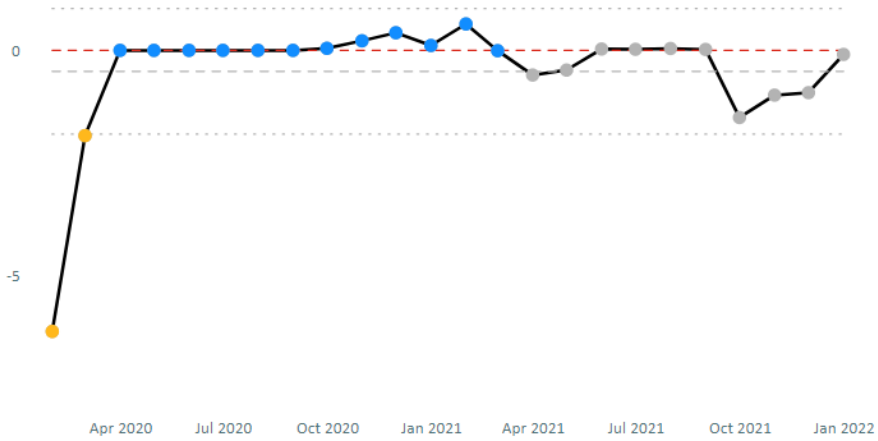
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

Since April 2020 the Trust's I&E margin has been broadly achieving a breakeven position. The data for the second half of the 2021/22 financial year (H2) has fallen below the mean but remains within common cause variation. As long as the threshold remains within common cause variation the Trust cannot be sure of consistently hitting the target.

Interventions and Planned Impact

The deficit position in Q3 2021/22 is driven by the unplanned Omicron variant meaning additional costs incurred for treating patients with Covid-19 combined with treating less elective patients than planned therefore receiving less variable Elective Recovery Fund (ERF) income.

The Trust is working with the regional Kent & Medway system partners and NHSEI to ensure we are appropriately reimbursed for unavoidable costs and additional funding has been agreed for the increase in patients seen through the emergency department.

The impact of this is that the Trust is forecasting to deliver a breakeven for the second half of the 2021/22 financial year which would mean a breakeven position for the full 2021/22 financial year consistent with the plan and threshold.

Risks/Mitigations

The main risks relate to continued additional costs due to treating patients with Covid-19 and reduced capacity to treat elective patients.

The mitigating actions are to continue to work with system partners to ensure appropriate reimbursement of costs and continue to reduce discretionary costs where appropriate to appropriately reflect the volume of patients we are treating.

Our sustainability

Liz Shutler

Carbon Footprint (CO2e)

Implementing environmentally sustainable principles and reducing the Trust's greenhouse gas emissions adds value to our patients and reflects the ethics of our staff. The national requirement is for the Trust to be net zero for the emissions it controls by 2040 (80% by 2028 to 2032). Being environmentally sustainable is therefore a key element of our Trust's True North.

The Trust's carbon emissions are made up of direct emissions i.e. natural gas; indirect and direct emissions i.e. electricity consumption, waste, water and steam usage. It is these areas we will be focussing on improving over the coming five to ten years, although as metrics are developed we will add in other scope one, two and three measures such as travel, freight transport and food and catering.

Our aim is to reduce the net emissions controlled by the Trust directly by 50% by 2025/26.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
63.95	57.34	54.35	47.80	38.27	36.74	39.60	39.77	43.52	60.90	60.34	

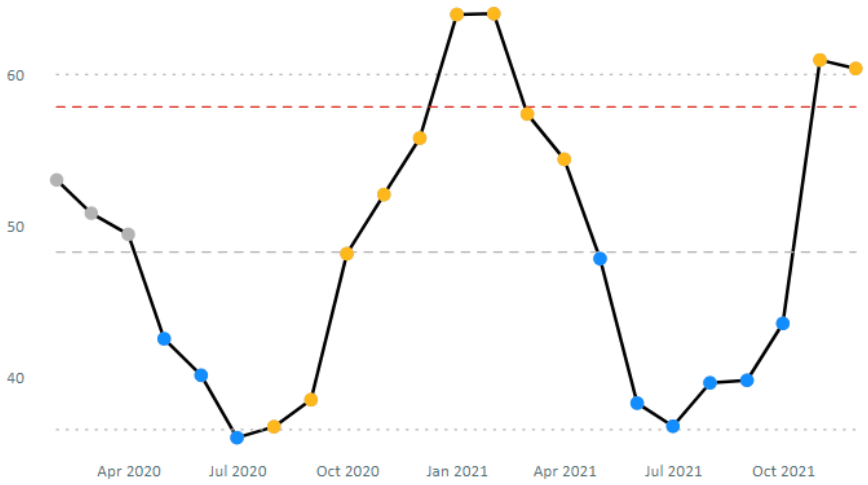
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

There is a clear seasonal effect to the Trust's Carbon Footprint as demonstrated in the chart. In the main, the position remains below the threshold with the exception of the winter months.

The November position is above the threshold of 60 and is above the same period last year.

Interventions and Planned Impact

The Trust is working with Breathe Energy to recommend opportunities for a continuing programme of carbon reduction and to bid, on the Trust's behalf, for central monies to enable long term carbon reduction as part of the Public Sector Decarbonisation Scheme. Schemes are currently being developed and analysed to determine the carbon reduction savings.

In addition to electricity, gas, waste and steam, work is ongoing to include additional data and measures aligned to NHSE/I's report "Delivering a Net Zero NHS". Those currently being explored include: Anaesthetics Usage; Medicines Waste; NHS Fleet and leased vehicles; and Staff Travel.

A Joint Carbon Reduction Steering Group is in place which includes representatives from both the Trust and 2gether Support Solutions.

Risks/Mitigations

- Appropriate funding to trigger significant change is not available.
- Potentially lack of behaviour change and culture in the organisation to promote net zero carbon target.
- Due to the backlog maintenance programme and age of the estates we will have inefficient use of energy.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	Type	BO	KPI	Thres.	Oct-21	Nov-21	Dec-21	Jan-22
Financial Position	W4		Total Pay	0.0%	-1.9%	-1.5%	-1.2%	-1.2%
Carbon Footprint			CO2e Gas (tonnes/day)	38.19	21.68	33.96	36.48	

Total Pay

The pay position is adverse to plan due to higher than planned usage of temporary staffing primarily to backfill staff who were either sick or isolating due to Covid-19 Omicron variant. It is proposed that the pay metric is not promoted to a driver metric at this time as the financial plan and pay expenditure budget will be reset in April due to the start of the new financial year. Additionally, the Trust Board has approved a breakthrough objective in 2022/23 of agency expenditure which will monitor this position.

Carbon Footprint

Gas tonnage per day is alerting due to the latest data points breaching the upper control limits of the SPC chart. This is due to the seasonality of the metric and high usage during the winter months, we would envisage a reduction as we head into spring and therefore do not at this time consider that this metric should be promoted to a driver metric.

Our future


Our patients
Our people
Our future
Our sustainability
Our quality and safety

Our future

Rebecca Carlton

Not fit to reside (pats/day)

We have embedded the recording of criteria to reside (C2R) via daily board rounds through the course of the pandemic, this enables us to identify patients who no longer need to reside in hospital. As such this allows us to easily identify the ongoing support and care patients need to facilitate discharge.

Patients are delayed in hospital awaiting a supported discharge which may be Domiciliary care such as a Care Package, discharge to a Community Hospital for rehabilitation or discharge to a nursing or residential home. There may also be patients delayed for internal reasons, such as a diagnostic test or a change in clinical condition.

The Trust works closely with local health economy (LHE) stakeholders to ensure that external capacity is sufficient to meet the needs of the local population. This includes reviewing the available out of Hospital capacity and ensuring patients are reviewed daily for timely discharge.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
166.1	206.5	220.2	223.2	297.1	309.9	299.6	303.0	299.5	332.0	346.2	314.3

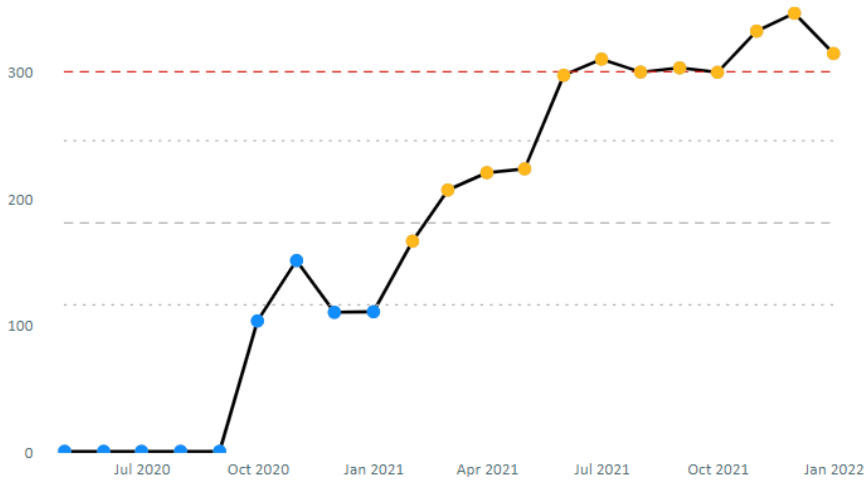
P — Variation indicates consistently passing the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

The number of patients who no longer meet the criteria to reside (C2R) in hospital is increasing however this chart also reflects improved data capture since the inception of C2R. In June '21 the levels stabilised at approx. 300 patients. A more recent increase to 346 occurred during the Covid-19 third wave due to insufficient capacity available outside of secondary care.

Intervention and Planned Impact

- Working very closely with the local health economy (LHE), meeting 3 times p/w, inclusive of KCHFT, KCC, CCG, Hospice and Mental Health Trust colleagues ensure appropriate capacity is available externally to meet the discharge needs of our local population.
- LHE multi agency discharge events (MADE) to review all patients with a length of stay (LOS) over 7 days (>7d) with a view to identifying alternative pathways to support safe discharge.
- Weekly MDT meeting with a Consultant lead, Matrons, Ward Managers, Senior Therapist and members of the Discharge Team to review all patients with a LOS >7d to confirm patients pathway is optimal and reduce risk of internal and external delays.
- Daily board rounds include documentation of the C2R category, reported daily within Trust &LHE.
- ECIST have reviewed our processes on Board Rounds in January and will be working with the Trust in February to train clinical champions who will lead the embedding of 'Modern Ward Round' document. Cascade training to each ward will follow.

Risks/Mitigations

- Insufficient external capacity, particularly in PW1 and PW3 to meet patients needs; Mitigation is to work through the LHE to highlight capacity to be commissioned.
- Patients and their families refuse to be discharged into an alternative discharge pathway; Mitigation is to provide every patient with a letter from the CMO and CNO confirming discharge arrangements.

Our future

Liz Shutler

Innovation (Virtual OP Apps)

The current process for achieving innovation at the Trust is cumbersome and untimely. A cultural shift needs to take place using IT as a key enabler to drive the process. Outpatients are working towards the targets set by our commissioners of at least 25% of all patient appointments and 60% of all follow ups to be conducted virtually, where clinically appropriate, and to that end we have developed an enhanced engagement plan to encourage the shift from face to face to virtual mediums such as phone and telemedicine.

Our aim is to increase the use of technology and innovation in the delivery of high quality care for the EK population.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
64.0%	58.4%	52.7%	50.0%	47.9%	45.7%	43.8%	43.5%	41.9%	40.2%	39.4%	39.4%

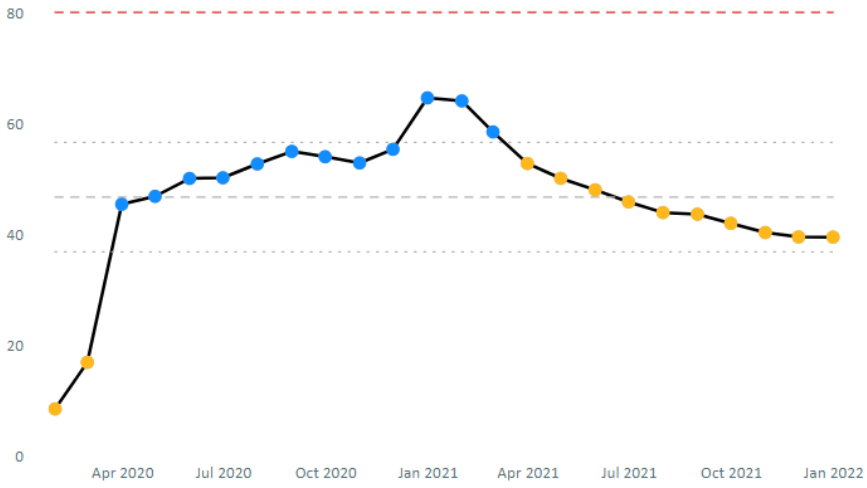
Variation indicates consistently falling short of the target

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

Flag Description

Below Mean Run Group
Descending Run Group
Two Out Of Three Beyond Tw...

XMR Run Chart



What the chart tells us

Performance has remained static with a very slight downward trend within a few percentage points over the last six months. Performance for January 2022 is at 39.4% which is below our current threshold of 80%.

Nationally the target is for 25% of all outpatients to be via telemedicine and our current position shows we achieve this, with first appointments at 33.5% and follow-up appointments at 41.8%

Intervention and Planned Impact

The Outpatient Transformation Steering Group has reviewed the national benchmarking data and recommended that the Trust needs to review the ambitious threshold of 80%. The Trust is currently 23rd in the rankings for delivery within the benchmarked data. Following discussion and review of individual specialty data, it was felt reasonable to aspire to move into the top 10 providers by setting a new threshold of 50%.

HCC E-clinic will roll out at the end of February with full completion by end of March 2022.
Updated Telemedicine SOP has been completed and is in the ratification stages
Further engagement with specialties to improve telemedicine usage will commence in March 2022 following the deployment of E-Clinic

Care Groups are liaising with other providers to identify best practice opportunities

Risks/Mitigations

- Lack of clinical /operational buy in.
- More patients are being brought back to face-to-face appointments.
- There are IG concerns about how long the patient data is held which may affect the E-clinic launch in Feb/March.

To mitigate the above, an enhanced engagement plan and focused project work, champions and advocates for virtual consultations are being put in place.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	Type	BO	KPI	Thres.	Oct-21	Nov-21	Dec-21	Jan-22
Innovation			Virtual OP Appts - First	25.0%	33.2%	32.0%	31.0%	33.5%
			Virtual OP Appts - Follow Up	25.0%	45.6%	43.8%	43.0%	41.8%

Virtual Appointments

Both virtual outpatient metrics are alerting due to the latest data points breaching the lower control limits of the SPC charts. Following the high performance in the percentage of virtual outpatient appointments carried out during the pandemic levels are now beginning to stabilise to what we feel is a clinically appropriate level. The percentage achievement remains above the national threshold of 25% and the Trust continues to be the highest performer in the Kent & Medway region. At this point we do not feel it is appropriate to drive any further improvement in this metric.

Appendix 1
Non-Alerting Watch Metrics

NHS
East Kent Hospitals University
NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Oct-21	Nov-21	Dec-21	Jan-22
Harm Events	W		52w Severe Harm Review	0	0	0	0	0
	W		Medication Errors; All	110	169	187	179	175
	W		Medication Errors; Severity C+	1	1	2	0	2
	W		Nutrition Incidents	60	54	61	68	66
	W		Pressure Ulcers: Cat 2	32	32	37	33	32
	W		Pressure Ulcers: Cat 3 & 4	3	2	0	0	1
	W		Pressure Ulcers: DTI	10	7	6	6	8
	W		Pressure Ulcers: Unstageable	10	7	5	9	7
	W		IPC: Audits Composite	80.0%	88.0%	87.5%	87.4%	87.6%
	W		Safeguarding Incidents	20	14	17	12	30
	W		IP Spells with 3+ Ward Moves	500	516	505	474	497
	W		Clinical Incidents	2,500	2,058	2,202	1,962	2,113
	W		Never Events	0	0	0	0	0
Mortality	W		Extended Perinatal Mortality	6.32	7.08	5.47	5.47	4.63

True North Domain	Type	BO	KPI	Thres.	Oct-21	Nov-21	Dec-21	Jan-22
Staff Turnover Rate	W		Vacancy Rate	9.0%	8.8%	9.3%	9.9%	9.3%
	W		Premature Turnover Rate	25.0%	19.6%	19.3%	19.3%	19.9%
Staff Engagement	W		Sickness	5.0%	4.8%	4.8%	5.4%	
	W		Appraisals Compliance	73.0%	76.6%	78.1%	76.9%	77.1%
	W		Statutory Training	91.0%	90.1%	90.3%	91.6%	91.9%
	W		Safeguarding Children Training	85.0%	90.6%	90.6%	91.2%	91.3%
Financial Position	W		Premium Pay	Traj.	6,783	7,255	6,441	7,168
	W		Non Pay	0.0%	0.8%	0.1%	-0.2%	-0.2%
Carbon Footprint	W		CO2e Waste (tonnes/day)	0.28	0.22	0.21	0.22	
	W		CO2e Electricity (tonnes/day)	18.00	13.04	15.42	13.38	
	W		CO2e Water (tonnes/day)	0.55	0.20	0.23	0.13	
	W		CO2e Steam (tonnes/day)	9.21	8.38	11.08	10.12	

True North Domain	Type	BO	KPI	Thres.	Oct-21	Nov-21	Dec-21	Jan-22
Cancer 62d	W		Cancer 2ww Performance	93.0%	98.2%	98.0%	97.7%	96.6%
	W		Cancer 31d Performance	96.0%	98.6%	97.9%	97.7%	97.3%
	W		Endoscopy vs Plan	Traj.	1,401	1,367	1,044	1,262
RTT - 18 Weeks	W		RTT 52w Breaches	Traj.	4,863	4,695	4,475	4,327
	W		OPA vs Plan	Traj.	57,589	63,756	53,807	52,330
	W		Elective Admissions vs Plan	Traj.	5,957	6,183	5,272	5,105
ED Compliance	W		A&E Atts vs Plan	Traj.	22,964	21,408	19,760	19,748
	W		Unplanned Re-attendance ED	10.0%	9.7%	9.0%	10.3%	10.9%
	W		NEL Readmissions	15.0%	10.6%	10.0%	11.2%	11.5%
	W		Stroke Ward within 4 Hours	50.0%	50.0%	60.9%	74.3%	58.7%
FFT	W		FFT IP Response Rate	15.0%	16.3%	16.8%	16.9%	12.1%
	W		FFT OP Response Rate	17.0%	16.9%	15.8%	17.7%	13.2%
	W		Complaints	100	93	105	60	70
	W		PALS Enquiries	550	607	619	527	677
	W		Mixed Sex Breaches	500	272	289	69	129

Appendix 2
Trust Priority Improvement Projects

NHS
East Kent Hospitals University
NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
Accommodation Strategy	Phil Cave	To enhance the functionality, experience and investment opportunities in the staff and student non-clinical estate at K&C, WHH and QEQM.	May 2022	• Delay due to growth in scope of project to cover the accommodation strategy, office space and medical education.	• A3 to be reviewed along with delivery plan
Job Planning (Trust wide)	Rebecca Martin	To ensure every substantive SAS and Consultant doctor has a signed job plan on the e-job system, that accurately reflects their workload	April 2022	• Asked for data to be run at specialty level with names • Plan to do info graphics to drs every month to get positive friendly competition going • JP policy will be presented at next meeting end of Oct. Also looking at JP of 10 or less PAs	• CThe job planning policy was deferred to February 2022 LNC meeting. LNC Chair was not in agreement and wanted to receive views from doctors before going ahead with approval. • Develop 1st draft of infographics.
Safe & Effective Discharge	Rebecca Carlton	All patients discharged have an accurate EDN completed and appropriately authorised in a timely fashion	May 2022	• Dec & Jan meetings cancelled • Lack of medical engagement has been highlighted and could inhibit progression of project. • VP organising meetings with Clinicians	• Frontline attendance at Driver meetings remains variable. • Will Willson to collate data relating to EDN completion to support Consultant engagement.
Governance of Clinical Guidelines	Tina Ivanov	To have a central repository of for all clinical guidelines	Jan 2022	• Post recruited to but candidate withdrew • Clinical Guidelines draft policy completed and in circulation for comments. • No decision made on either upgrade of micro-guide or to look at another software solution	• Re-attempt to recruit or provide cover from NHSP • Clinical Guidelines Policy to be finalised • Decision required with regards IT solution.
Improving End of Life Care	Sarah Shingler	Deteriorating patients who's death can be recognised in a timely way enabling better care in the right place at the right time this will also improve HSMR, reduce unnecessary use of hospital resource, increase personalised care planning	TBC Scoping as new project	• Collect and collate the data for analysis and discussion	• Collect and collate the data for analysis and discussion

Appendix 2
Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
National & Local Clinical Audit	Rebecca Martin	An agreed vison, roles & responsibilities of an audit lead. To have 75% of all audits that are effectively managed within each of the Care groups (Must do's - nationally dictated, Local audits requested by local Commissions)	April 2022	• Share vision statement at an away day booked for 15th Nov • Alison D has revised the monthly exception report to show trends by CG to be presented at Nov meeting • Reporting schedule now in place 1st CGs to participate C&YP and Women's health. For Nov will be UEC & GSM	• Clinical Audit team to clarify any remaining areas for improvement against the problem statement. • Commence drafting a TPIP Closure Request as relevant
Safeguarding	Sarah Shingler	Assessment of Mental Health risk to determine the level of support required carried out for 100% of patients	Dec 2021	• Communicate changes to Enhanced Observation tools and audits • Communicate roles and responsibilities around safeguarding • Produce first dashboard report on Information Portal • Focussed work at QEQM to reduce KASAFs	• Safeguarding team to draft a TPIP Closure Request, to enable the progress to continue as Business as Usual

Appendix 2
Completed Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date
CITO Management	Liz Shutler	To replace WINDIP with an EDM which will meet the needs of users, support the Trust's Electronic Patient Record objectives and the rollout of Sunrise by providing scanning capability for documentation which has yet to be or cannot be directly captured or integrated into Sunrise EPR	Jan 2022
ITU Expansion	Liz Shutler	Expanded 24 bed Critical Care unit operational for patients to be admitted	Feb 2022 - BAU
ED Expansion	Liz Shutler	Expansion to current ED footprints to enable provision of 'Emergency Village / Same Day Emergency Care' facilities	Dec 2023 - BAU
Sepsis Audit tool	Sarah Shingler	Ensure the correct sepsis audit tool is used for the right people at the right time, initial threshold 85% completion	Complete
Hospital Out of Hours	Rebecca Martin	Provision of a Hospital out of Hours Team to ensure timely response & co-ordination to Deteriorating Patients	Complete
Falls on Datix	Sarah Shingler	Improved data quality of reporting of falls on Datix ensure high quality accurate reporting	Complete

Appendix 3: Glossary of Terms

East Kent Hospitals University NHS Foundation Trust

Term	Description
A3 Thinking Tool	Is an approach to thinking through a problem to inform the development of a solution. A3 also refers to the paper size used to set out a full problem-solving cycle. The A3 is a visual and communication tool which consists of (8) steps, each having a list of guiding questions which the user(s) work through (not all questions may be relevant). Staff should feel sure each step is fully explored before moving on to the next. The A3 Thinking Tool tells a story so should be displayed where all staff can see it.
Breakthrough Objectives	3-5 specific goals identified from True North. Breakthrough Objectives are operational in nature and recognised as a clear business problem. Breakthrough Objectives are shared across the organisation. Significant improvement is expected over a 12 month period.
Business Rules	A set of rules used to determine how performance of metrics and projects on a scorecard are discussed in the Care Groups Monthly Performance Review Meetings.
Catchball	A formal open conversation between two or more people (usually managers) held annually to agree the next financial year's objectives and targets. However, a 6 monthly informal conversation to ensure alignment of priorities is encouraged to take place. The aims of a Catchball conversation are to: (1) reach agreement on each item on a Scorecard e.g. driver metrics, watch metrics tolerance levels, corporate/ improvement projects. (2) Agree which projects can be deselected. (3) Set out Business Rules which will govern the process moving forward.
Corporate Projects	Are specific to the organisation and identified by senior leaders as 'no choice priority projects'. They may require the involvement of more than one business unit, are complex and/or require significant capital investment. Corporate Projects are often too big for continuous daily improvement but some aspect(s) of them may be achieved through a local project workstream.
Countermeasure	An action taken to prevent a problem from continuing/occurring in a process.
Countermeasure Summary	A document that summarises an A3 Thinking Tool. It is presented at monthly Performance Review Meetings when the relevant business rules apply.

Appendix 3: Glossary of Terms

East Kent Hospitals University NHS Foundation Trust

Term	Description
Driver Lane	A visual tool containing specific driver metric information taken from the A3 (e.g. problem statement, data, contributing factors, 3 C's or Action Plan). The driver lane information is discussed every day at the improvement huddle and in more detail at weekly Care Group driver meetings and Monthly Performance Review Meetings. The structure of a driver lane is the same as the structure of a countermeasure summary.
Driver Meetings	Driver Meetings are weekly meetings that inform the Care Group of progress against driver metrics on their scorecard. Having a strong awareness of how driver metrics are progressing is vital for continuous improvement. Driver meetings also enable efficient information flow. They are a way of checking progress to plan.
Driver Metrics	Driver Metrics are closely aligned with True North. They are specific metrics that Care Group's choose to actively work on to "drive" improvement in order to achieve a target (e.g. 'reduce 30 day readmissions by 50%' or 'eliminate all avoidable surgical site infections'). Each Care Group should aim to have no more than 5 Driver Metrics.
Gemba Walk	'Gemba' means 'the actual place'. The purpose of a Gemba Walk is to enable leaders and managers to observe the actual work process, engage with employees, gain knowledge about the work process and explore opportunities for continuous improvement. It is important those carrying out the Gemba Walk respect the workers by asking open ended questions and lead with curiosity.
Huddles (Improvement Huddle) Boards	Huddle or Improvement Boards are a visual display and communication tool. Essentially they are a large white board which has 9 specific sections. The Huddle or Improvement Boards are the daily focal point for improvement meetings where staff have the opportunity to identify, prioritise and action daily improvement ideas linked to organisational priorities (True North). The Huddle or Improvement Board requires its own Standard Work document to ensure it is used effectively. The aims of the Huddle/Improvement board includes: 1. help staff focus on small issues 2. prioritise the action(s) 3. gives staff ownership of the action (improvement)
PDSA Cycle (Plan Do Study Act)	PDSA Cycle is a scientific method of defining problems, developing theories, planning and trying them, observing the results and acting on what is learnt. It typically requires some investigation and can take a few weeks to implement the ongoing cycle of improvement.
Performance Board	Performance boards are a form of visual management that provide focus on the process made. It makes it easy to compare 'expected versus actual performance'. Performance Boards focus on larger issues than a Huddle Board, e.g. patient discharges by 10:00am. They help drive improvement forward and generate conversation e.g.: 1. when action is required because performance has dropped 2. what the top 3 contributing problems might be 3. what is being done to improve performance

Appendix 3: Glossary of Terms

NHS
East Kent
Hospitals University
NHS Foundation Trust

Term	Description
Scorecard	The Scorecard is a visual management tool that lists the measures and projects a ward or department is required to achieve. These measures/projects are aligned to True North. The purposes of a Scorecard include: 1. Makes strategy a continual and viable process that everybody engages with 2. focuses on key measurements 3. reflect the organization's mission and strategies 4. provide a quick but comprehensive picture of the organization's health
Standard Work	Standard work is a written document outlining step by step instructions for completing a task or meeting using 'best practice' methods. Standard Work should be shared to ensure staff are trained in performing the task/meeting. The document should also be regularly reviewed and updated.
Strategy Deployment	Strategy Deployment is a planning process which gives long term direction to a complex organisation. It identifies a small number of strategic priorities by using an inch wide mile deep mindset and cascades these priorities through the organisation.
Strategy Deployment Matrix	A resource planning tool. It allows you to see horizontal and vertical resource commitments of your teams which ensures no team is overloaded.
Strategic Initiatives	'Must Do' 'Can't Fail' initiatives for the organisation to drive forward and support delivery of True North. These programmes of work are normally over a 3-5 year delivery time frame. Ideally these should be limited to 2-3. Initiatives are necessary to implement strategy and the way leaders expect to improve True North metrics over time (3-5 years).
Structured Verbal Update	Verbal update that follows Standard Work. It is given at Performance Review Meetings when the relevant business rules apply.
Tolerance Level	These levels are used if a 'Watch Metric' is **red** against the target but the gap between current performance and the target is small or within the metrics process control limits (check SPC chart). A Tolerance Level can be applied against the metric meaning as long as the metrics' performance does not fall below the Tolerance Level the Care Group will continue watching the metric.
True North	True North captures the few selected organisation wide priorities and goals that guide all its improvement work. True North can be developed by the Trust's Executive team in consultation with many stakeholders. The performance of the True North metrics against targets is an indicator of the health of the organisation.
Watch metrics	Watch metrics are measures that are being watched or monitored for adverse trends. There are no specific improvement activities or A3s in progress to improve performance.

NHS
East Kent
Hospitals University
NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**MONTH 10 FINANCE REPORT**				
MEETING DATE:	**10 MARCH 2022**				
BOARD SPONSOR:	**ACTING DIRECTOR OF FINANCE AND PERFORMANCE**				
PAPER AUTHOR:	**REPORTING ACCOUNTANT**				
APPENDICES:	**APPENDIX 1: M10 FINANCE REPORT**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion
Purpose of the Report:	The report is to update the Trust Board on the current financial performance and actions being taken to address issues of concern.				
Summary of Key Issues:	The Trust delivered a £0.8m surplus position in January which was on plan with the year-to-date (YTD) position improving to a £0.1m deficit. The YTD adverse variance remains £0.3m. In month saw a reduction in drugs expenditure that previously had put pressure on the position in November and December, thereby supporting the bottom line. The sale of Beautiful Information has also been realised in month contributing £0.6m to the position. Due to the on-going Covid-19 pandemic, the traditional NHS funding and administration process remains suspended in 2021/22, with fixed funding arrangements at a System level (Kent & Medway Integrated Care System (ICS)) split into two halves of the year: April to September 2021 (H1) and October to March 2022 (H2). The Trust's forecast continues to demonstrate a break-even position at year end. The major risk to the achievement of breakeven is the ability to reduce additional expenditure due to Covid-19 with the emergence of the omicron variant where we continue to see high levels of staff sickness as well as having to utilise Spencer Private Hospitals (SPH) beds at Margate which means increased costs for the group as SPH are unable to generate any income from elective inpatient activity.				

	This Month			Year to Date		
£'000	Plan	Actual	Variance	Plan	Actual	Variance
EKHUFT Income	71,067	70,592	(474)	673,253	677,027	3,774
EKHUFT Employee Expenses	(41,446)	(41,800)	(353)	(403,897)	(408,715)	(4,817)
EKHUFT Non-Employee Expenses	(28,807)	(28,692)	115	(269,887)	(269,965)	(78)
EKHUFT Financial Position	813	100	(713)	(531)	(1,652)	(1,121)
Spencer Performance After Tax	17	15	(2)	181	79	(102)
2gether Performance After Tax	0	410	410	0	1,264	1,264
Rephasing/Rounding Adjustment	(17)	167	184	701	1	(700)
Consolidated I&E Position (pre Technical adjs)	813	692	(121)	351	(308)	(659)
Technical Adjustments	(35)	66	101	(106)	218	324
Consolidated I&E Position (incl Top Up)	778	758	(20)	245	(90)	(335)

East Kent Hospitals University NHS Foundation Trust

	The Trust has identified £2.4m of additional costs due to Covid-19 in January which brings the year-to-date total to £18m. In-envelope spend being £0.6m and £1.8m greater than plan in month and H2 YTD. The Elective Recovery Funding (ERF) methodology has changed for H2, and is now based on monthly Referral to Treatment (RTT) completed pathway submissions instead of elective activity levels. £6.7m has been included for H2 performance, which is below planned levels as most elective activity was cancelled due to the surge in Covid-19 patients and increased emergency demand. Planning guidance for the new financial year 2022/23 was received in December 2021 but the Trust is still awaiting the financial baseline from Commissioners; the Trust will continue to work closely with system partners to maintain a breakeven position, however it is anticipated that the efficiency target will be more challenging with a nationally applied 1.1% efficiency, a 55% reduction in Covid-19 funding and a differential convergence adjustment which is being applied to systems.
Key Recommendation(s):	The Board is asked to review and **NOTE** the financial performance and actions being taken to address issues of concern.

Implications:				
Links to 'We Care' Strategic Objectives: **Healthy finances:** Having Healthy Finances by providing better, more effective patient care that makes resources go further.				
Our patients	Our people	Our future	**Our sustainability**	Our quality and safety

Link to the Board Assurance Framework (BAF):	**BAF 38:** Failure to deliver the financial breakeven position of the Trust as requested by NHS England/NHS Improvement (NHSE/I) may result in the Trust 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.	
Link to the Corporate Risk Register (CRR):	None	
Resource:	Y	Key financial decisions and actions may be taken on the basis of this report.
Legal and regulatory:	N	
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	1 March, Finance and Performance Committee (FPC) 9 March, Clinical Executive Management Group (CEMG)	

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2021/22

January 2022

Acting Director of Finance and Performance Management
Guy Dentith

Contents and Appendices

Month 10 (January) 2021/22

Contents

Appendices

Executive Summary
Month 10 (January) 2021/22

Executive Summary

The Trust delivered a £0.8m surplus position in January which was on plan with the year-to-date (YTD) position improving to a £0.1m deficit. The YTD adverse variance remains £0.3m. In month saw a reduction in drugs expenditure that previously had put pressure on the position in November and December, thereby supporting the bottom line. The sale of Beautiful Information has also been realised in month contributing £0.6m to the position.

Due to the on-going Covid-19 pandemic, the traditional NHS funding and administration process remains suspended in 2021/22, with fixed funding arrangements at a System level (Kent & Medway ICS) split into two halves of the year: April to September 2021 (H1) and October to March 2022 (H2).

The financial plan for the second half of the year (H2) is to achieve an I&E breakeven position to bring the full year I&E plan to breakeven. The plan was submitted to NHSEI in November following confirmation of the available funding consisting of baseline funding consistent with H1 and additional funding through the Elective Recovery Fund (ERF), subject to meeting the required activity thresholds and gateways.

	This Month			Year to Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
EKHUFT Income	71,067	70,592	(474)	673,253	677,027	3,774
EKHUFT Employee Expenses	(41,446)	(41,800)	(353)	(403,897)	(408,715)	(4,817)
EKHUFT Non-Employee Expenses	(28,807)	(28,692)	115	(269,887)	(269,965)	(78)
EKHUFT Financial Position	**813**	**100**	**(713)**	**(531)**	**(1,652)**	**(1,121)**
Spencer Performance After Tax	17	15	(2)	181	79	(102)
2gether Performance After Tax	0	410	410	0	1,264	1,264
Rephasing/Rounding Adjustment	(17)	167	184	701	1	(700)
Consolidated I&E Position (pre Technical adjs)	**813**	**692**	**(121)**	**351**	**(308)**	**(659)**
Technical Adjustments	(35)	66	101	(106)	218	324
Consolidated I&E Position (incl Top Up)	**778**	**758**	**(20)**	**245**	**(90)**	**(335)**

The Trust has identified £2.4m of additional costs due to Covid-19 in January which brings the year-to-date total to £18m. In-envelope spend being £0.6m and £1.8m greater than plan in month and H2 YTD.

The Elective Recovery Funding (ERF) methodology has changed for H2, and is now based on monthly RTT completed pathway submiss ions instead of elective activity levels. £6.7m has been included for H2 performance, which is below planned levels as most electi ve activity was cancelled due to the surge in Covid-19 patients and increased emergency demand.

Planning guidance for the new financial year 2022/23 was received in December 2021 but the Trust is still awaiting the financ ial baseline from Commissioners; the Trust will continue to work closely with system partners to maintain a breakeven position, however it is a nticipated that the efficiency target will be more challenging with a nationally applied 1.1% efficiency, a 55% reduction in Covid -19 funding and a differential convergence adjustment which is being applied to systems.

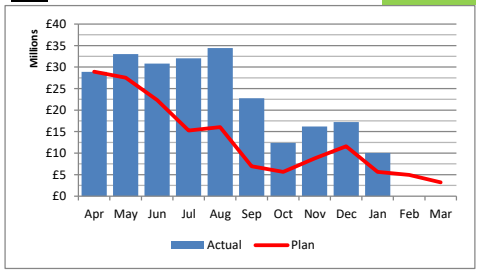
Income and Expenditure G

In January, the Trust delivered a surplus of £0.8m which is on plan. The Trust has recognised the agreed level of income for Q3 for our ERF funding allocation from the Kent & Medway ICS system, however due to the surge in demand for emergency beds the Trust did not earn the planned level of ERF funding in January. Whilst this caused a pressure on the income position in month, benefits were realised with a lower than planned expenditure on drugs and a one-off benefit from the sale of Beautiful Information of £0.6m.

The Trust's forecast continues to demonstrate a break-even position at year end.

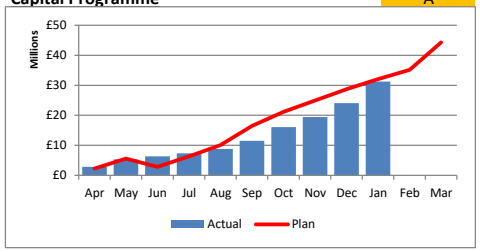
The major risk to the achievement of breakeven is the ability to reduce additional expenditure due to Covid-19 with the emergence of the omicron variant where we continue to see high levels of staff sickness as well as having to utilise Spencer Private Hospital (SPH) beds at Margate which means increased costs for the group as SPH are unable to generate any income from elective inpatient activity.

Cash G



The Trust's cash balance at the end of January was £10m which was £4.4m above the plan but a significant drop from the March 20/21 year-end closing balance of £68m due to a combination of capital payments clearing creditor balances and the reversal of the NHSE/I block payment on account to cover anticipated operational costs in advance.

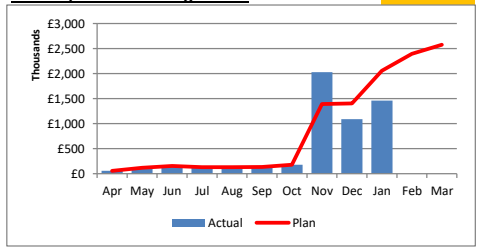
Capital Programme A



Total capital expenditure at the end of January was £31.3m which was £0.8m below our internal Trust plan.

The capital plan has been re-phased following a detailed assessment of deliverability. Progress against this plan is being managed by weekly meetings led by the Deputy CEO to ensure the Trust delivers in line with this.

Cost Improvement Programme A



In light of the national directive to focus on the operational response to Covid-19 EKHUFT has a reduced ability to make efficiency savings. The Trust delivered £1.5m of savings in January which brought the YTD position to £5.6m which was £0.3m behind the planned level.

Income and Expenditure Summary
Month 10 (January) 2021/22

Unconsolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Electives	7,791	5,958	(1,833)	77,907	67,362	(10,544)	93,488
Non-Electives	16,198	18,326	2,128	161,980	181,332	19,351	194,376
Accident and Emergency	3,101	3,414	313	31,007	36,083	5,076	37,208
Outpatients	8,139	7,721	(418)	81,388	80,380	(1,008)	97,665
High Cost Drugs	4,013	4,249	236	38,784	39,510	727	46,810
Private Patients	24	7	(17)	276	213	(63)	324
Other NHS Clinical Income	27,575	25,467	(2,109)	236,818	226,957	(9,861)	290,381
Other Clinical Income	108	91	(17)	1,377	1,105	(272)	1,593
Total Income from Patient Care Activities	**66,949**	**65,233**	**(1,716)**	**629,536**	**632,942**	**3,406**	**761,847**
Other Operating Income	4,118	5,359	1,241	43,717	44,085	369	51,952
Total Income	**71,067**	**70,592**	**(474)**	**673,253**	**677,027**	**3,774**	**813,799**
Expenditure							
Substantive Staff	(36,073)	(36,146)	(73)	(353,804)	(353,899)	(95)	(425,980)
Bank	(2,651)	(2,847)	(196)	(21,050)	(25,591)	(4,541)	(26,353)
Agency	(2,722)	(2,807)	(85)	(29,043)	(29,225)	(181)	(34,487)
Total Employee Expenses	**(41,446)**	**(41,800)**	**(353)**	**(403,897)**	**(408,715)**	**(4,817)**	**(486,820)**
Other Operating Expenses	(27,966)	(27,846)	121	(261,354)	(261,657)	(303)	(317,468)
Total Operating Expenditure	**(69,413)**	**(69,646)**	**(233)**	**(665,252)**	**(670,372)**	**(5,120)**	**(804,288)**
Non Operating Expenses	(841)	(847)	(6)	(8,533)	(8,308)	225	(10,214)
Income and Expenditure Surplus/(Deficit)	**813**	**100**	**(713)**	**(531)**	**(1,652)**	**(1,121)**	**(704)**

Consolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Income from Patient Care Activities	68,093	65,889	(2,204)	642,649	643,057	408
Other Operating Income	4,498	4,622	124	46,422	42,977	(3,445)
Total Income	**72,591**	**70,511**	**(2,080)**	**689,071**	**686,034**	**(3,037)**
Expenditure						-
Employee Expenses	(45,042)	(45,980)	(938)	(435,518)	(444,532)	(9,014)
Other Operating Expenses	(25,802)	(22,966)	2,836	(244,085)	(233,372)	10,713
Total Expenditure	**(70,844)**	**(68,946)**	**1,898**	**(679,602)**	**(677,904)**	**1,698**
Non-Operating Expenses	(934)	(873)	61	(9,118)	(8,438)	680
Income and Expenditure Surplus/(Deficit)	**813**	**692**	**(121)**	**351**	**(308)**	**(659)**

Income from Patient Care Activities

The H1 and H2 2021/22 Covid-19 finance regime has remained largely as set out in October 2021. Allocated payments support Group income at a level which allow delivery of a break-even position.

During M8 the nationally mandated revised H2 plan was submitted by all Trusts incorporating changes such as ERF funding and the 3% pay award. For H2 the pay award has been funded in full at the same £6.2m value as H1, however, the National and ICS efficiencies and a reduction for Covid-19 funding resulted in a monthly increase of £0.3m compared to £1.0m per month in H1.

The ERF methodology changed in H2 and is now based on monthly RTT completed pathway submissions instead of activity levels. To adjust for this change in methodology the baseline target has also been adjusted to 89% of the completed pathways delivered in 19/20. Further to this, the Trust has secured £8.4m of guaranteed ERF+ funding, the minimum level of ERF income in H2.

In M10 an additional full year value of £1m for additional Covid-19 pressures from Kent and Medway CCG has been accrued, which has generated a £0.7m YTD increase in income.

The YTD planned TIF fund income of £2.4m in M10 has not been received due to a delay in it commencing. This is offset with an underperformance in expenditure.

Following a review of the Trust's provisions, £1m has been released into the position.

The Commissioner allocated payments have been rolled over from the previous year with the changes that were implemented in the last half of the year, which are:

A budget of £2.8m per month to cover Covid-19 costs, Top up funding of £4m and an additional £3.5m of growth funding. The growth funding no longer includes CCG invoices from Spencer Private Hospitals, but does include the UTCs. All these payments are being commissioned by Kent and Medway CCG.

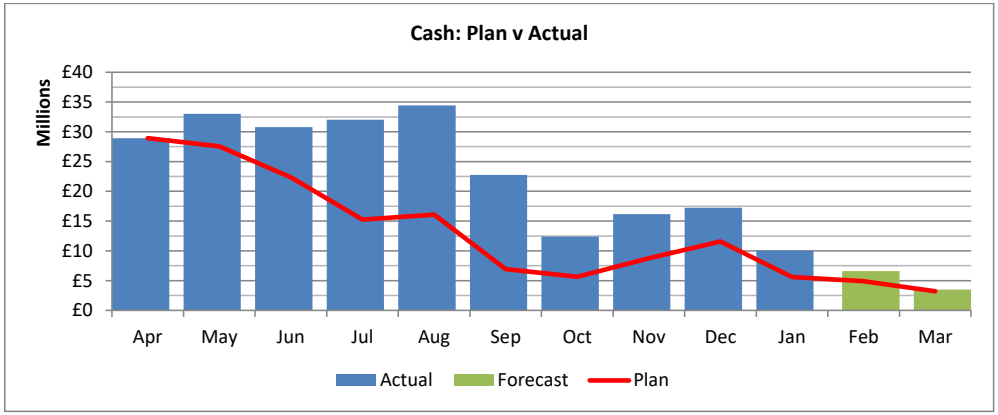
Other Operating Income and Expenditure

Other operating income is favourable to plan in January by £1.2m and by £0.4m YTD. The in-month variance is driven mainly by above plan Covid-19 income of £0.7m inclusive of the Nightingale surge hub and net income relating to the sale of Beautiful Information of £0.6m. YTD, Covid-19 income is below plan by £0.7m mainly driven by out of envelope performance and Harmonia Village income is adverse to plan by £1m. This is offset by a favourable variance on Education and Training income of £1.7m and sale of Beautiful Information £0.6m.

Total operating expenditure is adverse to plan in January by £0.2m and by £5m YTD. Covid-19 expenditure stands at £2.4m in month and £18m YTD, with in-envelope spend being £0.6m and £1.8m greater than plan in month and H2 YTD.

Employee expenses performance is adverse to plan in January by £0.4m and adverse to plan by £4.8m YTD (1.19%). Expenditure relating to all Covid-19 pay streams is £1.1m in month and £10.4m YTD. Total expenditure on pay in January was £41.8m, an increase of £0.8m when compared to December. Costs relating to bank staff increased by £0.7m and substantive staffing costs increased by £0.1m.

Other operating expenditure is favourable to plan in January by £0.1m and adverse to plan by £0.3m YTD (0.12%). Expenditure on all Covid-19 non-pay streams is £1.3m in month and £7.5m YTD. Referrals to the Independent Sector remain significantly below plan at £1.5m in month and £6.8m YTD, offset by spend on contracted out medical services in UTCs originally planned as pay which causes a technical overspend of £3.5m YTD and drugs which are adverse to plan by £3.9m YTD. Actual expenditure on non-pay in January was £27.8m, a reduction of £1m when compared to December. The underlying reduction relates to expenditure on drugs which fell by £1.1m.



Unconsolidated Cash balance was £10.0m at the end of January 22, £4.4m above plan.

Cash receipts in month totalled £66.8m (£2.5m above plan)

Block payments were received on the 15th of the month: £50.5m from K&M CCG and £10.3m from NHS England. These receipts were as per the notified H2 figures, but a combined £1.9m above initial plan.

Other NHS Receipts were £0.8m above plan.

VAT reclaims were £1.4m (£1.1m below plan)

Other receipts were £1.7m above plan

Cash payments in month totalled £74.0m (£3.8m above plan)

Creditor payment runs including Capital payments were £27.0m (£4.8m above plan).

Payments to 2gether Support Solutions were £10.7m (£2.4m below plan)

Payroll was £36.3m (£1.4m above plan).

2021/22 Plan

Plan assumptions for 2021/22 were based on the I&E plan for H1. It was initially planned that contract values for H2 would remain consistent with H1 for cash purposes.

Whilst the 2021/22 plan will require strict cash management to eliminate risks towards the end of the year, there is no expected requirement for any additional revenue funding.

H2 block payments have been reforecast in line with details received from NHS Kent & Medway CCG. Forecasting has been reviewed further following the completion of the H2 plan, and will be continually monitored.

Creditor Management

Cash planning in late March/early April showed areas of high risk around Month 6. To reduce this risk, the Trust reverted back to pay invoices to 30-day terms from 1st April 2021.

Payments to creditors were brought back from 30 days to 23 days in June and then further brought back to 16 days on the 23rd September. On the 21st October the Trust brought creditor days back to 9 days, and in November the Trust brought terms back to the 7-day target. Timing of expected receipts in the month mean that payment terms may be moved as required on a weekly basis to ensure the Trust maintains a positive balance.

At the end of January 2021, the Trust was recording 80 creditor days (Calculated as invoiced creditors at 31st January/ Forecast non-pay expenditure x 365).

Income from Patient Care Activities

Month 10 (January) 2021/22

Trust Income Plan	Trust Actual Income	Income Variance
£629.537m	£632.942m	£3.405m

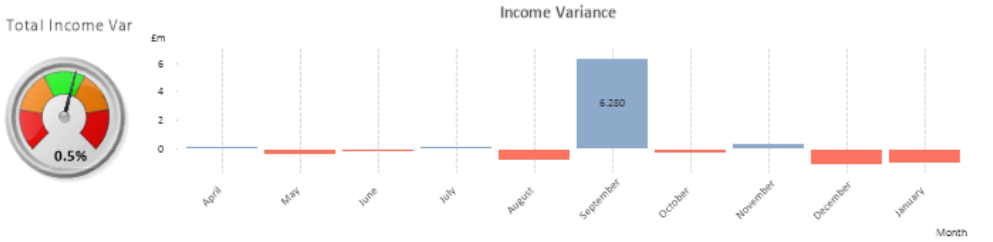
2021/22 - Month 10 Model

East Kent Hospitals University NHS
NHS Foundation Trust

	Year to Date			This Month vs. Run Rate		
Summary	Plan	Actual	Variance	Actual	Run Rate to M9	Var to M9 Run Rate
1 Total Non Elective Spells	162.0	181.3	19.3	18.1	18.1	(0.1)
2 Accident & Emergency	31.0	36.1	5.1	3.4	3.6	(0.2)
3 Total Elective Spells	77.9	67.4	(10.5)	6.0	6.8	(0.8)
4a New Outpatient Attendances	36.8	34.8	(2.0)	3.3	3.5	(0.2)
4b Outpatient Follow Up Attendances	44.6	45.6	1.0	4.4	4.6	(0.2)
5 Other Cost Per Case	135.4	128.3	(7.2)	12.6	12.9	(0.2)
6 Block Agreements	19.4	18.9	(0.5)	1.9	1.9	(0.0)
7 Income Additional to PbR	106.5	111.3	4.8	15.4	10.7	4.7
8 Risks and Adjustments	(0.0)	(2.3)	(2.2)	(0.5)	(0.2)	(0.3)
9a Elective Recovery Fund	15.9	11.5	(4.4)	1.4	1.1	0.3
9c Adjust Prior Month Reported Position	-	-	-	(0.0)	0.0	(0.0)
Grand Total	**629.5**	**632.9**	**3.4**	**66.0**	**63.0**	**3.0**

	This Month			Year to Date			Annual
Commissioner Group	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Kent and Medway CCG	55.3	52.5	(2.8)	521.0	520.8	(0.3)	630.1
NHS England SS	8.0	8.4	0.4	79.4	84.6	5.2	95.4
Public Health & Secondary Dental	1.3	1.4	0.1	12.9	13.6	0.7	15.5
Cancer Drugs Fund and Hep C	0.9	0.5	(0.5)	6.0	5.3	(0.7)	7.9
Other Organisations	0.4	0.3	(0.1)	4.4	3.4	(1.0)	5.1
Prior Year Income	0.6	2.8	2.2	1.9	3.4	1.5	3.1
NHS England - Other	0.2	-	(0.2)	2.2	-	(2.2)	2.6
Out of Area CCGs	0.2	0.2	(0.0)	1.7	1.8	0.1	2.1
	66.9	**66.0**	**(0.9)**	**629.5**	**632.9**	**3.4**	**761.8**

	This Month			Year to Date			Annual
Care Group Income £m	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Cancer Services	4.3	4.3	(0.0)	42.8	42.8	(0.0)	51.3
Central	16.2	15.3	(0.9)	122.5	125.9	3.4	153.4
Child Health	3.5	3.5	(0.0)	35.2	35.2	(0.0)	42.2
Clinical Support Services	5.1	5.1	(0.0)	51.1	51.1	(0.0)	61.3
General and Specialist Medicine	12.7	12.7	0.0	126.7	126.7	0.0	152.0
Surgery - Head and neck, Breast Surgery a...	3.6	3.6	(0.0)	36.4	36.4	(0.0)	43.7
Surgery and Anaesthetics	10.0	10.0	(0.0)	100.1	100.1	(0.0)	120.1
Urgent and Emergency Care	7.6	7.6	0.0	76.4	76.4	0.0	91.7
Womens Health	3.8	3.8	(0.0)	38.4	38.4	(0.0)	46.1
	66.9	**66.0**	**(0.9)**	**629.5**	**632.9**	**3.4**	**761.8**



Almost all Income for H1 and H2 has been set by NHSE/I and allocated to commissioners at a level of £46.3m per month due to the Covid-19 finance regime. The significant favourable variance is due to the backdated funding of £6.2m paid in M6 to cover the 3% staff pay award which wasn't planned. From M7 onwards the staff pay award of 3% is offset by efficiency savings and Covid-19 funding reduction, which increases the monthly income by £0.3m.

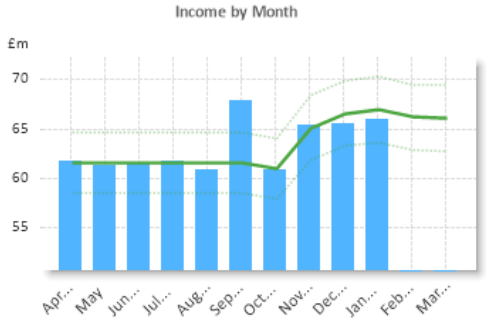
In addition, £9.6m per month consisting of Covid-19 and other top-ups are being paid by Kent and Medway CCG and are fixed. The elements are Covid-19 funding and support £3.0m, Central Top-Up £4.0m and Growth of £3.5m, including the CCG-funded elements of the new UTCs.

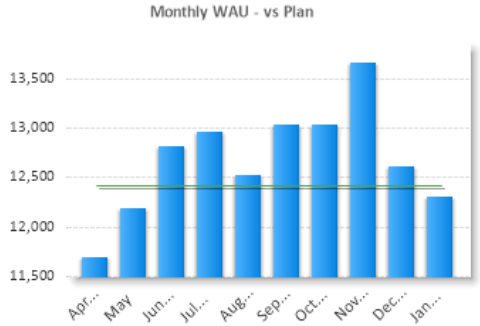
The YTD Elective Recovery Funding (ERF) is £11.5m. This is primarily below planned levels due to the H1 revised target of 95% which came into effect from 1st July. From M7 the baseline and performance has changed to be measured against RTT completed pathways instead of against pure activity. As part of this change the target has also been updated to 89%. The Trust has accrued £1.1m in Q3 for ERF performance above the guaranteed ERF+ level, which is set at £8.4m for H2. However, the plan is to achieve an additional £4.6m, taking the total H2 plan to £13m.

The variable element of High Cost drugs with NHS England is currently £0.7m over plan. However, this is cost neutral as these are pass through costs and the Trust's expenditure is also higher.

NHSE High Cost Devices are paid as pass through costs under the visible cost model, meaning income and expenditure balance off. From the start of December, the vascular stents have been added to the visible cost model.

There are small variances present in Private, Overseas, Compensation Recovery Unit and Provider to Provider income.





Activity

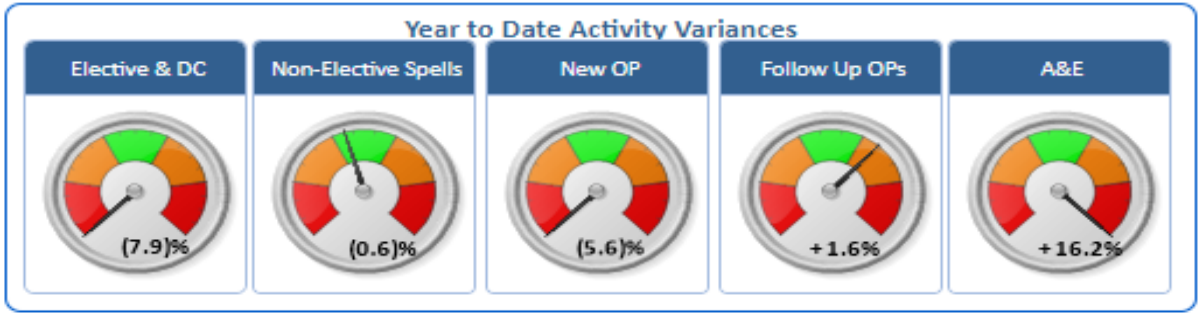
Month 10 (January) 2021/22

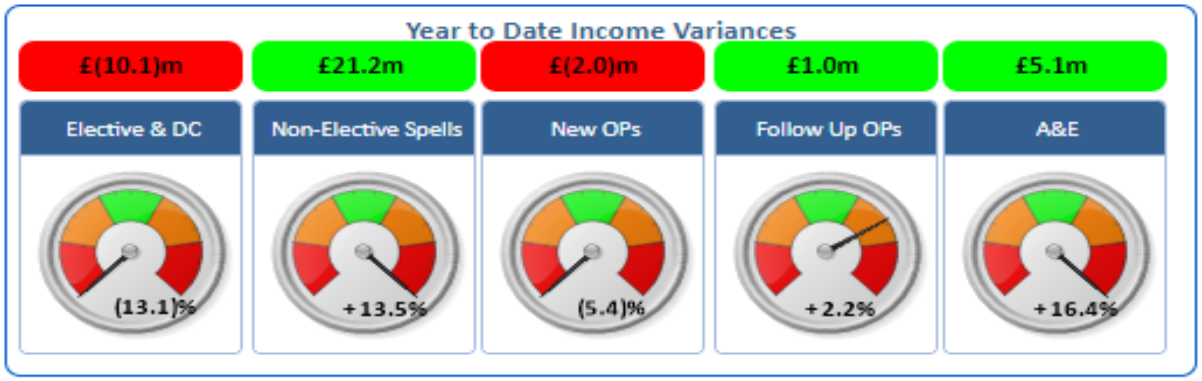
Trust Income Plan	Trust Actual Income	Income Variance
£629.537m	£632.942m	£3.405m

East Kent Hospitals University NHS
NHS Foundation Trust

2021/22 - Month 10

	Year to Date Activity			Year to Date Income £m			Average Tariffs	
Point of Delivery	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual
1a Total Non Elective Spells	72,881	72,446	(435)	£156.9 m	£178.1 m	£21.2 m	£2,153	£2,459
2 Accident & Emergency	192,690	223,958	31,268	£31.0 m	£36.1 m	£5.1 m	£161	£161
3a Total Elective Spells	73,976	68,143	(5,833)	£77.2 m	£67.1 m	£(10.1)m	£1,043	£984
4a New Outpatient Attendances	203,321	191,981	(11,340)	£36.8 m	£34.8 m	£(2.0)m	£181	£181
4b Outpatient Follow Up Attendances	449,251	456,223	6,972	£44.6 m	£45.6 m	£1.0 m	£99	£100





The activity plan for 2021/22 has been based on Pre-Covid-19 2019/20 actuals and is phased in 12ths.

The Trust has been paid £4.8m for the Elective Recovery Fund in H1. The Q3 value is expected to be £1.1m over the fixed ERF+ value of £4.2m once confirmed nationally. No Additional ERF funding has been accrued in January above the fixed ERF+ value, due to additional cancellations caused by a surge in Covid-19 patients. This has resulted in performance being 88% against the target of 89%.

Outpatients have operated at 5% under planned levels in January. YTD Outpatients are 3% over plan.

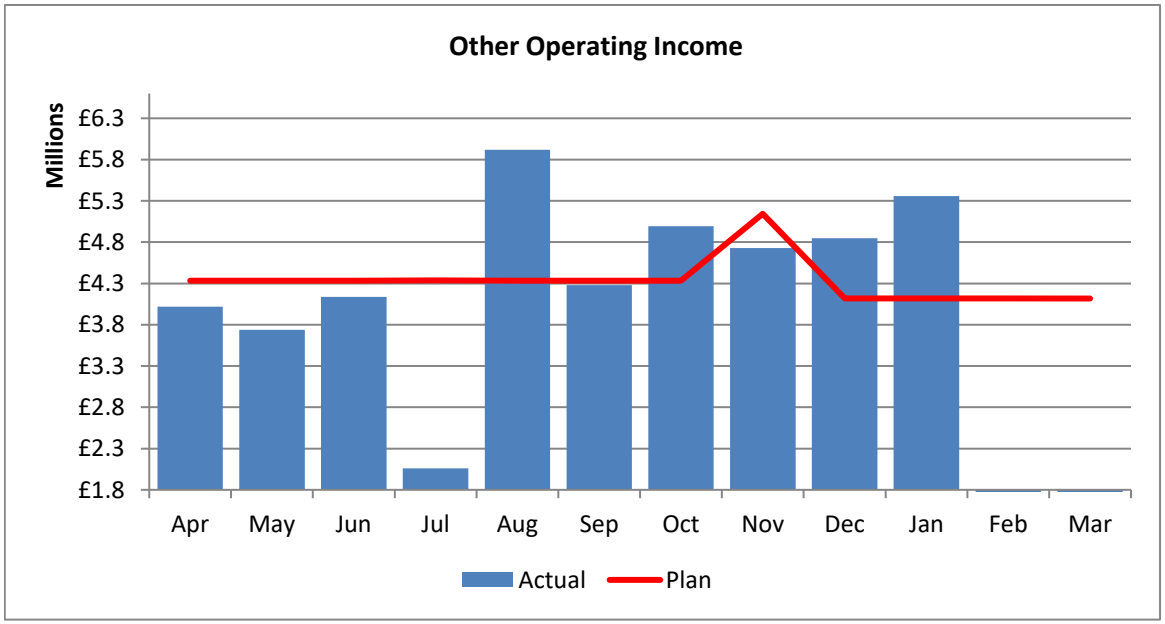
Elective inpatient activity has underperformed by 11% against plan in January. This is largely due to a surge in Covid-19 patients, resulting in cancelled elective operations.

The level of A&E attendance continues to run an overperformance against plan. Activity in January is 6% over plan, with YTD activity showing 16% over plan.

Non-Elective activity in month is 4% under plan, however the case mix is richer with income being 13% over plan. This is in line with the YTD position where activity is on plan, but income is 13% over plan. This is being driven by an increase in longer stay admissions.

Other Operating Income
Month 10 (January) 2021/22

Other Operating Income	This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Non-patient care services	2,016	1,715	(300)	19,106	18,296	(810)	23,137
Research and development	226	188	(38)	2,080	1,979	(101)	2,531
Education and Training	1,178	1,577	399	13,261	15,002	1,740	15,615
Car Parking income	105	59	(46)	977	1,027	50	1,186
Staff accommodation rental	171	185	14	1,865	1,611	(254)	2,206
Property rental (not lease income)				8		(8)	8
Cash donations / grants for the purchase of capital assets	81	20	(61)	744	642	(102)	906
Charitable and other contributions to expenditure	15	6	(9)	150	142	(8)	180
Other	327	1,609	1,282	5,526	5,387	(139)	6,181
Total	**4,118**	**5,359**	**1,241**	**43,717**	**44,085**	**369**	**51,952**
			30.14%			0.84%	
			Favourable			Favourable	

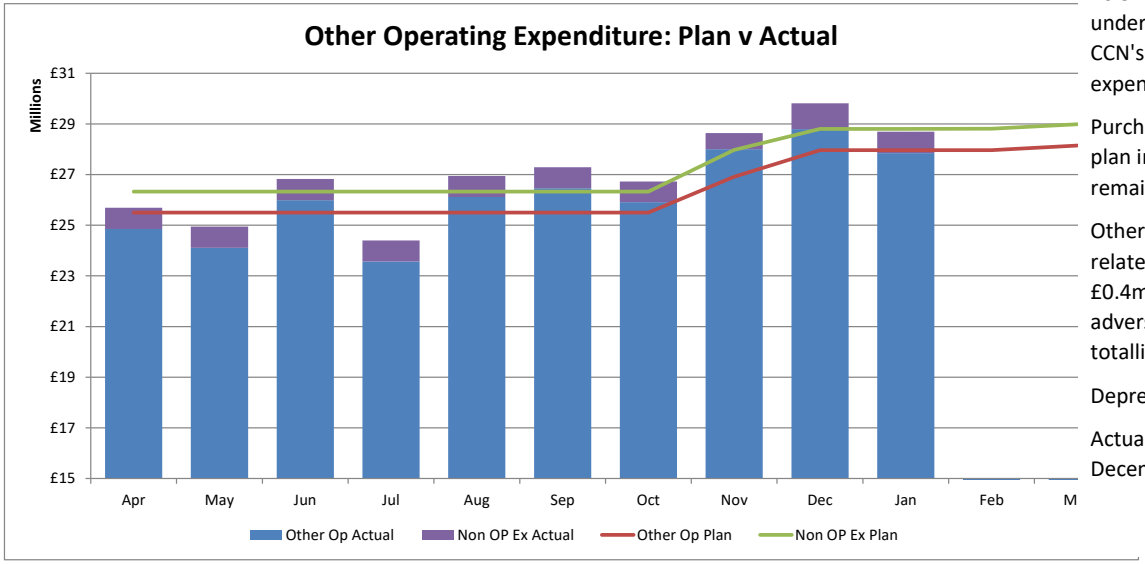


Other operating income is favourable to plan in January by £1.2m and by 0.4m YTD. The in-month variance is driven mainly by above plan Covid-19 income of £0.7m inclusive of the Nightingale surge hub and net income relating to the sale of Beautiful Information of £0.6m. Above plan education and training income of £0.4m is offset by deficits on Harmonia Village income and deferral of income relating to Maternity training totalling £0.2m.

YTD, Covid-19 income is below plan by £0.7m mainly driven by out of envelope performance and Harmonia Village income is adverse to plan by £1.0m. This is offset by a favourable variance on Education and Training income of £1.7m and sale of Beautiful Information £0.6m.

Other Operating Expenditure
Month 10 (January) 2021/22

	This Month			Year to Date			Annual
£000	**Plan**	**Actual**	**Var.**	**Plan**	**Actual**	**Var.**	**Plan**
Drugs	(6,326)	(6,359)	(32)	(62,037)	(65,925)	(3,888)	(74,690)
Clinical Supplies and Services - Clinical	(3,272)	(4,253)	(981)	(28,703)	(30,461)	(1,758)	(35,248)
Supplies and Services - Non-Clinical	(9,219)	(8,815)	404	(94,739)	(90,126)	4,613	(113,237)
Non Executive Directors	(17)	(16)	1	(175)	(198)	(23)	(208)
Purchase of Healthcare	(2,388)	(844)	1,544	(12,679)	(5,833)	6,846	(17,456)
Education & Training	(171)	(200)	(29)	(1,939)	(2,659)	(720)	(2,281)
Consultancy	(70)	(52)	18	(559)	(464)	95	(699)
Premises	(1,072)	(1,208)	(136)	(10,350)	(11,534)	(1,184)	(12,494)
Clinical Negligence	(2,330)	(2,328)	2	(23,296)	(23,280)	16	(27,955)
Transport	(251)	(338)	(88)	(2,296)	(2,428)	(132)	(2,797)
Establishment	(336)	(420)	(85)	(3,152)	(3,841)	(689)	(3,823)
Other	(772)	(1,349)	(577)	(4,921)	(8,796)	(3,876)	(6,580)
Depreciation & Amortisation-Owned Assets	(1,742)	(1,663)	79	(16,510)	(16,113)	397	(20,001)
Total Other Operating Expenditure	**(27,966)**	**(27,846)**	**121**	**(261,354)**	**(261,657)**	**(303)**	**(317,468)**
Profit/Loss on Asset Disposals		**(35)**	**(35)**		**(127)**	**(127)**	
PDC Dividend	(742)	(769)	(27)	(7,848)	(7,690)	158	(9,332)
Interest Receivable	186	187		1,862	1,869	7	2,235
Interest Payable	(285)	(229)	56	(2,547)	(2,360)	187	(3,117)
Total Non Operating Expenditure	**(841)**	**(847)**	**(6)**	**(8,533)**	**(8,308)**	**225**	**(10,214)**
Total Expenditure	**(28,807)**	**(28,692)**	**115**	**(269,887)**	**(269,965)**	**(78)**	**(327,683)**



Other operating expenditure is favourable to plan in January by £0.1m and adverse to plan by £0.3m YTD (0.12%). Expenditure on all Covid-19 non-pay streams is £1.3m in month and £7.5m YTD.

Drug spend is marginally adverse to plan in January and adverse to plan by £3.9m YTD. Drugs historically classed as rechargeable are adverse to plan in January by £0.4m, and by £3.9m YTD. All other drugs are favourable to plan by £0.4m in month and marginally favourable to plan by less than £0.1m YTD.

Supplies and services - clinical are adverse to plan in January by £1m and by £1.8m YTD. In month scanning services are showing an adverse variance of £1.1m due to MRI scanning services previously commissioned via the OHF now being commissioned directly with In-Health, with a catch-up of cost in January. Adverse variances on visible cost model consumables and pathology reagents (excluding Covid-19 testing) totalling £0.3m are offset by favourable variances on equipment maintenance and prostheses totalling £0.5m. YTD, expenditure reclassified from non-clinical supplies causes a technical overspend against the Trust's original plan of £3.4m, visible cost model items are overspent by £1.1m, scanning services are overspend by £0.7m and pathology reagents are adverse to plan by £0.4m. These overspends are offset by underspends on Covid-19 testing reagents, prostheses, equipment maintenance and theatre consumables totalling £4.0m.

Supplies and services - non-clinical are favourable to plan in January by £0.4m and favourable to plan by £4.6m YTD. The in-month variance is driven by MRI scanning services £1.1m favourable now being commissioned directly and showing against Clinical supplies, offset by slippage against CIP targets of £0.5m in month and £1.2m YTD. YTD, expenditure reclassified to clinical supplies causes a technical underspend of £3.4m with the remainder of the YTD variance relating mainly to slippage on anticipated CCN's to the OHF contract in prior months and MRI scanning now classified as clinical supplies expenditure.

Purchase of healthcare from the independent sector including the use of Spencer beds is favourable to plan in month by £1.5m and by £6.8m YTD. The outsourcing of activity to the independent sector remains below plan.

Other expenditure is adverse to plan in January by £0.6m and by £3.9m YTD. In month, the variance relates mainly to overspends on legal costs, fees for professional services and contracted out services £0.4m. Outsourced medical services originally planned as pay expenditure account for £3.5m of the adverse variance YTD. Overspends on legal costs, staff permits, security services and hospitality totalling £1.5m YTD are offset by a favourable position of £1.8m on provisions against bad debt.

Depreciation was marginally above plan in month and favourable to plan by £0.4m YTD.

Actual expenditure on non-pay in January was £27.8m, a reduction of £1.0m when compared to December. The underlying reduction relates to expenditure on drugs which fell by £1.1m.

Employee Expenses
Month 10 (January) 2021/22

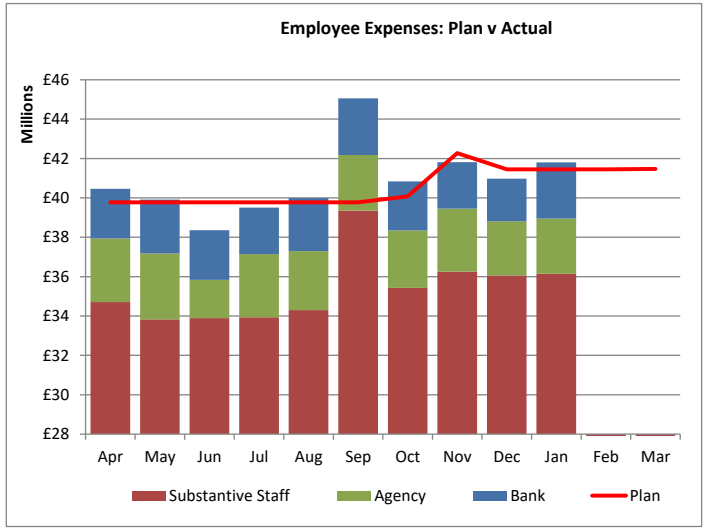
Employee Expenses	WTE This Month			This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Permanent Staff										
Medical and Dental	1,360	1,311	48	(11,557)	(10,977)	580	(112,381)	(109,681)	2,700	(135,495)
Nurses and Midwives	3,275	2,543	732	(10,053)	(10,353)	(301)	(97,992)	(98,031)	(38)	(118,128)
Scientific, Therapeutic and Technical	1,659	1,539	120	(5,366)	(5,513)	(147)	(53,651)	(54,281)	(630)	(64,384)
Admin and Clerical	1,730	1,472	258	(3,565)	(3,466)	99	(35,141)	(34,792)	349	(42,270)
Other Pay	1,774	1,496	277	(5,063)	(4,959)	104	(49,677)	(48,441)	1,236	(59,803)
Permanent Staff Total	**9,798**	**8,362**	**1,436**	**(35,604)**	**(35,268)**	**336**	**(348,843)**	**(345,226)**	**3,617**	**(420,080)**
Waiting List Payments										
Medical and Dental	0	0	0	(248)	(338)	(90)	(1,906)	(3,553)	(1,647)	(2,401)
Waiting List Payments Total	**0**	**0**	**0**	**(248)**	**(338)**	**(90)**	**(1,906)**	**(3,553)**	**(1,647)**	**(2,401)**
Medical Locums/Short Sessions										
Medical and Dental	5	39	(34)	(222)	(541)	(319)	(3,055)	(5,120)	(2,065)	(3,498)
Medical Locums/Short Sessions Total	**5**	**39**	**(34)**	**(222)**	**(541)**	**(319)**	**(3,055)**	**(5,120)**	**(2,065)**	**(3,498)**
Substantive	**9,803**	**8,401**	**1,402**	**(36,073)**	**(36,146)**	**(73)**	**(353,804)**	**(353,899)**	**(95)**	**(425,980)**
Bank										
Medical and Dental	0	28	(28)	(308)	(382)	(74)	(3,346)	(3,216)	130	(3,962)
Nurses and Midwives	56	248	(192)	(1,202)	(1,343)	(142)	(9,680)	(11,981)	(2,301)	(12,083)
Scientific, Therapeutic and Technical	1	2	(1)	(11)	(9)	2	(142)	(79)	63	(164)
Admin and Clerical	13	67	(53)	(131)	(205)	(73)	(1,309)	(1,895)	(586)	(1,571)
Other Pay	41	261	(220)	(999)	(908)	91	(6,574)	(8,421)	(1,847)	(8,571)
Bank Total	**111**	**606**	**(494)**	**(2,651)**	**(2,847)**	**(196)**	**(21,050)**	**(25,591)**	**(4,541)**	**(26,353)**
Agency										
Medical and Dental	5	42	(37)	(1,259)	(884)	374	(17,210)	(10,451)	6,759	(19,728)
Nurses and Midwives	42	174	(132)	(951)	(940)	11	(7,293)	(10,959)	(3,666)	(9,195)
Scientific, Therapeutic and Technical	0	0	0	(18)		18	(144)	(191)	(47)	(180)
Admin and Clerical	0	2	(2)	(1)	(17)	(16)	(7)	(57)	(50)	(8)
Other Pay	2	27	(26)	(110)	(183)	(73)	(477)	(604)	(127)	(697)
Agency Total	**49**	**245**	**(197)**	**(2,338)**	**(2,024)**	**314**	**(25,131)**	**(22,262)**	**2,869**	**(29,808)**
Direct Engagement - Agency										
Medical and Dental	4	52	(48)	(384)	(777)	(393)	(3,423)	(6,894)	(3,471)	(4,191)
Scientific, Therapeutic and Technical	0	1	(1)		(6)	(6)	(489)	(68)	421	(489)
Direct Engagement - Agency Total	**4**	**53**	**(49)**	**(384)**	**(782)**	**(399)**	**(3,913)**	**(6,963)**	**(3,050)**	**(4,680)**
Agency	**53**	**298**	**(245)**	**(2,722)**	**(2,807)**	**(85)**	**(29,043)**	**(29,225)**	**(181)**	**(34,487)**
Total	**9,967**	**9,304**	**663**	**(41,446)**	**(41,800)**	**(353)**	**(403,897)**	**(408,715)**	**(4,817)**	**(486,820)**
						-0.85%			-1.19%	
						Adverse			Adverse	

Employee expenses performance is adverse to plan in January by £0.4m and adverse to plan by £4.8m YTD (1.19%). Expenditure relating to all Covid-19 pay streams is £1.1m in month and £10.4m YTD.

Total expenditure on pay in January was £41.8m, an increase of £0.8m when compared to December. Costs relating to bank staff increased by £0.7m due to increased shifts worked and substantive staffing costs increased by £0.1m with bank holiday costs of £0.5m being offset by a reduction in arrears, waiting list and additional session payments totalling £0.4m.

Expenditure on all substantive staff is adverse to plan in January and YTD by £0.1m.

Expenditure on bank and agency staff combined is adverse to plan in January by £0.3m and adverse to plan by £4.7m YTD.



Cost Improvement Summary

Month 10 (January) 2021/22

Delivery Summary	This Month			Year to Date			Forecast	
Programme Themes £000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Outturn**	**Variance**
Agency	1,140	648	(492)	2,580	2,642	62	5,401	(38)
Bank	-	-	-	-	-	-	-	-
Workforce	20	13	(7)	180	156	(23)	212	(7)
Outpatients	-	-	-	-	-	-	-	-
Procurement	25	30	5	248	310	62	343	46
Medicines Value	-	-	-	-	-	-	-	-
Theatres	-	-	-	-	-	-	-	-
Care Group Schemes *	317	448	130	1,360	937	(423)	1,994	-
Sub-total	**1,502**	**1,138**	**(363)**	**4,368**	**4,045**	**(323)**	**7,951**	**0**
Central	555	321	(234)	1,387	1,433	46	2,775	(0)
Grand Total	**2,057**	**1,459**	**(598)**	**5,755**	**5,477**	**(277)**	**10,726**	**0**

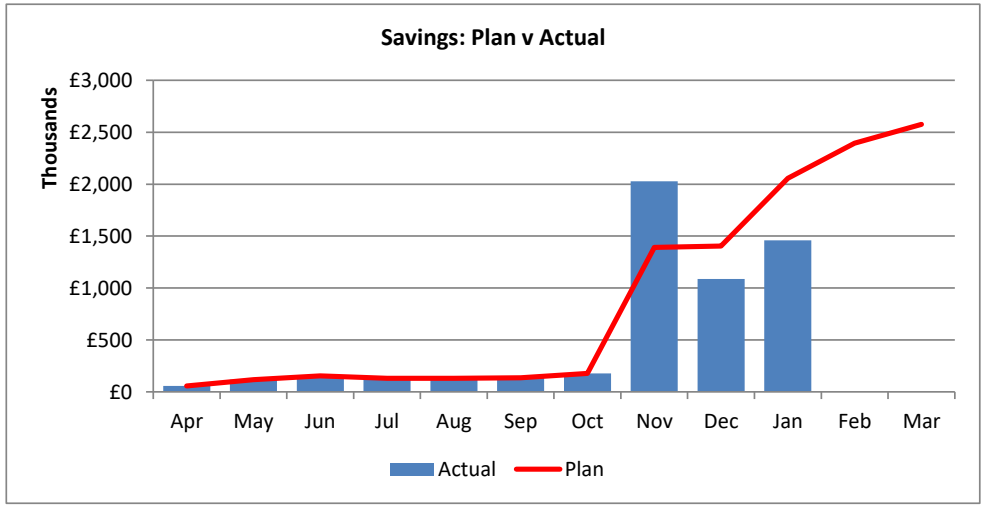
* Smaller divisional schemes not allocated to a work stream

Delivered £000		
Month	**Target**	**Actual**
April	57	57
May	118	118
June	154	154
July	130	130
August	131	131
September	135	135
October	178	178
November	1,390	2,027
December	1,404	1,088
January	2,057	1,459
February	2,395	
March	2,576	
	10,726	**5,477**

Savings and Efficiencies

The agreed savings plan for H2 is £10m. The savings achieved in January of £1.5m was below the plan of £2.1m. The in-month shortfall relates to timing of efficiencies yet to be identified. The YTD delivery is below plan with the FOT meeting the targeted value.
Schemes are being worked up to cover the £2.2m unidentified efficiencies included in the £10.0m Plan for delivery in Q4.

Recurrent savings in January amounted to £1.2m, with £0.3m being on a non-recurrent basis. A pipeline of ideas is being developed as the basis for delivery of the 2022-23 efficiency programme and should be ready in February.



Capital Expenditure
Month 10 (January) 2021/22

Capital Programme	Annual	Annual	Year to Date		
£000	Plan	Forecast	Plan	Actual	Variance
ED Expansion WHH	10,647	5,991	5,565	3,901	1,664
ED Expansion QEQM	10,295	5,508	5,866	3,142	2,723
ED Expansion Other	2,058	2,240	1,470	306	1,164
Energy Performance Contract (EPC - Breathe)	1,710	2,310	1,710	2,271	(561)
Mammography equipment - 2 x rooms K&C	130	752	130	508	(378)
Electronic Medical Record (T3 'Sunrise' system)	780	779	780	776	4
Cardiac Catheter Lab QEQM	1,198	1,150	1,198	846	352
Installation of replacement MRI - QEQM	740	779	740	779	(39)
New Interventional Radiology (IR) suite - K&C	2,850	3,190	2,670	2,642	28
Endovascular theatre (EVT) kit installation - K&C	880	30	430	11	419
Clinical Trials Unit	1,600	807	1,350	184	1,166
Community Diagnostic Hub - BHD		4,250		348	(348)
MDG - Medical equipment replacement (<£250k per item)	1,500	1,500	1,500	1,098	402
IDG - IT hardware/ systems replacement	1,000	1,750	1,000	2,798	(1,798)
2Gether Support Solutions	350	350	350	118	232
Spencer Private Hospitals	150	170	150	66	84
PEIC - Backlog maintenance/ Patient environment improvement	3,000	3,100	2,333	1,058	1,275
ITU Expansion - 24 bed Unit WHH	2,530	4,938	2,530	4,424	(1,894)
East Kent Transformation Programme	200	196	200	127	73
Donated Assets	900	900	700	548	152
K&M ICS Prioritisation	1,178	650	829	357	472
Restore and Recovery	588	397	588	89	499
Elective Orthopaedics		2,582		2,545	(2,545)
ED Enabling Works - PEIC		3,180		1,090	(1,090)
ED Enabling Works - IDG		800		101	(101)
All Other		2,604		1,151	(1,151)
GP and Community Order Comms.		2,367			
ED Enabling - MDG		1,200			
Pre and intra-operative digital solution		980			
Home Reporting		568			
iRefer		227			
Supporting implementation of EeRS and Kent Ophthalmology Rec		400			
Discharge Lounge refurbishment		700			
	44,284	**57,347**	**32,089**	**31,283**	**806**

Funded By:		
Depreciation	19,206	19,206
Grants and Donations	900	975
Public Dividend Capital	24,178	36,689
In-year disposals	0	91
	44,284	**56,961**

Summary Capital Spend Position - January 2022

The Group gross capital year-to-date spend to the end of January is £31.3m, against an internal capital re-phased plan year-to-date of £32.1m., representing a £0.8m underspend. Weekly Capital meetings confirm that this will be recovered on a full year basis and we are still expecting to fully spend to plan.

However, since the original Capital Plan submitted to NHSE/I in April 2021, the 2021/22 Capital Programme increased by circa £13m, to an estimated forecast as at M10 of £57.3m. A detailed paper on the 2021/22 Capital Programme bridging the original plan position to the M9 forecast has been presented to Finance and Performance Committee (FPC) in January 2022.

Additional Funding:

• **Targeted Investment Funding (TIF) -** The Trust received MOUs for both TIF funding streams (Estates and Digital) in December 2021. The final amounts in the Memorandum of undertsanding (MOUs) have since been under discussion. Other Trusts in the system have reported similar iss ues.

Whilst the schemes have been submitted as part of the Trust Governance process and approved to proceed to implementation, the Trust is awaiting written confirmation from NHSE/I on recommended course of action, as the MOUs include additional capital for schemes not related to E KHUFT.

• **Diagnostics Digital Capability:** The Trust signed the letter of Agreement for an award of £2.4m in November 2021, for the delivery of:

- GP and Community Order Communications;

- Digital Pathology; and

- Point of Care Testing (POCT);

The associated MOU confirming the PDC Central Funding has now been received.

• **Unify Tech Funding** - the Trust received confirmation in December 2021 that was successful in securing £1m funding for the associated bid submittedand IDG was approved to proceed to implementation on this basis. **An** MOU has now been received for the maternity element from NHSX, for a total of £0.02m. MOUs for the main element of £0.97m Frontline Digitisation are yet to be received.

Risk Management

• **ED Expansion**

The main risk to the 2021/22 Capital Programme was an initial £9.5m underspend, following the revised ED programme approved b y the FPC and the Trust Board earlier in the year.

Whilst the planned ED Expansion slippage has now been fully mitigated, there is still a significantly high inherent risk asso ciated with the delivery of the programme as planned, primarily revolving around the impact of Covid -19 on timescales (including access and supply chain issues) and global supply shortages and increased delivery times for both materials and finished products.

• **ED Expansion - Funding**

In the absence of a variation letter to the original £23m MOU for 2021/22, the Trust has been asked by the regional NHSE/I te am and the K&M ICS to fully utilise the PDC amount awarded and to stay true to the agreed CDEL limit. The Trust has therefore reported on this basis in t he M10 PFR an under-utilised internally generated capital of £4m with the new total being £15.2m, the £4m is the agreed share of UEC PDC to be overspent b y other organisations in the ICS therefore capital is balanced at a Kent & Medway system level.

• **MOU's**

The Trust is still awaiting MOUs totalling circa £4.2m for the Frontline Digitisation (£1m) and Emergency PDC Application (£3 .2m), which represents a significant risk in terms of the cash draw down process, as the final submission of requests if due at the end of February 20 22.

Another risk related to the MOUs received is that they include significant amounts of capital of circa £0.5m which are in res pects of non-EKHUFT Capital Schemes. Written advice from NHSE/E advises there is a risk of variation letters not being received on time due to the volume being handled, and advises the Trust sign the existing MOU but draw down the value of what we should get as waiting for a variation letter may mean missing out entirely on funding.

Statement of Financial Position

Month 10 (January) 2021/22

£000	Opening	To Date	Movement	
Non-Current Assets	**392,497**	**405,685**	**13,189**	▲
Current Assets				
Inventories	4,198	5,627	1,429	▲
Trade and Other Receivables	31,065	33,989	2,924	▲
Assets Held For Sale			-	
Cash and Cash Equivalents	67,943	10,028	(57,915)	▼
Total Current Assets	**103,207**	**49,645**	**(53,562)**	▼
Current Liabilities				
Payables	(36,206)	(37,514)	(1,308)	▲
Accruals and Deferred Income	(83,474)	(47,382)	36,091	▼
Provisions	(3,826)	(2,367)	1,459	▼
Borrowing			-	
Net Current Assets	**(20,299)**	**(37,619)**	**(17,320)**	▼
Non Current Liabilities				
Provisions	(3,171)	(3,060)	111	▼
Long Term Debt	(87,360)	(81,657)	5,703	▼
Total Assets Employed	**281,666**	**283,349**	**1,682**	▲
Financed by Taxpayers Equity				
Public Dividend Capital	394,480	397,814	3,334	▲
Retained Earnings	(172,005)	(173,657)	(1,652)	▼
Revaluation Reserve	59,191	59,191	-	
Total Taxpayers' Equity	**281,666**	**283,349**	**1,682**	▲

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 balances for January was £10m (£17.2m in December) £4.4m above plan. Whilst cash remains above plan, the potential for in-month deficits during the remainder of the financial year could increase pressure on cash - the management of which remains a top priority task. See cash report for further details.

Trade and other receivables have increased from the 2020/21 opening position by £2.9m (£5.2m decrease in December), the increase this month being driven by increases in NHS Debtors.

Payables have increased by £1.3m YTD (£3.2m decrease in December).

No additional capital related PDC was drawn in month.

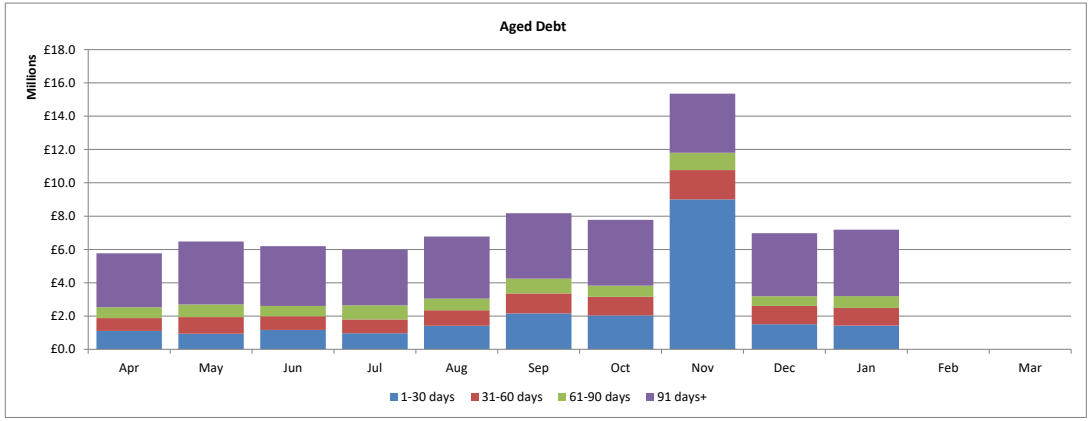
The large decrease in accruals and deferred income relate to year-end activity not being replicated in November.

The long-term debt entry relates to the long-term finance lease debtor with 2gether. The movement in Retained earnings reflects the year-to-date unadjusted deficit.

Working Capital
Month 10 (January) 2021/22

Top ten debtor balances outstanding as at 31/01/2022

Debtor Name	Current	1+	31+	61+	91+	Total
SPENCER PRIVATE HOSPITALS LIMITED	5	389	441	450	628	1,913
2GETHER SUPPORT SOLUTIONS LTD	1,267	40	35		201	1,543
DARTFORD AND GRAVESHAM NHS TRUST	73	96		87	841	1,097
MEDWAY NHS FOUNDATION TRUST	51	125	28	38	494	736
NHS KENT AND MEDWAY CCG	144	253				397
KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	286				0	287
KINGS COLLEGE HOSPITAL NHS FOUNDATION TRUST	134				139	272
PHILIPS RESPIRONICS			245			245
MONITOR 90T	10				195	205
NHS ENGLAND Q88 SOUTH EAST (KENT, SURREY AND SUSSEX) LOCAL OFFICE	2	2	2	1	144	151
Total	**1,971**	**905**	**751**	**576**	**2,642**	**6,846**



Total invoiced debtors have increased from the opening position of £8.2m by £1.4m to £9.6m (of which £2.3m is current debt)

At 31st January there were 3 debtors owing over £1m.

- 2gether Support Solutions owe £1.5m (£1.3m is current)
- Spencer Private Hospitals owe £1.9m. The Trust is working with subsidiaries to bring reciprocal balances down.
- Dartford & Gravesham NHS Trust owe £1.1m. (£0.8m for P2P invoices has been received in early February)

Top ten creditor balances outstanding as at 31/01/2022

Supplier Name	Current	1+	31+	61+	91+	Total
Other Creditors	3,421	1,565	262	538	721	6,508
2gether Support Solutions Ltd		4,085	352	3	105	4,546
Spencer Private Hospitals Ltd		229	430	83	1,073	1,815
NHS Professionals Ltd	1,732					1,732
NHS Business Services Authority Prescription Pricing Division		284	284		276	844
Medway NHS Foundation Trust (RPA)	185	7	2	23	589	806
Maidstone & Tunbridge Wells NHS Trust (RWF)	190	161	213	158	51	773
AAH Pharmaceuticals LTD	375	162			0	537
NES Holdings (UK) Ltd		255	228	27	18	528
InHealth Ltd	486		1			487
	6,390	**6,748**	**1,773**	**833**	**2,833**	**18,577**

Better Payment Practice Code	Last Year YTD Number	Last Year YTD £'000	This Year YTD Number	This Year YTD £'000
Non NHS				
Total bills paid in the year	52,262	413,096	58,295	487,573
Total bills paid within target	47,536	371,281	53,848	442,763
Percentage of bills paid within target	**91.0%**	**89.9%**	**92.4%**	**90.8%**
NHS				
Total bills paid in the year	2,401	39,485	2,272	10,053
Total bills paid within target	1,782	35,114	1,827	8,073
Percentage of bills paid within target	**74.2%**	**88.9%**	**80.4%**	**80.3%**
Total				
Total bills paid in the year	54,663	452,581	60,567	497,626
Total bills paid within target	49,318	406,395	55,675	450,836
Percentage of bills paid within target	**90.2%**	**89.8%**	**91.9%**	**90.6%**

Invoiced creditors have decreased by £1.6m from the opening position to £18.6m.

34% relates to current invoices with 15% or £2.8m over 90 days.

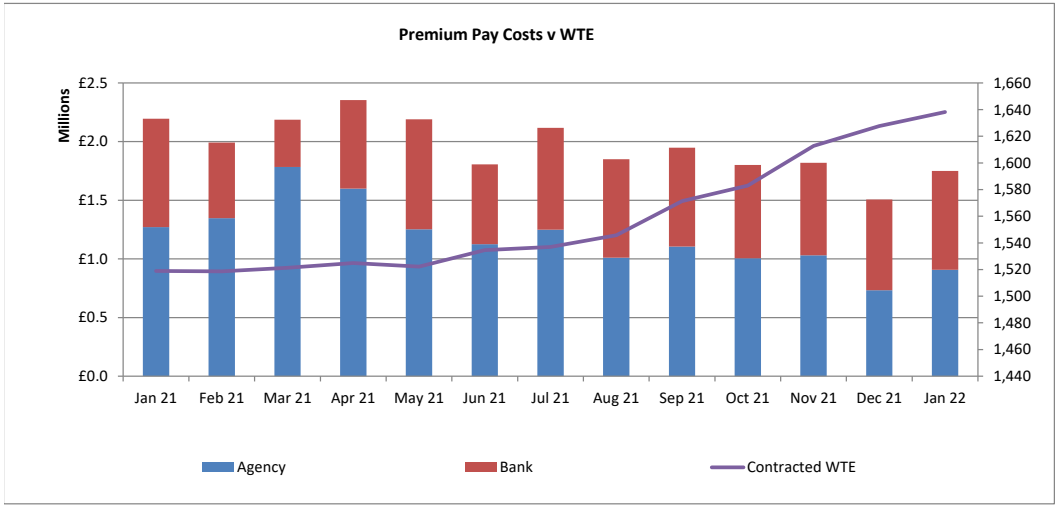
Over 90 days NHS creditors have increased by 60k:

- Kent Community Health NHS Foundation Trust (RYY) - £51k
- Maidstone & Tunbridge Wells NHS Trust (RWF) - £7k
- Royal Brompton And Harefield NHS Foundation Trust (RT3) - (£9k)

General and Specialist Medicine

Month 10 (January) 2021/22

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,747	1,567	(180)	17,468	15,995	(1,472)
Non-Electives	5,978	7,371	1,393	59,778	72,223	12,445
Outpatients	1,993	1,966	(27)	19,931	20,024	93
High Cost Drugs	845	864	20	8,449	8,816	367
Private Patients	0	1	1	0	17	17
Other NHS Clinical Income	2,107	896	(1,211)	21,069	9,556	(11,513)
Other Clinical Income	0	3	3	0	63	63
Total Income from Patient Care Activities	**12,669**	**12,669**		**126,694**	**126,694**	
Other Operating Income	166	59	(107)	1,977	974	(1,003)
Total Income	**12,836**	**12,729**	**(107)**	**128,671**	**127,668**	**(1,003)**
Expenditure						
Substantive Staff	(7,280)	(6,691)	589	(68,644)	(63,091)	5,553
Bank	(478)	(843)	(365)	(4,918)	(8,123)	(3,205)
Agency	(581)	(906)	(326)	(7,035)	(11,019)	(3,984)
Total Employee Expenses	**(8,339)**	**(8,441)**	**(102)**	**(80,597)**	**(82,233)**	**(1,636)**
Purchase of Healthcare	(212)	(94)	118	(2,199)	(1,954)	245
Supplies and Services Clinical	(933)	(1,088)	(155)	(9,851)	(9,940)	(88)
Supplies and Services General	(51)	(31)	20	(568)	(271)	297
Drugs	(1,162)	(1,200)	(38)	(11,531)	(11,502)	29
All Other, incl Transport	(309)	(455)	(146)	(1,646)	(2,359)	(713)
Total Operating Expenditure	**(11,006)**	**(11,309)**	**(303)**	**(106,392)**	**(108,259)**	**(1,867)**
Contribution	**1,830**	**1,420**	**(410)**	**22,279**	**19,410**	**(2,869)**



The Care Group financial position deteriorated by £0.4m in January to £2.9m adverse to plan YTD. Income is £1m adverse to plan YTD due to Harmonia being temporarily suspended, expenditure is adverse by £1.9m YTD primarily due to ward costs of premium pay and additional staffing. Costs are increasing due to Covid-19, nursing recruitment, patient safety issues and elective and diagnostic recovery.

Clinical Income:

Clinical Income is on-plan in line with Covid-19 reporting; the income position is reduced by £11.4m YTD, predominantly due to an overperformance on NEL of £12.4m. Due to site pressures and focus on flow, elective and outpatients was under plan for January by £0.2m. Activity in some specialities is restricted due to capacity constraints, including Renal (pending implementation of dialysis business case) and Cardiology (temporary closure of Cath lab at QEQM), or by lack of availability of consumables, specifically in Respiratory where activity has been restricted due to a global shortage of devices.

Other Income:

Plans to secure a partner for Harmonia remain in the bidder evaluation stage.

Pay:

January pay is £0.1m adverse (£1.6m adverse YTD), the driver being premium pay pressures to maintain safe ward staffing levels, manage site pressures and address activity backlog. The run rate increased by £0.3m (due to a non-recurrent credit in December) and is consistent with prior months. Agency spend is £0.1m lower than the recent trend, due to a drop in Consultant costs. The approved Safer Staffing Business Case is reflected in January budgets, resulting in a breakeven variance for Nursing/HCA, compared to £3m adverse in December YTD. Covid-19 pay costs are also on an increasing trend.

Non-Pay:

Non-Pay is £0.2m adverse this month due to higher clinical consumable costs particularly in Respiratory (where stock availability has been restricted until now) and Cardiology. Endoscopy insourcing costs are reducing, as activity is being converted to in-house.

The run rate is consistent with last month.

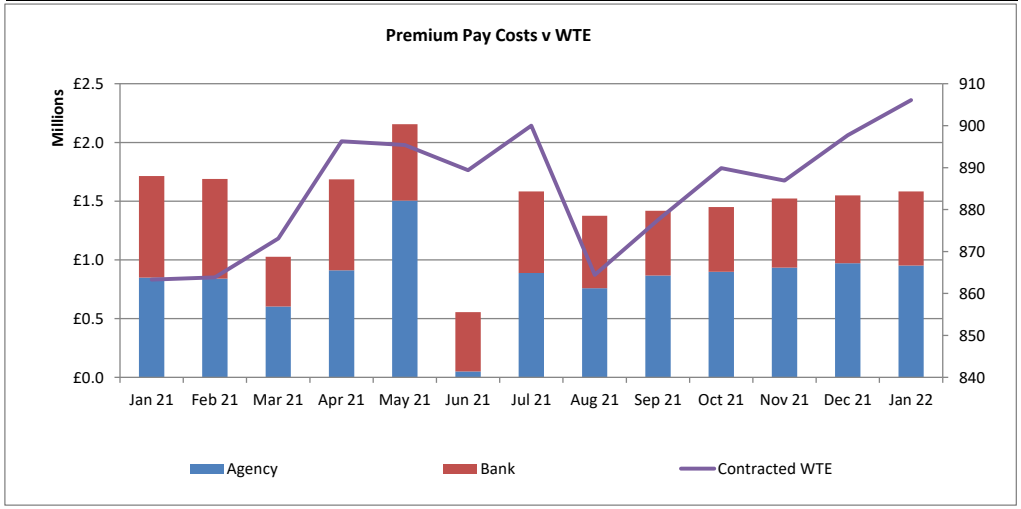
Covid-19:

Covid-19 costs of £0.3m were incurred in January, an increase for the fourth consecutive month and £0.1m higher than plan. The cumulative position is £3.1m spend, which is £0.4m favourable YTD.

Prepared by: Joanne Smith
Reviewed by: Alex McVey

Urgent and Emergency Care
Month 10 (January) 2021/22

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	123	84	(39)	1,227	836	(391)
Non-Electives	4,265	4,320	56	42,649	42,054	(595)
Accident and Emergency	3,101	3,414	313	31,007	36,083	5,076
Outpatients	56	59	4	558	568	10
High Cost Drugs	1	4	4	5	89	83
Other NHS Clinical Income	(1)	(307)	(306)	(6)	(4,103)	(4,097)
Other Clinical Income	98	67	(31)	980	893	(87)
Total Income from Patient Care Activities	**7,642**	**7,642**	**0**	**76,420**	**76,420**	**0**
Other Operating Income	(1)	18	18	1	72	71
Total Income	**7,641**	**7,660**	**18**	**76,421**	**76,492**	**71**
Expenditure						
Substantive Staff	(4,510)	(4,306)	204	(41,817)	(41,739)	78
Bank	(408)	(631)	(223)	(4,238)	(6,140)	(1,902)
Agency	(827)	(952)	(126)	(8,714)	(8,739)	(25)
Total Employee Expenses	**(5,745)**	**(5,890)**	**(145)**	**(54,769)**	**(56,617)**	**(1,849)**
Purchase of Healthcare	0	0	0	0	0	0
Supplies and Services Clinical	(158)	(158)	1	(1,590)	(1,682)	(92)
Supplies and Services General	(18)	(47)	(29)	(190)	(206)	(16)
Drugs	(141)	(178)	(37)	(1,515)	(1,856)	(341)
All Other, incl Transport	(674)	(790)	(116)	(7,200)	(7,047)	153
Total Operating Expenditure	**(6,735)**	**(7,063)**	**(327)**	**(65,264)**	**(67,408)**	**(2,144)**
Contribution	**906**	**597**	**(309)**	**11,157**	**9,084**	**(2,074)**



The Care Group's position was £0.3m adverse in January, driven mainly by pay and non-pay overspends associated with activity levels being significantly ahead of plan.

Income:

January's attendances were 6% (1,100) above plan. Actual attendances are averaging 22,400 per month this year and are persistently exceeding pre-Covid-19 levels (when activity was averaging 20,000 attendances a month in 19/20). Added to this, the general acuity of patients attending is more complex and more patients are requiring support with mental health conditions. OPEL (Operational Pressures Escalation Levels) 4 has often been applied and reflects current pressures. Consequently, the overall adjustment required to counter the overperformance was £0.3m in January and is £4.1m YTD.

Employee Expenses:

Pay was £0.1m overspent in January and continues on an upward trajectory. Overall actual pay expenditure was £0.1m higher than last month and £0.2m higher than the average for the year, driven by an increase in substantive pay.

Substantive costs have largely risen due to recruitment successes, particularly for HCAs/Nurses.

Although premium pay costs (agency, bank, locum and overtime) were £0.05m lower than last month, they were £0.09m higher than the average for the year. Decreases this month are split between agency and medical locum spend. The rise over the year is mostly linked to the staffing of additional escalation areas/beds on the ED floor and AMU/SDEC; escalated rates/incentives to ensure minimum staffing during peak times and additional cover to provide some resilience in the team due to Covid-19 illness/contact isolation.

Covid-19 costs totalled £0.24m in January. This was £0.04m higher than last month and £0.11m higher than the allocation. Covid-19 budget allocations have now been capped at September levels (£0.13m per month).

Acute Junior Dr costs have also increased over funded levels over the last two years. Approximately 70% of these costs relate to GSM services (e.g. Stroke cover at KCH, Oxford, Cambridge M1 and Kings D2 ward cover) and are therefore outside of the Care Group's control.

Other Operating Expenditure:

Non-pay was £0.2m adverse to plan in January. Actual costs were significantly higher (by £0.1m) than the average for the year. This was partly due to increasing drugs costs and clinical supply costs across the year and is attributable to the higher levels of activity.

Additional sub-contracted GPs hours have also been required to staff the Urgent Treatment Centres. Other pressures are due to 2gether recharges for ad hoc security/cleaning costs and the purchase of non-recurrent equipment.

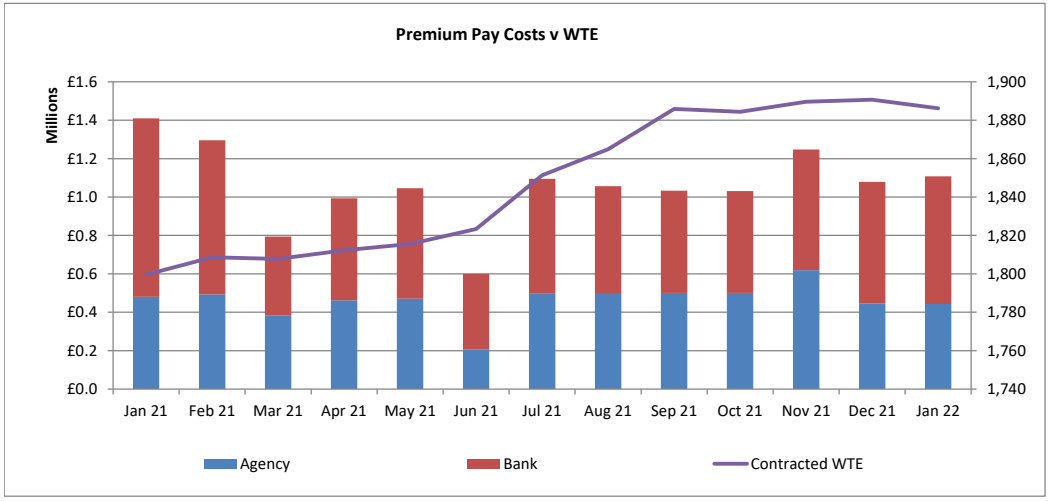
CIPs:

A small amount of savings was recognised this month. Focus is now moving into identifying savings opportunities for 2022/23.

Prepared by: Stephen Lazell
Reviewed by: David Bogard & Hillary Mitchell

Surgery and Anaesthetics
Month 10 (January) 2021/22

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	3,601	2,118	(1,483)	36,009	28,019	(7,990)
Non-Electives	3,326	3,744	418	33,263	39,284	6,021
Outpatients	1,436	1,264	(173)	14,365	13,475	(890)
High Cost Drugs	27	37	10	268	314	46
Private Patients	0	0	0	0	142	142
Other NHS Clinical Income	1,617	2,836	1,219	16,170	18,773	2,603
Other Clinical Income	0	9	9	0	70	70
Total Income from Patient Care Activities	**10,007**	**10,007**	**()**	**100,075**	**100,077**	**2**
Other Operating Income	38	31	(7)	645	751	106
Total Income	**10,046**	**10,038**	**(7)**	**100,720**	**100,827**	**107**
Expenditure						
Substantive Staff	(8,390)	(8,235)	155	(81,343)	(81,711)	(368)
Bank	(312)	(665)	(353)	(3,269)	(5,646)	(2,377)
Agency	(260)	(443)	(182)	(2,981)	(4,642)	(1,661)
Total Employee Expenses	**(8,962)**	**(9,343)**	**(380)**	**(87,593)**	**(91,999)**	**(4,406)**
Purchase of Healthcare	()	(1)	(1)	(2)	(2)	(1)
Supplies and Services Clinical	(1,972)	(1,744)	228	(17,344)	(16,215)	1,129
Supplies and Services General	(52)	(47)	5	(518)	(514)	4
Drugs	(385)	(336)	49	(3,798)	(3,801)	(3)
All Other, incl Transport	(41)	(3)	38	(2,203)	(2,354)	(151)
Total Operating Expenditure	**(11,412)**	**(11,474)**	**(62)**	**(111,457)**	**(114,886)**	**(3,428)**
Contribution	**(1,367)**	**(1,436)**	**(69)**	**(10,737)**	**(14,058)**	**(3,321)**



The Care Group is £3.3m adverse to plan YTD, with a small deficit in month of £0.1m.

Income:

SLA Income has been adjusted YTD to break-even by £1.9m, for the impact of Covid-19.

Elective income is adverse £8m YTD and Outpatients £0.9m YTD. As expected both underperformed considerably in January with the continued impact of the new Covid-19 variant on non-urgent patient activity.

4 R plans had been developed for all specialties to deliver activity and reduce waiting times in line with National guidance, however risks of Theatre & Bed capacity remain limiting factors notwithstanding the additional impact of the new Covid-19 variant.

Non-Elective income however continues to overperform and is favourable YTD by £6.0m.

Pay:

Pay is adverse £4.4m YTD.

Both Bank (£2.4m) and Agency (£1.7m) are overspent YTD mainly due to increased Nursing to support additional workloads from Covid-19 patient pathway changes, 4 R plans and cover for sickness & vacancies.

Non-Pay:

Non-Pay is favourable £1.0m YTD, with underspends on clinical supplies from reduced patient activity.

Covid-19:

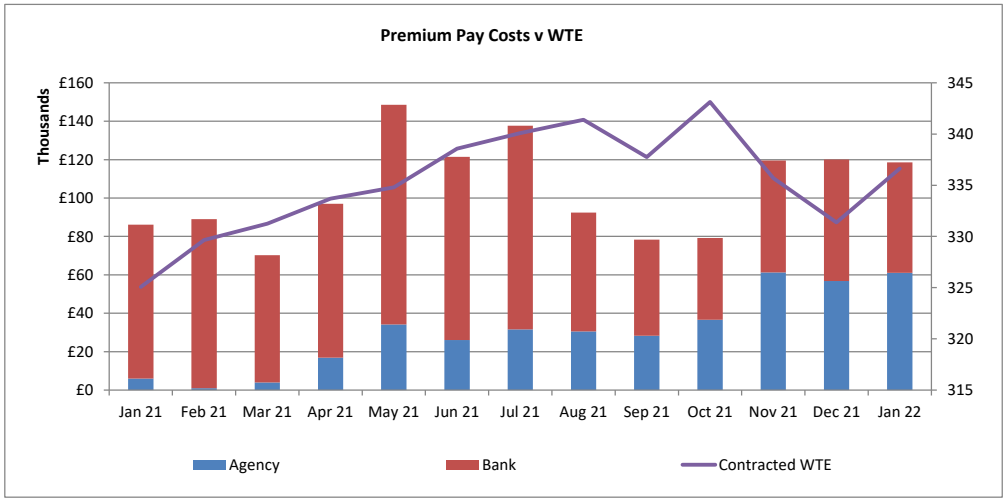
Covid-19 additional costs incurred of £2.5m are in the above, with all but £0.3m funded. The costs mainly relate to temporary staffing for the additional workforce requirements of pathway changes incurred supporting Critical Care services & emergency wards and also backfilling of staff.

Prepared by: James Isard
Reviewed by: Sue Travis

Surgery - Head and neck, Breast Surgery and Dermatology

Month 10 (January) 2021/22

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,244	1,171	(73)	12,435	11,865	(570)
Non-Electives	167	235	68	1,670	1,511	(159)
Outpatients	1,912	1,720	(192)	19,120	17,968	(1,152)
High Cost Drugs	249	290	42	2,489	3,165	677
Private Patients	0	5	5	0	37	37
Other NHS Clinical Income	69	217	148	691	1,857	1,166
Other Clinical Income	0	0	0	0	2	2
Total Income from Patient Care Activities	**3,640**	**3,638**	**(2)**	**36,405**	**36,405**	
Other Operating Income	10	6	(4)	104	99	(5)
Total Income	**3,651**	**3,645**	**(6)**	**36,508**	**36,503**	**(5)**
Expenditure						
Substantive Staff	(1,969)	(1,634)	335	(16,845)	(16,728)	117
Bank	(64)	(58)	6	(932)	(730)	202
Agency	(9)	(61)	(52)	(105)	(383)	(279)
Total Employee Expenses	**(2,042)**	**(1,753)**	**289**	**(17,882)**	**(17,841)**	**41**
Purchase of Healthcare	(49)	(53)	(3)	(491)	(567)	(76)
Supplies and Services Clinical	(103)	(76)	27	(1,009)	(897)	112
Supplies and Services General	(1)	(4)	(3)	(11)	(19)	(9)
Drugs	(429)	(479)	(50)	(4,384)	(4,495)	(110)
All Other, incl Transport	192	(57)	(249)	(392)	(354)	38
Total Operating Expenditure	**(2,433)**	**(2,422)**	**11**	**(24,169)**	**(24,173)**	**(4)**
Contribution	**1,218**	**1,223**	**4**	**12,339**	**12,330**	**(9)**



The Care Group is slightly adverse to plan YTD, with a small surplus in month.

Income:

SLA Income has been adjusted YTD to break-even by £0.9m, for the impact of Covid-19.

Elective income is £0.6m adverse YTD and Outpatients £1.2m adverse YTD. As expected both underperformed in January with the continued impact on patient activity of the new Covid-19 variant.

4 R plans were in place for most specialties to deliver activity in H2. However, Theatre capacity/outpatient clinic room capacity & staffing remain limiting factors notwithstanding the additional impact of the new Covid-19 variant.

Non-Elective income is adverse YTD by £0.2m.

Pay:

Pay is slightly favourable YTD.

Substantive & Bank staff are underspent offsetting the Agency overspend (£0.3m YTD) for Medical Staffing to cover vacancies and support RTT improvements.

Non-Pay:

Non-Pay is adverse by £0.04m YTD.

Underspends on clinical supplies and services offsetting increased AMD patient costs for Drugs and Spencer Hospitals service.

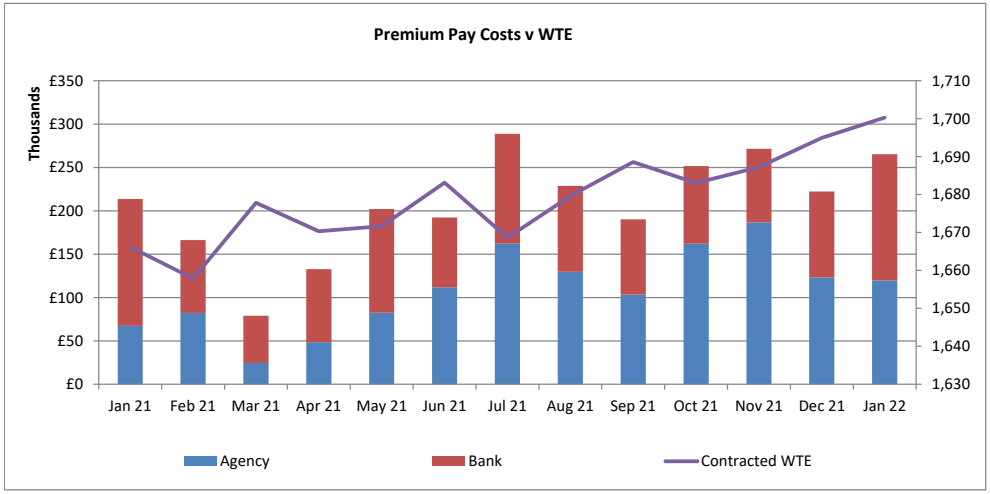
Covid-19:

Covid-19 additional costs of £0.03m have been funded in the above and relate mostly to temporary staffing.

Prepared by: James Isard
Reviewed by: Sarah Hyett

Clinical Support
Month 10 (January) 2021/22

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	77	45	(31)	766	481	(285)
Non-Electives	10	7	(3)	97	9	(87)
Outpatients	856	657	(200)	8,564	6,721	(1,843)
High Cost Drugs	1,422	879	(543)	14,221	14,185	(36)
Private Patients	0	0	0	0	18	18
Other NHS Clinical Income	2,747	3,523	776	27,467	29,700	2,233
Total Income from Patient Care Activities	**5,111**	**5,111**	**0**	**51,114**	**51,114**	**0**
Other Operating Income	769	710	(59)	7,653	7,298	(355)
Total Income	**5,880**	**5,820**	**(59)**	**58,768**	**58,413**	**(355)**
Expenditure						
Substantive Staff	(6,152)	(6,085)	67	(60,861)	(60,405)	456
Bank	(55)	(145)	(91)	(564)	(1,015)	(451)
Agency	(185)	(120)	65	(1,857)	(1,230)	628
Total Employee Expenses	**(6,392)**	**(6,350)**	**42**	**(63,283)**	**(62,650)**	**632**
Purchase of Healthcare	(22)	0	22	(222)	(40)	182
Supplies and Services Clinical	(2,819)	(2,710)	108	(26,347)	(25,624)	723
Supplies and Services General	(14)	(13)	2	(142)	(122)	21
Drugs	(1,484)	(1,362)	122	(17,744)	(17,401)	343
All Other, incl Transport	(245)	(287)	(42)	(2,704)	(2,920)	(216)
Total Operating Expenditure	**(10,976)**	**(10,721)**	**254**	**(110,442)**	**(108,757)**	**1,685**
Contribution	**(5,095)**	**(4,901)**	**195**	**(51,674)**	**(50,344)**	**1,330**



The CSS position is improved this month due to a significant reduction in Non-Pay costs predominantly driven by underspends in Radiology against plan mainly due to a credit note received in relation to the PACS contract.

Income:

There was an upwards 'Top-up' adjustment to meet the income plan. This was due to the low level of Homecare drugs reimbursements which was £1.1m this month, £0.3m below plan, a significant reduction compared to last month.

Primary care and externally referred activity, outpatients and diagnostics were below plan across all directorates. However, within Therapies, Outpatient activity has increased 8% on last month (430 more attendances). Pathology income/activity levels were for direct access & GUM tests were similar to last month. Radiology direct access & unbundled outpatient activity is up 14% on November, however, still behind plan leading to a £0.1m adjustment in month. The net top-up adjustment to plan total for the year to date is now £1.5m.

Pay:

Overall was underspent in January, however increased by 2% (£0.1m) compared with December levels. Agency and waiting list payments both increased in month with the latter being attributed to a significant rise in Radiology costs. Additionally, Radiology accounts for 57% of the £0.06m rise in Bank costs. Premium pay cost across the Care Group remained within the We care threshold. Largest underspends in Pay this month were in Pathology & Therapies, being partially offset by overspends in Radiology, Pharmacy & Outpatients.

Non-Pay:

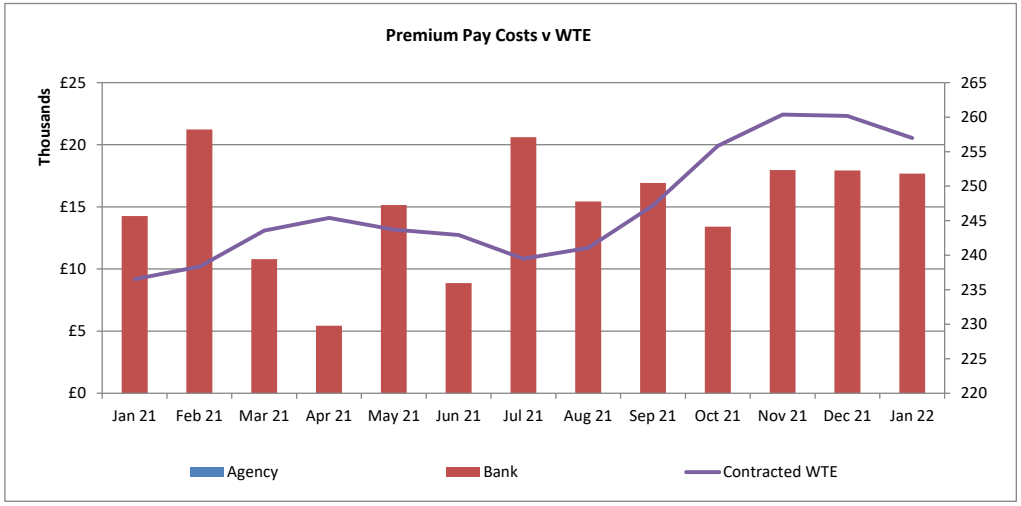
Non-Pay demonstrates an improved position and significant reduction in run rate. This is predominantly driven by Radiology due to a £0.3m credit note received from GE for the PACs/RIS contract overcharge in previous months. Furthermore, duplicate accruals were removed from Buckland Hospital which were funded by the community diagnostic centre. However, Therapies represent a cost pressure this month and were overspent in month as a result of retrospective billing on appliances, but are however, underspent year to date. Outsourced MRI scanning continues to feature as a cost pressure while the backlog and demand is still high. The Homecare drugs cost in Pharmacy this month is lower than last month by £0.6m.

Covid-19:

Inside-envelope Covid-19 expenditure costs in January was lower than December. Total year to date £1.2m. However, Outside Envelope costs (Covid-19 testing) were similar to last month (£0.4m). Year to date, Outside Envelope costs now total £2.6m. Income losses attributed to Covid-19 impact are now reported at £2m in CSS including patient care income.

Cancer Services
Month 10 (January) 2021/22

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	390	504	113	3,905	5,137	1,232
Non-Electives	26	14	(12)	257	337	80
Outpatients	846	1,094	249	8,456	11,400	2,944
High Cost Drugs	2,251	2,716	465	22,510	24,160	1,650
Other NHS Clinical Income	765	(53)	(819)	7,654	1,734	(5,920)
Other Clinical Income	0	4	4	0	13	13
Total Income from Patient Care Activities	**4,278**	**4,278**	**0**	**42,782**	**42,782**	**0**
Other Operating Income	102	93	(9)	992	948	(44)
Total Income	**4,380**	**4,371**	**(9)**	**43,774**	**43,730**	**(44)**
Expenditure						
Substantive Staff	(1,032)	(948)	83	(9,736)	(9,632)	105
Bank	(13)	(18)	(4)	(133)	(149)	(16)
Agency	0	0	0	(4)	0	4
Total Employee Expenses	**(1,045)**	**(966)**	**79**	**(9,874)**	**(9,781)**	**93**
Purchase of Healthcare	()	(1)	()	(4)	(8)	(5)
Supplies and Services Clinical	(225)	(208)	17	(2,250)	(2,095)	155
Supplies and Services General	(5)	(7)	(2)	(45)	(76)	(31)
Drugs	(2,749)	(2,790)	(41)	(24,922)	(25,042)	(120)
All Other, incl Transport	(45)	(56)	(12)	(452)	(436)	15
Total Operating Expenditure	**(4,068)**	**(4,028)**	**40**	**(37,546)**	**(37,439)**	**107**
Contribution	**312**	**343**	**31**	**6,229**	**6,291**	**62**



The CCHH care group is reporting a small surplus in January and remains in surplus year to date.

Income:

The adjustment to plan was lower than last month at £0.7m and reflects lower activity levels and drugs income in all 3 specialities, Clinical Oncology, Haematology & Haemophilia than in December. Additionally, unbundled chemotherapy was under plan for the first time in several months. However, Clinical oncology was above plan (except for drugs/chemo), continuing the trend for the year. Palliative care inpatient bed days reduced in January by 36% although still on YTD trend. Drugs recharged for Clinical Oncology & Clincal Haematology remain above plan at £1.2m and 0.9m respectively, partially offset by Haemophilia which is £0.5m under.

Employee Expenses:

Pay costs in January reduced in comparison to December, increasing the surplus year to date. Premium pay costs remain low and are within the We Care metric set for the Care Group as is the overall pay position. Medical, Senior manager and A&C staff costs are overspending within the CCHH which are offset by underspends in Nursing and Healthcare Assistant budgets.

Other Operating Expenditure:

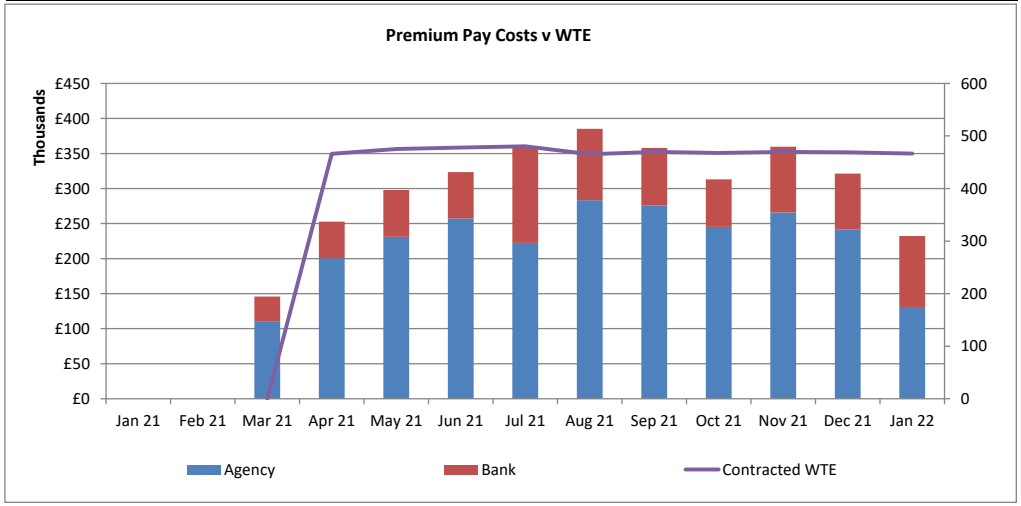
Non-Pay marginally overspent both in month and YTD. Driven primarily by overspends in blood products being partially offset by high cost drugs recharges.

Covid-19:

There were some admin and clerical and very low nursing pay costs recorded as Covid-19 costs in January. Total Covid-19 costs claimed remains minimal at £0.03m, with £0.01m for overtime utilised for the patient vaccination programme, rechargeable to NHSE/I as it is an 'Outside of Envelope' cost and the balance for additional staffing costs.

Child Health
Month 10 (January) 2021/22

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	99	43	(56)	988	544	(444)
Non-Electives	664	645	(19)	6,635	5,473	(1,162)
Outpatients	651	589	(62)	6,509	6,154	(354)
High Cost Drugs	33	43	10	333	261	(72)
Other NHS Clinical Income	2,071	2,198	127	20,714	22,742	2,028
Other Clinical Income	0	0	0	0	4	4
Total Income from Patient Care Activities	**3,518**	**3,518**	**0**	**35,179**	**35,179**	**0**
Other Operating Income	71	70	(1)	763	759	(5)
Total Income	**3,589**	**3,588**	**(1)**	**35,943**	**35,938**	**(5)**
Expenditure						
Substantive Staff	(2,485)	(2,299)	186	(24,225)	(22,349)	1,876
Bank	(43)	(101)	(58)	(449)	(847)	(399)
Agency	(126)	(131)	(5)	(1,360)	(2,354)	(994)
Total Employee Expenses	**(2,654)**	**(2,531)**	**123**	**(26,034)**	**(25,550)**	**483**
Purchase of Healthcare	0	(1)	(1)	0	(5)	(5)
Supplies and Services Clinical	(136)	(148)	(11)	(1,362)	(1,570)	(209)
Supplies and Services General	(3)	(15)	(12)	(53)	(82)	(30)
Drugs	(128)	(133)	(5)	(1,085)	(1,104)	(19)
All Other, incl Transport	(35)	(132)	(97)	(440)	(620)	(179)
Total Operating Expenditure	**(2,957)**	**(2,960)**	**(4)**	**(28,973)**	**(28,932)**	**41**
Contribution	**633**	**628**	**(5)**	**6,969**	**7,006**	**36**



The Care Group's position was slightly adverse in January.

Income:

The Covid-19 adjustment to bring income up to breakeven was £0.6m in January and is £6.7m year to date. There are continued signs that activity is increasing in some areas, particularly across non-electives and NICU/SCBU, however overall activity is still well below plan.

Employee Expenses:

Pay was underspent by £0.1m in January. Pay actuals were slightly lower than in December and are also comparable to the average for the year. Substantive pay costs were higher than trend but premium pay cost (agency, bank, locum overtime) reductions offset the impact. Premium pay decreased due to:

• Lower medical agency costs, at both acute sites but particularly at the WHH. The reason for this to be investigated since reductions were not anticipated.

• Decreasing paediatric nursing agency costs associated with lower admissions of children requiring 1-2-1 care.

Covid-19 expenditure (£0.03m) was slightly higher than December but was equal to the allocation. Covid-19 budget allocations have now been capped at September levels (£0.03m per month).

In previous months, unused paediatric business case funding was returned to central reserves. However, given the level of medical temporary staffing expenditure year to date, to cover vacancies, there was insufficient capacity to do this in January.

Other Operating Expenditure:

Non-Pay was £0.1m overspent in January. Actuals costs increased significantly, by £0.1m compared the average for the year. This was partly due to ad hoc cleaning costs and non-recurrent expenditure to improve facilities. This included £0.07m expenditure associated with the reconfiguration of Padua to create extra space for outpatient consulting rooms as of restore and recovery efforts.

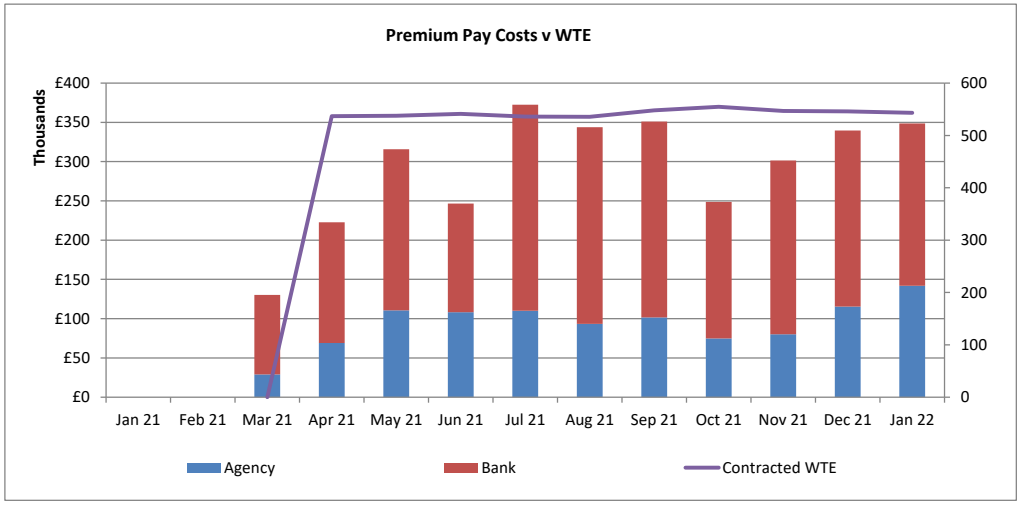
CIPs:

A small amount of non-recurrent pay savings relating to vacancies have been recognised this month. Focus is now moving into identifying savings opportunities for 2022/23.

Prepared by: Stephen Lazell
Reviewed by: Karen Costello

Women's Health
Month 10 (January) 2021/22

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	511	425	(85)	5,109	4,484	(625)
Non-Electives	1,763	1,991	228	17,633	20,440	2,807
Outpatients	389	371	(17)	3,886	4,070	184
High Cost Drugs	11	1	(11)	115	5	(110)
Other NHS Clinical Income	1,163	1,045	(119)	11,633	9,335	(2,298)
Other Clinical Income	0	4	4	0	42	42
Total Income from Patient Care Activities	**3,838**	**3,838**	**0**	**38,375**	**38,375**	**0**
Other Operating Income	222	81	(141)	818	489	(329)
Total Income	**4,060**	**3,918**	**(141)**	**39,193**	**38,864**	**(329)**
Expenditure						
Substantive Staff	(2,700)	(2,426)	274	(25,290)	(24,393)	897
Bank	(164)	(207)	(42)	(1,817)	(2,086)	(269)
Agency	(62)	(142)	(80)	(650)	(1,005)	(355)
Total Employee Expenses	**(2,927)**	**(2,775)**	**152**	**(27,756)**	**(27,484)**	**272**
Purchase of Healthcare	(1)	(1)	1	(12)	(11)	1
Supplies and Services Clinical	(131)	(101)	30	(1,348)	(1,306)	43
Supplies and Services General	(4)	(2)	2	(43)	(30)	14
Drugs	(89)	(84)	5	(885)	(847)	37
All Other, incl Transport	(46)	(61)	(15)	(510)	(517)	(7)
Total Operating Expenditure	**(3,198)**	**(3,024)**	**174**	**(30,555)**	**(30,195)**	**359**
Contribution	**862**	**895**	**33**	**8,639**	**8,669**	**31**



The Care Group's position was £0.03m favourable to plan in January.

Income:

After a dip in December due to Covid-19 pressures, Women's Health activity returned to performing above plan in January, primarily due to higher non-elective (NEL) activity. There has been a sustained increase in NEL short stay activity since the Women's Health Suite in Ashford was opened, and also an increase in QEQM Gynaecology Assessment Unit (GAU) activity. Outpatient attendances and elective activity have also been rising as part of Restore & Recovery efforts.

Consequently, the Covid-19 adjustment to bring income up to breakeven was £0.2m in January and is £3.0m for the year to date.

Central NHSEI Ockenden maternity funding continues to be phased into the budget - £1.0m of funding has been allocated to the Trust for 2021/22, with £1.5m expected for 2022/23.

Employee Expenses:

Pay was £0.2m favourable to plan in January, primarily due to Ockenden funding being added to the budget- although this is largely offset in 'other operating income'.

Pay actuals were £0.02m lower than in December but £0.04m higher than the average for the year. Falls in substantive pay cost offset rises in premium pay (agency, bank, locum and overtime) costs.

Premium pay increased slightly compared to December and was £0.05m higher than the average for the year. Bank costs fell because shift incentives were reduced from the start of January. However, this was offset by an increase in medical agency costs, particularly at QEQM to cover vacancies and sickness leading to on call rota gaps.

Covid-19 expenditure (£0.08m) was £ 0.03m higher than in December and £0.03m higher than the allocation. Covid-19 budget allocations have now been capped at September levels (£0.05m per month).

Other Operating Expenditure:

Non-Pay was slightly underspent in January. Actual expenditure was £0.02m lower than average due to a decrease in clinical costs in month and costs are currently being contained within the overall budget.

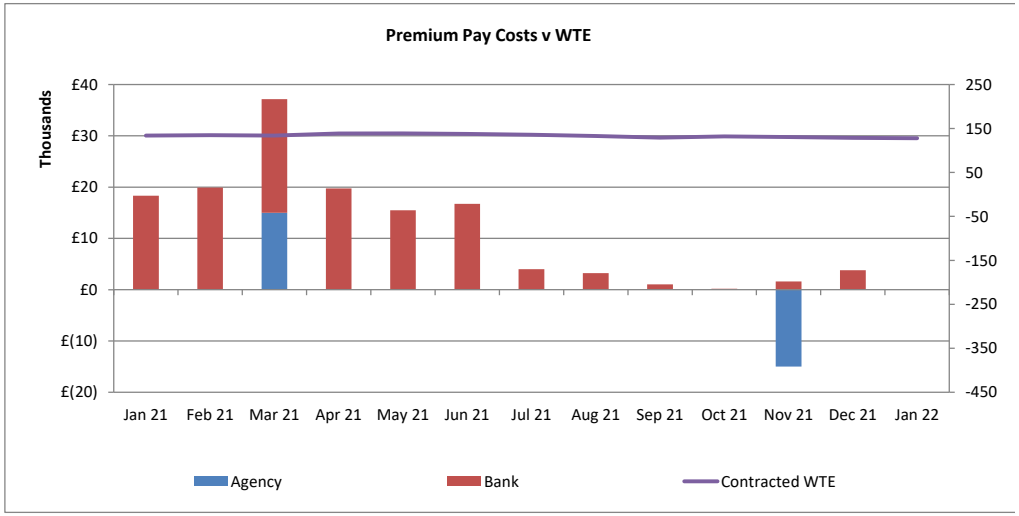
CIPs:

A small amount of non-recurrent pay savings relating to vacancies have been recognised this month. Focus is now moving into identifying savings opportunities for 2022/23.

Prepared by: Stephen Lazell
Reviewed by: Tori Harrison

Strategic Development and Capital Planning
Month 10 (January) 2021/22

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Non Patient Care Services	93	32	(61)	471	511	40
Car Parking	99	59	(40)	989	1,027	38
Staff Accommodation	197	156	(41)	1,954	1,616	(338)
All Other Income	194	188	(6)	1,688	1,690	2
Total Income	**583**	**435**	**(148)**	**5,103**	**4,844**	**(259)**
Expenditure						
Substantive Staff	(680)	(548)	132	(5,900)	(5,373)	528
Bank	(33)	0	33	(324)	(66)	259
Agency	0	0	0	0	15	15
Total Employee Expenses	**(713)**	**(548)**	**165**	**(6,225)**	**(5,423)**	**802**
Supplies and Services General	(4,892)	(4,886)	7	(45,832)	(45,780)	51
Establishment	(132)	(214)	(82)	(1,304)	(1,677)	(373)
Premises and Rates	(250)	(249)	1	(2,502)	(2,490)	12
Premises Other	(808)	(709)	99	(8,125)	(8,187)	(61)
Transport	(21)	(44)	(23)	(212)	(139)	73
Education and Training	(14)	(15)	(1)	(144)	(57)	87
All Other	(52)	(52)	()	(128)	(79)	49
Total Operating Expenditure	**(6,882)**	**(6,716)**	**166**	**(64,472)**	**(63,833)**	**639**
Contribution	**(6,299)**	**(6,281)**	**18**	**(59,369)**	**(58,989)**	**381**



Strategic Development and Capital Planning is favourable to budget by £0.4m YTD as at the end of January.

Income:

Income is adverse £0.1m in month and adverse £0.3m YTD. Car parking income is adverse £0.04m in month and favourable £0.04m YTD, this is net of the Covid-19 top up which was based on month 12. IT income is adverse in month £0.04m and £0.05m favourable YTD. The favourable position is due to Covid-19 certificate project income, there are non-pay costs which offset this. Accommodation is adverse £0.04m in month and £0.3m YTD. However, this needs to be looked at in conjunction with internal recharges for overseas nursing accommodation which is £0.3m favourable YTD resulting in a net position of adverse against plan of £0.1m, occupancy levels influenced by Covid-19 and overseas nurses' bookings.

Pay:

Pay is favourable £0.2m in month and £0.8m favourable YTD the position in month is due to vacancies and a prior period budget adjustment between income. Facilities favourable £0.03m in month and £0.3m favourable YTD which is attributable to inter site transfers, a review has been carried out on this service and it has now ceased. Strategic Development £0.01m favourable in month and £0.1m YTD due to 3 WTE vacant posts which are out to recruit/have been recruited into and awaiting to start. This has been reconciled and agreed with the department. IT favourable £0.1m in month and £0.4m YTD. The in-month position is higher than previous due to the prior period budget adjustment previously mentioned. There are 18.15 WTE vacancies in IT of which 85% of the total vacancies of SD&CP and these relate to the Electronic Medical Records Project and the project change team.

Non-Pay:

Non-Pay is breakeven in month and £0.2m adverse YTD.

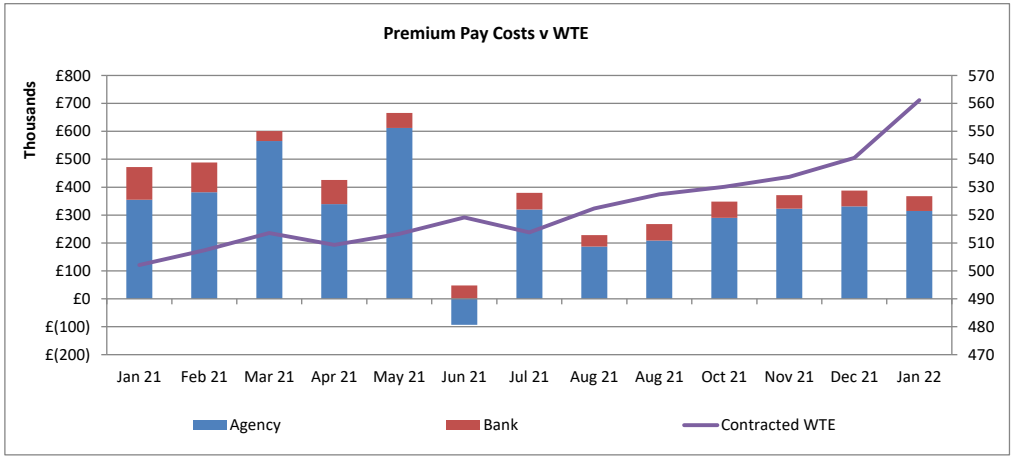
Utilities favourable in month and £0.5m adverse YTD. However, it needs to be noted the budget profile is in 12ths and has not been changed to account for seasonality. The in-month position is due to sewerage bills having now been reconciled with new supplier. Gas is adverse £0.2m, electricity £0.2m these variances are being investigated in conjunction with the Energy and Sustainability Engineer with regards to price and activity.

Patient's Travelling Expenses were favourable £5k in month and £0.06m YTD. Rent/Hire Premises is £0.24m favourable YTD but needs to be looked at in conjunction with the accommodation income as stated above.

There are various under and overspends that are not that material but are still being monitored with departmental leads.

Prepared by: Darren Raggett
Reviewed by: Greta Garrod

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Non Patient Care Services	69	145	76	1,056	1,210	155
Research and Innovation	219	185	(35)	2,020	1,908	(112)
Education and Training Income	1,297	1,418	121	13,026	13,386	360
Staff Accommodation	0	0	0	0	(5)	(5)
All Other Income	104	605	501	690	861	171
Total Income	**1,689**	**2,353**	**664**	**16,791**	**17,360**	**569**
Expenditure						
Substantive Staff	(2,810)	(2,589)	221	(26,064)	(25,288)	776
Bank	(24)	(53)	(28)	(257)	(562)	(305)
Agency	(20)	(315)	(295)	(23)	(2,833)	(2,810)
Total Employee Expenses	**(2,854)**	**(2,956)**	**(102)**	**(26,344)**	**(28,683)**	**(2,338)**
Supplies and Services General	(96)	(219)	(123)	(709)	(1,297)	(588)
Establishment	(54)	(118)	(64)	(674)	(974)	(300)
Premises and Rates	(4)	(8)	(4)	(38)	(59)	(20)
Premises Other	(188)	(263)	(75)	(1,659)	(2,396)	(737)
Transport	(44)	(53)	(9)	(391)	(389)	2
Clinical Negligence	(2,328)	(2,328)	()	(23,280)	(23,280)	0
Education and Training	(236)	(151)	85	(2,484)	(2,398)	86
All Other	(1,679)	(1,639)	40	(11,426)	(8,561)	2,865
Total Operating Expenditure	**(7,483)**	**(7,734)**	**(251)**	**(67,005)**	**(68,036)**	**(1,032)**
Contribution	**(5,793)**	**(5,381)**	**412**	**(50,213)**	**(50,676)**	**(463)**



The Corporate position is favourable £0.4m in month and £0.5m adverse YTD. The position in month is due to sale of Beautiful Information. The YTD position is made up as follows: Clinical Quality & Patient Safety (CQ&PS) favourable £0.4m, HR breakeven, Finance favourable £0.7m (Income from sale of Beautiful Information reported in here), Operations adverse £2m (Covid-19), Trust Board breakeven, PGME and R&I favourable £0.4m.

Income:

Income is favourable £0.7m in month and £0.6m YTD.

The position in month and YTD is mainly due to the sale of Beautiful Information.

Pay:

Pay is adverse £0.1m in month and adverse £2.3m YTD. This is mostly attributable to Covid-19 which is adverse £0.4m in month and £3.5m YTD. The funding envelope is held in non-pay, therefore, subjectively the total variance seems higher. The charges from 2gether are currently being reconciled and potential exit strategies being discussed on a weekly basis.

The adverse Covid-19 variances are partly offset by vacancies/underspends in other Corporate areas. CQ&PS breakeven in month/favourable £0.05m YTD, HR favourable £0.06m in month/£0.3m YTD, Finance adverse £0.02m in month/favourable £0.2m YTD, Trust Board £0.05m favourable in month/£0.4m YTD respectively. All posts being reviewed and monitored especially against business case allocations.

Non-Pay:

Non-Pay is adverse £0.01m in month and £1.3m favourable YTD.

CQ&PS adverse £0.04m in month and favourable £0.04m YTD. Position in month due to interpreter fees, prior period invoices.

HR favourable £0.07m in month and adverse £0.3m YTD. The position in month is due to the fact the permits for overseas nurses' higher activity than forecast. YTD is mainly due to work permits due to a large intake of overseas nurses as well as the Covid-19 testing packages which are required upon arrival and budget phased in 12ths. Forecast on permits is to come back in line in future months due to decreased activity, this is to be reviewed in light of current months activity.

Finance adverse £0.03m in month and favourable £0.06m YTD, minor adverse and favourable variances.

Trust Board adverse £0.03m in month and adverse £0.3m YTD. The position in month and YTD is mainly due to legal fees - monitoring with department is ongoing as part of forecast process.

Operations favourable £0.02m month and favourable £2m YTD due to Covid-19 underspends against the non-pay allocation which, at present, being used to offset the shortfall in pay. The total Covid-19 envelope income, pay and non-pay is £1.7m adverse YTD, as stated before reviews of all Covid-19 expenditure are being carried out to ascertain ongoing requirements.

Spencer Private Hospitals
Month 10 (January) 2021/22

Summary Profit & Loss January 2022 and Outturn Forecast

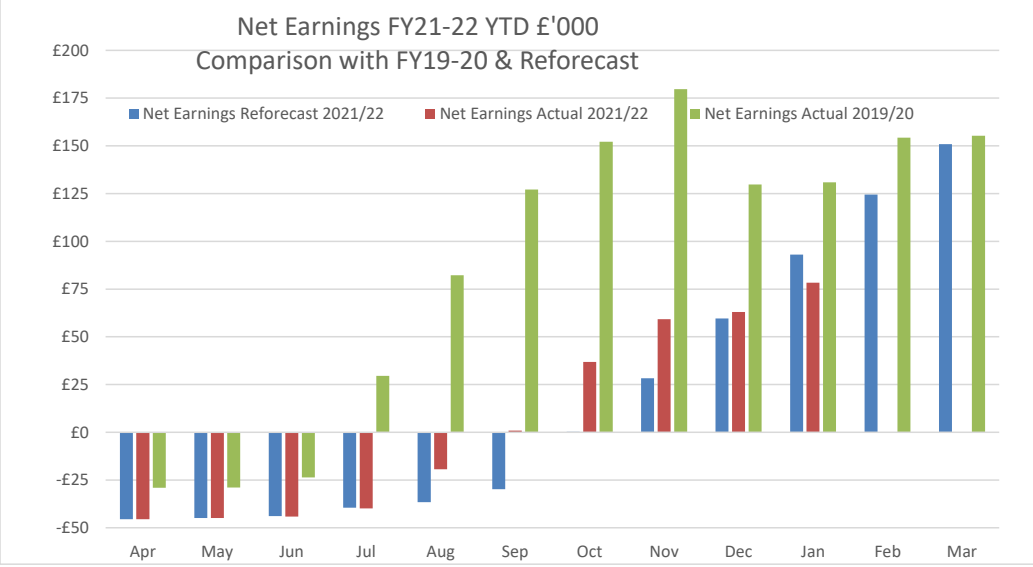
£'000s	Month			YTD			Full Year 2020-21		
	Actual	Budget	Variance	Actual	Budget	Variance	Outturn	Budget	Variance
Income	1,251	1,376	(125)	12,874	14,078	(1,204)	15,032	16,855	(1,824)
Pay	(554)	(682)	129	(6,221)	(6,940)	719	(7,351)	(8,313)	962
Non Pay	(397)	(545)	148	(5,090)	(5,634)	543	(5,877)	(6,759)	882
Other Costs	(280)	(122)	(158)	(1,464)	(1,224)	(240)	(1,696)	(1,468)	(228)
Operating Profit	21	27	(6)	99	280	(181)	108	316	(208)
OP %	*1.6%*	*2.0%*	*5.2%*	*0.8%*	*2.0%*	*15.1%*	*0.7%*	*1.9%*	*11.4%*
Interest Receivable							0		
Interest Expense	(2)	(3)	1	(2)	(28)	26	(0)	(33)	33
Net Profit before Tax	19	24	(6)	97	252	(155)	108	282	(174)
NPBT %	*1.5%*	*1.8%*	*4.5%*	*0.7%*	*1.8%*	*13.8%*	*0.7%*	*1.7%*	*65.3%*
Tax	(4)	(7)	3	(18)	(71)	53	(20)	(83)	63
Net Profit after Tax	15	17	(2)	79	181	(102)	88	200	(112)
NPAT %	*1.2%*	*1.3%*	*1.7%*	*0.6%*	*1.3%*	*8.4%*	*0.6%*	*1.2%*	*6.1%*

Salient comments on month / YTD results:

During this financial year we have seen significantly reduced theatre activity in comparison to pre-Covid-19 levels, due to a number of constraining factors and despite demand from both private and NHS patients.

With the Covid-19 situation worsening in early 2022 beds at both sites have been reserved for EKHUFT patients with theatre access unavailable. This has had a significant impact on the P&L, with the previously forecast profits for the last quarter of the year revised to a breakeven position.

We foresee a swift return to profitability once theatres are again made available as demand for both NHS and private surgeries remain strong.



2gether Support Solutions
Month 10 (January) 2021/22

Summary Profit & Loss January 2022

£'000s	Month			YTD			Full Year 2021-22		
	Actual	Prior Year	Variance	Actual	Prior Year	Variance	Forecast	Prior Year	Variance
Income	13,628	12,066	1,562	123,198	111,702	11,495	160,617	113,604	47,013
Costs	(13,199)	(11,932)	(1,267)	(121,821)	(110,469)	(11,352)	(159,087)	(112,223)	(46,864)
Operating Profit/(Loss)	430	134	295	1,376	1,233	143	1,530	1,381	149
OP %	*3.2%*	*1.1%*	*2.0%*	*1.1%*	*1.1%*	*0.0%*	*1.0%*	*1.2%*	*-0.3%*
Operating Profit/Loss EKHUFT	440	20	421	821	475	345	931	482	449
Operating Profit/Loss Retail	(11)	115	(125)	556	758	(202)	599	899	(300)
Interest Receivable	229	248	(19)	2,358	2,546	(188)	2,812	3,037	(224)
Interest Expense	(185)	(190)	6	(1,867)	(1,923)	56	(2,235)	(2,302)	67
Net Profit/(Loss) before Tax	474	192	282	1,867	1,857	11	2,107	2,115	(8)
NPBT %	*3.5%*	*1.6%*	*1.9%*	*1.5%*	*1.7%*	*-0.1%*	*1.3%*	*1.9%*	*-0.6%*
Tax	(64)	(103)	38	(603)	(897)	294	(803)	(710)	(93)
Net Profit/(Loss) after Tax	410	89	321	1,264	960	305	1,304	1,405	(101)
NPAT %	*3.0%*	*0.7%*	*2.3%*	*1.0%*	*0.9%*	*0.2%*	*0.8%*	*1.2%*	*-0.4%*

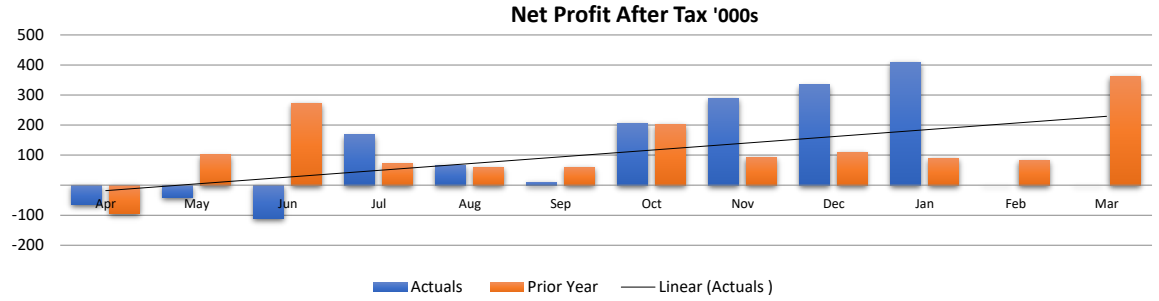
The YTD Operating Profit and Profit after Tax level is a profit of £1.4m and £1.3m respectively.

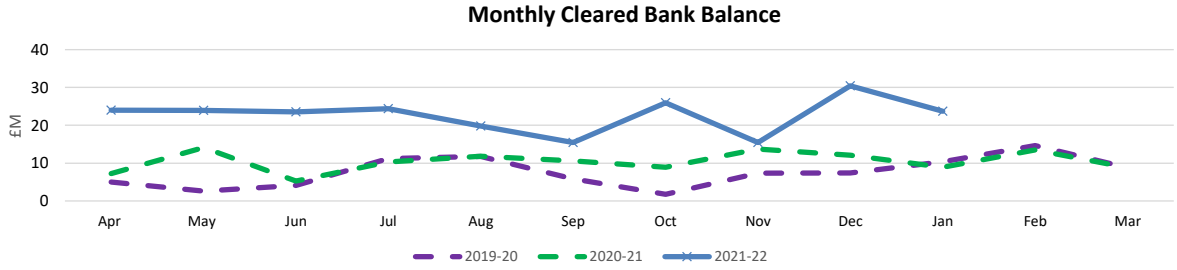
Within the profit for the month,there is benefit of £0.3m due to catch up of inflation funding. The further efficiencies highlighted in October are also on track for delivery of the current £1.5m Operating Profit forecast.

All other operating costs and overheads continue to be actively managed and in line with the year-end forecast.

Operating Working Capital has increased to £18.7m. Cash is £23.7m. (we have started paying suppliers in 7 days in line with EKHUFT and NHS guidance). EKHUFT debt is £20.1m.

BALANCE SHEET £000's	**Mar-21**	**Jan-22**	**Movement**
Total non-Current Assets	**85,894**	**80,248**	**(5,646)**
Trade and other Receivables	49,708	22,287	(27,421)
Prepayments	1,608	2,713	1,105
Accrued Income	4,412	951	(3,461)
Total Debtors	**55,727**	**25,951**	**(29,776)**
Stocks	**4,481**	**4,532**	50
Creditors and other payables	(26,795)	(10,399)	**16,396**
Accruals	(20,112)	(15,369)	4,743
Deferred Revenue	(8,720)	(9,783)	(1,062)
Total Creditors	**(55,628)**	**(35,551)**	**20,077**
Cash	**8,804**	**23,725**	**14,921**
Operating Working Capital	**13,384**	**18,657**	**5,272**
Borrowings	**(65,771)**	**(64,134)**	**1,637**
Net Assets	**33,507**	**34,770**	**1,263**
Share Capital	30,267	30,267	0
Retained Profit/(Loss) - Prior Year	3,240	4,503	1,263
Shareholders Funds	**33,507**	**34,770**	**1,263**





Cash Flow

Month 10 (January) 2021/22

Year to Date Actual		This Month Plan	Actual	Variance	Apr Actual	May Actual	Jun Actual	Jul Actual	Aug Actual	Sep Actual	Oct Actual	Nov Actual	Dec Actual	Jan Actual	Feb Forecast	Mar Forecast
67,943	**Opening Cash Balance**	11,575	17,244	5,669	67,943	28,920	33,022	30,796	32,047	34,447	22,755	12,409	16,187	17,244	10,028	6,603
	Prior Year Main Contract CCGs															
501,961	Kent & Medway CCG Contract	49,894	50,483	589	40,239	50,720	53,258	49,902	49,896	49,906	55,712	50,480	51,366	50,483	50,473	42,049
9,783	Prior Year Main Contract CCGs		271	271	256	2	100	11	188	77	11	74	8,793	271	13	
1,689	Other CCG block Contracts		168	168	166	166	167	166	166	166	187	168	168	168		
113,010	NHS England	9,790	10,498	707	9,967	10,286	10,044	11,335	13,228	12,052	11,210	11,877	12,514	10,498	9,790	9,790
28,093	All Other NHS Organisations	838	967	129	6,212	284	1,297	6,942	97	849	1,849	363	9,234	967	1,864	3,360
0	Capital Receipts															
61,167	All Other Receipts	3,715	4,374	659	7,006	581	9,972	2,786	7,359	3,913	5,931	12,169	7,076	4,374	3,902	34,288
715,703	**Total Receipts**	**64,238**	**66,761**	**2,524**	**63,846**	**62,038**	**74,837**	**71,142**	**70,934**	**66,962**	**74,900**	**75,131**	**89,151**	**66,761**	**66,043**	**89,487**
	Opening Cash Balance															
(356,259)	Monthly Payroll inc NI & Super	(34,950)	(36,290)	(1,340)	(34,532)	(34,347)	(34,667)	(34,946)	(34,743)	(36,836)	(37,725)	(35,858)	(36,313)	(36,290)	(35,968)	(35,961)
(412,960)	Creditor Payment Run	(34,237)	(37,687)	(3,450)	(68,339)	(23,588)	(42,396)	(34,945)	(33,791)	(37,418)	(47,520)	(35,495)	(51,781)	(37,687)	(32,750)	(46,677)
0	Capital Payments	(1,000)		1,000											(750)	(5,000)
(4,400)	PDC Dividend Payment									(4,400)						(4,958)
(773,619)	**Total Payments**	**(70,187)**	**(73,977)**	**(3,790)**	**(102,870)**	**(57,936)**	**(77,063)**	**(69,891)**	**(68,534)**	**(78,655)**	**(85,245)**	**(71,353)**	**(88,095)**	**(73,977)**	**(69,468)**	**(92,596)**
(57,915)	**Total Movement In Bank Balance**	**(5,950)**	**(7,216)**	**(1,266)**	**(39,024)**	**4,102**	**(2,226)**	**1,251**	**2,400**	**(11,693)**	**(10,346)**	**3,779**	**1,057**	**(7,216)**	**(3,425)**	**(3,109)**
10,028	**Closing Bank Balance**	**5,625**	**10,028**	**4,403**	**28,920**	**33,022**	**30,796**	**32,047**	**34,447**	**22,755**	**12,409**	**16,187**	**17,244**	**10,028**	**6,603**	**3,493**
	Plan				28,930	27,537	22,345	15,272	16,067	6,941	5,649	8,766	11,575	5,625	4,918	3,208
	Variance				(10)	5,484	8,451	16,775	18,380	15,814	6,759	7,421	5,669	4,403	1,684	286

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**BOARD ASSURANCE FRAMEWORK (BAF) AND CORPORATE RISK REGISTERS (CRR)**				
MEETING DATE:	**10 MARCH 2022**				
BOARD SPONSOR:	**GROUP COMPANY SECRETARY**				
PAPER AUTHOR:	**RISK MANAGER**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	This report provides the BoD with updates on and changes to risks on the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) as at 28 February 2022.				
Summary of Key Issues:	• BAF – 1 increased current risk score: BAF 34 as agreed at the last Clinical Executive Management Group (CEMG). • CRR – 1 reduced current risk score: CRR 113. • 2 new risks added to the CRR relating to Datix; and Venous Thromboembolism (VTE) assessment compliance.				
Key Recommendation(s):	The BoD is asked to **DISCUSS** whether: • the correct risks are identified in the BAF and CRR; • any reports or assurances received in the work of the Board and its Committees impact on the assurance levels in the BAF and CRR; • controls, assurance, gaps and actions are appropriate; • any further controls may be required to mitigate the risks identified.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	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	Resource implications are considered as part of the risks.			
Legal and regulatory:	N	Legal and Regulatory implications are considered as part of the risks.			
Subsidiary:	N	The Trust has a Subsidiary Shared Risk Register that is monitored at the Contract Performance Meeting.			
Assurance Route:					
Previously Considered by:	Clinical Executive Management Group; Executive Risk Assurance Group; Board Committees – People & Culture Committee and Quality & Safety Committee.				

East Kent Hospitals University NHS Foundation Trust

BAF/CRR RISK REGISTERS

1. Purpose of the report

1.1. This report provides the BoD with an update on and changes to risks to the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) as at 28 February 2022.

2. Board Assurance Framework

2.1 The BAF (summary provided on Pages 3 – 8 of the report) contains the principal risks for the Board corporately to assure itself about successful delivery of the organisation's strategic objectives.

2.2 The reporting of risk to the Board of Directors and its Committees has been streamlined to ensure clarity in relevant risk information. The Board and its Committees will receive the full BAF quarterly. For completeness the full BAF is and will be available in the meeting folder in the reading room on Admin Control for this and each meeting.

2.3 As part of this work, the BAF risks are currently being re-articulated to clearly define the emergent risks and issues. This will support the calibration of risk scoring as the risk is clearly defined. The separation of emergent risks and issues will enable the identification of gaps in controls and the actions required to address these gaps.

2.4 **Key changes** - Since the last report to the BoD, there has been one key change to the BAF.

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. The current risk rating has been increased from a moderate (12) to a high (16). The rationale for this is the fluctuating nature of Covid-19 and the implications of infection control measures to manage this within the hospitals. **This was agreed at the last CEMG meeting and has now been updated on the BAF.**

East Kent Hospitals University NHS Foundation Trust

STRATEGIC GOAL: 1) Our Quality & Safety:
Objective: Improve **patient safety** reduce harm
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.

Executive Lead: Chief Medical Officer (CMO)

BAF REF	Principal Risk	Initial	Current	Overall Assurance Level	Target	Key Changes during this period	Latest Commentary
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.	L4 x S5 = 20	L3 x S5 = 15	Limited	L1 x S5 = 5	**Actions completed**: None **New actions identified**: None **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	Future opportunities to mitigate the risk have been identified through review of the risk with the Chief Medical Officer, these are the realisation of the Safer Staffing Business Case which is due to be delivered by December 2022; refreshed in year breakthrough objectives for the 2022/23 financial year and the exit from the Recovery Support Programme. The target date for mitigation of this risk is 31 March 2025 in line with our Care Quality Commission (CQC) Improvement Plan to an Outstanding rating. **Actions planned** 1) Approval of Quality Strategy by Quality & Safety Committee (Q&SC) **Chief Nursing Officer Mar 22** 2a) Building on training and experience of centre of excellence team by KPMG **Deputy Chief Executive Officer Mar 22** 2b) Revised trajectory for roll-out of frontline teams agreed by 'Centre of Excellence' team to complete **Deputy Chief Executive Officer** 3) Implement outputs of quality and safety reporting meetings and structure review with emphasis on learning with Terms of Reference (ToR) **Director of Quality Governance Mar 22** 4) Review of subsidiary governance and reporting structures and feed into Q&SC reporting structures **Group Company Secretary** 5a) Agree model for matrix working **Chief Operating Officer Jan 22** 5b) Implement agreed model **Chief Operating Officer TBC once pilot concluded** 6a) Review clinical effectiveness structures and meetings **Chief Medical Officer** 6b) Establish effective governance of National Institute for Health and Care Excellence (NICE) guidance **Chief Medical Officer** 6c) Review governance and approval for clinical guidelines **Director of Quality Governance**

East Kent Hospitals University NHS Foundation Trust

Executive Lead: Director of Infection Prevention and Control (DIPC)				
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	L4 x S5 = 20 L3 x S5 = 15 Limited L1 x S5 = 5	**Actions completed**: None **New actions identified**: Presentation of annual IPC plan for 2022/23 to Board of Directors in April 2022 **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	IPC workplan in development which will be presented to the Board of Directors in April 2022; this will include the IPC workplace for 2022/23 and the hygiene code action plan. The target date for mitigation of this risk is 31 March 2025 in line with our CQC Improvement Plan to an Outstanding rating. The emergent risks/issues to this risk are the ongoing Covid pandemic and the fragility of the Trust's infrastructure. Future opportunities identified are a plan to increase surveillance. **Actions planned** 1) Annual IPC plan to be presented to the Board of Directors **Director of Infection Prevention and Control Apr 2022** 2a) Completion and agreement of priorities for infrastructure investment and inclusion in business planning and investment strategy **Director of Infection Prevention and Control/ Managing Director of 2gether Support Solutions/Deputy Chief Executive Officer Mar 22** 2b) Implementation of year one of agreed plan for infrastructure improvement **Managing Director of 2gether Support Solutions Mar 22**

East Kent Hospitals University NHS Foundation Trust

STRATEGIC GOAL: 2) Our Patients:
Objective: Improve **Patient Experience** deliver excellent clinical outcomes
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.

Executive Lead: Director of Quality Governance (DQG) and Group Company Secretary (CoSec)

BAF REF.	Principal Risk	Initial	Current	Overall Assurance Level	Target	Key Changes during this period	Latest Commentary
33	Failure to adequately resource, implement and embed effective governance processes throughout the Trust	L2 x S5 = 10	L2 x S5 = 10	Limited	L1 x S5 = 5	**Actions completed**: None **New actions identified**: None **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	Meeting scheduled to review risk progress 28 February 2022. **Actions planned** 1a) Undertake a review of all strategies/policies in relation to governance framework to streamline/simplify **Group Company Secretary/ Director of Quality Governance Jul 22** 1b) Once reviewed strategic/policies are in place communicate/train and embed **Group Company Secretary/ Director of Quality Governance Jul 22** 2) Review the structure in 6 months' time **Chief Executive/Director of Human Resources (HR) and Organisational Development (OD) Dec 22** 3) Undertake a review of the clinical and corporate governance team structure **Group Company Secretary/ Director of Quality Governance Jul 22** 4a) Undertake a review of the Care Group governance support and team structure and present a business case to ensure adequate resource is in place **Director of Quality Governance Jul 22** 4b) ensure the knowledge, qualification and skills in the job description are fit for purpose **Group Company Secretary/ Director of Quality Governance Jul 22** 5a) Governance review action plan to be delivered **Director of Finance Apr 22** 5b) Agree how the focussed work will move to business as usual **Director of Finance Apr 22** 6) Develop specific risk management training and roll out across the Trust **Group Company Secretary Jul 22** 7) Develop overarching governance principles for the Trust **Group Company Secretary/ Director of Quality Governance Apr 22**

East Kent Hospitals University NHS Foundation Trust

Executive Lead: Chief Operating Officer (COO)							
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.	L4 x S4 = 16	L4 x S4 = 16 ⇧	Adequate	L3 x S4 = 8	**Actions completed**: None **New actions identified**: Access Policy to be presented to CEMG in February 2022 **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	The reintroduction of national/localised restrictions in future waves of Covid-19 has been identified as a gap in control and as such a trigger tool has been implemented to activate the transfer of elective services to the K&CH site and the independent sector when Covid-19 number are increased. The impact of the Omicron variant has delayed the trajectory of patients waiting 104 weeks to 0 from March 2022 to June 2022. **Actions planned** 1) Review of outpatient clinic space, allocations and specialties **Deputy Chief Operating Officer Mar 22** 2) Tender for insourcing across four key specialties; orthopaedics, general surgery, gynaecology and ENT **Deputy Chief Operating Officer Sep 21** 3) Clinical validation of patients needing procedures to reduce cancellation on the day targeting high risk groups **Medical Director for Recovery Sep 22** 4) Weekly meeting with Care Group Directors, COO and Medical Director for Recovery for individual case management. Trajectory to reduce to 0 by June 22 **Chief Operating Officer Mar 22** 5) Access Policy to be presented to CEMG for approval **Deputy Chief Operating Officer Feb 22**

STRATEGIC GOAL: 3) Our People: **Objective**: To deliver our People Strategy to develop a positive culture and address key risks faced in terms of retention and recruitment to become an "**employer of choice**" by enabling staff to maximise their potential. **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.							
BAF REF.	**Principal Risk**	**Initial**	**Current**	**Overall Assurance Level**	**Target**	**Key Changes during this period**	**Latest Commentary**
Executive Lead: Director of HR and OD							
35	Negative patient outcomes and impact on the delivery of services due to a failure to recruit and retain high calibre staff	L4 x	L3 x	Limited	L2 x	**Actions completed:** Use of bank, agency and other temporary workforce solutions in place via NHS Professionals platform **New actions identified**: Centralised booking team and development of collaborative bank approach across the system due to be delivered by April 2023 International Nurse and midwifery recruitment pipeline utilisation with cohorts planned throughout 2022 to achieve 370 additional nurses by winter 2022 Active involvement in Healthcare Professional (HCP) recruitment and retention strategy systemwide **New Assurances**: 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	Risk reviewed with Director of HR and OD. The use of bank, agency other temporary workforce solutions action has been closed and is listed as a control. New actions have been identified and added to the risk including the international recruitment of midwives by December 2022. TMP have been appointed as an advertising strategic partner. The recruitment strategy is being refreshed in particular the long-term hard to recruit areas. Additional controls have been added included developing a positive culture strategic initiative, a refreshed Equality, Diversity and Inclusion (EDI) strategy, launch of cultural programme and a revised people strategy. The target date for mitigation of this risk is 31 January 2023. **Actions planned** 1a) Centralised booking team and development of collaborative bank approach across the system **Director of HR and OD Apr 23**

East Kent Hospitals University NHS Foundation Trust

						regular People team processes each month and reported through the People and Culture Committee. **Overall Assurance Level rationale (if changed):** N/A	1b) International Nurse and midwifery recruitment pipeline utilisation with cohorts planned throughout 2022 to achieve 370 additional nurses by winter 2022 **Deputy Director of HR Dec 22** 2a) Links with HCP and newly formed Kent and Medway Medical School (KMMS) to develop rotational and joint posts to support medical staff recruitment **Director of HR and OD Jun 22** 2b) Recruitment and retention working group to review and overhaul recruitment, marketing, targeting and attraction strategy **Deputy Director of HR and OD *ongoing*** 3) Ready to Care Programme launched to address Healthcare Assistant retention **Associate Director of OD *ongoing*** 4) Active involvement in HCP recruitment and retention strategy **Director of HR and OD *ongoing***

STRATEGIC GOAL: 4) Our Future:
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).**
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.

Executive Lead: DCEO

BAF REF.	Principal Risk	Initial	Current	Overall Assurance Level	Target	Key Changes during this period	Latest Commentary
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), could result in lapses in core clinical standards and patient safety issues, and may affect adherence to estate statutory compliance, increased estate backlog risks and impact on the Trust's reputation.	L4 x S5 = 20	L3 x S5 = 15	Limited	L1 x S5 = 5	**Actions completed**: None **New actions identified**: None **New Assurances**: Clear lines of accountability and responsibility for the sign off, of the East Kent Transformation (including the PCBC) is identified in the Sustainability and Transformation Plan (STP)/Integrated Care System (ICS) Partnership Board Strategic Priorities **Overall Assurance Level rationale (if changed):** None	Formal approval from NHS England/NHS Improvement (NHSE/I) to go to market from February. NHSE/I national COO visiting Queen Elizabeth the Queen Mother Hospital (QEQM) 25 February 2022 in order to gain support for the new hospital programme. **Actions planned** 1a) Trust has put an expression of interest to joining the new hospital improvement programme. Due to be finalised by Autumn 22 **Deputy CEO Sep 22** 1b) Continue to lobby key stakeholders to maximise success of Expression of Interest (EOI) **DCEO Sep 22** 2a) Continue to implement annual investment plan for statutory compliance and monitor in year improvements against the agreed trajectory **DCEO Mar 22** 2b) Prioritise through Strategic Investment Group (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/I on reducing the backlog position and the ARUP report. Investment will be monitored through FPC and BoD **DCEO Mar 22**

East Kent Hospitals University NHS Foundation Trust

STRATEGIC GOAL: 4) Our Future:
Objective: Develop a Trust wide strategy to deliver **cultural change, innovation and improvement**.
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.

Executive Lead: Chief Executive

BAF REF.	Principal Risk	Initial	Current	Overall Assurance Level	Target	Key Changes during this period	Latest Commentary
30	Failure to deliver the full benefits of the We Care improvement system	L4 x S4 = 16	L4 x S3 = 12	Adequate	L1 x S4 = 4	**Actions completed:** Leadership behaviour road map agreed for implementation **New actions identified:** Transition plan in place with newly appointed Chief Executive. **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	Roadmap developed to review programme and reset numbers in line with business planning for 2022/23. Proposal due to be presented to Board of Directors in March 2022. New Chief Executive undertaking bootcamp in April 2022 to ensure the continuity of We Care programme through transition. **Actions planned** 1) Methodology to be established and agreed by Senior Leadership Team (SLT), sub Board Committees and BoDs. **DCEO May 22** 2) Stage two road map established with KPMG at SLT. **DCEO Jul 21** 3) In line with business planning for 22 / 23, True North and Breakthrough Objectives reviewed and priorities agree with the BoDs. **DCEO Mar 22** 4) Transition plan in place with newly appointed Chief Executive. Bootcamp in April 22. **Head of Transformation Apr 22**

STRATEGIC GOAL: 5) Our Sustainability:
Objective: Achieve sustainable financial health
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.

Executive Lead: Director of Finance and Performance (DoF)

BAF REF.	Principal Risk	Initial	Current	Overall Assurance Level	Target	Key Changes during this period	Latest Commentary
38	Failure to deliver the financial breakeven position of the Trust as requested by NHSE/I may result in the Trust 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.	L4 x S5 = 20	L3 x S5 = 15	Limited	L1 x S5 = 5	**Actions completed**: Plan for the second of the year has been developed following the receipt of planning guidance from NHSE/I. **New actions identified:** None **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	Meeting scheduled to review risk progress 01 March 2022. **Actions planned** 1) Trust to develop medium term and long-term financial plans in conjunction with NHSE/I and Kent and Medway ICS. **Director of Finance Q4 2021** 2) Robust activity plan to deliver ERF targets **COO Oct 2021**

3. Corporate Risk Register (CRR)

3.1 The CRR (summary provided on Pages 10 - 20 of the report) is the high-level risk register that captures overarching risks with a current rating of 12 and above, that may be escalated from Care Group Risk Registers and that take on a wide scope.

3.2 The reporting of risk to the Board of Directors and its Committees has been streamlined to ensure clarity in relevant risk information. The Board and its Committees will receive the full CRR quarterly. For completeness the full CRR is and will be available in the meeting folder in the reading room on Admin Control for this and each meeting.

3.3 The risks are currently being re-articulated to clearly define the emergent risks and issues. This will support the calibration of risk scoring as the risk is clearly defined. The separation of emergent risks and issues will enable the identification of gaps in controls and the actions required to address these gaps.

3.4 Since the last report to the BoD, the national team has now stepped down the Nightingale Surge for William Harvey Hospital. There are no plans for alternative use and the process for decommissioning has now begun; as such the risk previously approved for escalation to the Corporate Risk Register will be revised.

3.5 **Key changes** - Since the last report to the BoD, there has been one key change to the CRR.
CRR 113 – Insufficient capacity within tier 4 Children and Young People's Mental Health Services (CYPMHS) resulting in patients being inappropriately placed within the Trust impacting on staff and patients. The current risk rating has been reduced from an extreme (20) to high (16) due to the increased partnership working with the system reducing the number of CYPMHS being placed inappropriately.

3.6 **New risks for escalation**
The following risks have been approved for escalation at the Executive Risk Assurance Group in February.

3.5.1 **Datix/NHSmail (Risk Owner: Director of Quality Governance)** – Risk of delay/omissions in incident and complaint management and additional work for staff due to intermittent fault in the Datix system / NHSmail interface. This means that emails sent directly from the Datix system are not received. This means that automated responses to reporters (on reporting and closure of incidents) are not received; automated notifications to investigators, specialists and corporate leads are not received; feedback messages are not sending from the system. This risk has increased as the intermittent fault is now occurring on a daily basis. The current mitigations do not reduce workload for teams, however should reduce likelihood of incidents being 'missed'.

3.5.2 **Compliance with VTE assessment (Risk Owner: Chief Medical Officer)** – Failure to demonstrate compliance with national standards for VTE assessments in in-patients using VitalPAC assessment tool. Patients are at potential risk of avoidable VTE or avoidable bleeding if lack of recording of assessment translates into anticoagulation in those at risk of bleeding or no anticoagulation in those at risk of clotting and no increased bleed risk. The information portal highlights that against a target of 95% the Trust is 89% compliant. The risk is identified on the General and Specialist Medicine and Urgent and Emergency Care risk registers; however, Surgery and Anaesthetics and Women's Health Care Groups also fall below the 95% compliance standard.

East Kent Hospitals University NHS Foundation Trust

STRATEGIC GOAL: 1) Our Quality & Safety:
Objective: Improve **patient safety** reduce harm
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.

Executive Lead: Chief Medical Officer (CMO)

CRR REF	Corporate Risk	Initial	Current	Overall Assurance Level	Target	Key Changes during this period	Latest Commentary
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. **Linked to BAF Ref. 32**	L5 x S4 = 20	L4 x S4 = 16	Limited	L2 x S4 = 8	**Actions completed**: None **New actions identified**: None **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	The Discharge paper was tabled at GOLD 12/01/2022 but was stood down by the chair. Action updated to review paper and take into the Trust Priority Improvement Project (TPIP) on safer discharge and review issues in light of 7-day review that is forthcoming. **Actions planned** 1) Implementation of electronic prescribing to support improved culture towards medicines prescription and administration at ward and department level **Director of Pharmacy Jun 22** 2a) Safe and effective discharge Trust Priority Improvement Project **Medical Director for Recovery Mar 22** 2b) Present update on discharge issues particularly at weekend to CEMG **Director of Pharmacy Feb 22** 3) Review of terms of reference of Medicines Safety Group to include attendance as part of wider quality governance review **Medication Safety Officer Mar 22** 4a) Develop a clear training needs analysis for insulin safety training **Medication Safety Officer Mar 22** 4b) Implement training for insulin safety **Medication Safety Officer Jun 22** 5a) Develop a clear training needs analysis for medical gases safety training **Medication Safety Officer Mar 22** 5b) Implement training for medical gases safety **Medication Safety Officer Jun 22** 6) Review reporting metrics for Medication Safety to effectively monitor delivery against the plan **Medication Safety Officer Mar 22**
Executive Lead: Chief Nursing Officer (CNO)							
77	Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services **Linked to BAF Ref. 32**	L4 x S5 = 20	L3 x S5 = 15	Limited	L2 x S5 = 10	**Actions completed**: **New actions identified**: None **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	Review of risk with Risk Owner and Care Group scheduled for 21 March 2022. **Actions planned** 1) Recovery of Cardiotocograph (CTG) training **Interim Director of Midwifery Jun 22**

110	Children may receive sub-optimal quality of care and poor patient experience in our children's services **Linked to BAF Ref. 32**	L5 x S4 = 20	L4 x S4 = 16	Limited	L2 x S4 = 8	**Actions completed**: None **New actions identified**: None **New Assurances**: None **Overall Assurance Level rationale (if changed)**: N/A	Locum recruitment progressing. Where gaps remain in the rotas these are being mitigated by locums until substantive occurs. **Actions planned** 1) Recruitment of six additional consultants at each acute site **Operations Director - Paediatrics Jun 22** 2) Revised plans for Emergency Department (ED) to include separate triage for paediatrics **Hospital Director – Emergency Care May 22**
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) **Linked to BAF Ref. 32**	L4 x S4 = 16	L3 x S4 = 12	Limited	L2 x S4 = 8	**Actions completed:** None **New actions identified:** None **New Assurances:** None **Overall Assurance Level rationale (if changed):** N/A	Restraint Policy approved at the February Safeguarding Assurance Committee; to be presented at the Drugs and Therapeutics Committee before final sign off at the Policy Authorisation Group in April 2022. Work continues with the Performance team on the development of a Safeguarding Dashboard and a vulnerability flag on the inpatient Patient Tracking List (PTL). Safeguarding scorecard in place in the interim. **Actions planned** 1a) Care Group governance meetings to include safeguarding as standard item. Safeguarding team to attend quarterly or by exception **Director of Nursing Mar 22** 1b) Care Groups to invite Safeguarding team to Care Group governance meetings **Head of Nursing Feb 22** 1c) Evidence of safeguarding attendance at Care Group governance meetings **Head of Safeguarding Feb 22** 2) Inpatient PTL with vulnerabilities flagged on ward and departmental whiteboards **Head of Information Development and Data Architecture Jan 22** 3) Development of a safeguarding dashboard to enable staff to view real team safeguarding data **Head of Information Development and Data Architecture Jan 22** 4) General Specialist Medicine (GSM) and Urgent and Emergency Care (UEC) Care Groups to provide trajectory to demonstrate how they will meet training compliance gaps **Director of Nursing Dec 21** 5) Review and ratify restraint policy and roll out actions to embed **Head of Safeguarding Apr 22** 6a) Roll out MAYBO training (adults) **Mental Health Professional Advisor Jun 22** 6b) Roll out MAPA training for children **Paediatric Practice Development Nurse Jun 22** 7) Roll out of awareness training for model of enhanced observation and managing people at risk **Director of Nursing Jan 22** 8) Strengthen Safeguarding Champion roles in Children's and Maternity services **Head of Safeguarding Children Jun 22** 9) Establish Safeguarding Champion roles for adults. Create JD for role involving Care Group Triumvirates. Advertise and recruit. Establish programme of workshops and mentoring for roles **Adult Safeguarding Practitioner Jun 22** 10) Implement Think Family safeguarding assessment tool on Sunrise **Head of Nursing – IT Feb 23** 11) Ward Managers Enhanced Observation Audit Tool **Head of Nursing – IT Dec 21**

125	Patients may suffer harm due to their nutrition and hydration needs not being met as a result of inadequate supervision during mealtimes **Linked to BAF Ref. 32**	L4 x S3 = 12	L4 x S3 = 12	Limited	L3 x S3 = 9	**Actions completed:** None **New actions identified:** None **New Assurances:** None **Overall Assurance Level rationale (if changed):** N/A	Awaiting update at the time of writing this report. **Actions planned** 1) Development of a spilled hot drinks aggregate action plan **Director of Nursing Mar 22** 2) Development of a food allergy aggregate action plan **Director of Nursing Mar 22** 3) Additional training, support and audit to be provided by the Nutrition and Hydration Nursing Team **Director of Nursing Mar 22**
129	There is a risk that the Trust may not be adequately prepared for a Care Quality Commission (CQC) inspection. The Trust needs to know its current position in relation to CQC rating, including the areas that require improvement, and those that are good or outstanding. Inspection ratings are indicative but many core services have not been inspected for several years and so these cannot be relied upon. In the past self-assessments were undertaken against the CQC's Key Lines of Enquiry (KLOEs), and these were last undertaken in February 2020. **Linked to BAF Ref. 32**	TBC	TBC	TBC	TBC	**Actions completed:** None **New actions identified:** Internal CQC assurance framework approved at Board of Directors December 2021, to be implemented in Spring 2022 Care Groups and corporate leads to self-assess, rate themselves and identify actions to get to good and then outstanding **July 2022** Focussed assurance visits and reviews to be undertaken examining progress against CQC inspection action plans **June 2022** Head of CQC Compliance and Quality recruited to new position in Chief Nursing Officer's (CNO's) structure **June 2022** Explore options for an information system to manage CQC compliance and assurance **September 2022** Delivery of the Trust's ward accreditation programme **December 2022** Develop Care Group dashboards to incorporate measures relating to CQC compliance **April 2022** **New Assurances:** Monthly reports to Quality and Safety Committee CQC Action plans monitored by Care Group Governance systems CNO and CMO have engagement meetings with CQC **Overall Assurance Level rationale (if changed):** N/A	New risk articulated **Actions planned** 1) Internal CQC assurance framework approved at Board of Directors December 2021, to be implemented in Spring 2022 **Compliance and Assurance Lead Jun 22** 2) Care Groups and corporate leads to self-assess, rate themselves and identify actions to get to good and then outstanding **Compliance and Assurance Lead July 2022** 3) Focussed assurance visits and reviews to be undertaken examining progress against CQC inspection action plans **Compliance and Assurance Lead June 2022** 4) Head of CQC Compliance and Quality recruited to new position in CNO's structure **Chief Nursing Officer June 2022** 5) Explore options for an information system to manage CQC compliance and assurance **Compliance and Assurance Lead September 2022** 6) Delivery of the Trust's ward accreditation programme **Compliance and Assurance Lead December 2022** 7) Develop Care Group dashboards to incorporate measures relating to CQC compliance - **Compliance and Assurance Lead April 2022**
Executive Lead: Deputy Chief Executive Officer (DCEO)							
128	Failure to ensure adequate controls and safeguarding arrangements are in place at mortuaries increases the risk of distress to families and exposes the Trust to legal challenge and reputational damage Linked to BAF Ref. 36	L3 x S5 = 15	L2 x S5 = 10	Adequate	L1 x S5 = 5	**Actions completed**: None **New actions identified**: Human Tissue Authority (HTA) Inspection due March 2022 **New Assurances**: None **Overall Assurance Level rationale (if changed):** Assurance changed from limited to adequate. CCTV and access ID control now in place and live.	CCTV has been installed and has gone live. Access ID control has been installed and has gone live. The mortuary have updated their standard operating procedures as a consequence of the installations. Process of audit agreed with information governance expert. **Actions planned** 1) Deliver mortuary security action plan **Head of Pathology Mar 22** 2) HTA inspection in March **Head of Pathology Mar 22**

NHS East Kent

STRATEGIC GOAL: 2) Our Patients:
Objective: Improve **Patient Experience** deliver excellent clinical outcomes
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.

Executive Lead: Chief Operating Officer (COO) / Chief Nursing Officer (CNO)

CRR REF.	Principal Risk	Initial	Current	Overall Assurance Level	Target	Key Changes during this period	Latest Commentary
113	Insufficient capacity within tier 4 Children and Young People's Mental Health Services (CYPMHS) resulting in patients being inappropriately placed within the Trust impacting on staff and patients. **Linked to BAF Ref. 32**	L5 x S4 = 20	L4 x S4 = 16	Limited	L3 x S4 = 8	**Actions completed**: None **New actions identified**: None **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	The risk has been reduced from an extreme (20) rated risk to a high (16) rated risk due to the increased partnership working with the system reducing the number of CYPMHS being placed inappropriately. Dialogue is in place at an Multi-Disciplinary Team (MDT) level with specific case reviews undertaken with commissioners. **Actions planned** 1) Increase in MAYBO training for all staff in ED **Director of Nursing Jun 22** 2) Recruitment of band 6 Child and Adolescent Mental Health Service (CAMHS) support for each acute ward enabling liaison and support for ward teams **Deputy Head of Nursing Paediatrics Mar 22** 3) Consideration and planning for designated spaces to be developed with support from Health & Safety (H&S) and North East London NHS Foundation Trust (NELFT) to enable a safe environment for placement of CYPMHS within the acute wards **Deputy Head of Nursing Paediatrics Mar 22** 4) Dialogue with regional and system partners and CAMHS providers to increase access **Chief Operating Officer Mar 22**
Executive Lead: Chief Operating Officer (COO)							
78	There is a risk that patients do not receive timely access to emergency care within the ED **Emergent risks/issues** Lack of capacity (internal/external) Increase in attendances Expansion of the ED reducing physical footprint Increased numbers of Covid-19 inpatients **Effect** Patient harm Poor patient experience Staff morale Reputation Failure to meet access standards **Linked to BAF Ref. 34**	L5 x S4 = 20	L5 x S4 = 20	Limited	L3 x S4 = 8	**Actions completed**: None **New actions identified**: None **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	Reset and restore action plan monitored daily with UEC to improve performance and reduce overcrowding. Emergency Care Improvement Support Team (ECIST) working with the Trust from January with a focus on improving patient flow through the hospital. Validation Policy being presented to CEMG in February. Work undertaken with Dragon Dictate to reduce administration time. Build work has been delayed with Phase 1 completion now due May 2022. **Actions planned** 1a) Introduction of criteria led discharge and continued collaboration with system partners to improve timeliness to community capacity **Chief Operating Officer Mar 22** 1b) Decision to admit tool is being implemented to ensure patients have access to the right care to meet their needs **Chief Operating Officer Feb 22** 2a) Deliver Flow Plan to reduce overcrowding in ED **Chief Operating Officer May 22**

East Kent Hospitals University NHS Foundation Trust

							2b) Deliver expansion of Emergency Departments at QEQM and William Harvey Hospital (WHH) **Chief Operating Officer May 22** 3a) Kent Community Health NHS Foundation Trust (KCHFT) and Kent County Council (KCC) with EKHUFT are reviewing ways to support recruitment of care workers. This is part of winter discussions. **Chief Operating Officer Mar 22** 3b) Looking at alternatives to pathway 1 spot purchasing additional beds **Chief Operating Officer Mar 22** 3c) Regional level – Kent and Medway Integrated Care System meeting with social care providers to help facilitate an improvement with their position with staffing and support **Chief Operating Officer Mar 22** 4) The Trust Winter Plan actions focus on; Simple Discharges to discharge lounge before midday 33%; 7 day working and medical model; re-siting any elective work to Kent & Canterbury Hospital (K&C) for January and February. Active work undertaken to improve performance on a daily basis **Chief Operating Officer Mar 22**

STRATEGIC GOAL: 3) Our People:
Objective: To deliver our People Strategy to develop a positive culture and address key risks faced in terms of retention and recruitment to become an "**employer of choice**" by enabling staff to maximise their potential.
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.

CRR REF.	Principal Risk	Initial	Current	Overall Assurance Level	Target	Key Changes during this period	Latest Commentary
Executive Lead: Director of HR and OD							
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. Specifically, there is a requirement for urgent and significant improvement in relation to staff attitudes and behaviours. **Linked to BAF Ref. 35**	L5 x S4 = 20	L4 x S4 = 16	Limited	L2 x S4 = 8	**Actions completed**: Freedom to Speak Up service extended **New actions identified**: Review of HR policies to be undertaken to include approved Decision Tree. This will be presented to Staff Committee in May 2022. **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	Awaiting single tender waiver approval to map roles and responsibilities to appropriate levels of the leadership development framework to develop clear career pathways. Options for funding to resource roll out of culture and leadership programme to additional Care Groups being presented to Executive Management Team (EMT) on 23 February 2022. Simultaneous funding request submitted to NHSE/I. Review undertaken of EDI and culture by external consultants concluded and presented to the People & Culture Committee (P&CC), presentation to be delivered to BoD. Decision tree to be presented to Staff Committee on 3 March 2022. Formal training for decision makers will begin in June 2022. We Care Strategic Initiative follow up workshop being undertaken on 04 March in light of staff survey data. **Actions planned** 1) Map roles and responsibilities to appropriate levels of the leadership development framework to develop clear career pathways **Director of HR and OD Mar 22** 2) Freedom to Speak Up Champion job description being developed to expand network **Director of HR and OD Mar 22** 3a) NHSE/I culture and leadership programme for Women's Health and Children and Young People Care Group **Director of HR and OD Mar 22** 3b) Launch Peer Messenger Programme **Director of HR and OD Mar 22** 3c) Review of EDI and culture by external consultants **Director of HR and OD Apr 22** 4a) Share the decision tree with Staff Committee and Executives **Deputy Director of HR Mar 22** 4b) Deliver formal training for decision makers **Deputy Director of HR Jun 22** 5) Workshop to identify root causes for We Care Strategic Initiative – reduction in bullying and harassment **Assistant Director Learning & OD Mar 22** 6) Review of HR policies to be undertaken to include approved Decision Tree. **Director of HR and OD May 22**
88	Staff health and wellbeing is compromised due to the sustained level of work created by Covid-19 pandemic **Linked to BAF Ref. 35**	L5 x	L4 x	Limited	L2 x	**Actions completed**: None **New actions identified**: None **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	System-wide Health and Wellbeing pilot project is ongoing; use of the funding being reported back to NHSE/I. Kent and Medway People Board has health and wellbeing as a key workstream. Staff survey results due to be released on 24 February. **Actions planned** 1) Working with system to develop a system-wide response to health and wellbeing **Director of HR and OD Mar 22** 2a) Developing range of benefits and activities to encourage social interaction and physical wellbeing **Head of Staff Experience Mar 22** 2b) Extend Wellbeing Wednesday events throughout 2022 following positive response **Head of Staff Experience Mar 22**

East Kent Hospitals University NHS Foundation Trust

							3) Engaging with charities for additional support for staff experience **Head of Staff Experience Mar 22**
Executive Lead: Chief Nursing Officer							
76	There is a risk that nursing staffing levels and skill mix is inadequate to meet patient needs **Emergent risks/issues** Nursing establishment is not adequate Vacancy rate for current establishment High sickness absence due to Covid Skill mix of current nursing workforce High use of agency staff **Effect** Patient outcomes Patient experience Patient safety Staff morale Reputation Legal challenge **Linked to BAF Ref. 35**	L5 x S4 = 20	L5x S4 = 20	Limited	L1 x S4 = 4	**Actions completed**: Safer Staffing reviews completed and recommendations made to Trust Board. Safer Staffing Policy in place to cover day to day monitoring and on-going six-month acuity reviews Development of recruitment pipeline in collaboration with local universities and proposal to increase international nurse recruitment pipeline. Analysis of retention data to identify areas of local variation and concern **New actions identified**: Recruit additional cohort of return to practice nurses in conjunction with Christchurch University Complete professional judgement review for ED **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	The number of international nurses has been increased from 30 a month to 40 a month. Virtual open days are being undertaken for students with updates provided on Safer Staffing. HealthRoster system is being amended so we can identify on a quarterly basis where there are gaps in staffing at ward level reducing the need for agency and bank staff. Safe Care Live Tool for ED is due to be released by NHSE/I with training being delivered in April 2022. Establishment review will then be undertaken in May with ED Safer Staffing Improvement Plan being developed by June 2022. **Actions planned** 1a) Review and increase international recruitment pipeline **Director of Nursing Dec 22** 1b) Recruit additional cohort of return to practice nurses in conjunction with Christchurch University **Director of Nursing Apr 22** 1c) Increase student placements **Director of Nursing Sep 22** 2) Site triumvirate reviewing and taking action to mitigate risk where levels of escalation are a cause for concern **Director of Nursing Apr 22** 3) Complete professional judgement review for ED **Director of Nursing Jun 22** 4) The 4R programme is working with Care Groups to support the delivery of services in a pandemic. **Chief Operating Officer Mar 22** 5) Recruitment and retention strategy to be developed in line with HR People Plan following the Safer Nursing Care Tool (SNCT) outcome **Director of Nursing Jun 22**
122	There is a risk that midwifery staffing levels are inadequate **Emergent risks/issues** Midwifery establishment is not adequate Vacancy rate for current establishment High sickness absence due to Covid Suspension of Continuity of Carer Use of agency **Effect** Patient outcomes Patient experience Patient safety Staff morale Reputation Legal challenge **Linked to BAF Ref. 35**	L5 x S4 = 20	L5 x S4 = 20	Limited	L2 x S4 = 8	**Actions completed**: None **New actions identified**: None **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	Review of risk with Risk Owner and Care Group scheduled for 21 March 2022. **Actions planned** 1a) Develop business case for appropriate workforce funding. This will include funding for specialist roles, a leadership structure and a retention premium for band 6 roles **Interim Director of Midwifery Mar 22** 1b) Establish working group to recruit to the business case once approved. Deployment of further strategies to attract staff e.g. recruitment premium, also working with region re international recruitment **Interim Director of Midwifery Mar 22** 2) Daily mitigation of risk **Interim Director of Midwifery Mar 22**

East Kent Hospitals University NHS Foundation Trust

Executive Lead: Chief Medical Officer								
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. **Linked to BAF Ref. 35**	L5 x S3 = 15	L5 x S3 = 15	Limited	L3 x S3 = 9	**Actions completed: Regular** audit of all pre-employment checks and local induction for new locums. **New actions identified:** Audit of implementation of escalation of requests to extend locums beyond two years **New Assurances:** None **Overall Assurance Level rationale (if changed):** N/A	Terms of reference for the Medical Workforce Group were agreed at CEMG in February 2022. Independent PMO support has been agreed for the review of the Resident Medical Officer (RMO) contract to improve quality assurance. Chief Medical Officers team meeting with HR business partners to discuss. A phasing out plan will be developed by April 2022 to reduce reliance on RMO. Recruitment to Chief Medical Officers team is underway with interviews being held through February. Meeting arranged with external training provider to ensure medical appraisers are appropriately skilled and competent. **Actions planned** 1a) Work with Kent and Medway Medical School to create joint roles at junior doctor level **Chief Medical Officer Mar 22** 1b) Review the medical workforce strategy and medical recruitment process **Chief Medical Officer Mar 22** 2a) Establish a task and finish group to support doctors to appropriate substantive roles including use of the new specialist contract **Chief Medical Officer Team Dec 21** 2b) Request to extend beyond two years will be escalated to **Chief Medical Officer Nov 21** 2c) Policy to be developed **Chief Medical Officer Dec 21** 3a) Review RMO contract to improve quality assurance pending a long-term solution **Chief Medical Officer Apr 22** 3b) Regular audit of all pre-employment checks and local induction to be established **Head of Temporary Staffing Dec 21** 4a) Establish a medical workforce group **Chief Medical Officer Dec 21** 4b) Development of a business case for funding to recruit a central medical staffing function **Chief Medical Officer Jul 22** 5) Temporary Staffing team to monitor and regularly audit the process **Head of Temporary Staffing Mar 22** 6a) To review capacity within CMO team to support **Chief Medical Officer Feb 22** 6b) Ensuring medical appraisers are appropriately skilled and competent **Chief Medical Officer May 22** 6c) Develop action plan against gap analysis of GMC clinical governance standards **Chief Medical Officer Feb 22** 6d) Review PReP platform to ensure it is fit for purpose **Senior Business Operational Manager to the Chief Medical Officer Jul 22** 7) Identifying medical workforce impacted. Compassionate conversations currently underway with identified members of staff. Care Groups working to identify services at risk through clusters of staff. **Chief Medical Officer Apr 22** 8) Audit of implementation of escalation of requests to extend locums beyond two years **Chief Medical Officer Date TBC**

East Kent Hospitals University NHS Foundation Trust

STRATEGIC GOAL: 4) Our Future:
Objective: To ensure the Trust is aware of the risks related to the statutory compliance and backlog of its estate and implements an agreed programme of revenue and capital investment to address the prioritised 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.

Executive Lead: DCEO

CRR REF.	Principal Risk	Initial	Current	Overall Assurance Level	Target	Key Changes during this period	Latest Commentary
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. **Linked to BAF Ref. 36**	L4 x S5 = 20	L3 x S5 = 15	Adequate	L2 x S5 = 10	**Actions completed**: None **New actions identified**: None **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	Total investment for backlog for 2021/22 is £6.8million; PEIC have confirmed full allocation will be spent by March 2022. Due to current site pressures and the surge of infection the full ward decant and refurbishment programme has been paused. **Actions planned** 1a) Ensure plans are in place to BF backlog investment if additional STP / central funding becomes available. **DCEO Mar 22** 1b) Finalisation of the Site Control Plans, based on the Six Facet Survey and ARUP Report to include a proposed ward decant and refurbishment programme. **DCEO Oct 21**. 2a) Ensure additional investment to increase compliance is prioritised as part of the 21/22 Business Planning process **DCEO Mar 22**

STRATEGIC GOAL: 4) Our Future:
Objective: To develop a Trust wide strategy to deliver innovation and change through the implementation of new technology
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.

Executive Lead: DCEO

CRR REF.	Principal Risk	Initial	Current	Overall Assurance Level	Target	Key Changes during this period	Latest Commentary
60	Potential negative impact during transition from paper health records to T3 which may result in a reduction in performance, loss of patient information and reputational damage **Linked to BAF Ref. 36**	L4 x S4 = 16	L3 x S4 = 12	Adequate	L2 x S4 = 8	**Actions completed**: None **New actions identified**: None **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	Planned upgrade for Sunrise to enable implementation of ePMA on track for delivery April 22. **Actions planned** 1) Upgrade currently planned to go live in April 22. Testing is ongoing to enable this go live date.

East Kent Hospitals University NHS Foundation Trust

STRATEGIC GOAL: 5) Our Sustainability: **Objective:** To ensure the Trust is aware of the risks related to the equipment replacement programme and implements an agreed programme of revenue and capital investment to address the prioritised risk. **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.							
Executive Lead: DCEO							
CRR REF.	**Principal Risk**	**Initial**	**Current**	**Overall Assurance Level**	**Target**	**Key Changes during this period**	**Latest Commentary**
13	Failure to allocate and/or attract significant additional capital and revenue will inhibit the Trust's ability to implement an adequate asset replacement programme for equipment and devices approaching the end of their asset life. **Linked to BAF Ref. 36**	L4 x S5 = 20	L3 x S4 = 12	Adequate	L2 x S4 = 8	**Actions completed**: None **New actions identified**: Medical Devices Group reporting of clinical risks to Patient Safety Committee in May 2022 **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	The De Minimis includes a bid for £36 million for replacement equipment over the next five years. **Actions planned** 1) Ensure plans are in place to BF investment if additional STP/central funding becomes available. **DCEO Mar 22** 2) The De Minimis includes a bid for £36million for replacement equipment over the next five years **DCEO Sep 22** 3) MDG reporting of clinical risks to Patient Safety Committee **Head of Medical Physics May 22**

STRATEGIC GOAL: 5) Our Sustainability: **Objective**: To implement a strategy that sustained and improved health and safety standards and compliance across the Trust. **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							
Executive Lead: DCEO							
CRR REF.	**Principal Risk**	**Initial**	**Current**	**Overall Assurance Level**	**Target**	**Key Changes during this period**	**Latest Commentary**
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. **Linked to BAF Ref. 36**	L4 x S4 = 16	L2 x S4 = 8	Adequate	L1 x S4 = 4	**Actions completed**: None **New actions identified**: None **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	Annual audit of health and safety standards being undertaken by Internal Auditors in April 2022. **Actions planned** 1) Planned roll out of link worker training in 2021/22. Dates in place and attendance by Care Group will be monitored. **DCEO Mar 22** 2) Review the current HASTA process and questions to include policy changes and add in Care Group specific sections taking out unnecessary sections to further enhance performance and compliance **DCEO May 22** 3) Produce a three-year Health and Safety Strategy **DCEO Oct 22**

East Kent Hospitals University NHS Foundation Trust

STRATEGIC GOAL: 5) Our Sustainability:
Objective: To minimise delays in the supply chain and deliver on time and to budget the capital programme in 2021/22
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

Executive Lead: DCEO

CRR REF.	Principal Risk	Initial	Current	Overall Assurance Level	Target	Key Changes during this period	Latest Commentary
124	Additional regulations have been put in place at the UK borders and as a consequence the supply chain to the Trust is facing delays in delivery of goods and materials. This may impact on the delivery of the capital programme in 2021/22. **Linked to BAF Ref. 36**	L3 x S4 = 12	L3 x S4 = 12	Limited	L2 x S4 = 8	**Actions completed**: Stickers displayed on all menus to notify that supply chain issues may change the menu **New actions identified**: None **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	Backlog in signing off invoices will be fully resolved by March 22. **Actions planned** 1) Where delays are significant alternative products will be sought through the Procurement department **DCEO Mar 22** 2) Reverted to previous Business World system and additional resource will be funded if required **DoF Mar 22**

STRATEGIC GOAL: 5) Our Sustainability:
Objective: To establish an Accommodation Strategy that ensure the Trust has access to adequate residential, office and training and education facilities
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

Executive Lead: Director of Finance and Performance (DoF)

CRR REF.	Principal Risk	Initial	Current	Overall Assurance Level	Target	Key Changes during this period	Latest Commentary
126	There is a risk that we are unable to recruit and retain staff due to the current capacity and / or standard of residential, office accommodation and training and education facilities. **Linked to BAF Ref. 36**	L3 x S4 = 12	L2 x S4 = 8	Adequate	L1 x S4 = 4	**Actions completed**: None **New actions identified**: None **New Assurances**: None **Overall Assurance Level rationale (if changed):** N/A	Meeting scheduled to review risk progress 1 March 2022. Actions planned 1a) Additional investment in 2gether team to deliver Accommodation Management Plan **Intelligent Client Mar 22** 1b) Update Accommodation Policy and tenancy agreements I**ntelligent Client Mar 22** 1c) Deliver additional external capacity in Canterbury and Thanet **Intelligent Client Mar 22** 2) Central management of all education and training spaces to be developed **Director of HR Mar 22** 3a) Agile working policy to be developed **Director of HR Mar 22** 3b) Space utilisation review **Intelligent Client Mar 22**

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**INFECTION PREVENTION AND CONTROL (IPC) BOARD ASSURANCE FRAMEWORK (BAF)**				
MEETING DATE:	**10 MARCH 2022**				
BOARD SPONSOR:	**CHIEF EXECUTIVE**				
PAPER AUTHOR:	**DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC)**				
APPENDICES:	**APPENDIX 1: IPC BAF**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	**Assurance**	Discussion
Purpose of the Report:	The IPC BAF is required to be updated and reviewed by the Trust Board on a monthly basis during the Covid-19 pandemic.				
Summary of Key Issues:	At the time of writing, 1 March 2022, there has not been the anticipated reduction in hospital cases of Covid-19. As suggested previously, this may be related to the removal of all formal societal restrictions related to Covid-19. The data on community incidence and prevalence of Covid-19 is much less reliable due to the reduction in testing. Omicron continues to present the challenges previously described, i.e. increased infectiousness and presentation that is incidental to the patient's reason for admission. In addition, we are seeing increased cases that are related to the patients' visitors testing positive having recently visited. The proportion of healthcare associated cases (probable and definite as defined) to total cases of Covid-19 is slightly higher than in the surge associated with the Alpha variant in late 2021/early 2022 but this needs to be seen in the context of the increased infectiousness of Omicron which has been estimated at three times that of the Delta variant and ten times of the original 'wild type' virus. The number and extent of outbreaks (as defined) is beginning to slow but the overall number of cases had recently increased again to around 120 inpatients. A verbal update will be given at the meeting. Proposals to remove some of the burden of additional personal protective equipment in some patient areas are being considered by Gold at the time of writing (these proposals are consistent with national guidance). Changes to the BAF this month: Section 4. • An update on national visiting guidance is awaited. Current visiting risk assessments have been reviewed and re-published for clarity. • Front of house 'meet and greet' processes are being reviewed by the Chief Operating Officer's (COO) team and site leadership teams to establish a sustainable approach.				

East Kent Hospitals University NHS Foundation Trust

	Section 5. • Revised guidance from the joint Royal Colleges reinforces the current Trust approach to delaying elective surgery in the context of Covid-19 infection. Section 8. • Revising elective surgical pathway in line with recent guidance, to be agreed by Gold (planned for 4 March). Section 10 • Change in national guidance that removes distinction between vaccinated and unvaccinated staff when deemed a contact – implemented, awaiting updated Kent & Medway (K&M) risk assessment.
Key Recommendation(s):	The Board of Directors is asked to discuss and **NOTE** the contents of the IPC BAF report.

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

Link to the Board Assurance Framework (BAF):	BAF 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.	
Link to the Corporate Risk Register (CRR):	N/A	
Resource:	Y/N	N
Legal and regulatory:	Y/N	N
Subsidiary:	Y/N	N
Assurance Route:		
Previously Considered by:	N/A	

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Infection Prevention and Control (IPC) board assurance framework (BAF)

The IPC BAF is required to be updated and reviewed by the Trust Board on a monthly basis during the Covid-19 pandemic.

This version of the BAF is a completely revised update, based on the version published by NHS England/NHS Improvement (NHSE/I) on 26 December 2021. The previous iteration presented to the Trust Board in November 2021 has been archived and will be available as a record of the iterations to that date.

Note that since the previous Board meeting, all formal societal restrictions related to Covid-19 have been removed and plans are in place to decommission all public testing, track and trace and contact tracing structures and processes. NHS precautions have not been stood down at this stage (subject to those provisions previously published in November 2021).

Changes to the BAF this month in red in the body of the BAF

Section 4.

- An update on national visiting guidance is awaited. Current visiting risk assessments have been reviewed and re-published for clarity.
- Front of house 'meet and greet' processes are being reviewed by the COO team and site leadership teams to establish a sustainable approach.

Section 5.

- Revised guidance from the joint Royal Colleges reinforces the current Trust approach to delaying elective surgery in the context of Covid-19 infection.

Section 8.

- Revising elective surgical pathway in line with recent guidance, to be agreed by Gold (planned for 4 March).

Section 10

- Change in national guidance that removes distinction between vaccinated and unvaccinated staff when deemed a contact – implemented, awaiting updated K&M risk assessment.

Infection prevention and control board assurance framework

NHS East Kent Hospitals University NHS Foundation Trust

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • a respiratory season/winter plan is in place: ○ that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services ○ to enable appropriate segregation of cases depending on the pathogen. ○ plan for and manage increasing case numbers where they occur. ○ a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	The Trust Covid-19 response escalation plans include the need to test for other respiratory viruses, including POCT for influenza and Respiratory Syncytial Virus (RSV). Cases of confirmed Covid-19 are managed in Covid-19 areas (Blue) and confirmed cases of other seasonal respiratory viruses are managed in single rooms according to specialty/clinical need.		
• health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone. • Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: ○ based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. ○ applied in order and include elimination; substitution, engineering, administration and Personal Protective Equipment (PPE)/Respiratory Protective Equipment (RPE). ○ communicated to staff. • safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	The Trust has maintained all workplace requirements as instituted previously, including, but not limited to, social distancing, appropriate PPE, hand hygiene, enhanced cleaning and alterations to work patterns (including work from home requirements and staggered breaks). Existing risk assessments for individual staff are all in the process of being updated. Risk assessments for staff as contacts of Covid-19 cases are agreed on a Kent and Medway-wide basis. Other risk assessments have been approved within the organisation.		

• if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.
• risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.
• if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.
• ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.
• the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases
• there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.
• resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).
• the application of IPC practices within this guidance is monitored, e.g.:
  • hand hygiene.
  • PPE donning and doffing training.
  • cleaning and decontamination.
• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.
• the Trust Board has oversight of ongoing outbreaks and action plans.
	The trust has maintained compliance with current iteration of the national guidance and has not derogated any matters.
	
	Environmental risk assessments done in response to previous surges of Covid-19 are being reviewed in light of changing epidemiology of the Omicron variant.
	RPE has been made available to all staff in any area, not limited to 'Blue' areas and if specified in individual risk assessments.
	IPC are monitoring and reviewing patient movements and any impact on transmission.
	CEO or exec sign off for data submissions, DIPC signs off IIMARCH forms for outbreaks, Daily Sitrep analysis shared with senior staff
	
	Gemba and other senior leader engagement activities continue. Execs and senior leaders frequently in clinical and non-clinical areas.
	
	All necessary resources are in place
	
	IPC audits are conducted in all clinical areas and the results are monitored by the IPC Committee and the IPC Team. Additional audits are conducted by the IPC Team when indicated (e.g. outbreak situations)
	
	IPC BAF is reviewed at every Board meeting
	
	The DIPC reports to the Quality and Safety Committee and The Trust
		Not all areas have had an environmental risk assessment based on previous Covid-19 epidemiology	Data on previous risk assessment completeness being reviewed to inform further work

• the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	Board and provides updates on outbreaks and, where relevant, trust-wide actions. The trust has access to a range of FFP3 with sufficient stocks, monitored at Gold.		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and processes are in place to ensure that:
 	
• the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.
• the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms
• cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.
• increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.
• Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.
• if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.
• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.
• a minimum of twice daily cleaning of:
  ○ patient isolation rooms.
  ○ cohort areas.
  ○ Donning & doffing areas
  ○ 'Frequently touched' surfaces e.g., door/toilet handles, patient call bells, over bed tables and bed rails.
  ○ where there may be higher environmental contamination rates, including:
  • toilets/commodes particularly if patients have diarrhoea.
	The Trust Board has approved the business case for implementation of 2021 National Standards of Healthcare Cleanliness and 2gether Support solutions have developed an implementation plan to achieve full compliance by the October 2022 deadline for Trusts. This will include mechanisms to identify and communicated changes in functionality of rooms/areas Cleaning issues are escalated through existing processes and to the IPC Team if required. Cleaning escalations are discussed at the IPC Committee
	
	Cleaning schedules and methods for isolation areas are as per policy. EKHUFT uses Tristel Fuse™ which is a Chlorine Dioxide based environmental disinfectant approved by the IPCT.
	
	Products are used as per protocol (incorporating manufacturers' instructions).
	
	In addition enhanced technologies (UV and Hydrogen Peroxide Vapour) are deployed as per IPC protocol.
	
	Cleaning frequencies, protocols and procedures meet these requirements		

• A terminal/deep clean of inpatient rooms is carried out:
  ○ following resolutions of symptoms and removal of precautions.
  ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens);
  ○ following an Aerosol Generating Procedure (AGP) **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).
• reusable non-invasive care equipment is decontaminated:
  ○ between each use**.**
  ○ after blood and/or body fluid contamination
  ○ at regular predefined intervals as part of an equipment cleaning protocol
  ○ before inspection, servicing, or repair equipment.
• Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.
• As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance.
• In patient Care Health Building Note 04-01: Adult in-patient facilities.
• the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.
• a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways
• where possible air is diluted by natural ventilation by opening windows and doors where appropriate
• where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.
	Terminal cleans (including enhanced technologies deployed where appropriate) are done, as described across, according to Trust IPC policy as described in the 'What Clean do You Need' posters.
	
	This is business as usual and included in the decontamination policy
	
	Cleaning is monitored by 2gether and as part of IPC audits and reported to the IPC Committee.
	Much of the EKHUFT clinical estate is older property without mechanical ventilation (other than specialist systems as described in HTM 03-01, specialist ventilation for healthcare building).
	As described above, previous assessments of ventilation have focussed on areas for known or suspected Covid-19 cases (Blue).
	The Omicron variant has significantly different epidemiology with cases in any clinical setting.
	
	Alternative technologies under consideration but experience from other organisations is that there is no
		Described above	Described above

• when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	advantage to their deployment. IPC and estates/facilities discuss all physical changes to estate, incorporating impact on air flow where relevant.		

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and process are in place to ensure that:
• arrangements for antimicrobial stewardship are maintained
• previous antimicrobial history is considered
• the use of antimicrobials is managed and monitored:
  ○ to reduce inappropriate prescribing.
  ○ to ensure patients with infections are treated promptly with correct antibiotic.
• mandatory reporting requirements are adhered to, and boards continue to maintain oversight.
• risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.
	The Antimicrobial Stewardship Group (ASG) meets monthly and monitors and implements the ASG work plan.	The Antimicrobial Stewardship resource is small and fragile (person dependent)
		
		Further work is needed to increase the scope and cover of the ASG programme
			A Consultant Pharmacist (AMS) is being recruited
			
			A proposal for further work under the auspices of the We Care programme will form part of the work plan for 2022/2023

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • national guidance on visiting patients in a care setting is implemented. • restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment. • there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing. • if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an Fluid Repellent Surgical Mask (FRSM).	Trust visiting policy reflects this guidance as described across (all bullet points in this section) - agreed by Gold command An update on national visiting guidance is awaited. Current visiting risk assessments have been reviewed and re-published for clarity Front of house 'meet and greet' processes are being reviewed by the Chief Operating Officer (COO) team and site leadership teams to establish a sustainable approach.		
• visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible. • visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian. • Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Relevant aspects of the toolkit implemented as part of the communications approach and approved by Gold Command	Not all elements in the toolkit in use	Further review of toolkit by IPC to establish if any elements will add further value

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival. • infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred. • staff are aware of agreed template for screening questions to ask. • screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment. • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance. • triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible. • there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	Signage in place at entry points to hospital sites, using national toolkit graphics and information Included in transfer protocols, including those patients deemed medically fit for discharge Standard screening questions in place for admission/triage/transfer across all protocols – on Trust intranet Covid-19 pages and IPC policies (for other respiratory viruses) In place as per existing protocols (as above) as per national guidance. See above Routine testing protocol compliance constantly monitored via the Patient Tracking List (PTL)		

• patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated. • patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result. • patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing. • patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be	All patients are currently supplied with and encouraged to wear a surgical face mask as described (not limited to these criteria) As per existing IPC policies and Covid-19 specific protocols already in place This is business as usual and supported by existing IPC policies and management Patients who were previously classified as Clinically Extremely		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that:			
• appropriate infection prevention education is provided for staff, patients, and visitors.	Education for staff is described in mandatory training requirements. Patients and visitors have patient information and communications materials as required.		
• training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	FFP3 training as part of fit testing protocols. IPC measures as part of mandatory training, ad-hoc supplemented by IPC (e.g. outbreaks, on request)		
• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	As above		
• adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	Included in regular IPC audits, monitored by the IPC Committee		
• gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	This is business as usual supported by existing policies, protocols and training.		
• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.	Hot air dryers not in use in clinical areas. Paper towels as per guidance.		
• staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	No derogation from 2 metre distancing where possible (as described above)		
• staff understand the requirements for uniform laundering where this is not provided for onsite.	Scrubs are worn on all Covid wards and several other wards and clinical areas by clinical and facilities staff. Scrubs are laundered by the Trust and staff are advised not to take		

• all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance. • to monitor compliance and reporting for asymptomatic staff testing • there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals). • positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	them off-site Staff launder their own uniforms. Guidance has been published through the Covid intranet page. All staff advised to travel to and from work in their own clothes and change on site Staff changing and shower facilities provided on all acute sites Full information and support available on Covid intranet pages, Kent and Medway wide risk assessment in place and supported by Occupational Health and approved by Gold Epidemiology and modelling reported to Gold on at least a weekly basis for information and action as advised by DIPC Managed as per national protocols and reported to the national system and local partners (Clinical Commissioning Group (CCG)/Integrated Care System (ICS) and Health Protection Team)		

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and processes are in place to ensure: • that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients. • patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals. • patients are appropriately placed ie, infectious patients in isolation or cohorts. • ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements). • standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result • the principles of SICPs and Transmission Based Precautions (TBPs) continued to be applied when caring for the deceased	Clear advice in place and regularly reinforced by leaders at site huddles and by IPC team Remains in place as previously established for Covid-19 surges, includes other seasonal respiratory viruses Covid-19 patients have specific 'Blue' pathways, well established. Other respiratory viruses managed using existing IPC policies all available on intranet As per protocols, business as usual and Covid-19 specific Dealt with as part of business as usual and with IPC input on request or in light of issues/incidents Business as usual supported by existing IPC policies and protocols Business as usual supported by specific IPC policy		
8. Secure adequate access to laboratory support as appropriate			

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals. • patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance; • staff testing protocols are in place	Testing undertaken by registered biomedical scientists with documented competencies Methods validated prior to diagnostic testing National testing protocols remain in place as previously described including for non-Covid seasonal viruses in symptomatic patients Staff testing protocols in place supervised and supported by Occupational Health		

• there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data). • screening for other potential infections takes place. • that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission. • that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise. • that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission. • that sites with high nosocomial rates should consider testing COVID-19 negative patients daily. • that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. • those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance • there is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case	Testing turnaround times reported to Gold weekly Constantly monitored via the PTL system As per protocol and part of business as usual All Emergency Department (ED) patients and other emergency patients are POCT or LFT (SDEC) tested Part of clinical protocols Monitored by the PTL system with testing prompts on electronic whiteboards and PTL Enhanced testing used when advised by IPC Team As per national protocol – in place As per national protocol – in place		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that • the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	IPC audits in all care groups, reported to IPC Committee monthly		
• staff are supported in adhering to all IPC policies, including those for other alert organisms. • safe spaces for staff break areas/changing facilities are provided.	IPC team and microbiology/virology support staff in managing all alert organisms. Policies/Standard Operating Procedures (SOPs) in place for all organisms specified in the "hygiene code"		
• robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	Outbreak policy updated in 2021 and followed – Covid-19 outbreaks recorded on national database using IIMARCH format		
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance.	Treated as infected linen as per protocol		
• PPE stock is appropriately stored and accessible to staff who require it.	Managed locally and supported by IPC		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy. • bank, agency, and locum staff follow the same deployment advice as permanent staff. • staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance) • staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE. • a fit testing programme is in place for those who may need to wear respiratory protection. • where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: ○ lead on the implementation of systems to monitor for illness and absence.	Occupational Health service available to all staff and staff reminded and encouraged to seek support Agreed Kent and Medway wide approach implemented and on Covid intranet pages Change in national guidance that removes distinction between vaccinated and unvaccinated staff when deemed a contact – implemented, awaiting updated K&M risk assessment. Covered in previous section Fit testing programme in place and widely advertised and information on intranet Occupational Health team review all staff cases of Covid-19 and advise if deemed work related and support staff as required		
○ facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce ○ lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 ○ encourage staff vaccine uptake. • staff who have had and recovered from or have received vaccination for a	See above and supported by microbiology/virology Staff illness and absence (Covid related and total) as well as vaccine uptake monitored and reported to Gold at least weekly Included in business as usual and Covid-19 specific requirements		

specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.			
• a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19.	Individual risk assessments for all staff, taking into account all of the criteria described are in place and being updated with booster vaccination status		
• A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups;	As part of the above Risk Assessment (RA) process		
• that advice is available to all health and social care staff, including specific advice to those at risk from complications.	As above with Occupational Health (OH) support where needed		
• Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff .			
• A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	OH policies and processes in place		
• vaccination and testing policies are in place as advised by occupational health/public health.	Covered in above (repeated point)		
• staff required to wear FFP3 reusable respirators undergo training that is compliant with Health and Safety Executive (HSE) guidance and a record of this training is maintained andheld centrally/Electronic Staff Record (ESR) records.	Policies in place and approved by Gold or existing policy	Records are held locally not centrally (although reported by contractor back to the trust)	Revising arrangements for managing fit testing contract/service to include recording
• staff who carry out fit test training are trained and competent to do so.	Training contracted to an accredited training organisation and conducted to HSE standards		
• all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	As above (accredited trainers)		
• all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	As per policy and above	Not all staff tested on more than one mask	Included in review described above
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	Not fully implemented as staff previously tested only tested on 1 type of mask and supply of those masks is stable	Records are held locally not centrally (as above)	Included in review described above
• those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	Records exist and alternative respirators and hoods area available		

• that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	For failed fit testing, alternative is use of PAPR hoods		
• members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	Managed locally and supported by occupational health (but PAPR hood option is always available as fit test not required).		
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	Managed locally, occupational health support available as required – Covid-19 individual risk assessments are held centrally and include where FFP3 is agreed as personal mitigation.	Records are held locally not centrally (other than Covid-19 RA)	To be included in review of fit testing contract and arrangements
• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	A fit testing service is in place as described and available across the organisation. Not currently reported to Board or held centrally	Records are not held centrally or reported to Board regularly, managers are responsible for ensuring staff are fit tested	To be included in review of fit testing and to come to Board via Health and Safety Committee.
• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	IPC advise on a case by case basis if staff need to work across care pathways. Avoided where possible and mitigated if necessary		
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	Covered in earlier section (repeated point)		
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing.	Covered in earlier section (repeated point)		
• staff who test positive have adequate information and support to aid their recovery and return to work.	Covered in earlier section (repeated point)		

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**OCKENDEN REVIEW OF MATERNITY SERVICES - ONE YEAR ON PROGRESS REPORT**
MEETING DATE:	**10 MARCH 2022**
BOARD SPONSOR:	**CHIEF NURSING & MIDWIFERY OFFICER: MATERNITY AND NEONATAL BOARD SAFETY CHAMPION**
PAPER AUTHOR:	**INTERIM DIRECTOR OF MIDWIFERY** **CHIEF NURSING & MIDWIFERY OFFICER**
APPENDICES:	**APPENDIX 1: LETTER FROM NHS ENGLAND AND NHS IMPROVEMENT** **APPENDIX 2: OCKENDEN AND CNST ASSESSMENT AND ASSURANCE TOOL - FEBRUARY 2022** **APPENDIX 3: RECOMMENDATIONS FROM MORECAMBE BAY REVIEW - FEBRUARY 2022** **APPENDIX 4: NATIONAL MATERNITY SELF - ASSESSMENT TOOL AND ACTION PLAN FEBRUARY 2022**

Executive Summary:

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

Purpose of the Report:

On 11 December 2020 Donna Ockenden's first report: *Emerging Findings and Recommendations from the Independent Review of Maternity Services at Shrewsbury and Telford Hospitals NHS Trust* was published.

This report is to provide the Board of Directors with a one-year on progress update to support discussions by the end of March 2022, to cover:

- Progress with implementation of the 7 Immediate and Essential Actions (IEAs) outlined in the Ockenden report and the plan to ensure full compliance.
- Maternity services workforce plans around recruitment and spending against the National investment funding to support additional Midwife roles and Obstetric Multi-Disciplinary Team (MDT) and Fetal Monitoring Training.
- A review against recommendations from the Kirkup Morecambe Bay investigation report, Clinical Negligence Scheme for Trusts (CNST) safety actions and Care Quality Commission (CQC) action plans.
- For East Kent there is an additional request to include an update on our position against the NHS England (NHSE) Maternity Self-Assessment Tool.

Ensuring local system oversight of maternity services was a key element in the Ockenden review and therefore the Trust's progress will be shared and discussed with the Kent and Medway Local Maternity and Neonatal System (LMNS) and Integrated Care Board (ICB).

In April 2022 Trusts are expected to provide a progress update to the regional team after which insight visits involving the regional team and LMNS are expected to occur.

East Kent Hospitals University NHS Foundation Trust

Summary of Key Issues:	The following common themes for the Maternity Service to address have been identified: • Appraisal rates remain below that required for Trust compliance. This is being addressed so that all appraisals will have been completed by 31 June 2022 (Maternity Self-Assessment, Morecambe Bay). • Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHS Resolution (NHSR) requirements that will be in place by May 2022 (Ockenden IEA 3 and 6, Morecambe Bay, Maternity Self-Assessment). • Personal Care and Support plans are not yet in place these are being coproduced through an LMNS workstream that includes Maternity Voices Partnership (MVP) membership but hasn't yet been launched. • Information available to women in terms of: accessibility (navigation, language etc), quality of information (clear language, all/minimum topic covered) and general patient information leaflets, apps, websites. A review of information has taken place by the MVP and a report is imminent. Once received, information will be reviewed and updated to reflect the benchmarking exercise feedback (Ockenden IEA 7, Morecambe Bay).
Key Recommendation(s):	The Trust Board is invited to: 1. **NOTE** and **DISCUSS** the Ockenden Review of Maternity Services – One Year On progress report; 2. Receive **ASSURANCE** that the 10 Safety Actions and 7 IEAs will be met subject to the assessment and assurance provided within the Maternity services assessment and assurance tool; 3. **APPROVE** the request for this paper, including the completed assurance and assessment tool, review against recommendations from the Kirkup Morecambe Bay investigation report, CQC action plans and update on position against the Maternity Self-Assessment Tool be submitted to the LMNS and Regional Midwifery Officer; 4. **SUPPORT** the broader considerations and the development of further improvements as seen in section 6 of this report; 5. Receive **ASSURANCE** that there is an effective process established of ongoing assessment and that the evidence provided is sufficiently robust.

East Kent Hospitals University NHS Foundation Trust

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

Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.	
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.	
Resource:	**Y**	Ockenden National Funding and Trust Midwifery Staffing Business Case additional funding has been accessed to support the workforce investment.
Legal and regulatory:	**Y**	CNST, Saving Babies Lives Care Bundle.
Subsidiary:	**N**	
Assurance Route:		
Previously Considered by:	Maternity and Neonatal Assurance Group 8 March 2022	

East Kent Hospitals University NHS Foundation Trust

Ockenden Review of Maternity Services-One Year on Progress Report

1. Purpose of the report

1.1 On 11 December 2020 Donna Ockenden's first report*: Emerging Findings and Recommendations from the Independent Review of Maternity Services at Shrewsbury and Telford Hospitals NHS Trust* was published. This report is to provide a one-year on progress update to support discussions at Public Board of Directors meeting, by the end of March 2022, to cover:

1.1.1 Progress with implementation of the 7 Immediate and Essential Actions (IEAs) outlined in the Ockenden report and the plan to ensure full compliance,

1.1.2 Maternity services workforce plans around recruitment and spending against the National investment funding to support additional Midwife roles and Obstetric MDT and Fetal Monitoring Training.

1.1.3 A review against recommendations from the Kirkup Morecambe Bay investigation report, CNST safety actions and CQC action plans.

1.1.4 For East Kent there is an additional request to include an update on position against the Maternity Self-Assessment Tool.

1.2 Ensuring local system oversight of maternity services was a key element in the Ockenden review and therefore the Trusts progress will be shared and discussed with the Kent and Medway LMS and ICS.

1.3 In April 2022 Trusts are expected to provide a progress update to the regional team after which insight visits involving the regional team and LMNS are expected to occur. by 15 April 2022.

2. Background

2.1 The Ockenden Report was published in December 2020 as a result of an investigation into concerns regarding services and care at Shrewsbury and Telford NHS Trust.

2.2 Within the report 7 Immediate and Essential Actions (IEA) were highlighted

2.3 Between 15 December and 24 December 20, Trusts were required to implement 12 Urgent Clinical Priorities' (UCPs) and submit their position to the Regional team following Board sign off.

2.4 Trusts were next required to benchmark their current position against all of the IEAs and submit in January 2021.

2.5 This phase 1, was a self-assessment process undertaken regionally by a panel of peers, service users and the regional maternity team.

2.6 In May 2021 Trusts were presented with a set of evidence that was expected to be in place to support compliance.

2.7 In June and July 2021 Trusts submitted evidence of progress towards / compliance with each IEA to a national central portal and this was quality assured by the regional maternity team, supported by the Commissioning Support Unit (CSU).

2.8 Trusts were informed of their phase 2 outcomes in December 2021.

2.9 Overall East Kent Hospitals achieved 73% compliance in phase 2, which is comparable with other Trusts within the LMNS (Dartford and Gravesham 70%, Maidstone and Tonbridge Well 67%, and Medway 61%).

2.10 One year on, Trusts have been asked by NHS Improvement (NHSI) to review progress against the 7 Ockenden IEAs and plans to ensure full compliance, along with a gap analysis against the Morecombe Bay recommendations and in addition, East Kent Hospitals has been asked to complete the Maternity Services Support programme self-assessment tool.

2.11 Appendix 1 is the letter from NHS England and NHS Improvement.

2.12 Appendix 2 shows Ockenden IEA and CNST Assurance and Assessment Tool review.

2.13 Trusts were also asked to review themselves against recommendations from the Kirkup, Morecambe Bay investigation report, CNST safety actions, Workforce Planning and any existing CQC action plans.

2.14 See Appendix 3 Morecambe Bay Review.
See Appendix 4 Maternity Self-Assessment and 5 Maternity Self-Assessment Action Plan.

2.15 The aim is to support a discussion at Board of Directors meetings by the end of March 2022 to discuss progress and review action plans to meet the IEAs.

2.16 In April 2022 Trusts are expected to provide a progress update to the regional team after which insight visits involving the regional team and LMNS are expected to occur.

3. Ockenden Immediate and Essential Actions (IEAs)

3.1 Appendix 2 of this report describes the elements of specific questions within each IEA where the Trust was deemed non-compliant and the Trust's current position of progress made following receipt of the feedback template on 2nd December 2021.

3.2 **Compliance with Ockenden**

3.3 IEA 1 – Enhanced Safety

- East Kent achieved 81% compliance for IEA 1.

The Trust was non-compliant against one element of:

- **Question 4: *Using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths***

Elements of non-compliance:

- Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.

Current position:

- The audit was completed on all cases since January 2021 and showed 97% compliance. There was just one case January 2021 that did not have an external reviewer. Since then 100% compliance has been maintained. The PMRT Generated report has now been completed and shows 100% compliance for CNST year 4 reporting periods.
- **The Trust is now 100% compliant against Q4**

The Trust was non-compliant for two elements of:

- **Question 7: *Plan to implement the Perinatal Clinical Quality Surveillance Model***

Elements of non-compliance:

- Full evidence of full implementation of the perinatal surveillance framework by June 2021.
- LMNS Standard Operating Procedure (SOP) and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.

Current position

- There is now a Trust and Local Maternity and Neonatal Systems (LMNS) perinatal surveillance framework in place which has been implemented fully in October 2021 and is reported through the Maternity and Neonatal Assurance Group (MNAG).
- There is now an LMNS Standard Operating Process (SOP) which defines the governance structure, and minutes of the LMNS Quality assurance meeting to demonstrate embedding in the Integrated Care System (ICS) governance structure.
- **The Trust is now 100% compliant against Q7**

3.4. IEA 2 - Listening to women and families

East Kent achieved 88% compliance for IEA 2.

The Trust was non-compliant for one Element of:

- **Question 13:** ***Demonstrate mechanism for gathering service user feedback, and work with service users through MVP to coproduce local maternity services*** **and**
- **Question 15:** ***Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your MVP to coproduce local maternity services*****, asked for the same evidence**

Elements of non-compliance:

- Clear co-produced plan, with MVP's that demonstrate that co-production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.

Current position:

- Evidence of coproduction and Safety Action 7 was submitted but the coproduction plan was not completed within the required timeframe. This has now been developed with the MVP's that demonstrate that coproduction and co-design of service improvements, changes and developments will be in place and will be embedded. A new patient experience role, has been implemented who will work with the MVP, Staff and Service users to prospectively plan involvement in processes and service design as well as gathering and responding to feedback.

The maternity team have discussed this area with the NHSE/I advisor and although progress has been made, it is recognised that this needs to be fully embedded and therefore **it is recommended that the Trust remains amber against this question.**

3.5. IEA 3 – Staff training and working together

East Kent achieved 72% compliance for IEA 3.

The Trust was non-compliant for two elements of:

- **Question 17:** ***Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.***

Elements of non-compliance

- LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.
- Submit TNA that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.

Current position

- The LMNS Quality Assurance Group (QAG) now has core competency assessment on the agenda three times a year and this is supported through a workforce and training forum that is led by the LMNS workforce lead midwife, the first meeting of which was held in November 2021. This is then reported by exception to the Regional Maternity and Neonatal Safety and Concerns Group (RMNSCG) from the LMNS QAG
- A training needs matrix has been completed and will inform the TNA that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training, aligned to CNST, NHSR requirements. This has been developed, and is going through the Governance approval process and will be completed by end of March 2022.

Whilst progress has been made this area remains amber.

The Trust was non-compliant for one element of:

- **Question 21:** ***90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session*** **and**
- **Question 23:** ***The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime, assurance is being sought that a MDT training schedule is in place*****.**

- Elements of non-compliance
- LMNS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.

Current position:

- The unmet elements related to the same evidence as the above Q17 point one, which was the governance processes for reporting training through the LMNS which are now in place.
- **The Trust is now 100% compliant against these Questions**

The Trust was non-compliant for one element of:

- **Question 18:** ***Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.***

Element of non-compliance

- SOP created for consultant led ward rounds.

Current position:

- The guideline has been updated to include Consultant Led Ward Rounds. The Trust is now 100% compliant against this Question.

3.6. IEA4 – Managing complex pregnancy

East Kent achieved 86% compliance for IEA 4.

The Trust was non-compliant for two elements of:

- **Question 29:** ***Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres (MMC)****.*

Elements of non-compliance:

- Agreed pathways
- Criteria for referrals to MMC

Current position:

- There is work being scoped with the LMNS for a system wide approach.
- The Trust is involved in the LMNS workstream and there are plans to set up a sub hub to further progress plans through the Clinical Commissioning Group (CCG)
- Evidence of MMC LMNS discussions around pathways and criteria to support future plans.

3.7. IEA 5 - Risk assessment throughout pregnancy

East Kent achieved 73% for IEA 5.

The Trust was non-compliant for two elements of:

- **Question 30:** ***All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional***

Element of non-compliance:

- Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.
- SOP that includes definition of antenatal risk assessment as per the National Institute for Health and Care Excellence (NICE) guidance.

Current position:

- This is being coproduced through an LMNS workstream but isn't yet launched.
- Euroking workflow to be shared to guide staff on how to complete within the Maternity information system.
- LMNS wide approach to produce a document for women.
- Definition of antenatal risk assessment as per NICE guidance, has been added to the Antenatal Care Guideline and is also captured on the Euroking workflows and asked at each antenatal contact.

The Trust was not compliant against one element of:

- **Question 31:** ***Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture***.

Element of non-compliance:

- Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of out with guidance pathway.

- **Current position**
- See Question 30

The Trust was no compliant against one element of:

- **Question 33:** ***A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance***.

Element of non-compliance:

- Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.

Current position

- See Question 30

3.8. IEA 6 – Monitoring fetal wellbeing

East Kent achieved 67% for IEA 6.

The Trust was non-compliant for five elements of:

- **Question 35:** ***The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health*****.**

Elements of non-compliance

- Consolidating existing knowledge of monitoring fetal wellbeing.

- Improving the practice & raising the profile of fetal wellbeing monitoring.
- Keeping abreast of developments in the field-demonstrated through evidence of training updates, reading and guideline updates.
- Lead on the review of cases of adverse outcome involving poor fetal heart rate (FHR) interpretation and practice-leads to attend PMRT meeting for relevant cases which will be evidenced through meeting minutes and PMRT reports.
- Plan and run regular departmental FHR monitoring meetings and training, this can be demonstrated through the training lesson plan, training matrix and once completed the TNA.

Current position:

- The Practice Development and fetal monitoring leads have provided clear examples of how they meet the requirements of this question and the Trust is now 100% compliant.

The Trust was non-compliant against one element of:

- **Question 37:** ***Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?***

Element of non-compliance:

- Submit TNA that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.

Current position:

- The TNA is being updated so that it clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to CNST, NHSR requirements. A workshop was held and a training matrix has been completed to inform the TNA, which has been developed and is currently going through Governance approval. This will be completed by end of March 2022.

3.9. IEA 7 – Informed consent

East Kent achieved 50% compliance for IEA 7.

The Trust was non-compliant in one element of:

- **Question 39:** ***Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery***

Element of non-compliance

- Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.

Current position:

- Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites, has been completed and the Trust is waiting for the report to be shared.
- Following Gap review and MVP Chair rating report a process will be agreed to update, monitor and report updates and submit requests for future updates.

The Trust was non-compliant for one element of:

- **Question 41:** ***Women must be enabled to participate equally in all decision-making processes*** **and**
- **Question 42:** ***Women's choices following a shared and informed decision-making process must be respected***

Element of non-compliance

- An audit of 1% of notes demonstrating compliance.
- An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.

Current Position

- The Trust is being supported on content, process and completion of audits by NHSE/I Improvement Director support team.

The Trust was non-compliant for one element of:

- **Question 43:** ***Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?***

Element of non-compliance

- Clear coproduced plan, with MVP's that demonstrate that coproduction and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.

Current position:

- Evidence of coproduction and Safety Action 7 was submitted but the coproduction plan was not completed within the required timeframe. This has now been developed with the MVP's that demonstrate that coproduction and co-design of service improvements, changes and developments will be in place and will be embedded. The Trust has implemented a new patient experience role who will work with the MVP, Staff and Service users to prospectively plan involvement in processes and service design as well as gathering and responding to feedback.

The Trust was non-compliant for three elements of:

- **Question 44:** ***Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. These are duplicate actions as described below with progress captured above.***

Elements of non-compliance

- Co-produced action plan to address gaps identified.
- Gap analysis of website against Chelsea & Westminster conducted by the MVP.
- Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.

Current position:

- See Q43

3.10. Workforce Actions

East Kent Achieved 70% for Workforce Actions

The Trust was non-compliant for two elements of:

- **Question 45:** ***Demonstrate an effective system of clinical workforce planning to the required standard***

Elements of non-compliance

- Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan.
- Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.

Current position:

- Workforce planning at LMNS/ICS level was completed in October 2021.
- 6 monthly reviews and reporting is provided for midwifery.
- An obstetric workforce paper was presented to MNAG in January 2022.
- The Trust submitted all evidence for CNST year 3 for Safety Action 4 demonstrating compliance and so clarification has been sought around additional requirements to support meeting this element.

The Trust was non-compliant for one element of:

- **Question 49:** ***Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.***

Element of non-compliance:

- Evidence of risk assessment where guidance is not implemented.

Current position:

- The Trust has two Guidelines that do not currently follow NICE. Fetal Monitoring, which follows Physiological Interpretation and Induction of Labour due to recent changes that have a capacity issue which impacts on immediate adoption, but the plan will be to implement once resolved.
- A risk assessment is to be completed for both guidelines and this will be added to the risk register by end of March 2022.

4. Maternity Workforce Planning

4.1 Each Trust on the publication of Ockenden in December 2020 was requested to have in place a signed off Birth-rate Plus Implementation Plan.

4.2 The maternity service can demonstrate an effective system of midwifery workforce planning to the required standard by utilising the Birthrate Plus tool. Current funded establishment reflects the outcomes of the Birthrate Plus assessment published in November 2020, and a further workforce review that was completed in September 2021. A midwifery workforce report is presented at Trust Board every 6 months, most recently in December 2021.

5. Compliance against Kirkup Review into Failings at Morecambe Bay

5.1 The Kirkup review into failings within maternity services and the wider Trust at Morecambe Bay was published in 2015. As well as 18 recommendations for action by the Trust in question there were 26 recommendations for the wider NHS. Many of these, including the need for a review of maternity care and paediatric provision, led to the national Better Births strategy in 2016 and wider changes such as the abolition of the supervisors of midwives' role. The full list of recommendations and East Kent's benchmark exercise (appendix 3) **demonstrates that there is still work to do to reach compliance for the following areas:**

- Completion of a Training Needs Analysis (by end of March 2022).
- Updating and ratification of the maternity Risk Management strategy (by end of March 2022).

- Provision of second obstetric theatre at Queen Elizabeth the Queen Mother Hospital (QEQM) (part of wider estates strategy under the Maternity Improvement Plan).

6. Compliance against Maternity Self-Assessment

6.1 The NHS Improvement Maternity Services System Learning: Maternity Self-Assessment tool was first published in February 2020 for NHS maternity services and private maternity providers to self-assess whether their operational service delivery meets national standards, guidance and regulatory requirements.

6.2 An updated version was published in July 2021. This incorporates the findings of the Ockenden review, 7 features of safety culture, the emerging themes from services on the safety support programme and areas the Care Quality Commission (CQC) found to be outstanding in other maternity units across England.

6.3 The tool is structured according to seven key areas which arose out of the Maternity Safety Support Programme (MSSP).

6.4 These include:

- directorate infrastructure and leadership;
- multi-professional team dynamics;
- governance infrastructure and ward to board accountability;
- application of national standards and guidance;
- positive safety culture across the division and trust;
- comprehension of business and impact on quality;
- meeting the requirements of equality and inequality and diversity legislation and guidance.

6.5 **Current Compliance**

The maternity team have reviewed the tool with the NHSE/I maternity advisor for East Kent Hospitals:

- 102 areas in the tool were rag rated as **Green.**
- 53 areas in the tool were rag rated as **Amber.**
- 3 areas in the tool were rag rated as **Red.**

6.6 **The areas that require attention are being actioned and monitored through our Maternity Improvement Plan. Overall governance, competent and safe staffed workforce, and professional behaviours demonstrating our values at all times** are the themes in our self-assessment.

6.7 See Appendix 4 for the full completed self-assessment tool and appendix 2 for the action plan prepared by the maternity service.

7. CNST Compliance

7.1 CNST year 4 Safety Action Implementation is in progress and updates are provided monthly to the Board of Directors via the Perinatal Quality Surveillance Tool and quarterly full update reports.

7.2 CNST reporting was paused in December 2021 for at least 3 months because of recognition of the impact of a further the Covid-19 surge on Trusts.

7.3 The Trust has continued to apply the principles and progress with implementation but await the revised guidance document for changes in year 4 requirements.

7.4 **Safety Action 1: Action 1** Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Year 3 achievement- MBRRACE confirmation to NHSR of Trust compliant against Standard.

Year 4 progress- Compliant against all standards confirmed by Quarterly reporting and PMRT Case Summary Report.

7.5 **Safety Action 2 – Maternity Services Data Set Submission**
Year 3- The Trust was fully compliant for year 3 for this Safety Action
Year 4- NHSR were to meet in mid-February to discuss changes to this standard and timelines for data submissions.
No further Scorecards will be released until this is agreed but the Data Quality is still available, and we have passed all 11 of the CQIMs for October, the target is 9 out of 11.
We passed all but one of the Midwifery Continuity of Care Data Quality Measures also, the non-compliant area is being reviewed.

7.6 **Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?**
Year 3- Declared full Compliance.
Year 4 progress- Obstetric Workforce: Paper to Board around Consultant attendance and audit of compliance.
Anaesthetic: Audit and rotas to be provided to measure compliance against anaesthetic standards.
Neonatal Clinical: Audit and rotas to be provided to benchmark against British Association of Perinatal Medicine (BAPM) junior workforce Standards.
Neonatal Nursing workforce: review completed and associated action plan in place.
Business case being progressed to support workforce requirements.

7.7 **Safety Action 6: Compliance with all five elements of the Saving Babies Lives Care Bundle**
Year 3 achievement - The Trust declared non-compliance against Element 3 - Computerised CTG for women attending with reduced Fetal Movements. This had been implemented and audit showed compliance but Trust Board was not assured that the process had been fully embedded as so new.
Year 4 progress - There is an area of risk around CO Monitoring at 36 weeks which is currently at 74.4%. The compliance standard is 80% and the Trust has a robust action plan in place and is working closely with the teams to mitigate.
Antenatal Steroid administration is below target of 80%. There is focussed work aligned to MatNeo National Drivers in progress to try to improve this.

7.8 **Safety Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?**
Year 3 achievement – Fully compliant Year 3.
Year 4 progress - Outstanding elements are Sign off of MVP workplan and process for CCG renumeration of expenses process for all members of the MVP.

7.9 **CNST Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?**
Year 3 achievement -Declared Compliance.
Year 4 progress- A TNA has been produced and is being taken through Governance for approval. Business case to support has been submitted. Trajectory and plan to meet compliance has been presented.

7.10 **CNST Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?**

Year 3 achievement- Declared non-compliance Year 3 as unable to demonstrate feedback received from January 2020 Safety Champion Walkabout. Quality Committee Paper by Board Safety Champion referenced doing the session but not the feedback received or actions. Safety Champion had left the Trust when this was exposed and evidence was being reviewed.
Year 4 progress- Compliant to date against Standards.

7.11 **Safety Action 10: Have you reported 100% Qualifying cases to Healthcare Safety Investigation Branch (HSIB)**
And or 2019/20 births To NHS Resolution Early Notification scheme?
Year 3 achievement - All required cases reported for 2020/2-21 period to HSIB.
Year 4 progress- Duty of Candour met and information provided on role of NHSR for all cases.
No cases reported by HSIB to NHS Resolutions Early Notification Scheme so far in this reporting period from 1 April 2021.

4. CQC Must and Should do Plan

4.5. The CQC undertook an unannounced inspection of the maternity services of East Kent Hospitals University Foundation Trust (EKHUFT) on 20 and 21 July 2021.

4.6. The inspection reports were published on 16 October 2021.

4.7. The maternity services developed a Maternity CQC Must and Should Do action plan which was approved by the Director of Midwifery and Chief Nursing and Midwifery Officer, reporting into, and with oversight from, the Maternity and Neonatal Assurance Group (MNAG).

4.8. There are 20 Recommendations with 59 sub actions addressed in the plan; 43 sub actions are complete (73%) and evidence is stored within the central CQC folder. Of the remaining 16 sub actions, 12% are dependent on other actions completing and have not yet started, and 15% are in progress (overdue). Details of the 27% (16 actions) of the plan to be delivered are provided in Table 1.

Table 6: Summary of Not Started / In progress (overdue) actions within Maternity CQC Must/ Should Do action plan

Recommendation (Must / Should Do)	No. Actions (Not started / Overdue)	Details
MD03.MAT.QEQM The service must ensure all staff receive an induction when working in areas they are not familiar with. (Regulation 18 (2) (a))	2	The local induction pack is due to be circulated with supporting guidance of when and how to complete the document, and where to store it so that completion rates can be monitored through the maternity governance structure
MD04.MAT. William Harvey Hospital (WHH) The service must ensure that it reviews the escalation policy and provides clear guidance to the expectations of safe working hours for on-call staff called into cover the unit so that community midwives are not working excessive hours that lead to lethargy and neurological impairment (Reg. 17 - Good Governance)	2	The Maternity Escalation Policy has been reviewed and is due to be launched at the end of March, supported by a series of communications to ensure people are aware of, and understand, the updated document

MD05.MAT.QEQM The service must ensure there are effective systems to assess, monitor and improve the quality and safety of the services provided. (Regulation 17 (2) (a)).	1	Installation due of Quality & Safety boards in maternity areas for sharing quality and safety information to encourage locally-driven improvements. In the meantime, the Women's Health governance structure is being finalised to provide robust monitoring of the care group's quality and safety data.
MD06.MAT.COMMUNITY The service must ensure that midwives working in the community have the required competencies and knowledge to autonomously assess the care for women and babies and make informed decisions regarding their care (Reg. 12 - Safe Care and Treatment)	1	Competencies to be added to SITREP discussions
MD10.MAT.QEQM.WHH The service must embed an effective system to ensure the service meets the Trust targets for mandatory training, including Safeguarding training, to protect vulnerable adults and children and young people from harm and abuse (Reg. 12 - Safe Care and Treatment)	1	As at December 2021, the maternity workforce is compliant with 15 of 21 modules (71.5%). The subjects currently below the compliance targets of 90% or 85%, are: - NLS: 88.8% against a target of 90% - Fire: unknown. Not recorded - SGA L3: 50.9% against a target of 85% - DEM: 61.5% against a target of 85% - HH: 50.7% against a target of 85% - Resus (Adult): 59.1% against a target of 85% We anticipate these figures to increase in January 22 dataset, and will contact all staff in person yet to complete their in-year statutory and mandatory training
SD03.MAT.WHH The Trust should consider implementing incident reporting and review training to all midwives, to nurture a culture of active reporting and learning from incidents, themes and trends	1	Department workforce to undertake incident reporting self-assessments to identify and inform any development needs

SD04.MAT.WHH The Trust should complete a review of the virtual consultations standard operating procedure to ensure that pregnant women and new mothers are appropriately assessed	2	A review of the SOP is underway and once approved will be published on the Trust's Policy Centre, supported by a series of communications to ensure people are aware of, and understand, the updated document
SD05.MAT.WHH The service should make sure that it monitors telephone calls from women using the service so that midwifery staffing can be adjusted to ensure qualified staff conduct telephone assessments	1	Decision to be made as to whether incidents involving triage calls not being handled by a midwife should be entered into Datix for recording, monitoring and service improvement purposes
SD06.MAT.WHH The service should consider monitoring the use of SBAR tool so that staff use it effectively and practice is embedded	4	SBAR processes for Maternity Services to be reviewed, and governance route for reporting, monitoring, and sharing learning to be agreed. Impact of shared learning to be measured through local SBAR audit work.
SD09.MAT.QEQM The service should consider displaying safety information	1	Pending installation of quality and safety boards
Expected date of completion	30 April 2022	

5. Summary of common themes from all reviewed documents

5.1 This paper sets out the Trusts position in relation to progress against the 7 Ockenden IEAs and plans to ensure full compliance, as requested by NHS England and NHS Improvement.

5.2 This includes:

- ✓ A benchmark against the 7 Ockenden Immediate and Essential Actions (IEA)
- ✓ Recommendations from the Kirkup, Morecambe Bay investigation report
- ✓ CNST safety actions
- ✓ Workforce plans
- ✓ Existing CQC action plan
- ✓ Maternity Self-Assessment Tool

5.3 The following common themes for the Maternity Service to address have been identified:

5.3.1 Appraisal rates remain below that required for Trust compliance. This is being addressed so that all appraisals will have been completed by 31 June 2022 (Maternity Self-Assessment, Morecambe Bay).

5.3.2 Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements will be in place May 2022 (Ockenden IEA 3 and 6, Morecambe Bay, Maternity Self-Assessment).

5.3.3 Personal Care and Support plans are not yet in place these are being coproduced through an LMNS workstream that includes MVP membership but isn't yet launched.

5.3.4 Information available to women in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites. A review of information has taken place by the MVP and a report imminent. Once received, information will be reviewed and updated to reflect the benchmarking exercise feedback (Ockenden IEA 7, Morecambe Bay)

Appendix 1: Letter Received regarding Ockenden one-year on requirements

Classification: Official
Publication approval reference: PAR1318

To: NHS Trust and Foundation Trust Chief Executives

cc. Trust Chairs and Directors of Nursing
ICS, CCG, LMS Leaders,
Regional Directors,
Regional Chief Nurses,
Regional Chief Midwives,
and Regional Obstetricians

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

25 January 2022

Dear colleagues,

Ockenden review of maternity services – one year on

Thank you for all your efforts in response to the Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust published in December 2020, and for your continued focus on the Immediate and Essential Actions (IEAs) despite the sustained pressure on your services throughout the pandemic. As well as ensuring progress continues, we need to prepare for the publication of further reports into maternity services during 2022.

The national response to the Ockenden report included a £95.6M investment into maternity services across England including funding for:

- 1200 additional midwifery roles,
- 100 wte equivalent consultant obstetricians,
- backfill for MDT training
- International recruitment programme for midwives
- Support to the recruitment and retention of maternity support workers

In our letter of 14 December 2020, we asked you to use the Assurance Assessment Tool, which includes the recommendations from the Morecambe Bay investigation report and the Ockenden report, to support a discussion at your trust public Board. One year on, we are asking that you again discuss progress at your public Board before the end of March 2022.

We expect the discussion to cover:

- Progress with implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance,
- Maternity services workforce plans,

Ensuring local system oversight of maternity services was a key element in the Ockenden review and therefore you should ensure progress is shared and discussed with your LMS and ICS. Progress must also be reported to your regional maternity team by 15 April 2022.

As you will no doubt agree, women and families using our maternity services deserve the best of NHS care. We recognise the huge efforts being made across the system and thank you for your continued commitment and support in driving the improvements required.

Yours faithfully

Sir David Sloman
Chief Operating Officer
NHS England and NHS Improvement

Ruth May
Chief Nursing Officer, England
NHS England and NHS Improvement

East Kent Hospitals University NHS Foundation Trust

Appendix 2: Ockenden and CNST Assessment and Assurance Tool- February 2022

Section 1

Immediate and Essential Action 1: Enhanced Safety
Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

Q1. Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

Q2. External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

Q3. All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Q4. Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Q5. Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Q6. Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:
Q7. (a) A plan to implement the Perinatal Clinical Quality Surveillance Model
Q8. (b) All maternity Sis are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?	RAG	
IEA1: Overall compliance as assessed by NHSE in 2021 was 81%							**Question Compliance as assessed by NHSE in 2021 was**	**Current RAG**
Q1. **Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.** **Maternity Dashboard presented to LMS every 3 months.** • Maternity Dashboard with Nationally driven KPIs • LMNS Maternity and Neonatal Quality Assurance Board established where the Dashboard is discussed • Trust Maternity and Neonatal Assurance (MNAG) ToR, agendas and minutes (reports to Board) where Dashboard reviewed. • Shared Learning through the LMS forums • Governance, Fetal Wellbeing Midwives and Better Births Midwives providing link between Maternity and LMS • Monthly reporting of Improvement Plan Progress, including CNST and Ockenden recommendations through the Maternity and Neonatal Improvement Group, with LMNS representation, into Trust Board • Implementation of the Perinatal Quality Surveillance Model reporting tool	• Reviewed and improved Governance processes to ensure embedded learning from risk and incidents as well as good practice • Monthly maternity dashboard exception report to MNAG – attended by LMNS • Comparing and benchmarking performance of key KPIs across LMNS used to support improvement across service • Maternity and Neonatal Assurance Group supports joining up of conversations and improvement pathway action plans across maternity, neonatal and anaesthetic teams i.e. Maternity Specific training, clinical outcomes, trends • Early enquiry and exploration of evidence to inform actions	Through the exception reporting 100% 1:1 care in labour QEQM since July- 7 months. WH 98.7-100% • Supernumerary Labour Suit Status QE 99.2, WHH 96%-action plan in place • Fully compliant against CNST PMRT Standards • Fetal Monitoring and PROMPT Training Compliance over 90% for maternity staff groups • Reduction in referrals to HSIB • Reduction in Term stillbirths • Reduction in Neonatal Deaths • Average Avoidable Term Admission remains below national (National ATAIN Target 5%) • Reduction in Cooling Babies Reduction in babies <37weeks gestation requiring therapeutic cooling • Breast feeding rates above National benchmark (68.7%) at 71.6% January 2022 • Feedback has supported refinement of reporting processes to maximise sharing of the right information	• Working with LMNS to finalise shared Dashboard - this will further support shared learning and early alerting of outlying data trends.	• Led by LMNS and supported by maternity representatives from each Trust	NA	• Continue to share Trust Dashboards at LMNS Maternity and Neonatal Quality Board, as well as Trust MNAG and Trust Board	**100%**	

East Kent Hospitals University NHS Foundation Trust

• LMS Perinatal Quality Surveillance model established- Guideline demonstrates how the trust reports this both internally and externally through the LMS – • Clinical Governance Meeting agenda and minutes • Organogram • Women's Health Risk and Governance Strategy • Care Group Structure Chart	/risk/ escalation in for example: ○ 3rd degree tears ○ Elective Caesarean Rates ○ Emergency Caesarean Rates ○ Booking before 12+6 ○ Booking and Delivery rates	• Safety Champion support in escalating and resolving issues raised by staff						
Q2. **External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.** • All HSIB cases referred • External membership Perinatal review Meetings at PMRT • Change in PMRT Governance to improve membership, frequency and ensure standards and timelines are met. • External review of all perinatal losses and Still Birth cases • External membership of Maternity and Neonatal Assurance Group and oversight of dashboard and improvement plan • Audit to demonstrate external PMRT membership and review of all cases and that women views are sought. • Guideline for involving external clinical specialists in reviews in place • LMS PQSM Guideline • Incident Management Policy, • Maternal Death Policy • Risk and Governance Strategy • MNAG ToR • PMRT Board Report • Perinatal Meeting Terms of Reference and Example attendee lists, • CNST Year 4 Safety Action 1 Quarterly Reports	• Fresh eyes and unbiased scrutiny of processes and care provision • Welcoming and responding to received feedback • Early awareness and opportunity for shared learning • Positive relationship building • Where indicated learning is taken back through the MNAG • MBRRACE reporting-PMRT Board generated reports and Case summary lists to evidence compliance Sharing of action plans and thematic analysis of areas for	• Learning from and best practice • 100% of PMRT reviews from February 2022 have had an external reviewed • Learning from staff attending as external reviewers at other Trusts. • 100% compliant with CNST Safety Action 1 standards • TNA responsive to actions • External clinical opinions are being sought appropriately • Quarterly HSIB meetings	• LMNS Approach to increasing pool of external reviewers to support timely reviews and mitigate risk of cancelling.	LMS and Maternity Team June 2022	LMS Support	• Continue to escalate early whenever risk of non-compliance and reach out widely to known staff for support as well as logging with LMNS Bureau	**100%**	
Q3. **Maternity SI's are presented to Trust Board & LMS every 3 months.** • Perinatal Quality Surveillance Tool shares SI data monthly • SI reports going to Trust Board along with PQSRT • Presentations and discussions at Clinical Governance Meetings. Minutes and agendas to evidence • SI Pathway Map, defined roles and responsibilities within Sis, SI Terms of Reference • LMS Perinatal Quality Surveillance Model reporting structure in place with guideline and pathway of reporting/review defined • Women's Health Risk and Governance Strategy – SI process captured • February 2022- Monday, Wednesday and Friday Care group led Rapid review process, with onward presentation to Executive SI panel	• Reported and discussed through Perinatal Quality Surveillance Tool Report into ○ Maternity Governance ○ Maternity and Neonatal Assurance Group ○ Trust Board ○ Extract taken into LMNS Maternity and Neonatal Quality Assurance Board • Proactive Rapid review process meeting initiated as touchpoint to discuss review cases with Triumvirate, provide oversight and facilitate communication, sharing, learning and action • Executive oversight by CNO and CMO to review all suspected Sis • Thematic analysis and individual lessons learnt shared with staff to improve safety and quality of care	• Reduction in recurring themes • Reduction SI's	• Ongoing Board Paper-SI reporting directly to Trust Board	LMS and Maternity Governance Matron	NA	NA	**100%**	
Q4.	• Expanding frequency and	• Audit completed since last submission	• LMNS Approach to	• LMS and	• LMS Support	Continue to escalate	50%	

East Kent Hospitals University NHS Foundation Trust

Using the National Perinatal Mortality Review Tool to review perinatal deaths. • Audit of PMRT completed demonstrating parents notified in all cases and external review in all cases since January 2021.This was area of non-compliance phase 2 • Compliant against PMRT CNST Standards for year 1, 2, 3 and year 4 to date • Quarterly PMRT Reports are provided through Governance processes to Trust Board and include Case Summary report and PMRT Board Generated Report. • PMRT Guideline describes how parents and women are involved in the PMRT process as per the PMRT guidance • Change in PMRT Governance to improve membership, frequency and ensure standards and timelines are met. • Audit to demonstrate external PMRT membership and review of all cases and that women views are sought. • Guideline for involving external clinical specialists in reviews • Perinatal Mortality Review Meeting Terms of Reference and Example attendee lists • Monthly reporting through the PQST into MNAG and Trust Board	attendance at the PMRT meetings to support case review and maximise learning. • Monthly reporting through the PQST into MNAG and Trust Board ensures oversight of cases and themes • Quarterly reports give oversight of compliance against CNST and MBRRACE standards and delivery of action plans.	which was area of non-compliance • 100% Compliant against standard. Monitored through PMRT • Case Summary and action plans generated through PMRT • Standard met CNST Year 1 and 2. • Parental views sought. • Multidisciplinary representation at review meetings. • External membership at review panel.	increasing pool of external reviewers to support timely reviews and mitigate risk of cancelling.	Maternity • June 2022		early whenever risk and reach out widely to known staff for support as well as logging with LMNS Bureau		
CNST Action 1 Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Year 3 achievement- MBRRACE confirmation to NHSR of Trust compliant against Standard. Waiting for formal CNST reporting for Year 3 to be published. Year 4 progress- Compliant against all standards confirmed by Quarterly reporting and PMRT Case Summary Report.							
Q5. **Submitting data to the Maternity Services Dataset to the required standard** • Compliance achieved on required standards for CNST Year 1, 2 and 3 • CNST Action plan in place. • Awaiting further timescales for reporting from NHSR • Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	• The data generated MSDS is used to look at outcomes, health inequalities, commissioning	• Tracking of Score card data when received with leads and PQST Trust Board reporting supports awareness and oversite	• The MSDS part of CNST won't be measured on January data now-NHSR are meeting in mid-Feb to discuss when that will take place. • Resolve issues in submitting data via Euroking MIS to reduce manual corrections	Information Lead 30.06.22	Euroking, LMNS and Trust IT support in resolving data submission issues via MIS	Submit data directly	100%	
CNST Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?	**Year 3 achievement** • Standard declared as compliant. Waiting for published CNST report to confirm. **Year 4 progress** • Meeting 11/11 of the Quality metrics. Data submitted via Euroking Maternity Information System not being accurately received into the Maternity Services Data Set. Data Analyst working with provider to resolve and are confident this will be in time to meet standard requirements.							
Q6. **Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme**. • 100% compliance achievement demonstrates effective systems and processes in place	• 100% of cases reported against standard demonstrate transparency. • Early identification of actions • Monthly tracking of evidence with leads and inclusion within PQST Trust Board reporting supports awareness and oversite	• All required cases reported for 2020/2-21 period to HSIB • Duty of Candour met and information provided on role of NHSR for all cases. • No cases reported by HSIB to NHS Resolutions Early Notification Scheme so far in this reporting period from 1 April 2021	NA	Process embedded Risk Lead MW	NA	NA	**100%**	
CNST Action 10:	**Year 3 achievement**							

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Have you reported 100% Qualifying cases to HSIB And or 2019/20 births To NHS Resolution Early Notification scheme? CNST published compliance report once received	• All required cases reported for 2020/2-21 period to HSIB **Year 4 progress** • Duty of Candour met and information provided on role of NHSR for all cases. • No cases reported by HSIB to NHS Resolutions Early Notification Scheme so far in this reporting period from 1 April 2021							
Q7. **Plan to implement the Perinatal Clinical Quality Surveillance Model** • Implement the Perinatal Clinical Quality Surveillance Model Internal Governance process for monthly reporting into the MNAG and Trust Board • Perinatal Clinical Quality Surveillance Model Guideline and governance structure in place for reporting into LMNS and the region. • Full evidence of full implementation of the perinatal surveillance framework IN PLACE September 2021. • LMS minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS. • Safety Messages flow chart showing local reporting process and into LMNS and Region	• PQST Monthly tracking of evidence with leads and inclusion within MNAG and Trust Board reporting supports awareness and oversight	• Actions reported the previous month are not repeated through learning at Trust and System Level • Reports received each month and agenda item on MNAG for discussion	NA	NA	NA	NA	**33%**	
Q8. **All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB** • Perinatal Quality Surveillance Tool shares SI data monthly • SI reports going to Trust Board along with PQSRT • Presentations and discussions at Clinical Governance Meetings. Minutes and agendas to evidence • SI Pathway Map, defined roles and responsibilities within Sis, SI Terms of Reference • LMS Perinatal Quality Surveillance Model reporting structure in place with guideline and pathway of reporting/review defined • Women's Health Risk and Governance Strategy – SI process captures on pages 30 and 31 • February 2022- Monday, Wednesday and Friday Care group led Rapid review process, with onward presentation to Executive SI panel	• Reported and discussed through Perinatal Quality Surveillance Tool Report into ○ Maternity Governance ○ Maternity and Neonatal Assurance Group ○ Trust Board ○ Extract taken into LMNS Maternity and Neonatal Quality Assurance Board • Proactive Rapid review process meeting initiated as touchpoint to discuss review cases with Triumvirate, provide oversight and facilitate communication, sharing, learning and action • Executive oversight by CNO and CMO to review all suspected Sis • Thematic analysis and individual lessons learnt shared with staff to improve safety and quality of care	• Reduction in recurring themes • Reduction SI's •	• Ongoing Board Paper-SI reporting directly to Trust Board	LMS and Maternity Governance Matron	NA	NA	**100%**	

Immediate and Essential Action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

Q9. Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. **No expectation that this action is met - national guidance awaited**
Q10. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. **No expectation that this action is met - national guidance awaited**
Q11. Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Q12. Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Q13. Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Q14. Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified **issues?**

Link to urgent clinical priorities:

Q15. (a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.

East Kent Hospitals University NHS Foundation Trust

Q16. (b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.								
What do we have in place currently to meet all requirements of IEA 2?	**How will we evidence that we are meeting the requirements?**	**How do we know that these roles are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**	**RAG**	
IEA2: Overall compliance as assessed by NHSE in 2021 was 88%							**Compliance as assessed by NHSE in 2021 was**	**Current RAG**
Q 11. **Non-executive director who has oversight of maternity services** • **NED Safety Champion in Place** • Safety Champion Posters • NED Job Description • MNAG and Trust Board minutes showing NED discussion • Maternity and Neonatal Assurance Group Terms of Reference demonstrating membership • SBLCBV2 Quarterly reports to MNAG • Continuity of Care plan and paper to MNAG and Trust Board • Evidence of how all voices are represented: • Evidence of link in to MVP: through attendance at the MNAG • Email confirmation of appointment	• Oversee delivery of the Maternity Improvement plan which includes regulator, CQC and CNST recommendations and actions and Improvement Workstream progress through MNAG and Trust Board • Monthly Safety Champion Meetings with key clinical leads • Reporting of Safety and Quality through MNAG	• Raised Board Awareness of Maternity Improvement Programme, CNST, Specialist Lead Roles and impact • Delivery of actions are robustly considered including supporting evidence	• Strengthen NED walk arounds and subsequent actions	Improvement and Transformation Manager 30.03.22	NA	NA	**100%**	
Q13. **Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity** • Co-produced forward plan on how to improve communication with women through the MVP • Table top exercise completed to triangulate themes from complaints, I and MVP feedback – informed MVP workplan for 21/22 Planning event held 19.1.22 to coproduce a work programme to increase the amount of feedback received from women through proactive measures • this was the area of noncompliance for phase 2 • Evidence of service user feedback being used to support improvement in maternity services -you said, we did, • FFT amended in response to service user feedback • 15 Steps action plans • CNST evidence of co-production in submitted evidence. • CNST evidence review signed off by the MVP. • Service user feedback repository • Maternity Strategy coproduced document • Safety Champion feedback repository/action plan • MVP Meetings well represented • Have a mechanism for gathering service user feedback in place and work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services • Quarterly updates of feedback are captured, within a repository,	• Examples of co-production include development of the Maternity Strategy, Continuity of Carer Working Party Group, Whose Shoes event, • Attenders and membership at Maternity and Neonatal Assurance Group • Antenatal pathway mapping 17/1/22 • MVP chair attendance on interview panels on interview panels • Repository of feedback • You Said We Did Boards • 'Your voice or future' working party group	• Increase in feedback from women and decrease in complaints, PALS, Social Media, FFT. • Listening to feedback • Demonstrating improvement • Implementation of change as a consequence of feedback e.g. 15 steps Challenge • Close working relationships with both the MVP and Healthwatch. influenced Maternity Strategy and • MVP chair member of MNAG • Feedback demonstrates actions completion of actions from You Said We Did	• Sign off of MVP workplan • Renumeration of expenses process for all members of the MVP • Update action plan to address any gaps not addressed after receipt of CQC user survey	MVP March 2022	CCG Process for renumeration	• Conversation taking place to mitigate and capture in MVP minutes and as agenda item March meeting	**67%**	

East Kent Hospitals University NHS Foundation Trust

• This repository describes the feedback mechanism, how frequently it is captured, where it is captured, themes and examples of the feedback, examples of how this has been responded to and evidence documents to support the narrative. • Appointment of 2 patient experience midwives • MVP Chair involved in recruitment for key roles								
CNST Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	**Year 3 achievement** Declared Compliance Year 3 **Year 4 progress** Outstanding elements are Sign off of MVP workplan and process for CCG renumeration of expenses process for all members of the MVP							
Q 14. **Trust safety champions meeting bimonthly with Board level champions** • Monthly Safety Champion update within Perinatal Quality Surveillance Tool Report • Safety Champion Maternity and Neonatal Assurance Group Reports • You Said We Did Boards • MNAG Agendas and Minutes of Discussions • Repository of Safety Champion Feedback from walkabouts	• Perinatal Quality Surveillance Tool Report • Safety Champion Maternity and Neonatal Assurance Group Reports • MNAG Agendas and Minutes of Discussions • Repository of Safety Champion Feedback from walkabouts Action log and actions taken. • TOR that includes role descriptors for all key members who attend by-monthly safety meetings.	• Provides Board to Ward understanding of issues • Supports unblocking of issues • Opportunity to celebrate success	• Minutes of the meeting and minutes of the LMS meeting where this is discussed.	Continue to capture impact and from embedding of the Safety Champions Process	NA	NA	**100%**	
CNST Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	**Year 3 achievement** Declared non-compliance Year 3 as unable to demonstrate feedback received from January 2020 Safety Champion Walkabout. Quality Committee Paper by Board Safety Champion referenced doing the session but not the feedback received or actions. Safety Champion had left the Trust when this was exposed and evidence was being reviewed. **Year 4 progress** Compliant to date against Standards							
Q 15. Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. • Co-produced forward plan on how to improve communication with women through the MVP • Table top exercise completed to triangulate themes from complaints, I and MVP feedback – informed MVP workplan for 21/22 Planning event held 19.1.22 to coproduce a work programme to increase the amount of feedback we receive from women through proactive measures • this was the area of noncompliance for phase 2 • Evidence of service user feedback being used to support improvement in maternity services -you said, we did, • FFT amended in response to service user feedback • 15 Steps action plans • CNST evidence of co-production in submitted evidence. • CNST evidence review signed off by the MVP. • Service user feedback repository • Maternity Strategy coproduced document • Safety Champion feedback repository/action plan • MVP Meetings well represented • We do have a robust mechanism for gathering service user feedback in place and work with service users through your	• Examples of co-production include development of the Maternity Strategy, Continuity of Carer Working Party Group, Whose Shoes event, • Attenders and membership at Maternity and Neonatal Assurance Group • Antenatal pathway mapping 17/1/22 • MVP chair attendance on interview panels on interview panels • Repository of feedback • You Said We Did Boards • 'Your voice or future' working party group	• Increase in feedback from women and decrease in complaints, PALS, Social Media, FFT. • Listening to feedback • Demonstrating improvement • Implementation of change as a consequence of feedback e.g. 15 steps Challenge • Close working relationships with both the MVP and Healthwatch. influenced Maternity Strategy and • MVP chair member of MNAG • Feedback demonstrates actions completion of actions from You Said We Did	• Sign off of MVP workplan • Renumeration of expenses process for all members of the MVP	MVP March 2022	CCG Process for renumeration	• Conversation taking place to mitigate and capture in MVP minutes and as agenda item March meeting	**0%**	

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Maternity Voices Partnership (MVP) to coproduce local maternity services • Quarterly updates of feedback are captured, within a repository, • This repository describes the feedback mechanism, how frequently it is captured, where it is captured, themes and examples of the feedback, examples of how this has been responded to and evidence documents to support the narrative. • Appointment of 2 patient experience midwives • MVP Chair involved in recruitment for key roles								
Q 16. **Non-executive director supports the Board maternity safety champion** • Safety Champion Posters • NED JD • Trust Board minutes showing NED discussion • Maternity Evidence Review Meeting Terms of Reference for CNST showing NED attendance on panel • email confirmation of NED acceptance to Maternity Safety Champion role • Safety Champions Poster • Maternity Evidence Review Meeting Terms of Reference, • Safety Messages Flowchart • Maternity and Neonatal Assurance Group Terms of Reference • SBLCBV2 Quarterly reports to MNAG • Continuity of Care plan and paper to MNAG and Trust Board • Evidence of link in to MVP: through attendance at the MNAG	• Oversee delivery of the Maternity Improvement plan which includes regulator, CQC and CNST recommendations and actions and Improvement Workstream progress through MNAG and Trust Board • Monthly Safety Champion Meetings with key clinical leads • Reporting of Safety and Quality through MNAG	• Raised Board Awareness of Maternity Improvement Programme, CNST, Specialist Lead Roles and impact • Delivery of actions are robustly considered including supporting evidence	• Strengthen NED walk arounds and subsequent actions • Photo to be added to poster	Improvement and Transformation Manager 30.03.22	NA	NA	**100%**	
Immediate and essential action 3: Staff Training and Working Together **Staff who work together must train together** Q17. Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. Q18. Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. Q19. Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.								
Link to Maternity Safety actions: **Q20. Action 4:** Can you demonstrate an effective system of clinical workforce planning to the required standard? **Q21. Action 8:** Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?								
Link to urgent clinical priorities: Q22. (a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Q23 (b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place								
What do we have in place currently to meet all requirements of IEA 3?	**What are our monitoring mechanisms?**	**Where will compliance with these requirements be reported?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**	**RAG**	

East Kent Hospitals University NHS Foundation Trust

IEA3: Overall compliance as assessed by NHSE in 2021 was **72%**							Question Compliance as assessed by NHSE in 2021 was	Currant RAG
Q 17. **Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.** • Training Matrix in place demonstrating Training Content aligned Core Competency Framework • Evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session is presented on the Training Tracker LMS report showing review of training data (attendance, compliance coverage) and training needs assessment • Trajectory is mapped on the training tracker to meet and maintain compliance • Monitoring of training through MNAG meeting agenda and minutes and presentation of update papers to which the LMNS attend • PQSRT Reporting of training data monthly to MNAG and Trust Board • Fetal monitoring face to face training in place supported by competency assessment • PROMPT virtual in place • Training content reviewed in workshop to ensure content is fully aligned to Core Competency Framework • New training programme developed around 5 day blocks • The LMNS Quality Assurance Group (QAG) now has core competency assessment on the agenda three times a year and this is supported through a workforce and training forum • This is then reported by exception to the Regional Maternity and Neonatal Safety and Concerns Group (RMNSCG) from the LMNS QAG.	• Training Tracker and trajectory reported through maternity governance, as well as MNAG to Q&S as well as Trust Board • PQST reporting to Trust Board and MNAG • LMNS attendance at Maternity and Neonatal Assurance Group • LMNS Training Assurance PP populated with EK data • LMNS Training Assurance Board Minutes • LMNS Training Assurance ToR demonstrating attendance by the EK PD team	• Women's Health Governance • Internal Governance through MNAG, Trust Board • Training compliance update papers and monthly PQSRT Reports • The LMNS Quality Assurance Group (QAG) now has core competency assessment on the agenda three times a year and this is supported through a workforce and training forum that is led by Andrea Curling (LMNS workforce lead MW), the first meeting of which was held in November 2021. • This is then reported by exception to the Regional Maternity and Neonatal Safety and Concerns Group (RMNSCG) from the LMNS QAG. Meeting notes and agenda requested to evidence	• Translate the Training Matrix into a full TNA • Training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Final approval of Business case to increase faculty • Sourcing of appropriate facility for training to take place	TNA-PD Team March 2022 Estates-MNAG	Approval of Business case	Maintain existing training programme	**60%**	
Q 18. **Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.** • Consultant led MDT ward rounds take place twice a day at WHH and QEQM sites • Guideline updated to include consultant led ward rounds. • In place and embedded • Captured on the SNAP tool audit • Audit of compliance in place	• Auditing of compliance attendance through capture on SNAP tool • Escalation to Midwifery Manager on call if Consultant doesn't attend Ward Round	• Updates through Clinical workforce biannual papers to Maternity and Neonatal Assurance Group through to Trust Board	• Biannual Clinical Workforce Papers • SNAP Tool findings to be reported through Governance •	Clinical Director April 2022	• Clarification of content requirements for Bi annual clinical workforce papers.	• Workforce paper being prepared and clarification being sought via Maternity Support Programme aligned contact	**50%**	
CNST Action 4: **Can you demonstrate an effective system of clinical workforce planning to the required standard?**	**Year 3 achievement** Declared Compliant **Year 4 progress** Obstetric Workforce: Paper to Board around Consultant attendance and audit of compliance Anaesthetic: Audit and rotas to be provided Neonatal Clinical: Audit and rotas to be provided Neonatal Nursing workforce: review completed and associated action plan in place. Business case not able to be submitted to support workforce requirements.							
Q 19. **External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only** • Training funding is ringfenced in finance budgets for Maternity.	• Register of all funding and how it was spent available • Training funding is ringfenced in finance budgets for Maternity	• Training plan that is developed each year by the care group and signed off by leadership team • This is then discussed at the workforce meetings and senior matron meetings	• To agree process of reporting training funding and spends at Care group Formal Senior	Education Leads, Care Group Leadership, Finance, HR	NA	NA	100%	

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• HEE Safer Maternity training funds supported the implementation of a programme aligning to National Safety 2018 • Leadership Training funding accessed through NHSE/I - training. Matrons have completed connected leadership, Band 7 bespoke leadership programme commences May 2022 • Register of all funding and how it was spent available • MTP spend reports to LMS Maternity -LMS invoicing spreadsheet • Training Plan Proforma • Email from Care Group Finance Lead detailing LMS spend, Business Case for CNST - training sections highlighted, Example Medical Rota QEQM showing time allocated for study leave, Consultant Contract Template section 5.5. shows allocation of SPA time and Study Leave, Consultant Contract Ts and Cs Schedules 3 and 18 detail SPA time, teaching sessions feedback, Maternity Study Days Report from Healthroster • Email from Finance Team showing requisitions raised for Maternity Training,	• MTP spend reports to LMS Maternity -LMS invoicing spreadsheet • LMS invoicing spreadsheet • Maternity Study Days Report from Healthroster	• Process to be agreed as currently there isn't a specific forum to track training expenditure.	Management Meeting • Embed process to ensure that the training plan that is developed each year by the care group and signed off by leadership team, is then discussed at the workforce meetings and senior matron meetings	In place				
Q 21. **90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session** • Training Matrix in place demonstrating Training Content aligned Core Competency Framework • Evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session is presented on the Training Tracker LMS report showing review of training data (attendance, compliance coverage) and training needs assessment • Trajectory is mapped on the training tracker to meet and maintain compliance • Monitoring of training through MNAG meeting agenda and minutes and presentation of update papers to which the LMNS attend • PQSRT Reporting of training data monthly to MNAG and Trust Board • Fetal monitoring face to face training in place supported by competency assessment • PROMPT virtual in place • Training content reviewed in workshop to ensure content is fully aligned to Core Competency Framework • New training programme developed around 5 day blocks • The LMNS Quality Assurance Group (QAG) now has core competency assessment on the agenda three times a year and this is supported through a workforce and training forum • This is then reported by exception to the Regional Maternity and Neonatal Safety and Concerns Group (RMNSCG) from the LMNS QAG.	• Training Tracker and trajectory reported through maternity governance, as well as MNAG to Q&S as well as Trust Board • PQST reporting to Trust Board and MNAG • LMNS attendance at Maternity and Neonatal Assurance Group • LMNS Training Assurance PP populated with EK data • LMNS Training Assurance Board Minutes • LMNS Training Assurance ToR demonstrating attendance by the EK PD team	• Women's Health Governance • Internal Governance through MNAG, Trust Board • Training compliance update papers and monthly PQSRT Reports • The LMNS Quality Assurance Group (QAG) now has core competency assessment on the agenda three times a year and this is supported through a workforce and training forum that is led by Andrea Curling (LMNS workforce lead MW), the first meeting of which was held in November 2021. • This is then reported by exception to the Regional Maternity and Neonatal Safety and Concerns Group (RMNSCG) from the LMNS QAG. Meeting notes and agenda requested to evidence	• Translate the Training Matrix into a full TNA • Training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Final approval of Business case to increase faculty • Sourcing of appropriate facility for training to take place	TNA-PD Team March 2022 Estates-MNAG	Approval of Business case	Maintain existing training programme	**67%**	
CNST Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	**Year 3 achievement** Declared Compliance **Year 4 progress** TNA Produced and being taken through Governance for approval. Business case to support has been submitted. Trajectory and plan to meet compliance has been presented							

East Kent Hospitals University NHS Foundation Trust

Q 22 **Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.** • Consultant led MDT ward rounds take place twice a day at WHH and QEQM sites • Guideline updated to include consultant led ward rounds. • In place and embedded • Captured on the SNAP tool audit • Audit of compliance in place	• Auditing of compliance attendance through capture on SNAP tool • Escalation to Midwifery Manager on call if Consultant doesn't attend Ward Round	• Updates through Clinical workforce biannual papers to Maternity and Neonatal Assurance Group through to Trust Board	• Biannual Clinical Workforce Papers • SNAP Tool findings to be reported through Governance • Need to ensure B7 Coordinators are aware of need to escalate if non attendance	Clinical Director April 2022	• Clarification of content requirements for Bi annual clinical workforce papers.	Workforce paper being prepared and clarification being sought via Maternity Support Programme aligned contact	**100%**	

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Q24. Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

Q25. Women with complex pregnancies must have a named consultant lead

Q26. Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Q27. Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

Q28. (a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
Q29. (b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?	RAG	
IEA4 Overall Compliance as assessed by NHSE in 2021 was 86%							**Compliance as assessed by NHSE in 2021 was**	**Current RAG**
Q 24. **Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre** • Antenatal Care Guideline • Antenatal Clinical Risk Guideline • Consultants Obstetricians referral to and attendance on Labour Ward • Obstetric Scanning Guideline • Antenatal Screening Guideline • Women's Health Risk and Governance Strategy • Care Plan Audit	• Care Plan Audit Findings 2020 • 21/22 Audit Programme - Maternity Care Plans scheduled for re-audit	• Audit data shared at audit meetings and risk and Governance meetings	• SOP to be developed that includes referral pathways and criteria for referral to the maternal medicines centre pathway • Committed to supporting Regional Tertiary Maternal • Medicine Centres and contributing to plans	SMT, Trust Exec Team, LMS, Regional Teams	Further guidance and support as available	Continue with internal early referral to Fetal Medicine Team	**100%**	
Q 25. **Women with complex pregnancies must have a named consultant lead** • Maternal Medicine Lead Consultants on each Acute site • Specialist Consultant Leads for perinatal Mental Health,	• The standard is that every women who is high risk has a named Consultant, this is recorded on the Maternity Dashboard	• Dashboard is presented monthly at Performance Review Meeting and Maternity and Neonatal Assurance Group.	Improve recording compliance -Currently 44%	Site HOMS Site Obstetric Leads	NA	NA	**100%**	

• Diabetes, Pre-term, Twins and Fetal Medicine. • We have acute and satellite sites for Renal Medicine • We are the Regional Stroke Centre • Cardiac, Neurology and Gastro through Links to London • Hospitals								
Q 26. **Complex pregnancies have early specialist involvement and management plans agreed** • Guidelines that identify where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams and referral pathways: ○ Antenatal Care Guideline ○ Antenatal Clinical Risk Guideline ○ Consultants Obstetricians referral to and attendance on Labour Ward ○ Obstetric Scanning Guideline ○ Antenatal Screening Guideline ○ Women's Health Risk and Governance Strategy • Antenatal Assessment Guideline to support early referral of defined conditions • Early Consultant Appointment to enable early referral and shared care • Care Plan Audit	• Care Plan Audit Findings: 30.3%-43% between Jan and March 20 had a management plan made at booking, Where women had risk factors requiring a referral to other specialities there was initially poor documentation of a plan of care (42% for January). During the course of the audit compliance improved to 68% of women having a clearly documented plan of care where other specialities were involved • 21/22 Audit Programme - Maternity Care Plans scheduled for re-audit	• Audit data shared at audit meetings and risk and Governance meetings	• Progress Personalised care and support plans • Formalise referral criteria and pathways internal and external to trust	SMT, Trust Exec Team, LMS, Regional Teams June 2022	Further guidance and support as available	Continue with internal early referral to Fetal Medicine Team	**100%**	
Q 27. **Compliance with all five elements of the Saving Babies' Lives care bundle Version 2** • Fetal Wellbeing Midwives for each acute site leading on care bundle delivery • 2 fetal monitoring midwives appointed and lead Obstetrician on each consultant unit to lead on element 4 • Smoking Cessation Midwife in post • PQST Monthly reporting of progress and risk through the Maternity and Neonatal Assurance Group • Quarterly reporting against compliance with all five elements of the Saving Babies' Lives care bundle V2 • Audits for each element. • Guidelines with evidence for each pathway • Dashboard section for SBLCB to track compliance • Perinatal Optimisation MatNeo Sip QI project in line with National Drivers	• Audits for each element. • Dashboard section for SBLCB to track compliance monthly • CNST Project/action plan • Neonatal optimisation We care watch metric	• Women's Health Governance • PQST Monthly reporting of progress and risk through the Maternity and Neonatal Assurance Group (MNAG) • Summary report from above into the LMNS Maternity and Neonatal Quality Board and Region. • Quarterly reporting against compliance with all five elements of the Saving Babies' Lives care bundle Version 2 into MNAG • Quarterly Care Bundle reporting into the Region (currently paused)	• Focus on improving CO monitoring compliance at 36 weeks • Focus on pre-term steroid administration	Smoking Cessation MW, Fetal Wellbeing MW Community Matrons Obstetric Consultants/LW leads	30 June 2022	Deep dive reporting down to themes and staff/staff groups to understand reasons for compliance	**100%**	
CNST Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	**Year 3 achievement** Declared non-compliance against Element 3- Computerised CTG for women attending with reduced Fetal Movements. Had been implemented and audit showed compliance but Board not assured process fully embedded as so new **Year 4 progress** Area of risk-CO Monitoring at 36 weeks. Antenatal Steroid administration is below target. Focussed work aligned to MatNeo National Drivers in progress top try to improve.							
Q 28. **All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.** • Maternal Medicine Lead Consultants on each Acute site • Specialist Consultant Leads for perinatal Mental Health, • Diabetes, Pre-term, Twins and Fetal Medicine.	• The standard is that every women who is high risk has a named Consultant, this is recorded on the Maternity Dashboard	Dashboard is presented monthly at Performance Review Meeting and Maternity and Neonatal Assurance Group.	Improve recording compliance -Currently 44%	Site HOMS	NA	NA	**100%**	

East Kent Hospitals University NHS Foundation Trust

• We have acute and satellite sites for Renal Medicine • We are the Regional Stroke Centre • Cardiac, Neurology and Gastro through Links to London Hospitals								
Q 29. **Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres** • Agreed pathways-to be mapped and developed • Criteria for referrals to MMC- to be mapped and developed • Email demonstrating discussions are ongoing re maternal medicine centres • KSS regional presentation that outlined the work • Presentation that was delivered at the LMNS June operational board, with the tracking docs from that meeting that indicate that EKHUFT were represented there • Audit tool that was completed by all K&M providers and sent to the KSS regional network in August 2022 • There is work being scoped with the LMNS for a system wide approach. • Evidence of MMC LMNS discussions around pathways and criteria to support future plans ○ emails and LMNS working party group work to ○ Agreed pathways ○ Criteria for referrals to MMC	• Audit Findings Jan and March 2020 • 21/22 Audit Programme - Maternity Care Plans scheduled for re-audit	• Progress monitored on Ockenden Project/Action Plans • Women's Health Governance • PQST Monthly reporting of progress and risk through the Maternity and Neonatal Assurance Group (MNAG) • Summary report from above into the LMNS Maternity and Neonatal Quality Board and Region. • Audit data shared at audit meetings and risk and Governance meetings	• The Trust is involved in the LMNS workstream and there are plans to set up a sub hub to further progress plans through the CCG • Continue to support MMC LMNS discussions around pathways and criteria to support future plans ○ LMNS working party group work to ○ Agreed pathways ○ Criteria for referrals to MMC	Clinical Director Maternity Governance June 2022	Further guidance and support as available	Continue with internal early referral to Fetal	**33%**	
Immediate and essential action 5: Risk Assessment Throughout Pregnancy **Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.** Q30. All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Q31. Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.								
Link to Maternity Safety actions: **Q32. Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?**								
Link to urgent clinical priorities: Q33. (a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.								
What do we have in place currently to meet all requirements of IEA 5?	**What are our monitoring mechanisms and where are they reported?**	**Where is this reported?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	**RAG**	
IEA 5 Overall Compliance as assessed by NHSE in 2021 was 73%							**Compliance as assessed by NHSE in 2021 was**	**Current RAG**
Q 30. **All women must be formally risk assessed at every antenatal contact so that they have continued access to**	• Recorded on Euroking Maternity Information System (MIS) • Risk assessment completed compliance is reported on the	• Performance Review Meetings • Women's Health Governance	Personal Care and Support plans are not in place and an ongoing audit of 1% of records	Transformation Lead May 2022	Audit process once PCSP in place	Working with LMNS to progress PCSP	**60%**	

East Kent Hospitals University NHS Foundation Trust

care provision by the most appropriately trained professional • Currently risk assessed at all antenatal contacts throughout pregnancy journey. • This has been added as a question to the Euroking Maternity Information System (MIS) • Personal Care and Support plans (PCSP) are not yet in Place but there is LMNS wide work being progressed to standardise a PCSP across the Trusts-this is area of non-compliance from phase 2 • PCSP e-learning package has been launched for completion by all staff by March-work in progress and Comms to support. • Intended place of birth is reviewed and discussed and documented at every visit, this is recorded on Euroking MIS. • Guideline updated to includes definition of antenatal risk assessment as per NICE guidance This is now in place.	Maternity Dashboard and reported through to Maternity Governance and MNAG-	• PQST Monthly reporting of progress and risk through the Maternity and Neonatal Assurance Group (MNAG) • Summary report from above into the LMNS Maternity and Neonatal Quality Board and Region. • Monthly dashboard exception report to MNAG • Reported through our Maternity Dashboard Exception Reporting and MNAG and Trust Board	that demonstrates compliance of the above has not been completed					
Q 31. **Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture**. • Personal Care and Support plans (PCSP) are not yet in Place but there is LMNS wide work being progressed to standardise a PCSP across the Trusts • Women requesting care outside of guidance • Antenatal Care Guideline • Out of Guidance Women for Home Birth - Options Clinic Spreadsheet • Care Plan Audit Presentation - slide 8 evidence referral to Birth After CS Clinic • email confirming updates made to Euroking Maternity Information System to capture risk assessment • Women's Health Risk and Governance Strategy • Homebirth guideline incorporates risk assessment prior to and at time of homebirth	• Recorded on Euroking Maternity Information System (MIS) • Risk assessment completed reported on the Maternity Dashboard • Prospective homebirth audit for compliance •	• Progress monitored on Ockenden Project/Action Plans • Women's Health Governance • PQST Monthly reporting of progress and risk through the Maternity and Neonatal Assurance Group (MNAG) • Summary report from above into the LMNS Maternity and Neonatal Quality Board and Region.	Personal Care and Support plans (PCSP) are not in place and an ongoing audit of 1% of records that demonstrates compliance of the above has not been completed	Better Births Midwife May 2022	Audit process once PCSP in place	Working with LMNS to progress PCSP	75%	
Q 33. **A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.** • Currently risk assessed at all antenatal contacts throughout pregnancy journey. • This has been added as a question to the Euroking Maternity Information System (MIS) • Personal Care and Support plans (PCSP) are not yet in Place but there is LMNS wide work being progressed to standardise a PCSP across the Trusts-this is area of non-compliance from phase 2 • PCSP e-learning package is to be accesses by all staff by March-work in progress and Comms to support. • Intended place of birth is review and discussed and documented at every visit, this is recorded on Euroking MIS.	• Recorded on Euroking Maternity Information System (MIS) • Risk assessment completed reported on the Maternity Dashboard	• Progress monitored on Ockenden Project/Action Plans • Women's Health Governance • PQST Monthly reporting of progress and risk through the Maternity and Neonatal Assurance Group (MNAG) • Summary report from above into the LMNS Maternity and Neonatal Quality Board and Region.	Personal Care and Support plans are not in place and an ongoing audit of 1% of records that demonstrates compliance of the above has not been completed	Better Births Midwife May 2022	Audit process once PCSP in place	Working with LMNS to progress PCSP	**83%**	

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• Guideline updated to includes definition of antenatal risk assessment as per NICE guidance. • Women requesting care outside of guidance • Out of Guidance Women for Home Birth - Options Clinic Spreadsheet • Care Plan Audit Presentation - slide 8 evidence referral to Birth After CS Clinic • Women's Health Risk and Governance Strategy								
CNST Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	**Year 3 achievement** Declared non-compliance against Element 3- Computerised CTG for women attending with reduced Fetal Movements. Had been implemented and audit showed compliance but Board not assured process fully embedded as so new **Year 4 progress** Area of risk-CO Monitoring at 36 weeks. Antenatal Steroid administration is below target. Focussed work aligned to MatNeo National Drivers in progress top try to improve.							
Immediate and essential action 6: Monitoring Fetal Wellbeing Q34. All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. Q35. The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - • Improving the practice of monitoring fetal wellbeing • Consolidating existing knowledge of monitoring fetal wellbeing • Keeping abreast of developments in the field • Raising the profile of fetal wellbeing monitoring • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported • Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. • They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice • The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.								
Link to Maternity Safety actions: **Q36. Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?** **Q37. Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?**								
Link to urgent clinical priorities: Q38. (a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.								

What do we have in place currently to meet all requirements of IEA 6?	**How will we evidence that our leads are undertaking the role in full?**	**What outcomes will we use to demonstrate that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	**RAG**	
IEA 6 Overall compliance as assessed by NHSE in 2021 67%							**Compliance as assessed by NHSE in 2021**	**Current RAG**
Q 34. **Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring** • Lead Consultant and Midwifery Leads in Place. • Supported by Fetal Wellbeing Midwives leading on SBLCBV2 • Lead Consultants for SBLCBV2 in place both acute sites • 2 Fetal Monitoring Midwifes appointed to who lead on embedding learning into practice • Monitoring and tracking of compliance levels of all appropriate staff	• Consultant Leads Fetal Wellbeing Obstetricians Job Description • Perinatal Mortality Review Meeting Attendee Lists demonstrating Fetal Wellbeing Leads present for case reviews • Term Admission Terms of Reference - Fetal Wellbeing Leads shown in membership • SBLCBV2 Quarterly reporting to Maternity and Neonatal Assurance Group (MNAG)	• Change in HSIB and SI themes showing • impact of learning • PMRT associated fetal monitoring themes • Training compliance tracker list showing over 90% of all relevant staff groups trained • Closed loop Governance reporting of themes to influence training needs • Training needs analysis from appraisals	Training Needs Analysis to be Completed	PD Team April 2021	NA	NA	**100%**	

East Kent Hospitals University NHS Foundation Trust

• Utilisation of Labour Ward Huddles and Ward Rounds for Training opportunities • Training sessions to capture medical staff • Social media sharing of messages and updates to training/FM	• CNST report to Board containing update on all safety actions including 6 • Fetal Monitoring Training evidence including; Maternity Training Policy showing Fetal Monitoring Study Day is a mandatory requirement, Fetal Monitoring Competency Assessment Standard Operating Procedure • Fetal Monitoring Training and how this has adapted throughout pandemic • Fetal Monitoring Policy • CCG minutes showing approval to Fetal Monitoring approach Narrative on physiological approach adopted at East Kent							
Q 35 **The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health** • Consultant Leads Fetal Wellbeing Obstetricians Job Description **Consolidating existing knowledge** • the assessment and competency document demonstrate consolidating knowledge • Sound Knowledge of fetal monitoring and Physiological Interpretation **Improving the practice & raising the profile of fetal wellbeing monitoring** • FM MW currently runs weekly virtual “case study” sessions for all staff and sends out updates around fetal monitoring. • The implementation of Dawes Redman and the launch campaign also demonstrate this • Review of incidents involving Fetal Monitoring • Daily presence in the clinical areas Supporting interpretation of fetal heart interpretation • If there is learning, translate into clinical practice **Keeping abreast of developments in the field- demonstrated through evidence of training updates, reading and guideline updates** • Looking to attend a course run by Neoventa • Offer to be extended to Obstetric fetal monitoring leads. • Attendance at a fetal monitoring masterclass. • PD and FM MW all involved in LMNS workstream • Request to join national working group for fetal monitoring • FM MW attends sessions run by Susanna Periera • Review of the guideline with regards to IA is in progress • Consider an update with regards to STAN **Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice-leads to attend**	• Perinatal Mortality Review Meeting Attendee Lists demonstrating Fetal Wellbeing Leads present for case reviews • Term Admission Terms of Reference - Fetal Wellbeing Leads shown in membership • SBLCBV2 Quarterly reporting to Maternity and Neonatal Assurance Group (MNAG) • CNST report to Board containing update on all safety actions including 6 • Fetal Monitoring Training evidence including; Maternity Training Policy showing Fetal Monitoring Study Day is a mandatory requirement, Fetal Monitoring Competency Assessment Standard Operating Procedure • Example completed Locum Induction Checklist which includes a check on Fetal Monitoring understanding	• Change in HSIB and SI themes showing impact of learning • PMRT associated fetal monitoring themes • Training compliance tracker list showing over 90% of all relevant staff groups trained and Competency assessed • Closed loop Governance reporting of themes to inform training needs Training needs analysis from appraisals	• Training Needs Analysis to be Completed • Benchmarking/peer review • Develop an Internal mechanism to benchmark/peer review competency against the LMNS to ensure competency is maintained around specialist roles	PD Team April 2021	NA	NA	**38%**	

East Kent Hospitals University NHS Foundation Trust

PMRT meeting for relevant cases which will be evidenced through meeting minutes and PMRT reports • PD and FM MW Team attend the PMRT meetings and relevant ATAIN meetings. • Attendance at risk meetings • Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training, • this can be demonstrated through the training lesson plan, training matrix and once completed the TNA. • Obstetric lead has been running sessions with the trainees • FM MW runs sessions for Midwives								
Q 36. Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? • Fetal Wellbeing Midwives for each acute site leading on care bundle delivery • 2 fetal monitoring midwives appointed and lead Obstetrician on each consultant unit to lead on element 4 • Smoking Cessation Midwife in post • PQST Monthly reporting of progress and risk through the Maternity and Neonatal Assurance Group • Quarterly reporting against compliance with all five elements of the Saving Babies' Lives care bundle V2 • Audits for each element. • Guidelines with evidence for each pathway • Dashboard section for SBLCB to track compliance • Perinatal Optimisation MatNeo Sip QI project in line with National Drivers	• Audits for each element. • Dashboard section for SBLCB to track compliance monthly • CNST Project/action plan	• Women's Health Governance • PQST Monthly reporting of progress and risk through the Maternity and Neonatal Assurance Group (MNAG) • Summary report from above into the LMNS Maternity and Neonatal Quality Board and Region. • Quarterly reporting against compliance with all five elements of the Saving Babies' Lives care bundle Version 2 into MNAG • Quarterly Care Bundle reporting into the Region (currently paused)	• Focus on improving CO monitoring compliance at 36 weeks Focus on pre-term steroid administration	Smoking Cessation MW, Fetal Wellbeing MW Community Matrons HOMs	30 June 2022	Deep dive reporting down to themes and staff/staff groups to understand reasons for compliance	**100%**	
CNST Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	**Year 3 achievement** Declared non-compliance against Element 3- Computerised CTG for women attending with reduced Fetal Movements. Had been implemented and audit showed compliance but Board not assured process fully embedded as so new **Year 4 progress** Area of risk-CO Monitoring at 36 weeks. Antenatal Steroid administration is below target. Focussed work aligned to MatNeo National Drivers in progress top try to improve.							
Q 37. **Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?** • Training Matrix in place demonstrating Training Content aligned Core Competency Framework • Evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session is presented on the Training Tracker LMS report showing review of training data (attendance, compliance coverage) and training needs assessment • Trajectory is mapped on the training tracker to meet and maintain compliance • Monitoring of training through MNAG meeting agenda and minutes and presentation of update papers to which the LMNS attend • PQSRT Reporting of training data monthly to MNAG and Trust Board • Fetal monitoring face to face training in place supported by competency assessment • PROMPT virtual in place	• Training Tracker and trajectory reported through maternity governance, as well as MNAG to Q&S as well as Trust Board • PQST reporting to Trust Board and MNAG • LMNS attendance at Maternity and Neonatal Assurance Group • LMNS Training Assurance PP populated with EK data • LMNS Training Assurance Board Minutes • LMNS Training Assurance ToR demonstrating attendance by the EK PD team	• Women's Health Governance • Internal Governance through MNAG, Trust Board • Training compliance update papers and monthly PQSRT Reports • The LMNS Quality Assurance Group (QAG) now has core competency assessment on the agenda three times a year and this is supported through a workforce and training forum that is led by Andrea Curling (LMNS workforce lead MW), the first meeting of which was held in November 2021. • This is then reported by exception to the Regional Maternity and Neonatal Safety and Concerns Group (RMNSCG) from the LMNS QAG. Meeting notes and agenda requested to evidence	• Translate the Training Matrix into a full TNA • Training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Final approval of Business case to increase faculty • Sourcing of appropriate facility for training to take place	TNA-PD Team March 2022 Estates-MNAG	Approval of Business case	Maintain existing training programme	**37%**	

East Kent Hospitals University NHS Foundation Trust

• Training content reviewed in workshop to ensure content is fully aligned to Core Competency Framework • New training programme developed around 5 day blocks • The LMNS Quality Assurance Group (QAG) now has core competency assessment on the agenda three times a year and this is supported through a workforce and training forum • This is then reported by exception to the Regional Maternity and Neonatal Safety and Concerns Group (RMNSCG) from the LMNS QAG.								
CNST Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	**Year 3 achievement** Declared compliance **Year 4 progress** Above 90% compliant in Fetal Monitoring across all relevant staff groups Above 90% compliant in PROMPT across all maternity staff groups. Anaesthetic staff compliance low but mitigation in place to address this. Not all staff groups are above 90% compliant in NLS Training-mitigations in place to address							
Immediate and essential action 7: Informed Consent Q39. All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. Q40. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care Q41. Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Q42. Women's choices following a shared and informed decision-making process must be respected								
Link to Maternity Safety actions: **Q43. Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?**								
Link to urgent clinical priorities: Q44. Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.								
What do we have in place currently to meet all requirements of IEA 7?	**Where and how often do we report this?**	**How do we know that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	**RAG**	
Overall Compliance as assessed by NHSE in 2021 was 50%							**Question Compliance as assessed by NHSE in 2021 was**	**Current RAG**
Q 39. **Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery** • Information available through East Kent Maternity MOMA App and Trust Maternity Website. • Supported by paper information if required including different languages • Links to National documents and information via MOMA • Choosing to have a C-Section Leaflet • Birth options after previous C-Section,	• Monthly working established to look at information available and will report this via maternity improvement updates MNAG	• MOMA and Trust site are repositories that women are directed to for information • Staff training is based on best practice • guidance and local learning themes to ensure information sharing is current • Responding to staff and women feedback to develop Euroking Maternity Information • System • Feedback from women • Feedback from staff	• Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient	MVP Chair February 2022	• Identify lead to review and maintain update information	• Patient Liaison Midwives being appointed on each site and Digital Midwife who will support this work	50%	

East Kent Hospitals University NHS Foundation Trust

• LMNS Website information for Women and Families • Source of information document available • Gap analysis tool to support MVPs in their submission • Regional Gap Analysis Toolkit Checklist		• Monitoring of outcomes • Website gap analysis LMS funding update- report with LMNS and to be shared with Trust soon	information leaflets, apps, websites. • This has been performed and waiting for report • Updates to information available once gaps are known • Ongoing process to review and update information • Following Gap review and MVP Chair rating report a process will be agreed to update, monitor and report updates and submit requests for future updates • Maternity Leaflets and Guideline Tracker • Present MOMApp user data	Patient Liaison Midwife May 2022				
Q 41. **Women must be enabled to participate equally in all decision-making processes** • Women requesting care outside of guidance Guideline • Antenatal Care Guideline • Maternity Record Keeping Policy • Information available through East Kent Maternity MOMA App and Trust Maternity Website. • Supported by paper information if required including different languages • Links to National documents and information via MOMA • Choosing to have a C-Section Leaflet • Birth options after previous C-Section, • LMNS Website information for Women and Families • Source of information document available • Gap analysis tool to support MVPs in their submission Regional Gap Analysis Toolkit Checklist	• Following Gap review and MVP Chair rating report a process will be agreed to update, monitor and report updates and submit requests for future updates • Monthly Group established to look at information available and will report this into MNAG	• MOMA and Trust site are repositories that women are directed to for information • Staff training is based on best practice • guidance and local learning themes to ensure information sharing is current • Responding to staff and women feedback to develop Euroking Maternity Information • System • Feedback from women • Feedback from staff • Monitoring of outcomes • Website gap analysis LMS funding update- report with LMNS and to be shared with Trust soon	• An audit of 1% of notes demonstrating compliance.	Compliance Midwife April 2022	Improvement Director offer of support	Agree audit approach	**67%**	
Q 42. **Women's choices following a shared and informed decision-making process must be respected** • Women requesting care outside of guidance Guideline • Antenatal Care Guideline • Maternity Record Keeping Policy • Information available through East Kent Maternity MOMA App and Trust Maternity Website. • Choosing to have a C-Section Leaflet • Birth options after previous C-Section, • LMNS Website information for Women and Families	• Following Gap review and MVP Chair rating report a process will be agreed to update, monitor and report updates and submit requests for future updates • Monthly Group established to look at information available and will report this into MNAG	• MOMA and Trust site are repositories that women are directed to for information • Staff training is based on best practice • guidance and local learning themes to ensure information sharing is current • Responding to staff and women feedback to develop Euroking Maternity Information • System • Feedback from women • Feedback from staff • Monitoring of outcomes	• An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean	Compliance Midwife April 2022	Improvement Director offer of support	Agree audit approach	**50%**	

East Kent Hospitals University NHS Foundation Trust

		• Website gap analysis LMS funding update- report with LMNS and to be shared with Trust soon •	section during labour or induction.					
Q 43. Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? • Co-produced forward plan on how to improve communication with women through the MVP • Table top exercise completed to triangulate themes from complaints, I and MVP feedback – informed MVP workplan for 21/22 Planning event held 19.1.22 to coproduce a work programme to increase the amount of feedback we receive from women through proactive measures • this was the area of noncompliance for phase 2 • Evidence of service user feedback being used to support improvement in maternity services -you said, we did, • FFT amended in response to service user feedback • 15 Steps action plans • CNST evidence of co-production in submitted evidence. • CNST evidence review signed off by the MVP. • Service user feedback repository • Maternity Strategy coproduced document • Safety Champion feedback repository/action plan • MVP Meetings well represented • We do have a robust mechanism for gathering service user feedback in place and work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services • Quarterly updates of feedback are captured, within a repository, • This repository describes the feedback mechanism, how frequently it is captured, where it is captured, themes and examples of the feedback, examples of how this has been responded to and evidence documents to support the narrative. • Appointment of 2 patient experience midwives • MVP Chair involved in recruitment for key roles • Regular rounds by managers, matrons and HOM to gain feedback develop plans in response	• Attenders and membership at Maternity and Neonatal Assurance Group • Antenatal pathway mapping • Invitation to attend on interview panels • Repository of feedback • You Said We Did Boards	• Implementation of change as a consequence of feedback e.g. 15 steps Challenge • Close working relationships with both the MVP and Healthwatch. • Valued members of the Continuity of Carer working party • Influenced Maternity Strategy and active Members of the Maternity and Neonatal Assurance Group	• Sign off of MVP workplan • Renumeration of expenses process for all members of the MVP	MVP Chair CCG March 2022	CCG Process for renumeration	• Conversation taking place to mitigate and captured in MVP minutes and as agenda item March meeting	**67%**	
CNST Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	**Year 3 achievement** Declared Compliance Year 3 **Year 4 progress** Outstanding elements are Sign off of MVP workplan and process for CCG renumeration of expenses process for all members of the MVP							
Q 44. **Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.** • **Developed a small working party group to look at information available and updates required** • MVP chair rating of trust information on website and MOMApp in terms of: accessibility (navigation, language etc) quality of info (clear language,	• Following Gap review and MVP Chair rating report and report to MNAG • a process will be agreed to update, monitor and report updates and submit requests for future updates	• Feedback from women • Feedback from staff • Monitoring of outcomes	• Co-produced action plan to address gaps identified from the gap analysis	MVP Chair February 2022 Patient Liaison Midwife May 2022	• Identify lead to review and maintain update information	• Patient Experience Midwives appointed on each site and Digital Midwife who will support this work	**25%**	

East Kent Hospitals University NHS Foundation Trust

all/minimum topic covered) has been completed- results not yet shared with Trust • Gap analysis of website against Chelsea & Westminster conducted by the MVP has been completed and results are with the LMS, soon to be shared with Trust • Information on maternal choice is available, including choice for caesarean delivery. • Working group established to update all information for women								

East Kent Hospitals University NHS Foundation Trust

Appendix 3: Recommendations from Morecambe Bay Review- February 2022

Maternity Unit:- East Kent Hospitals University NHS Foundation Trust	**Date:- February 2022**	**Completed by:- Women's Health Triumvirate**		
Recommendations for the University Hospitals of Morecambe Bay NHS Foundation Trust for other Trusts to benchmark against.	**Linked to further reviews/regulation**	**Examples of evidence**	**Embedded Compliance Red none Amber partially Green fully**	**Actions to be embed compliance fully**
1. Is an apology given to those affected, for the avoidable damage caused and any previous failures to act. **Action: Trusts**	Duty of Candour legislation regulation 20 CQC Safe Domain	• Application of Duty of Candour principles and policy as part of Governance and Risk Management Policies. • All required Early Notification Cases reported for 2020/2-21 period to HSIB • Duty of Candour met and information provided on role of NHSR for all cases. • No cases reported by HSIB to NHS Resolutions Early Notification Scheme so far in this reporting period from 1 April 2021		
2. Review the skills, knowledge, competencies, and professional duties of care of all obstetric, paediatric, midwifery and neonatal staff, and agency, locums caring for the critically ill in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. **Action: Trusts**	CNST SA8 Ockenden IEA 3 CQC Effective Domain	• Above 90% compliant in Fetal Monitoring across all relevant staff groups • Above 90% compliant in PROMPT across all maternity staff groups. • Training Tracker showing compliance by staff group • Compliance Trajectory is mapped on the training tracker • LMS report showing review of training data and training needs assessment • Maternity and Neonatal Assurance group meeting agenda and minutes and presentation of training compliance update papers • Perinatal Quality Surveillance Tool (PQSRT) Reporting of training data monthly to MNAG and Trust Board • Fetal monitoring face to face training resumed • Commitment to resume PROMPT face to Face training once safe to do so • Training workshop to ensure content is fully aligned to Core Competency Framework • Training Matrix- 5-day blocks to commence by May 2022 • The LMNS Quality Assurance Group (QAG) now has core competency assessment on the agenda three times a year and this is supported through a workforce and training forum • This is then reported by exception to the Regional Maternity and Neonatal Safety and Concerns Group (RMNSCG) from the LMNS QAG. • HDU level 2 training, recovery training and scrub technique training is not required as undertaken by main theatres and supported by critical care teams		• Training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training has been developed and going through the Governance approval process. • Business case submitted for additional Faculty Membership Training does not cover maternal critical care and there is not a guideline / maternal critical care chart. • Anaesthetic staff compliance low but mitigation in place to address this.
3. Identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. **Action: Trusts**	CNST SA8 CQC Well Led Domain Ockenden IEA 3	• Preceptorship Programme in place • Induction Programme in place • 1 on secondment to LMNS quality. • Networking opportunities in place for governance team. • Mentors have been identified for some members of the MDT clinical leadership team		• Build mentoring opportunities for key roles to expand knowledge •

East Kent Hospitals University NHS Foundation Trust

4. Continuing professional development of staff and link this explicitly with professional requirements including revalidation. **Action: Trusts**	CNST SA 8 Ockenden IEA 3 CQC Safe Domain	• Appraisal and revalidation policy • All staff met revalidation requirements • Appraisal systems in place with HR notification systems. • Appraisal rates are below 85% target-tracked on Maternity Dashboard • Feedback from clinicals in terms of professional development opportunities is captured via the Practice Development and Governance Team processes. • TNA developed and going through Governance approval • Robust revalidation processes in place to ensure revalidation is completed in a timely manner. • Maternity Professional Midwifery Advocates in place support this continuing professional development for midwives. • Appointment of lead PMA to support • Matrons have completed connected leadership programme • Mentorship programme identified for HOMs		• PMA Strategy updated and plan to relaunch under development to focus on A-QUIP model • Focussed QI work to address appraisal rates • Appraisals below expected standard, but plan in place to reach 85%
5. Promote effective MDT working, joint training sessions. **Action: Trusts**	CNST SA 8 Ockenden IEA 3 CQC Effective Domain	• MDT Mandatory Training for PROMPT remains virtual due to adaptations made during Covid. This will return to Face to Face once safe to do so. • Fetal Monitoring Face to Face Training resumed • CTG training compliance 90% across all required staff groups • Live Skills & Drills • Senior leadership and Governance Team strengthened • Safety huddles • Cross site working strategies • Cross site working for corporate governance, specialist practitioners e.g. Perinatal Mental Health Team and leadership teams. • Joint training and meetings support communication between professional groups. • Training resources that include human factors and communication skills in place.		• Resume face to face training once safe to do so to support principles of 'Working together and Learning together' • Currently Scoping Venues
6. Protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of high or low risk care. **Action: Trusts**	Ockenden IEA 5 CQC Safe Domain	• Women are risk assessed at all antenatal contacts throughout pregnancy journey. • Risk assessments tracked on Euroking Maternity Information System (MIS) • Intended place of birth is review and discussed and documented at every visit • Intended place of birth is recorded on Euroking MIS. • Guideline updated to includes definition of antenatal risk assessment as per NICE guidance. • Women requesting care outside of guidance Guideline • Care Plan Audit Presentation, evidences referral to Birth After CS Clinic • Women's Health Risk and Governance Strategy • Escalation of Care protocols in place and safety huddles enhance operational discussions on high risk cases. • Process in place for referring to Obstetric colleague when a woman's risk changes from low to high in the antenatal period		• Personal Care and Support plans (PCSP) are not yet in Place but there is LMNS wide work being progressed to standardise a PCSP across the Trusts-this is area of non-compliance from phase 2
7. Audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols. **Action: Trusts**	CNST SA 6 Ockenden IEA 5 CQC Effective Domain	• Guideline updated to includes definition of antenatal risk assessment as per NICE guidance. • Women are risk assessed at all antenatal contacts throughout pregnancy. • Risk assessment question on Euroking Maternity Information System (MIS) • Care Plan Audit Presentation, evidences referral to Birth After CS Clinic • Escalation of Care protocols in place • 2 x daily Safety huddles and out of hours huddle audited through SNAP tool audit Process in place for referring to Obstetric colleague when a woman's risk changes from low to high in the antenatal period		

East Kent Hospitals University NHS Foundation Trust

8. Identify a recruitment and retention strategy achieving a balanced and sustainable workforce with the requisite skills and experience. **Action: Trusts**	CNST SA 4 & 5 Ockenden IEA Workforce CQC Safe Domain	• Recruitment and Selection Policy • Biannual report to Maternity and Neonatal Assurance Group • Perinatal Quality Surveillance Tool (PQST) Monthly workforce updates reports into Maternity and Neonatal Assurance Group (MNAG) and into the LMNS • LMNS Workforce meetings established • Reporting through Performance review meetings • Staff sickness, vacancies and turnover monitored on the Maternity Dashboard • Recruitment tracked against business case HR report including return to work policy and procedure • Most recent BR+ report • Board minutes agreeing to fund business case to support additional core midwives and increase midwifery leadership posts • Recent recruitment has included consultants, senior and newly qualified midwives and specialist practitioners • Care Group is accountable for recruitment plans in line with safe staffing reviews. • Birthrate Plus staffing reviews are presented to Maternity and Neonatal Assurance Committee/ Trust Board in line with CNST Safety Actions and Ockenden Recommendations. • Midwifery workforce planning at LMS/Regional completed • A rolling, central monthly audit of midwifery staff captures the number of midwives, hours worked, posts offered, annual leave, sickness, maternity leave and leavers. • Maternity E Roster systems for the shift allocation of staff • labour wards have an identified Band 7 midwifery coordinator providing the clinical • leadership within supernumerary status and supports the requirement for one-to-one care in active labour. • Operational Midwifery Manager guideline • Obstetric Workforce: Paper to Board around Consultant attendance for required situations and audit of compliance		• 6 monthly Clinical Workforce Papers scope to be clarified • Robust recruitment plan in place but vacancies remain and staff are not attending/dropping out of interview • Regional overseas recruitment - we are responsible for OSCE provision
9. Joint working between its main hospital sites, including the development and operation of common policies, systems and standards. **Action: Trusts**	CNST SA 9 Ockenden IEA 1 & NICE CQC Effective Domain	• Standardised guidelines across all Trust sites. • Cross site standard operating protocols and systems of work. • Leadership, governance and educational processes are united in standardised requirements. • Safety huddles across all clinical sites • Cross site strategy. • The Multiprofessional Faculty for Learning in Maternity ensure strong governance processes, continuous plan, monitor and review service training requirements. • MDT actively involved in joint training requirements- modified in 2020 in response to Covid and adoption of PROMPT tools. • Joint LMNS projects including Personalised Care and Support Plans, Digital solutions • Perinatal Quality Surveillance Framework embedded September 2021		• Monitoring via cultural staff surveys would be advantageous. Cross site strategy working and huddles enhance communication but evaluation required. • Changing to Flow coordinator role and new SOP to accompany (not yet written)
10. Forge links with a partner Trust, to benefit from opportunities for learning, mentoring, secondment, staff development and sharing. **Action: Trusts**	CNST SA 8 Ockenden IEA 1 & 4 CQC Well Led Domain	• External review of SI's and PMRT • LMNS Maternity and Neonatal Quality Assurance Board established • LMNS Workstream meetings • NHSE/I Maternity advisor • LMNS wide approach to develop Personalised Care and Support Plans and a Maternity Information System • Monthly reporting of Improvement Plan Progress, including CNST and Ockenden recommendations through the Maternity and Neonatal Improvement Group, with LMNS representation • LMS Perinatal Quality Surveillance model established-Guideline demonstrates how the trust reports this both internally and externally through the LMS • Process in place to support quarterly SI reports going to Trust Board as well as monthly summary in the PQSRT report and into Regional Governance • The LMNS Quality Assurance Group (QAG) now has core competency assessment on the agenda three times a year and this is supported through a workforce and training forum • The Multiprofessional Faculty for Learning in Maternity include MDT, University and South East Coast Ambulance Service (SEAmb) membership		• Regional PMA forum • Lead MW Educator meetings • Regional international recruitment with each Trust responsible for varying aspects

11. Staff awareness of incident reporting, review its policy of openness and honesty. Duty of Candour compliance. **Action: Trusts**	CNST SA 8 &10 Ockenden IEA 2 & 9 CQC Safe Domain	• Safety Champion Posters • NED Job Description • Trust Board minutes showing NED discussion • Safety Messages Flowchart • Monthly Safety Champion Walkabouts and feedback shared • Monthly Safety Champion Meetings to discuss Safety and Quality items • You Said We Did feedback Boards in clinical areas • Trust is an active member of the Kent and Medway Local Maternity System (LMS). • Duty of Candour Policy • Exception reports and escalation • Application of Duty of Candour principles and policy as part of Governance and Risk Management Policies. • All required cases Early Notification Cases reported for 2020/2-21 period to HSIB • Duty of Candour met and information provided on role of NHSR for all cases.		• Communication through Risky Business • Message of the Week (MOW)
12. Review the structures, processes and staff involved in investigating incidents, RCA, learning, training. Include arrangements for staff debriefing and support following a serious incident.	CNST SA 3 Ockenden IEA 1 CQC Safe Domain	• .Using the National Perinatal Mortality Review Tool to review perinatal deaths. • Change in PMRT Governance to improve membership, frequency and ensure standards and timelines are met. • Staff involved in cases are invited to be part of review meetings • External membership of Maternity and Neonatal Assurance Group and oversight of dashboard and improvement plan • Audit to demonstrate external PMRT membership and review of all cases and that women views are sought. • Perinatal Meeting Terms of Reference and Example attendee lists, • Guideline for involving external clinical specialists in reviews • Perinatal Meeting Terms of Reference and Example attendee lists • Monthly reporting through the PQST into MNAG and Trust Board • February 2022- Monday, Wednesday and Friday Rapid review process meeting commenced to ensure senior care group oversight, reporting into Exec SI panel • Monitoring and reporting HSIB and SI themes showing to review impact of learning • PMRT associated fetal monitoring themes Reviews • Training compliance tracker list showing over 90% of all relevant staff groups trained • Closed loop Governance reporting of themes to influence training needs • Strengthening of the Governance team and review of processes with support from Maternity support programme • TRiM Training for staff involved in incidents • Message of the week shared learning		• Maternity Risk Management Strategy under review to strengthen further systems and processes
13. Review the structures, processes and staff involved in responding to complaints, and learning are the public involved. **Action: Trusts**	CNST SA 1 & 7 Ockenden IEA 2 CQC Effective Domain	• Complaints management policy in date • PALS, Complaints, FFT and MVP feedback themes are reported monthly through the Perinatal Quality Surveillance tool and reported through he Perinatal Quality Surveillance Governance model • You said we did boards in clinical areas • You said we did responses captured on the service user feedback repository and action progress fed back via the MVP Chair • All PMRT cases, SI's and HSIB reports reflect the family's voice/feedback • MVP Watch are engaged in the review of Maternity services and contribute to discussions and meetings • All complaints are overseen by Patient Safety Nurse, as part of WH Governance Team and reviewed by clinical leadership teams. • Final sign off via CNO. PALs and resolution of concerns encouraged at local level. • Maternity Voices partnerships (MVP)- actively involved and collaborative arrangements in place. • 2 Patient experience midwives appointed • AN Pathway diagnostic event held with involvement of local users		• Further work to do to involve service users in system and process design. Coproduction plan developed to support this. • RCA training for staff who need it

East Kent Hospitals University NHS Foundation Trust

14. Review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. **Action: Trusts**	CNST SA 8 Ockenden IEA 3 & Workforce CQC Safe Domain	• RCM leadership requirements met in full • RCOG workforce issues/role-responsibilities guidance • Leadership development programme and succession planning for Clinicians • Active recruitment of midwifery managers, consultant obstetricians and specialist midwives. • Application of the obstetric, midwifery and BAPM Neonatal workforce staffing reviews. • Biannual workforce papers • Training Tracker • LMS report showing review of training data and training needs assessment • Trajectory is mapped on the training tracker • Monitoring of training through MNAG • PQSRT Reporting of training data monthly to MNAG and Trust Board • Fetal monitoring face to face training resumed • Commitment to resume PROMPT face to Face training once safe to do so • Training workshop to ensure content is aligned to Core Competency Framework • Training Matrix 5- day blocks to commence March 2022 • LMNS Quality Assurance Group (QAG) has core competency assessment on the agenda three times a year, supported through a workforce and training forum • This is then reported by exception to the Regional Maternity and Neonatal Safety and Concerns Group (RMNSCG) from the LMNS QAG.		• Consider further BR+ review before launch of Midwifery Continuity of Carer
15. Review of governance systems clinical governance, so that the Board has adequate assurance of the quality of safe care. **Action: Trusts**	Ockenden IEA 1 CQC Well Led Domain CNST 10 SA	• Maternity Risk Management strategy is under review-due March 2022 • Risk Register • DOM attends and presents at Board not sub-committees • Maternity Dashboard presented to Trust Board with Nationally driven KPIs • SI reports to Trust Board • Maternity and Neonatal Assurance Group (MNAG) ToR, agendas, reports and minutes • MNAG Chaired by Board Safety Champion • Monthly reporting of Improvement Plan Progress • Implementation of the Perinatal Quality Surveillance Model reporting tool • Governance processes to ensure embedded learning from risk, incidents and good practice • ATAIN and Transitional Care reporting • Saving Babies Lives Care Bundle Quarterly Reporting • CNST Reporting • Quarterly PMRT Reports • External review of SB cases • External membership of Maternity and Neonatal Assurance Group and oversight of dashboard and improvement plan • Audit to demonstrate external PMRT membership and review of all cases and that women views are sought. • Guideline for involving external clinical specialists in reviews • Monthly ‘We care’ performance review meetings • Clinical Governance Meeting agenda and minutes • Incident Management Policy, • Maternal Death Policy • Women’s Health Risk and Governance Strategy • Care Group Structure Chart • All required Early Notification Cases reported for 2020/2-21 period to HSIB • Duty of Candour met and information provided on role of NHSR for all cases. • No cases reported by HSIB to NHS Resolutions Early Notification Scheme so far in this reporting period from 1 April 2021 • LMS Perinatal Quality Surveillance model established		

East Kent Hospitals University NHS Foundation Trust

		• LMNS Maternity and Neonatal Quality Assurance Board established • Shared Learning through the LMS forums • Governance, Fetal Wellbeing Midwives and Better Births Midwives providing link between Maternity and LMS		
16. Ensure middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and provide appropriate guidance and training. **Action: Trusts**	CNST SA 4,5 & 8 Ockenden IEA Workforce CQC Well Led Domain	• TNA developed and going through Governance approval • Appraisal systems in place with HR notification systems. • Appraisal rates are below 85% target-tracked on Maternity Dashboard • JD include roles and responsibilities • NED walk rounds engagement • Visibility of the Senior Leadership Team • Safety Champions walk rounds engagement sessions in clinical areas and capture of safety concerns • Job descriptions illustrate clearly the corporate requirements of roles and responsibilities in terms of governance, leadership and quality care for women. • This is enforced and monitored by the work of the Maternity Safety Champions which have become established over the last 4 years. • Regular meetings of the Maternity Safety Champions take place- quality of care is a key feature and this ensures that ward to board discussions on safe effective care take place. • Active recruitment of midwifery managers, consultant obstetricians and specialist midwives. • Application of the obstetric, midwifery and BAPM Neonatal workforce staffing reviews. • Biannual report to Maternity and Neonatal Assurance Group • Perinatal Quality Surveillance Tool (PQST) Monthly workforce and Training updates reports into Maternity and Neonatal Assurance Group (MNAG) and into the LMNS • Reporting through Performance review meetings • Maternity Specific Training compliance monitored on the Training Tracker • Recent recruitment has included consultants, senior and newly qualified midwives and specialist practitioners • Care Group is accountable for recruitment plans in line with safe staffing reviews. • Birthrate Plus staffing reviews are presented to Maternity and Neonatal Assurance Committee/ Trust Board in line with CNST Safety Actions and Ockenden Recommendations. • Biannual Workforce report to Maternity and Neonatal Assurance Group • Operational Midwifery Manager guideline reviewed and Changing to Maternity Flow Coordinator role • Obstetric Workforce: Paper to Board around Consultant attendance for required situations and audit of compliance • Focussed QI work to address appraisal rates		• Band 7 connected leaders commissioned bespoke programme • Band 7 away day to discuss role clarity and expectations
17. Review access to theatres, and ability to observe and respond to all women in labour and ensuite facilities; arrangements for post-operative care of women. **Action: Trusts**	CNST SA 9 Ockenden IEA 4 & 5 CQC Safe Domain	• Immediate access to 2nd theatre at WHH • Midwives are not scrubbing for theatre, supported by main theatre • Recovery staff provided by main theatres, are trained, and competency assessed in line with national guidance • LW coordinators supernumerary status is monitored on the Maternity Acuity Tool and safe staffing Red Flags • One to one care given in established labour is monitored on the Maternity Dashboard • Estates workstream established to review options to improve dated estates facilities and environment • Maximising the use and appearance of existing labour ward/obstetric theatres continues. • Quality Reviews have highlighting the need to improve the visual appearance of maternity facilities. • Risk assessments monitor and record estate concerns.		• Ensuite facilities not available on Acute Labour Wards or Maternity Wards • Level 2 HDU care is not provided by Maternity Teams • Access for 2nd theatre at QEQM Theatre is a long distance from Labour Ward • Estates workstream established to review options to improve dated estates facilities and environment • Resuscitaires do not fit into the delivery rooms-risk assessments completed and on risk register

East Kent Hospitals University NHS Foundation Trust

18. All of above should involve CCG, and where necessary, the CQC and Monitor. **Action: Trusts**	CCG assurance visits CQC regulation visits	• Outcomes of visits • CQC ratings • Action plans and evidence repositories • Actions plans monitored governance floor to Board • Feedback to staff		
The recommendations below were allocated to be actioned by the wider NHS and selected stakeholders we suggest reviewing how these apply at provider level				
19. Professional regulatory bodies should review the findings of this report: **Action: NMC, GMC**	None Known	Gap analysis supports local review of findings		
20. National review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions: **Action: NHSE, CQC, RCOG, RCPCH, NICE**	CNST 10 safety actions CQC Safe Domain	Local Assessment Better Births report LMNS implemented Maternity transformation		
21. We recommend that NHS England consider the review of requirements to sustain safe provision to services difficult to recruit to or isolated is not restricted to maternity care and paediatrics: **Action: NHSE**	Ockenden IEA 1 CQC Safe Domain CNST SA 4 & 5	Regional workforce workstream Local assessment. NICE safer staffing guidelines BR+ LMNS to implement maternity transformation workstream		
22. Review of the opportunities and challenges to assist remote or smaller units in promoting services and the benefits to larger units of linking with them. **Action: HEE, RCOG, RCPCH, RCM**	Ockenden IEA 1 CQC Safe Domain CNST SA 4, 5 & 9	Local Assessment Girth visits Mergers of some Trusts LMNS to implement maternity transformation workstream Cross Site Working Strategy		
23. Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. **Action: CQC, DOH**	Ockenden IEA 1 CQC Safe Domain CNST SA 10	Maternity Risk Management strategy in date Governance structure strengthened NHS resolution HSIB		

East Kent Hospitals University NHS Foundation Trust

24. Introduction of the duty of candour for all NHS professionals. **Action: CQC, NHSE**	Ockenden IEA 3 CQC Safe Domain	CQC DOC guidance for providers DOC policy in date DOC compliance Audit of compliance		
25. NHS Boards to report openly the findings of any external investigation, including prompt notification of relevant external bodies such as the CQC and Monitor. **Action: DOH, CQC**	CNST SA 10 Ockenden IEA 1 CQC Safe Domain	Reports from external reviews Action Plans		
26. Introduction of a clear national policy on whistleblowing. **Action: DOH**	CQC Well Led Domain	Raising Concerns Policy FTSUG policy FTSUG representatives Just culture work Speak up safely Maternity Guardian appointed Trust speak up safely Guardian		
27. Reinforce the duty of professional staff to report concerns about clinical services, and patient safety issues. **Action: GMC, NMC, PSAHSC**	CNST SA 8 Ockenden IEA 1 CQC Safe Domain	WB policy Governance structure Staff training		
28. Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels Trusts should provide evidence to the CQC. **Action: CQC, NMC, GMC, NHSE**	CQC Well Led Domain Ockenden Workforce	JD's Internal leadership structure/Organogram RCM leadership requirements RCOG workforce issues/role-responsibilities guidance Utilising National JDs such as Legacy Midwife		
29. Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, should provide evidence to the Care Quality Commission. **Action: CQC, NHSE**	CQC Well Led Domain Ockenden Workforce	JD's Internal leadership structure/organogram RCM leadership requirements RCOG workforce issues/role-responsibilities guidance		

East Kent Hospitals University NHS Foundation Trust

30. A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. To include, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. **Action: NHSE, CQC**	CQC Well Led Domain	HSIB Process followed HSIB reporting /Action plans Internal legal team guidelines for staff attending coroners court Maternity Risk Management Strategy		
31. A fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. **Action: DOH, NHSE, CQC**	CNST SA 7 Ockenden IEA 2 CQC Effective Domain	Complaints policy including in date PALS You said we did responses MVP involvement All PMRT cases, SI's and HSIB reports reflect the family's voice/feedback Patient experience midwife EACH Consultant Led Site		
32. Local Supervising Authority system for midwives was ineffectual at detecting manifest. Urgent review and reform is required. **Action: DOH, NHSE, NMC**	CQC Well Led Domain	Full time lead PMA		
33. Organisations draw up a memorandum of understanding specifying roles, relationships and communication of regulation by CQC and financial and performance by Monitor. **Action: CQC, DOH, Monitor**	None Known			
34. A memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap with complaints. **Action: CQC, PHSO**	None Known	To follow up		
35. NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility.	None Known	Local meetings CQC, HSIB and NHSEI sharing intelligence		

Action: CQC, NHSE, DOH, Monitor				
36. DOH should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. **Action: DOH**	None Known	HSCSC Report into Maternity Services – published June 2021		
37. An explicit protocol be drawn up setting out how such processes will be managed in future Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. **Action: DOH**	None Known	CQC report any concerns to NHSEI prior to a merger LMNS Quality Board established Regional Perinatal Quality Oversight Group includes all stakeholders		
38. Recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. **Action: NHSE**	Ockenden IEA 1 CQC Safe Domain CNST SA 1	PMRT Tool completed to the required standard 100%		
39. There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. **Action: DOH**	Ockenden IEA 1 CQC Safe Domain CNST SA 1 & 10	PMRT Tool completed to the required standard 100% HSIB reporting 100%		
40. Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. **Action: DOH**	Ockenden IEA 1 CQC Safe Domain	Risk Management Strategy Policy for review of deaths Does this include all stillbirths		Requires national policy change
41. Systematic guidance drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. **Action: Academy of Medical Royal Colleges, RCN, RCM**	Ockenden IEA 1 CQC Safe Domain	GIRTH visits CQC core service framework NHSEI self-assessment framework tool reviewed and updated February 2022 LMNS external reviewers External review sought on the spike in still births in November 2020		

East Kent Hospitals University NHS Foundation Trust

42. All external reviews of suspected service failures be registered with the CQC and Monitor, and that the CQC develops a system to collate learning from reviews and disseminate it to other Trusts. **Action: CQC, Monitor**	Ockenden IEA 1 CQC Safe Domain	Part of the MMSP Programme National HSIB Report CQC maternity reports		
43. The importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. **Action: NHSE, DOH**	National NHSEI team ICS	CQC report any concerns to NHSEI prior to a merger LMNS Board Regional Perinatal Quality Oversight Group includes all stakeholders		
44. Establish a proper framework, on which future investigations could be promptly established. This would include setting out the arrangements necessary to access to documents, clarifying responsibilities of current and former health service staff to cooperate. **Action: DOH**	National NHSEI team ICS	Information Governance Policy IG training SLT support for staff before, during and after external investigations.		

East Kent Hospitals University NHS Foundation Trust

Appendix 4: National Maternity Self-Assessment Tool and Action Plan- February 2022

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	Clinically-led triumvirate	Trust and service organograms showing clinically led directorates/care groups	G	Need to ensure updated to reflect split for Women's and Children
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes	G	Triumvirate job descriptions for Clinical Director, DOM and Director of Operations
	Director of Midwifery (DoM) in post (current registered midwife with NMC)	DoM job description and person specification clearly defined	G	JD and PS
		Agenda for change banded at 8D or 9	G	DOM banded as Band 9 New role Deputy DOM is band 8D
		In post	G	Interim appointed – Out to recruit Deputy
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate	G	JD of Director of Midwifery (DoM) to Chief nurse. CD to CMO and Dir Ops to COO
		Clinical director to executive medical director	G	JD Clinical Director to CMO
		DoM to executive director of nursing	G	JD to CNO
		General manager to executive chief operating officer	G	JD of Director of Operations to COO
		Maternity services standing item on trust board agenda as a minimum three- monthly Key items to report should always include: SI Key themes report, Staffing for maternity services for all relevant professional groups Clinical outcomes such as SB, NND HIE, AttAIN, SBLCB and CNST progress/Compliance. Job essential training compliance Ockendon learning actions	G	Maternity SI's reported to Q&S Committee as well as via the monthly PQST to Trust Board, via the Maternity and Neonatal Assurance Group (MNAG) CNST standards reported to Trust board as per guidance. PQST used to report monthly, includes incidents, training and workforce Oversight of Ockenden action plan by MNAG and reported to Trust Board
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]	G	Reporting monthly using PQST to Trust Board via MNAG in place
		There should be a minimum of three PAs allocated to clinical director to execute their role	G	3 PAs allocated for role
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team	A	Care Group structure in place. Site/unit leadership requires further strengthening – not yet embedded although in progress
		Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave	G	Named HR business partner in place for Women's services – shared with other divisions

East Kent Hospitals University NHS Foundation Trust

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate	G	Finance business partner in place
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area	A	Weekly meetings with HOMS, Matrons and managers commenced Jan 2022 – to monitor via meeting with DOM as reports generated – not embedded
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways	A	Additional operational manager required for WHH – Out to advert
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups	A	Women Clinical Governance meeting in place, Divisional Senior management Group, Maternity Risk Meetings and Labour ward Forum. MNAG. Risk Management Strategy under review due end of March 2022 will then need embedding
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, eg senior midwifery leadership assembly	A	Woman's Directorate, Maternity Labour Ward Forum, Maternity Risk meeting, Women Services Guidelines Group. Senior Midwifery Group Risk Management Strategy under review due end of March 2022 will then need embedding
		Leadership culture reflects the principles of the '7 Features of Safety'.	A	https://for-us-framework.carrd.co/ Recognised there are challenges around professional behaviours – cultural change programme in place and includes robust mechanisms for delivery of positive cultural and behavioural change
	Leadership development opportunities	Trust-wide leadership and development team in place	G	Organisational development team trust wide. Additional programme in progress to support leadership of maternity teams, supported by HR
		Inhouse or externally supported clinical leadership development programme in place	G	Mentoring arranged for HOMs Leadership programmes for matrons Externally funded Connected Matron and HOM Programme delivered 2020-21. Inhouse Clinical Leads programme delivered 2020-21. Externally funded Connected Band 7 programme commences 31/5/22 and will be run over three cohorts from 2022-23. Bespoke inhouse sessions will be delivered in line with personal training needs.

East Kent Hospitals University NHS Foundation Trust

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Leadership and development programme for potential future talent (talent pipeline programme)	A	As above – exploring band 6 opportunities for aspiring leaders External programmes utilised Trust succession planning and Talent Management tool currently being piloted and will be rolled out across the Trust.
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship	A	Mentoring for HOMs secured Coaching and mentoring offered one to one Band 7 programme commissioned Matrons have completed programme
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy	G	Organogram
		Organisational vision and values in place and known by all staff	G	Trust values aligned to We care programme – maternity part of programme
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]	G	See above regarding Vision and Values Workshops. Just and Learning Culture decision tool developed and shared with HR and RCM. Freedom to Speak Up Guardian Policy and Maternity representatives in place.
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years	G	Strategy in place, but under review to align to maternity improvement programme Expected date of completion 31/3/2022 for Trust Board review prior to LMNS file:///C:/Users/hayley.marle1/Downloads/EKHUFT_Maternity%20Strategy_FINAL%20Jan%202021%20(1).pdf
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan	G	Maternity action plan in place – strategy aligned to national priorities
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.	A	Strategy in place and being updated scheduled completion date 31/03/2022 file:///C:/Users/hayley.marle1/Downloads/EKHUFT_Maternity%20Strategy_FINAL%20Jan%202021%20(1).pdf
		Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]	G	Processes in place but need to be embedded and strengthened. Plan developed and going to Board 10.3.22

East Kent Hospitals University NHS Foundation Trust

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity strategy aligned with trust board LMNS and MVP's strategies	A	Strategy being updated scheduled completion date 31/03/2022
		Strategy shared with wider community, LMNS and all key stakeholders	A	Strategy being updated scheduled completion date 31/03/2022
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor	G	NED for maternity services in place
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor	G	DoM/CDs/HOMs
		All Safety champions lead quality reviews, eg 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)	G	15/1/22 AN pathway diagnostic with MVP and users across MDT Led by DOM 19/1/22 – Widening the way feedback is obtained from women with MVP, Led by CNO
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services	G	Reports presented at both MNAG and Trust Board reflect challenge by Maternity NED safety champion
		A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]	G	Safety Champion report to Trust Board on 3/2/22
Multiprofessional team dynamics	Multiprofessional engagement workshops	Planned schedule of joint multiprofessional engagement sessions with chair shared between triumvirate, ie quarterly audit days, strategy development, quality improvement plans	A	New MDT meeting structure developed, and open staff forums planned led by triumvirate
		Record of attendance by professional group and individual	G	Audit day's attendance list
		Recorded in every staff member's electronic learning and development record	G	Training records are maintained for each individual within the ESR and maternity training team database Maternity specific training is recorded on PTL at individual level. Documented as part of the appraisal process. ESR records all MAST, generic training
	Multiprofessional training programme	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see	A	Training Matrix in place and presented to MNAG Supported by lesson plans. LMNS QSG Core competency assessment agenda 3 times a year exception reporting Maternity, Neonatal Safety Concerns group
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority	A	Training matrix in place, TNA being finalised – Programme of training including hours agreed
		All staff given time to undertake mandatory and job essential training as part of working hours	G	Attendance records

East Kent Hospitals University NHS Foundation Trust

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Full record of staff attendance for last three years	G	Spreadsheet of training compliance
		Record of planned staff attendance in current year	G	As above – moving to block training days – attendance ahead currently being updated from April 2022. Recorded on Training Tracker
		Clear policy for training needs analysis in place and in date for all staff groups	A	Training needs analysis guideline – Currently being updated
		Compliance monitored against training needs policy and recorded on roster system or equivalent	A	Recorded via ESR and training dashboard maintained. Monitored via training matrix
		Education and training compliance a standing agenda item of divisional governance and management meetings	G	In the Perinatal Quality Surveillance Tool monthly through to MNAG and WHCG Governance Committee
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]	G	MDT, prompt and CTG training sessions in place
		Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal	A	Training matrix in place
	Clearly defined appraisal and professional revalidation plan for staff	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation	G	Trust standards for appraisal
		Compliance with annual appraisal for every individual	A	Monthly monitoring by divisional senior team in conjunction with HR. Reflects appraisal rate. Compliance dropped during COVID-19. Teams working to achieve 85% required compliance rate
		Professional validation of all relevant staff supported by internal system and email alerts	G	Staff receive email alerts re: professional revalidation
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities	A	Monthly monitoring by divisional senior team in conjunction with HR. Reflects appraisal rate. Compliance dropped during COVID-19. See above.
		Schedule of clinical forums published annually, eg labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings	G	Meeting schedules in place.
	Multiprofessional clinical forums	HR policies describe multiprofessional inclusion in all processes where applicable and appropriate, such as multiprofessional involvement in recruitment panels and focus groups	G	Recruitment policy reflects diversity and equality and requirement of recruitment and retention training for staff involved in selection of staff
	Multiprofessional inclusion for recruitment and HR processes	Organisational values-based recruitment in place	G	Recruitment principles based on diversity and questions based around Trust values
		Multiprofessional inclusion in clinical and HR investigations, complaint and compliment procedures	G	Trust policies regarding HR investigations complaints and compliance support diversity MVP included in the recruitment of key posts

East Kent Hospitals University NHS Foundation Trust

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Standard operating procedure provides guidance for multiprofessional debriefing sessions following clinical incidents or complaints	A	Risk Management Strategy under review due end of March 2022 Performance plan process
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy	A	Through use of TRIM practitioners and PMAs debrief sessions available Risk Management Strategy under review due end of March 2022 will detail
		Schedule of attendance from multiprofessional group members available	A	Risk Management Strategy under review due end of March 2022
	Multiprofessional membership/ representation at Maternity Voices Partnership forums	Record of attendance available to demonstrate regular clinical and multiprofessional attendance.	G	Training records and attendance kept
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design	G	MVP and service users involved in pathway development for AN care, improving feedback from women, part of recruitment process for key roles Co-produced the maternity Strategy – good attendance at MVP meetings for all stakeholders. Co-production annual work plan
		Quality Improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users	G	We Care Programme is our QI approach across the trust. Maternity Improvement Plan in infancy. MatNeoSip perinatal optimisation aligned
	Collaborative multiprofessional input to service development and improvement	Roles and responsibilities in delivering the QIP clearly defined, ie senior responsible officer and delegated responsibility	G	All improvement work in the trust has an SRO and project Lead. Internal programme structure (13 workstreams) enables the MIP and is reported to the MNAG
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP	G	The care group have 6 quality improvement drivers, that are clearly defined and measured on a weekly and monthly basis. The outcome of the drivers will either directly impact on staff and/or patients. KPIs are defined by local or national requirements on Maternity Dashboard e.g. SBL Care bundle, CNST. We Care. FFT outcome measure

East Kent Hospitals University NHS Foundation Trust

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Identification of the source of evidence to enable provision of assurance to all key stakeholders	G	The actions identified to address the issues are developed as a result of a root cause analysis which involves all stakeholders. Each driver is pre-agreed with the executive team along with the measure and data used to evidence success. Evidence folders in place. Evidence review process and action plan assurance process
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access	G	The Trust has developed electronic dashboards for the care group drivers, with access linked to login. Evidence folders in place
		Clear communication and engagement strategy for sharing with key staff groups		Is there a Trust wide comms/engagement strategy?
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements	G	The we care improvement drivers are all linked to the Trusts true north measures, which are the agreed areas for improvement. The Trust level true norths are all aligned to the national and local ask, and are reviewed annually. For example, the deteriorating patient. All service level and local improvements are aligned to the care group drivers or Trust true norths.
		Weekly/monthly scheduled multiprofessional safety incident review meetings	G	3 times a week a Rapid Review with Senior Staff Weekly MDT Risk meetings held a cross site Monthly Patient Safety Group
	Multiprofessional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	R	Will seek LMNS advice
		Positive and constructive feedback communication in varying forms	G	Message of the Week Risky Business Audit meetings, Perinatal meetings, PMA forums, closed Facebook page SMT 1:1s TRIM/SBIC
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach	G	Weekly MDT Risk meetings cross sites are open forums with core membership to discuss unusual cases
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]	A	Risk Management Strategy under review due end of March 2022 PMA Strategy

East Kent Hospitals University NHS Foundation Trust

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Schedule of focus for behavioural standards framework across the organisation	A	Organisation development 'living our values, we care' work started in Women's Health and to be rolled out across Agreed set of Values and Behaviours across the organisation. Included in Recruitment process, Appraisal and Training. Work to embed and live these behaviours in Maternity commenced 17/1/22 through vision and values workshops.
	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month	G	Values added to agenda paperwork and used as ground rules.
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]	G	HR Policies and procedures in place Use of the behaviour leaflets and giving feedback through the SBIC model is encouraged at the vision and Values workshops. FTSU Guardian for Maternity Trust updating the Resolution Policy to align with Just and Learning Culture methodology.
		All policies and procedures align with the trust's board assurance framework (BAF)	G	Organisational policies and procedures. All policies go through Staff Committee and Trust Board.
Women services Governance infrastructure and ward-to-board accountability	System and process clearly defined and aligned with national standards	Governance framework in place that supports and promotes proactive risk management and good governance	A	Risk Management Strategy under review due end of March 2022
		Staff across services can articulate the key principles (golden thread) of learning and safety	A	Risk Management Strategy under review due end of March 2022 Poor behaviours demonstrated in a minority of staff Just Culture work underway
		Staff describe a positive, supportive, safe learning culture	A	Risk Management Strategy under review due end of March 2022 Poor behaviours demonstrated in a minority of staff Just Culture work underway
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams	A	Risk Management Strategy under review due end of March 2022

East Kent Hospitals University NHS Foundation Trust

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity governance structure within the directorate	Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife Clinical educators to include leading preceptorship programme Appropriate Governance facilitator and admin support	A	Risk Management Strategy under review due end of March 2022. The structure is already in place and needs to be articulated in strategy Governance Matron – EOI and advert out Obstetrician – 2 PAs secured recruiting to post 2 WTE PS Midwives 3 WTE PD Midwives Admin support 0.6 PMRT Lead Funding and support needed to strengthen
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member	A	As above
		Team capacity able to meet demand, e.g. risk register, and clinical investigations completed in expected timescales	A	SI investigations not completed timely. Funding approved and recruitment processes underway
		In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF	A	The Risk Management Strategy in place is for Women's Health (not maternity specific). It is under review due end of March 2022
	Maternity-specific risk management strategy	Clearly defined in date trust wide BAF	A	Standardised BAF
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board	G	Trust perinatal quality surveillance highlight report implemented Oct 2021
		Mechanism in place for trust-wide learning to improve communications	G	Intranet – Safety Pins, Risk Wise. Social media accounts
	Proactive shared learning across directorate	Mechanism in place for specific maternity and neonatal learning to improve communication	A	Message of the week – in place in Neonatal & maternity Risky business Maternity closed Facebook. Plans to start learning videos & podcasts. No assurance of message sent was message received.
		Governance communication boards	A	Q&S Boards in all clinical areas.
		Publicly visible quality and safety board's outside each clinical area	A	Check dates – no mechanism for updating
		Learning shared across local maternity system and regional networks	A	Data sharing in its infancy and embedding learning. Awaiting governance strategy to highlight where reporting should be. Check – shared eLearning events – is there Q&S sub group of LMNS?
		Engagement of external stakeholders in learning to improve, eg CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups	G	LMNS links Regional meetings LMNS CAROL LMNS perinatal

East Kent Hospitals University NHS Foundation Trust

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.	G	Trustwide communication strategy as above
		Multi-agency input evident in the development of the maternity specification	G	The mat spec is agreed by the LMNS Mat commissioner on an annual basis therefore is it a LMNS maternity specific agreed with all acute trusts
Application of national standards and guidance	Maternity specification in place for commissioned services	Approved through relevant governance process	G	The mat spec is agreed by the LMNS Mat commissioner on an annual basis therefore is it a LMNS maternity specific agreed with all acute trusts
		In date and reflective of local maternity system plan	G	The mat spec is agreed by the LMNS Mat commissioner on an annual basis therefore is it a LMNS maternity specific agreed with all acute trusts
		Full compliance with all current 10 standards submitted	A	Currently below compliance for CO monitoring at 36 weeks
	Application of CNST 10 safety actions	A SMART action plan in place if not fully compliant that is appropriately financially resourced.	G	Action place and monitored via MNAG
		Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance	G	LMNS and improvement leads part of MNAG
		Clear process for multiprofessional, development, review and ratification of all clinical guidelines	G	Guideline group in place
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multiprofessional meetings for a rolling 12 months programme.	G	Monthly meetings in place.
		All guidance NICE complaint where appropriate for commissioned services	A	Addressed through guideline group however some delay in implementation due to covid working pressures and rotas
		All clinical guidance and quality standards reviewed and updated in compliance with NICE	A	Addressed through guideline group however some delay in implementation due to covid working pressures and rotas. IOL and Fetal monitoring non compliant.
		All five elements implemented in line with most updated version	A	Part of CNST action plan
	Saving Babies Lives care bundle implemented	SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.	A	Under review
		Trajectory for improvement to meet national ambition identified as part of maternity safety plan	G	Implemented
		All four key actions in place and consistently embedded	A	
	Application of the four key action points to reduce inequality for BAME women and families	Application of equity strategy recommendations and identified within local equity strategy	G	A maternity continuity care COC plan following Dec 2021 national publication. This asks for a clear plan for 100% of women to be placed on a COC pathway by March 2024 and this prioritises BAME. Is there a guideline on these principles? Check Guidelines Jess

East Kent Hospitals University NHS Foundation Trust

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All actions implemented, embedded and sustainable	G	A maternity continuity care COC plan following Dec 2021 nat publication. This asks for a clear plan for 100% of women to be placed on a COC pathway by March 2024 and this prioritises BAME. Is there a guideline on these principles? Check Guidelines Jess
	Implementation of 7 essential learning actions from the Ockendon first report	Fetal Surveillance midwife appointed as a minimum 0.4 WTE	G	Both sites
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs	G	Within the trust there is 2 foetal monitoring/surveillance consualnts who both have 1 PA a week.
		Plan in place for implementation and roll out of A-EQUIP	G	Lead PMA in post leading on implementation of A-EQUIP
	A-EQUIP implemented	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team	G	PMA strategy relaunch has begun and supports governance framework
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered	G	4 new staff members allocated to PMA training. Workshop to plan next steps
		Service provision and guidance aligned to national bereavement pathway and standards	A	Review of model of services needed to provide
	Maternity bereavement services and support available	Bereavement midwife in post	G	
		Information and support available 24/7	G	
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities	A	Facilities at WHH are not in ideal location
		Quality improvement leads in place	G	Maternity service has a dedicated Improvement and Transformation Manager
	Quality improvement structure applied	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation	G	Comprehensive maternity Improvement plan in place with dedicated programme manager to support
		Recognised and approved quality improvement tools and frameworks widely used to support services	G	We Care methodology used
		Established quality improvement hub, virtual or otherwise	A	Programme established, but location to be found for hubs
		Listening into action or similar concept implemented across the trust	G	Change Team members – 33 staff in the Care Group
		Continue to build on the work of the MatNeoSip culture survey outputs/findings.	G	EKUFT MatNeoSip Wave 1. PMA Lead led on the Score Culture Survey in April 2018. Survey results and and presentations available. Work evolved into the We Crae – Postive behaviour culture change
	MatNeoSip embedded in service delivery	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan	A	Risk Management Strategy under review due end of March 2022
	Maternity transformation programme (MTP) in place	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)	G	Maternity Improvement Plan – 13 workstreams reported monthly to MNAG.

East Kent Hospitals University NHS Foundation Trust

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Positive safety culture across the directorate and trust	Maternity safety improvement plan in place	Standing agenda item on key directorate meetings and trust committees	G	Monthly MNAG, Trust Board, Care Group
		FTSU guardian in post, with time dedicated to the role	G	1 FTE in post dedicated to maternity
	Freedom to Speak Up (FTSU) guardians in post	Human factors training lead in post	A	All training incorporates HF and a cohort of staff are specialised HF trained in the Trust
	Human factors training available	Human factors training part of trust essential training requirements	G	All training incorporates HF
		Human factors training a key component of clinical skills drills	G	All training incorporates HF
		Human factors a key area of focus in clinical investigations and formal complaint responses	A	Embedded into incident investigations and starting to be used in complaint investigations
		Multiprofessional handover in place as a minimum to include Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas eg, antenatal/postnatal ward/triage.	A	Not all roles always present.
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern	G	
		A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's	G	
	Safety huddles	Guideline or standard operating procedure describing process and frequency in place and in date	G	Present within the maternity escalation guideline.
		Audit of compliance against above	A	Audit and monitoring process under deveoplment
		Annual schedule for Schwartz rounds in place	G	Schedulded
	Trust wide Swartz rounds	Multiprofessional attendance recorded and supported as part of working time	G	attendance is recorded.
		Broad range of specialties leading sessions	G	Various specialities leading sessions throughout the year
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse	G	
	Trust-wide safety and learning events	Robust process for reporting back to divisions from safety summit	R	Under consideration to implement

East Kent Hospitals University NHS Foundation Trust

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Annual or biannual trust-wide learning to improve events or patient safety conference forum	A	Other mechanisms utilised more frequently such as Risk Wise, and Trust News
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes	A	Not every month
		In date business plan in place	G	Business planning cycle in progress
Comprehension of business/ contingency plans impact on quality. (i.e. Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)	Business plan in place for 12 months prospectively	Meets annual planning guidance	G	Business planning cycle in progress
		Business plan supports and drives quality improvement and safety as key priority	G	Maternity Improvement programme driving quality improvements
		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups	A	Confidence in using BR+ being embedded
		Consultant job plans in place and meet service needs in relation to capacity and demand	A	Under review to meet demand
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans	G	
		Business plans ensures all developments and improvements meet national standards and guidance	G	Aligned to maternity improvement programme
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.	A	Maternity strategy to be revised to align to local and national requirements by 31/3/22
		Business plans include dedicated time for clinicians leading on innovation, QI and Research. That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.	G	We Care Programme Mat CoC plan
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidances.	That Employment Policies and Clinical Guidances meet the publication requirements of Equity and Diversity Legislation.	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.	G	Continuity of Carer action plan submitted to Board in Jan 2022 to meet requirements of 35% of all women booked onto CoC by March 2023 (assuming building blocks achieved) to include 35% BAME women booked onto CoC.
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template	G	Stepping Up to Public Health Model launched with RCM represenattaives and embedded

East Kent Hospitals University NHS Foundation Trust

Key lines of enquiry	Kirkup recommendation number
Leadership and development	2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18
Governance: Covers all pillars of Good governance	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Quality Improvement: application of methodology and tools	5, 6, 9, 12, 13, 15, 16, 17, 18
National standards and Guidance: service delivery	2, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Safety Culture: no blame, proactive, open and honest approach, Psychological safety	2, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Patient Voice: Service user involvement and engagement through co-production and co-design. MVP and wider	6, 9, 11, 12, 13, 15, 17, 18
Staff Engagement: Harvard System two leadership approach, feedback and good communication tools	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Business Planning: aligned with LMNS plans and the National Maternity Transformation agenda, Maternity safety strategy and the Long term plan	8, 9, 10, 14, 15, 16, 17, 18

Maternity services system learning: Maternity self-assessment tool Action Plan 2021

RAG Key:

	No action required. Trust process that meets current recommendations in place and evidenced.
	Process in place. Minor action only required; in progress and on target to achieve.
	Action required and on target.
	Action required and overdue.

Recommendations	GAP	Action	Lead	Date for Achievement	RAG
Maternity Improvement Plan (Workforce)					
Collaborative leadership at all levels in the directorate/ care group	6 areas rated Amber	Action included and Monitored through the Maternity Improvement Plan (Workforce)	Director of Midwifery	31/03/2022	
Leadership development opportunities	3 areas rated Amber				
Multiprofessional inclusion for recruitment and HR processes	3 areas rated Amber				
Clearly defined appraisal and professional revalidation plan for staff	2 areas rated Amber				
Maternity Improvement Plan (Governance)					
Women services Governance infrastructure and ward-to-board accountability	2 areas rated Amber	The Quality Management System including a maternity specific risk management strategy will enable safe and high quality care for all.	Interim Head of	31/03/2022	

East Kent Hospitals University NHS Foundation Trust

Recommendations	GAP	Action	Lead	Date for Achievement	RAG
Accountability framework	1 area rated Amber	Action included and Monitored through the Maternity Improvement Plan (Governance) A Quality improvement structure needs to be applied Patient Safety Group set up in December and evolving.	Governance		
Maternity strategy, vision and values	3 areas rated Amber				
System and process clearly defined and aligned with national standards	6 areas rated Amber A maternity-specific risk management strategy is being developed				
Proactive shared learning across directorate	4 areas rated Amber				
Application of CNST 10 safety actions	2 areas rated Amber				
Clinical guidance in date and aligned to the national standards	3 areas rated Amber				
Multiprofessional approach to positive safety culture	2 areas rated Amber				
Implementation of 7 essential learning actions from the Ockenden first report	2 area rated Amber				
Positive safety culture across the **directorate** and trust - Trust-wide safety and learning events	3 areas rated Amber and 2 areas rated Red				
Multiprofessional team dynamics - training programmes and engagement workshops	6 areas rated Amber	Block contents developed and Location for simulation training being sought. Faculty of Multi-Professional Learning in Maternity established. TOR approved and first meeting 02/03/2022	Clinical lead for Education – Women's health	30/04/2022	
Collaborative multi-professional input to service development and improvement and Positive safety culture across the directorate and **trust** - Trust-wide safety and learning events	area rated red– A Schedule is not in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	Set up a schedule for monthly organisational wide safety summits	Director of Quality Governance /Head of Patient Safety	30/04/2022	
Comprehension of business/ contingency plans impact on quality. (i.e. Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan) Business plan in place for 12 months prospectively	3 areas rated Amber	Business planning has commenced and lead through the Care Group triumvirate in partnership with corporate teams	Women's Director of Operations	30/4/22	
Application of national standards and guidance Saving Babies Lives care bundle implemented	1 area rated Amber	Embedding SBLCB. KPIs recorded on Maternity Dashboard. Exception reported Monthly to Maternity and Neonatal Assurance Group (MNAG) and Trust Board and through the Perinatal Quality Surveillance Model to LMNS/Region. Quarterly Detailed Reporting to MNAG and Trust Board. Rational for Amber is CO monitoring at 36 weeks being below 80% target at 74%-mitigations in place. MCoC-Plan submitted to Board and LMNS around ensuring that the building blocks are in place to move to this as the default model of care provision. CNST Safety Actions are being implemented. Ockenden Recommendations 72% implemented. PCSP being progressed supported by an LMNS wide approach.	Maternity Transformation Lead	30/6/22	

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) SAFETY ACTION 6: SAVING BABIES LIVES CARE BUNDLE VERSION 2 REPORT**
MEETING DATE:	**10 MARCH 2022**
BOARD SPONSOR:	**CHIEF NURSING & MIDWIFERY OFFICER (CNMO): MATERNITY AND NEONATAL BOARD SAFETY CHAMPION**
PAPER AUTHOR:	**INTERIM DIRECTOR OF MIDWIFERY: MIDWIFERY SAFETY CHAMPION**
APPENDICES:	**APPENDIX 1: SAVING BABIES LIVES VERSION 2 ACTION PLAN**

Executive Summary:

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

Purpose of the Report:

- To update the BoD on East Kent Hospital's Maternity's progress in implementing the Saving Babies Lives Care Bundle version 2 (SBLCBv2), also aligned to Safety Action No:6 CNST.
- To highlight risks in achieving the recommendations and describe the action plan that is in place to mitigate (see Appendix 1: SBLCBv2 Action Plan).
- To update with regards to the national pause in reporting procedure regarding the Maternity Incentive Scheme received 23 December 2021.

Summary of Key Issues:

Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?		
5 Elements of SBLCBV2	**RAG**	Risks
ELEMENT 1: Reducing smoking in pregnancy		CO monitoring at 36 weeks is below 80% compliance level at 76.4 %. Actions in place to mitigate
ELEMENT 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction		Uterine artery Dopplers (UtAD) Implementation 2 February 2022. Appendix G reduced scanning schedule stops on introduction of UtADs
ELEMENT 3: Raising awareness of reduced fetal movement		Compliance 74.4% (requirement 80%) for women attending with reduced Fetal Movements having Computerised Cardiotocograph (CTGs). Workflow changes to improve data quality being introduced
ELEMENT 4: Effective fetal monitoring during labour		Compliant across all staff groups for January 2022

East Kent Hospitals University NHS Foundation Trust

	ELEMENT 5: Reducing preterm births		Not meeting Steroid and Magnesium Sulphate standards. This is a recognised National challenge - will not fail if isn't achieved. Action plan and Maternity Neonatal Quality Improvement work in progress to support

Key Recommendation(s):	The Board of Directors is invited to: 1. **NOTE** the receipt and content of this Quarterly Saving Babies Lives Care Bundle version 2 update report; and 2. **NOTE** the identified risk in reaching the required compliance of Carbon Monoxide (CO) Monitoring at 36 weeks of pregnancy, to the required compliance of 95%, in line with Element 1: Reducing Smoking in Pregnancy, National guidance.
Implications:	
Links to 'We Care' Strategic Objectives:	
Our patients / **Our people** / **Our future** / Our sustainability / **Our quality and safety**	
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35**: Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.
Resource:	N
Legal and regulatory:	Y — CNST, SBLCBv2, NHS Long Term Plan-standard contract, Ockenden Report Recommendations 2021
Subsidiary:	N
Assurance Route:	
Previously Considered by:	Maternity and Neonatal Assurance Group 8 March 2022

East Kent Hospitals University NHS Foundation Trust

CNST Safety Action 6: Saving Babies Lives Care Bundle Version Two Quarterly Report

1.	**Purpose**
1.1.	The purpose of this report is to update the Trust Board on East Kent Maternity's progress in implementing the CNST, Maternity Incentive Schemes Safety Action 6 Standards: Demonstrating compliance with all five elements of the SBLCBv2.
1.2.	Raise awareness of risks in achieving this Safety Action and describe the action plan in place to mitigate (see Appendix 2: SBLCBv2 Action Plan).
2.	**Background and Executive Summary**
2.1.	The Saving Babies' Lives Care Bundle is a group of actions that have been developed to improve outcomes for women and babies but its success ultimately depends on how well it's implemented.
2.2.	The NHS Long Term Plan reiterates the NHS's commitment to a 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury and a reduction in preterm birth rate, from 8% to 6%, by 2025. To this end, implementation of the care bundle has been included in the planning guidance and incorporated into the standard contract.
2.3.	In version 2 of the Care Bundle, published in April 2019, its scope extended to reducing preterm birth and improving care when preterm birth cannot be avoided. It is known from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) surveillance data that 70% of all stillbirths and neonatal deaths occur in babies born before term and nearly 40% are extremely preterm, being born before 28 weeks' gestation. From this it is clear that achieving the national ambition to halve perinatal deaths will not be met until efforts are focused on preventing preterm birth and optimising the management for those babies who are nevertheless born preterm.
2.4.	In Year 3 of the CNST scheme, the Board Declared non-compliance against this Safety Action. Computerised Fetal Monitoring for assessing risk and care planning for women attending with reduced fetal movements had been newly introduced and while audits on both hospital sites had demonstrated compliance, the Trust Board did not feel that enough time had passed to be assured that this was an embedded service change.
2.5.	CNST Year 4 was launched 8 August 2021 and requires there to be evidence of Trust Board level consideration of how the Trust is complying with the SBLCBv2.
2.6.	A quarterly care bundle survey, distributed by the Clinical Networks, must be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey was last completed in May 2021 and communication received by both the Clinical Network and confirmed by NHS Resolution (NHSR) advises that this will be paused until January 2022.
2.7.	The table below provides a summary of implementation against each element of SBLCBv2 and current risks to achieving.

Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?		
5 Elements of SBLCBV2	**RAG**	Risks
ELEMENT 1: Reducing smoking in pregnancy		CO monitoring at 36 weeks is below 80% compliance level at 76.4 %. Actions in place to mitigate.
ELEMENT 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction		Uterine artery Dopplers (UtAD) Implementation 2 February 2022. Appendix G reduced scanning schedule stops on introduction of UtADs
ELEMENT 3: Raising awareness of reduced fetal movement		Compliance 74.4% (requirement 80%) for women attending with reduced Fetal Movements having Computerised CTGs. Changes to improve data recording
ELEMENT 4: Effective fetal monitoring during labour		Compliant across all staff groups for January 2022
ELEMENT 5: Reducing preterm births		Not meeting Steroid and Magnesium Sulphate standards. This is a recognised National challenge- will not fail if isn't achieved. Action plan and Mat Neo Quality Improvement work in progress to support

3. CURRENT POSITION

3.1. **Pause in reporting procedure regarding the maternity incentive scheme**

3.1.1. In recognition of the current pressure on the NHS and maternity services, the majority of reporting requirements relating to demonstrating achievement of the Maternity Incentive Scheme (MIS) 10 safety actions are paused with immediate effect from 23 December 2021, for a minimum of 3 months.

3.1.2. This will be kept under review. Trusts are asked to continue to apply the principles of the 10 safety actions, given that the aim of the MIS is to support the delivery of safer maternity care.

3.1.3. The reporting period for MIS year 4 will also be kept under review and may potentially be extended by the MIS Collaborative Advisory Group (CAG) who will reconvene in February 2022.

3.1.4. Trusts will be provided with a timetable and revised technical guidance in due course.

3.2. **Element 1: Reducing smoking in pregnancy**

3.2.1. The Trust Board should receive data from the organisation's MIS evidencing an average of 80% compliance over a six-month period on the percentage of women where Carbon Monoxide (CO) measurement at booking and at 36 is recorded.

3.2.2. Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80% for a six month average. **December data shows compliance to be at 93.3% at booking but 76.4% at 36 weeks.**

3.2.3. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. An action plan is in place to meet 36 week CO compliance but this will only support CNST declaration position if the six month average can be increased to above 80%.

3.2.4. CO Monitoring was suspended during the Covid-19 pandemic on National advice and reintroduced in July 2021.

3.2.5. The Smoking Cessation Midwife has undertaken significant amounts of engagement work to increase compliance again to pre-pandemic percentages.

3.2.6. Actions include feedback to Community Midwives on team and individual compliance to raise awareness and address any training/education gaps this exposes.

3.2.7. The following outcome indicators are now reported on the maternity dashboard

- Percentage of women with a CO measurement ≥4ppm at booking.
- Percentage of women with a CO measurement ≥4ppm at 36 weeks.
- Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment.
- Next steps included generating and reviewed these outcome case by case to identify themes and learning.

3.2.8. Trusts are required to pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric.

3.2.9. The Trust passed this for July and August 2021. However, the September dataset was submitted used the Euroking extract to test the providers system and in doing so the Trust failed this Data Quality metric on CQDIMDQ04 – smoking status recorded for at least 70% of bookings.

3.2.10. This will not affect our compliance which is based on final submission data. Final submission was to be on January data but this has been postponed and no new date has been provided yet.

3.2.11. October data was submitted using the internal process and there is confidence this will meet compliance.

3.2.12. Trusts are required to have a referral pathway to smoking cessation services (in house or external). Referral compliance is captured on the Maternity Dashboard and is currently 84.8%. No metric target is set for this within CNST but internal target is 85%.

3.2.13. An audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service is a planned piece of work to be carried out by the smoking Cessation Lead Midwife and will be reported next Quarter, pending any changes to Year 4 requirements.

3.2.14. The table below shows Smoking data recorded on the Maternity dashboard

Month	Aim	Aug	Sept	Oct	Nov	Dec
Total Bookings	600	555	653	538	628	570
Smoking at Booking	No national target set EK 12.1%	16.5% (91)	14.3% (93)	12.9% (69)	15.2% (95)	14% (79)
% CO taken at Booking	80%	88.3% (490)	91.9% (600)	92.6% (498)	94.4% (593)	93.3% (532)

% CO taken at 36 weeks	80%	71% (276)	79% (338)	73.6% (285)	74.7% (293)	76.4% (291)
Referral for smoking cessation	No national target set EK 85%	94.5%	90.3%	79.7%	88.4%	84.8%
CO >=4ppm at Booking %	No national target set EK 12.1%	21.6% (106)	20.0% (120)	15.5% (77)	17.4% (103)	16.5% (88)
CO >=4ppm at 36w %	No national target set EK 17%	12.4% (48)	9.6% (41)	9.8% (38)	8.2% (32)	8.7% (33)
CO >=4ppm at Booking and <4ppm at 36w %	No national target set EK 25%	0	33.3% (1)	0	0	38.5% (5)

3.3. **Element two: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction**

3.3.1. Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and is currently 97.5%.

3.3.2. An additional question is to be added to the Euroking, Maternity Information System to allow this to also be captured following the 20 week scan.

3.3.3. In pregnancies identified as high risk at booking, uterine artery Doppler flow velocimetry must be performed by 24 completed weeks gestation.

3.3.4. The antenatal pathway: Appendix D, risk assessment pathway, which is Nationally approved, will be fully implemented on 2 February 2022. This will be initiated through the 'Go Live' of Uterine Artery Doppler Scans and resuming normal scanning service rather than following Appendix G reduced scanning service that was in place during Covid.

3.3.5. Women with a Body Mass Index (BMI) BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards.

3.3.6. Evidenced through 40 case audits conducted on women who delivered between September 2021 - December 2021, with a BMI over 35. Scans were reviewed via Euroking throughout their pregnancies to ensure they followed the serial scan pathway from 32 weeks gestation (or earlier/more frequently if medically indicated). This audit evidenced 100% compliance.

3.3.7. The detection of babies at risk of Small for Gestational Age (SGA) / FGR Babies is reliant on midwives and Obstetricians performing serial measurement of the fundal height, plotting accurately on Grow Charts, recognising a change, appropriate referral to ultrasound for growth assessment and accurate scan detection Data is submitted to the Perinatal Institute and compliance reports are returned to Trusts quarterly.

3.3.8. The Table below shows Quarter 3 Results and shows the Trust to be above gap and grow user average for both referral and detection rates.

Centile: 10th / 3rd		Trust / Hospital Q1	Q2	Q3	Q4	National GAP Average Q1	Q2	Q3	Q4	Top Ten GAP Average Q1	Q2	Q3	Q4
Completed records [1]	N	1454	1568	1527		-	-	-	-	-	-	-	-
	%	90.5	97.6	95.1		-	-	-	-	-	-	-	-
SGA at birth [2]	n	208	213	207		-	-	-	-	-	-	-	-
	%	14.3	13.6	13.6		12.9	13.3	13.8		12.4	11.5	12.4	
Antenatal referral for SGA [3a]	n	98	96	110		-	-	-	-	-	-	-	-
	%	47.1	45.1	53.1		42.2	41.8	41.1		45.3	48.3	51.9	
False positive antenatal referral for SGA [3b]	n	113	102	111		-	-	-	-	-	-	-	-
	%	9.1	7.5	8.4		14.1	14.3	13.8		15.4	14.3	15.0	
Antenatal detection of SGA [4a]	n	99	99	95		-	-	-	-	-	-	-	-
	%	47.6	46.5	45.9		41.4	41.3	41.2		60.9	60.7	61.4	
False positive antenatal detection of SGA [4b]	n	83	85	68		-	-	-	-	-	-	-	-
	%	6.7	6.3	5.2		6.4	6.6	6.4		10.3	10.3	9.0	

Numbers in brackets refer to definitions below

3.3.9. (3b) Shows the proportion of babies NOT SGA at birth that had been suspected antenatally by fundal height measurement to be SGA/FGR. The Trust is below the National Average and the Top 10 Trusts GAP Average.

3.3.10. (4a) Shows the proportion of babies that had had an Ultrasound Scan (USS) and estimated the fetal weight (EFW) to be under the 10th centile. The Trust is above the National Average for the 3rd quarter running.

3.3.11. (4b) Shows the proportion of babies NOT SGA at birth that were suspected SGA by USS EFW. The Trust is below the national average and the Top 10 Trusts GAP Average.

3.3.12. Below shows the congratulatory e-mail received from the Perinatal Institute for Quarter 3.

Dear Team,

We are pleased to inform you that as a Trust you are **above the GAP user average** for detection rates of SGA babies for Quarter 3 (October - December 2021), please do cascade our congratulations to your team.

Trust Q3 Detection Rate	GAP User Average Q3 Detection Rate
45.9%	41.2%

3.3.13. There is an ongoing quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). No direct themes have been identified but opportunities to further improve are being looked into and will be included in the next report.

3.3.14. The Trust have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT). No cases since January 2021 have been related to the management of FGR.

3.3.15. The risk assessment and management of growth disorders in multiple pregnancy complies with the National Institute for Health and Care Excellence (NICE) guidance. The Fetal Growth Guideline has been updated to reflect this and the Multiple pregnancy Guideline is also to be updated.

3.4. **Element 3: Raising awareness of reduced fetal movement (RFM)**

3.4.1. Note: A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

3.4.2. The percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy is captured on the Maternity dashboard and asked as a question within the Euroking, Maternity Information System workflow. Compliance is 92.2% and actions to improve are captured on the SBLCBv2 Action Plan.

3.4.3. The percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation) is 74.4%. An action plan is in place to improve.

3.4.4. A new Euroking, Maternity Information System workflow went live 25 January 2022, which will improve data capture and quality around compliance which has previously been done via a manual data extraction. This will be captured on the Maternity Dashboard and is also a 'We Care' Driver metric.

3.5. **Element 4: Effective fetal monitoring during labour**

3.5.1. There should be Trust Board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are conducted annually.

3.5.2. This is included in the Fetal Monitoring Training Program and will be taken through the Evidence Review governance process to provide Board Assurance.

3.5.3. The fetal monitoring sessions are consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness.

3.5.4. 90% of eligible staff are required to attend local multi-professional fetal monitoring training annually.

3.5.5. Fetal Monitoring compliance including all relevant staff is shown in the table below

Sum of Compliance	Colum					
Row Labels	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Maternity Support W						
Midwife - Acute	78.6%	76.7%	82.9%	87.4%	89.8%	91.8%
Midwife - Community	93.0%	93.3%	91.5%	95.7%	95.7%	94.6%
Obstetric Consultant	90.9%	88.2%	91.2%	81.3%	87.9%	84.8%
Other Obstetric Docto	87.5%	82.1%	96.0%	84.0%	92.0%	95.7%
Grand Total	**84.9%**	**83.6%**	**87.2%**	**89.2%**	**91.3%**	**92.0%**

3.5.6. Fetal Monitoring compliance with staff on maternity leave and long-term sick removed.

Sum of Compliance	Colum					
Row Labels	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Maternity Support W	#DIV/0!					
Midwife - Acute	84.8%	83.1%	89.9%	94.2%	94.3%	95.4%
Midwife - Community	96.2%	96.3%	94.4%	99.0%	99.0%	97.9%
Obstetric Consultant	93.5%	90.6%	93.8%	83.9%	90.6%	87.5%
Other Obstetric Doctc	91.3%	85.2%	96.0%	84.0%	91.7%	95.5%
Grand Total	**89.8%**	**88.3%**	**92.1%**	**94.0%**	**94.9%**	**95.1%**

3.5.7. Obstetric Consultants are the only staff group non-compliant in Fetal Monitoring training this month but predicted as compliant for Jan 2022.

3.5.8. A full time dedicated Fetal Monitoring Lead Midwife (requirement 0.4 Whole Time Equivalent (WTE)) and Lead Obstetrician (0.1 WTE) per consultant led unit were appointed at the end of 2021.

3.6. **Element 5: Reducing preterm births**

3.6.1. The percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth is 44.4% (target 80%). An action plan is in place to improve and Quality Improvement work aligned to the Maternity and Neonatal Service Improvement Programme, National Drivers is in progress.

3.6.2. The percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids is 11.1% compliant (target less than 20%).

3.6.3. The percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior to birth is 100% compliant (target 80%).

3.6.4. The Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance) is 100% (target 80%).

3.6.5. A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However, Trusts must have an action plan for achieving >80%.

3.6.6. The Trust has a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. Best practice is to also appoint a dedicated Lead Midwife. The Fetal Wellbeing Midwives are the Leads for this workstream.

3.6.7. Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided.

3.6.8. An audit of 40 consecutive cases of women booking for antenatal care is to be completed by April 2022, to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway.

3.6.9. The Preterm Guideline has been updated to include risk assessment and management in multiple pregnancy and complies with NICE guidance. The multiple pregnancy guideline is also being updated to reflect this and will be completed March 2022.

4. Next Steps

4.1. Implement CNST Year 4 update changes once National pause is lifted and new guidance is received.

4.2. Submit Quarterly SBL Care Bundle audit data once this is shared.
4.3. Continue to progress with actions to mitigate areas of non-compliance (see Appendix 3: SBLCBv2 Action Plan) With a particular focus on.
4.4. Launch Uterine Artery Dopplers 2 February 2022.
4.5. An additional question is to be added to the Euroking, Maternity Information System to allow risk assessment to also be captured following the 20 week scans.
4.6. There is an ongoing quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues).
4.7. Monitor impact of launching new fetal monitoring workflow on Computerised CTG data quality.
4.8. Update of multiple pregnancy guideline to include risk assessment and management of growth disorders in multiple pregnancy in compliance with NICE guidance.

5. References

- CNST Maternity Incentive Scheme Year 4 Revised timeframe October 2021: https://resolution.nhs.uk/wp-content/uploads/2021/08/MIS-Y4-guidance.pdf
- SBL care bundle: https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatalmortality/
- The SBLCB v2 Technical Glossary which includes the numerators and denominators for all of the process indicators can be found on the NHS Digital webpages here:
- https://digital.nhs.uk/binaries/content/assets/website-assets/data-and-information/data-sets/maternity-services/sblcbv2-msds-v2.0-technical-glossary-for-publication.xlsxPreterm Birth Clinics: https://www.tommys.org/sites/default/files/202103/reducing%20preterm%20birth%20guidance%2019.pdf

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Appendix 1: SBLCBv2 Action Plan:

Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?							
Action Number	**Safety Action Requirement**	**Action**	**BRAG Status**	**Update/Progress/Rational for status**	**Care Group Lead**	**Planned Completion Date**	**Date of completion**
ELEMENT 1 - Reducing smoking in pregnancy							
SBLCB.E1.1	The Board of Directors should receive data from the organisation's MIS evidencing an average of 80% compliance over a six month period of number of women at booking and 36 weeks gestation who have had CO Monitoring recorded. If compliance is less than 95% then an action plan should be completed	Monitor and track progress on the maternity dashboard. Information analyst to investigate possible dilution of compliance numbers due to more than one contact at 36/40 and only recording CO Monitoring data at one	Complete	**17.11.21** CO Monitoring at booking is 92% and at 36 weeks is 73.6%. Action plan for improving to above 95% target has been developed by Smoking Cessation Midwife. Yet actions are around engaging and sharing data with staff and raising awareness of own and overall compliance to ensure any training/education, process or equipment issues are obstructing ability to provide this recording. **07.12.21** Dashboard data now update to remove any additional touchpoints at 36 weeks so now just the one that CO monitoring was performed/declined	Smoking Cessation Midwife	30.06.22	08.12.21

East Kent Hospitals University NHS Foundation Trust

SBLCB.E1.2		Escalation to GPLs and community matron in order to support CMWs with compliance	In progress (At risk/Overdue)	**17.11.21** Action plan for improving to above 95% target has been developed by Smoking Cessation Midwife. Most actions are around engaging and sharing data with staff and raising awareness of own and overall compliance to ensure any training/education, process or equipment issues are obstructing ability to provide this recording. **07.12.21** Further email out to GPLs requesting specific actions to improve compliance. Team data is being shared weekly and capability being provided to drill down to staff level and understand if CO Monitoring is declined-the reasons that were given for this. Focussed work to then be done to address themes to support safe choices being made by women. Escalation to leadership team of risk and through internal governance and PQST.	Smoking Cessation Midwife	30.06.22	
SBLCB.E1.3		Email "countdown" to highlight focus of 36/40 monitoring.	Complete	**17.11.21** email sent to all **07.12.21** Further email out to GPLs requesting specific actions to improve compliance. Team data is being shared weekly and capability being provided to drill down to staff level and understand if CO Monitoring is declined-the reasons that were given for this. Focussed work to then be done to address themes to support safe choices being made by women.	Smoking Cessation Midwife	30.06.22	31.12.21
SBLCB.E1.4		Target and support community areas/individuals with low compliance	Complete	**17.11.21** email shared asking for teams to be made aware of this and for feedback on any blocks and risk to completing monitoring.	Smoking Cessation Midwife	30.06.22	01.12.21

SBLCB.E1.5		SiP midwife presence in acute sites and community areas to support staff.	Complete	**07.12.21** All areas and teams visited to offer support and understand any challenges. That had been equipment issues with an out of service monitor and straws but all resolved. No current Equipment or education issues.	Smoking Cessation Midwife	30.06.22	
SBLCB.E1.6		Continue with mandatory training.	In progress	**07.12.21** Ongoing as part of virtual training day.	Smoking Cessation Midwife	30.06.22	
ELEMENT 2 - Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction							
SBLCB.E2.1.1	Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan (e.g. Appendix D) must be over 80% and if less than 95% an action plan must be in place. This is currently unachievable as we are still following the Covid scanning schedule (appendix G) and we do not perform Uterine artery Dopplers, we are unable to follow appendix D, the national risk assessed scanning schedule	Working party group with care group and radiology to discuss issues and find solutions	Complete	**19.11.21** Non-compliant as unable to follow appendix D due to following appendix G and not performing Uterine Artery Dopplers **25.01.22** Plan to go live with UtADs 2 February 2022	Fetal Wellbeing Midwives	30.06.22	31.12.21
SBLCB.E2.1.2		Workshop to review training programme and TNA in line with National Core Competency Framework	In progress	**07.12.21** Workshop took place in October and Training Needs Analysis (TNA) to be updated to meet compliance	Fetal Wellbeing Midwives	10.10.21	
SBLCB.E2.1.3		Develop TNA and implement new training programme	In progress (On schedule)	**07.12.21** Workshop took place in October and TNA to be updated to meet compliance. Launch of new programme will be April 2022	Fetal Wellbeing Midwives	01.04.21	

SBLCB.E2.2.1	Standard 2) women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards (or an alternative intervention that has been agreed with the Clinical Commissioning Group (CCG) and that the Trust's Clinical Network)	Audit Notes for compliance-20 sets per site. Compliance must be above 80% and an action plan in place if below 95%.	Complete	**15.09.21** Included in the guideline as current practice. **19.11.21** emailed NHSR to clarify if an audit is required as well as evidencing guideline is in place that includes this requirement. Expectation is that this will be in auditable standards. FWB MW to audit 20 sets of notes each site and add to audit schedule. Audit completed December 2020-January 2021 showed 77% compliance at 32 weeks and 87% compliance at 36 weeks. As covid scanning schedule is being followed these are the only dates scans are offered. Audit to be repeated by FWB MW. **31.01.22** Audit repeated showing compliance against standard for BMI scans being performed in line with Covid scanning schedule. From 2 February normal schedule will resume.	Fetal Wellbeing Midwives	30.06.22	31.12.21
SBLCB.E2.2.2		Engage Exec team support to resolve issues that are prohibiting return to national risk assessed scanning schedule	In progress	17.11.21 Escalated scanning concerns through the Neonatal and Maternity Assurance Group in the Quarterly SBLCBv2 update. Aiming to have a solution in place by January 2022. **25.01.22** Launch Appendix G scanning schedule and stop reduced scanning schedule 2 February 2022	Fetal Wellbeing Midwives		
SBLCB.E2.3.1	Standard 3) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation (or an alternative intervention that has been agreed		In progress	**15.09.21** Not in place. Biweekly Radiology/maternity meetings in place. Escalated to Board Safety Champion and Trust Board. Looking at opportunities to reduce capacity i.e. appropriateness of routine 36 week USS 02.11.21 Escalated to Maternity and Neonatal Assurance Board November reporting • Uterine Artery Doppler Velocimetry	Fetal Wellbeing Midwives	30.06.22	

East Kent Hospitals University NHS Foundation Trust

	with the CCG and that the trust's Clinical Network)			Ø Uterine artery Doppler flow velocimetry is not performed by 24 completed weeks gestation in pregnancies identified as high risk at booking. This has been a requirement since the launch of SBLCBv2 in April 2021 but has continued to create a significant challenge to implement. Ø A meeting has been diarised to scope all requirements to inform Business Case development. Ø Scoping to date has identified a number of issues that need to be addressed 1. Radiology staffing capacity 2. Radiology training gaps 3. Ultrasound scanning machines and interfaces **19.11.21** Extraordinary meeting with Ops director and Radiology. Cost neutral position to implementation based on drop of the 28 week scan for low and moderate risk women and only continue for High risk pregnancies. Capacity would also be released through stopping the universal 36 week USS for all but women risk assessed as requiring through following appendix D scanning schedule. Escalated to MNAG and aim is to implement by January 2021 **25.01.22** UtADs to launch 2 February 2022			
ELEMENT 3 Raising awareness of reduced fetal movement							

East Kent Hospitals University NHS Foundation Trust

SBLCB.E3.1.1	Percentage of women who attend with RFM who have a computerised CTG must be above 80% and if below 95% then an action plan must be in place	Add question on whether a computerised CTG was performed following an attendance with reduced fetal movements to the Fetal Monitoring MIS workflow and monitor on the Maternity dashboard	In progress (At risk/Overdue)	02.11.21 • Recording accurately the Percentage of women who attend with RFM who have a computerised CTG is not robust because this isn't currently able to be captured on the Maternity Information System, Euroking, as a specific question and therefore makes it difficult monitor and track. • Plans are in place to add the Euroking workflow and will be progressed as the next priority on the digital transformation programme plan within the Fetal Monitoring updates. • Until this is implemented, free text data entered on Euroking for attendances for reduced fetal movements, is being used to review if 'Dawes Redman, computerised CTG' is documented. Using this data compliance is currently 75% but needs to be over 80% with an action plan in place if below 95%. **19.11.21** Testing on new MIS workflow has begun which records whether Dawes Redman Computerised CTG was performed. Data currently pulled manually and to be added to dashboard in the interim. Findings reported through Driver meetings **08.12.21** Compliance 74.1%. Action continues to be the Go Live of the updated Fetal Monitoring workflow	Fetal Wellbeing Midwives	30.06.22	

East Kent Hospitals University NHS Foundation Trust

SBLCB.E3.1.2		Drive improvement through being a 'We Care' Quality Improvement Driver and discuss at weekly Care group and Monthly performance review meetings with the exec team.	Complete	**02.11.21** This is a 'We Care Driver Metric' for maternity because of the significance reduced fetal movements has as a predictor of fetal wellbeing and associated poor outcomes **25.01.22** New workflow launched	Fetal Wellbeing Midwives	30.06.22	
SBLCB.E3.1.3	Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy is above 80% but below 95%	Raise staff awareness of importance of providing this information and recording that this has been done on Euroking Maternity Information System	In progress (On schedule)	**08.12.21** Current compliance is 91.7%. FWB MW has some planned work to raise awareness including an awareness day, posters and information update.	Fetal Wellbeing Midwives	30.06.22	

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ELEMENT 4 Effective fetal monitoring during labour							
SBLCB.E4.1.1	Can you evidence that 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness.	Workforce review and Business case to fill gaps exposed should ensure that staff booked onto training sessions are less likely to be pulled to cover rota gaps.	In progress (At risk/Overdue)	**02.09.21** Midwives-Acute 87.3% Midwives Community 98.3% **02.11.21** Fetal Monitoring Oct Midwife - Acute 87.4% Midwife - Community 95.7% Obstetric Consultant 81.3% Other Obstetric Doctor 84.0% Grand Total 89.2% • Focussed work continues to ensure there are sufficient training sessions, led by competent and skilled trainers, and also that staff are booking on to sessions within appropriate timescales to avoid compliance lapses and that time is protected able enable them to attend **19.11.21** Non-compliant against all staff groups. Community MW and all non-consultant obstetric doctors are compliant 08.12.21 overall compliance is 95.0% Midwife - Acute 94.6% Midwife - Community 99.0% Obstetric Consultant 90.9% Other Obstetric Doctor 92.0%	Fetal Monitoring Midwife/ Obstetrician	30.06.22	
SBLCB.E4.1.2		Workshop to review training programme and TNA in line with National Core Competency Framework	In Progress (On schedule)	**07.12.21** Workshop took place in October and TNA to be updated to meet compliance	Fetal Monitoring Midwife/ Obstetrician	10.10.21	
SBLCB.E4.1.3		Develop TNA and implement new training programme	In progress (On schedule)	**07.12.21** Workshop took place in October and TNA to be updated to meet compliance. Launch of new programme will be April 2022	Fetal Monitoring Midwife/ Obstetrician	01.04.21	
ELEMENT 5 Reducing preterm births							

East Kent Hospitals University NHS Foundation Trust

SBLCB.E5.1.1	Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth, Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids and Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth must be above 80% compliant or an action plan in place to achieve this.	Record metrics on Maternity Dashboard to monitor and report compliance	In progress (On schedule)	02.09.21 AN steroids – not included on MSDS, but presume will be in SNOMED once we submit that. Need to test **02.11.21** • The percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth currently stands at 20%. The requirement is to be over 80% and if less than 95% for there to be an action plan in place to achieve. • This is a quality improvement project aligned to the Maternity and Neonatal Service Improvement National Drivers for Perinatal Optimisation. • We are working as a Maternity and Neonatal project team with the MatNeoSIP Regional Lead to ensure work alignment and have been applauded for the quality of work that is being progressed around review of patient level data and route cause analysis of cases to draw out learning. • Progression of plans to implement Fetal Fibronectin testing when women attend preterm clinic and Maternity Triage as a predictor of preterm labour will support more timely steroid use. Case reviews has evidenced that the single biggest reason for steroid administration not being within the correct timeframes is giving the first dose too early through incorrect diagnosis of labour. **19.11.21** Update at audit day 18.11.21 This is recorded on the dashboard-16.7% compliance	Fetal Wellbeing Midwives	30.06.22	

East Kent Hospitals University NHS Foundation Trust

SBLCB.E5.1.2		Perinatal Optimisation Working Party Group developed to drive improvement using quality improvement methodology aligned to the National MatNeoSIP Drivers.	In progress (On schedule)	**07.12.21** Presented work at audit day to the MatNeo Sip lead for region who was really positive around our approach and the work being done. Preterm Passport developed and will soon launch	Fetal Wellbeing Midwives	30.06.22	
SBLCB.E5.1.3		Implement Fetal Fibronectin to increase detection rates of preterm birth risk	In progress (On schedule)	**07.12.21** Funding approved to expand use into the Triage and Clinic areas as well as for women attending preterm clinic.	Fetal Wellbeing Midwives	*30.06.22*	

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**CHIEF NURSING AND MIDWIFERY OFFICER (CNMO) NURSING AND ALLIED HEALTH PROFESSIONALS (AHP) WORKFORCE UPDATE**
MEETING DATE:	**10 MARCH 2022**
BOARD SPONSOR:	**CHIEF NURSING AND MIDWIFERY OFFICER**
PAPER AUTHORS:	**INTERIM DIRECTOR OF NURSING (DoN) (NURSING & AHP WORKFORCE & EDUCATION)** **HEAD OF NURSING (HoN) (NURSING & AHP WORKFORCE & EDUCATION)** **AHP WORKFORCE LEAD**
APPENDICES:	**NONE**

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	**Assurance**	Discussion
Purpose of the Report:	The Trust's Safe Staffing position should be reported to the Board monthly with in depth bi-annual reports as set out by the National Quality Board guidance and Developing Workforce Safeguards guidance from NHS England and NHS Improvement (NHSE/I). The Quality and Safety Committee will continue to receive the monthly update, with exception reporting to the BoD via the Chair's Assurance report. In addition, due to the challenges and changes currently at East Kent Hospitals University NHS Foundation Trust (EKHUFT) a quarterly in-depth report will be provided to the BoD demonstrating progress against the CNMO's key priorities in relation to strengthening and developing the non-medical professional workforce. This report will also be received by the People and Culture Committee before presentation to the BoD.				
Summary of Key Issues:	• Update on inpatient wards business case. • Update on recruitment. • Update on supporting teams. • AHP Workforce project. • Governance processes. • Daily Site management and escalation.				
Key Recommendation(s):	The BoD is invited to: 1. **NOTE** the contents of the CNMO Nursing and AHP Workforce update report and; 2. Receive **ASSURANCE** on the progress being made against delivery of the safer staffing business case and the strengthened governance arrangements that are in place to safely mitigate nurse staffing challenges.				

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

East Kent Hospitals University NHS Foundation Trust

Link to the Board Assurance Framework (BAF):	BAF 35 - Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.	
Link to the Corporate Risk Register (CRR):	CRR 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.	
Resource:	Y	Business case approved December 2021
Legal and regulatory:	Y	
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	People and Culture Committee 2 March 2022	

CNMO NURSING & AHP WORKFORCE UPDATE

1. Purpose of the report

1.1. The purpose of this paper is for the Chief Nursing and Midwifery Officer (CNMO) to provide the Board of Directors with a quarterly update of the work that has been undertaken for the Trust to achieve meeting the NQB 2016 and NHSE/I 2018 safe staffing guidance, to right size the nursing workforce since the Board approved the safe staffing business case for the 41 adult inpatient wards in December 2021 and minimise the key risks pertaining to nurse staffing, vacancies, temp staffing fill rates and the 'worry wards' identified across all sites.

1.2. It is important that the Quality and Safety Committee (Q&SC) and the Board of Directors truly understand the nursing and AHP staffing risks that the Trust is carrying on a daily basis, examples are included in the paper to demonstrate '*what this means in practice'* and the impact that this is having on safety and on frontline teams.

1.3. However, following the CNMO's diagnostic there is still much more to do in relation to improving the governance and reporting arrangements of the nursing workforce information in order to provide complete and robust assurance. The HoN (Nursing Workforce) is currently working with the Directors of Nursing and Care Group HoNs to localise existing workforce scorecards and HealthRoster dashboards which have been developed by other high performing Provider Trusts who are rated 'outstanding' by the Care Quality Commission (CQC).

1.4. This paper highlights the work that has been done so far and highlights where the key risks are pertaining to the Inpatient Ward (Adults and Paediatrics), Emergency Department (ED), Critical Care and Neonatal Intensive Care across all three acute sites and the priorities for the CNMO over the next 3 months in strengthening the current governance arrangements within the Trust.

2. Evidence Based Workforce Planning

2.1. Adult Inpatient Wards Business Case

Appendix 1 – The safe staffing improvement plan demonstrates where we are in the time line of the safe staffing review and we are on track to meet all deadlines set by NHSE/I.

The safe staffing business case for the 41 wards was approved and we are in the process of updating all of the establishments at the same time as when the Healthroster team have updated all of the ward roster templates so they match the establishments. We anticipate this work to be completed end of February 2022 with the additional vacancies showing in the March 2022 reporting.

2.2. Paediatric Inpatient Wards

The establishment reviews of the paediatric wards took place in January 2022 and we are pleased to report that while one ward needed an increase the other requires a decrease in staffing and so broke even with the money/position numbers being moved across the establishments, with no requirement for a business case.

2.3. ED Safe Staffing Review

The ED Establishment review is being planned with the two HoN, we now have the licence for the Safe Nursing Care Tool (SNCT©) for ED and are waiting on training dates to be released by NHSE/I our plan is to run the SNCT data collection in March or latest April 2022. The progress of this review will be monitored on the Action plan and reported to Q&SC monthly.

2.4. HealthRoster Shift Patterns

It came to light when the roster templates were being updated that a number of wards when doing long day and night shifts were doing 12.5 hour shifts rather than 13 this is not the NHS standard long day shift and results in the loss of one shift per four-week roster per Whole Time Equivalent (WTE). The Care Groups that had this issue were General and Specialist Medicine (GSM), Urgent and Emergency Care (UEC) and Child Health. GSM and UEC are about to undergo a consultation to change the shift times and bring the rosters inline to 13 hour shifts per roster. Child Health are going to undergo this consultation in the summer. We anticipate that a consultation will take around 3 months.

3. Recruitment Pipeline

3.1. Internationally Educated Nurses (IEN) Pipeline

The planned pipeline to fill the vacancies is initially coming from the International recruitment pipeline. The process of on-boarding these nurses has been updated as we are moving from 30 a month to 40 a month in February 2022. This is being monitored at a bi-monthly review meeting co-chaired by the HoN for Workforce and Education and the Head of Strategic Resourcing with the IEN recruitment Lead and IEN OSCE Lead reporting in.

The CNMO has prioritised sending IENs to Queen Elizabeth the Queen Mother Hospital (QEQM) currently as this is our site that is most in need of nursing staff and QEQM ED especially. The challenge is that accommodation for the IENs at QEQM is limited and can put restrictions on the number of nurses that we can send each month. A strategy is currently being developed to resolve this issue.

Eight of the IENs will be specifically recruited for Child health as they have a high vacancy at 22.59% at the time of writing this report. The first IEN has commenced in post and is doing well. They are feeling supported by the team and there are no concerns that they will not pass their specialist child OSCE in early March. The pipeline is to recruit 2 IENs per month until the units are fully established.

3.2. Local Recruitment

The Trust is now working with an external recruitment company TMP and we hope that this will increase our local recruitment pipeline. For nursing we are hoping to see around 25 a month from this route.

3.3. IEN Recruitment & Pastoral Team

Two Nursing 8b posts historically sat in the resourcing team. One of these staff members has left, the other is in the process of retirement. The plan is to create a recruitment and pastoral team specifically to oversea the IENs that are recruited into the Trust. Currently an 8a Matron role to lead this team is out to advert. Once the finances are in place from the other 8b there will be two more clinical posts (banding to be confirmed) advertised to create a team of three. These posts are critical to onboard our IENs but also ensure that their pastoral needs are met which will in turn lead to improved retention and hopefully attract other IENs from London to come and join us at East Kent.

3.4. IEN Training

The plan for the IEN OSCE training is based on feedback from wards and the challenges they have in the support that is required for this group of nurses.

The process last year was to split the IENs so that some were in training for a week and some on the wards for a week and then they swapped for a week and then swapped again so that all nurses had done their two weeks of OSCE training. This did not work for the ward managers or the trainers, the managers felt they could not do what was required on the ward because they were focussed on the OSCE and did not take ward training in. The OSCE team found the IENs were tired and often went over their hours as the wards were not taking into consideration the hours they had done or were going to in training. On scoping other Trusts and in discussion with ward managers we have changed our training and recruitment process from January 22 so that we take 20 nurses every two weeks after quarantining and then they commence the following programme:

- Week 1 OSCE Training;
- Week 2 OSCE Training;
- Week 3 Exam – and commencement of Transition (Ward ready programme);
- Week 4 Transition Programme;
- Week 5 Commence on ward.

This does not make the training time any longer but structures the training better and will make the IENS better prepared to ‘hit the ground running’ on week 5.

The introduction of the Transition week has come about from ward managers feedback, mandatory training data and an NHS England review and their recommendations.

With this new process and the speed that the Nursing and Midwifery Council (NMC) are currently turning around the PIN numbers (2 weeks from OSCE Pass) we anticipate that most IENs will receive their PIN during week 5 or just after in week 6. This will not affect what they can do on the ward because at this point they will not have completed their medicines competencies so would not be able to administer medications.

4. Christchurch Canterbury University (CCCU)– Student & Apprentices

4.1. Return to Practice

The CNMO has been successful in her approach for CCCU to run an additional cohort in April 2022 to support our recruitment pipeline. So far, they have 15 applications, we are waiting to hear if all 15 are acute nurse experienced and want to work at EKHUFT.

4.2. Student Placements

We are in the process of reviewing and expanding our student placements so that we can increase the number of students to support our long-term recruitment plan. To support this, we have reviewed where the current student tariff is sitting with our finance colleagues, this tariff is not currently being used to support students and we plan to use this tariff to resource additional student support to our front line so that our Practice Assessors and our Student numbers can be increased. This will provide the sustainability moving forwards, meaning that the Trust should not get back into the position of having high Band 5 RN vacancies.

The CNMO from April 2022 will be writing to each nursing student when they are on their first placement within the Trust and offering them an unconditional offer of employment for when they qualify as a nurse. This offer will be repeated for each year of their training. The CNMO has done this in previous organisations and it has worked well – with the Trust retaining over 90% of their students, it also encourages the ward teams to support and invest in their students and train them the East Kent way.

4.3. Apprentices

The Trust supports both Nursing Associate and Registered Nurse apprentices. We are reviewing the current Trust process of recruiting into these posts with the Care Group HoN in the hope that we can also increase the numbers here.

5. Nursing Workforce Development Education and Training (WDET) Team Update

The WDET team has been expanded so that they can support the newly recruited registered nurses on each site. We now have a Band 7 Practice Development Nurse (PDN) lead on each site and an additional band 6 practice facilitator to support new nurses directly on the frontline this is in addition to continuing to run all the corporate nursing programmes that are required.

6. Allied Health Professions (AHP) Workforce Supply Strategy Project

It is recognised that currently there is no specific corporate AHP strategic leadership structure within the Trust. However, there is work being undertaken to scope the workforce and workforce supply and produce a development strategy by an AHP Workforce Lead and an AHP Support Workforce Lead currently employed on a secondment basis funded by Health Education England (HEE). The project is on track to be completed by the end of April 2022, however, the seconded posts finish on 31 March 2022, with a request having been submitted for the HEE funding for these posts to be carried into the next financial year and extended to make full use of the funding rather than return it to HEE which matches the continuation of the posts being continued in other Trusts in the region, for example, Maidstone and Tunbridge Wells have made full use of the funding and extended the position until December 2022.

The investment from HEE supports the project aims which are to help NHS Trusts achieve the target as set out in the pre-pandemic NHS People Plan of having 27,000 additional AHPs by 2024 to meet future AHP Workforce demand. This is considered a conservative estimate given the additional workforce demand arising from the 2020 Diagnostics Review (Richards Review).

The Workforce project comprises of seven elements, each with their own deliverables; Finance; Workforce, Data and intelligence; Retention and support for students, the newly qualified workforce, and early careers; Supporting AHP Return to Practice; AHP International Recruitment; and AHP Apprenticeships', AHP Support Workforce, The project covers the seven Allied Health Professions currently employed by the Trust; Operating Department Practitioners, Orthoptists, Dieticians, Diagnostic Radiographers, Physiotherapists, Occupational Therapists and Speech and Language Therapists.

6.1 Workforce, Data and Intelligence

The strategic aim of the Workforce, Data and Intelligence element of the project is to support effective short and long term AHP Workforce planning through timely access to accurate AHP Workforce supply and demand data and intelligence. To provide organisational workforce intelligence to inform AHP Workforce strategic planning to address AHP Workforce shortfall and build sustainable future supply.
Initially, it was identified the Trust's Electronic Staff Record (ESR) data was significantly inaccurate, ESR data cleansing is now underway which will ensure correct occupational coding and accurate reporting to HEE/NHS England.

Solutions to workforce gaps are beginning to be identified and work initiated to address these, for example, there is a significant deficit in Operating Department Practitioners (ODPs) resulting in difficulties proving Surgical First Assistants, Surgical Assisting is with proper competency-based training, within the scope of practice of an Orthoptist. Training is currently underway to upskill the Orthoptists filling the gap in the workforce as well as adding career development and role diversity making the Trust a more attractive place for Orthoptists to work.

6.2 Retention and Support for Students, the Newly Qualified Workforce and Early Careers

The strategic aim of the Retention and Support for Students, the Newly Qualified Workforce and Early careers element of the project is to support the growth of band 5 posts, reduce student attrition and improve the retention of students and new graduates across the region by ensuring sufficient band 5 posts for the number of graduates in the region across all AHP professions and developing a plan for a standardised AHP Preceptorship programme and supporting a 25% increase of uptake of National Education and Training Survey (NETS).

Working group for AHP Preceptorship up and running, good progress made with a plan in place for the programme which supports HEE's career development and the four pillars. Topics for the programme agreed, programme format agreed. If project work is able to continue further than 31 March it could be ready to pilot September 2022.

Best practice ideas shared around support for pandemic impacted cohorts including incorporating wellbeing, empowerment and resilience into the preceptorship and NETS results discussed at Faculty level.

6.3 Supporting AHP Return to Practice (RtP)

The strategic aim of the Supporting AHP RtP element of the project is to maximise RtP opportunities to support the regions RtP target (a minimum of three per Trust).
Trust has supported 13 RtP predominantly in Diagnostic radiography and Theatres over the past 12 months, a significantly higher number than the expectation of three by HEE. Regional work has been incredibly successful, 25k was secured by the regional AHP leads to promote RtP, final draft of the advertisement is to be reviewed this week, Trust communications teams will then be engaged and the advertisement will be sent to all Communications teams within Kent and Medway Trusts to promote Return to Practice. Trust standard operating procedure document is being reviewed by AHP Workforce lead in collaboration with the Trust's Nursing workforce and education team with a view to amend to incorporate AHP return to Practice procedures.

AHP Workforce Lead has requested AHP department leads amend job advertisements to enable easier accessibility for potential RtP applicants.

6.4 AHP International Recruitment

The strategic aims of the AHP International recruitment element of the project are to explore the potential for further workforce growth through targeted International recruitment and actively support National, regional and faculty international recruitment activities.

The Trust has now established good links with regional/National programme and professions identified where there have been successful International recruitment in other Trusts. The Trust has had successful International recruitment within Diagnostic Radiography. Good working relationships have been established with Trust International recruitment lead with work planned to establish a process for AHP International recruitment in anticipation of the need arising within the AHP Professions.

6.5 AHP Apprenticeships

The strategic aim of the AHP Apprenticeships element of the project is to support workforce growth and widening participation by maximising access routes into pre-registration level 6 AHP apprenticeship training. To support the development of Integrated Care System (ICS) and regional apprenticeship expansion plans and work with the faculty to ensure supply pipeline opportunities are maximised.

The Trust has an excellent award-winning Apprenticeships team who work towards providing both Nursing and AHP Apprenticeships and is ahead of many Trusts regionally in terms of having cohorts in more of the AHP Professions. Intelligence data readily available due to a dedicated Apprenticeship team in place.

6.6 AHP Support Workforce

The strategic aim of the AHP Support Workforce element of the project is to support and deliver the National AHP Support Workforce Programme.

The Seconded AHP Support Workforce Lead has been recruited and began in post on 21 February 2022. They have commenced AHP Support Workforce scoping and working with department leads.

6.7 AHP Summary

As a result of this HEE funded project we are beginning to understand our AHPs at EKHUFT and the challenge the AHP workforce faces however, with an AHP deficit of 27,000 workers predicted by 2024 nationally we cannot under estimate the importance and volume of work required to put into place the right infrastructure to support robust governance and reporting and support systems of our AHP workforce data intelligence and the impact that a lack of AHP Leadership and development is having on our ability to provide a workforce who deliver consistent safe, quality care.

7 Governance Processes

7.1 Nursing, Midwifery and AHP (NMAHP) Board

The NMAHP Board has been created and the terms of reference are in the process of being agreed. The aim of the NMAHP Board is to provide strategic leadership and direction to the safe and effective delivery of nursing, midwifery and AHP across all services at East Kent Hospitals University NHS Foundation Trust (EKHUFT), to develop, monitor and maintain the standards of Nursing, Midwifery and AHP care across the Trust, ensuring staff are supported to be compliant with the NMC and the Health and Care Professions Council (HCPC) and to provide the leadership and direction to achieve safe, effective staffing and a workforce that is able to support the delivery of the Trust's strategy.

7.2 Councils

In the process of creation is both a Nursing and AHP workforce council and nursing and AHP practice education council that will report in to the NMAHP Board. These councils will oversea the Workforce and Education of these professional groups in conjunction with workforce and resourcing teams.

8 Nursing and Midwifery (N&M) Strategy

The sessions to create the N&M Strategy are booked in the diary. The plan is to be ready to launch this in June 2022.

9 Safe Staffing

9.1 Daily Monitoring and Escalation

The Directors of Nursing (DoNs) for each site (representing the CNMO) oversee the daily staffing on the sites. The HealthRoster team currently pull off a weekly report to support the DoNs in creating the daily safer staffing templates that follow the NHSE/I Safe Staffing SBAR reporting system so that there is a whole Trust view of staffing risks,

rather than just looking at a single site, this is alongside the daily safety huddles. The Directors of Nursing escalate to the CNMO as required with an end of day position shared at 5pm.

The clinical areas in the Trust use the Red Flag Process on the Safe Care system to escalate staffing concerns and these are responded to by the Matron or Deputy HoN on site.

9.2 Hot Shifts

This is a temporary process that has been introduced to further incentivise specific shifts. Where an area is sustained **black** and is unsafe the DoN will authorise the number of incentivised shifts to be put out to Bank NHS Professionals (NHSP) for this area to take it to **red** which is the minimum to deem a clinical area safe as per the Safe Staffing policy. This decision will be taken where possible at 48 hours before the shift start time to allow for adequate communication.

A 'hot shift' will be an additional £10 per hour and will therefore encourage staff to pick up an 11.5 hour long day or night shift rather than just pick up a 7.5 hour shift.

The process has taken some time to put into place due to NHSP systems but is now in place.

9.3 Shifts requested outside of HealthRoster

The Trust's Nursing Workforce, Temporary Staffing and HealthRoster teams are working with NHSP to turn off the ability for clinical areas to put out bank and agency shifts via the NHSP 'my bank' portal. All shifts should be put out via Healthroster so that its clear and transparent how many shifts are out to NHSP and can be monitored. Currently 25% of shifts are put out via the 'my bank system'.

Before we close this workaround, we need to ensure that all staff that need to put out shifts have the ability and correct access to do this via Healthroster. There will be a series of planned communication coming from the HoN for Workforce and Education and Healthroster team instructing staff that this will be happening and guiding them on how to get access and training leading to the workaround being closed on Monday 4 April.

This will ensure greater visibility and more accurate management of NHSP shifts.

10 Conclusion

As a Trust we are in a better place of understanding our nursing workforce challenges, however we cannot under estimate how much work is required to put into place the right infrastructure to support robust governance and reporting of our nursing workforce information and the impact that poor staffing levels is having on our ability to provide consistent safe, quality care. There has recently been significant investment into nursing to right size our workforce on the inpatients wards but this will need to continue with ED and AHPs. We have made a good start in recruiting large numbers of nurses and will continue to monitor the progress. It is important that we recognise the low baseline that we have started at and the focussed energy and support that is required in order to take this agenda forward and deliver sustainable change and a high quality, appropriately resourced nursing and AHP workforce.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**CHIEF MEDICAL OFFICER'S REPORT**				
MEETING DATE:	**10 MARCH 2022**				
BOARD SPONSOR:	**CHIEF MEDICAL OFFICER (CMO)**				
PAPER AUTHOR:	**SENIOR BUSINESS OPERATIONAL MANAGER TO THE CMO**				
APPENDICES:	**APPENDIX 1: CLINICAL DIRECTORS AND CLINICAL LEADS WITH EXTERNALLY FACING ROLE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	This report provides an update to the Board on progress with medical workforce and professional standards.				
Summary of Key Issues:	A number of clinical directors and clinical leads perform external facing roles, that ultimately benefit the Trust in the experience and knowledge they gain from performing these roles. With the growth in the medical establishment with a prescribed connection, medical appraisal and revalidation continues to be a key area of focus for quality improvement with an update provided on recent actions. The report outlines in brief further work to support engaging with our medical workforce. The Clinical Ethics Committee has commenced with recruitment underway, accruing a number of potential candidates for the committee membership. King's College London School of Medicine undertook an Educational Quality visit in February with initial feedback very positive, particularly reflecting the holistic care of students and transparent systems for use of educational resources.				
Key Recommendation(s):	The Board is asked to review and discuss the paper and to close action B/20/21.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	Our people	Our future	Our sustainability	Our quality and safety	
Link to the Board Assurance Framework (BAF):	BAF 35 - Failure to recruit and retain high calibre staff could potentially result in negative patient outcomes and experience and impact on the Trust's reputation. BAF 32 – There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered.				
Link to the Corporate Risk Register (CRR):	CRR123 - Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate medical staffing levels and skill mix to meet patients' needs.				
Resource:	~~Y~~/N	*None*			

East Kent Hospitals University NHS Foundation Trust

Legal and regulatory:	~~Y~~/N	*None*
Subsidiary:	~~Y~~/N	*None*
Assurance Route:		
Previously Considered by:	N/A	

East Kent Hospitals University NHS Foundation Trust

CHIEF MEDICAL OFFICER'S REPORT

1. Purpose of the report

1.1 This report provides an update on action B/20/21 discussed on 28 October 2021 along with progress on other areas of medical workforce and professional standards.

2. Background

2.1 On the 28 October 2021 Board of Directors meeting an action was raised to request a list of the Clinical Directors and Clinical Leads with externally facing roles.

2.2 In previous CMO reports to the Board of Directors, Medical Appraisal and Revalidation, workforce engagement, ethics committee, and development of our junior doctor workforce have been discussed. This paper will also provide an update on these areas.

3. Clinical Directors and Clinical Leads with Externally Facing Roles

3.1 The appended report provides a list of Clinical Directors and Clinical Leads with external facing role. The report was compiled comparing our e-job plan system with the reports communicated by the care groups. The report currently suggests that four of the seven Clinical Directors are performing at least one externally facing role, along with thirteen of seventy-one Clinical Leads. Due to the methodology available there will be some underreporting of activity.

4. Medical Appraisal and Revalidation

4.1 There are currently 839 doctors connected to East Kent Hospital University Foundation Trust for appraisal and revalidation. Forty-five percent of the appraisals for medical staff have been completed with thirty-six percent in progress, and twenty percent overdue.

4.2 A number of actions are being taken to drive forward the improvements in medical appraisal compliance. Below you will find a summary of actions related to the items on the risk register.

4.3 The appraisal and revalidation lead will be receiving support from the Faculty of Medical Leadership and Management (FMLM) to help identify areas of improvement and to support the development of the appraisal lead to manage any changes required to improve quality and compliance. This is set to commence on 2 March 2022.

4.4 External resources are being explored that will provide support on the training and development of medical appraisers within the Trust. A meeting was held on 21 February 2022, and a list of options were provided which are being discussed and mapped into plans to review the current e-portfolio system.

4.5 Members of the Chief Medical Officer team are attending the NHS England Responsible Officers (RO) training to further develop the skills and tools necessary to support the delivery of the responsibilities of the RO.

4.6 The current appraisal and revalidation system (e-portfolio) for the medical workforce is being reviewed as per the actions to address CRR123. The

review has commenced and the projected date a decision will be reached is 22 April 2022.

4.7 We are anticipating a quality assurance visit from the South East Higher Level Responsible Officer's (HLRO) team in early summer.

5. Medical Workforce Engagement

5.1 The medical engagement scale (MES) is a nationally validated tool that has been previously used to test and develop actions in relation to the medical workforce. The MES is being commissioned again with the support of NHS England/NHS Improvement (NHSE/I) to obtain vital information from our medical workforce to compare to our previous MES and develop actions to move forward.

5.2 Unlike the staff survey this piece of work will allow us to gather and understand feedback from every level of the medical workforce rather than all of our doctors as one whole group. The focus of local questions, specific to our Trust, will be around clinical leadership and change management.

5.3 The MES is due to commence in May 2022, with results and analysis available from July 2022.

5.4 We are working with FMLM supported by NHSE/I to pilot a mentoring scheme to support new consultants with the pilot due to start in summer 2022.

6. Ethics Committee

6.1 A core group of the Clinical Ethics Committee met in February. We are currently recruiting to the committee as per the terms of reference ratified at Board and have already received nearly fifty of expressions of interest from staff.

6.2 In addition, the opportunity to attend ethics committee has been extended to Kent Medway Medical School (KMMS) medical students supported by our independent ethicist and is currently open to applicants.

6.3 In March and April, the focus will be on selecting and supporting new members through an introduction to the ethical framework and working through test cases. Our membership of the UK Clinical Ethics Network (UKCEN) offers further educational opportunities to members.

7. King's College London (KCL) School of Medicine Education Quality Visit

7.1 On 24 February Queen Elizabeth the Queen Mother Hospital (QEQM) hosted a quality visit from the medical school represented by the interim Dean of Medical Education, Dean of Educational Partnerships, Deputy Dean for Stage 3, Teacher Development Lead, Professional Record Standards Body (PSRB) Placement Finance and Quality Manager, Senior Quality Manager, Lay and Student Representatives from KCL.

7.2 The meeting included session with cohorts of the year 4 and 5 students, the educational supervisors, block leads, and the medical education team in addition to the Chief Executive Officer (CEO), Chief Medical Officer (CMO), and finance and estates representatives. Overall the visit was reported as very positive and the immediate verbal feedback reflected below.

7.3 Commendations were received in relation to:

- Students reported experiencing a positive culture with patient centred care;

- The external reviewers identified a positive culture of caring about the student's wellbeing in addition to educational needs with holistic care of the students;
- The students reported block leads and trainers as approachable and they would have no problem raising educational or other concerns;
- The Trust had developed a system of transparency and clarity in funding for educational roles aligned to delivery for medical, nursing, midwifery and Allied Health Professionals (AHP) educators;
- Response to feedback from last quality visit had been addressed and acknowledged how well the students were supported during Covid pandemic;
- Excellent administrative support for students, including prior to arrival.

8. Women's Health Care Group Consultant Development

8.1 The first externally facilitated consultant development session for obstetric consultants was held on the 25 February with the second session due on 4 March 2022. The purpose of the sessions is to create a group code of conduct based around the Royal College of Obstetrics and Gynaecologists guidance "Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology".

9. Conclusion

9.1 In conclusion, a number of actions are in development/underway to continue to develop and support a high-quality medical workforce.

9.2 Medical Appraisal and Revalidation is under review with a number of elements being addressed to assure quality and improvement.

9.3 MES is being commissioned to review the effectiveness of our actions to date and to develop new ones to engage and develop our medical workforce

9.4 The ethic committee has commenced with a very positive recruitment picture

9.5 The visit from King's College London School of Medicine was successful with a number of areas of positive feedback provided.

Directorate	Department	Role	Surname	First initial	External Duty (1)	External Duty (2)	External Duty (3)	External Duty (1)
Upper Surgery - Head, Neck, and Dermatology	Maxillifacial	Clinical Director	Goodger	N	Kent & Medway Cancer Alliance Head & Neck Cancer TSSR Chair	Chair Canterbury Cancer Care Club		
Upper Surgery - Head, Neck, and Dermatology	Maxillifacial	Clinical Lead	Tighe	D	Kent & Medway Cancer Alliance Head & Neck Cancer TSSR Deputy Chair	Deputy chair British Association of Oral & Maxillofacial Surgery Quality Outcomes group		
Upper Surgery - Head, Neck, and Dermatology	Maxillifacial	Clinical Lead	DiBiase	A	Outgoing secretary British Orthodontic society	Board member Faculty of Dental Surgery Royal College of Surgeons of England		
Upper Surgery - Head, Neck, and Dermatology	Maxillifacial	Clinical Lead	Wood	C	Deputy Chair Kent Local Dental Committee board			
Upper Surgery - Head, Neck, and Dermatology	Maxillifacial	Clinical Lead	Patel	M	Member Kent Local Dental Committee and KSS Oral Surgery Managed Clinical Network	British Dental Association (BDA) Hospital Group Treasurer, member of Central Committee for Hospital Dental Services (CCHDS) (BDA Committee)		
Upper Surgery - Head, Neck, and Dermatology	ENT	Clinical Lead	Wasson	J	Kent and Medway Integrated Care System (ICS) lead for ENT surgery			
Upper Surgery - Head, Neck, and Dermatology	ENT	Clinical Lead	Sharp	H	Council Member British Rhinological society			
Upper Surgery - Head, Neck, and Dermatology	Opthalmology	Clinical Lead	Dong	B	Kent and Medway ICS lead for Opthalmology			
Surgery and Anaesthetics	Chronic Pain	Clinical Lead	Collighan	N	Chair of the National Guideline committee			
Surgery and Anaesthetics	General Surgery	Clinical Lead	Evans	J	College tutor for the Royal College of Surgeons			
Surgery and Anaesthetics	General Surgery	Clinical Director	Basnyat	P	Kent and Medway Colorectal TSSG lead			
Surgery and Anaesthetics	Trauma & Orthopaedics		Yanni	O	NHSE/I role clinical leadership aspect of the *Restoration & Recovery* and pathway improvement for the south east region for Musculoskeletal (MSK)	NHSE/I role clinical leadership aspect of the Restoration & Recovery and pathway improvement for the south east region for Trauma and Orthopaedics		
Surgery and Anaesthetics	Trauma & Orthopaedics	Clinical Lead	Casha	J	Regional Director of Royal College of Surgeons	Honarary senior lecturer		
Children and Young People	Paediatrics	Clinical Lead	Siddiqui	A	Designated doctor for child death review			
Children and Young People	Paediatrics	Clinical Lead	Shah	V	Lecturer at Medical School			
Women's Health		Clinical Director	Seaton	J	Ombusdmen for Parlimentary and Health Service			
General and Specialist Medicine	Stroke services	Clinical Lead	Hargroves	D	Stroke lead for south coast NHSE/I	National Cliical Lead for Getting it Right First Time (GIRFT) NHSE/I		
Cancer		Clinical Director	Nordin	A	National Clinical Advisor for the National Cancer Registration and Analysis Service (NCRAS)	Chair of the Cancer outcomes and services (COSD) dataset governance boards		

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**LEARNING FROM DEATHS – QUARTER 3 2021/22**				
MEETING DATE:	**10 MARCH 2022**				
BOARD SPONSOR:	**CHIEF MEDICAL OFFICER (CMO)**				
PAPER AUTHOR:	**CHAIR, MORTALITY STEERING & SURVEILLANCE GROUP & CMO**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	**Assurance**	Discussion
Purpose of the Report:	This is a quarterly mandated report to update the Board on how we are complying with the National Quality Board 'Learning from Deaths'. It also provides assurance on how we monitor and respond to mortality data.				
Summary of Key Issues:	Close surveillance on the Trust's performance in mortality and learning from deaths continues through the We Care improvement system, with a True North objective around reducing mortality to be one of the best performing Trusts. Outside of this framework, the Learning from Deaths team continues to respond to mortality alerts as these arise. This report highlights this activity from October to December 2021 (Q3). Seven conditions have triggered a Cumulative Sum (CUSUM) alert in the last year at the 99% (high) threshold. Five of these alerts pre-date this quarter and include pneumonia, sepsis, other perinatal conditions, fracture neck of femur, malaise & fatigue. There are two new alerts reported within the December mortality report, namely short gestation, low birth weight, and fetal growth retardation and intrauterine hypoxia and birth asphyxia. All of these alerts are reviewed to determine actions for both improving data quality though clinical documentation and clinical pathways. The Hospital Standardised Mortality Ratio (HSMR) for the rolling 12 months to October 2021 is 97.6 remains statistically as expected and is line with peer Trusts regionally. This is a consistently improved position since period to March 2020 to February 2021. Compliance with Structured Judgement Reviews has fallen overall in Q3, in part a consequence of the Covid-19 pandemic. The Trust has engaged with the "Better Tomorrow" NHS England/NHS Improvement (NHSE/I) led programme to support us in best practice in learning from deaths.				
Key Recommendation(s):	The Board are asked to **NOTE** the report and the systems in place to regularly review our mortality data and perform deep dives into clinical pathways as indicated by the mortality alerts.				

East Kent Hospitals University NHS Foundation Trust

Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	Our people		Our future	Our sustainability	**Our quality and safety**
Link to the Board Assurance Framework (BAF):	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 77, 36,125, 76, 122, 123, 117				
Resource:	N				
Legal and regulatory:	N				
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	In part by Quality and Safety Committee				

East Kent Hospitals University NHS Foundation Trust

Mortality and Learning from Deaths – Q3 2021/22

1. Introduction

Close surveillance on the Trust's performance in mortality and learning from deaths continues through the We Care improvement system. Outside of this framework, the Learning from Deaths team continues to respond to mortality alerts as these arise with oversight at the monthly Mortality Steering and Surveillance Group. This report highlights this activity from October to December 2021 (Q3). Particular reference is made to current mortality alerts and the relevant diagnostic and improvement work being done in response to these alerts.

2. EKHUFT Mortality summary report December 2021

2.1 Overview

For this quarter, mortality summary reports were available for the months of October and December 2021 only. The infographic (Figure 1) below highlights the data shared in the latest mortality report from December 2021. Figure 2 illustrates the rolling 12-month trend in HSMR (Hospital standardised mortality ratio).

97.7 (October 20- September 21) The HSMR recorded in the most recent 12 months	**100.6** The national HSMR from the most recent 12 months	**103.23** (August 2020-July 2021) SHMI (Summary Hospital-level mortality indicator)
2 The number of new validated CUSUM alerts (99.9% detection threshold)	**4** The number of diagnosis groups with SMR alerts (after validation)	**7** The number of consecutive months the SMR has been reducing

Figure 1. Overview

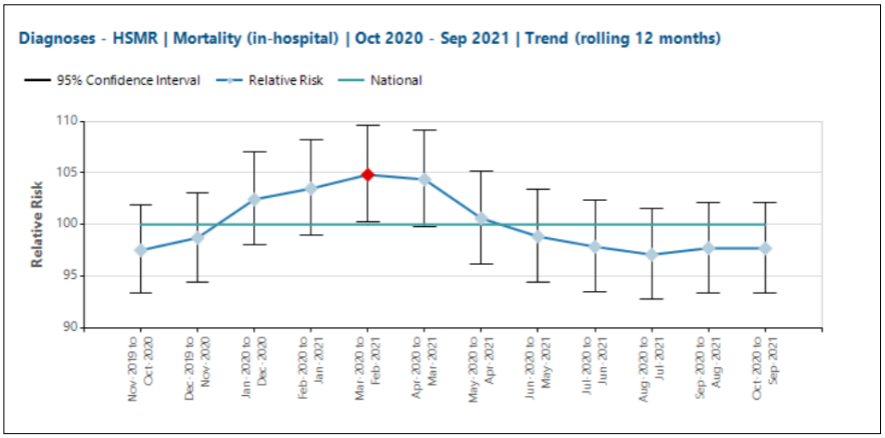


Figure 2. Rolling 12-month HSMR trend

2.2 Performance against peers

Of the four Kent Trusts, three have recorded mortality in the expected range.

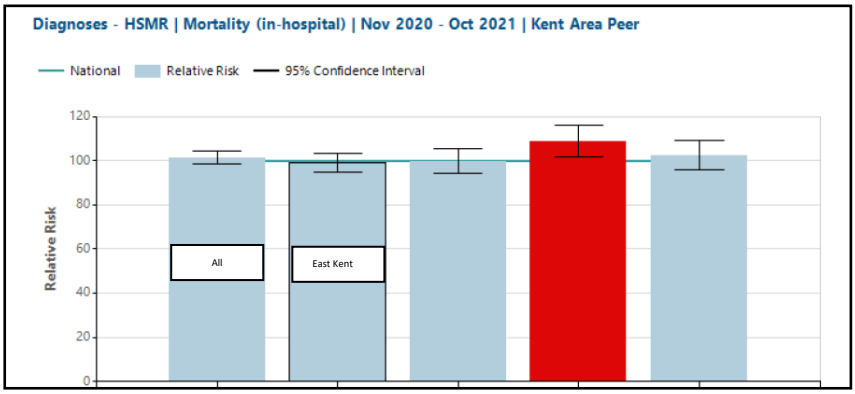


Figure 3. Performance against peer Trusts

2.3 Standardised Mortality Ratio (SMR)

Since May 2021 the SMR has been within the expected range.

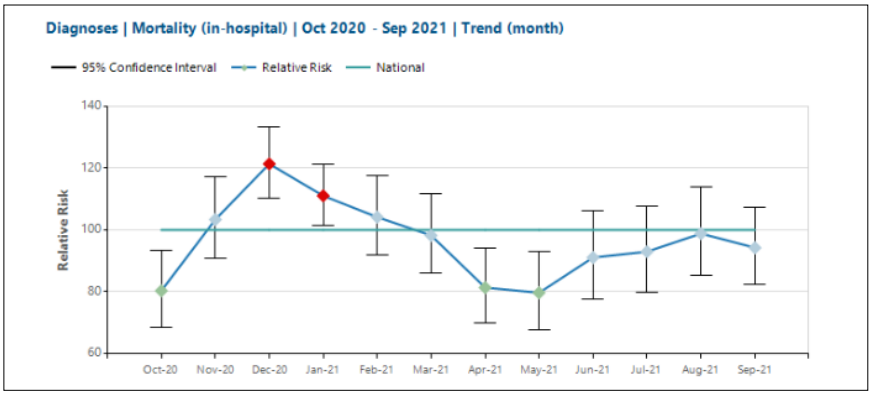


Figure 4. SMR trend over 12 months

There are currently 4 alerts in the following diagnostic groups

- Greater than 100 deaths: none
- Between 10 and 100 deaths: skin & subcutaneous infections; short gestation, low birth weight, and fetal growth retardation
    - Regarding the skin and subcutaneous infections alert, a desktop cluster review was undertaken led by the Tissue Viability team. This analysis found that a significant majority of patients presented with chronic skin ulceration (combination of leg ulceration and decubitus ulceration) which preceded hospital admission. All of these patients were frail with multiple co-morbidities that contributed to skin failure. These patients received appropriate multi-disciplinary input during admission with appropriate treatment strategies.
- Less than 10 deaths: trauma to perineum and vulva

- When investigated, this alert was found to be generated from a discharge error on Patient Administration System (PAS). The error was retrospectively corrected but this diagnostic group is still alerting in Hospital Episode Statistics data as the Trust did not re-submit retrospectively amended data outside of the current reporting period. This has changed from January 2022.

2.4 Cumulative sum (CUSUM) alerts

A CUSUM alert is designed to signal that a pattern of activity appears to have gone beyond a defined threshold. They are triggered when the CUSUM statistic passes a national benchmark. After each alert, the CUSUM is reset to zero so that if any changes subsequently occur there is time for them to take effect. If poor outcomes persist, a further signal is likely to occur. False alarms can be triggered as the control limits are set to ensure differences in mortality can be detected.

Seven conditions have triggered a CUSUM alert in the last year at the 99% (high) threshold (Figure 5).

Five of these alerts predated this quarter and include pneumonia, sepsis, other perinatal conditions, fracture neck of femur, malaise & fatigue.

- The “Pneumonia” alert has been investigated through a desktop top, multi-professional case note analysis and is due for presentation to Mortality Steering and Surveillance Group in March 2022.
- Sepsis is the focus of the breakthrough objective aligned with the True North of Mortality; weekly work is undertaken through the driver meetings with monthly reports to Senior Leadership Team meetings.
- Improvement in the fracture neck of femur clinical pathway is being undertaken at Queen Elizabeth Queen Mother Hospital following an alert identifying excess mortality. This metric is discussed monthly at Surgery & Anaesthetic Care Group’s performance review meeting.
- The “malaise & fatigue” alert was investigated with support of the clinical coding team. Two deaths in this cohort were retrospectively changed to a different primary cause of death. It is thought that these errors contributed to the alert.

There are 2 new alerts reported within the December mortality report namely

- Short gestation, low birth weight, and fetal growth retardation;
- Intrauterine hypoxia and birth asphyxia.

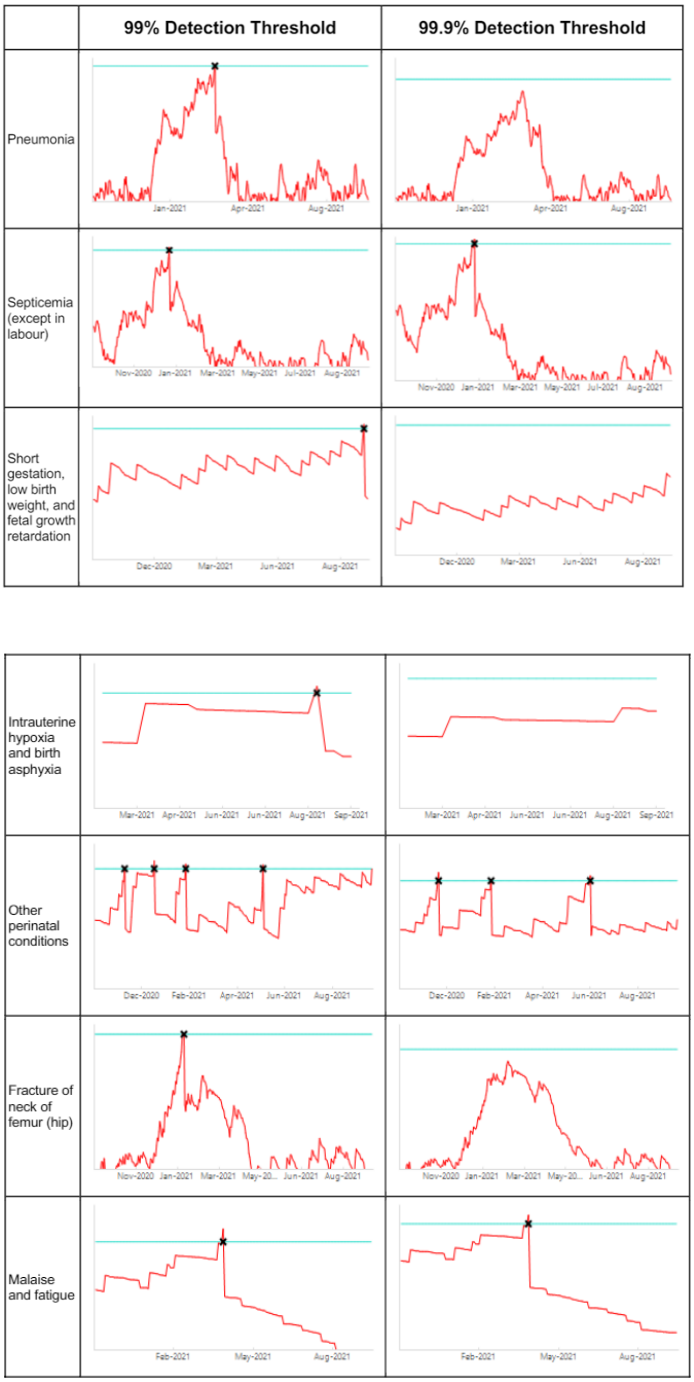


Figure 5. CUSUM alerts

2.5 SMR and CUSUM alerts in perinatal conditions

Between the SMR alert of 'Other perinatal conditions' and CUSUM alerts of 'Short gestation, low birth weight, and fetal growth retardation' and 'Other perinatal conditions', there were 981 super spells recorded. Within these super spells, there were 46 deaths at a rate of 4.7%. This dataset uses different definitions to Mothers and Babies Reducing Risk through Audit and Confidential Enquiries (MBRRACE) and, for example, may include late terminations.

In December 2021, the Women's Health Clinical Director presented the latest MBRRACE-UK (Birth report to the Mortality Steering and Surveillance Group. This annual report is

based on 2019 data and focuses on the surveillance of perinatal deaths from 22 weeks' gestational age (including late fetal losses, stillbirths, neonatal deaths). This report compares Trusts with Level 3 Neonatal Intensive Care Units (NICUs). Stillbirths and neonatal deaths are all reviewed for learning using the perinatal mortality review tool (PMRT) with external panel members and reported through the Maternity and Neonatal Assurance Group (MNAG). These data sources are being triangulated with the maternity dashboard data to ensure data quality, that all cases have been reviewed and actions identified monitored to completion with evidence of impact through MNAG.

3. Learning from Deaths summary

In Quarter 3, there were 59 cases reviewed through Structured Judgement Reviews (SJR). Compliance with timely completion fell again in Q3 from 13.6% in Q2. The Trust is working with NHSE/I "Better Tomorrow" team who have undertaken a desktop review and are in the process of feeding back recommendations to support improving compliance and further embed good practice in learning from deaths.

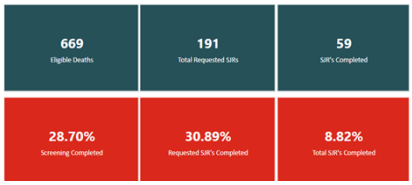


Figure 6 SJR performance

In Quarter 3, there were 59 cases reviewed through Structured Judgement reviews (SJR). The SJR dashboard illustrated by Figures 7 & 8 identify that there was presence of poor care in 7 cases with 1 case being described as causing harm. This was a surgical complication and will be reviewed at the SJR panel and if harm agreed considered at the Serious Incident Declartion Panel.

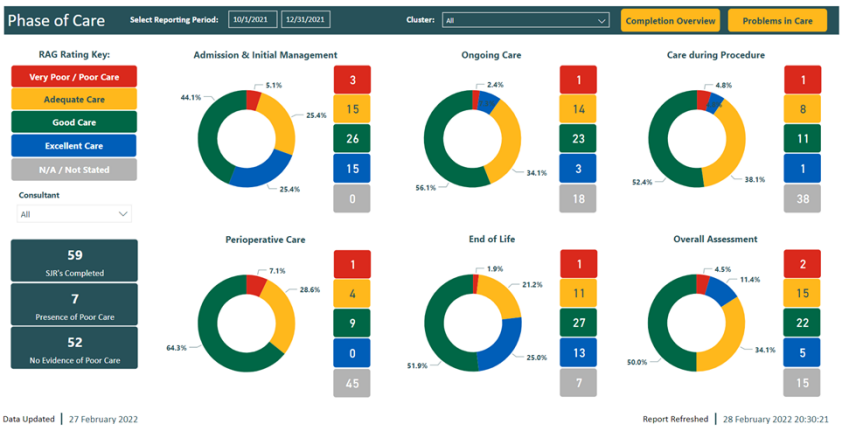


Figure 7. Phases of care for SJRs done in Quarter 3

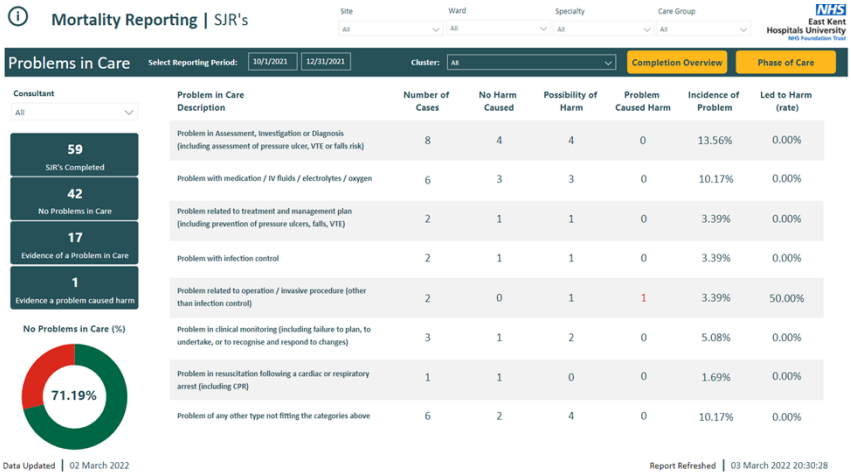


Figure 8. Problems in care

Based on the outputs of SJRs (both first and second reviews) and learning from serious incidents, the Learning from Deaths facilitators and panel continue to provide the golden thread between identification of themes leading to harm and individual Speciality teams in Care Groups. Their activities are primarily focused on the following areas.

- This team uses established Morbidity & Mortality (M&M) meetings to highlight themes with clinical teams. In more complex cases, co-ordination and facilitation is required to include multiple Specialities at the same M&M meeting. Recent examples include bringing together the William Harvey Hospital (WHH) Anaesthetics and Trauma team which has highlighted the importance of the major haemorrhage protocol.
- Focused work has been done by the Learning from Deaths facilitators and panel to ensure that more Speciality teams are holding M&M meetings to ensure that learning is taking place. At present, 82% of Speciality teams engage in a meeting that includes learning from deaths. This is a significant improvement in the last 12 months.
- Clinical Executive Management Group meetings have included a quarterly Mortality and learning from deaths update which has improved awareness of Care Group triumvirates. In addition, regular engagement has resulted in further support to particular Care Groups. An example to celebrate is General & Specialist Medicine's engagement with the pneumonia cluster review. This one-off exercise has resulted in significant clinical engagement such that the Respiratory team are now embarking on regular team SJR reviews.

4. Conclusion

The Trust's HSMR remains statistically as expected and is line with peer Trusts regionally. The standardised mortality ratio has remained within expected range since May 2021. Current alerts (SMR and CUSUM) relate to perinatal mortality. This report outlines some of the clinical improvements being undertaken by the relevant Care Groups. While the SJR and M&M process continues, using the outputs of the "Better Tomorrow" review will support strengthening our Learning from Deaths programme.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**POLICIES, GUIDANCE AND CODE OF CONDUCT REVIEW – COUNCIL OF GOVERNORS' RECOMMENDATIONS**				
MEETING DATE:	**10 MARCH 2022**				
BOARD SPONSOR:	**TRUST CHAIRMAN**				
PAPER AUTHOR:	**CORPORATE GOVERNANCE & RISK CONSULTANT**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	**Approval**	Information	Assurance	Discussion
Purpose of the Report:	This report presents recommendations from the Council of Governors (CoG) in response to a report from the Constitution and Policy Review Group (C&PRG), which was discussed and approved at the Council meeting on 9 December 2021.				
Summary of Key Issues:	The C&PRG is a task and finish group convened to undertake a review of the Trust Constitution and the policies and guidance relating to the work of Council. The group comprised: • Governors - Alex Lister (AL) (Chair), Carl Plummer (CP), Bernie Mayall (BM), Ross Britton (RB) and Ken Rogers (KR). RB and KR have since left the CoG. • Non-Executive Director (NED) - Nigel Mansley (NM). • Group Company Secretary - Alison Fox (AF). At the May 2021 meeting of Council recommendations were brought with respect to changes in the Constitution and it was noted that with respect to the policies and guidance significantly more time would be needed to complete the work. The review, which has now been completed, looked at the following documents: 1. *Appraisal Chair and NEDs guidance (Council owned document).* 2. **Governor Code of Conduct** (Trust owned document) comprising: a. The Main Code; b. Governor Role summary; c. Media Policy; d. Nolan Principles. 3. *Recruitment Guidance (Council owned document).* 4. **Dispute Resolution** (Jointly owned). 5. **Travel and expenses policy** (Trust owned). 6. **Managing allegation of a breach of the code of conduct** (Jointly owned). 7. **Fit and Proper persons policy** (Trust owned).				

	To make the workload more manageable, a lead/leads was assigned to each document and they presented their assessment at a meeting held on **22 July 2021**. This report provides the outcome of that work – the relevant recommendations for Board approval (**relating to Trust owned and jointly owned documents**) have been included in Pages 3 to 6 of this report. The group noted that all the documents would benefit from the use of plain English. It was recognised that to amend the text in this way would take a significant amount of work and time; resources were not available to do so at present. It is recommended that this is considered when each document is next reviewed.
Key Recommendation(s):	The Board is asked to discuss and **APPROVE** the specific recommendations presented on **Pages 3 to 6** of this report and summarised below: **Governor Code of conduct:** - Revise the Code of conduct to: o Include Lead Governor in initial discussions when a Governor raises concerns about an aspect of Trust's activity. o Align the Governor disqualification criteria to reflect changes to the Constitution. o Align the definition of 'Best interests' to reflect the wording in the roles and responsibilities document. o Amend the text in the Media Policy to reflect that Governors are able to express their personal view as long as it is made clear that this is the case. **Dispute resolution:** - Revise the Dispute resolution policy to: o Remove 'agreement' from paragraph 2.2 in respect of the effect of recommendations arising from the external review. o Re-word paragraph 4.5 to reflect modern technology. o Amend paragraph 4.7 for clarity that this agreement of disputes being put in writing. **Managing allegations of a breach of the code of conduct:** - Revise the guidance to: o Ensure clarity on the process for virtual voting. o Include Lead Governor in the process for review of the initial review of Governor complaints (if complaint is about Lead Governor, include the Deputy Lead Governor). o Clarity that allegations of a breach can be made by the public and staff. o Remove examples of potential breaches.

East Kent Hospitals University NHS Foundation Trust

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

Link to the Board Assurance Framework (BAF):	None	
Link to the Corporate Risk Register (CRR):	None	
Resource:	N	
Legal and regulatory:	N	
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	Council of Governors – 9 December 2021	

East Kent Hospitals University NHS Foundation Trust

POLICIES, GUIDANCE AND CODE OF CONDUCT REVIEW – COUNCIL OF GOVERNORS' RECOMMENDATIONS

1. Purpose of the report

1.1. This report presents recommendations from the Council of Governors in response to a report from the Constitution and Policy Review Group (C&PRG), which was discussed and approved at the Council meeting on 9 December 2021.

2. Recommendations

The Board is asked to discuss and approve the specific recommendations made:

Recommendation 1:
Overarching all documents: where reference is made to the original regulatory body Monitor, replace with the current regulator 'NHS England/NHS Improvement (NHSE/I)' and add a note at the start of the document that Monitor remains the legal entity.

Governor Code of Conduct
2a Main document
Recommendation 2a:
Add the Lead Governor to Paragraph 1.8:

Should any individual member of the Council become concerned about an aspect of the Trust's activities or that of the Council they should discuss this in the first instance with the Chair, **Lead Governor** or the Trust Secretary.

Recommendation 2a.1:
As with Recommendation 6.1 below, Section 3.2 relating to the disqualification of a governor should be updated to reflect changes in other documents, including the Constitution:

> 3.1 Governors will also be disqualified if they cease to meet the eligibility criteria, (mandatory or otherwise) for becoming governors, or if, through changing circumstances, they fall into the category of those who are excluded from becoming governors. Failure to meet the mandatory requirements under paragraph 17.1 of the Trust's Constitution will result in automatic termination. In circumstances where disqualification is under consideration for the non-mandatory reasons set out in Annex 6 of the Trust's Constitution, three weeks' notice of the resolution must be given to the Council of Governors, and termination as a governor will require the approval of three quarters of those members of the Council of Governors present and voting at the meeting.

Recommendation 2a.2
Section 5 Personal conduct: 5.1.1 Governors are to act in the best interests of the Trust.

This should be replaced by the definition given in the roles and responsibilities document:

> Governors must act in the best interests of the NHS Foundation Trust (FT) and are not expected to undertake the duties assigned to Directors or to be responsible for the operations and, ultimately, performance of the FT.

2b Governor roles summary
No changes recommended.

2c Media Policy
Recommendation 2c.1
Point 2 to be re-drafted so that it is clear that governors can give personal opinions as long as it is made clear that this is the case and that that will be reflected in any media coverage of the statement. Suggested addition in bold:

2. The Trust recognises that the Council has an appropriate role in providing information to the Trust's membership and wider public. However, to ensure such messages reflect the opinion of the whole Council and are consistent with other statements made by the Trust any statements by members of the Council of Governors must be issued through the Trust's Communications Department. **Governors may express their personal view as long as it is made clear that this is the case and that that will be reflected in any media coverage of the statement.**

Section 5 below to be amended accordingly.

5. With regard to communication to Governors from the press and media these must be immediately directed to the Communications Department on 01227 866384 who will take responsibility for providing and delivering a response. **Governors may express their personal view direct as long as it is made clear that this is the case and that that will be reflected in any media coverage of the statement.**

Recommendation 2c.2
It was suggested that section 6 be deleted from the policy.

6. Under no circumstances should an individual member of the Council of Governors discuss, publish or otherwise distribute information on matters pertaining to the Trust or their role as a member of the Council without the knowledge and agreement of the Chair of Governors and the Trust.

The Group Company Secretary said that this statement properly reflected the situation that when speaking as a governor it was important that view expressed must be one agreed by Council. She suggested that the section could be amended as above to caveat that personal opinions can be given if it is made clear that it was a personal opinion and not given as a governor.

Recommendation 2c.3
An addition to be made to the policy to stress that there is a responsibility on governors to make sure that information they provide is factually correct.

2d Nolan Principles

These are a nationally recognised set of principles – a reference document; not open for change.

DISPUTE RESOLUTION
Owned jointly. Lead reviewers: Ross Britton and Alex Lister

Recommendation 4.1
Paragraph 2.2: remove 'on agreement' from the following sentence.

> The recommendations arising from the external review will be binding on all parties, on agreement.

Recommendation 4.2
Paragraph 4.5 to be re-written to reflect modern technology – reference to 'tapes, discs' etc to be covered by 'all information'.

Recommendation 4.3
Paragraph 4.7: change:

> If parties reach agreement on the resolution of the dispute that agreement shall be **reduced to writing** and shall be binding upon the relevant parties.

To:

> If parties reach agreement on the resolution of the dispute that agreement shall be **put in** writing and shall be binding upon the relevant parties.

TRAVEL AND EXPENSES POLICY
Trust owned. Lead reviewer: Amanda Bedford

No changes recommended.

MANAGING ALLEGATIONS OF A BREACH IN THE CODE OF CONDUCT
Owned jointly. Lead reviewers: Ross Britton and Alex Lister

Recommendation 6.1
Section 3.2 of the Governor Code is referenced in Section A of this document. This should be revised so that the process for virtual voting is made clear and is consistent with the Constitution as required.

Recommendation 6.2
Section B – Process. As drafted the initial review of the allegation is undertaken by the Trust Chair and the Group Company Secretary. The recommendation is that the Lead Governor should also be involved in this stage of the review. If the complaint is against the Lead Governor, then the Deputy Lead Governor should be involved. Document to be amended accordingly.

Recommendation 6.3
Amend the document so that it is clear that allegations of a breach can be made by the public and staff.

Recommendation 6.4
The Trust to be asked to explore with NHSE/I whether they would agree to adjudicate in any case where there is a failure to reach an agreed outcome.

Recommendation 6.5
Annex B – examples of potential breaches to be removed.

FIT AND PROPER PERSONS POLICY
Trust owned. Lead Reviewer: Alison Fox

No changes recommended.

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**HEALTH & SAFETY (H&S) AND ESTATES STATUTORY COMPLIANCE UPDATE**
MEETING DATE:	**10 MARCH 2022**
BOARD SPONSOR:	**DIRECTOR OF STRATEGIC DEVELOPMENT AND CAPITAL PLANNING**
PAPER AUTHOR:	**INTELLIGENT CLIENT** **ASSOCIATE DIRECTOR OF SAFETY** **DIRECTOR OF CAPITAL & ESTATES**
APPENDICES:	**APPENDIX 1: STATUTORY COMPLIANCE PRIORITIES**

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	This report updates the Trust Board on the Trust's position in relation to statutory compliance, backlog, critical infrastructure and progress to date on the annual Health and Safety Toolkit Audit (HASTA) performance.				
Summary of Key Issues:	• The average statutory compliance levels have risen from 69% in Q1 2020/21 to 87% to date 2021/22 as a result of the agreed increased funding in 2020/21. We are targeting an overall increase in statutory compliance to 89%. by the end of March 2021/22 and 95% in 2022/23. • Backlog maintenance: The £3.1m allocation for 2021/22 has all been allocated against urgent priority risks; in September 2021/22 an additional £3.78m slippage monies was allocated; spend has been jointly reviewed with 2gether Support Solutions (2gether) and the Trust is content that the appropriate risk areas are being targeted. The spend for 2021/22 is being reviewed by the Patient Environment Investment Committee (PEIC) and is reported on a weekly basis at the Capital Programme Meeting which is chaired by the Deputy Chief Executive Officer (CEO). • The HASTA schedule is on course to be completed by the end of the financial year. Good progress is seen particularly in Urgent and Emergency Care. Audits will continue and support provided by 2gether's Safety Team will enable further improved outcomes which will be evidenced in the HASTA outcomes.				
Key Recommendation(s):	The Trust Board is asked to **NOTE** the Trust's current position in relation to statutory compliance, backlog maintenance, critical infrastructure and progress to date on the Health and Safety Toolkit Audit outcomes.				

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

Link to the Board Assurance Framework (BAF):	**Strategic Goal 4: Objective:** Develop a clinical strategy for the Trust that addresses key risks faced in terms of service delivery, workforce and estate condition (backlog and statutory compliance).	
Link to the Corporate Risk Register (CRR):	CRR34 – Inadequate Health and Safety systems embedded within the Care Groups.	
Resource:	Y	£3.1m allocation for 2021/22 has all been allocated against urgent priority risks. 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	Statutory estates compliance (regulatory and legislative), backlog, critical infrastructure and annual Health and Safety Toolkit Audit.
Subsidiary:	Y	2gether is providing health and safety advice and guidance in line with the Service Level Agreements.
Assurance Route:		
Previously Considered by:	The 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 Clinical Executive Management Group (CEMG) has received briefings and updates relating to Health and Safety and Statutory Compliance. The Strategic Capital Planning and Performance Committee has received briefings and updates relating to Health and Safety and Statutory Compliance.	

HEALTH & SAFETY (H&S) AND ESTATES STATUTORY COMPLIANCE UPDATE

1. Background and Executive Summary

1.1 This report updates the Trust Board on the Trust's position in relation to statutory compliance, backlog, critical infrastructure and progress to date on the annual Health and Safety Toolkit Audit (HASTA) performance.

2. Estate Statutory Compliance

Background and funding

2.1. The average statutory compliance levels have risen from 69% in Q1 2020/21 to 87% to date 2021/22 as a result of the agreed increased funding in 2020/21. The measure and reporting of statutory compliance requirements are consistent with the East Kent Hospitals legacy desktop methodology.

2.2. The priority work on meeting the statutory compliance requirements has been on water safety, electrical improvements and the completion of the Fire Safety tender. As previously discussed with East Kent Hospitals, there are gaps in statutory compliance requirements across all sites but in particular in the area of fire safety relating to:

a. fixed wire testing;
b. emergency lighting;
c. fire door inspection/maintenance;
d. fire smoke damper inspection and maintenance;
e. thermostatic mixing valves and water safety; and
f. ductwork inspection and cleaning.

2.3. There is a four-year investment plan and programme to increase statutory compliance levels and to move to a real time asset monitoring system. This monitoring system has been fully adopted for water safety compliance and will be rolled out to fire safety compliance next. Moving forward, Zetasafe will be adopted as part of Terms & Conditions for all new service contracts.

Compliance Overview January 2022 - Desk Top Audit	KCH					WHH					QEQM					Overall Total				
Category	No of Compliance areas	No of areas fully complied with	% of areas fully complied with	% of areas part complied with	% of areas not complied with	No of Compliance areas	No of areas fully complied with	% of areas fully complied with	% of areas part complied with	% of areas not complied with	No of Compliance areas	No of areas fully complied with	% of areas fully complied with	% of areas part complied with	% of areas not complied with	No of Compliance areas	No of areas fully complied with	% of areas fully complied with	% of areas part complied with	% of areas not complied with
Fire & Smoke Statutory & HTM 05	12	8	66.67	16.67	16.67	17	13	76.47	11.76	11.76	14	9	64.29	14.29	21.43	43	30	69.77	13.95	16.28
Energy, environment & HTM 03	19	17	89.47	10.53	0.00	18	16	88.89	11.11	0.00	18	14	77.78	22.22	0.00	55	47	85.45	14.55	0.00
Electrical & HTM 06	16	13	81.25	18.75	0.00	16	13	81.25	18.75	0.00	17	13	76.47	23.53	0.00	49	39	79.59	20.41	0.00
[illegible] equipment,nurse call HTM08	10	10	100.00	0.00	0.00	9	9	100.00	0.00	0.00	11	11	100.00	0.00	0.00	30	30	100.00	0.00	0.00
Mechanical plant	15	15	100.00	0.00	0.00	16	16	100.00	0.00	0.00	16	16	100.00	0.00	0.00	47	47	100.00	0.00	0.00
H&S Management	2	1	50.00	50.00	0.00	2	1	50.00	50.00	0.00	2	1	50.00	50.00	0.00	6	3	50.00	50.00	0.00
Water management & HTM 04	22	22	100.00	0.00	0.00	23	23	100.00	0.00	0.00	23	22	95.65	4.35	0.00	68	67	98.53	1.47	0.00
Working at height	4	4	100.00	0.00	0.00	4	4	100.00	0.00	0.00	3	3	100.00	0.00	0.00	11	11	100.00	0.00	0.00
Decontamination	4	4	100.00	0.00	0.00	5	5	100.00	0.00	0.00	2	2	100.00	0.00	0.00	11	11	100.00	0.00	0.00
Gases	9	9	100.00	0.00	0.00	9	9	100.00	0.00	0.00	9	9	100.00	0.00	0.00	27	27	100.00	0.00	0.00
Site records	7	3	42.86	28.57	28.57	7	3	42.86	28.57	28.57	7	3	42.86	28.57	28.57	21	9	42.86	28.57	28.57
Total	120	106	88.33	8.33	3.33	126	112	88.89	7.94	3.17	122	103	84.43	11.48	4.10	368	321	87.23	9.24	3.53

3. Forecast Statutory Compliance Position

3.1. Within the business planning process undertaken by the East Kent Hospitals in April 21, 2gether requested additional funding to support bringing forward statutory compliance improvements. Subsequently and following recent approvals of Contract Change Notice (CCN) 24 and CCN 25 on 7 October 2021 which total an additional £1.5m in 2021/22 financial year, we are targeting an overall increase in statutory compliance to 89% by the end of March 2021/22, and 95% in 2022/23.

3.2. This surpasses the original target for this financial year of 84%. Works are currently ongoing to expedite the procurement and scheduling of these improvements against tight timeframes. Works are being prioritised on a balance of ability to complete (downtime), availability of supply chain and coordination with other services.

3.3. Appendix1 provides breakdown of planned and estimated spend against compliance areas and assuming requisite procurement support. All assets detailed in each respective service area will aim to have planned preventative maintenance completed in compliance with statutory standards and best practice guidance e.g. Healthcare Technical Memorandums (HTM) where applicable. It should be noted that the aim is to demonstrate 'best practice' where compliance with HTM's exceeds standards stipulated in British Standards or Approved Codes of Practise (ACOP).

3.4. If this statutory compliance plan is achieved, the remaining non-compliances relate predominantly to automatic fire/smoke dampers, and ductwork inspection and cleaning. Given the complexities around access, enabling works and the ongoing fire compartmentalisation survey it wasn't possible to schedule these works before end of this financial year. These works will be prioritised for 2022/23 and a plan developed to deliver across the Trust and throughout the year.

3.5. The role out of further targeted improvements in statutory compliance and migration to new asset-based system will be overseen by a compliance manager who was appointed in January 2022.

4. Backlog Maintenance

4.1. The annual capital schedule is submitted to the Trust's Strategic Investment Group (SIG) for approval and the spend is monitored each month at SIG and the PEIC committee. PEIC committee membership includes EKHUFT Intelligent Client, Director of Infection Prevention Control (DIPC), Deputy Chief Nurse, Finance and 2gether's Director of Capital and Estates.

4.2. SIG membership includes all care group operational directors who have oversight and influence on priority spending. Any amendments or additions to the PEIC programme and agreed at PEIC committee and recommended to SIG for approval.

4.3. Utilising the six-facet survey and initial findings of the ARUP critical infrastructure report, the Heads of Technical Services at William Harvey Hospital (WHH), Queen Elizabeth Queen Mother (QEQM) and Kent and Canterbury Hospital (K&C) have reviewed the backlog maintenance priorities

for each site. These have been risk scored and ranked into medium, high and urgent priorities.

4.4. The £3.1m originally allocation for 2021/22 has all been allocated against urgent priority risks. Any additional capital and future funding will be allocated based on output of ARUP Critical Infrastructure Risk Survey and joint risk workshops.

4.5. In September 2021/22 an additional £3.78m slippage monies was allocated. Increasing the PEIC allocation to £6.88m, with an additional over commitment of £0.3m for next year bring the total commitment shown in the tables below to £7.18m. Which has been jointly reviewed by the Director of Technical Services, Managing Director and Financial Director of 2gether who are content that it is targeting appropriate risk areas but understand that more funding is required to deal with the immediate risks in the short term.

4.6. It is worth noting that the phasing of spend for 2021 is currently under review by the PEIC and is reported on a weekly basis at the Capital Programme Meeting which is chaired by the Deputy CEO.

4.7. The three tables below detail the proposed PEIC allocation and funds currently committed at each of the acute sites and include extra funding as part of Emergency Department enabling works.

CAPITAL PEIC PROJECTS	ALLOCATION	COMMITTED
KCH		
Fire Compartmentation	£30,000	£0
Theatre 4&5 - AHU Replacement	£1,000,000	£1,065,733
ED Enabling - HV Supplies	£650,000	£596,860
Fire Alarm Upgrade - Phase 2	£344,768	£344,768
1937 Transformer Replacement	£125,000	£120,383
A&E Condesate Receiver/Pipework	£32,025	£32,025
Replacement MRI Unit Boiler	£33,103	£33,103
Replacement Post-Grad Boiler	£109,777	£109,777
Roof Repairs/Window Replacement	£94,855	£94,855
Aseptics & Hydropool AHU	£100,790	£100,790
Renal Unit Water Booster	£20,000	£0
Building Management System Upgrades	£16,336	£16,336
1937 Building - Water Tank (Was WHH Legionella)	£100,000	£100,162
KCH TOTAL	**£2,656,654.00**	**£2,614,792**

CAPITAL PEIC PROJECTS	ALLOCATION	COMMITTED
QEQM		
RRW HV/LV - Phase 3	£150,000	**£150,000**
ED Enabling - HV Supplies	£750,000	**£1,047,862**
Legionella	£100,000	**£105,996.25**
Replace Windows & Cladding	£85,655	**£85,655.00**
Replace AHU Day Surgery Theatre 1	£320,000	**£177,361.00**
Fire Alarm Upgrade	£0	**£0.00**
Fire Compartmentation	£190,000	**£190,486.30**
St Peters Road Roofing	£25,000	**£23,654.00**
Oxygen Ring Main	£325,000	**£324,000.00**
QEQM TOTAL	**£1,945,655**	**£2,105,015**

CAPITAL PEIC PROJECTS		ALLOCATION	COMMITTED
WHH			
Fire Alarm Works		£200,000	£186,556
ED Enabling - HV Supplies		£1,300,000	£1,519,657
Laundry tank replacement works		£174,216	£174,216
CT scanner reduced duct size		£16,835	£16,835
HPV Machines		£166,968	£166,968
Endoscopy Chiller Replacement		£90,000	£99,695
Channel Day Plant Room		£27,500	£28,998
NICU DHW PHEX		£87,500	£49,525
Renal Unit Water Booster	#	£20,000	£0
Medical Air Plant		£150,000	£150,482
Nurse Call system in Cambridge M1 & 2		£28,500	£38,781
WHH TOTAL		**£2,261,519.00**	**£2,431,712**

5. Critical Infrastructure

5.1. A critical infrastructure survey (undertaken by ARUP) was commissioned to assess, score and prioritise the critical infrastructure risk elements associated with backlog maintenance identified. This process was then followed by a review and re-prioritisation process involving IP&C, the Hospital Management teams and Strategic Development along with the 2gether site technical estate teams.

5.2. Critical infrastructure typically refers to the critical engineering services and plant that serve hospital buildings and keep the 'heat, light and power on' and, if they failed would have a significant impact on service delivery and / or patient safety. Guidance on the management and maintenance of critical infrastructure is prescribed in a suite of Department of Health (DOH) documents called Health Technical Memorandums (HTMs).

5.3. Through this process a joint agreement has been arrived at on the timeline for future funding priorities, the extent of any residual risk and the quantum of funding required to deal with critical infrastructure issues in the Trust.

5.4. The outcome of the Critical Infrastructure Risk (CIR) survey and prioritisation process commissioned and led by 2gether between January and July 2021 was presented at the October 2021, Clinical Executive Meeting Group.

6. Health & Safety

6.1 HASTA:

a. The HASTA schedule is on course to be completed by the end of the financial year. Good progress is seen particularly in Urgent and Emergency Care. Audits will continue and support provided by the Safety Team to help Care Groups continue this good work.

Care Group	2019	2020	As at 31st December 2021
Cancer	98%	92%	93%
Child Health	80% (known as Women's and Children's' care group)	98%	99%
Corporate	99%	90%	90%
Clinical Support Services	96%	96%	95%
General & Specialist Medicine	98%	89%	86%
Head & Neck	64%	90%	90%
Surgery & Anaesthetics	93%	90%	86%
Urgent & Emergency Care	69%	67%	87%
Women's Health	80% (known as Women's and Children's at the time)	90%	84%
Trust	87%	89%	90%

6.2 Trust Health and Safety Leads

a. It should be noted that the Trust Health and Safety Leads continue to work well to embed Health and Safety standards in their Care Groups.

6.3 Health and Safety Training

a. Health & Safety link worker training in 2021/22 continues. Further sessions are scheduled February and March 2022. Whilst the training will be based around the WebEx platform, there will be an opportunity for socially distanced hazard spotting session carried out on a site by site basis. First Aid training has now resumed after a lull due to Covid.

b. The Strategic Health and Safety Committee continue to oversee Health and Safety related training

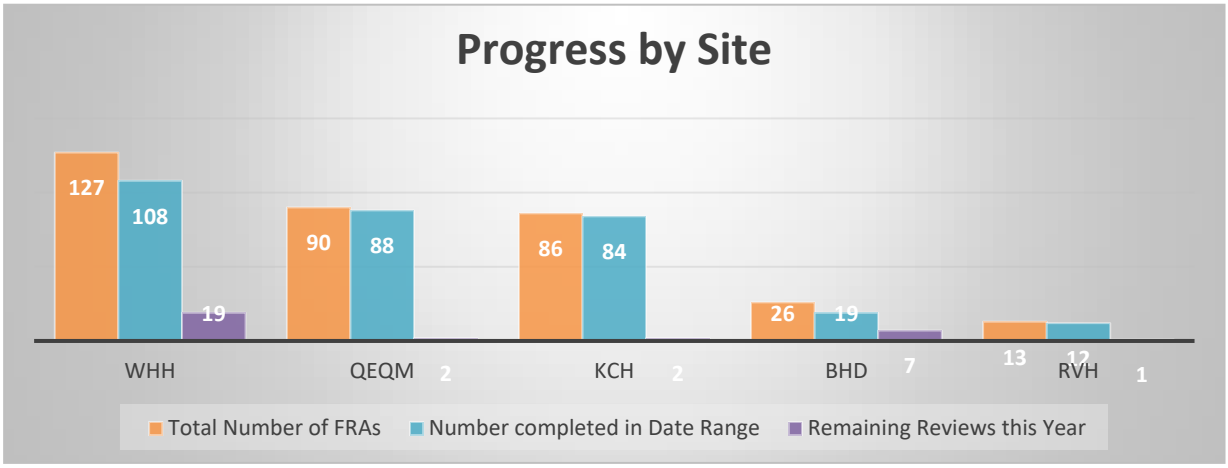
6.4 Fire Safety

a. The Fire Risk Assessment programme is progressing well and on target with approximately 91% of the reviews completed so far this year with all assessments scheduled for completion on time and there are no reported issues with the delivery of the programme.

b. Currently there is 1 substantial risk at QEQM, in the St Peters Rd Basement, this will be reviewed in March following the remediation works and at this point the risk will reduce to Moderate.

c. There is an annual review undertaken by Fire Engineers who have identified 66 Moderate rated Fire Risk Assessments (FRAs) across the 3 main clinical sites, with none at Buckland Hospital Dover (BHD) or Royal Victoria Hospital (RVH). Estates teams are working on all maintenance related items and are prioritising these by risk rating. Where health and safety issues have been raised i.e. obstruction, fire doors being left open these risks will be addressed at the time the risk assessment was undertaken or a short time after the issue has been identified.

d. FRA Progress by Site, as at 28 January 2022.



Risk level	Action and timescale
Tolerable	No major additional fire precautions required. However, there might be a need for reasonably practicable improvements that involve minor or limited cost.
Moderate	It is essential that efforts are made to reduce the risk. Risk reduction measures, which should take cost into account, should be implemented within a defined time period. Where moderate risk is associated with consequences that constitute extreme harm, further assessment might be required to establish more precisely the likelihood of harm as a basis for determining the priority for improved control measures
Substantial	Considerable resources might have to be allocated to reduce the risk. If the premises are unoccupied, it should not be occupied until the risk has been reduced. If the premises are occupied, urgent action should be taken.

6.6 Fire Training

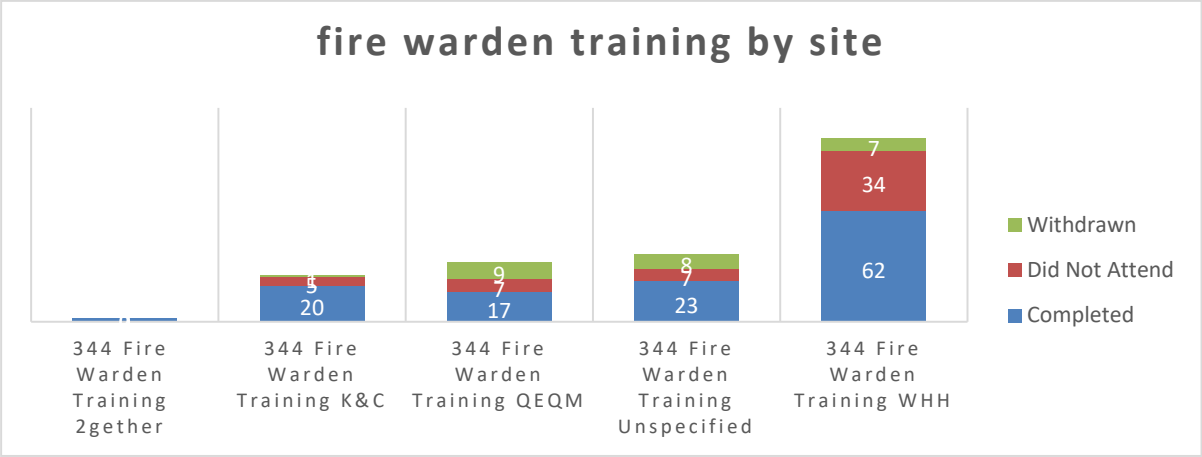
a. There is a Trust sponsored training programme in place for Fire Incident Managers, Fire Wardens and extinguishers using an external consultant with training figures from May 2021 – December 2021. Additionally, via Webex, there is EKHUFT Specific Basic Fire Awareness training programme delivered by the Fire Safety Manager offered to all new starters in the Trust (with around 60% uptake). An annual programme of Fire Evacuation training begins in April 2022, delivered by the Manual Handling team prioritised on a risk basis.

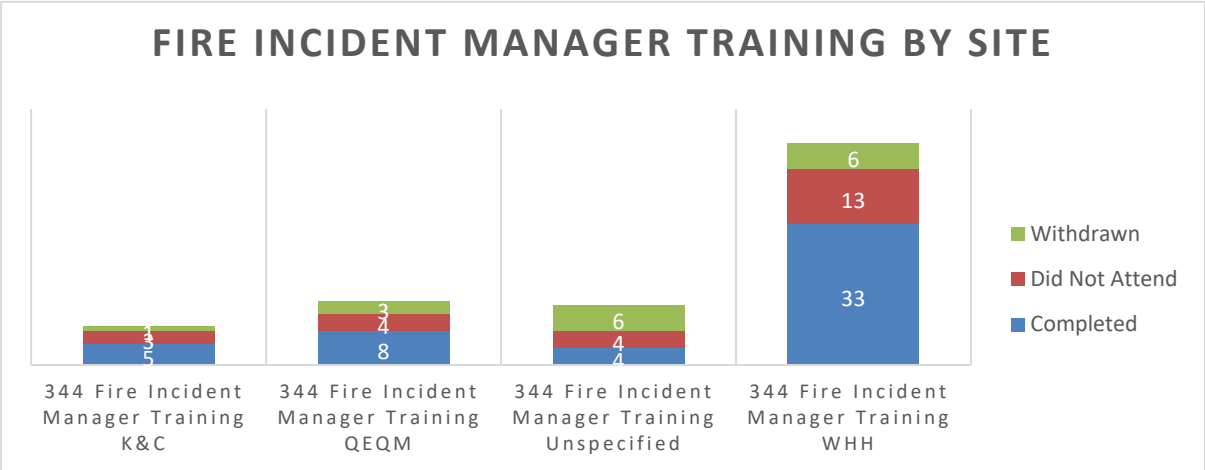
b. Learning and Development (L&D) monitor the training statistics and record on Electronic Staff Record (ESR). There is a programme of training for specialist teams such as Theatres, Intensive Therapy Units (ITUs), Neonatal Intensive Care Units (ICUs), Microbiology, Clinical Site Management (CSMs) and some planned for certain wards delivered in situ based on their risks.

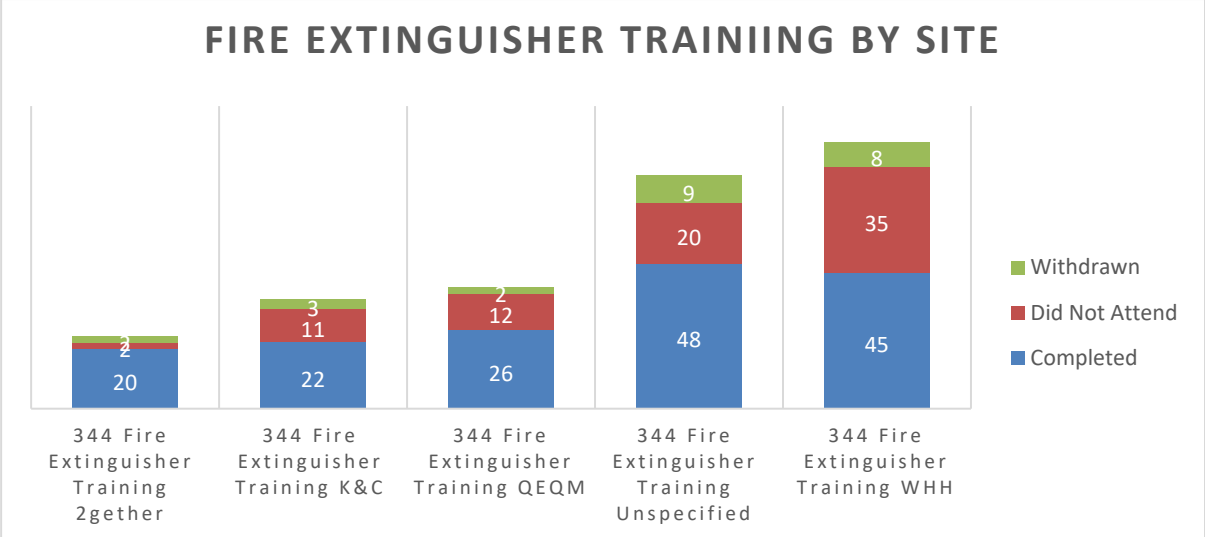
c. The training is self-bookable via ESR and the feedback is generally very good. However, there is a risk of low attendance and no shows due to workplace pressures.

d. Fire Safety section of HASTA folders was updated this year to reflect current training, and further improvements to follow in 2022/23 with a specific Fire Safety folder created and monthly Fire Warden checks instigated.

e. It should be noted that there was a greater gap of staff requiring training at the William Harvey site and therefore additional courses were scheduled to address this gap in trained fire warden staff.







6.7 Fire System maintenance standards

a. 2gether is implementing a maintenance programme to the Industry Standard SFG 20, which is currently underway, with fire door inspections, extinguishers, fixed gas extinguishing systems, fire hydrants and risers and fire alarm maintenance with fire dampers and emergency lighting to follow. Fire Compartmentation surveys have been completed across the 3 main clinical sites.

7. Conclusion

7.1 The Health and Safety Team together with Health and Safety Leads (Trust) has worked together to ensure continued compliance against the HASTA framework. HASTA outcomes will be monitored via monthly Health and Safety meetings chaired by the Intelligent Client. Formal quarterly compliance reports are presented to the Strategic Health and Safety Committee chaired by the Deputy CEO.

Service	Assets to be maintained/Services required		Full position
Professional Services	**Statutory Compliance Manage**	£	60,000.00
	Fire Manager	£	65,000.00
	Procurement Support	£	40,000.00
	MTC Tender	£	6,280.00
	Authorised Engineers and Specialist Advisers		
	HTM 01 Decontamination	£	6,500.00
	HTM 02 Medical Gas	£	7,100.00
	HTM 03 Ventilation	£	10,000.00
	HTM 04 Water	£	32,500.00
	HTM 05 Fire	£	33,000.00
	HTM 06 Electrical	£	20,700.00
	HTM 08 Lifts	£	13,600.00
	Asbestos	£	40,000.00
	Confined Spaces	£	10,000.00
	Pressure Vessels	£	10,000.00
	Water Consultancy	£	65,000.00
Water Services	**Water Risk Assessment**	£	79,941.74
	Water Hygiene and TMV Servicing & Testing	£	154,364.00
	TMV Servicing	£	204,212.00
	Zeta Safe Software	£	9,310.00
	RPZ Testing	£	1,500.00
AC	**Air Conditioning**	£	80,000.00
	Prochill Steam Absorbtion Chiller	£	5,000.00
Controls	**Boiler & Calorifier Controls**		
	BMS	£	59,551.00
Fire	**Fire Risk Assessments**	£	84,750.00
	Fire Safety Software	£	3,000.00
	Fire Doors	£	151,943.00
	Fire Alarms/Interfaces	£	165,560.00
	Fire Fighting Equipment	£	21,598.00
	Emergency Lights	£	168,061.00
	Fire Suppression System	£	19,202.00
	Dry Risers	£	22,537.00
	Fire Hydrants	£	3,000.00
	Door Guards	£	30,000.00
Electrical	**HV Maintenance**	£	30,000.00
	Fixed Wire, Electrical & Switchgear Testing	£	220,000.00
	Portable Appliance Testing	£	20,137.00
	Medical IPS/UPS Maintenance	£	29,000.00
	General UPS Maintenance	£	15,000.00
	Lightning Conductors	£	10,000.00
	Generators	£	53,000.00
	Smart Scan Contract	£	3,577.00
Medical	**Medical Gases**	£	29,380.00
	Medical Equipment/Sterilizer/RO		
Mechanical	**Gas Boilers & Water Heaters**	£	20,000.00
	Steam Boilers	£	15,000.00
	Refrigeration	£	4,927.00
	Critical Ventilation Verification	£	184,000.00
	Non Critical Vent Maintenance	£	30,000.00
	Compressors	£	4,400.00
	LEV	£	2,000.00
	Plate Heat Exchanger	£	30,000.00
	Condensate Receivers	£	5,000.00
	Pressurisation Units	£	4,999.26
	Lifts	£	26,060.00
	Automatic Doors	£	10,000.00
General	**Oil/LPG Storage & Bundguards**	£	5,190.00
	Drains	£	20,000.00
	Insurance Inspections	£	23,120.00
	Chimney Inspections	£	2,000.00
Training		£	60,000.00
TOTAL SERVICE		**£**	**2,540,000.00**
TOTAL REPAIR		£	560,000.00
TOTAL INVESTMENT		**£**	**3,100,000.00**

NHS
East Kent Hospitals University
NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
People & Culture Committee (P&CC)	2 March 2022	Stewart Baird, Non-Executive Director	Corporate Governance & Risk Consultant	**Yes**	~~**No**~~
Appendices:	None				
Declarations of Interest made:					
No declaration of interest was made outside the current Board Register of Interest.					
Assurances received at the Committee meeting:					
January 2022 Integrated Performance Report (IPR) – We Care True North Objectives	• The Committee received and discussed the IPR report and noted the following: ○ Turnover: 12-month rolling average of the total staff turnover (12.3%) remained above the 10% threshold for the 10th month in succession. ○ In-month data shows an increase for the first time in the last three months due to premature and nurse turnover. ○ The Committee received re-assurance of the intensive onboarding work taking place with regional colleagues across the Kent and Medway Retention Programme and programme of work in place; and of the exit interview process including a face to face meeting with managers in addition to completion of an online survey. ○ The Committee requested for the exit interview dashboard to be presented to the next meeting of the Committee. ○ Staff engagement: The Committee noted the National Pulse Survey data for Quarter 4 is expected in time for the next meeting of the Committee. ○ The Committee noted that considerable work had been undertaken to understand the National Staff Survey data and that a report will be presented to the next full meeting of the Committee following the lifting of the embargo nationally. In the meantime, the team is working with the Care Group Triumvirate to develop action plans. ○ Sickness absence: A slight decrease in sickness absence (primarily associated with stress and anxiety) to below 5% was reported in January 2022. ○ The Committee noted that this is the lowest sickness absence has been since the *pandemic* and the commendation to the Wellbeing and Occupational Health teams for the ongoing work to address this.				
Board Assurance Framework (BAF) & Corporate Risk Register (CRR)	• The Committee noted that at the last meeting of the Executive Risk Assurance Group (ERAG), the Executive Directors had conducted a Peer-review deep-dive of BAF 35. Following the review, changes to the risk information have been reflected on the BAF. • No other changes were reported on the BAF and the CRR.				

People Strategy Update	• The Committee received the update and **APPROVED** the continuation of the Our People Strategy.
	• The Committee was assured that the Strategy is fit for purpose and continues to align to the national people plan, our ambitions to exit the recovery support programme and overall trust vision.
	• The Committee noted the following:
	  ○ The refreshed People Strategy reflects a slight change in Our People promise. This has been revised in line with the reimaging of the national People promise.
	  ○ The Cultural change programme is being launched with a reinvigorated Equality Diversity and Inclusion (EDI) Strategy.
	  ○ The Strategy recognises we are under the Recovery Support Programme (RSP).
	  ○ The People Dashboard has been developed as a working tool to enable formal monitoring of key metrics that align to the strategic priorities.
	• The Committee agreed that the Strategy is brought back to the Committee in September 2022 when the strategy is due for annual review.

Diversity and Inclusion report – update on independent review report	• The Committee was informed an independent review had been commissioned and draft report received in December and noted the following:
	  ○ The report was currently being finalised;
	  ○ A fresh Equality, Diversity and Inclusion (EDI) Strategy and action plan is being developed;
	  ○ A development session with the Trust Board on Diversity and Culture is being arranged (forms part of the Board Development Programme for 2022/23).
	  ○ The EDI Team had commenced working on actions ahead of the final report.
	• The Committee noted a formal report will be presented to the Committee at the next meeting before being presented to the full Board.
	• The Committee had a robust discussion about Diversity and Inclusion and the following were noted:
	  ○ A steady increase of Black, Asian and Minority Ethnic (BAME) staff in leadership roles (band 7 and above) has been recognised.
	  ○ Recent promotions of international nurses.
	• The Committee considered a survey and/or listening event for BAME staff in leadership to understand their experiences and challenges will be beneficial.

Recruitment update – pipeline against establishment	**Nursing:** • The Committee received an update on the recruitment pipeline which is initially coming from the international recruitment pipeline. • The Committee was partially assured that the recruitment was achievable. It was noted there is a significant increase in Registered Nurse (RN) new recruits planned from the summer (2022) and as such assurance was sought that this uplift was achievable by way of a report from the Director of HR & OD at the end of Quarter 1.

	Consultants: • The Committee received an update on Consultant vacancies noting the pipeline remains strong with some hard to recruit roles remaining. • The Committee requested for the vacancy tracker showing red flags in areas of concern to be brought to future meetings.

Chief Nursing and Midwifery Officer (CNMO) Nursing and AHP Workforce Update	• The Committee received an update of the Trust's safe staffing position and noted the following:
	  ○ Progress of the safe staffing improvement plan;
	  ○ key risks areas across the three acute sites; and
	  ○ the priorities over the next three months in strengthening the current governance arrangements within the Trust.
	• The Committee received assurance that the Trust is meeting NHS England/NHS Improvement (NHSE/I) 2018 safe staffing guidance.
	• The Committee was informed that there is a risk of potential delay to the pipeline due to national shortage of the nursing and midwifery Objective Structures Clinical Examination (OSCE).
	• Although this will not impact on the international recruitment, it will delay the process of on-boarding including turning around of PIN numbers to enable the new staff work as nurses.
	• The National shortage will impact on 33 nurses who are ready for their OSCEs next week.
	• The Committee requested that this issue is escalated to the Board of Directors through the Chair's assurance report.

Trust-wide Cultural Change Programme	• The Committee received and discussed the evidence-based methodology to measure culture and leadership and the programmes and interventions in development to facilitate cultural change. • The Committee noted the recommendation that the Culture and Leadership Programme (CLP) is implemented throughout the Care Groups, using a phased approach with start times spanning 2022/23 and that the identified programmes/interventions, currently in development, are fully supported. • The Committee agreed that this should progress to a full Business Case, specifically noting it may be beneficial to complete the Discovery phase and then re-assessing the business for the full programme. • It was noted that there is significant support for this programme from the Board of Directors and Council of Governors alike.

Freedom to Speak Up Guardians (FTSUGs) Report	• The Committee received and discussed the FTSUGs quarterly report and noted the following:
	  ○ The Freedom to Speak Up Team has expanded to include two full time Guardians who have been in post since January 2022.
	  ○ Increase in contact to the team in Quarter 3.
	  ○ There are plans in development to proactively engage with staff to increase the number of concerns being raised and to improve the experiences of those who speak up.
	  ○ Work has begun to understand what challenges there are to speaking up so that collaborative interventions can be put in place to break down those barriers.
	  ○ Future triangulation of information we have across the organisation on speaking up to present an overall picture of the speaking up culture at EKHUFT.

	○ Currenting working with NHSE/I to review the Trust's speaking up policy.
Guardian of Safe Working Report	• The Committee received the Guardian of Safe Working report and noted the outcome of the rota compliance audit. • The Committee received assurance that the fine recently imposed on the Trust was an isolated incident and therefore unlikely to reoccur to the same scale.
Professional Education Workforce Independent Review Update	• The Committee discussed the outcome of the independent review of professional education workforce, noting the progress made by the Trust since the review was undertaken. • The Committee requested that the full report is presented to the Committee at the next full meeting in addition to providing a gap analysis and an action plan.
HR Dashboard – The People Dashboard	• The Committee received and noted progress of the development of the people dashboard and the summary of dashboard metrics not covered in other papers.
Occupational Health (OH) & Wellbeing Activity Report – Quarter 3	• The Committee received and noted the activity undertaken by the Occupational Health service in Quarter 3. • The Committee noted the Trust achieved the Kent and Medway Workplace Wellbeing Silver Award; the assessors noted areas of good practice being: wellbeing information, access to a range of OH and Wellbeing support services and initiatives with investment in training to support sickness absence reduction and a positive mental health culture.
Referrals to other Board Committees	• There were no referrals to other Board Committees at this meeting.

Referrals from other Board Committees	• The following referrals were made from other Board Committees:
	  • **Quality & Safety Committee – January 2022 meeting**: Review assurances from the Agency and Bank staff perspective on their opinion of the local induction they receive.
	  • **Quality & Safety Committee – March 2022 meeting:** The Committee noted limited progress in developing supervision after incidents and the additional changes required to appraisal paperwork and agreed that the issue is referred to People and Culture Committee for action.
	  • **Finance & Performance Committee – March 2022 meeting:** IPR - The Committee agreed a referral of the Harm measure and the Accommodation strategy (Trust Priority Improvement Project) to the People and Culture Committee.

Other items of business	• Committee Annual Work Programme 2022 (For information). • Feedback from Staff Committee (For information). • Feedback from Integrated Education, Training and Leadership Development (For information). • Feedback from Diversity and Inclusion Steering Group (For information).

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

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

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

Item	Purpose	Date
• **Trust-wide cultural change programme:** ○ The Board is asked to note the Trust-wide cultural change programme.	Information	10 March 2022

• **Chief Nursing and Midwifery Officer (CNMO) Nursing and AHP Workforce Update:** ○ The Board is asked to note that there is a risk of potential delay to the pipeline due to national shortage of the nursing and midwifery Objective Structures Clinical Examination (OSCE). ○ Although this will not impact on the international recruitment, it will delay the process of on-boarding including turning around of PIN numbers to enable the new staff work as nurses. ○ The National shortage will impact on 33 nurses who are ready for their OSCEs during the week of 7 March 2022.		

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) PUBLIC					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Finance & Performance Committee (FPC)	1 March 2022	Nigel Mansley, Non-Executive Director	Corporate Governance & Risk Consultant	**Yes**	~~**No**~~
Appendices:	Appendix 1: Referral to Treatment (RTT) performance report (appended to 21/149.2 -Waiting List Overview report)				
Declarations of Interest made:					
No declaration of interest was made outside the current Board Register of Interest.					
Assurances received at the Committee meeting:					
Matters arising from previous meetings	• The Committee recommended that the Board undertakes a strategic review of the Group structure during 2022/23.				
Month 10 Finance Report	• The Trust delivered £0.8m surplus position in January 2022, which brought the year to date (YTD) position to a £0.1m deficit resulting in an adverse position against plan of £0.3m. • The Trust's cash position at the end of January 2022 was £10m which was £4.4m above the plan. • Key risks to delivering breakeven were noted as ability to reduce additional expenditure due to Covid-19 with the emergence of the Omicron variant and achieving planned levels of elective activity required to receive the variable element of Elective Recovery Funding (ERF) income. The Trust is working well with Commissioners to ensure this is mitigated. • The Committee received re-assurance that the Trust's forecast continues to demonstrate a break-even position at year end. • The Group gross capital year to date spend to the end of January is £31.3m against a re-phased plan of £32.1m, representing a £0.8m underspend. • The main risk to the 2021/22 capital programme is the Emergency Department (ED) expansion as a result of the impact of Covid-19 and global supply chain shortages. The Trust is in discussions with NHS England/NHS Improvement (NHSE/I) to address this. • Additional costs of £2.4m was identified in January 2022 due to Covid bringing the YTD total to £18m. In-envelope spend being £0.6m and £1.8m greater than plan in month and H2 YTD. • In view of the change in H2 of the ERF methodology based on monthly Referral to Treat (RTT) completed pathway submissions instead of elective activity levels. £6.7m was included for H2 performance which was below planned levels of activity. • Planning guidance for 2022/23 was received in January 2022 and the Trust is in discussions with Commissioners regarding the financial baseline.				
We Care Integrated Performance Report (IPR)	• The Committee received an update and discussed progress made in modifying the IPR and noting the need to develop reporting alongside the IPR to include key financial and operational metrics not covered by the We Care IPR measures				

	• The Committee was assured on the NHSE/I Statistical Process Control (SPC) icons added to the IPR and recommended that a workshop for the Board on the new SPC charts will be beneficial. • The Committee agreed a referral of the Harm measure and the Accommodation strategy (Trust Priority Improvement Project) to the People and Culture Committee. • The Committee received re-assurance on the progress of the ED restart programme noting that teams in both EDs were making progress on fundamentals of care and that as Covid-19 reduces there will be an improvement in the 4-hour performance standard.

Financial Recovery Plan (FRP)	• The Committee received assurance on the progress of the FRP to date and agreed the following next steps:
	  • Finalise the medium-term system financial model working with the Integrated Care System (ICS) and national leads.
	  • Continue development of the 2022/23 operating plan including minimising financial cost pressures and identifying the full £25m of efficiencies target.
	  • Continue work with NHSE/I, Financial Improvement Director, Kent & Medway system leads and Medway NHS Foundation Trust (MFT) to develop and refine our financial model and FRP.
	  • Present a draft FRP to April FPC for discussion.
	  • Present the final FRP and summary financial model to the May FPC and Trust Board. Noting NHSE/I confirmation that this will not adversely affect the planned timescales to exit Recovery Support Programme (RSP) is required.

Operational Planning Update 2022/23	• The Committee were informed the final draft of the operational plan could not be presented to the meeting due to ongoing conversations relating to income from Commissioners and level of activity planned to deliver.
	• Discussions are ongoing with Commissioners with regards funding for 2022/23 and the financial baseline offer will be dependent on variables such as available ERF.
	• The Committee reviewed the draft plan noting the key drivers of the projected deficit and current progress with identifying efficiencies for 2022/23.
	• The Committee agreed the following:
	  • Establish a £5m central contingency for critical emergent safety/quality/Care Quality Commission (CQC) concerns with Board approval to access.
	  • Continue to target £25m of efficiencies.
	  • An Extraordinary meeting will be required to approve the final draft plan.
	  • Provide this update to the Closed Board on 10 March 2022 as a stand-alone report.

Update on Recovery, Reset, Restore and Recovery Programme (4Rs)	• The Committee received assurance of the activity across the Elective and Emergency workstreams supported by the 4R programme and the monitoring arrangements in place to support the programme. • The Committee noted that consideration is being given to wrapping up the 4R programme as recovery moves into the Business As Usual phase. • Elective workstreams remain focussed on the re-establishment of theatre sessions and elective activity in place prior to Omicron.

	• All specialties are focussed on activity planning to meet the activity targets outlined in the '2022/23 priorities and operational planning guidance'. • The roll out of schemes identified as improving emergency standards are regularly monitored to ensure improvements are measurable and can be evidenced with supporting data. • 52 week waits: The Committee noted that some specialties remain challenged although improvements are being seen within ENT and Trauma and Orthopaedics as a result of patients transferred under the West Kent Shared Patient Tracking List (PTL) arrangement. • 104 week waits: The Committee received re-assurance that the Trust is on track to eliminate the longest waiting patients (except when it is the patient's choice) by July 2022. • The Committee received re-assurance that the 7 Day pilot over three weekends provided insight over the use of our bed base over the weekend.
Month 10 Savings and Efficiency Update	• The Trust is required to report efficiencies of approximately £10m for H2 2021/22. • The Committee noted that savings achieved in January 2022 were £1.5m, below the plan of £2.1m. • The month 10 shortfall relates to timings of efficiencies yet to be identified. • The Committee received re-assurance that schemes are being worked to cover the unidentified efficiencies in the last two months of the year. • The Committee noted that a pipeline of ideas is being developed as the basis for delivery of the 2022/23 efficiency programme.

Business Cases	• The Committee **approved** the following Business cases and were assured they had been through the appropriate approval process:
	  • Dermatology relocation to Estuary House and Service Expansion – revenue funded solution.
	  • Mechanical Thrombectomy: The Committee approved the Business case in principle subject to funding and agreed that once funding is in place, to be brought back to the Committee for formal approval prior to ratification by Board.
	  • Patient Voice and Involvement Business case: The Committee approved funding for Year 1 of the Business case and agreed to review the position in nine months.
	
	• The Committee **did not approve** the following business cases:
	  • Development of Medical Physics: The Committee requested for a review of the Care Group's existing budget to determine if it could fund the Business case and come back to the Committee in April.
	  • Perioperative Care of Older people Undergoing Surgery (POPS) at Kent and Canterbury Site: The Committee requested for benefits realisation to be quantified and clarity on transfer funding and agreed for a Chairs action to be taken outside the meeting.
	
	• The Committee noted the update on the Investment in Recruitment Team Function Business case update and agreed to review progress in two months.

Service Line Reporting (SLR)/	• The Committee received assurance that the Q3 SLR position is fully reconciled to the reported Income & Expenditure (I&E) position and

Management Update	includes additional funding to cover the increased costs of responding to the pandemic. • The Committee noted significant local changes to operational and clinical practices as a result of the Covid-19 pandemic. • The Committee noted that this is not a situation exclusive to EKHUFT and has been acknowledged by NHSE/I and HFMA.
Contract Negotiations Update	• The Committee received an update on the contract negotiations which are being progressed with Commissioners for 2022/23 following two years of NHS contracting suspension. • The Trust is working to develop a new aligned incentive arrangement with Kent & Medway Clinical Commissioning Group which will reduce collective risk regarding our agreed activity baseline; Commissioning for Quality and Innovation (CQUIN) delivery and potential financial penalties associated with any failure to deliver the quality Key Performance Indicators (KPIs). • Contract negotiation meetings have commenced and progress is being made towards delivering the signed contract by the deadline of 31 March 2022.
Post Project Evaluation of Business Cases	• The Committee agreed a new process for post project evaluation of all business cases that have been approved by the Committee and Board to be provided to the Committee for assurance, on a quarterly basis to ensure the projects are delivered in line with expectations.
National CQUIN Programme 2022/23	• Following the suspension of the CQUIN Programme during 2019 – 2021 due to the pandemic, NHSE have set out guidance for the 2022/23 CQUIN Programme which will be for the duration of one year. • For 2022/23 the financial value of the National CQUIN is 1.25% of the fixed element of the acute contract value, equating to £8.5m. with each indicator worth 0.25%, equating to £1.7m. • The Trust assessed each CQUIN Indicator against the criteria of relevance to EKHUFT's True Norths and local Quality Strategy, scope for improvement, and financial cost against potential benefit to the patient and agreed 5 indicators. • The Committee recommended that briefings on CQUINs should be provided to the Board and Council of Governors.
Other items of business	• Strategic Investment Group (SIG) Chair's report and minutes (For information). • Financial Improvement Oversight Group (FIOG) Chair's report and minutes (For information). • Committee Work Plan 2022 (For information).
Referrals to other Board Committees	• The following referrals were made to the People & Culture Committee at this meeting: • IPR - The Committee agreed a referral of the Harm measure and the Accommodation strategy (Trust Priority Improvement Project) to the People and Culture Committee.
Referrals from other Board Committees	• There were no referrals from other Board Committees at this meeting.
Items to come back to the Committee outside its routine business cycle:	
• Operational Planning update 2022/23: The Committee agreed an Extraordinary meeting to approve the final draft plan. • Perioperative Care of Older people Undergoing Surgery (POPS) at Kent and Canterbury Site: The Committee requested for benefits realisation to be quantified and clarity on transfer funding and agreed for a Chair's action to be taken outside the meeting cycle.	

Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
The Committee referred the following items to the BoD for approval: • IPR: The Committee recommended a workshop on the new Statistical Process Control (SPC) charts will be beneficial to the Board (item for Board Development Programme 2022/23). • The Committee recommended that the Board undertakes a strategic review of the Group structure during 2022/23. • The Committee recommended that briefings on CQUINs should be provided to the Board and Council of Governors (item for Board Development Programme 2022/23). The Committee referred the following items to the BoD for information: • Appendix 1: RTT performance report • Operational Planning Update 2022/23: The Committee recommended that the update is presented to the Closed Board on 10 March 2022 as a stand-alone report.	Approval For information	10 March 2022

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**DISCHARGE PROCESS AND CRITERIA TO RESIDE**				
MEETING DATE:	**10 MARCH 2022**				
BOARD SPONSOR:	**CHIEF OPERATING OFFICER**				
PAPER AUTHOR:	**DEPUTY CHIEF OPERATING OFFICER**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion
Purpose of the Report:	To provide clarification on the discharge pathways and key issues for patients who require supported discharge from Hospital to home or a community setting.				
Summary of Key Issues:	Patients leaving hospital have experienced delay in accessing the onward care they need. This paper details the issues that influence a patient's discharge that relate to the process in the Hospital, and those that reflect the challenge in accessing capacity outside of a hospital setting. Capacity is particularly challenged for patients requiring domiciliary care in their own home and for those patients requiring longer-term residential care.				
Key Recommendation(s):	The Board is asked to discuss and **NOTE** the report.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	Our people	Our future	**Our sustainability**	Our quality and safety	
Link to the Board Assurance Framework (BAF):	Our Patients Our Quality and Safety				
Link to the Corporate Risk Register (CRR):	CRR: 78 CRR: 71, 77, 110 and 36				
Resource:	N				
Legal and regulatory:	N				
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	None				

East Kent Hospitals University NHS Foundation Trust

DISCHARGE PROCESS AND CRITERIA TO RESIDE

1. Purpose of the report

1.1 This report will confirm the current process for assessing a patient's discharge needs in order to ensure that a patient can be discharged home safely or to be discharged to a Community Hospital for ongoing rehabilitation; or to be discharged to a residential or nursing home for longer term care.

1.2 This report will also explain the national discharge guidance which is called 'Criteria to Reside' and the 'Discharge to Assess' model, which has been adopted by our Local Health Economy (LHE).

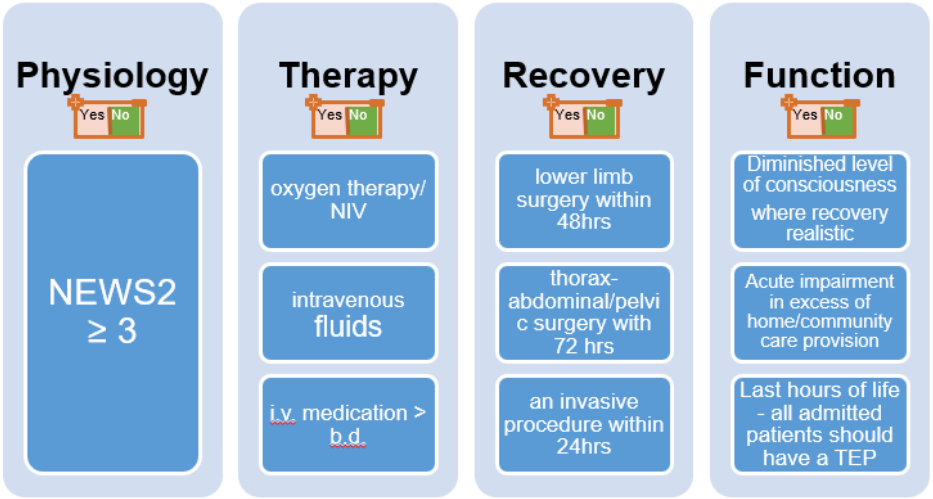
2. Background

2.1 Across EKHUFT and neighbouring Trusts there is a variation between the number of patients that are fit and well enough to be discharged from our care, and the number of patients the Trust is actively able to discharge.

2.2 To enable the discharge of our patients, two key assessments are made as part of our on-going clinical reviews:

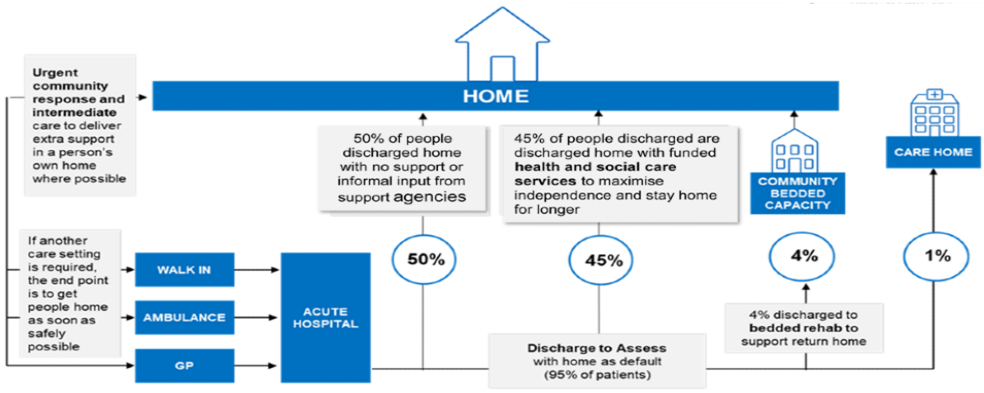
Does the patient present symptoms and have treatment needs that require them to be in an acute hospital? Do they meet the 'Criteria to Reside'.
If they are eligible to be discharged from our care, what are the on-going care needs of the patient? Which type of pathway of the 'Discharge to Assess' model will they follow.

The table below outlines the basis of the Criteria to Reside assessment:



2.3 Subsequent to the 'Criteria to Reside' assessment and determination, clinical teams will assess the on-going care needs of each individual patient. The outcome of this review informs the type of exiting pathway the patient will follow.

2.4 The 'Discharge to Assess' model, outlined below, provides the hospital with a proportional estimate of the expected number of patients to follow each type of discharge pathway and the associated degree of on-going care required.



On the basis that a proportion of our patients require onward care the Government provides a national discharge fund to support these patients outside of the care of acute trusts

2.5 Health and social care systems are expected to use the Government's national discharge fund to support the best outcomes for people leaving hospital and further reduce the length of stay of acute admissions. This fund is designed to support a higher proportion of people being discharged on the same day it is determined they no longer meet the 'Criteria to Reside'.

2.6 LHE systems must ensure they provide adequate health and care discharge services, to improve people's outcomes as well as timely discharge from hospital. It is also recognised that the LHE needs to support elective recovery plans and use available resources to fund discharge schemes.

3. Hospital Process

3.1 Central to the delivery of effective discharge and timely discharge planning is professional and clinical leadership together with good communication. Daily morning board rounds to review every person and make decisions, informed by the criteria to reside, are the foundation for avoiding delays and improving outcomes for individuals.

3.2 Transfer from the ward to a dedicated discharge area should happen promptly; for simple discharges for patients requiring no structured support this should be within one hour of that decision being made and on the same day for people with more complex discharge needs. Patients may be discharged directly from the ward or for those waiting for family/friends to collect them or for planned transport transfer will be arranged to the Discharge Lounge.

3.3 The Discharge Lounges at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) are currently undergoing refurbishment to enable them to accommodate patients in a bedded bay comfortably, ensuring privacy and dignity. Each Hospital aims to have 'golden' patients who will be discharged the following morning and are suitable to go to the Discharge Lounge before 10am. These are usually

patients who are being discharged with planned support, such as a care package or transferring to a residential or nursing home.

3.4 Staffed by a registered nurse, health care assistant and with access to portering and pharmacy, the Lounges are able to collect patients from wards and give medications. The Patient Transport Service (PTS) are co-located in the Lounges which is beneficial for timely allocation of patient transport and effective communication. In order to enhance the use of the Discharge Lounges and make them a welcoming area for patients to wait in, staff have implemented schemes such as 'breakfast clubs', access to televisions and power points to use electrical devices, furnished with comfortable chairs and reading material.

3.5 The need for a timely discharge, however, should not result in discharges that are unsafe, such as happening overnight, or lead to people not being fully informed as to the next stages of their care.

3.6 Emergency Care Improvement Support Team (ECIST) are supporting the Trust in training nine 'clinical champions' who will be coached in the 'Modern Ward Round' methodology and will be supported to cascade the coaching down through all wards in the Trust. The training will begin in early March with a launch of the programme and there will be three 'champions' in each Hospital. The team will consist of a consultant, senior nurse and pharmacist.

3.7 Modern Board Rounds will support the We Care drivers of the Care Groups, which are focussed on early discharge and reducing length of stay. There is also a Trust Priority Improvement Project (TPIP) which is focussed on safe and effective discharge process, including pharmacy and documentation. In the longer term the Trust have a strategic initiative working with our system partners concentrating on 'sustained access'.

3.8 The We Care 'True North' under 'Our Future – Criteria to Reside' has a Trust and also the LHE element. Internally, if all clinicians embraced Criteria to Reside on the board rounds and discharged Pathway 0 patients within the suggested timeframes there would be a positive impact on the Breakthrough Objective of Aggregated Time in Emergency Department (ED) by increasing discharges before 12 noon and enabling early patient flow.

3.9 From the LHE system perspective, there remains an issue of insufficient external capacity to meet the local populations needs, both within the Trust and also the community setting. Patients are being transferred into community hospital bed or residential home beds due to a lack of domiciliary care packages. Although this is a national issue, it will not be resolved locally until appropriate pathway capacity is commissioned.

Discharge to Assess Model – Overview of pathways

4. Pathway 0 – Simple discharge home.

4.1 Likely to be 50% of all discharges.

4.2 No new or additional support is required to get the person home or such support constitutes only informal input from support agencies or a continuation of an existing health or social care package that remained active whilst the person was in hospital.

5. Pathway 1 – complex discharge

5.1 Likely to be minimum of 45% of people discharged: able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home.

5.2 Every effort should be made to follow Home First principles, allowing people to recover, rehabilitate or die in their own home.

5.3 Kent Community Health NHS Foundation Trust facilitate Pathway 1 across East Kent and utilise the Rapid Response service. Rapid Response teams support patients in their own home following hospital discharge and are able to provide short-term rehabilitation and enablement at home, including equipment and adaptations at home.

5.4 Following support from Rapid Response, patients can further access support via Kent Enablement at Home (Kent County Council (KCC) service) if they require a further period of enablement and following this Social Services will complete an assessment of the patients care and support needs to determine if a long-term care package is required or alternative care provision.

6. Pathway 2 – complex discharge

6.1 Likely to be maximum of 4% of people discharged: recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, ideally before returning home.

6.2 Patients are transferred from the acute into Community Hospital beds with many locally located across the East Kent coastline. Community Hospitals that are utilised by East Kent Hospitals are as follows:

- Faversham Cottage Hospital
- Queen Victoria Memorial Hospital in Folkestone
- Victoria Hospital in Deal
- Whitstable and Tankerton Hospital
- Westview Hospital in Tenterden, Ashford

6.3 Pro-active Assessment Units (PAU) are also utilised to support with rehabilitation, recovery and further assessment of needs. The local PAU is Hawkinge House, which also has designated beds, which are beds that have been identified as suitable for covid positive patients.

6.4 Community Beds are supported by matrons, registered nurses, rehabilitation assistants, health care assistants, physiotherapists, occupational therapists, Social Service case managers, pharmacists, visiting medical officers and medical consultants.

7. Pathway 3 – complex discharge

7.1 For people who require bed-based 24-hour care: includes people discharged to a care home for the first time (likely to be a maximum of 1% of people discharged) plus existing care home residents returning to their care setting (for national data monitoring purposes, returning care home residents will count towards the 50% figure for Pathway 0).

7.2 Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.

7.3 Recently more patients are being assessed as requiring Pathway 3, in the last week on February the number had reached 50. There is concern across the LHE that this number is increasing rapidly and also because East Kent has a very high number of funded beds and patients being assessed as requiring Pathway 3. Best practice is that we should be aiming to enable patients to return to their own home with Pathway 1/domiciliary support.

7.4 There is a shared view in the LHE that patients have become more frail post covid and are therefore presenting in a more acute condition. An audit of 32 referrals is being completed to also test this assumption and also whether there is a pattern of 'known' patients to the social care system, who have been struggling in the community with some form of domiciliary care, which has now failed as the persons health has deteriorated or social needs have increased.

Partnership in complex care

8. NHS Continuing Healthcare (CHC)

8.1 Only a small number of individuals on the discharge to assess pathways will have needs that require assessment for NHS continuing healthcare. NHS CHC assessments should be undertaken when an individual's longer-term needs are clearer, following a period of recovery. In such circumstances where an extended period of recovery is required, this will need to be funded through local health arrangements.

8.2 NHS CHC teams must work closely with community health and social care staff in supporting people on discharge pathways 1, 2 and 3, to ensure appropriate discussions and planning concerning a person's long-term care options happen at the appropriate time on the discharge pathway.

9. NHS Continuing Care - Fast Track

9.1 It is used for patients who have urgent health needs and/or nursing needs and are rapidly deteriorating and/or in a terminal phase of life. It is also used if a patient's health is likely to deteriorate rapidly.

9.2 Fast Track allows a quick decision to be made about Continuing Healthcare funding – bypassing the lengthier formal assessment process. It facilitates appropriate end of life support to be put in place quickly by the NHS, free of

charge and it means patients are able to have care provided in their preferred location, including at home.

9.3 Essentially, Fast Track allows for a decision to be made quickly for patients who have a 'primary health need', they have a rapidly deteriorating condition or are in the terminal phase of life.

10. Homeless Patients

10.1 All people who are homeless or at risk of homelessness should be determined on admission to hospital. During the hospital stay the person should be referred by acute hospital staff to the local authority homelessness or housing options teams, under the requirements of the Homelessness Reduction Act (2017). Care Navigators work within the Rapid Transfer Service to arrange and support accommodation for homeless patients on discharge. This group of patients can often become delayed in hospital, particularly if they have disparate lives and/ or mental health issues which make them difficult to place.

11. Voluntary Sector

11.1 **Care Navigators** are embedded within the Rapid Transfer Service across the Trust. The service offers bespoke advice and assistance to find the best way to manage patients' problems and needs after discharge from hospital, from falls prevention to finding long-term care packages, looking at housing options to signposting for benefits advice. Other services include; befriending, benefit advice, day services and meals on wheels provisions.

11.2 The service aims to increase independence to enable you patients to stay in their own home and avoid unnecessary hospital admissions through the selection of appropriate pathways.

12. Red Cross

12.1 EKHUFT works closely with Red Cross support across the organisation and is able to collect patients and provide a service to ensure they have everything they require for the first 24 to 72 hours back at home. On the day the patient is discharged, Red Cross is able to help them pack up their belongings, prescriptions, mobility aids and will support with transporting patients home.

12.2 Red Cross is able provide practical and emotional support, whether that's stocking the fridge, checking for trip hazards, feeding the cat or a just cup of tea and may provide up to 12 weeks of support to help patients recover as quickly as possible.

13. South East (SE) Region actions taken over Winter 2021/22

13.1 NHS England/NHS Improvement (NHSE/I) set a trajectory in December 2021 to reduce the number of patients who no longer met the Criteria to Reside and not discharged by 30%. Progress against this trajectory is monitored by the SE Region with a discharge update published monthly and discussed at the Kent and Medway Chief Operating Officers meeting which is chaired by Kent & Medway Integrated Care System (K&M ICS).

13.2 The baseline for our Trust was 153 patients who were in hospital and no longer met the Criteria to Reside. To achieve the 30%, or a stretch 50% target, the number of patients who no longer met the criteria to reside would be 107 and 77 respectively. As a LHE we have not achieved these targets. All regions have shown a rising trend in the number of patients being discharged daily and this number reflects both simple and complex discharges. However, the number and complexity of patients requiring complex discharge (PW1,2 or 3) has increased.

13.3 160 additional beds have been commissioned during this winter; these beds have been essential to maintain flow across the LHE due to insufficient domiciliary / care package capacity. The Clinical Commissioning Group (CCG) have tried via KCC to commission additional domiciliary care without success. It is acknowledged by the LHE that it is important to withdraw from these additional beds as quickly as possible as they are not a cost-effective resource and more importantly, in many cases, they are not the ideal discharge destination for those patients who could have been discharged home with a care package.

13.3 In order to support improving discharge and also to challenge all partners discharge plans, MADE (Multi Agency Discharge Events) have been held prior to Christmas with the aim of achieving the 30% and also in January. These events are complimented by weekly Long Length of Stay (LLOS) review meetings. The LLOS meetings are chaired by a senior clinician and include a review of all patients with a LOS over 7 days in order to confirm and challenge the discharge plans. ECIST have joined these meetings during February and noted the team engagement and recommended that the actions agreed each week are followed up to assess whether patients' pathways are being effectively progressed to reduce LOS.

14. Conclusion

14.1 The Trust is focused on maximising the discharges of patients on a simple pathway with no or very limited on-going care needs and reducing the delays for patients with more complex needs.

14.2 To do this we need to continue to work actively with the LHE and providers within to support a reduction in those patients for whom the acute phase of care has been completed. Areas of work in the next month include improving communication and the quality of written referrals to local providers.

14.3 It is important to listen to our patients, understand their wishes and include them in any decisions made about them, with them. We are also evaluating recent changes in communication with our patients with discharge information to help inform patients, their carers and relatives on how the process works and how it can support them.

14.4 For the health and care system the mapping of capacity in the community to support patients with care at home, rehabilitation and on-going support in managing chronic or long-term health needs constant vigilance and proactive management. The on-going challenge of patients with care needs and covid requires stronger engagement and education on rapidly evolving infection prevention guidance in designated beds.

14.5 Ultimately, the ability of the health and care system to support patients who are leaving the hospital environment is compromised by the lack of capacity and resources to meet the needs of patients who need on-going care in their own home or who need access to longer term residential care. The impact of these system delays results in extended length of stay in an acute hospital bed or in a community hospital assessment bed which reduces the available acute health beds for emergency admission.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**WAITING LIST OVERVIEW IN CONSIDERATION OF NHS ENGLAND/NHS IMPROVEMENT (NHSE/I) 2022/23 OPERATIONAL AND PLANNING GUIDANCE**				
MEETING DATE:	**10 MARCH 2022**				
BOARD SPONSOR:	**CHIEF OPERATING OFFICER**				
PAPER AUTHOR:	**DEPUTY CHIEF OPERATING OFFICER – ELECTIVE CARE**				
APPENDICES:	**APPENDIX 1: REFERRAL TO TREATMENT (RTT) JANUARY 2022 DATA** **APPENDIX 2: 20211223-B1160-2022-23-PRIORITIES-AND-OPERATIONAL-PLANNING-GUIDANCE-V3.2 (AVAILABLE IN READING ROOM)**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion
Purpose of the Report:	To provide the Board with a summary of the updated operational planning guidance provided by NHSE/I (Appendix 2). Guidance for 2022/23 was originally issued on 24 December 2021 with subsequent updates on 10 January and 24 February 2022. The updates to the guidance came in response to the recognised impact of this winter's Omicron wave and the resultant further increase to patient waiting times across the UK. This report, and supporting appendices, provides a brief overview of: • The changes in guidance, what this means for EKHUFT and the strategies in place to reduce the Trust's waiting list backlog; • Referral to Treatment (RTT) pathways; • and the ongoing monitoring of the Trust's management and delivery of RTT against the operational targets.				
Summary of Key Issues:	RTT waiting times for the last two years have been significantly impacted by the three waves of Covid 19 and the cessation and interruption of routine elective activity. NHSE/I published the 2022/23 priorities and operational guidance sets out the key priorities for restoring services and reducing the waiting list backlog prevalent across the UK. A detailed RTT paper (Appendix 1) outlining current delivery and EKHUFT's strategy for managing our waiting lists, and associated backlog, is produced on a monthly basis and reviewed by the Finance and Performance Committee and discussed at the Quality and Safety Committee forums. The elective backlog for EKHUFT is significant which is reflective of the size of the population the Trust serves and treats. EKHUFT continues to make good progress in maintaining our current wait list and make in-roads to clear the backlog. This has been achieved in spite of site and				

	staffing pressures caused by the three significant waves of Covid and the on-going restrictions to prevent infection.				
Key Recommendation(s):	The Board is asked to discuss and **NOTE** the report.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	Our people	Our future	**Our sustainability**	Our quality and safety	
Link to the Board Assurance Framework (BAF):	**STRATEGIC GOAL: 2) Our Patients:** **Objective:** Improve **Patient Experience** deliver excellent clinical outcomes. **Principal Risk:** Failure to deliver the operational constitutional standards due to the national directive to stop all planned care following the Covid-19 Pandemic **CRR 78**				
Link to the Corporate Risk Register (CRR):	**CRR 68:** Risk to the delivery of the operational constitutional standards and undertakings for planned care. **CRR 84:** Deteriorating Patient.				
Resource:	N				
Legal and regulatory:	N				
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	Finance and Performance Committee Quality and Safety Committee				

WAITING LIST OVERVIEW IN CONSIDERATION OF NHSE/I 22/23 OPERATIONAL AND PLANNING GUIDANCE

Background

A patient may be on a waiting list for a variety of reasons: waiting for an outpatient appointment, a diagnostic for an operation or a patient who is required to be seen on a regular basis. Waiting lists are classed as follows:

- Referral to Treatment (RTT) waiting list – patients referred to a consultant led service (non-emergency) with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner. An RTT pathway is the length of time that a patient waits from referral to the start of treatment, or if the patients has not yet started treatment, the length of time that a patient has waited so far.
- Non RTT waiting lists - these are specialties which are not included in RTT reporting such as physiotherapy, fracture clinic appointments, non-consultant led activity.
- Follow up waiting lists – patients who have been treated but require follow up by the specialty team
- Planned patients – patients who must be treated or seen at a particular time and this date is recorded within the patient administration system (PAS)

Only Referral to Treatment (RTT) patients/ pathways have to be reported nationally and have a constitutional standard associated with the waiting time. The RTT standard is 92% of patients who have not started treatment should be waiting no more than 18 weeks. It is expected that no patients should wait over 52 weeks. To put this into context, pre-covid, in January 2020 EKHUFT had an RTT standard rating of 81.2% with a wait list size of 46,211. As of January 2022, this figure 59.6% with a waiting list size of 64,291.

Across all patient list classifications, patients should be booked in clinical priority treating the most urgent patients first; then in chronological order, prioritising the longest waiting patient first.

NHSE/I Priorities and Operational Guidance

RTT waiting times for the last two years have been significantly impacted by Covid – 19 and the cessation of routine elective activity. NHSE/I published the 2022/23 priorities and operational guidance on the 24 December which set out the key priorities for restoring services. This included an ambitious recovery plan that aims to continue to treat urgent and cancer patients but also focus on treating long waiting patients. The plan set out includes:

- In 2022/23 to deliver 10% more elective activity than before the pandemic and reduce long waits. The 10% comparison is made against activity levels in 2019/20.
- To deliver around 30% more elective activity across the system by 2024/25 than before the pandemic (measured against activity levels in 2019/20), after accounting for the impact of an improved care offer through system transformation, and specialist advice, including advice and guidance.
- Accelerate the progress already made towards a more personalised approach to follow-up care in hospitals or clinics, reducing outpatient follow-ups by a minimum of 25% by March 2023, against 2019/20 activity levels.

The 2022/23 priorities and operational planning guidance was amended and updated on the 22 February 2022 to provide key dates for the management of waiting patients.

The key changes are detailed in the table below:

Target / Standard	NHSE/I Guidance published 24 December 2021	NHSE/I Guidance published 22 February 2022	EKHUFT January 2022
Patients waiting 104 weeks	Eliminate waits of over 104 weeks as a priority and maintain this position through 2022/23 (except where patients choose to wait longer) by end of March 2022	Eliminate waits of over 104 weeks as a priority by **July 2022** and maintain this position through 2022/23 (except where patients choose to wait longer)	97 - January 2022 There is high confidence in the treatment plans for each individual patient to ensure there are 0 patients waiting 104 weeks by June 2022. *(Pre-Covid Jan 2020: 0)*
Patients waiting 78 weeks	Reduce waits of over 78 weeks and conduct three-monthly reviews for this cohort of patients, extending the three-monthly reviews to patients waiting over 52 weeks from 1 July 2022	Eliminate waits of over 78 weeks by **April 2023,** except where patients choose to wait longer or in specific specialties, and conduct three-monthly reviews for this cohort of patients, extending the three-monthly reviews to patients waiting over 52 weeks from 1 July 2022	811 - January 2022 *(Pre-Covid Jan 2020: 0)*
Patients waiting over 65 weeks	Not referenced	Eliminate waits of over 65 weeks by March 2024, except where patients choose to wait longer or in specific specialties, and conduct three-monthly reviews for this cohort of patients, extending the three-monthly reviews to patients waiting over 52 weeks from 1 July 2022 (Ref. "Delivery plan for tackling the COVID-19 backlog of elective care")	2,204 - January 2022 *(Pre-Covid Jan 2020: 0)*
Patients waiting over 52 weeks	Develop plans that support an overall reduction in 52-week waits where possible	Develop plans that support an overall reduction in 52-week waits where possible, in line with ambition to eliminate them by **March 2025,** except where patients choose to wait longer or in specific specialties	4,327 - January 2022 *(Pre-Covid Jan 2020: 4)*
Patients waiting for a diagnostic		By **March 2025 95%** of patients receive their diagnostic within 6 weeks.	62.3% - January 2022 *(Pre-Covid Jan 2020: 99.7%)*

EKHUFT Plans and Response

The Trust is focussed on reducing long waits for patients and include a number of actions based on management of waiting lists, use of other providers to treat patients and increase internal elective activity. This activity is detailed in Appendix 1.

Management of waiting lists to reduce waiting times

- Weekly meetings continue to provide oversight and management of our patients waiting over 104 weeks. Treatment plans are in place for each of the individual patients and an agreed trajectory is in place to eliminate by end of June 2022.
- Weekly meetings will continue as we manage patients waiting over 78 weeks, then 65 and 52 weeks. The same principles will be used to ensure that each patient is discussed and a plan agreed.
- Allocation to theatres will continue to be provided to the specialties who have require capacity for cancer and urgent patients, followed by those specialties with the longest waiting patients.
- Clinical and administrative validation will continue to review patients who are fit and able remain on the waiting list and, where required, re-prioritised.

Activity planning 2022/23

Each year the Trust is asked to submit expected activity for each specialty to NHSE/I. This process has been underway over the course of the last month with the Trust's 1st submission going to the Integrated Care System (ICS) for review on Tuesday 1 March.

Each specialty outlines their current capacity, their assumed activity and how they intend to address any gaps to meet the increased activity targets outlined in the planning guidance of:

- Increase in new appointments across the system to 110% against 2019/20 activity, with a minimum target of 104% at Trust level.
- Reduction in follow-up appointment targets of 25% against 2019/20 activity.
- Increase in elective activity across the system to 110% against 2019/20 activity, with a minimum target of 104% at Trust level.
- Increase diagnostic activity to a minimum of 120% against 2019/20 activity.
- Increase in the use of Patient Initiated Follow-Up (PIFU) pathways.
- Delivery of 16 advice and guidance requests per 100 outpatient first attendances.

Additional capacity

- EKHUFT will continue to work with the East Kent Independent sector to support with additional activity. Current contracts are in place until April 2022 and discussions are on-going to secure activity throughout 2022/23.
- Contract negotiations are in progress with West Kent Independent Sector providers, as part of the Shared Patient Tracking List (PTL) initiatives.
- Current contracts with East Kent Community providers continue for the next three years to support with additional activity.
- Bid supported for additional theatres at Canterbury submitted to the ICS in February 2022.

The activity supported by external capacity is detailed in the monthly RTT paper and, where relevant factored in to EKHUFT's activity planning for 22/23.

In summary, the revised priorities and operational planning guidance has outlined the national expectation for trusts to reduce elective waiting times with clear time frames, recognising that some patients may choose to wait longer. As a system we need to address health inequalities. As a Trust our focus is to ensure we meet the targets outlined by NHSE/I whilst continuing to ensure we treat our priority patients. And for the Trust to conduct regular clinical reviews of our long waiting patients to ensure their prioritisation remains correct and to monitor our patient's wellbeing whilst they await their treatment.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Elective Care and Referral to Treatment (RTT) February Update (January 2022 Performance)

Introduction

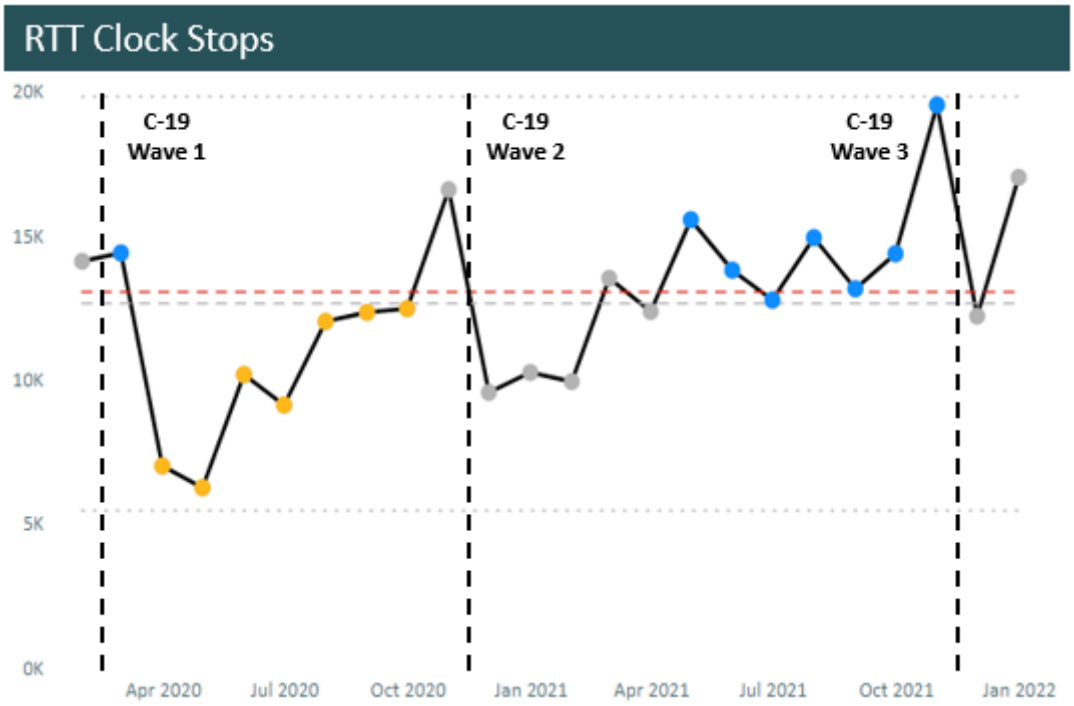
This paper is intended to provide a supporting narrative to the Committee in relation to Elective Care and Referral to Treatment (RTT) and will highlight the expected Trust activity alongside some of the key internal risks and mitigations related to the RTT constitutional standard.

Elective Care - 2021/22 Priorities and Operational Planning Guidance – Update

The Elective Recovery Fund (ERF) for H2 is based upon specialty weighted completed RTT pathways and is therefore a slightly different calculation in comparison to H1 (in H1 ERF was based on activity across all PODS rather than stop clocks in H2). With the inclusion of insourcing and independent sector schemes and increased throughput of the Elective Orthopaedic Centre, EKHUFT was projecting achievement of the 89% threshold which should assist the Kent & Medway Integrated Care System (K&M ICS) and EKHUFT in accessing ERF.

For January 2022 EKHUFT achieved 16,955 clock stops in month, an improvement of 4795 compared to December. The impact of the Shared Patient Tracking List (PTL) in January has contributed to this improvement in month (RTT clocks have been transferred from EKHUFT to the alternate West Kent Providers).

Clock stops by month



H2 Activity against Plan

Performance to date in H2 against each point of delivery can be seen below:

Point of Delivery		Oct-21	Nov-21	Dec-21	Jan-22
Consultant-led first outpatient attendances (Spec acute)	Plan	18,932	21,532	19,817	18,916
	Actual	18,397	20,753	17,553	17,860
Consultant-led follow-up outpatient attendances (Spec acute)	Plan	38,398	39,225	38,217	36,861
	Actual	39,192	43,003	36,643	37,494
Daycase Electives	Plan	4,901	5,219	5,093	5,107
	Actual	5,068	5,281	4,481	4,537
Ordinary Electives	Plan	970	1,038	904	910
	Actual	889	902	794	634
Magnetic Resonance Imaging (MRI)	Plan	4,658	4,884	4,674	4,446
	Actual	5,025	4,851	4,650	5,082
Computed Tomography (CT)	Plan	7,831	8,305	8,026	7,615
	Actual	7,414	7,589	7,102	7,301
Non-Obstetric Ultrasound	Plan	4,054	4,247	4,054	3,861
	Actual	3,993	3,799	3,205	3,391
Colonoscopy	Plan	533	558	584	580
	Actual	590	624	426	525
Flexi Signmoidoscopy	Plan	177	224	185	184
	Actual	196	213	152	186
Gastroscopy	Plan	587	591	617	613
	Actual	615	530	466	551

Elective Care – 2022/23 Priorities and Operational Planning Guidance – Update

The 2022/23 priorities and operational planning guidance was updated on the 14 January 2022. There has been no change to the elective care guidance, which remain the following:

- In 2022/23 systems to deliver over 10% more elective activity than before the pandemic and reduce long waits.
- Deliver circa 30% more elective activity by 2024/25 than before the pandemic.
- Eliminate waits over 104 weeks as a priority and maintain this position throughout 2022/23 (unless patients choose to wait longer).
- Reduce waits of over 78 weeks and conduct three-monthly reviews for this cohort of patients, extending the three-monthly reviews to patients waiting over 52 weeks from 1 July 2022.
- Develop plans that support an overall reduction in 52 week waits where possible.
- Reduce outpatient follow ups by a minimum of 25% against 2019/20 activity levels by March 2023.
- Expand the uptake of Patient Initiated Follow Ups (PIFU) to all major specialties, moving 5% of outpatient attendances to PIFU pathways by March 2023.
- Return the number of people waiting for longer than 62 days to the level in February 2020.
- Increase diagnostic capacity to a minimum of 120% of pre-pandemic levels across 2022/23.

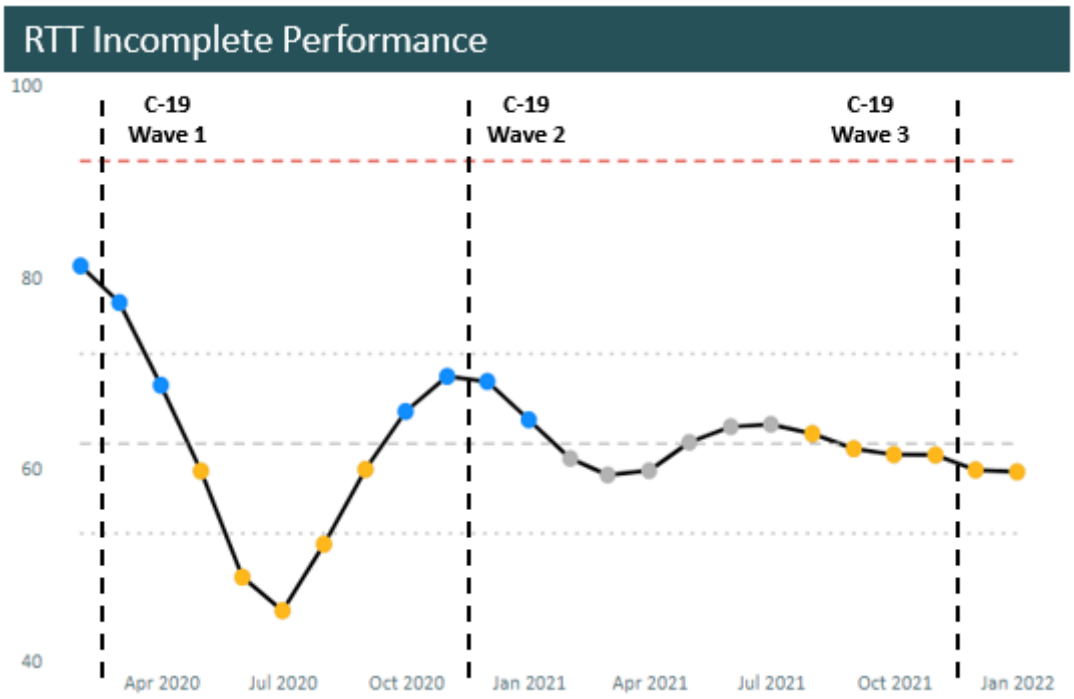
We still await further details regarding the allocation of the funding stream (£2.3 billion) to support our elective recovery in 2022/23.

Referral to Treatment (RTT)

The standard is 92% of patients who have not yet started treatment should be waiting no more than 18-weeks.

In March 2021, the 2021/22 Priorities and Operational Planning Guidance was published and East Kent Hospitals University Foundation NHS Trust (EKHUFT), like all other Trusts, submitted an elective recovery plan that would focus on treating clinically prioritised patients and long-waiters.

The reported RTT performance for January 2022 at EKHUFT was 59.6**%** with a waiting list size of 64,291. The graph below details performance and waiting list size.



The ‘backlog’ (patients waiting longer than 18 weeks), are those patients waiting for:

- A new appointment
- A follow up appointment
- Diagnostics
- Treatment

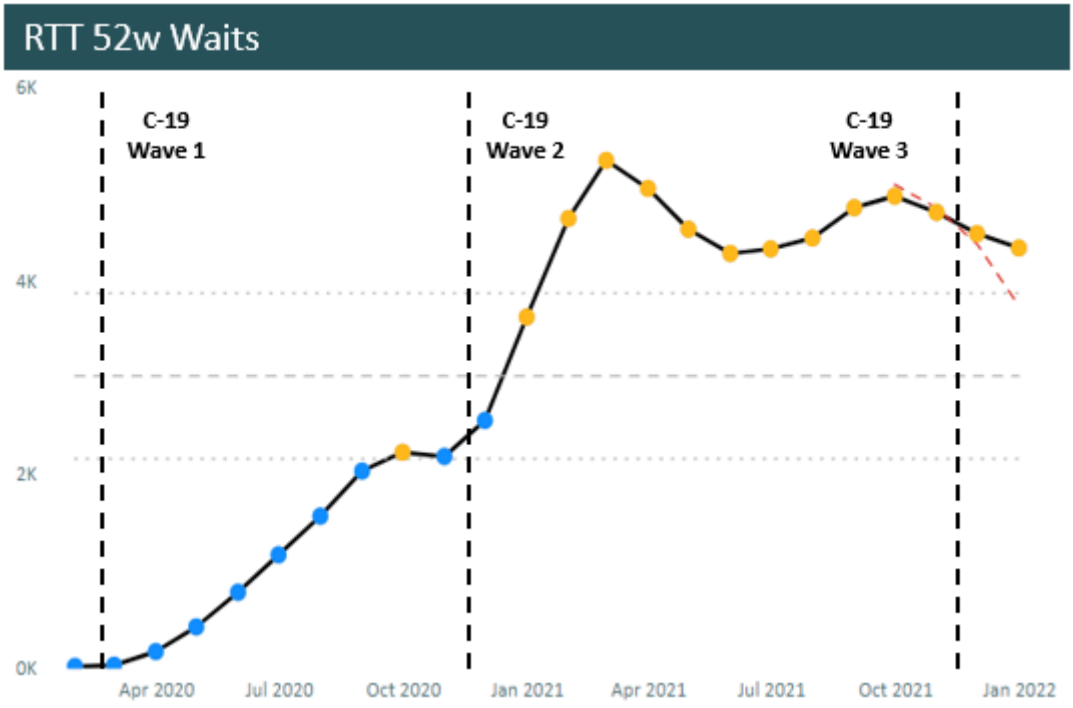
The table below details the volumes of patients within our backlog:

Specialty	No. Patients Waiting 18w+ Jan '22	Variance to Prev Month
100 - General Surgery	4,908	152
101 - Urology	1,496	-3
110 - Trauma & Orthopaedics	4,708	-113
120 - Ear, Nose & Throat	3,993	21
130 - Ophthalmology	1,547	29
140 - Oral Surgery	1,080	102
170 - Cardiothoracic	0	0
300 - General Medicine	6	1
301 - Gastroenterology	1,685	51
320 - Cardiology	450	27
330 - Dermatology	1,281	7
340 - Respiratory Medicine	510	13
400 - Neurology	525	-4
410 - Rheumatology	164	-1
430 - HCOOP	166	14
502 - Gynaecology	2,157	185
X01 - Other Specs	0	-3
X02 Other - Medical Services	203	30
X02 Other – Medical Services		0
X04 Other - Paediatric Services	82	8
X05 Other – Surgical Services	1,008	-24
X06 Other – Other Services	10	2
Trust Total	**25,979**	**494**

Patients waiting over 52 weeks

The number of patients reported waiting over 52 weeks in January 2022 was 4327. Trauma and Orthopaedics, General Surgery, ENT and Gynaecology remain our challenged specialties, although we have seen improvements within ENT and Trauma and Orthopaedics as a result of the patients transferred to the West Kent Independent Sector sites under the West Kent Shared PTL arrangement.

The graph below shows the growth in the number of 52-week breaches by month from January 2020.



Each specialty continues to work on plans to reduce the number of patients waiting over 52 weeks including validation and working with alternative providers.

The number of patients waiting over 52 weeks reported in January is shown below by specialty.

Specialty	No. Patients Waiting 52w Jan '22	Variance to Prev Month
100 - General Surgery	1,232	1
101 - Urology	276	-38
110 - Trauma & Orthopaedics	1,317	-23
120 - Ear, Nose & Throat	821	-77
130 - Ophthalmology	110	-23
140 - Oral Surgery	29	1
170 - Cardiothoracic	0	0
300 - General Medicine	0	0
301 - Gastroenterology	20	-7
320 - Cardiology	3	3
330 - Dermatology	11	-8
340 - Respiratory Medicine	0	0
400 - Neurology	0	0
410 - Rheumatology	0	0
430 - HCOOP	0	0
502 - Gynaecology	430	11
X01 - Other Specs	0	0
X02 Other - Medical Services	0	0
X02 Other – Medical Services		0
X04 Other - Paediatric Services	0	0
X05 Other – Surgical Services	78	12
X06 Other – Other Services	0	0
Trust Total	**4,327**	**-148**

Whilst the volume of 52-week patients is reducing we continue to see an increasing number of patients who have declined to come in either because they have Covid or do not want to have the surgery at this point in time. Clinical and administrative validation of the waiting lists continues, along with robust adherence to the access policy where patients are not proceeding with their surgery.

104 week waits

Weekly meetings continue to provide oversight and management of our patients waiting over 104 weeks and good progress was made until the impact of the Covid Surge, where we triggered at level 5 resulting in cancellation of elective surgery in December/January.

We have set the ambition of eliminating the longest waiting patients, except when it is the patient's choice, by July 2022. ENT remains high risk due to the inability to secure complex otology capacity required via alternate providers. Requests via the 'West Kent Shared PTL' and the 'Acute Trusts Shared PTL' have been made but limited capacity has been offered to support this specialities recovery. The revised 104 week forecast trajectory can be seen below.

Month (End)	104+ wk wait Forecast	104+ wk wait Actual
Sep-21	65	29
Oct-21	72	37
Nov-21	36	27
Dec-21	0	51
Jan-22	100	97
Feb-22	90	
Mar-22	70	
April-22	50	

May-22	30	
June-22	0	

Theatre Capacity and Utilisation

Theatre activity delivered in January was predominantly cancer and urgent patients as a result of trigger level 5 being enacted due to Covid surge. The consequence of the theatre timetables being amended naturally impacted our elective recovery, our theatre performance and particularly our longest waiting 104-week breach patients.

These revised plans were planned to be in place until the 7 February 2022 with a weekly review of current pressures at Gold.

Our dropped sessions can be seen below alongside the two previous months performance to draw comparison to the scale of the impact as a result of the latest Omicron Covid surge:

- November 2021 – 102 sessions
- December 2021 – 165 sessions
- January 2022 – 307 sessions

With the revised January theatre timetables performance was:

- Average cases per session - 2.3 (above 2.2 threshold for the last 3 months: Nov – 2.3 / Dec – 2.5)
- Booked occupancy – 79.9% (below 95% threshold for the last 3 months: Nov – 86.1% / Dec – 84.3%)
- Actual occupancy – 71.8% (below 85%threhold for the last 3 months: Nov – 77.9% / Dec – 76.6%)

Trust wide Cancellations on the Day

A revised escalation process for cancelling patients on the day, for non-clinical reasons has been established. All escalations should be escalated to operational directors, hospital directors (if the cancellation is due to lack of beds) then to the Interim Medical Director for Recovery and the Chief Operating Officers office for final sign off. This ensures that no patient is cancelled without exploring all available options to prevent the cancellation. Cancellations are divided into the following:

- Clinical
- Non-Clinical
- Patient

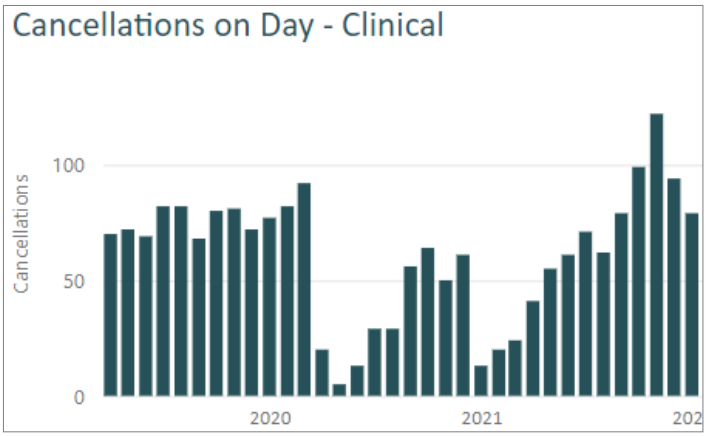
Cancellations have improved across all three domains in January, see below summary for the last three months performance:

Cancellation Type	November 21	December 21	January 22
Clinical	122	94	79
Non-Clinical	24	42	24
Patient	41	31	29

Clinical Cancellations on the day

Clinical cancellations on the day of surgery remains an area of focus. 79 patients were cancelled on the day for clinical reasons in January with Ophthalmology, Urology and ENT contributing the highest volumes across the specialties.

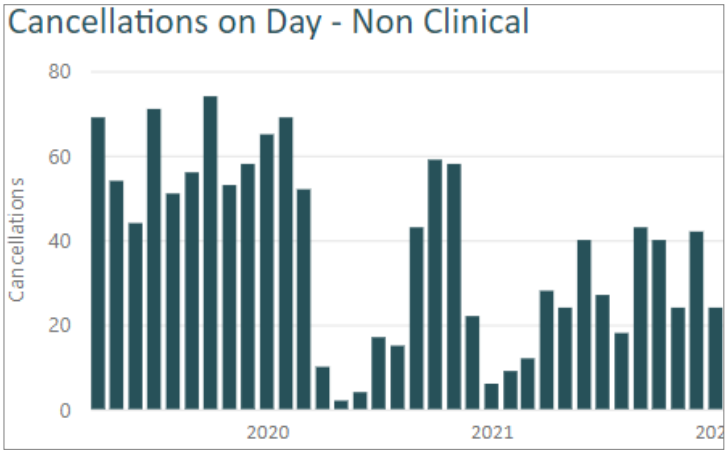
Ophthalmology is being explored by the Head, Neck, Breast & Dermatology (HNBD) Care Group through their We Care driver meetings to identify cancellation themes and agree countermeasures due to the ongoing volume of cancellations.



Specialty	Nov	Dec	Jan
Ophthalmology	24	16	22
Urology	23	12	16
ENT	12	10	12
Vascular	4	4	9
Trauma and Orthopaedics	19	15	5
Gynaecology	6	8	4
Max Fax	9	9	4
General Surgery	20	13	3
Breast	1	2	2
Pain	0	3	1
Gynaecology Oncology	0	0	1
Anaesthetics	0	2	0

Non-Clinical Cancellations

We have seen a significant improvement in January's non-clinical cancellations. We do however continue to see a number of non-clinical cancellations on the day as a direct result of not having Intensive Therapy Unit (ITU) beds available, equipment failures and where emergency operations have taken priority. All non-clinical cancellations are escalated before final cancellation.

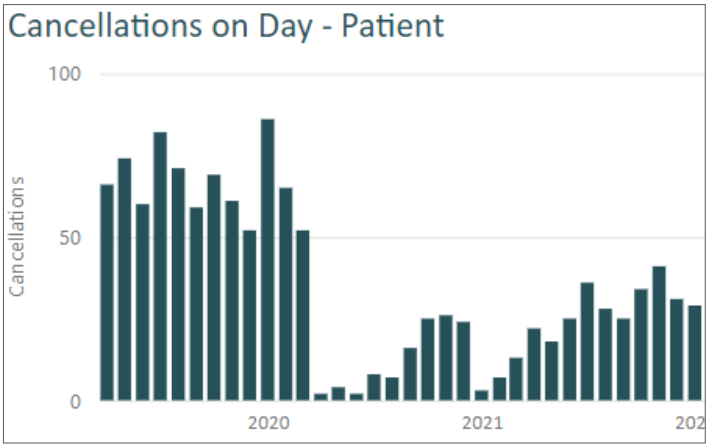


Specialty	Nov	Dec	Jan
Ophthalmology	3	8	9
General Surgery	8	9	4
Breast	0	0	3
Gynaecology Oncology	0	0	2
Trauma and Orthopaedics	4	12	1
Gynaecology	4	6	1
Urology	0	0	1
Vascular	1	4	1
ENT	2	1	1
Max Fax	0	0	1

Patient Cancellations

Patient cancellations were noted across all specialties, with a number of reasons identified – including DNAs (Did Not Arrive), patients advising us they have tested positive, or patients advising us they need to isolate following Covid contact. We continue to see similar volumes each month as a result of Covid.

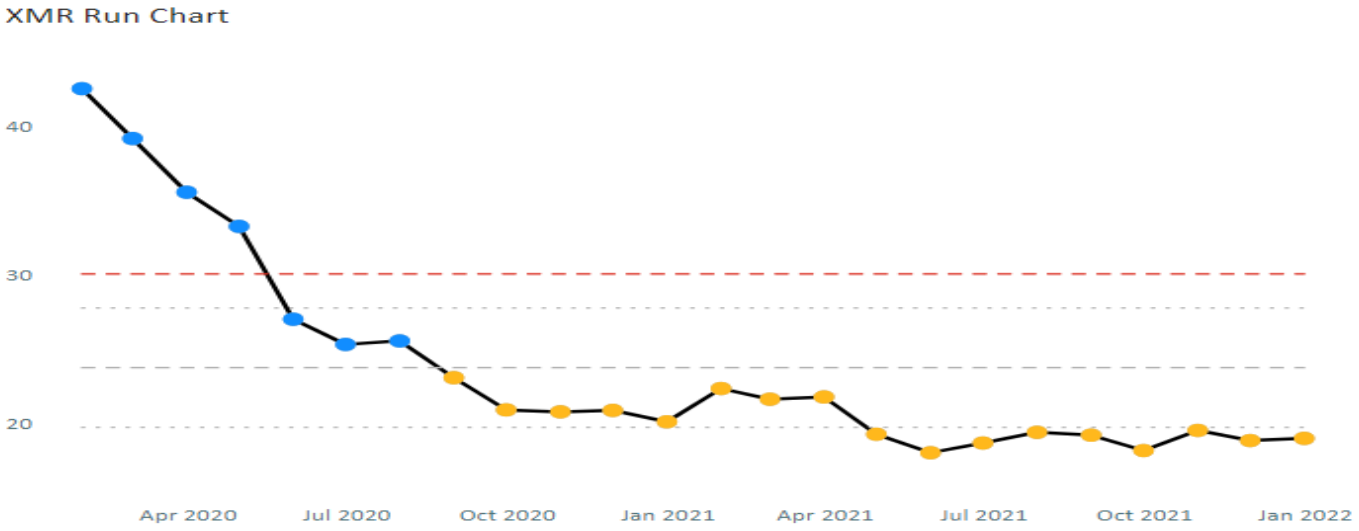
Specialty	Nov	Dec	Jan
ENT	5	2	5
General Surgery	2	7	4
Trauma and Orthopaedics	14	7	1
Urology	6	6	6
Ophthalmology	6	2	1
Gynaecology	6	2	1
Pain	0	3	0
Vascular	2	1	4
Max fax	0	1	6
Gynaecology Oncology	0	0	1



Pre-Operative Assessment

The pre-assessment pool is the number of patients on our waiting list who have been pre-assessed. Our ambition is to have at least 25% of our patients assessed ready for their To Come In (TCI) date with a further planned trajectory of 35% of our patients being assessed. An improvement trajectory is being developed in line with the operational guidance and business planning for 2022/23.

January 2022 Pre-Op Assessment rate was 19%(0.6% improvement from last month) the chart below shows the Pre-Op Assessment Rate:



Vacancy in the service is having a significant impact on the teams plan to deliver 650 pre-assessment slots per week. The gap is circa 200 slots per week due to the ongoing recruitment challenges.

Since last month's the position remains a risk - in summary:

- 2 Whole Time Equivalent (WTE) have been appointed awaiting start dates
- 1.5 WTE recruited have since withdrawn
- Vacancy gap at 31.01.22 is 5.13 WTE

The service is also trying to mitigate a further 3.44 wte gap due to:

- 2.44 WTE maternity leave
- 1 WTE long term sickness

The two insourcing companies we are using for elective recovery at weekends have been approached to secure additional pre-assessment nurses. Both companies have identified nurses that could be deployed in

EKHUFT in March and indicative activity plans are being agreed. Insourcing support will have to form part of our short-term recovery whilst recruitment and business planning is being developed.

High volumes of patient cancellations due to Covid remains a signifcant factor impacting performance. Did Not Attend (DNA) rate in January was 134 and cancelled appointments on the day were 74.

Issues remain with the postal swabbing service and results not being available on the day. A weekly review meeting has been established with the national elective care centre to action any issues and troubleshoot to prevent further lost or late reporting of Covid testing. To overcome this continuous challenge, we continue to rely on the internal swabbing provision to prevent cancellations for surgery.

RTT Training

A comprehensive knowledge of RTT rules is fundamental to good waiting list management and whilst the organisation had provided key training, it has become apparent that there is a gap in staff knowledge. The training programme continues but operational pressures have made it difficult for staff to be released at times. However:

- 647 users have registered to undertake the Web on line Introduction Course to RTT, of this 452 have completed the course with an average pass rate of 86%.

- 406 users have registered to undertake the Web on line Advanced RTT course with 198 staff members completing the course and an average pass rate of 84%.

- 117 staff have completed face to face training. Staff from Dermatology, Breast, Ophthalmology, Max Fax, ENT and Trauma & Orthopaedics have attended these sessions.

Feedback from staff undertaking the face to face training have included:

- Clearer understanding on the purpose of the Access Policy particularly around DNAs and patient cancellations.
- Secretaries need to check that the letter reflects the outcome for the RTT pathway.
- Better understanding of what starts and stops a clock.

It is encouraging the average pass rate continues to be high, which indicates staff do understand the rules for Referral to Treatment, however we have identified that staff have struggled to apply the rules on the Patient Administration System (PAS). The face to face/ WebEx training, supported by the data quality team, is now focussed on training staff how to update the PAS system.

Validation

Validation is the term applied to the systematic review of In Patient (IP) and Out Patient (OP) elective waiting lists and the objective is to:

- Ensure that there has been the correct application of the RTT rules.
- To identify recurrent themes in poor data quality/entry.
- To identify key individuals who consistently make errors when adding patients to the waiting lists, book appointments.
- Provide support to one off projects around data quality.

Kent and Medway provided funding for external validation which commenced on the 2 November and finished at the end of January. The team validated 24,996 pathways during this time and found the greatest number of errors in the following specialities:

- Urology

- Dermatology
- Ophthalmology

Focussed training has been delivered/ planned for these key specialties using the outcomes of the external validation team for feedback.

The validation team removed 2591 patients – a removal rate of 10.3%. 112 of the patients removed were 52-week breaches in General Surgery and ENT.

The validation team have been funded for a further period of time to supporting validation of the endoscopy waiting lists, progress and findings will be shared in next months paper.

Clinical Harm Review Update (CHR)

All patients who have treatment completed who have been waiting longer than 52 weeks should have a documented CHR. In January 2022 a total of 1007 patients were treated who were waiting over 52 weeks, with 385 having a documented CHR (38%). Less elective patients were treated in January due to the impact of the Omicron variant and the need to prioritise cancer, P2 patients and our longest waiting patients. Four cases of low harm were identified following treatment, and no cases of moderate or low harm. Work is underway with our Business Information and Governance teams to agree a process for documenting a 3 monthly CHR for all patients waiting > 78 weeks from April 2022.

A revised process has been agreed with Care Group governance leads to enable clinical teams to record the CHR in a timelier manner, recognising the large numbers of patients involved and the very low relative risk of moderate/serious harm identified at the time of treatment.

East Kent Independent Sector (EKHUFT Sub-Contracts)

Our local Independent Sector Providers (ISP) continue to perform better in H2 compared to H1. We received an unrealistic capacity offering from One Ashford, Chaucer and Spencer Hospitals in this period which was attributed to the actual performance seen below in H1.

- H1 – planned capacity offering: 1967/actual performance: 412 patients (21% of the plan delivered)
- H2 – planned capacity offering: 915/actual performance: 472 patients (52% of plan delivered as at 31.01.22)

West Kent Independent Sector Shared PTL (Clinical Commissioning Group (CCG) Contract Variations)

The Kent and Medway ICS Recovery Director established a Task and Finish Group on 12 August 2021 to plan a Shared PTL with oversight from the Elective Care Programme Board. As such the system offered to support the transfer of 1500 long waiting patients from EKHUFT to another provider. EKHUFT identified this as 'high risk'. Further work did identify that the acute trusts were not willing to wholly support this volume of activity and as such Independent Sector Providers (ISP) were approached in West Kent.

Due to the risk associated with Shared PTL at this time the indicative activity offering was reduced to 250 which was subsequently adjusted in our H2 elective recovery trajectory.

Internal attempts to contract with West Kent Independent Sector Provider (ISP) sites had already been established in H1 prior to the Shared PTL Task and Finish Group being established. The activity transferred to West Kent is being referred to as Shared PTL.

CCG contract variations were signed in December 2021 with:

- Nuffield Health, Benenden Health, KIMS, Practice Plus Group and Spire Healthcare

In essence the 'West Kent Shared PTL' Standard Operating Procedure (SOP) was developed by EKHUFT and subsequently approved by the ICS/CCG Contracting Team.

Performance at 31 January 2022 against the 250 Shared PTL trajectory is detailed below.

West Kent Shared PTL	Total Patients Transferred – as at 31.01.22
Nuffield	86
Benenden	108
KIMS	61
Practice Plus Group	78
Spire Hospitals	131
Total	464

Acute Trust Shared PTL (EKHUFT Sub-Contract)

The ICS Recovery Director confirmed the West Kent Shared PTL contract variation and Standard Operating Procedure (SOP) would not be applied to our neighbouring Acute Trusts as their Executive Board had not approved the West Kent Shared PTL SOP which would see EKHUFT patients RTT pathway transferred via an Inter-Provider Transfer process (this would mean the whole pathway and RTT reportable position would be the responsibility of the receiving Trust and removed from EKHUFT's RTT reportable position). Maidstone and Tunbridge Wells is the only Trust who can support ENT activity and as such EKHUFT have established a Sub-Contract arrangement to enable the transfer of patients for treatment.

At the end of January, we have only been able to send a very limited number of ENT patients and we continue to request additional capacity to address the inequitable waiting time across Kent and Medway for ENT otology patients.

Acute Trust Shared PTL	Total Patients Transferred – as at 31.01.22
Maidstone & Tunbridge Wells	9

Insourcing

At the outset we have seen delays which have impacted the performance of the insourcing plan. The initial insourcing trajectory was set to deliver 1500 patients but had to be revised due to contract award delays, it was subsequently revised to circa 1024 patients and this was included in the H2 business plan/recovery trajectory.

Once contracts were awarded and signed we had further constraints with the unavailability of insourcing staff due to the Covid Surge. Due to internal pre-operative performance insourcing teams were asked to secure Pre-Assessment Nursing staff to build a pool of patients to enable insourcing lists to be scheduled. As a result, we not commence any insourcing activity until 18/19 December 2021. Due to the insourcing mobilisation plans only one speciality could commence, this was ENT. Gynaecology and General Surgery commenced in January.

Patient outcomes are being monitored within the specialities and as such a meeting was held in January with the Insourcing/EKHUFT ENT Clinical Leads due to a higher than average re-admission rate. A weekly review of performance and patient outcomes is in place, and where necessary, action has been taken by the Insourcing team to address our clinical concerns. Performance will continue to be monitored to ensure our patients are receiving the best care and outcome we expect from this service.

The 18 Weeks orthopaedic contract mobilisation has not progressed as planned in January due to the workforce requirements to deliver the elective recovery support required for the spinal injection services (pre-assessment/Radiographer/Orthopaedic Surgeon/full theatre team/out-patient follow up). Options to progress the model of care are underway with the Insourcing and EKHUFT Orthopaedic Clinical Leads.

A benefit analysis is being prepared to assess the quality, performance and financial impact the insourcing business case has delivered.

Performance to date can be seen below:

H2 INSOURCING PLAN	GYNAE	ENT	GEN SURG	ORTHO	FORECAST PLAN	ACTUAL - AS AT 31.01.22
Oct-21	0	0	0	0	0	0
Nov-21	16	16	16	16	64	0
Dec-21	48	48	48	48	192	13
Jan-22	64	64	64	64	256	99
Feb-22	64	64	64	64	256	
Mar-22	64	64	64	64	256	
TOTAL	**256**	**256**	**256**	**256**	**1024**	**112**

East Kent Community Provision (EKHUFT Sub-Contracts)

Two sub contracts were awarded to Estuary View and Faversham Medical Practice to support H2 elective recovery plan. Contracts were formally signed in January and activity is planned to commence in February/March where the Providers have the workforce and equipment available to commence day case activity. These contracts provide additional capacity for EKHUFT that will support our recovery due to the risk the Insourcing and ISP contracts present to our elective recovery trajectory. This activity was not included in the H2 elective recovery trajectory as contracts had not been established at the time of business planning.

Estuary View have placed equipment orders to secure stack systems for both Hysteroscopy and Cystoscopy activity and this is due to be delivered at the end of February, planned activity is due to commence 8 March 2022. Indicative activity is detailed below:

ESTUARY VIEW - DAY CASE ACTIVITY	GYNAE	UROLOGY	ORTHO	TOTAL
Feb-22	0	0	10	10
Mar-22	60	80	25	165
TOTAL	**60**	**80**	**35**	**175**

FAVERSHAM - DAY CASE ACTIVITY	GYNAE	GEN SURG	ORTHO	TOTAL
Feb-22	6	6	10	22
Mar-22	12	12	20	44
TOTAL	**18**	**18**	**30**	**66**

ISP/Insourcing/Shared PTL – Elective Recovery Trajectory

Our H2 elective recovery trajectory, performance to date and the forecast position at the end of March 2022 can be seen in the table below. Shared PTL is set to deliver the full capacity offering from the West Kent ISP sites (1046).

Trajectory Scheme	H2 Trajectory Target	Performance – as at 31.01.22	Forecast Activity Planned - Feb/March	Forecast Performance - at 31.03.22

IS*/Insourcing (*East Kent ISP Sub-Contracts)	1128	584	516* EK ISP/Community Providers/Insourcing)	1100
Shared PTL* (*West Kent ISP & Acute - MTW)	250	473	573	1046
Total	**1378**	**1057**	**1089**	**2146**

Outpatient Transformation

Telemedicine

EKHUFT continues to perform above the national target of 25% for new and follow up appointments and remains the highest performer of tele-medicine across Kent and Medway, January performance was:

- New outpatient appointments - 26.5%
- Follow up performance - 33.3%

Work is ongoing to secure a new platform for telemedicine as the contract expires in March 2022. In the meantime, specialties continue to undertake telephone consultations.

Patient Initiated Follow Ups (PIFU)

In January we recorded 347 PIFU pathways started and 136 pathways were completed, whilst this is below the planned trajectory we have 12 specialties live with a new focus of implementing this across all major specialties where appropriate. The highest performing specialties using PIFU pathways are within MSK therapies.

Advice and Guidance

The East Kent ICP Advice & Guidance Task & Finish Group meeting has met this month and includes clinical representation from the Trust and Primary Care. The focus of the group is to improve usage of Advice & Guidance and agree pathways. Process mapping and agreed expectations are included as part of the terms of reference to ensure standardisation across the ICP. Current issues identified include response times and the teams are working on how time can be allocated within job plans to support Advice and Guidance.

Actions this month

- Revise theatre timetables following completion of the recovery works at the WHH and QEQM
- Develop improvement trajectory for pre-op assessment
- Continue activity/business planning in line with the newly published 2022/23 priorities and operational planning guidance
- Elective activity restored following Covid surge
- Progress plan to secure a platform for telemedicine
- Investigate Ophthalmology clinical cancellation rate and agree remedial actions
- Secure additional West Kent/MTW ENT otology capacity to support our 104week recovery plan
- Orthopaedic insourcing mobilisation plan

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Quality and Safety	1 March 2022	Sarah Dunnett, Non-Executive Director	Corporate Governance & Risk Consultant	**Yes**	~~**No**~~
Appendices:	None				
Declarations of Interest made:					
No declaration of interest was made outside the current Board Register of Interest.					
Assurances received at the Committee meeting:					

Integrated Performance Report (IPR) – We Care Breakthrough Objectives & Watch Metrics	• The Committee received an update on the progress made in modifying the IPR and noted the following:
	  • The overall mortality position has improved. Due to the challenge of tracking this metric against specific interventions it is being reviewed for 2022/23.
	  • The Trust commissioned a desktop review of mortality review processes through the NHS England/NHS Improvement (NHSE/I) Better Tomorrow team and the outcome of the review is awaited.
	  • The Committee requested an annotation on the Statistical Process Control (SPC) charts to log interventions and tracking where they are made.
	  • Venous Thromboembolism (VTE) assessment compliance shows a fall in performance in some specialties. The Committee received re-assurance that the relevant Care Group Director is leading on focussed improvement work.
	  • The total number of harms has increased which is driven by the rise in Covid-19 infections in January 2022. Safe staffing challenges are a major contributory factor to patient harm. The Committee received re-assurance the recruitment pipeline is in place to address low staffing levels.
	  • Increase in falls reported due to significant staffing challenges. The Committee received re-assurance of the interventions in place to address areas of high numbers of falls.
	  • The Committee noted that pressure ulcers and tissue viability were to replace falls as new areas of focus and the work on falls will continue through the Fundamentals of Care Committee.
	  • Performance of the 8 week Referral To Treatment (RTT) has been adversely affected by global pandemic. Theatre utilisation was adversely affected in January 2022 compounded by the Covid-19 surge and limited availability of green beds at the William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) sites. The Committee received re-assurance of the measures in place to improve theatre utilisation and reduce waiting times including aligning green bed capacity and input from West Kent and insourcing.
	  • The Committee requested a graph showing a forward projection of demand versus available resource.
	  • The Cancer 62 Day RTT performance has dipped. The Committee received re-assurance that mitigations are in place including collaborating with regional colleagues at pace and instigating tumour site specific interventions for surgical patients.				

	• Long waits across the Emergency Department (ED) remains a challenge. The Committee received re-assurance of the interventions in place including the implementation by Senior ED management team of a weekend and evening rota to improve patient flow and timely transfer to wards. • The NHSE/I Improvement Director commended the updated format of the IPR.

Infection Prevention & Control (IPC) Monthly report	• The Committee discussed the monthly report and noted the following:
	  • Of the nationally reportable infections, one has breached the external threshold; P. aeruginosa. There are no concerns related to Klebsiella species, 'C diff' and E. coli.
	  • The Trust has been managing the surge in cases caused by the Omicron variant of the Covid-19 pandemic. The impact of this has been very challenging for EKHUFT and all acute healthcare providers locally and nationally.
	  • The Trust has 135 current Covid-19 inpatients which is down from an 'Omicron peak of 157 in mid-January.
	• The Committee took significant assurance from the IPC arrangements in place albeit having areas of performance that required improvement.

Care Group Governance Reports	The Committee discussed and noted the following matters of escalation: **Urgent & Emergency Care:** • On-going staffing gaps in nursing and medical workforce especially in QEQM – daily staffing calls continue for cross site support; and using consultants to mitigate middle grade gaps. • Length of stay for mental health attendances remain high – all Mental Health patients escalated to Hospital Director daily. • Continue to manage red and blue streams in ED dependent on need day to day – this can sometimes impact into ambulance off load due to available space. ED escalation processes have been refreshed. **General & Specialist Medicine:** • Nursing staffing gaps – use of NHS Professionals (NHSP) and agency. Matrons oversight and re-distribution of staff as appropriate via daily huddles. • Aerosol Generating Procedures (AGP) patients – plan being developed to create a red Non-Invasive Ventilation (NIV) ward to accommodate AGP patients in QEQM. • Mixed sex breaches – removal of AGP patients will mitigate breaches. • Healthcare Associated Infection (HCAI) – reiterating IPC practices to reduce risk of transmission. **Surgery & Anaesthetics:** • RTT 52 weeks – High number of elective patients awaiting procedures. Restarted Elective Orthopaedic Centre on 7 February 2022. The Committee received re-assurance on the actions in place to reduce long waiting lists. • High number of falls in January – Plans in place to mitigate include talking to patients who have experienced a fall. • Staffing challenges – ongoing recruitment and development of international nurses.

	Surgery – Head and Neck, Breast and Dermatology: • RTT 52 week breaches reduced to 981 in January – Continue to identify suitable patients for transfer to Spire/Maidstone and Tunbridge Wells NHS Trust (MTW). • 104 week breaches – working with MTW and Spire to eliminate by 1 July 2022. The Committee requested for future reports to include updates and assurance around this. • Ophthalmology follow-up waiting list – training for Did Not Attend (DNA)/ cancellation process in place. Numbers of high- risk waiters reduced to 4775 in January. • Theatre utilisation – training of middle grades to independently cover theatre sessions. **Clinical Support Services (CSS):** • Radiology action plan – 10 patients continue to be tracked no harm identified to date. • Increased volume of equipment breakdown – presenting and alerting Gold to equipment breakdown and service plans. • Staff sickness absence in WHH – plans in place to mitigate. **Women's Health:** • Care Quality Commission (CQC) patient survey report – pathway reviews with women to identify areas for improvement. • National Neonatal Audit Programme reported QEQM as an outlier – identified issues with survey and areas we are compliant. • Home birth service relaunched – The Committee received re-assurance that robust risk assessments are in place. **Child Health:** • High vacancy and sickness rates – NHSP being used; continued senior nurse on call; use of locum doctors to cover any gaps; ongoing international and local recruitment **Cancer, Haematology & Haemophilia:** • VTE assessment non-compliance – focussed improvement work in place. • Cancer compliance (28 and 62 days and 104s) – working with CSS, regional colleagues and the Cancer Alliance to resolve issues and agree a plan to improve timelines and access. • Delay to radiological investigations – finalising process and training to ensure this is mitigated.
Corporate Principal Mitigated Quality Risks	• The Committee noted the Corporate and Board Assurance Framework (BAF) risk registers report. • The Committee was assured that the risks relating to Our Patients, Our People and Our Quality and Safety were covered in the Care Group Governance reports.
Maternity and Neonatal Assurance Group (MNAG)	• The Committee received assurance on progress against the Maternity Improvement Plan; update on training; progress on the maternity dashboard; and Clinical Negligence Scheme for Trusts (CNST) compliance.

Integrated Claims/ Incidents/ Complaints and Learning from Serious Incidents Report (SIs) – Quarter 3	• The Committee received a detailed update on incidents, serious incidents, patient experience (complaints and Patient Advice and Liaison Service (PALS)), claims and inquests for Quarter 3 2021/22. • The Committee noted the completion of the Health Safety Investigation Branch (HSIB) investigation training complete and received re-assurance that this will improve the quality of reports and investigation process. • The Committee received re-assurance around the plans in place to reduce the backlog of Serious Incidents (SIs) and requested for the recovery plan to be included in the next report.

Mortality/ Learning from Deaths Report - Quarter 3	• The Committee received the quality report on mortality rates, mortality alerts and learning from deaths/ harm and noted the following:
	  • The Trust's Hospital Standardised Mortality Ratio (HSMR) remains as expected and is line with peer Trusts regionally.
	  • The Committee noted there are currently 4 alerts one relating to an error in coding which is being interrogated.
	  • The Committee received re-assurance that the data picked up by the Standardised Mortality Rate (SMR) and Cumulative Sum (CUSUM) alerts is the right data. The Committee requested for an update at the next meeting following cross referencing against the Perinatal Mortality Review Tool (*PMRT)* and briefing to MNAG.

Care Quality Commission (CQC) Update	• The Committee received a progress report of the CQC activity/correspondence noting the following:
	  • Action plans from previous inspections continue to progress slowly due to operational pressures.
	  • Queries from the CQC have remained low during January to February 2022, and there have been no inspections although it is anticipated activity may start to increase.
	  • A project plan has been produced to implement the Trust's new CQC Assurance Framework.
	  • A strategic initiative has been agreed to drive the journey to achieve an Outstanding CQC rating.

Safe Staffing	• The Committee received an update on delivery of the Safe Staffing Business case and requested for an update on recruitment pipeline to be included in future reports (including a paragraph on mitigation).
Quality Account	• The Committee received and noted the planned timetable for completion of the 2021/22 Quality Accounts Report and sign off process. • The Committee noted the Quality and Safety Committee (Q&SC) will receive draft versions and oversee the document production process.
Fundamentals of Care Committee Chair's Assurance Report	• The Committee received and noted the Chair's assurance report. • The Committee approved the terms of reference of the Fundamentals of Care Committee.
Safeguarding Committee Chair's Assurance Report	• The Committee received and noted the Chair's assurance report. • The Committee noted limited progress in developing supervision after incidents and the additional changes required to appraisal paperwork and agreed that the issue is referred to People and Culture Committee for action.
Other items of business	• Quality & Safety Work Programme (For information) • Patient Safety Committee Chair's Report - verbal (For Assurance) • Clinical Audit and Effectiveness Committee (CAEC) Chair's Report (For Assurance)

Referrals to other Board Committees	• There was **1 referral** to the People & Culture Committee as follows: • The Committee noted limited progress in developing supervision after incidents and the additional changes required to appraisal paperwork and agreed that the issue is referred to People and Culture Committee for action.
Referrals from other Board Committees	• There were no referrals from other Board Committees at this meeting.

Items to come back to the Committee outside its routine business cycle:		
There was no specific item over those planned within its cycle that it asked to return.		
Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
None		

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Integrated Audit and Governance Committee	22 February 2022	Olu Olasode Non-Executive Director (NED)	Board Support Secretary	**Yes**	~~**No**~~
Appendices:	Appendix 1: Gifts, Hospitality and Conflicts of Interest Policy				
Declarations of Interest made:					
No additional declarations of interest were made.					
Assurances received at the Committee meeting:					
Agenda item 1 (Board Assurance Framework (BAF) and Corporate Risk Registers (CRR)	• The Committee received and discussed the BAF and CRR report, took assurance of the risk management arrangements for the Trust following independent assurance received from the Internal Auditors. • The Committee noted the work in progress and the additional work to be done to further refine the presentation format of the risk registers providing a high assurance framework and evidence of effective processes in place. A revised iteration of the report was requested to be presented at its next meeting in April. • The Committee highlighted the importance of including target dates against risks to ensure robust challenge and discussion on progress against these at Board and Board Committees. • The Committee acknowledged the monitoring process in place with the Executive Risk Assurance Group in reviewing risks in detail and challenging progress against actions to mitigate and reduce risks. • The Committee noted the introduction of a new 'BAF and CRR on a page' from 2022/23 to strengthen reporting of risks to the Board and Board Committees. The Committee noted that more work needs to be done on risk definition, clarity of control actions and on the one page presentation of the report. Monthly summary BAF and CRR reports will be presented and the full BAF and CRR reported on a quarterly basis. • The Committee discussed and agreed returning to the previous three lines of assurance level of reporting.				
Agenda item 2 (Annual Accounts – 2021/22 Review of Accounting Policies)	• The Committee received and approved the draft accounting policies for 2021/22 to the Annual Accounts.				
Agenda item 3 (Going Concern Review 2021/22)	• The Committee received a 2021/22 Going Concern Review report, considered and took assurance of the evidence that the Group was a 'Going Concern'. The Committee agreed there were no material uncertainties that might cast significant doubt about its ability to continue over the next 12 months at the statement of financial position date. • The Committee agreed an action to ensure the Trust's subsidiaries consider a similar report for agreement to create their 2021/22 accounts on a Going Concern basis.				

Agenda item 4 (Annual Accounts 2021/22 – Process)	• The Committee received assurance and noted the process for the completion and submission of the 2021/22 Annual Accounts. • The Committee noted the agreement with the External Auditors to undertake an interim audit with the provision of a dedicated team to ensure a smooth process for this year's annual audit. • The Committee noted the 22 June submission date of audited accounts.
Agenda item 5 (Annual Report 2021/22 – Production Schedule)	• The Committee received assurance and agreed the approval process and timescale for the production of the 2021/22 Annual Report. • The Committee noted the production and submission will be in alignment with the 2021/22 Annual Accounts.
Agenda item 6 (Annual Presentation on the Process and Timetable of the Annual Quality Report 2021/22)	• The Committee received assurance and approved the planned timetable for completion of the 2021/22 Quality Accounts Report and sign off process. The Committee noted the requirement for this to be published on the Trust's website by 30 June and is not required to be audited. • The Committee noted the Quality and Safety Committee (Q&SC) will receive draft versions and oversee the document production process. The document will be produced in alignment with the required template that will include a Governors commentary.
Agenda item 7 (Gifts, Hospitality and Conflicts of Interest Policy)	• The Committee received assurance and approved the updated Gifts, Hospitality and Conflicts of Interest Policy (Appendix 1) and recommends this for approval by the Board. • The Committee noted the policy aligned with NHS guidance, reflected the streamlined process for declarations through the Electronic Staff Record (ESR) system. • The Committee noted following Board approval the policy will be disseminated for implementation throughout the Trust.
Agenda item 8 (IFRS16 – Implementation Plan)	• The Committee received and discussed a report about the implementation plan of IFRS16, a new accounting standard to be implemented from April 2022. • The Committee noted an initial review had been undertaken and it concluded that the new standard should not have a material impact for the Trust. The Committee will be kept updated on progress with implementation.
Agenda item 9 (External Audit Grant Thornton (GT) – Progress Report and Sector update)	• The Committee received and discussed an External Audit Progress Report and Sector update. • The Committee noted interim testing work has already commenced in relation to the annual accounts audit. • The Committee received assurance of close working between the Finance team and External Audit team in respect of the annual accounts audit, and ensuring updates about forecast and delivery of the Trust's capital funding expenditure. • The Committee noted the outcome of the Financial Reporting Council (FRC) review of GT's audits graded as 'Good' with limited improvements. • The Committee noted the annual work plan will be presented for approval at its April meeting.

Agenda item 10 (Internal Audit RSM Risk Assurance Services LLP – Progress Report)	• The Committee received and discussed an Internal Audit Progress Report, noting two finalised internal audit reports:
	  • Risk Management – Reasonable Assurance;
	  • Spencer Private Hospitals – Reasonable Assurance.
	• The Committee noted good progress on implementation of management actions by their agreed date, a few of which had been revised. A follow-up exercise is being undertaken in April on the remaining actions related to the onboarding of locums across the Trust. The Committee agreed an action to receive an update at its next meeting on the joint working of the clinical teams and HR, to provide clarity on the responsibilities of each function in respect of completion of the locum onboarding checklist.
	• The Committee noted that residual follow-up actions from previous audits remain high and asked for these to be addressed.
	• The Committee discussed whether an audit was needed to review progress of the maternity improvement programme. It was agreed this will be raised for discussion at the next Maternity Neonatal and Assurance Group (MNAG).
	• The Committee noted the external quality assessment of RSM's internal audit service that is compliant against Public Sector Internal Audit Standard.

Agenda item 11 (Local Counter Fraud Specialist (LCFS) RSM Risk Assurance Services LLP – Progress Report and Work Plan)	• The Committee received and discussed a LCFS progress report detailing LCFS activity that included:
	  • an update on investigations;
	  • completion and submission of a Fraud Prevention Guidance Impact Assessment (FPGIA) launched by the NHS Counter Fraud Authority (NHSCFA);
	  • Regional fraud forum hosted by RSM for LCFS staff across London and the South East;
	  • Review of Trust policies;
	  • Staff training and awareness.
	• The Committee received assurance that the Trust had taken onboard the latest NHS guidance and will continue to review its systems on a regular basis.
	• The Committee received and approved the LCFS draft work plan for 2022/23.

Agenda item 12 (Integrated Governance Guide)	• The Committee received and discussed a draft Integrated Governance Guide. • The Committee noted and received assurance on the governance structure and arrangements in place for the Board and Board Committees, and requested that this be reviewed in respect of their purpose as well as the Executive led Groups. It was acknowledged there was further work to be done in respect of the Sub-Groups and Service-Level Groups. This review will be around the flow of information both horizontally and vertically for communication, escalation and assurance. • The Committee agreed an updated version of the guide will be presented to its next meeting. This will also include a governance assurance map detailing the governance reporting structure across the organisation.

	• The Committee noted the guidance was work in progress and once completed a summary practical user guide will be produced for staff. • The Committee also reiterated its request for an integrated assurance map.
Agenda item 13 (Regulatory Compliance Group (RCG) Chair's Report)	• The Committee received and noted a report from the RCG Chair and took assurance from the process undertaken by RCG in reviewing and monitoring activity and compliance in respect of regulatory requirements. • The Committee agreed an action to undertake a benchmarking exercise to compare the number of current Trust policies against other trusts, and whether these were similar.
Agenda item 14 (Executive Risk Assurance Group (ERAG) Chair's Report)	• The Committee received and noted a report from the ERAG Chair and took assurance from this and the process undertaken by ERAG in reviewing the CRR and Care Group Risk Registers.
Other items of business	• The Committee noted a verbal report that regular Freedom to Speak Up (FTSU) Guardian reports will now be presented to the People & Culture Committee. • The Committee noted the IAGC 2022 annual work programme.

Actions taken by the Committee within its Terms of Reference:

- The Committee **APPROVED** the:
  - Draft accounting policies for 2021/22 to the Annual Accounts;
  - Updated Gifts, Hospitality and Conflicts of Interest Policy;
  - The LCFS draft work plan for 2022/23;
  - The planned timetable for completion of the 2021/22 Quality Accounts Report and sign off process.

- The Committee **AGREED** the:
  - 2021/22 accounts to be created on a Going Concern basis;
  - Approval process and timescale for the production of the 2021/22 Annual Report.

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

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

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

Item	Purpose	Date
The Committee recommends to the BoD the approval of the Gifts, Hospitality and Conflicts of Interest Policy.	Approval	To Board on 10 March 2022

East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals University NHS Foundation Trust

Gifts, Hospitality and Conflicts of Interest Policy

Version:	5.4 draft
Author:	Melinda Brewer, Interim Deputy Trust Secretary
Approving Committee	Board of Directors
Date approved:	TBC (planned for March 2022)
Date ratified by Policy Authorisation Group:	21 December 2021
Director responsible for implementation:	Group Company Secretary
Date issued:	TBC
Next scheduled review date:	July 2024
Applies to (include subsidiary companies):	All staff Non-Executive Directors Governors

Version Control Schedule

Version	Date	Author	Status	Comment
1	August 2011	Trust Secretary	Approved	
2	October 2012	Trust Secretary	Approved	
3	October 2014	Trust Secretary	Approved	Fully reviewed and simplified
4	April 2017	Trust Secretary	Approved	New Guidance from NHS England to be implemented by June 2017
4.1	January 2019	Trust Secretary	Approved	Amendments made to reflect revised process for declaration.
5	July 2021	Group Company Secretary	Approved	
5.4	December 2021	Interim Deputy Trust Secretary	Draft	Updates to reflect new system for declarations on Self Service (ESR).

Policy Reviewers

Name and Title of Individual	Date Consulted
Local Counter Fraud Specialist, RSM-UK	May 2021 November 2021

Name of Committee	Date Reviewed
Policy Authorisation Group	June 2021 November 2021
Board of Directors	July 2021 TBC

Summary of changes since last approved Version

Declarations to be made on Self Service (ESR) from 01 December 2021

Associated Documentation

Professional Codes of Conduct / ethics

Standing Financial Instructions

Anti-Fraud, Bribery and Corruption Policy

Financial Management and Control of Use of Resources Policy

Managing Close Personal Relationships at Work Policy
Requisitioning, Purchasing and Paying for Non-Stock Good and Services
Working Time Regulations and Secondary Employment Managers Toolkit
Disciplinary Procedure
Freedom to Speak Up policy

Contents

1. Policy Description

1.1. This policy outlines circumstances when gifts, gratuities, benefits and/or hospitality may be accepted or must be declined and when a declaration must be made. It will help our staff manage conflicts of interest risks effectively. It introduces consistent principles and rules, provides simple advice about what to do in common situations, and supports good judgement about how to approach and manage interests. This policy applies to all governors, directors, and staff of the Trust.

1.2. Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take.

As a member of staff you should…	As an organisation we will…
• Familiarise yourself with this policy and follow it. Refer to the guidance for the rationale behind this policy https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf • Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent • Regularly consider what interests you have and declare these as they arise. If in doubt, declare. • **NOT** misuse your position to further your own interests or those close to you • **NOT** be influenced, or give the impression that you have been influenced by outside interests • **NOT** allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money	• Ensure that this policy and supporting processes are clear and help staff understand what they need to do. • Identify a team or individual with responsibility for: ○ Keeping this policy under review to ensure they are in line with the guidance. ○ Providing advice, training and support for staff on how interests should be managed. ○ Maintaining register(s) of interests. ○ Auditing this policy and its associated processes and procedures at least once every three years. • **NOT** avoid managing conflicts of interest. • **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners

2. Introduction

2.1. East Kent Hospitals University NHS Foundation Trust (the Trust), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients. These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely, but there is a risk that conflicts of interest may arise.

2.2. Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

3. Definitions

3.1. **Bribe**: an inducement or reward offered, promised or provided to gain a personal commercial, regulatory or contractual advantage.

3.2. **Fees**: money paid to you for a service provided to an individual or an organisation.

3.3. **Gift**: tokens / offerings (including services such as massages, dinners etc) from a third party that have a financial value.

3.4. **Hospitality**: food, drink, accommodation, entertainment, travel or attendance as a corporate guest at an event.

3.5. **Sponsorship**: “NHS funding from an external source, including funding all or part of the costs of a member of staff, NHS research, staff, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (speakers), buildings or premises”.

3.6. Conflict of interest:

3.6.1. A ‘conflict of interest’ is: “A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.”

3.6.2. A conflict of interest may be:

3.6.2.1. Actual - there is a material conflict between one or more interests.

3.6.2.2. Potential – there is the possibility of a material conflict between one or more interests in the future.

3.6.3. Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

3.7. **Interests**:

3.7.1. 'Interests' can arise in a number of different contexts. A material interest is one which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision.

3.7.2. Interests fall into the following categories:

3.7.2.1. Financial interests: Where an individual may get direct financial benefit from the consequences of a decision they are involved in making.

3.7.2.2. Non-financial professional interests: Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

3.7.2.3. Non-financial personal interests: Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

3.7.2.4. Indirect interests: Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

3.8. **Staff**:

3.8.1. The Trust uses the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

3.8.1.1. All salaried employees;

3.8.1.2. All prospective employees – who are part-way through recruitment;

3.8.1.3. Contractors and sub-contractors;

3.8.1.4. Agency staff / temporary staff; and

3.8.1.5. Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation).

3.8.2. NHS England has published some frequently answered questions accessed through this link: https://www.england.nhs.uk/ourwork/coi/

3.9. Decision making staff:

3.9.1. Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff.' Decision making staff in the Trust are:

3.9.1.1. Executive and non-executive directors (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money.

3.9.1.2. Members of Board and Committees (including advisory groups) which contribute to direct or delegated decision making on the provision of taxpayer funded services.

3.9.1.3. Those at Agenda for Change band 8a and above.

3.9.1.4. Those identified in the Standing Financial Instructions who have delegated responsibility for a budget.

3.9.1.5. Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation.

3.9.1.6. Administrative and clinical staff involved in decision making concerning the purchasing of goods, medicines, medical devices or equipment, and such like.

4. Purpose and Scope

4.1. This policy will help our staff manage conflicts of interest risks effectively. It:

4.1.1. Introduces consistent principles and rules;

4.1.2. Provides simple advice about what to do in common situations; and

4.1.3. Supports good judgement about how to approach and manage interests.

4.2. This policy should be considered alongside the organisational policies listed under 'Associated Documents'.

4.3. This policy applies to all governors, directors and staff of the Trust.

5. Duties

5.1. **Chief Executive**: as Accountable Officer, has overall responsibility for this policy.

5.2. **Group Company Secretary**: provides advice and guidance in relation to the application of this policy; additionally, responsible for maintaining the register of interests and gifts, hospitality and sponsorship. Where there is a difference of opinion between the individual and the line manager, the Group Company Secretary will provide advice. In addition the Group Company Secretary will keep this policy under review to ensure it is in line with national guidance and include an audit of the processes in the internal audit plan on an annual basis.

5.3. **Line managers**: are responsible for considering and approving the receipt of gifts, hospitality, sponsorship and declaration of interest within 28 days.

5.4. **All individuals to whom this policy applies**: are responsible for ensuring that in the required circumstances, the individual records, declares and surrenders any gifts, hospitality, sponsorship and conflicts of interest. The individual is responsible for ensuring a copy of all declarations and approval by their line manager are kept on your personnel file or on ESR Self-Service.

6. Identification, Declaration and Review of Interests

6.1. All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If members of staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered.

6.2. Declarations should be made on Self Service (ESR):

6.2.1. On appointment with the Trust;

6.2.2. When a member of staff moves to a new role or their responsibilities change significantly;

6.2.3. At the beginning of a new project/piece of work;

6.2.4. As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

6.3. The Self Service (ESR) system will prompt decision-making staff on a regular basis, at least quarterly, to review declarations they have made and, as appropriate, update them or make a nil return.

6.4. Declarations must be reviewed by the line manager. Staff should notify their manager by email of any declarations.

6.5. Line Managers must review declarations on Self Service (ESR) and will receive a summary of declarations made each month.

7. Records and Publication

7.1. The Trust will maintain a register of interests, gifts, hospitality and sponsorship electronically.

7.2. The Trust will publish on the Trust's website the interests declared by:

7.2.1. Board of Directors;

7.2.2. Council of Governors;

7.2.3. Decision-making staff.

7.3. This information for 7.2.1 will be refreshed on a quarterly basis and the information on 7.2.2 and 7.2.3 will be refreshed on an annual basis.

7.4. If decision-making staff have substantial grounds for believing that publication of their interests should not take place, they should provide an explanation as part of the declaration on Self Service (ESR). In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be by exception and information will not be withheld or redacted merely because of a personal preference. The Group Company Secretary reserves the right to challenge the explanation provided on a case-by-case basis.

8. Wider Transparency Initiatives

8.1. The Trust fully supports wider transparency initiatives in healthcare, and encourages staff to engage actively with these. Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These "transfers of value" include payments relating to:

8.1.1. Speaking at and chairing meetings;

8.1.2. Training services;

8.1.3. Advisory board meetings;

8.1.4. Fees and expenses paid to healthcare professionals;

8.1.5. Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK;

8.1.6. Donations, grants and benefits in kind provided to healthcare organisations.

8.2. The above does not negate the requirement for staff to make the relevant declarations to the Trust.

8.3. Further information about the scheme can be found on the ABPI website: https://www.abpi.org.uk/reputation/disclosure-uk/

9. Management of Interests

9.1. If an interest is declared but there is no risk of a conflict arising, then no action is warranted. However, if a material interest is declared (including a gift or hospitality) then the general management actions that could be applied include:

9.1.1. Restricting staff involvement in associated discussions and excluding them from decision making;

9.1.2. Removing staff from the whole decision-making process;

9.1.3. Removing staff responsibility for an entire area of work;

9.1.4. Removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant.

9.2. Each case will be different and context-specific, and the Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

9.3. Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence and agree the action as set out in 9.1.

9.4. Where there is a dispute between the staff member with the interest and their line manager on the management action, it should be escalated to the Group Company Secretary who will decide the most appropriate course of action.

10. Gifts

10.1. Staff must not accept gifts that may affect, or be seen to affect, their professional judgement, create a conflict of interest or be perceived to affect the outcome of business transactions.

10.2. Staff must be alert to the risk that gifts, hospitality and expenses may be used as a subterfuge for bribery.

10.3. Gifts from suppliers or contractors:

10.3.1. Gifts from suppliers or contractors doing business (or likely to do business) with the organisation must be declined (and declared), whatever their value.

10.3.2. Low cost branded promotional aids such as pens or post-it notes may, be accepted where they are under the value of £6 in total, and need not be declared.

10.4. Gifts from other sources (e.g. patients, families, service users):

10.4.1. Gifts of cash and vouchers to individuals must always be declined (and declared).

10.4.2. Staff must not ask for any gifts.

10.4.3. Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the Trust, with prior line manager approval. The gift must be declared, the value agreed by the Group Company Secretary, and a donation made of that agreed amount by the staff member receiving the gift to the Charitable Funds.

10.4.4. Modest gifts accepted under a value of £50 do not need to be declared.

10.4.5. A common-sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

10.4.6. Multiple gifts from the same source over a 12 month period must be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

10.5. Gifts must be declared via Self Service (ESR) and approved by your line manager on Self Service (ESR) within 28 days of receipt.

11. Hospitality

11.1. Staff must not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement, create a conflict of interest or be perceived to affect the outcome of business transactions.

11.2. Hospitality may only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.

11.3. Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Multiple offers of hospitality from the same source should be treated in the same way as single offers of hospitality. Director level approval must be obtained prior to acceptance.

11.4. Meals and refreshments:

11.4.1. Under a value of £25 - may be accepted and need not be declared.

11.4.2. Of a value between £25 and £75 - may be accepted and must be declared (whether accepted or not).

11.4.3. Over a value of £75 - must be refused unless (in exceptional circumstances) senior approval is given in advance. A clear reason should be recorded on the organisation's register of Gifts and Hospitality as to why it was permissible to accept.

11.4.4. A common-sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate supported by internet research).

11.5. Travel and accommodation:

11.5.1. Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.

11.5.2. Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need advance approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the organisation's register of Gifts & Hospitality as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:

11.5.2.1. Offers of business class or first class travel and accommodation (including domestic travel);

11.5.2.2. Offers of foreign travel and accommodation.

11.6. Hospitality must be approved by your line manager prior to the event via email and declared via Self Service (ESR) within 28 days of the event. The Line Manager must document review on Self Service (ESR).

12. Outside Employment

12.1. Staff must declare any existing outside employment on appointment and any new outside employment when it arises using the applicable form in the Working Time Regulations and Secondary Employment Managers Toolkit.

12.2. Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.

12.3. Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

12.4. Staff should refer to their contract of employment and comply with policies regarding the disclosure of outside employment over and above this clause.

12.5. Staff should ensure that any outside paid employment completed within Trust time (e.g. speaking at conferences, etc.) should be declared and payment made to the Trust.

12.6. The following information should be declared to your line manager:

12.6.1. Staff name and your role within the outside organisation;

12.6.2. The nature of the outside employment (e.g. who it is with, a description of duties, time commitment);

12.6.3. Relevant dates;

12.6.4. Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

13. Shareholding and Other Ownership Issues

13.1. Staff must declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy that is doing, or might be reasonably expected to do, business with the organisation.

13.2. Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

13.3. There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

14. Patents

14.1. Staff must declare, on Self Service (ESR), patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are on-going, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.

14.2. Staff must seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc., where this impacts on the organisation’s own time, or uses its equipment, resources or intellectual property.

14.3. Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

15. Loyalty Interests

15.1. Loyalty interests must be declared using Self Service (ESR) by staff involved in decision making where they:

15.1.1. Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body that could be seen to influence decisions they take in their NHS role.

15.1.2. Sit on advisory groups or other paid or unpaid decision-making forums that can influence how an organisation spends taxpayers' money.

15.1.3. Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.

15.1.4. Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision-making responsibilities.

16. Donations

16.1. Donations made by suppliers or bodies seeking to do business with the Trust should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted with prior line manager approval but must always be declared using Self Service (ESR). A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

16.2. Staff must not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain.

16.3. Staff must obtain permission from the organisation if, in their professional role, they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.

16.4. Donations, when received, must be made to a specific charitable fund (never to an individual) and a receipt should be issued.

16.5. Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal

responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

17. Sponsored Research

17.1. Funding sources for research purposes must be transparent.

17.2. Any proposed research must go through the relevant health research authority or other approvals process.

17.3. There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.

17.4. The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.

17.5. Staff must declare involvement with sponsored research to the organisation via Self Service (ESR).

18. Sponsored Posts

18.1. External sponsorship of a post requires prior agreement with the Human Resources.

18.2. Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.

18.3. Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.

18.4. Sponsored post holders must not promote or favour the sponsor’s products, and information about alternative products and suppliers should be provided.

18.5. Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

19. Clinical Private Practice

19.1. Clinical staff must declare all private practice on appointment via Self Service (ESR), and/or any new private practice when it arises including:

19.1.1. Where they practise (name of private facility).

19.1.2. What they practise (specialty, major procedures).

19.1.3. When they practise (identified sessions/time commitment).

19.2. Clinical staff must (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

19.2.1. Seek prior approval of their organisation before taking up private practice.

19.2.2. Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.

19.2.3. Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

19.3. Hospital consultants must not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

19.4. Where clinical private practice gives rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks as set out in paragraph 9.

20. Procurement and Strategic Decision Making

20.1. Procurement

20.1.1. Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

20.1.2. Those involved in procurement exercises for and on behalf of the Trust should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

20.2. Strategic Decision Making

20.2.1. In common with other NHS bodies the Trust uses a variety of different groups to make key strategic decisions about things such as:

20.2.1.1. Entering into (or renewing) large scale contracts;

20.2.1.2. Awarding grants;

20.2.1.3. Making procurement decisions;

20.2.1.4. Selection of medicines, equipment, and devices.

20.2.2. The interests of those who are involved in these groups should be well known so that they can be managed effectively. For this Trust the types of groups are:

20.2.2.1. Procurement Strategy Group;

20.2.2.2. Procurement Assurance Group;

20.2.2.3. Care Group Procurement Boards;

20.2.2.4. Care Group Working Groups.

20.2.3. These groups should adopt the following principles:

20.2.3.1. Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.

20.2.3.2. Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.

20.2.3.3. Any new interests identified must be added to the organisation's register(s).

20.2.3.4. The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

20.2.4. If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

20.2.4.1. Requiring the member to not attend the meeting;

20.2.4.2. Excluding the member from receiving meeting papers relating to their interest;

20.2.4.3. Excluding the member from all or part of the relevant discussion and decision;

20.2.4.4. Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate;

20.2.4.5. Removing the member from the group or process altogether.

20.2.5. The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

21. Dealing with Breaches

21.1. There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as ‘breaches’.

21.2. Identifying and Reporting Breaches

21.2.1. Staff who are aware of actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to their line manager who should investigate and escalate to the appropriate Care Group / Directorate Director if required for further review.

21.2.2. To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised please refer to the Freedom to Speak Up Policy.

21.2.3. The Trust will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

21.2.4. Following investigation, the Trust will:

21.2.4.1. Decide if there has been or is potential for a breach and if so what the severity of the breach is.

21.2.4.2. Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.

21.2.4.3. Consider who else inside and outside the organisation should be made aware.

21.2.4.4. Take appropriate action as set out in the section 21.3.

21.3. Taking Action Against Breaches

21.3.1. Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and Trust auditors. Breaches could require action in one or more of the following ways:

21.3.1.1. Clarification or strengthening of existing policy, process and procedures.

21.3.1.2. Consideration as to whether HR/employment law/contractual action should be taken against staff or others.

21.3.1.3. Consideration being given to escalation to external parties. This might include referral of matters to external auditors, the NHS Counter Fraud Authority (NHSCFA), the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

21.3.2. Inappropriate or ineffective management of interests can have serious implications for the Trust and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

21.3.3. Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

21.3.3.1. Employment law action against staff, which might include:

21.3.3.2. Informal action (such as reprimand, or signposting to training and/or guidance);

21.3.3.3. Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal);

21.3.3.4. Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be;

21.3.3.5. Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach;

21.3.3.6. Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

21.4. Learning and Transparency around Breaches

21.4.1. Reports on breaches, the impact of these, and action taken will be considered by the Integrated Audit and Governance Committee at least six-monthly.

21.4.2. To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published in Risk Wise as appropriate, or made available for inspection by the public upon request.

22. Policy Development, Approval and Ratification Process

22.1. Consultation is outlined at the front of the document. The Board of Directors will approve this policy.

23. Review and Revision Arrangements

23.1. This policy will be reviewed as scheduled in three years' time unless legislative or other changes necessitate an earlier review.

24. Dissemination and Implementation

24.1. A communication to all staff will be arranged for this Policy and included in any bribery, corruption and anti-fraud training.

24.2. On a regular basis at least annually, staff will be reminded of their responsibilities through Trust News**.**

24.3. Staff will receive an automated prompt to update their declaration on Self Service (ESR) every quarter.

24.4. A written guide and video detailing how to complete declarations on Self Service (ESR) are available via the Electronic Staff Record intranet page.

25. Document Control including Archiving Arrangements

25.1. The Group Company Secretary will arrange for the policy to be made available through 4policies and retain previous versions.

26. Monitoring Compliance

26.1. Annual self-declaration by Band 8a and above and other required staff groups to confirm compliance with this policy is required. Compliance is monitored by the Group Company Secretary by way of a quarterly Self Service (ESR) compliance report.

26.2. Compliance will be monitored by the Integrated Audit and Governance Committee through the reporting of gifts, hospitality, sponsorship and conflicts of interest.

27. References

Bribery Act 2010

Nolan Principles: Seven Principles of Public Life (1995)

Standards of Business Conduct for NHS staff (HSG (93)5

ABPI Code of Practice

Managing Conflicts of Interest in the NHS (1 June 2017)

28. Appendices

Appendix 1 - Brief guidance for completion of Self Service (ESR) conflict of interests declarations form

INDIVIDUAL MAKING THE DECLARATION

If **no interests to declare**, check the box and apply.

If **interests to declare**, select **Category** and **Situation** from drop down lists (see below).

Category:

Financial interests - This is where an individual may get direct financial benefits from the consequences of a decision they are involved in making.
Indirect interests - This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making.
Non-financial personal interests - This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
Non-financial professional interests - This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career.

Situation:

Clinical Private Practice
Donations
Gifts
Hospitality
Loyalty Interests
Outside employment
Patents
Shareholdings and other ownership
Sponsored events
Sponsored posts
Sponsored research

Add a **Description** of the interest that is being declared. This should contain enough information to be meaningful (e.g. detailing the supplier of any gifts, hospitality, sponsorship, etc). That is, the information provided should enable a reasonable person with no prior knowledge should be able to read this and understand the nature of the interest. For gifts and hospitality, you should include: - The estimated value of the gifts or hospitality; details of the supplier/offeror; details of previous gifts and hospitality offered or accepted by the offeror/ supplier; whether the offer was accepted or not; and reasons for accepting or declining the offer. Remember, a benefit may arise from both a gain or avoidance of a loss.

Add a **Date From** – when the interest arose, and, if relevant, a **Date To**, when it ceased.

Add any **Comments** to detail any action taken to manage an actual or potential conflict of interest. It might also detail any approvals or permissions to adopt certain course of action.

MANAGER REVIEWING / APPROVING THE DECLARATION

On receipt of a notification from an individual making a notification (by email or the Self Service (ESR) system). Review the declaration made and add the **Date** and any **Manager Actions** taken.

Appendix 2 - Equality Analysis (EA)

An Equality Analysis not just about addressing discrimination or adverse impact; the policy should also positively promote equal opportunities, improved access, participation in public life and good relations.

Person completing the Analysis		
Name	Alison Fox	
Job title	Group Company Secretary	
Division/Directorate	Trust Management	
Date completed	July 2021	
Who will be impacted by this policy	[x] Staff (EKHUFT) [x] Staff (Other) [ ] Service Users	[ ] Carers [ ] Patients [ ] Relatives

Assess the impact of the policy on people with different protected characteristics. When assessing impact, make it clear who will be impacted within the protected characteristic category. For example, it may have a positive impact on women but a neutral impact on men.		
Protected characteristic	**Characteristic Group**	**Impact of decision** Positive/Neutral/Negative
e.g. Sex	Women Men	Positive Neutral
Age	**None**	**None**
Disability	**None**	**None**
Gender reassignment	**None**	**None**
Marriage and civil partnership	**None**	**None**
Pregnancy and maternity	**None**	**None**
Race	**None**	**None**
Religion or belief	**None**	**None**
Sex	**None**	**None**
Sexual orientation	**None**	**None**

If there is insufficient evidence to make a decision about the impact of the policy it may be necessary to consult with members of protected characteristic groups to establish how best to meet their needs or to overcome barriers.	
Has there been specific consultation on this policy?	This policy will be reviewed by Staff Committee and circulated widely prior to approval. The Local Counter Fraud Service will also review the policy.
Did the consultation analysis reveal any difference in views across the protected characteristics?	

Mitigating negative impact: Where any negative impact has been identified, outline the measures taken to mitigate against it.	

Conclusion: Advise on the overall equality implications that should be taken into account by the policy approving committee.	It is believed that there is no discrimination through implementation of this policy.

Appendix 3 – Policy Implementation Plan

To be completed for each version of policy submitted for approval.

Policy Title:	Gifts, Hospitality and Conflicts of Interest
Version Number:	5.4
Director Responsible for Implementation:	Group Company Secretary
Implementation Lead:	Group Company Secretary

Staff Groups affected by policy:	All
Subsidiary Companies affected by policy:	None
Detail changes to current processes or practice:	Declarations will be made on Self Service (ESR).
Specify any training requirements:	None
How will policy changes be communicated to staff groups/ subsidiary companies?	Trust News • Notification of change to declarations on Self Service (ESR). • Policy update section following approval by the Trust Board.

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Nominations and Remuneration Committee (NRC)	**8 March 2022**	**Jane Ollis, Non-Executive Director (NED)**	**Board Support Secretary**	**Yes**	**~~No~~**
Appendices:	None				
Declarations of Interest made:					
The Committee Chair declared she was currently Interim Chair for 2gether Support Solutions (2gether).					
Assurances received at the Committee meeting:					

Agenda item 1 (NRC Decisions outside the Committee)	• The Committee received and **RATIFIED** the decisions taken outside the NRC business cycle as noted below:
	  • Extension of Jane Ollis' term as NED In-common for 2gether until a new NED In-common is appointed;
	  • Appointment to the role of Managing Director (MD) of 2gether;
	  • Extension of Phil Cave's (EKHUFT's Director of Finance and Performance) secondment to the interim MD role in 2gether to 28 February 2022;
	  • Appointment of Jackie Churchward-Cardiff (2gether NED) as interim MD for 2gether from 1 March to 30 April 2022;
	  • Appointment of Jane Ollis as interim Chair for 2gether from 1 March to no later than 30 April 2022.
	• The Committee received a verbal update from the Trust Chairman on progress of the recruitment of a Chair for 2gether, interviews have been held with experienced candidates. He expected to be in a position shortly to present a recommendation on this appointment for virtual consideration and decision by the Committee.				

Agenda item 2 (Board Skills, Experience and Competency Review)	• The Committee received, discussed and **NOTED** a report on the outcome of the review of skills, experience and competency of the Board. • The Committee noted there was further work required on the NED skills matrix prior to this being presented to the Council of Governors (CoG) NRC in respect of recruiting to the NED vacancy in respect of the strategic needs of this individual supporting the skills and experience on the Board. The Trust Chairman will have a discussion with the Director of Human Resources & Organisational Development (DoHR&OD), Group Company Secretary and Corporate Governance & Risk Consultant about the outcome of this review. In respect of reviewing the strengths, identifying any gaps, and the skills required by the NED vacancy. Feedback on the output from these discussions will be presented to the Committee and a proposal presented to the CoG NRC for the vacant NED recruitment.				
Agenda item 3 (Board Development Programme 2022/23)	• The Committee received, discussed and **APPROVED** the draft Board Development Programme for 2022/23, noting this is around the development of the Trust. • The Committee acknowledged this was an ambitious programme that will need to be robustly managed, the areas to be covered will be prioritised and it was agreed the top priority is around the Trust's culture improvement programme.				

	• The Committee noted the importance of obtaining input from the incoming Chief Executive Officer (CEO) when they are in post.
Agenda item 4 (NED Commitments)	• The Committee received and **DISCUSSED** a report about the current NED commitments. • The Committee **AGREED** Stewart Baird, NED, will continue in the role of NED Safeguarding Champion; • The Committee **NOTED** Jane Ollis, NED, currently covered the Well-Being Guardian role. • The Committee **AGREED** to further review the NED commitments in six months.
Agenda item 5 (Succession Planning Update 2022)	• The Committee received and **DISCUSSED** the first iteration of the Trust's succession plan that will be refined at a talent review workshop to be held with the Executive Team. A revised iteration of the plan will be presented to the Committee following the workshop. • The Committee noted the Chief Nursing Midwifery Officer (CNMO) was currently recruiting to her direct reports within the nursing structure. The Committee emphasised the importance of the Head of Midwifery role and this being appointed to substantively, noting the current interim cover and good work being progressed, discussions were taking place about when this role will be advertised.
Agenda item 6 (Extension of Fixed-Term Contract for Independent Ethics Adviser – Clinical Ethics Committee (CEC))	• The Committee received, discussed and **AGREED** to refer to the Chief Medical Officer, Chair of CEC, the decision on the extension of this contract for a further two-year period. The Committee decided this is an Executive decision to review the needs of the CEC as well as the time commitment required of this independent role on that Committee.
Agenda item 7 (Fit and Proper Persons Requirements (FPPR) Audit 2021/22)	• The Committee received and **NOTED** a report on the outcome of the annual FPPR audit and received assurance all Board Directors met the FPPR.
Other items of business	• The Committee **NOTED** the 2022 Annual NRC Work Programme. • The Committee **NOTED** a report on the Transition Plan for the incoming CEO will be discussed at the Closed BoD meeting to be held on the 10 March 2022.
Referrals to other Board Committees	There were no referrals to other Board Committees at this meeting.
Referrals from other Board Committees	There were no referrals from other Board Committees at this meeting.

East Kent Hospitals University NHS Foundation Trust

Items to come back to the Committee outside its routine business cycle:		
The Committee **AGREED** to further review the NED commitments in six months.		
Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
The Committee asks that the BoD **NOTE** this assurance report.	To Note	10 March 2022

NHS
East Kent Hospitals University
NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Charitable Funds Committee (CFC)	**8 March 2022**	**Jane Ollis, Non-Executive Director (NED)**	**Board Support Secretary**	**Yes**	~~**No**~~
Appendices:	None				
Declarations of Interest made:					
None					
Assurances received at the Committee meeting:					

Agenda item 1 (Application for Grant – ENT Video Examination Equipment (Queen Elizabeth the Queen Mother Hospital (QEQM))	• The Committee received and approved an application for Charity funding for the purchase of ENT Video Examination Equipment (new nasal endoscopes) for QEQM at a cost of £58,000. The Committee noted the funding source and the benefits of this equipment for patients as noted below:
	  • Enhanced diagnostics, more timely and accurate diagnosis of issues relating to the upper airway, improved patient treatment, experience and potential patient outcomes;
	  • Expansion of clinic provision at QEQM, in addition to clinics currently provided at Kent and Canterbury Hospital (K&C) and William Harvey Hospital (WHH);
	  • Removes the need for manual examination, provides clear video images without the need for clinician to physically examine in close proximity;
	  • Increase diagnostics rates where pre-cancerous conditions are present;
	  • Reduces risk of infection to both patient and clinician;
	  • Support early detection of airway issues and treatment;
	  • Removes repeated hospital visits for diagnostics;
	  • System will be used for rhinoscopy, nasopharyngoscopy, laryngoscopy and laryngostroboscopy;
	  • Reduces the need for patients having to travel to the clinics at K&C or WHH.				

Agenda item 2 (Application for Grant – Rehabilitation Patients' Chairs (Stroke Services)	• The Committee received and approved an application for Charity funding for the purchase of Rehabilitation Patients' Chairs for Stroke Services at a cost of £35,000. The Committee noted the funding source and the benefits for patients as noted below:
	  • Improve and enhance patient experience, the environment and patient outcomes;
	  • Facilitate rehabilitation for Hyper acute, acute and Neurology patients in the respective wards;
	  • Fully adjustable to suit individual patient needs, fully supportive, provide pressure relief, help with patient's balance, light and manoeuvrable with static stability, and easy to clean;
	  • Staff training will be provided on the use of the chairs;
	  • Facilitate recovery and encourage patients and the Members of Multi-Disciplinary Team (MDT) to participate in rehabilitation of the patient;				

	• Ensure prompt rehabilitation of patients to facilitate their return to the community; • Funding provision for a total of 18 smart modern rehabilitation transitioning chairs, replacing old and uncomfortable chairs. This will include the purchase of 17 Milano chairs and 1 Sorrento bariatric chair.

Agenda item 3 (Finance Report – Charity Expenditure and Income 2022/23)	• The Committee discussed and noted a report on the current financial position, income and expenditure of the East Kent Hospitals Charity (EKHC). The Committee received assurance of the Charity's financial position, achievement of its objectives and sustainability, and noted the following key elements (as at 31 January 2022):
	  • Fund Balances – £2.7m adjusted for commitments £2.1m;
	  • Cash position - £0.2m;
	  • Investments (portfolio) - £2.7m;
	  • Income 1 April 2021 to 31 January 2022 - £0.4m;
	  • Gains on Investments 1 April 2021 to 31 January 2022 £0.15m;
	  • Expenditure 1 April 2021 to 31 January 2022 - £0.8m of which:
	  • Grants to Trust 1 April 2021 to 31 January 2022 £0.6m with a further £0.55m committed.
	• The Committee noted the sale of legacy estate that named the Charity as the sole beneficiary restricted to the QEQM only.
	• The Committee noted the £200,000 potential grant for the Ophthalmology Openeyes system.
	• The Committee approved the Charity Financial Plan for 2022/23.

Agenda item 4 (Fundraising update and Fundraising Strategy)	• The Committee received and discussed a presentation providing an update and assurance of the work of the Charity and its fundraising activities, noting:
	  • Continued fundraising support from the Community including:
	  • Superhero walking challenge that raised £700 for the Special Care Baby Unit (SCBU);
	  • 24 hour pool challenge that raised over £2,500 for the Rainbow Ward;
	  • Kent Fire and Rescue Service in Margate raised £380 through their festive collection;
	  • Family from Folkestone raised £331 for the WHH Critical Care Unit (CCU) with a festive light display following the hospitalisation of a family member;
	  • Corporate supporters that the Charity continued to work closely with.
	  • Upcoming events: Brighton Marathon, Ride 100 and Virtual London Marathon;
	  • The successful marketing campaign, promoting the Charity and increasing awareness, with increased donations received;
	  • Positive impact during the festive period with visits from Choirs and Santa Claus, gifts of around £820 donated through the Amazon Wish List, tubs of Heroes donated by Morrisons that were distributed across the hospital sites;
	  • The 3 Wishes Project at the CCU at WHH that families have accessed bringing them enormous comfort. The project is being rolled out to the CCUs at K&C and QEQM.

	• The Committee received and discussed a presentation providing an update and assurance of the development work of the Fundraising Strategy, noting:
	  • The key strategic aims and objectives for the Charity for the next three year period 1 April 2022 to April 2025:
	  • Charity vision to support patients, visitors and staff. Promotion through strong internal links and partnerships across the community;
	  • Strategic aims to maximise charitable income and impact of grants;
	  • Key areas of focus: provision of contactless giving, enhanced branding and marketing, and upgrading the database system. Identify new major appeal project that will be linked to the Clinical Strategy focussed on cancer or other disease group, fundraising events and engagement.

Agenda item 5 (CFC Devereux Trust update)	• The Committee received and noted an assurance report on the Devereux Trust and the liability of its Trustees in respect of a property bequeathed to the Charity, and maintaining the property in the best interests of the tenant.
Agenda item 5 (Trust Policy Document: Use of Trust Facilities and NHS Staff time for Fundraising)	• The Committee received and approved the Trust Policy Document: Use of Trust Facilities and NHS Staff time for Fundraising.
Other items of business	There were no other items of business raised.

Items to come back to the Committee outside its routine business cycle:		
There was no specific item over those planned within its cycle that it asked to return.		
Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
The Committee asks the BoD to **NOTE** this assurance report from the CFC.	To Note	10 March 2022