Board of Directors Meeting - Open (Thursday 27 May 2021)

Thu 27 May 2021, 09:30 - 12:20

WebEx teleconference

East Kent Hospitals University NHS Foundation Trust

Agenda

09:30 - 09:30
0 min

Agenda

To Note

00 - Agenda - BoD Public - 27.05.21 FINAL.pdf (3 pages)

09:30 - 09:45
15 min

21/18
Chairman's welcome (09:30)

To Note *Chairman*

Verbal

09:45 - 09:45
0 min

21/19
Apologies for Absence

To Note *Chairman*

Verbal

09:45 - 09:45
0 min

21/20
Declaration of Interests

To Note *Chairman*

21-20 - REGISTER 2021-22 V22 - from May 2021.pdf (4 pages)

09:45 - 09:45
0 min

21/21
Minutes of Previous Meeting held on 29 April 2021

Approval *Chairman*

21-21 - Unconfirmed BoD 29.04.21 Public Minutes.pdf (13 pages)

09:45 - 09:45
0 min

21/22
Matters Arising from the Minutes on 29 April 2021

Approval *Chairman*

21-22.1 - Front Sheet Actions from Public Board.pdf (2 pages)
21-22.2 - Appendix 1 Public Board of Directors Action Log.pdf (2 pages)

09:45 - 09:50
5 min

21/23
Chairman’s Report (09:45)

Discussion *Chairman*

- 21-23 - Chairman Report May 2021 BoD.pdf (6 pages)
- 21-23.1 - Appendix 1 new NEDs Chairman Report May 2021 BoD.pdf (2 pages)

09:50 - 10:00
10 min

21/24
Chief Executive’s Report (09:50)

Discussion *Chief Executive*

- **Kent & Medway (K&M) System Partnership Working**

- 21-24 - CEO Report FINAL.pdf (5 pages)

10:00 - 11:00
60 min

21/25
Corporate Reporting (10:00)

Discussion

21/25.1
Integrated Performance Report (IPR) (10:00) 10 mins

Approval *Chief Executive/Executive Team*

- 21-25.1.1 - IPR Front Sheet 27.05.21 Board.pdf (3 pages)
- 21-25.1.2 - Appendix 1 IPR_v3.0_Apr21_final.pdf (24 pages)
- 21-25.1.3 - Appendix 2 We Care Harm Metric Review 210518 (002).pdf (3 pages)

21/25.2
Finance Report (10:10) 10 mins

Discussion *Director of Finance and Performance*

- **Month 1 Finance Report**

- 21-25.2.1 - FRONT SHEET M1 Finance Report 21-22 TB.pdf (3 pages)
- 21-25.2.2 - Appendix 1 Finance Performance Report April 2021.pdf (2 pages)

21/25.3
Board Assurance Framework (BAF) (10:20) 20 mins

Discussion *Group Company Secretary/Executive Team*

- 21-25.3.1 - Risk Board Paper V1.3.pdf (3 pages)
- 21-25.3.2 - Appendix 1 BAF Q1 2021 21.05.2021 docx.pdf (16 pages)

21/25.4
Infection Prevention and Control (IPC) Board Assurance Framework (BAF) (10:40) 5 mins

Discussion *Director of IPC/Chief Executive/Chief Medical Officer/Interim Chief Nurse*

- 21-25.4.1 - Front Sheet BoD IPC BAF 27_05_21.pdf (2 pages)
- 21-25.4.2 - Appendix 1 IPC BAF 18_05_21.pdf (40 pages)

21/25.5
Estates Statutory Compliance and Health & Safety (H&S) Update (10:45) 15 mins

Discussion *Intelligent Client/Managing Director - 2gether Support Solutions*

21-25.5 - Health and Safety Stat Compliance May 2021.pdf (4 pages)

11:00 - 11:10
10 min

21/26
Constitution Review - Council of Governors Recommendations (11:00)

Decision *Chairman*

21-26.1 - Board paper constitution review.pdf (2 pages)
21-26.2 - Appendix 1 Discussion Recommendations.pdf (9 pages)

11:10 - 11:20
10 min

TEA/COFFEE BREAK (11:10 - 11:20)

11:20 - 11:30
10 min

21/27
Finance and Performance Committee (FPC) – Chair Report (11:20)

Approval *Chair Finance and Performance Committee - Nigel Mansley*

21-27 - FPC Chair report May 2021.pdf (4 pages)

11:30 - 11:40
10 min

21/28
Quality Safety Committee (QSC) - Chair Report (11:30)

Approval *Chair Quality Safety Committee - Sarah Dunnett*

21-28 - QC Chair report May 2021.pdf (3 pages)

11:40 - 11:50
10 min

21/29
Strategic Workforce Committee (SWC) – Chair Report (11:40)

Approval *Chair Strategic Workforce Committee - Jane Ollis*

21-29.1 - SWC Chair Report FINAL.pdf (2 pages)
21-29.2 - Appendix 1 People Strategy v2.pdf (13 pages)
21-29.3 - Appendix 2 Slavery Human Trafficking Statement.pdf (2 pages)

11:50 - 11:55
5 min

21/30
Nominations and Remuneration Committee (NRC) – Chair Report (11:50)

Approval *Chair Nominations and Remuneration Committee - Sunny Adeusi*

21-30 - NRC Chair Report May 2021.pdf (2 pages)

11:55 - 12:05
10 min

21/31
Communications and Engagement Strategy (11:55)

Approval *Director of Communications and Engagement*

21-31.1 - Front sheet Comms and Engagement Strategy.pdf (1 pages)
21-31.2 - Appendix 1 Comms and Engagement Strategy 2020-2025 FINAL.pdf (22 pages)

12:05 - 12:10
5 min

21/32
Any other business (12:05)

Discussion *Chairman*

Verbal

12:10 - 12:20
10 min

21/33
QUESTIONS FROM THE PUBLIC (12:10)

Discussion *Chairman*

Verbal

Date of Next Meeting: Thursday 29 July 2021, as a WebEx teleconference

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

NHS
East Kent
Hospitals University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING – THURSDAY 27 MAY 2021

Please find attached the agenda for the next Board of Directors meeting. The meeting will take place **as a WebEx teleconference –** commencing at **9.30 am to 12.20 pm**.

This Board meeting is held in public and will be conducted in line with the Trust Values below:

People feel **cared** for as individuals

People feel **safe**, reassured and involved

People feel teamwork, trust and **respect** sit at the heart of everything we do

People feel confident we are **making a difference**

AGENDA

21/

OPENING MATTERS

18	Chairman's welcome		**09:30**	Chairman
19	Apologies for Absence			
20	Declaration of Interests			
21	Minutes of Previous Meeting held on 29 April 2021			
22	Matters Arising from the Minutes on 29 April 2021			

Our patients

Our people

Our quality and safety

Our future

Our sustainability

23	Chairman's Report	**Discussion**	**09:45** **5 mins**	Chairman
24	Chief Executive's Report • Kent & Medway (K&M) System Partnership Working	**Discussion**	**09:50** **10 mins**	Chief Executive

We care

25	Corporate Reporting		**10:00**	
	25.1 Integrated Performance Report (IPR)	**Approval**	**10:00** **10 mins**	Chief Executive/ Executive Team
	25.2 Finance Report • Month 1 Finance Report	**Discussion**	**10:10** **10 mins**	Director of Finance and Performance
	25.3 Board Assurance Framework (BAF)	**Approval**	**10:20** **20 mins**	Group Company Secretary/ Executive Team
	25.4 Infection Prevention and Control (IPC) Board Assurance Framework (BAF)	**Discussion**	**10:40** **5 mins**	Director of IPC/ Chief Executive/ Chief Medical Officer/ Interim Chief Nurse
	25.5 Estates Statutory Compliance and Health & Safety (H&S) Update	**Discussion**	**10:45** **15 mins**	Intelligent Client/ Managing Director – 2gether Support Solutions
26	Constitution Review – Council of Governors Recommendations	**Decision**	**11:00** **10 mins**	Chairman
	TEA/COFFEE BREAK	**11:10 – 11:20** **10 mins**		
27	Finance and Performance Committee (FPC) – Chair Report	**Approval**	**11:20** **10 mins**	Chair Finance and Performance Committee – Nigel Mansley
28	Quality Safety Committee (QSC) - Chair Report	**Approval**	**11:30** **10 mins**	Chair Quality Safety Committee – Sarah Dunnett
29	Strategic Workforce Committee (SWC) - Chair Report	**Approval**	**11:40** **10 mins**	Chair Strategic Workforce Committee – Jane Ollis
30	Nominations and Remuneration Committee (NRC) - Chair Report	**Approval**	**11:50** **5 mins**	Chair Nominations and Remuneration Committee – Sunny Adeusi
31	Communications and Engagement Strategy	**Approval**	**11:55** **10 mins**	Director of Communications and Engagement

CLOSING MATTERS

32	Any other business	**12:05** **5 mins**
33	**QUESTIONS FROM THE PUBLIC**	**12:10** **10 mins**

Date of Next Meeting: Thursday 29 July 2021 at 9.30 am, WebEx teleconference

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 MAY 2021

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
ADEUSI, SUNNY	Non Executive Director	Leadership role for Zimmer Biomet (global US medical device/technology corporation in Europe, Middle East & Africa (EMEA) Regional Commercial & Marketing) (started 16 September 2019) **(4)**	1 November 2015 (Second 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
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)** Non Executive Director of Beautiful Information Limited (started 3 November 2017) **(1)** **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	Acting Chief Operating Officer	None	1 November 2020 (Interim)

REGISTER OF DIRECTOR INTERESTS – 2021/22 FROM MAY 2021

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
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	Non Executive Director of Maidstone and Tunbridge Wells NHS Trust **(1)** Director of Catalyst (London) Ltd **(1)**	1 January 2021 to 31 May 2021 (Interim)
FULCI, LUISA	Non Executive Director	Director of Digital, Customer and Commercial Services, Dudley Council (started 6 April 2021) **(1)**	1 April 2021 (First term)
HOLLAND, CHRISTOPHER	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)** Member of Liberal Democrats, until 14 June 2020 **(6)**	Appointed 13 December 2019
IVANOV, TINA	Director of Quality Governance	None	10 May 2021
JOLLY, MARTIN	Non Executive Director	None	1 April 2021 (First term)
JORDAN, SIOBHAN	Interim Chief Nurse	None	1 December 2020 (Interim)

REGISTER OF DIRECTOR INTERESTS – 2021/22 FROM MAY 2021

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
MANSLEY, NIGEL	Non Executive Director	Chair, Diocesan Board of Finance (Diocese of Canterbury) (started 22 January 2018) **(1)** **Closed interests** Jeris Associates Ltd (started 1 July 2017/finished 26 January 2021) **(1) (2) (3)**	1 July 2017 (Second term)
MARTIN, REBECCA	Chief Medical Officer	None	Appointed 18 February 2020
OLASODE, OLU	Non Executive Director	TL First Accountants (started 4 January 2006) **(1)** TL First Consultants (started 4 January 2006) **(1)** Integrated Management Group (started 22 March 2001) **(1)** ICEHUB UK (started 11 September 2018) **(1)**	1 April 2021 (First term)
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)

REGISTER OF DIRECTOR INTERESTS – 2021/22 FROM MAY 2021

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
SHUTLER, LIZ	Director of Strategic Development and Capital Planning/Deputy Chief Executive	None	Appointed January 2004
YOST, NATALIE	Director of Communications and Engagement	None	31 May 2016

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

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

2gether Support Solutions Limited:
Jane Ollis – Non-Executive Director in common
Alison Fox – Nominated Company Secretary

Spencer Private Hospitals:
Sean Reynolds – Chair
Nic Goodger – Nominated Director
Heather Munro – Nominated Director
Alison Fox – Nominated Company Secretary

Beautiful Information Limited:
Philip Cave, Nominated Director
Paul Stevens, 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 & TENTH MEETING OF THE BOARD OF DIRECTORS THURSDAY 29 APRIL 2021 AT 9.30 AM AS A WEBEX TELECONFERENCE

PRESENT:

Mr N Dickson	Chairman	ND
Ms S Acott	Chief Executive	SAc
Mr S Adeusi	Non-Executive Director	SA
Mrs A Ashman	Director of Human Resources & Organisational Development	AA
Ms R Carlton	Acting Chief Operating Officer (COO)	RC
Mr P Cave	Director of Finance and Performance	PC
Ms S Dunnett	Interim Non-Executive Director (for minute number 21/12)	SD
Ms L Fulci	Non-Executive Director	LF
Mr M Jolly	Non-Executive Director	MJ
Ms S Jordan	Interim Chief Nurse	SJ
Mr N Mansley	Non-Executive Director	NM
Dr R Martin	Chief Medical Officer (CMO)	RM
Dr O Olasode	Non-Executive Director	OO
Mrs J Ollis	Non-Executive Director/Deputy Chairman	JO
Ms L Shutler	Director of Strategic Development and Capital Planning/ Deputy Chief Executive	LS
Mr B Wilding	Non-Executive Director	BW

ATTENDEES:

Mrs A Fox	Acting Director of Governance, Project Director Independent Investigation into East Kent Maternity Services, and Group Company Secretary	AF
Professor C Holland	Associate Non-Executive Director (NED)	CH
Dr N Wigglesworth	Director of Infection Prevention and Control (DIPC)	NW
Mrs N Yost	Director of Communications and Engagement	NY

IN ATTENDANCE:

Miss S Robson	Board Support Secretary (Minutes)	SR
Ms F Wise	Executive Maternity Services Strategic Programme Director/ Improvement Director, NHS England/NHS Improvement (NHSE/I)	FW

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mr J Appleyard	Member of the Public
Mr R Britton	Governor
Ms C Gregory	Member of the Public
Mrs C Heggie	Member of the Public
Mrs L Judd	Governor
Ms S Pettifer	Governor
Mrs P Pryer	Member of the Public
Ms C Ramsay	Member of the Public
Mr A Ricketts	Member of the Public
Mr B Rylands	Member of the Public
Mrs M Smith	Member of the Public
Mrs M Warburton	Governor

MINUTE NO.		ACTION
21/01	**CHAIRMAN'S WELCOME** The Chairman welcomed those in attendance noting his first Board meeting since commencing, stating it was a great privilege having been appointment as its Chairman.	

The Chairman welcomed three new NEDs, MJ, OO, and LF, noting interviews for two additional NEDs had recently been held including appointing to the Clinical NED role. It was hoped announcements about these appointments would be confirmed soon. He acknowledged the benefits of re-implementing face to face meetings when it was safe to do so, as well as being able to visit frontline staff and teams to support them and improve engagement and communications. He would be looking at holding a Board Away Day in the near future as a new Board and to discuss how it could support frontline teams across the hospital sites to transform its services.

The Chairman reported the sad news that Keith Palmer a former NED had died. Keith had been caring and compassionate and dedicated to the Trust as Chair of the Trust's Charitable Funds Committee he was passionate about the work of the Charity and the schemes it had funded.

The Chairman commented on the need to review the volume of papers received for Board meetings, while making sure the Board has access to the appropriate level of detail, to provide assurance and enable it to exercise its responsibilities and offer about robust and informed challenge and discussion.

The Chairman extended tribute to BW for his support during the six years as a NED acknowledging his term of office ended in early-May 2021. He thanked BW for his wisdom, experience and dedication to the Trust, its staff and the Board, wishing him well for the future.

21/02 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Ms S Dunnett, Interim NED, who would be joining the Board meeting for minute number 21/12 to present the Quality Committee Chair report.

21/03 **DECLARATION OF INTERESTS**

There were no new declarations of interest.

21/04 **MINUTES OF THE PREVIOUS MEETING HELD ON 11 MARCH 2021**

DECISION: The Board of Directors **APPROVED** the minutes of the previous meeting held on 11 March 2021 as an accurate record.

21/05 **MATTERS ARISING FROM THE MINUTES ON 11 MARCH 2021**

DECISION: The Board of Directors noted the updates about the open actions and **APPROVED** the three actions recommended for closure.

21/06 **CHAIRMAN'S REPORT**

The Chairman highlighted the new appointments to Board members as well as new Governors. This provided the opportunity to create a new future for the Trust, working with the executive team to empower frontline staff. He emphasised the importance of visiting staff, wards and teams on the front line, listening, engaging

and talking to staff that was highlighted as a key area from the disappointing staff survey results. Solutions and improvements would be fed from clinical front line staff supported by the Trust's We Care quality improvement (QI) programme. He recognised this was in its early stages of implementation and it was important this be rolled out as soon as possible across the whole of the organisation. He stated as the lockdown restrictions were eased he was keen for NEDs to be involved in the We Care Gemba Executive Director visits in the future as well as Governors. This would provide the opportunity to support ward to board communication, embedding continued learning and that staff felt they were being listened to.

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

21/07 **CHIEF EXECUTIVE'S REPORT**

- **KENT & MEDWAY (K&M) SYSTEM PARTNERSHIP WORKING**

SAc welcomed the Chairman and new NEDs and thanked JO for covering the Chairman role during the interregnum.

SAc highlighted key points:

- Congratulations to Chris Hamson, Deputy Head of Nursing for General and Specialist Medicine, awarded Chief Nursing Officer. A great nursing accolade acknowledging this impressive member of staff who continued to support staff particularly during the pandemic;
- Thanks to the Acting COO and all staff for their hard work, support and co-ordinated efforts ensuring the extended Easter plan worked well and services continued to operate during this very busy bank holiday period;
- Introduction of a We Care inspired development Hospital Out of Hours (OOH) project and team providing multidisciplinary framework for managing unstable and poorly patients outside of normal hours, improving handover and communication between teams in the day and night. This would be reviewed in time to assess its benefits and outcomes;
- Dr George Findlay, seconded to the role of Chief Executive Officer (CEO) at Medway NHS Foundation Trust (MFT), who had experience of the Trust's We Care QI programme and methodology of working. He would be looking at implementing a similar programme at MFT, supporting the Trust's and MTW's QI programmes across the local acute provider organisations;
- Positive and constructive feedback from the Care Quality Commission (CQC) inspection visits to the Emergency Departments (EDs). Recognition of the hard work and significant infection prevention and control improvements and practices, noting the Section 31 notice had been lifted;
- Continued good progress with the vaccination programme, the vaccination hub remained open with the provision of vaccinations over the Easter bank holiday period;
- Thanks to PC, the Finance team and Trust staff for their work and support achieving the positive report and 'Good' rating received in respect of Use of Resources.

LF congratulated the Trust, its staff and teams on its improving finance and performance position from an external perspective and being new to the Trust. She recently visited William Harvey Hospital (WHH) highlighting the great work of Trust

staff, particularly the Frailty Unit. She commented the opportunity and scope to work with Local Authorities in respect of the Hospital OOH project and looked forward to seeing information about its impact. SAc confirmed the role of the Frailty Unit and Hospital OOH project in supporting the elderly and reducing unnecessary admissions that had been vital during the pandemic. In response to a question raised by SA; SAc confirmed the joint appointment of a Director of Frailty across the Kent & Medway health organisations. This role supported integrated working about the treatment of frailty patients, providing guidance and support to staff ensuring patient focussed care. The Chairman emphasised the importance to consider the needs of patients and families, linking with community teams, and acknowledged the close working relationships between Trust clinicians and the community during the pandemic. He stated the importance of the East Kent Integrated Care Partnership (ICP) Board a key focus in respect of strategic working and was committed to continue building this positive relationship, in his role as its Chair.

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

21/08 **CORPORATE REPORTING:**

21/08.1 **INTEGRATED PERFORMANCE REPORT (IPR)**

SAc stated the presented refreshed IPR reflected the Trust's new approach to quality improvement and performance management ensuring focussed discussion at Board and Board Committees driving forward improvements in the key red areas.

PC commented sessions had been held with NEDs and Governors about this new reporting approach, in relation to the five True North Trust-wide strategic objectives, against breakthrough objectives driving rapid improvement, and monitoring of Watch metrics to ensure these did not deteriorate. The refreshed IPR had been presented and discussed at the meetings held that week of the Finance and Performance Committee and Quality Committee. Feedback from these meetings would be considered for future reports. Care Group performance was monitored through the Performance Review Meetings (PRMs) with dissemination of the IPR breakthrough objectives to be achieved by Care Group staff supported by We Care.

LF queried whether challenges of providing virtual appointments for children had been considered as providing these services to children was difficult. LS commented a detailed piece of work would be undertaken to review patients that had not been accessing face to face consultations. This review would cover all speciality outpatient appointments, consultant feedback on the benefits and how virtual consultations were working. She agreed to provide an update to Board on the progress of this review. It was noted that virtual appointments remained popular with patients.

ACTION: Provide a briefing to the Board to be appended to the actions table in July 2021 with an update on the review of patient consultations being accessed by telephone, video conference and face to face, and the advantages and disadvantages of virtual appointments. LS

OO suggested considering reverse stress testing (RST) that provided a framework identifying gaps and assurance about plans being embedded throughout the organisation and these being sustained.

JO enquired about the increased high demand previously seen in the number of patients presenting to the EDs with a mental health issue and whether the Trust was able to maintain meeting this demand and support these patients. RC reported the number of adult patients had stablished but there were continued large number of presentations of children. She confirmed a good escalation process was in place with Kent and Medway NHS and Social Care Partnership Trust (KMPT) and system partners that was working well. She agreed to provide an update at a future Board meeting about the position in respect of demand and numbers of patients.

ACTION: Provide an update to the Board in July 2021 about the position, performance and number of patients (adult and children) with a mental health issue presenting to the EDs, that this demand is being effectively managed and the escalation in place was working and being sustained. RC

JO raised concern about the number of patients waiting over 52 weeks and queried whether there was any additional work that needed to be done system wide supporting each other. She recognised the on-going work of the Care Groups to reduce waiting times and patient numbers. RC reported there had been a reduction in patient numbers. She highlighted the County level programme of work being progressed in respect of shared management of these patients to review and address access. She agreed to provide an update on progress of the programme to reduce patient waiting times and the number of patients waiting over 52 weeks at a future Board meeting.

ACTION: Provide an update to the Board in July 2021 about progress of the programme of work to reduce patient waiting times and number of patients waiting over 52 weeks. RC

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

21/08.2 **STRATEGIC RISKS REPORT**

AF reported the new risks tools report had been discussed at the Board Committees held that month and resulting feedback had been incorporated in the report presented. The only exception was the additional presentation of the workup of two specific Board Assurance Framework (BAF) risks and the corporate risk register example.

LF emphasised the importance that when reviewing risks there be real challenge and focus on what the complications were to address the controls and identify whether these needed to be changed. It was also vital not to use passive tense and to be clear about individuals responsible for risks and those with actions. AF confirmed going forward the causes would be clearly identified and linked to controls or gaps and actions. She commented a future risk session would be held with the Board.

OO supported the proposed format emphasising the importance of risk management that was a priority, enabler and an integral part of everyday operational management within the Trust that all staff needed to be aware of. AF commented positive input and engagement from Care Groups that needed to be

embedded in the wards and incorporated within business as usual to ensure the risk processes were adhered to.

DECISION: The Board of Directors reviewed and:

- **APPROVED** the risk tools designed to simplify the risk processes and enable capture and monitoring of key outcomes and shared learning;
- **AGREED** the approach for delivery of the next steps of the risk workstream.

21/08.3 **INFECTION PREVENTION AND CONTROL (IPC) BOARD ASSURANCE FRAMEWORK (BAF)**

SAc stated the contents of the IPC BAF had provided assurance about the activities and evidence against the IPC improvement plan.

NW confirmed the key updates:

- Reducing incidence of Covid;
- Weekly evidence returns on all aspects of IPC, very positive feedback from the CQC inspection at WHH site leading to the successful lifting of the previous CQC Section 31 Order;
- Remaining recommendations 'should dos' would be incorporated into IPC business as usual;
- Extraordinary work of all staff supporting the IPC improvements;
- Areas of excellence as well as areas requiring further improvement, Trust's ambition to be seen as one of the best trusts supported by We Care breakthrough objective driving forward continued and sustained improvements in IPC. Consideration of after action review evaluating actions had been sufficiently embedded;
- As the new DIPC he would be taking a wider look in relation to the organisation's buildings, environment, storage facilities in respect of IPC requirements, best utilisation of space and decluttering.

The Board of Directors discussed and **NOTED** the IPC BAF.

21/09 **CHIEF MEDICAL OFFICER'S (CMO) REPORT**

RM stated the Ethics Committee established with a purpose specifically in relation to Covid-19 supporting clinicians during the pandemic, the structure and function would be reviewed to develop and have a broader remit and not only Covid-19. This would include expanding its membership, reviewing Terms of Reference (ToR), and exploring joining the UK Clinical Ethics Network. She requested the Board support the proposed extension of the structure and function of the Committee going forward.

RM reported the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme year three requirements had been further updated in March 2021 in response to the impact of the pandemic. She confirmed the Trust was progressing well against the ten safety actions, herself and JO were reviewing the evidence in advance of the 15 July submission date, and would keep the Board up to date about the evidence reviewed.

The Chairman confirmed the Board was supportive in principle of extending the

broader remit of the Ethics Committee, and its agreement that Quality Committee (QC) have an overview of CNST.

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

21/10 **FINANCE AND PERFORMANCE COMMITTEE (FPC) - CHAIR REPORT**

- **MONTH 12 FINANCE REPORT**
- **FPC TOR**

NM highlighted the main points from discussions at FPC meeting held that week:

- Month 12 finance report noting the Trust achieved a £0.6m deficit in March 2021 resulting in a breakeven position for 2020/21;
- Main challenge spending its capital funding by year-end, on-going issue of having insufficient capital allocation and constraints to address the Trust's significant backlog maintenance programme;
- Positive outcome of the NHSE/I Use of Resources assessment rated as 'Good' the second highest rating. Thanks to all staff across the Trust for their supported and hard work;
- Highlight report about performance on the National Constitutional Standards and FPC would monitor performance against the ED 4 hour wait and focus on progress of the Restore and Recovery (R&R) programme;
- 2021/22 planning arrangements were being progressed following guidance for the first six months of this year.

The Chair questioned whether a contingency plan of capital schemes had been developed to be put in place towards the end of the financial year if additional funding was received. LS confirmed a list of contingency capital schemes was developed and submitted against a prioritisation programme for the Trust for consideration for additional capital funding allocation. She highlighted the challenge in being able to spend capital funding at the end of the financial year in January to March, particularly in relation to putting in place building works and that purchasing of equipment was easier to implement.

OO queried the potential overlap in the FPC ToR in reviewing finance and operational performance with QC. AF explained the role of QC to review performance in respect of safety elements, and FPC reviewing achievement against access targets and finance and operational performance.

LF highlighted areas for opportunities to submit for funding grants in respect of initiatives for climate change and 5G technology and whether this had been considered by the Trust. LS confirmed the Trust was working in collaboration with the company Breathe, business cases developed to install sustainable projects, i.e. solar panelling, LED lighting. Work had started to look at developing projects to be put forward for submission against Government grants. The IT team had been successful with submitting Government grants. She would have a discussion with LF outside the Board meeting about further possible grant opportunities.

DECISION: The Board of Directors discussed and:

- **APPROVED** the FPC Chair Report;
- **NOTED** the Month 12 Finance Report; and

- **APPROVED** the FPC ToR.

21/11 **MATERNITY IMPROVEMENT COMMITTEE (MIC) – CHAIR REPORT**

JO reported that the MIC had received a deep dive report about the actions implementing the Royal College of Obstetricians and Gynaecologists Report (RCOG) recommendations.

JO highlighted MIC's recommendation to the Board that oversight of the CNST actions was removed from MIC and revert to the QC for oversight.

JO confirmed next steps for MIC were to review the outstanding Regulator reports and seek assurance learning from these reports was embedded throughout the Trust within the Care Groups through its 'Business as Usual' arrangements.

The Chairman noted the on-going Independent Investigation into East Kent Maternity Services. He highlighted the improvements and work undertaken to date with regards to these critical services, the work of the MIC in developing an overall integrated action plan. The Trust was committed to continuing to take forward this improvement programme, assurance about the level of provision of these services and moving towards having in place excellent maternity services.

DECISION: The Board of Directors:

- discussed and **NOTED** the MIC Chair Report;
- **CONFIRMED** it felt sufficient assurance had been obtained in respect of the RCOG Report; and
- **AGREED** oversight of CNST actions move to the QC and were removed from the integrated plan.

21/12 **QUALITY COMMITTEE (QC) – CHAIR REPORT**

SD highlighted key areas, which included pressure ulcer (PU) and the work being done to identify PUs that had been acquired in the Trust's hospitals and those in the community. This was a specific focus for the Chief Nurse to address category 3 and category 4 PUs. The Committee would receive an update report at its next monthly meeting.

SD reported challenge in relation to implementation of The National Institute for Health and Care Excellence (NICE) guidance and the need to improve assurance of the processes in place. It was noted further work to be taken forward to ensure a robust and timely process was in place, the Trust was up to date with current NICE guidance and where appropriate this had been implemented.

The Chairman questioned whether anything additional needed to be done to improve the NICE guidance implementation process. SD reported QC received assurance this was a legacy related issue and the process had been reviewed and would receive an update on the improvement implemented. RM stated issues had been identified in respect of ensuring timeliness of implementation of guidance and assurance that every guidance had been reviewed and implemented if appropriate. She confirmed the K&CH Medical Director, experienced in these processes had been assigned the lead taking this improvement work forward. She assured the

Board during Covid a specific robust process had in place for Covid related guidance.

SD stated the QC ToR presented for Board approval following a review of its role and function. She extended thanks to the two NHSE/I Improvement Directors who had supported the review of the QC. She highlighted the Committee was in transition to align with the organisational structure around being clinically led and going forward triumvirate leads would be invited to attend QC meetings. This would support the organisation being clinically led and timely dissemination of information across the organisation to Care Groups and staff.

The Chairman commented QC had only been held on the Tuesday that week and the very tight turnaround to present written reports to the Board that was held in the same week. SD reported the importance of presenting and reviewing current information and trends, and that we should consider the timings of Committee meetings, noting there had been robust challenge by the QC on the data presented. The Chairman agreed current data needed to be presented but that it might be beneficial for Committee meetings to be held the week prior to Board meetings. SAc emphasised the timing of Committee meetings had been revised a lot over the last few years and the need to consider their output and the governance review before making any further changes.

SAc raised the need for Care Groups to have a focus on complaints and themes, the actions being put in place that included effective mediation, and queried the flow and review of this information. SD stated a Care Group template report had been developed for presentation to QC, providing direct challenge to Care Groups in respect of their accountability and ownership. The Chairman commented the benefits of NEDs being able to review complaints and identify any themes supporting the Trust as a learning organisation.

DECISION: The Board of Directors discussed and **APPROVED**:

- the QC Chair report; and
- QC ToR.

21/13 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR REPORT**

BW commented the Committee reviewed the new reporting format for the Trust's risk management process, noting it had been unable to review the updated risk register and progress on mitigating actions. LF questioned the timeframe expected to review the full risk registers. BW reported the Committee had been assured the populated risk registers and updated progress actions would be reported to the next monthly Committee meetings.

SAc emphasised the importance that risk register reports were functional discussions focussed on content, these incorporated sufficient progress on actions and assurance that these were being addressed to reduce the level of risk. The risk structure and processes were being reviewed, along with the governance structure in respect of ward to board supported by the new reporting format to ensure focus on risks, any identified gaps and areas to be addressed.

OO agreed on the need to focus on the content of the risk reports and was happy with the new reporting format emphasising that this needed to provide assurance to the Board that this new process was working. He commented the Committee were reassured of the work and actions to mitigate risks and that progress updates would be reviewed at the next Committee meeting.

OO reported he would be taking on the role of IAGC Chair following the departure of its current Chair, BW, and thanked him for his support to this Committee, to him during the transition and wished him well for the future.

DECISION: The Board of Directors discussed and **APPROVED** the IAGC Chair report.

21/14 **NOMINATIONS AND REMUNERATION COMMITTEE (NRC) – CHAIR REPORT**

SA reported the successful appointments made substantively to the Executive roles of Director of Quality Governance (DoQC) and Chief Nursing Officer (CNO). Noting Dr Tina Ivanov, DoQG, commencing on 10 May 2021, and Sarah Shingler, CNO, commencing on 7 June 2021. These were experienced and strong candidates, who joined the Trust from other provider organisations bringing with them a wealth of knowledge to the Trust and its Board. As a result of these and recent Board member appointments a review of the Board Development Programme would be undertaken.

DECISION: The Board of Directors discussed and **APPROVED** the NRC Chair report.

21/15 **CHARITABLE FUNDS COMMITTEE (CFC) – CHAIR REPORT**

SA highlighted the two applications for grants approving the purchase of equipment. These included Paediatric Laparoscopic Equipment at a cost of £36k, noting this represented a new service and an action for the CMO had been referred to QC to make sure a process was put in place ensuring appropriately trained and skilled surgeons used this equipment and undertook these procedures. Approval of £26k for the purchase of a Hamilton MRI T1 Ventilator for the Intensive Therapy Unit (ITU) at Kent & Canterbury Hospital (K&CH).

SA reported there had been a comprehensive presentation and good discussion about the charity's strategy going forward. This focussed on opportunities to increase donations and promote the Charity, as well as recognising the current environment and uncertainties with regards to fundraising and level of continued donations, and the potential impact on future spending and the need to be conservative when considering funding grants for approval.

DECISION: The Board of Directors discussed and **APPROVED** the CFC Chair report.

21/16 **ANY OTHER BUSINESS**

The Chair reported he had not received notice of any additional items of business for discussion.

SAc extended thanks to BW for his contribution as a NED and Board member, complementing the Board with his range of background and experience. He had provided robust and thought-provoking challenge, worked hard and supported the Trust and the Board to be better and function effectively. She wished him well and success in the future. The Chairman concurred with these comments and acknowledged BW's commitment and support to the Trust that was much appreciated. BW highlighted the improvements the Trust had achieved since he had been in post and emphasised the on-going QI journey. He felt this would be supported by the revised focus on risk management as well as the strengthened clinical involvement and input.

21/17 **QUESTIONS FROM THE PUBLIC**

Mrs Pryer as Secretary of Option 2 Group raised questions:

- When would the public consultation on acute hospital services end. The Chairman responded the public consultation timeframe was not yet known for the Pre-Consultation Business Case (PCBC) as this was being managed centrally. Work across the Kent & Medway system was on-going who were supportive of the need for a new hospital and the Trust continued to highlight this and the need for this to be taken forward at pace with support from local MPs and Governors, as well as vital public support. Noting legitimate views supporting option 1 and option 2. Once progress was confirmed an update would be announced. LS stated submission against PCBC stage 2 questions in respect of workforce and backlog maintenance with a process sign-off meeting to be held in May 2021.
- Whether there had been any adverse outcomes from the Stroke Services more to K&CH. RM stated this move had been taken to keep patients safe during the pandemic and having these central services had provided real benefits in the quality of patient care resulting in improved patient outcomes around rapid access to the required care and clinical and therapy treatment. LS confirmed work continued with the Sustainability and Transformation Partnership (STP) and Clinical Commissioning Group (CCG) about funding provision. A decision on the consultation was awaited from the Secretary of State expected in the next couple of months.
- If Board minutes of the previous meeting could be circulated earlier. AF confirmed previous minutes were published in accordance with the Trust's constitution and published with the meeting pack for the next Board meeting. Draft minutes were circulated to Board members following the meeting prior to the next meeting.
- Staff rewarded for work during the pandemic. PC reported staff had been awarded with an additional day's annual leave to be used as a health and wellbeing day, equating to a cost of around £1.5m.

Mrs Warburton commended the hard work of all staff during the pandemic and particularly in respect of achieving the Section 31 requirements. The Chairman acknowledged the significant IPC improvements and progress made to date, the Trust's continued improvement journey that was moving in the right direction acknowledging further work was required.

Mr Appleyard raised a number of points:

- Thanked front line and all Trust staff for their continued hard work and the Trust supporting clinicians in managerial roles;
- Congratulated the Chairman's appointment to the Trust extending support as the local British Medical Association (BMA) division chair, and welcomed the opportunity to meet. The Chairman welcomed this support and would look at scheduling a meeting;
- In respect of the key preferred option about the three site option, in driving forward with support from front line staff the development of fully integrated services across the three hospital sites and development of centralised integrated specialist services;
- The IIEKMS and reference to lessons learnt and themes from this investigation but that these had not yet been published publicly. The importance of being open in relation to learning. The Chairman stated the Trust was working closely with the Investigation team and keen to receive on-going feedback about areas of learning identified, acknowledging the significant improvement work already undertaken and actions to address the recommendations for Maternity Services. RM reported the Trust's commitment in respect of being open about actions, timely responding and addressing concerns raised, and recognised this had not previously been the case. She highlighted the changes that had been made in respect of leadership at Board level, within the Care Group, Maternity team and strengthening staffing resources. A focus and commitment putting patients at the centre of care, promptly addressing issues of concern, learning from complaints, investigation outcomes and resulting actions. Progress of the on-going improvement programme would be reflected in the wider We Care QI programme;
- We Care was a self-reflecting framework and the importance of being patient focussed and putting the patient first to support driving forward QIs. LS commented We Care was a comprehensive programme not just QI focussed but wider ranging to change the organisation culture in alignment with the Trust's priorities with a focus on our patients, our sustainability and our staff. Executive Directors were undertaking weekly Gemba visits to front line teams and staff, talking, listening and receiving feedback from staff about their suggested changes and improvements that were discussed at the weekly Executive Management Team meetings. The Chairman commented as lock-down restrictions were lifted he was keen that NEDs and Governors be involved in Gemba and hospital visits in the future.

Mr Rylands questioned reference to potential abuse of enhanced payments in relation to Covid-19 pandemic support on page 192 point 11 of the meeting pack enquiring how many suspected cases and what the value of these were. PC reported this related to two cases that had been dealt with internally in respect of enhanced overtime rate, these overpayments approximately just under £1,000 were being recovered.

Mrs Smith asked for consideration when meetings returned to be held in meeting rooms the provision of hearing loops (binary) that she had raised previously, as it was difficult for those hard of hearing to follow the discussions. LS commented the majority of the rooms meetings were held in had been converted to clinical areas. She acknowledged the importance of addressing this provision for meetings held in public that would be considered when re-introducing face to face meetings.

Mrs Pryer enquired who had been appointed as the Trust's Chief Nurse. SAc confirmed the appointment of Sarah Shingler.

The Chair closed the meeting at 12.20 pm.

Date of next meeting in public: Thursday 27 May 2021 as a WebEx Teleconference.

Signature _____

Date _____

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**27 MAY 2021**
REPORT TITLE:	**MATTERS ARISING FROM THE MINUTES ON 29 APRIL 2021**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: ACTIONS TABLE**

BACKGROUND AND EXECUTIVE SUMMARY

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 required to be updated on progress of open actions and to approve the closing of implemented actions.

The Board is asked to consider and note the progress updates in the attached action log (appendix 1).

The Board is asked to consider and approve the action noted below for closure:

Action No.	Action	Target date	Action owner	Status	Progress Note (to include the date of the meeting the action was closed)
B/017/20	Present a report to a future Board meeting providing an update on the collaborative work being progressed with the Clinical Commissioning Group and local partners to address the high numbers of walk in patients. Along with the work of the Trust to improve and reduce the number of Emergency Department patient unplanned re-	May-21	RC	to Close	Update on progress will be provided in the Integrated Performance Report (IPR). **Progress update report - May 2021** Progress update Collaborative work - The summer surge plan is being led regionally and the Trust is working with regional and local health economy colleagues to develop a plan which will include mitigations due to the lifting of restrictions and potential increased visitors to Kent during the summer period. Progress update Emergency Department unplanned re-attendances/re-admissions - A review is underway with initial findings

	attendances/re-admissions.				identifying an administrative process issue which is being addressed with the provision of a training programme.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The Board may lose sight of progress of key actions if the action list is not properly updated and maintained. The Trust Secretariat ensures there is an efficient process for maintaining the action list.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	None
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	None

PRIVACY IMPACT ASSESSMENT: NO	**EQUALITY IMPACT ASSESSMENT:** NO

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and **NOTE** the progress updates on the actions from the previous meeting, the actions for a future Board meeting and **APPROVE** the action recommended for closure.

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/017/20	11.03.21	20/174.1	Integrated Performance Report (IPR)	Present a report to a future Board meeting providing an update on the collaborative work being progressed with the Clinical Commissioning Group and local partners to address the high numbers of walk in patients. Along with the work of the Trust to improve and reduce the number of Emergency Department patient unplanned re-attendances/re-admissions.	May-21	RC	to Close	Update on progress will be provided in the Integrated Performance Report (IPR). **Progress update report - May 2021** Progress update Collaborative work - The summer surge plan is being led regionally and the Trust is working with regional and local health economy colleagues to develop a plan which will include mitigations due to the lifting of restrictions and potential increased visitors to Kent during the summer period. Progress update Emergency Department unplanned re-attendances/re-admissions - A review is underway with initial findings identifying an administrative process issue which is being addressed with the provision of a training programme.
B/018/20	11.03.21	20/174.2	Strategic Risks Report	Updates in risk registers to be identified in colour enabling prompt identification of changes made.	~~May-21~~/ Jul-21	AF	Open	Draft Board Assurance Framework risk register presented to April 2021 Board meeting. First revised version presented to May 2021 Board meeting. Updates and changes identified in the risk register in colour will be implemented for the report to be presented at the July 2021 Board meeting.
B/01/21	29.04.21	21/08.1	Integrated Performance Report (IPR)	Provide a briefing to the Board to be appended to the actions table in July 2021 with an update on the review of patient consultations being accessed by telephone, video conference and face to face, and the advantages and disadvantages of virtual appointments.	Jul-21	LS	Open	Action for future Board meeting.

B/02/21	29.04.21	21/08.1	Integrated Performance Report (IPR)	Provide an update to the Board in July 2021 about the position, performance and number of patients (adult and children) with a mental health issue presenting to the Emergency Departments (EDs), that this demand is being effectively managed and the escalation in place was working and being sustained	Jul-21	RC	Open	Action for future Board meeting.
B/02/21	29.04.21	21/08.1	Integrated Performance Report (IPR)	Provide an update to the Board in July 2021 about progress of the programme of work to reduce patient waiting times and number of patients waiting over 52 weeks.	Jul-21	RC	Open	Action for future Board meeting.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**27 MAY 2021**
REPORT TITLE:	**CHAIRMAN'S REPORT**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: NEW NON-EXECUTIVE DIRECTORS**

BACKGROUND AND EXECUTIVE SUMMARY

The purpose of this report is to:

- Report any decisions taken by the Board of Directors outside of its meeting cycle;
- Update the Board on the activities of the Council of Governors; and
- To bring any other significant items of note to the Board's attention.

Key Events:

1. **Board**

1.1 I am pleased to report that the Council of Governors has approved the appointment of three new Non-Executive Directors (NEDs), who will take up their posts next month. They are Dr Raymond Anakwe, Stewart Baird and Sarah Dunnett. A brief note with their backgrounds is attached as an appendix to this report. Sarah has been supporting us in an interim capacity since January 2021 and we are delighted she will be joining us as a substantive NED. She will continue to chair our Quality Committee.

1.2 In large part we now have a new Board and we are planning to have an early discussion on the priorities and ambition for the Trust and what we aim to achieve over the next few years. As a first step we will be holding a Board Development Day on 1 July with our next formal Board meeting on 26 July.

1.3 At the centre of our work must be an absolute commitment to support the organisation to transform the way we operate and create a culture in which every member of staff, whatever they do, feels valued, supported and empowered to speak up and engage. It also means acknowledging and learning when things go well and when they don't. And as we listen to staff, we must also listen to patients and their families and make sure they are shaping our services as they adapt and change to the new world in which we are operating. The *We Care* quality improvement programme will be vital in helping us deliver this and it is encouraging that some of the early work undertaken as part of the programme is already showing positive results.

1.4 I was delighted to take part in an all-staff webinar hosted by the Chief Executive, which was a great opportunity to speak to a large group of staff and to answer their questions. There was good discussion and the webinar can be accessed by staff using the weblink on the Trust's Staff Zone Monthly Webinar and The Leader - East Kent Hospitals University NHS Foundation Trust (ekhuft.nhs.uk). Visibility of all of us as leaders is going to be important and I know my non executive colleagues are also keen to

make themselves available to managers and frontline staff and to listen and learn from them.

1.5 I have reviewed membership of our Board Committees given the arrival of the three new NEDs at the beginning of April. We will further adjust with the further three new NEDs in June.

Finance and Performance Committee (FPC) Nigel Mansley (Committee Chair) Sunny Adeusi Martin Jolly	**Integrated Audit and Governance Committee (IAGC)** Dr Olu Olasode (Committee Chair) Sunny Adeusi Sarah Dunnett Jane Ollis
Quality Committee (QC) Sarah Dunnett (Committee Chair) Luisa Fulci Jane Ollis Professor Chris Holland, Associate NED (Attendee)	**Charitable Funds Committee (CFC)** Sunny Adeusi (Committee Chair) Luisa Fulci Nigel Mansley
Nominations and Remuneration Committee (NRC) Sunny Adeusi (Committee Chair) Niall Dickson (Chairman) Sarah Dunnett Luisa Fulci Martin Jolly Nigel Mansley Dr Olu Olasode Jane Ollis	**Strategic Workforce Committee (SWC)** Jane Ollis (Committee Chair) Sarah Dunnett Martin Jolly Professor Chris Holland, Associate NED (Attendee)

2. National Issues

The national financial planning guidance only covers the first half of the financial year 2021/22 and continues along the same lines as 2020/21. This means that there will be no NHS contracts and that the Trust will continue to receive a block payment. The planning process is designed to encourage us to collaborate with other players in Kent and support 'system working' and we are determined to play a key part in this collaborative effort. As expected, the big focus is on making sure that elective activity (out-patient appointments, day case surgery and inpatient surgery) is ramped up and that we start to tackle the massive backlog of need and long waiting lists that have built up during the pandemic. The payment mechanism is based on the run rate of Q3 2020/21. In addition, there is £1bn available nationally for providers to increase elective activity and reduce waiting lists; the target we are expected to meet as an Integrated Care System is 85% of 2019/20 activity by September 2021. We are using our own resources with the support of the independent sector to maximise elective activity. The Kent and Medway (K&M) system financial plan is that we will breakeven this year and the Trust is also planning to achieve that result. The Board will be kept up to date on performance against the money and activity through direct reports to the Board and its Committees.

3. **Pre-Consultation Business Case (PCBC) Clinical Support**

We continue to make progress in our efforts to secure the major capital investment required to modernise our services and provide sustainable and excellent care to the people of East Kent. Working with the Kent and Medway Integrated Care System (ICS) we have now provided all the information NHS England/NHS Improvement (NHSE/I) had asked for as part of the Stage 2 Assurance Process and it has been accepted, so this stage is now finished. We now await a decision as to whether we will be given the green light after so many years of frustration and neglect. If there is a positive response, we would then progress to consultation.

Over the last month we have been working with the ICS to support the case for capital funding. Clinicians across primary, community and secondary care have come together with a united voice calling on the government and NHSE/I to sanction the investment that is needed. We have had similar support from MPs, professional bodies and royal colleges, the County Council and local district councils. The proposals for change are compelling and have a solid evidence base; they will provide much needed certainty as we develop our services for the future. It is significant that for the first time, there is agreement across Kent that the current situation is untenable, that no change is not an option for east Kent and that as health and social care partners, we are united in the need for investment and that either of the two options would deliver significant and necessary benefits for local people. We will also be organising a meeting to galvanise further support from partners across East Kent working with the ICS and the Integrated Care Provider (ICP).

4. **Integrated Care Provider (ICP) update**

4.1 As the Board is aware I chair the East Kent Integrated Care Partnership Programme Board. We see this work as a key component in our objective to support integrated care throughout East Kent and to promote ourselves as a valued and supportive partner to all the agencies and organisations working in East Kent.

At last week's meeting of the partnership Board I stressed the importance of focussing on practical actions that we could take together both to support each other and to work together; actions that will have a direct and positive effect on the lives of people in East Kent. Our Chief Executive is leading on our first priority area for the ICP which is around creating a sustainable workforce across health and social care and promoting East Kent as a great place to live and work. The plan will have tangible goals so we can demonstrate the difference we are making as a system across East Kent.
To help inform the work of the ICP, NHS Elect was commissioned by NHSE/I to conduct a review of existing improvement plans in east Kent. The aim was to inform a Recovery Support Programme (RSP) and explore whether there were already East Kent priorities that could become a core focus for the RSP.

4.2 The review found that there was a great deal of analysis of local health and social care provision and commitment to system change by senior leaders within the local system. However, until recently, there was little evidence that this commitment had been followed up with co-ordinated and systematic planning across East Kent .

4.3 The key recommendations arising from the review were to :

- support the East Kent ICP as the engine room for creating a new future for East Kent;
- invest in the ICP priorities;
- focus on providing support and expertise to deliver the priorities.

4.4 The next step will be to agree timeframes and deliverables, including how we translate the priorities into detailed, trackable plans with outputs/outcomes that can be evidenced.

4.5 An update on the Kent and Medway ICS, which will again become a much larger part of our lives at the Trust, is covered in the Chief Executive's report.

5. **Visits and meetings**

5.1 In the last couple of weeks I have visited our cancer services at Kent and Canterbury Hospital (K&CH), as well as the frailty unit, intensive care unit and operating theatres at William Harvey Hospital. I have also seen the Urgent Treatment Centre (UTC) operation at William Harvey which works alongside our Emergency Department and met members of the Board of the alliance which is responsible for the service together with our staff working with and supporting the UTC. This is a critical initiative alongside both our EDs and will be vital in helping us manage the inexorable rise is demand.

5.4 Since the last Board meeting I have met with:

- 2gether Support Solutions (2gether) Chairman
- Council of Governors' Lead Governor
- Fundraising Manager and Fundraising and Development Officer from East Kent Hospitals Charity
- Individual meetings with NEDs and executives
- KPMG consultants regarding the Trust's We Care quality improvement programme
- NHSE/I's Regional Director (South East)
- NHSE/I's National Director (Primary Care, Community Services and Strategy)
- NHSE/I's Locality Director
- NHSE/I's Director of Communications
- NHSE/I's Head of Culture Transformation
- NHS Kent & Medway (K&M) CCG's Accountable Officer
- Secondary Care Doctor from South Kent Coast CCG
- Kent Community Health NHS Foundation Trust's Chairman
- South East Coast Ambulance Service NHS Foundation Trust's Chairman
- Canterbury Christ Church University's Vice-Chancellor & Principal
- Professor of Cancer Medicine from the University of Oxford/Honorary Consultant Medical Oncologist at Oxford Cancer Centre

5.5 The Trust marked the International Day of the Midwife, International Nurses' Day, and Operational Department Practitioners (ODPs). Teams held their own celebrations and we held a Trust-wide staff webinar for International Nurses' Day. These have been opportunities to reflect on and recognise the dedication, commitment and contribution of our staff during the pandemic.

6. **Council of Governors**

I chaired my first meeting of Council on 20 May. There were elections in February for both staff and public governors and a new appointment for the Partner Governor representing volunteers. There is now a good mix of governors new to the role and those with experience, some of whom have served in other organisations.

There was a good representation from the Board, with both execs and NEDs present. Council heard presentations from the Chief Executive on the Trust's overall position, the Director of Finance and Performance on last year's performance and prospects for this coming year and the Director of Strategic Development and Capital Planning gave an update on the progress of the Pre-Consultation Business Case (PCBC) for capital investment. The Chief Medical Officer (CMO) also gave an update on maternity.

Council decided to increase to four their Committees creating a new Staff and Patient Experience Committee. Council also agreed a meeting schedule and annual workplan and there was enthusiasm at the prospect of resuming site visits. I indicated that I was keen to see a full programme of visits set up as soon as Covid restrictions allowed, and for these to involve Executive Directors, NEDs and Governors.

Council debated proposals from its Constitution and Policy Review Group and its recommendations are on the agenda of this meeting for the Board to consider.

Council also agreed the role description for their Lead Governor and Deputy Lead Governor positions and election process for these roles is now underway. I have a fortnightly meeting with the Lead Governor and we are planning regular short briefing sessions for Governors to keep Council informed.

Non-Executive Directors' (NEDs) Commitments

A brief outline of the NEDs' commitments are noted below:

Chair	6 May – NED/Lay and Elected Member Workshop – Developing the K&M ICS 7 and 21 May – K&M Chairs' fortnightly meeting 11 May – East Kent (EK) ICS/Sustainability and Transformation Partnership (STP) Board meeting 17 May – NHS Reset Chairs' meeting 20 May – CoG meeting 20 May - Chairing East Kent Integrated Care Partnership (ICP) Board meeting Visits to WHH and K&CH
Non-Executive Directors	4 May – NRC meeting 6 May – NED/Lay and Elected Member Workshop – Developing the K&M ICS 6 May – 2gether Board of Directors meeting 20 May – CoG meeting Clinical Negligence Scheme for Trusts (CNST) Evidence Review meeting

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	None
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**

East Kent Hospitals University NHS Foundation Trust

LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	None
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	None

PRIVACY IMPACT ASSESSMENT: NO	**EQUALITY IMPACT ASSESSMENT:** NO

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and **NOTE** the Chairman's report.

East Kent Hospitals University NHS Foundation Trust

NEW NON-EXECUTIVE DIRECTORS (NEDs)

Raymond Anakwe MB ChB, DMCC, MFSTEd, FRCS Ed(Tr&Orth), RAMC

Raymond is a Consultant Trauma and Orthopaedic surgeon at St Mary's and Charing Cross Hospitals Imperial College Healthcare NHS Trust in London, with expertise in surgery of the hand, wrist and elbow as well as the treatment of trauma. He is also currently the Associate Medical Director. He has worked with the Defence Medical Services, and also served as a Medical Officer in the Royal Army Medical Corps and as a Regimental Medical Officer.

Raymond has extensive leadership experience during his career with the Defence Medical Services and in the NHS. He has gained considerable practical experience in both staff and logistic management. As well as leading and managing people, teams, resources and projects in various roles throughout his career, along with formal leadership programmes of training. He has extensive experience of leading and chairing groups, as well as broad experience of working with boards and executive teams.

Raymond has developed a focus and experience around quality of care and a portfolio of experience that includes education and training, workforce development and staff well-being, professional development, appraisal and revalidation, patient safety and safety improvement as well as clinical audit, effectiveness and assurance. He values kindness, respect, a sense of duty, collaboration and inclusion. He is driven to continually learn from those around him and to improve the quality of care delivered. He has a strong interest in education, and is committed to the development and delivery of surgical training. He has published original research.

Stewart Baird

Stewart is the Chief Executive of a private investment house, with a wealth of non-executive experience, supporting the Board of Directors of numerous unique and diverse companies. His role includes supporting the senior leadership teams in the formation and execution of their strategies as well as enabling them to embrace the 'what could be' in developing their business vision.

Stewart is a coach and mentor, with a strong background in large multi-cultural organisations, previously holding executive roles with companies including Virgin and Eurostar, as well as more recently experience in the SME sector.

Stewart is a Trustee with Kent Search & Rescue. He has exceptional communication and influencing skills, working with a diverse range of stakeholders. He is committed to ensuring strong governance exists as well as helping shape the culture and strategic planning.

Stewart has extensive leadership experience, with a strong drive to 'make things better' and to see the possibilities beyond the present. With a strong focus on performance, having clear goals and building environments that are welcoming and challenging.

Sarah Dunnett OBE

Sarah has been supporting the Trust in an interim capacity since January 2021 and will be joining as a substantive NED. She will continue to chair the Trust's Quality Committee.

Sarah has sound business background in the commercial sector with senior management experience in the oil industry. She is an experienced and energetic NHS NED, and provides incisive challenge and is robust in seeking assurance. She has strong leadership, high visibility and effective partnership working.

Sarah is a strategic thinker with a strong grasp of the current health and care agenda, and is passionate about the provision of high quality, safe clinical services for patients and a supportive working environment where staff thrive and strive for excellence.

Sarah is a NED at Maidstone and Tunbridge Wells NHS Trust, is the Vice Chair, chair of the Quality Committee, and Vice Chair of the Finance and Performance Committee and the Charitable Funds Committee. She attends meetings of the People and Organisational Development, and Audit and Governance and Remuneration Committees.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**27 MAY 2021**
REPORT TITLE:	**CHIEF EXECUTIVE'S REPORT**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**CHIEF EXECUTIVE**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

1. Operational Update

The Restore & Recovery (4R) programme has recently completed a significant piece of work aligning our high volume, non-complex pathways with the Getting it Right First Time (GIRFT) best practice metrics. This will provide a dashboard and support improvements for patients in this group who are not clinically most urgent but for whom long waits can be distressing and problematic. We continue to make good progress in reducing our longest waiting patients and expect to have all theatres fully operational in June.

In emergency care demand has risen 45% since December 2020 with ambulance attendances rising 12% since December 2020. Despite this, performance has improved in Majors – a key to overall improvement. Overall performance has risen to 84.4% and developing the Emergency Village is improving and reducing exit block. An important metric to support improvements in patient flow is bed occupancy which is reduced, along with a significant increase in the use of the Discharge Lounges which has allowed a better match of discharges to admissions. The Urgent Treatment Centre (UTC) has increased its share of the work in Emergency Department (ED) to just over 30% and with the demand profile for this service increasing we are working with commissioners to ensure we have sufficient support and capacity across the patch to help manage this demand.

Cancer services are now delivering 62-day performance and a further reduction in longer waiting patients on complex and tertiary pathways has been delivered. We are now consistently delivering the 2 weeks wait performance standard Maintaining access to diagnostics is key and we continue to work with system partners developing ideas for a rapid implementation of a community diagnostic hub.

We Care Frontline teams are making good progress in their training and on Kings C2 ward their improvement driver is falls. They have only had 1 fall since the 26 March – great work by the team. Cambridge J1's driver metric is discharges and they are measuring EDN completion. They had a target of 85% of EDNs to be completed by 2pm. In April 96% of their EDNs were completed by 2pm – a great effort made by the junior doctors.

2. Single Item Quality Surveillance

The Trust is working closely with its regulators on its improvement plan for maternity. A single item quality surveillance meeting was held recently. We updated our regulators on the implementation of the Integrated Action Plan, progress on the Clinical Negligence Scheme for Trusts (CNST) requirements for the saving babies' lives bundle which will be complete by July and Board oversight via both the quality committee and the maternity improvement committee.

We are carrying out further work focussing on culture, multi-disciplinary working and communication and bringing forward the care groups involvement in the Quality Improvement Programme We Care, as a way of further involving front line staff.

As part of their work focussing on governance and assessment of quality risks, our newly appointed Director of Quality Governance is also carrying out a review of the skills, systems and guidance used in identifying and addressing risks in the service.

3. Integrated Care System (ICS) Update

At its meeting in March, the ICS Partnership Board approved a programme of engagement to consider partners' views regarding six primary topics, relating to both ICS end state and transitional governance arrangements. These were:

1. **Decision making and accountability;** There is a strong sense for the need to have a clear and simple articulation of the role and functions of the system, place and other partner bodies, with clearly defined expectations and agreement of what is and isn't "in scope".

2. **Clinical and professional leadership;** There is a common view that clinical and professional leadership is critical to system improvement and deliver, with clinical leadership encompassing the wider clinical community including related professions such as nursing, pharmacy, Allied Health Professionals (AHPs), social care and public health.

3. **Patient and public engagement**; Engagement with patients and members of the public should take time and effort and more focus needs to be given to hard-to-reach (engagement) groups, including children, young people and families, armed forces/veterans as well as the routinely identified hard-to-reach groups.

4. **The role and development of Primary Care Networks (PCNs);** Primary care needs a single voice at both system and local levels and needs supported development to enable this. There should be an updated primary care strategy at system level that encompasses the whole of the primary care agenda.

5. **The role and development of Integrated Care Providers (ICPs)**; There does not appear to be any appetite at this stage for ICPs to become formal Integrated Care Organisations, and whilst there will need to be consistency in terms of decision making, accountability and assurance, the ICP framework should be permissive and not prescriptive. ICPs should be responsible for setting local priorities and local population health outcomes, as well as planning for local populations.

6. **The role and development of provider collaboratives**; There is general agreement that collaboratives offer an opportunity for providers to deliver improved services, patient experience and deliver efficiencies in workforce, finance and structural change, and that individual providers are not able to achieve these in isolation.

Engagement with partners is now well underway and an Executive to Executive meeting between the Trust and the ICS is taking place in the near future and the engagement process with all partners is expected to be completed in May.

4. Clinical Executive Management Group (CEMG)

Business Cases APPROVED or recommended at the 12 MAY meeting of the CEMG included:

- Digital Histology.

Other Items of Note from CEMG

- The Strategic Outline Case (SOC) for the re-provision of oncology services was discussed and noted.
- The Violence and Aggression Policy/Issuing of Yellow Card Warnings and Red Card Sanctions Procedure Document was approved.
- The 4R Programme (the Trust response to the Covid19 Wave 2 Recovery Programme) was discussed and noted.
- The Group noted a summary of the background of the national GIRFT programme together with an update with regard to recent national and regional work, as well as the approach to GIRFT within EKHUFT.

5. Care Quality Commission (CQC) Update

The CQC has now published reports showing improvements to the performance of our emergency departments and recognising the commitment of our staff. The CQC inspected the departments in March, to assess the impact of winter pressures and Covid-19 on our urgent and emergency care services. The inspection team found the departments controlled infection risk well, with staff using equipment and control measures to protect patients, themselves and others from infection. Equipment and the premises were visibly clean. They found staff were focused on the needs of patients receiving care and the departments had an open culture where patients, their families and staff could raise concerns without fear.

Staff have worked hard to give patients the best possible urgent and emergency care during the extraordinary circumstances of the pandemic and I am pleased their hard work has been recognised in the CQC's reports.

6. Staff Update and Welcome

Director of Quality Governance

Tina Ivanov the Trust's new Director of Quality Governance, commenced her employment on 10 May; she is most welcome.

7. Webinar

On 6 May, I hosted a webinar which gave staff the opportunity to hear from our Chairman, Niall Dickson, as well as from staff on Kings C2 who've used 'We care' to make significant improvements in the number of falls on the ward. 'We care' is about being clear about what we want to focus on and why, and supporting staff to make real improvements, by training, coaching and all of us using one, standard method to make real improvements. It was great

to meet everyone and see for myself how the embedding of We Care is having such positive outcomes for patients.

8. New Elective Orthopaedic Centre

On 20 April, I held a podcast about the new Elective Orthopaedic Centre being built at the Kent and Canterbury Hospital. I spoke with Consultant Orthopaedic Surgeon Omar Yanni, General Manager Julia Blackwood and Orthopaedic Theatre Coordinator Kylie Brown about how the centre has come be and how they saw the opportunity in the national 'Getting it Right First Time' pilot to make a difference for their patients by protecting elective orthopaedic work from delays due to emergencies.

The centre, due to open this summer, contains four new operating theatres dedicated to patients needing planned inpatient orthopaedic operations, such as hip and knee replacements. Not only will this be a fantastic facility for patients and staff, it will be vital extra theatre capacity for these patients. I look forward to the opening – and a huge thank you to the theatre teams, ward teams and support services for all the work they are doing to get it ready.

9. Dying Matters Week

The week of 10 May was Dying Matters Week; a week designed to encourage people to talk about death, dying and bereavement. Throughout the week I encouraged everyone to get involved. Two events were organised by our partners across Kent that EKHUFT staff were invited to attend, designed to help us understand end-of-life care from the patient perspective and to think about the conversations we have with patients about death.

To help raise awareness of how everyone who works at East Kent Hospitals has a part to play in delivering the very best care at the end of life, the Trust supportive and palliative care team is producing an end-of-life care awareness training video, suitable for all staff, which will soon be available on Electronic Staff Record (ESR).

10. National Updates

Latest national updates are as follows:

International Nurses Day - NHS England » Thousands of new recruits join the health service as NHS marks International Nurses Day

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	None
LINKS TO STRATEGIC OBJECTIVES:	**We care about...** • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	The report links to the corporate and strategic risk registers.
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

East Kent Hospitals University NHS Foundation Trust

SUBSIDIARY IMPLICATIONS:	None

PRIVACY IMPACT ASSESSMENT: NO	**EQUALITY IMPACT ASSESSMENT:** NO

RECOMMENDATIONS AND ACTION REQUIRED:

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)**
DATE:	**27 MAY 2021**
REPORT TITLE:	**INTEGRATED PERFORMANCE REVIEW (IPR)**
BOARD SPONSOR:	**DIRECTOR OF FINANCE AND PERFORMANCE**
PAPER AUTHOR:	**DIRECTOR OF FINANCE AND PERFORMANCE**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: APRIL 2021 IPR** **APPENDIX 2: ADDITIONAL WATCH METRICS**

BACKGROUND AND EXECUTIVE SUMMARY

The Trust has been engaged with a new quality improvement programme called “We Care”.

The system is a trust-wide change that introduces a daily continuous improvement approach throughout the organisation, from front-line to Board. It is based on proven methodology that has a history of success in North America and in the NHS. Among the NHS trusts is Western Sussex and Brighton Trusts (now Sussex Hospitals) who have seen a shift in their Care Quality Commission (CQC) rating from Inadequate to Good.

The premise is that the Trust will focus on fewer metrics but in return will expect to see greater improvement.

This refreshed IPR reflects the new approach to quality improvement and performance management and provides the Board with a strategic overview of performance.

True Norths are the Trust wide key strategic objectives which it aims to have significant improvements on over the next 5 years. The areas are:

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

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

Breakthrough objectives are objectives that we are driving over the next year and are looking for rapid improvement. The key areas are:

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

Teams focus on a small number of breakthrough objectives that will make the biggest difference to our patients and staff and will drive us to achieve our 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 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.

There are five additional watch metrics that are requested by the Quality Committee as outlined in Appendix 2:

- Total Clinical Incidents Reported in month;
- Serious Incidents Declared in month;
- Never Events Declared in month;
- Maternity Serious Incidents Declared in month;
- Duty of Candour.

The Board are asked to **APPROVE** the additional metrics.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risk 1. The scorecard does not capture an accurate view of Performance for the Board. Mitigation 1. We've spent a long time agreeing with the subcommittees the level of detail contained within the scorecard, undertaken the catchball session with the Board and this discussion constitutes the next level of engagement to ensure when we go live the scorecard does accurately reflect performance. Risk 2. Perception/reputational risk with information provided without context. Mitigation 2. As the scorecard goes live a series of contextual reports will come to the Board to explain these areas.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	CRR47: Infection Prevention Control (IPC). CRR68: Constitutional Standards. CRR77: Maternity Services. CRR84: Deteriorating Patient. CRR87: Hospital. BAF30: Benefits of We Care. BAF29: Positive Culture.
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Finance and Performance Committee (FPC)/Quality Committee (QC) 25/05/21

East Kent Hospitals University NHS Foundation Trust

SUBSIDIARY IMPLICATIONS:	The Trust is working with its subsidiaries to involve them in We Care.

PRIVACY IMPACT ASSESSMENT: *NO*	**EQUALITY IMPACT ASSESSMENT:** *NO*

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to **CONSIDER** and **DISCUSS** the True North and Breakthrough Objectives of the Trust.

The Board of Directors is asked to **APPROVE** the five additional watch metrics to be formally added for the May 2021 IPR.

NHS
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NHS Foundation Trust

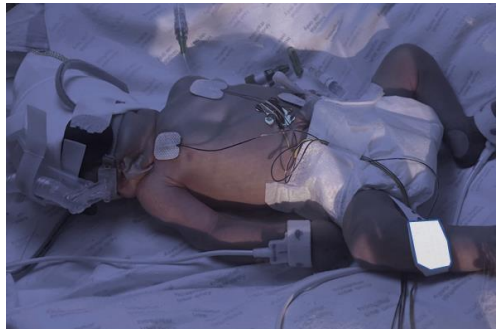
Integrated Performance Report

April 2021







We care

Our vision, mission and values

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

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

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

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

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

For the next five years, our strategic focus centres on five themes:

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

What is the Integrated Performance Report (IPR)?

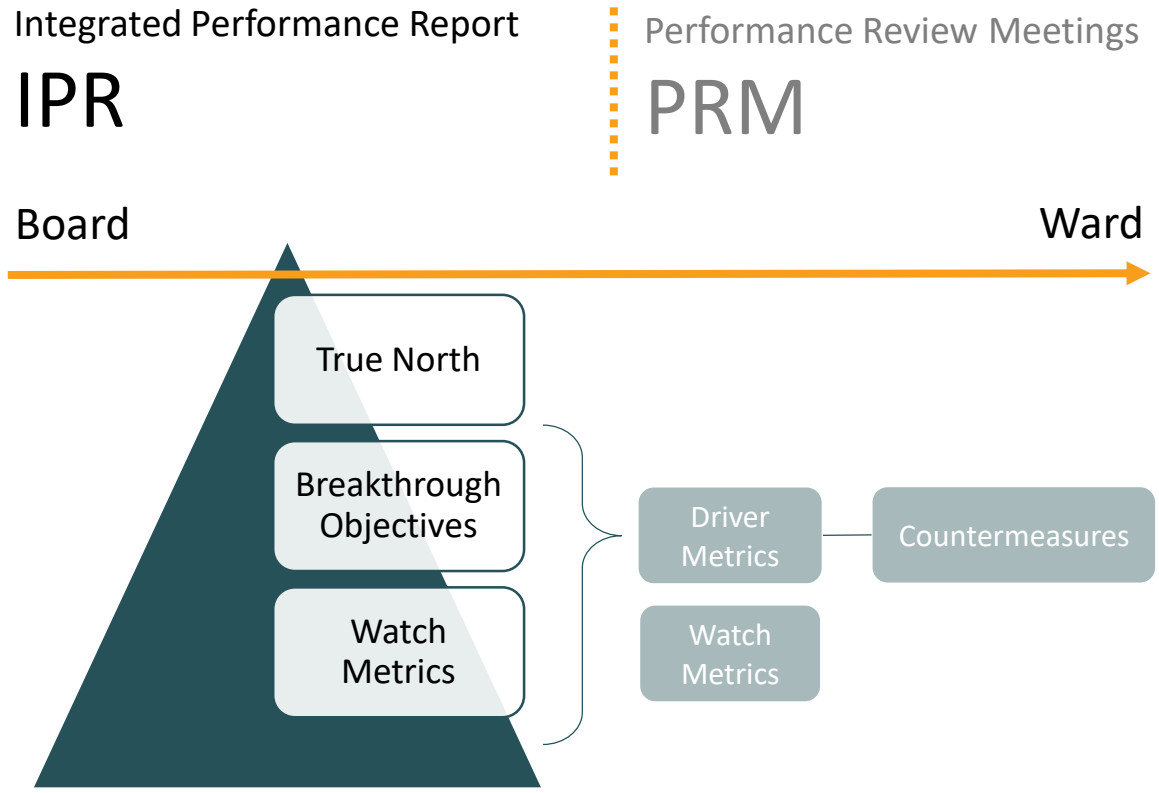
To turn these strategic themes into real improvements, we're focusing on five key objectives that contribute to these themes for the next year.

- Reducing falls
- Reducing healthcare acquired infections
- Reducing deaths from sepsis
- 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 we can make the most significant improvements by focusing our efforts. We'll also use data to measure how much we're making a difference.

Frontline teams will lead improvements in these areas of focus. They will be supported by our Improvement Office, which will help give teams the training and tools they need, and 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.



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.

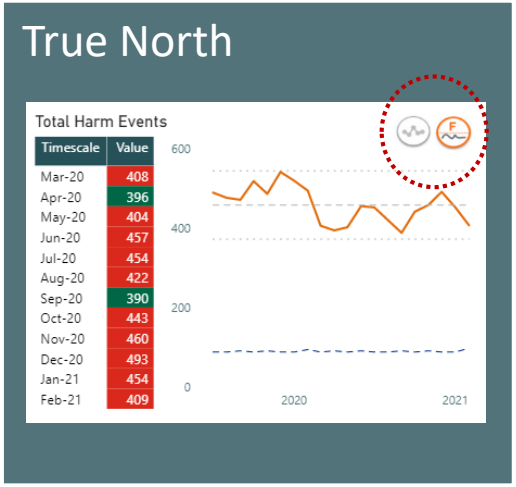
If data point falls outside these levels, an investigation would be triggered.

It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (ie 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

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)

East Kent Hospitals University NHS Foundation Trust

Our Quality & Safety

Siobhan Jordan

Rebecca Martin

Incidents Potentially Contributing to Harm
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.

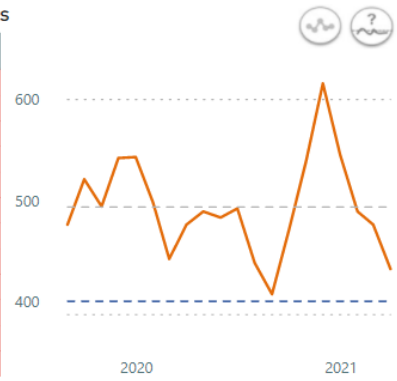
Mortality (HSMR)
Mortality metrics are complex but monitored and reported nationally as one of many quality indicators of hospital performance. While they should not be taken in isolation they can be a signal that attention is needed for some areas of care and this can be used to focus improvement in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

Our aim is to reduce mortality and be in the top 10% of all Trusts for the lowest mortality rates in 5 to 10 years.

Incidents Potentially Contributing to Harm
To achieve and sustain zero avoidable harm.

Total Harm Events

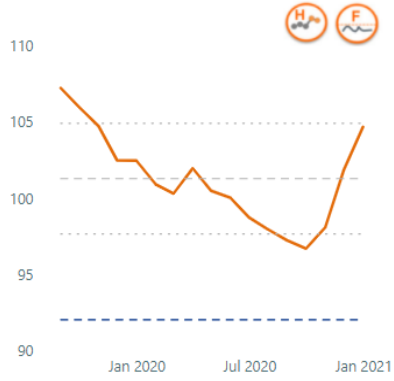
Timescale	Value
May-20	489
Jun-20	483
Jul-20	492
Aug-20	438
Sep-20	407
Oct-20	470
Nov-20	539
Dec-20	616
Jan-21	545
Feb-21	489
Mar-21	476
Apr-21	432



Hospital Standardised Mortality Ratio (HSMR)
To reduce our Hospital Standardised Mortality Ratio and be in the top 10% of all Trusts.

HSMR

Timescale	Value
May-20	100.5
Jun-20	100.0
Jul-20	98.7
Aug-20	97.9
Sep-20	97.2
Oct-20	96.7
Nov-20	98.1
Dec-20	101.9
Jan-21	104.7
Feb-21	
Mar-21	
Apr-21	



Executive Summary

NHS
East Kent Hospitals University
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Our Patients

Rebecca Carlton

Trust Access Standards (Cancer, RTT & ED)
It is poor patient experience to wait longer than necessary for treatment and failure against these key performance standards is a clinical, financial and regulatory risk for the Trust.

The Trust has struggled to achieve consistently the national access standards for ED, RTT and Cancer, for a number of years. It is therefore important that these form a key part of our True North strategy for the coming years.

Siobhan Jordan

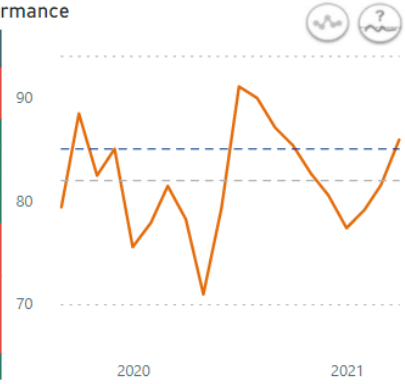
Patient Experience (FFT)
The Family and Friends Test is a national measure which confirms how likely patients are to recommend the Trust as a place for treatment. This data collection incorporates a scale for quantitative analysis and an area for free text comments and is gathered on a monthly basis.

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.

Cancer 62 Day
To achieve and sustain 85% performance for patients on a Cancer pathway.

Cancer 62d Performance

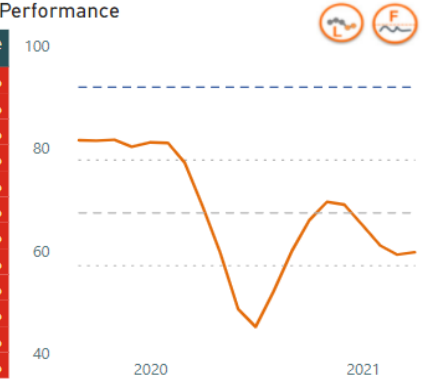
Timescale	Value
May-20	70.9%
Jun-20	79.2%
Jul-20	91.1%
Aug-20	90.0%
Sep-20	87.1%
Oct-20	85.4%
Nov-20	82.6%
Dec-20	80.5%
Jan-21	77.3%
Feb-21	79.1%
Mar-21	81.5%
Apr-21	85.9%



RTT: 18 Week Compliance
To achieve and sustain 92% of all patients waiting less than 18 weeks for first definitive treatment.

RTT Incomplete Performance

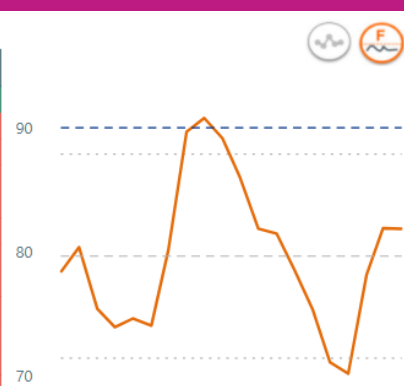
Timescale	Value
May-20	59.7%
Jun-20	48.6%
Jul-20	45.1%
Aug-20	52.1%
Sep-20	59.8%
Oct-20	65.9%
Nov-20	69.5%
Dec-20	69.0%
Jan-21	65.0%
Feb-21	61.0%
Mar-21	59.3%
Apr-21	59.7%



ED 4 Hour Compliance
To achieve and sustain 95% of all patients attending ED receiving treatment or admission with 4 hours.

ED Compliance

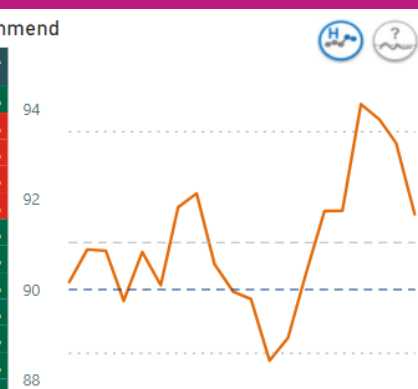
Timescale	Value
May-20	90.8%
Jun-20	89.2%
Jul-20	86.0%
Aug-20	81.9%
Sep-20	81.5%
Oct-20	78.6%
Nov-20	75.4%
Dec-20	71.1%
Jan-21	70.2%
Feb-21	78.1%
Mar-21	81.9%
Apr-21	81.8%



Patient Experience (Friends & Family Test)
To achieve consistent recommendation rates in excess of 90% from patient friends and family.

FFT Trust Recommend

Timescale	Value
May-20	90.6%
Jun-20	90.0%
Jul-20	89.8%
Aug-20	88.4%
Sep-20	88.9%
Oct-20	90.4%
Nov-20	91.7%
Dec-20	91.8%
Jan-21	94.1%
Feb-21	93.8%
Mar-21	93.3%
Apr-21	91.7%



Executive Summary

East Kent Hospitals University NHS Foundation Trust

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.

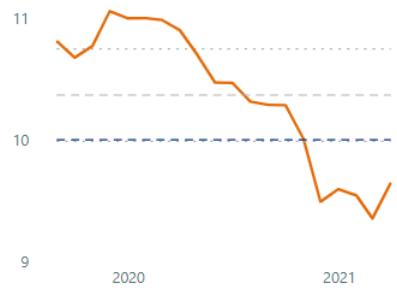
Staff Engagement (score)
Staff satisfaction levels are amongst the bottom 20% across the country, which can lead to difficulty in recruitment and retention.

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.

Staff Turnover
To achieve and maintain a 10% staff turnover rate.

Staff Turnover Rate

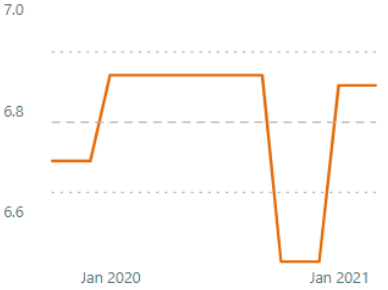
Timescale	Value
May-20	10.7%
Jun-20	10.5%
Jul-20	10.5%
Aug-20	10.3%
Sep-20	10.3%
Oct-20	10.3%
Nov-20	10.0%
Dec-20	9.5%
Jan-21	9.6%
Feb-21	9.5%
Mar-21	9.4%
Apr-21	9.6%



Staff Engagement
To improve our staff engagement score as demonstrated in the annual staff survey.

Staff Engagement Score

Timescale	Value
May-20	6.9
Jun-20	6.9
Jul-20	6.9
Aug-20	6.9
Sep-20	6.9
Oct-20	6.5
Nov-20	6.5
Dec-20	6.5
Jan-21	6.9
Feb-21	6.9
Mar-21	6.9
Apr-21	



Executive Summary

East Kent Hospitals University NHS Foundation Trust

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 terms 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.

Liz Shutler

Carbon Footprint (CO2e)
Being environmentally sustainable is a key element of our Trust; True North.

Implementing environmentally sustainable principles and reducing our greenhouse gas emissions, adds value to our patients and reflects the ethics of our staff.

The Trust's carbon emissions are made up of:

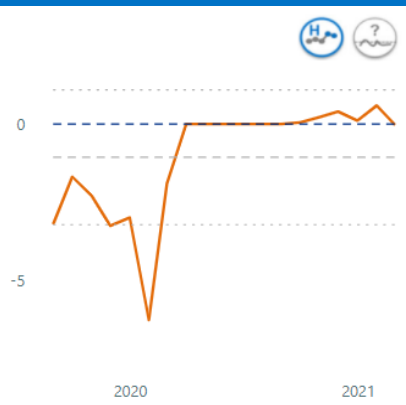
- Direct emissions: natural gas
- Indirect and direct emissions: from for example electricity consumption, waste and water
- Waste

It is these areas we will be focussing on improving over the coming five to ten years.

Financial Position
To achieve and sustain a break even financial position.

I&E Margin (£M)

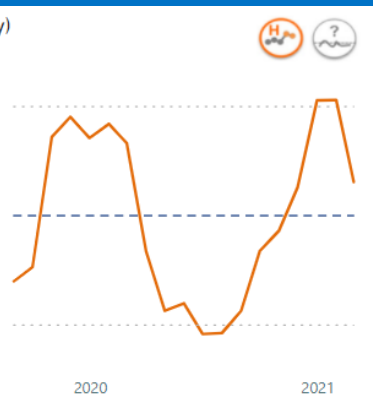
Timescale	Value
May-20	0.000
Jun-20	0.000
Jul-20	0.000
Aug-20	0.000
Sep-20	0.000
Oct-20	0.046
Nov-20	0.213
Dec-20	0.392
Jan-21	0.109
Feb-21	0.588
Mar-21	-0.007
Apr-21	



Carbon Footprint
To achieve an organisational carbon neutral footprint.

CO2e Total (tonnes/day)

Timescale	Value
May-20	31.87
Jun-20	32.69
Jul-20	29.23
Aug-20	29.33
Sep-20	31.84
Oct-20	38.59
Nov-20	40.90
Dec-20	45.83
Jan-21	55.64
Feb-21	55.69
Mar-21	46.43
Apr-21	



Executive Summary

NHS
East Kent
Hospitals University
NHS Foundation Trust

Our Future

Liz Shutler

Medically Fit for Discharge
Across the Trust, patients are deemed as 'ready' and 'medically fit for discharge' but continue to remain under our acute care.

Unnecessary bed stays can negatively affect patient experience. In addition prolonged stays in hospital (especially for those who are frail or elderly) can lead to an increased risk of falling, sleep deprivation, catching infections and sometimes mental and physical deconditioning.

By working with our partners in the wider heath & social care community to ensure patients return to their usual place of residence, or other care setting, as soon as it is safe to do so patient flow will improve thought the system. This metric was chosen as it represents the system working in an integrated way. As the system matures this metric my change to 'criteria to reside'.

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 via telemedicine, where clinically appropriate, and to that end we have developed an enhanced engagement plan to meet this target and also to encourage the shift to Web from phone were possible. We have also set a stretch target of 80% to drive innovation in this area.

Medically Fit for Discharge
To ensure patients are cared for in the appropriate setting in a timely manner.

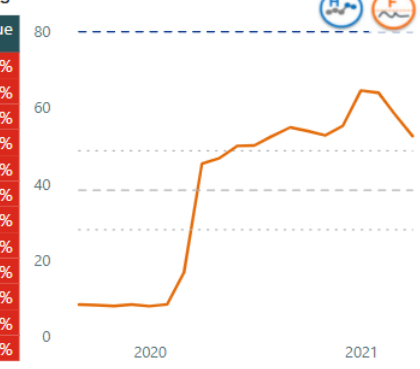
MFFD: Over 24 hours

Timescale	Value
May-20	13.9
Jun-20	31.1
Jul-20	34.0
Aug-20	40.2
Sep-20	46.3
Oct-20	43.4
Nov-20	52.8
Dec-20	49.1
Jan-21	50.1
Feb-21	36.6
Mar-21	40.9
Apr-21	35.1

Innovation
To increase the use of technology and innovation in the delivery of high quality care for the East Kent population.

Virtual OP Appts

Timescale	Value
May-20	46.7%
Jun-20	50.0%
Jul-20	50.1%
Aug-20	52.6%
Sep-20	54.9%
Oct-20	53.9%
Nov-20	52.8%
Dec-20	55.2%
Jan-21	64.5%
Feb-21	64.0%
Mar-21	58.3%
Apr-21	52.6%



2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Falls

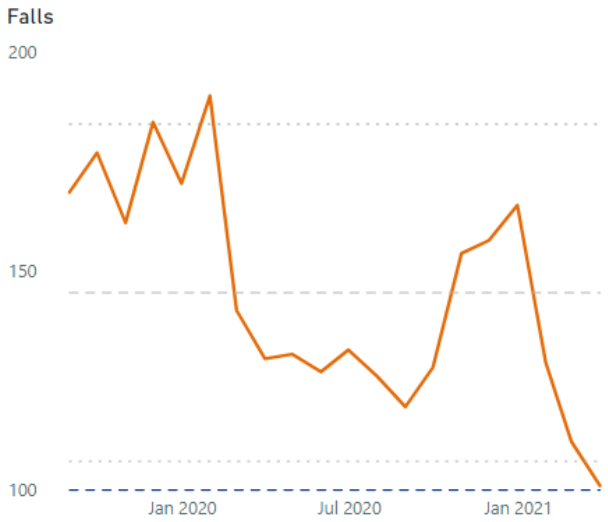
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
131	127	132	126	119	128	154	157	165	129	111	101

Domain	Our Quality & Safety
True North	Harm Events
Metric Focus	Driver
Threshold	100
Value	Number
Improvement Direction	Lower is Better

D2 Driver is red for 2

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

Variation indicates consistently falling short of the target



Understand the data

Total number of recorded falls. Assisted falls and rolls are excluded.
Data source - Datix

We are driving this measure because...

The Quality & Safety True North target is to achieve zero avoidable harm within 5-10 years. Our analysis shows that currently falls are the greatest contributor (40%) 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.

M_00320_Falls

Last Updated | 17/05/2021 08:04:00

Performance

Current Performance: 101 falls recorded in April 2021.This reducing trend for the last three months represents an improving picture.

Key areas of focus for this breakthrough objective are:

- Improving ward level visibility/focus on falls reduction/ level of harm.
- Standardising the trusts approach to reporting of falls on Datix.
- Improving the falls knowledge and access/visibility of ward level data.

Key achievements include:

- development of A3s at ward level with targeted understanding of route causes and focused actions.
- Sharing of learning/improvements through A3 presentations at driver meetings.
- development of a falls dashboard with accessible ward level data, co-designed and challenged at driver meetings.
- development of an MDT approach to reviewing falls through utilisation of a falls decision tool and a multi-professional falls/pressure ulcers panel to support the SI process.
- progression towards a self directed driver meeting with SRO co-chairing with surgical/medical matrons.

Risks

Risk of PDSA improvement cycles becoming 'stuck' in historical process. Mitigation is through escalation of blockages at We Care EMT discussions and through work progressed through the Governance Improvement Group.

2020/21 Breakthrough Objectives

NHS
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Composite HSMR: Sepsis/Resp

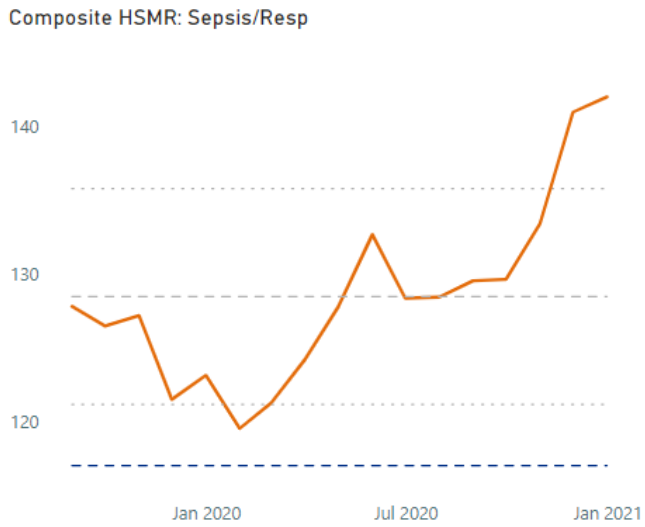
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
127.8	132.7	128.4	128.4	129.6	129.7	133.5	141.0	142.0			

Domain	Our Quality & Safety
True North	Mortality
Metric Focus	Driver
Threshold	117.0
Value	Number
Improvement Direction	Lower is Better

D2 Driver is red for 2

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

Variation indicates consistently falling short of the target



Understand the data

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality comparing a Trust's actual number of deaths to its expected/predicted number of deaths. This Composite HSMR metric is a subset of HSMR and only accounts for two of the 56 diagnosis groups: "Septicemia (except in labour)" and "Respiratory failure, insufficiency, arrest (adult)".

If a Trust has an HSMR of 100, this means that the number of patients who died is exactly as would be expected. Values above 100, suggest a higher than expected mortality and those below as within an acceptable range. HSMR is an important indicator that acts as a smoke signal for potential problems with the quality of care. The figures represent a 12-month rolling position.

We are driving this measure because....

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.

... | M_00133_Deteriorating_Patient

Last Updated | 17/05/2021 09:20:00

Performance

Current performance shows a rolling 12-month composite Hospital Standardised Mortality Ratio (HSMR) for respiratory failure and sepsis of 142.0 for January 2021. This data reflects the impact of the second wave of the COVID pandemic.

Key areas for focus to achieve the overall goal

- Recognition, escalation and response to patients deteriorating from sepsis and respiratory failure by clinical teams
- Sepsis
- Embedding learning from harm incidents

Achievements over the last 30 days

- Ongoing plan-do-study-act cycles of improvements by frontline teams
- Clinical discussions about what a good Morbidity & Mortality meetings looks like with Specialty and Care Groups based on outcome of gap analysis
- Engagement with Children's team to review their process with sepsis

Ambition for the next 30 days

- A3 conference 16 June 2021
- Sepsis engagement workshop 20 May 2021
- Learning from Deaths workshop 27 May 2021
- Include Maternity as a specialty in the deteriorating patient work

Risks

There are no identified risks to delivery of this breakthrough objective at this point.

Risks are identified and managed through weekly driver meetings and where needed escalated at We Care Executive Management meetings.

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

IPC: Total Infections

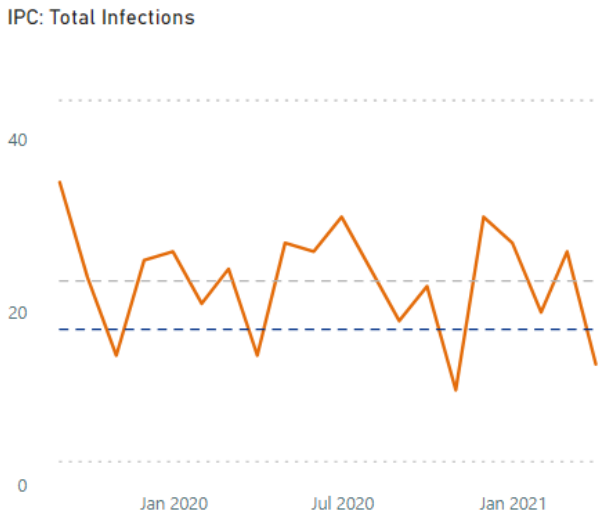
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
28	27	31	25	19	23	11	31	28	20	27	14

Domain	Our Quality & Safety
True North	Harm Events
Metric Focus	Driver
Threshold	18
Value	Number
Improvement Direction	Lower is Better

D1 Driver is green for

Common cause (no significant change)

Variation indicates inconsistently passing and falling short of the target



Understand the data

"Healthcare associated infection" (HCAI) also known "nosocomial" or "hospital" infection is an infection occurring in a patient during the process of care in a hospital or other health care facility which was not present of incubating at the time of admission. This aggregate measure will be updated to include a count of the number of MSSA*, MRSA, C diff, MRSA, E coli*, Klebsiella species* (spp.) and Pseudomonas aeruginosa* cases.

*bloodstream infections only

We are driving this measure because....

Infection prevention control has been a focus of the organisation throughout 2020 and great strides have been made to improve performance across all sites.

It is important to continue the good work set in place during the global pandemic and apply learning to reduce all in hospital infections.

... | M_01142_IPC_Infections_Combined

Last Updated | 19/05/2021 10:18:00

Performance

Current Performance for total in-hospital infections is 14 in April, Performance has shown common cause variation over the last three months.

In the last month:

- The metric and threshold have been revised as described in the previous update
- Quality assurance of the data flow is in progress
- Wards at the QEQM site and KCH sites have completed their A3s and begun work on their countermeasures
- Front line teams have been invited to the weekly driver meetings now chaired by the DIPC
- The Pareto analysis has been changed to focus on the organisms with the greatest impact on the metric
- Further analysis will lead to wards at WHH being selected to join the breakthrough objective
- Antimicrobial stewardship team have completed A3 training and have been invited to the weekly driver meetings as above

Next month

- Active engagement in the weekly driver meeting by all parties
- Identification of further front line teams based on specific organisms (Cdiff in particular)

Risks

The Director of Infection Prevention and Control (DIPC) as Senior Responsible Officer (SRO) has reviewed the metric associated with this breakthrough objective and decided that it should include the other infections that are the subject of the national reduction ambition (Klebsiella species and Pseudomonas aeruginosa). This has required a recalculation of the threshold and performance which may cause some temporary uncertainty.

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

ED - Aggregated Patient Delay

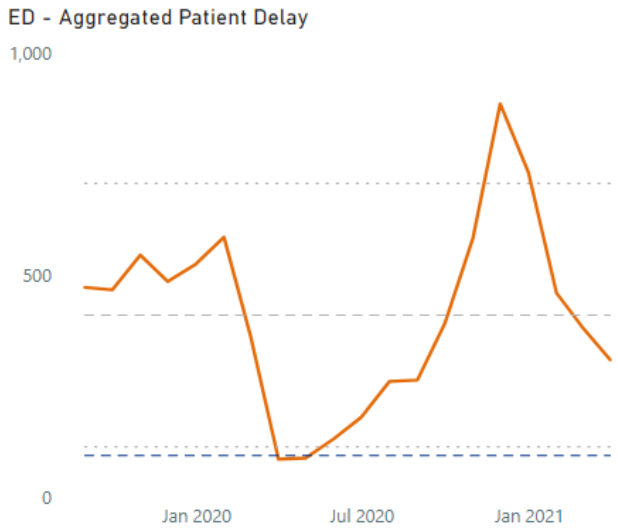
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
89	133	181	261	265	392	584	886	732	460	385	311

Domain	Our Patients
True North	ED Compliance
Metric Focus	Driver
Threshold	95
Value	Number
Improvement Direction	Lower is Better

D2 Driver is red for 2

Common cause (no significant change)

F Variation indicates consistently falling short of the target



Understand the data

A&E performance is directly dependent on the number and flexibility of available admitted beds, the aggregated patient delay measure counts the amount of time patients who breached the 4 hour standard spent in A&E awaiting admission to an Acute Medical Unit, Medical or Surgical Bed.

We are driving this measure because....

Long waits across our Emergency Departments have been a challenge to the organisation for several years, thought to be driven by a lack of access to inpatient beds. Recent improvements in bed availability have shown improvements in compliance. Consolidating and building on these improvements and improving timely care within ED will continue to improve patient care and the compliance against this metric.

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.

Performance

Performance for April is an aggregated delay of 311 hours. Performance improvement of this metric is now in its third month running.

Key areas of focus for this breakthrough objective are;

- Emergency Portals
- Time in Hospital
- Discharge Process

Activities for the coming period include:

- Implementation of agreed metrics related to ED processes and development of escalation actions to ensure that patient care is delivered in a timely and safe way at all times.
- Continued implementation of new Same Day Emergency Care (SDEC) pathways and alignment across sites to quickly stream patients from ED to appropriate care locations
- Implementation of Urgent Treatment Centre (UTC) actions to improve the numbers of patients seen and reduce crowding in ED
- Focus on improving the accurate collection of criteria to reside data and how this can help timely discharge
- Implementation of a new hospital discharge policy with a focus on early discharges and use of the discharge lounge

Risks

Engagement with ED leadership to improve focus on metrics and escalation actions

Engagement with specialty teams to reduce the risk of delays in the ward discharge process and delays in ED to access a bed.

Increase in demand to ED beyond planned levels

... | M_00888_Agg_Delay

Last Updated | 17/05/2021 11:24:00

2020/21 Breakthrough Objectives

NHS
East Kent
Hospitals University
NHS Foundation Trust

Theatre Session Opp.

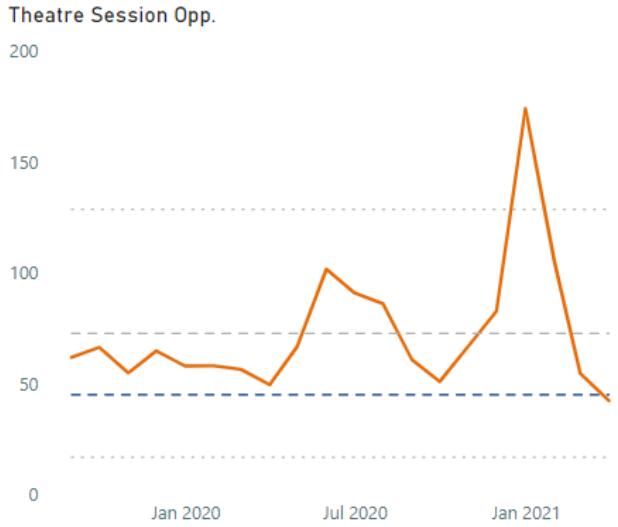
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
67	102	91	86	61	51	67	83	174	106	55	42

Domain	Our Patients
True North	RTT - 18 Weeks
Metric Focus	Driver
Threshold	45
Value	Number
Improvement Direction	Lower is Better

D1 Driver is green for

Common cause (no significant change)

Variation indicates inconsistently passing and falling short of the target



Understand the data

Total excess minutes (represented as 4 hr theatre lists) associated with specified non operative events during scheduled theatre time.

Non Operative Events (Cancelled Sessions, Turn Around Times Exceeding 10 Minutes, On The Day Cancellations, Early Finishes Exceeding 45 Minutes, Late Starts Exceeding 15 Minutes)

Exclusions (Emergency Lists, Non Bookable Lists (e.g. Trauma), Sessions Cancelled Due to Audit / Bank Holiday, Sessions Cancelled in Specialised Theatres (e.g. Ophthalmic Suite / Buckland), Sessions where Total available Opportunity <60 Minutes

We are driving this measure because....

Efficient use of our theatre complex is key to maximising the throughput of routine elective care.

Emerging from the second wave of COVID-19 it is imperative that deferred elective surgery 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.

... | M_00146_Theatres_Utilisation

Last Updated | 18/05/2021 09:31:00

Performance

Current Performance shows the equivalent of 42 sessions unused i.e. opportunity for April 2021. We have been displaying an improving performance for the last three months due to the national directive to recommence routine elective surgery, which is in line with our recovery plan. We are opening more theatres week on week in line with the recovery programme. Theatres continue to be allocated to the specialties delivering cancer and priority two (P2) surgery., but as more theatres come back on line we are now beginning to treat our long waiting patients.

Our investigations so far have led to three areas of focus for the coming month, booking processes, in session utilisation and staff cover to run our theatres 50 weeks per year. There is a Trust Priority Improvement Project (TPIP) that will focus on the availability of theatre sessions vs job planned activity.

Actions for next period continue to include review of booking processes to deliver six week advance booking of theatres as we move into our elective recovery programme (4R), Care Group root cause analysis on in session 'lost' time (eg late starts, early finishes) and creation of a rota system to optimise theatre allocation and booking. All patients cancelled on the day are reviewed to understand the reason for the cancellation, lessons learnt and how this may align with improving pre operative assessment processes.

Risks

3rd Wave of COVID could significantly impact on theatre utilisation if there is a directive to cease routine work.

Theatre staff recruitment has been challenging previously. This includes anaesthetic cover along with theatre personnel.

Alerting Watch Metrics: Our Quality & Safety

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jan-21	Feb-21	Mar-21	Apr-21
Harm Events			Nutrition Incidents	20	13	20	28	33
	W4		Optimal Cord Clamping <32w	85.0%	16.7%	71.4%	75.0%	0.0%

Performance

Harm Events

The main areas where incidents have been raised relating to nutrition during April remain delays in referring to specialist dietitians and Speech and Language Teams, provision of incorrect texture meals to patients with dysphagia (swallowing difficulties) and incomplete documentation of care for patients with Nasogastric feeding tubes. All incidents are shared with Care Groups and the Nutrition and Oral Hydration Steering Group. Additional support will be provided to ward teams once the Nutrition and Hydration Nursing Team have been recruited.

The Women's Health Care Group has selected optimal cord clamping as one of their focused improvement projects recognising there has been inconsistent performance in this area. The latest data represents a single case that was born rapidly within the triage area and optimal cord clamping was not applied. Continued work on countermeasures within the care group continues to focus actions to consistently deliver unless clinical reasons exist to preclude.

Alerting Watch Metrics: Our Patients

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jan-21	Feb-21	Mar-21	Apr-21
RTT - 18 Weeks	W4		RTT 52w Breaches	2,586	3,613	4,632	5,232	4,942
	W4		DM01 Compliance	99.0%	64.7%	67.7%	73.6%	73.9%
	W4		RTT 35w Undated	8,500	7,088	7,523	8,122	8,440
	W4		RTT 1st OPA Booking Breaches	14,000	12,331	12,346	12,888	13,288
ED Compliance	W4		Clinical Assessment within 1hr	50.0%	44.1%	42.5%	41.6%	39.1%
	W4		DTAs within 4hrs	600	777	1,137	1,326	1,420
	W4		Unplanned Re-attendance ED	10.0%	10.7%	10.5%	10.6%	10.3%
	W4		Super Stranded >21D	75	100	103	125	93
FFT	W4		FFT IP Response Rate	25.0%	16.6%	16.1%	17.3%	15.9%
	W4		FFT ED Response Rate	12.0%	14.9%	14.6%	14.6%	14.5%
	W4		FFT Maternity Response Rate	18.0%	6.3%	5.5%	5.7%	4.8%
	W4		Complaint Response	90.0%	65.1%	77.1%	65.5%	77.8%

Performance

RTT 18 Weeks

All RTT measures are alerting due to the significant impact of the second Covid-19 wave on elective services. The Trust is focussed on rapidly increasing access to elective services in order and in line with the national elective recovery programme. Booking teams are focussed on dating patients with an urgent requirement for surgery and long waiting patients. The Trust has a positive OP and Endoscopy schedule which has helped reduce risk and ensure priority patients are supported.

ED Compliance

Work is underway with local system and regional partners to understand the increase in walk-in ED patients attending post lock down.

The unplanned reattendance rate is inflated due to planned returns not recorded accurately. Work has commenced to understand and improve data quality.

There is positive engagement with community colleagues to work closely to identify patients and address process delays impacting on discharge to community inpatient beds or services which aims to reduce the number of super stranded patients.

Friends & Family Test (FFT)

The Trust is working to improve FFT response rates across all settings and has observed a slight improvement across the board in March. Workstreams have been initiated to trouble shoot specific areas, particularly the low rates in Maternity. Whilst the ED response rate remains above the national average it was trending down below the mean which is causing the metric to alert.

Alerting Watch Metrics: Our People

True North Domain	Type	BO	KPI	Thres.	Jan-21	Feb-21	Mar-21	Apr-21
Staff Turnover Rate	W4		Staff Turnover: Nursing	10.0%	10.5%	10.6%	11.0%	11.7%
Staff Engagement	W4		Appraisals Compliance	85.0%	69.5%	68.8%	69.8%	70.0%
	W4		Mandatory Training	93.0%	90.3%	90.7%	91.1%	91.7%

Performance

Staff Turnover

Although overall turnover (9.6%) is below the True North target of 10%, nurse turnover remains higher and has increased significantly over the last 3 months. Work to address this links to both the national and regional approaches and focuses on key areas – generational (those coming in and those leaving), international recruitment, flexible working and key elements of the NHS People Plan (Wellbeing, EDI). There is also recognition that there could be further attrition due to the aftermath of the pandemic and a perceived 'lack of value' of the nursing profession.

Staff Engagement

Appraisal compliance is continuing to improve as the year progresses. Although this is an alerting metric rather than a driver, it continues to be a good indicator of staff engagement and personal development planning and more recently has also included wellbeing conversations and personal risk assessment reviews.

Although mandatory training compliance is improving it remains below the threshold and continues to be an important 'watch' at monthly Performance Review Meetings.

Alerting Watch Metrics: Our Future & Our Sustainability

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jan-21	Feb-21	Mar-21	Apr-21
Financial Position			Premium Pay	18.6%	17.4%	17.5%	17.7%	
	W4		Non Pay	0.0%	-3.2%	-3.1%	-11.3%	
Carbon Footprint			CO2e Gas (tonnes/day)	38.19	37.43	37.65	29.12	
Med. Fit for Disch.	W4		MFFD: Spot Purchase	5.0	19.3	12.1	11.3	9.3
	W4		MFFD: Community Hospital	5.0	7.6	5.9	10.1	8.6
	W4		MFFD: Home With Support	5.0	7.6	7.6	10.3	9.4

Performance

Financial Position

The financial position watch metrics are alerting because pay and non-pay are up on the expected position or have shown a deteriorating position . This increase has been driven by
the Covid-19 response costs and have therefore been funded centrally but needs careful oversight during 21/22. The metrics for April are delayed whilst the targets are amended in line with the latest planning guidance. At M1 the overall position is a £0.5m deficit against a breakeven plan.

Carbon Footprint

Gas tonnage per day has breached the upper control limit in February 2021 and is therefore alerting this month. It is likely that usage will remain high into March due to seasonal variation and return back within the control limits as we move into the later part of spring.

Medically Fit for Discharge

The number of patients MFFD is alerting due to seven consecutive monthly data points above the threshold. This is being addressed and closely monitored through the 'Criteria to Reside' implementation to improve compliance throughout the Trust.

Appendix 1: Non-Alerting Watch Metrics

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jan-21	Feb-21	Mar-21	Apr-21
Harm Events	W		52w Severe Harm Review	0	0	0	0	0
	W		Covid-19 HCAI	1	112	95	53	1
	W		Medication Errors	90	54	62	60	49
	W		Pressure Ulcers: Cat 1 & 2	200	169	153	178	203
	W		Pressure Ulcers: Cat 3 & 4	40	25	19	30	35
	W		IPC: Audits Composite	80.0%	86.4%	85.6%	87.5%	87.0%
	W		VTE Assessment Compliance	90.0%	93.3%	93.6%	93.8%	93.1%
	W		Safeguarding Incidents	20	8	7	12	26
	W		IP Spells with 3+ Ward Moves	500	452	419	541	530
Mortality	W		Extended Perinatal Mortality	6.35	12.87	7.05	6.78	2.62
Cancer 62d	W		Cancer 2ww Performance	93.0%	98.3%	98.1%	98.8%	98.0%
	W		Cancer 31d Performance	96.0%	97.3%	98.4%	94.1%	98.4%
	W		Cancer 28d Performance	75.0%	59.4%	73.6%	79.7%	72.3%
	W		Radiology Diags vs Plan	Traj.	13,276	13,061	15,470	15,781
	W		Endoscopy vs Plan	Traj.	983	896	1,119	1,031
RTT - 18 Weeks	W		Referrals vs Plan	Traj.	34,630	36,970	48,098	42,464
	W		OPA vs Plan	Traj.	61,667	63,171	81,691	71,663
	W		Elective Admissions vs Plan	Traj.	3,223	3,298	4,604	4,474

Appendix 1: Non-Alerting Watch Metrics

NHS
East Kent Hospitals University
NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jan-21	Feb-21	Mar-21	Apr-21
ED Compliance	W		ED Non-Admitted Compliance	90.0%	84.7%	89.7%	91.2%	90.0%
	W		Ref to Spec 2.5h	40.0%	43.2%	45.0%	45.0%	43.3%
	W		A&E Atts vs Plan	Traj.	13,905	14,407	18,872	20,527
	W		Discharges by Midday	15.0%	17.4%	18.0%	17.7%	18.3%
	W		NEL Admissions vs Plan	Traj.	5,003	5,316	6,602	6,819
	W		NEL Readmissions	15.0%	11.3%	10.7%	12.3%	12.2%
	W		Stroke Ward within 4 Hours	50.0%	57.1%	58.4%	55.3%	57.1%
FFT	W		FFT DC Response Rate	30.0%	37.1%	33.2%	33.9%	32.4%
	W		FFT OP Response Rate	20.0%	20.2%	19.5%	19.2%	17.2%
	W		Complaints	100	60	60	65	63
	W		PALS Enquiries	550	493	447	599	507
Staff Turnover Rate	W		Vacancy Rate	9.0%	6.6%	6.4%	6.3%	6.5%
	W		Staff Turnover: HCA	13.5%	10.9%	11.6%	11.1%	10.6%
	W		Premature Turnover Rate	25.0%	20.8%	20.4%	20.1%	20.3%
Staff Engagement	W		Sickness	5.0%	6.3%	4.2%	3.5%	
	W		Safeguarding Children Training	85.0%	85.5%	86.8%	86.0%	90.7%
Financial Position	W		Total Pay	0.0%	0.5%	1.7%	0.2%	
Carbon Footprint	W		CO2e Waste (tonnes/day)	0.28	0.21	0.21	0.22	
	W		CO2e Electricity (tonnes/day)	18.00	17.44	17.31	16.61	
	W		CO2e Water (tonnes/day)	0.55	0.56	0.52	0.48	
Med. Fit for Disch.	W		MFFD: Assessment	5.0	3.7	1.3	0.7	1.1
Innovation	W		Virtual OP Appts - First	25.0%	53.1%	54.5%	49.0%	44.9%
	W		Virtual OP Appts - Follow Up	60.0%	69.0%	67.8%	62.2%	55.7%

Appendix 2: 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 2: 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 2: 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.

East Kent Hospitals University NHS Foundation Trust

21/25 – APPENDIX 2

We Care Exec Scorecard: Harm Metric Review/Additions

Executive Summary

Following feedback from the Quality Committee in April it was suggested that a number of metrics are added to the Executive We Care Dashboard and IPR in order to ensure visibility of Trust performance on incident reporting. This catch ball to be held at the May Board meeting. The process of this catch ball is in line with the We Care methodology and the outcome can be reflected in the Scorecard and IPR for the May 2021 publication.

Metrics

The suggested metrics to be added are as follows;

- Total Clinical Incidents Reported in month
- Serious Incidents Declared in month
- Never Events Declared in month
- Maternity Serious Incidents Declared in month
- Duty of Candour

Metric Code	Metric Name	Data Source	Description
M_00168	Clinical Incidents	Datix	Any clinical incident reported on Datix **[inc_type] = 'PATCLI' "Clinical incident (patient safety)"**. *See appendix for list of Incident types included. Sub categories for each type are available if that detail is required (extensive)
M_00170	Serious Incidents	Datix	Any incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System) - **[Inc_inquiry] = 'CONFSI' (confirmed SI)**. We also have a clause to exclude any that later get downgraded by the CCG.
M_00171	Never Events	Datix	Subset of Serious Incidents with the additional clause **[SI - Never event?] = Y**
M_00170_Maternity	Maternity Serious Incidents	Datix	Any incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System) - **[Inc_inquiry] = 'CONFSI' (confirmed SI).** Only includes **Obstetrics, Midwifery, Neonatal** and **Newborn Hearing Screening**. We also have a clause to exclude any that later get downgraded by the CCG.
TBC	Duty of Candour	TBC	TBC

21/25 – APPENDIX 2

The below table shows performance for each of these metrics (using existing definitions) for the last 12 months.

Metric	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Clinical Incidents	1,102	1,630	1,439	2,018	1,910	1,780	2,326	2,443	2,398	2,797	1,962	2,109
Serious Incidents (SIs)	12	15	27	14	14	11	9	31	18	11	28	27
Never Events	1	0	1	0	1	0	0	1	0	0	0	0
Maternity SIs	2	2	1	3	0	0	0	1	0	1	2	3

It is suggested that these metrics are added to the Executive We Care Scorecard as Watch metrics with the following thresholds;

Metric	Threshold
Clinical Incidents	2,500
Serious Incidents (SIs)	18
Never Events	0
Maternity SIs	0

Action Required

- Agree the methodology for the four-existing metrics (RM/SJ) - agreed
- Agree the thresholds for the four-existing metrics (RM/SJ) – as above
- Define the methodology for a Duty of Candour metric (RM/SJ) – in progress
- Extract data to the methodology for Duty of Candour metric (LP) – in progress
- Agree the threshold for Duty of Candour metric (RM/SJ) – in progress

21/25 – APPENDIX 2

***Appendix 1: Incident Types**

Category
Delay / failure
Tissue viability (incl Pressure ulcer)
Care / treatment
Patient Fall
Medication
Infection control
Pathology (Lab tests)
A&E breach or delay
Medical devices / equipment issues
Communication / behaviour
Medical notes / PAS record / Clinical systems - missing / problems / delays
Women's Health - obstetric complication
Women's Health - unexpected problem/outcome for baby
Operations / procedures
Staffing level difficulties
Venous Thrombo Embolism (VTE) events
Clinical assessment
Adult protection / Safeguarding of adults
Blood transfusion
Primary PCI Service issues
Child protection / Safeguarding of children
Women's Health - management of labour
Radiation (X-ray) affecting patient
Consent
Radiation (Radionuclide) affecting patient
Women's Health - Gynaecology
Pain - poor / inadequate pain management
Renal trigger events
Never events
Radiation (Other - MRI, Optical, Ultrasound)

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**27 MAY 2021**
REPORT TITLE:	**MONTH 1 FINANCE REPORT**
BOARD SPONSOR:	**DIRECTOR OF FINANCE AND PERFORMANCE**
PAPER AUTHOR:	**REPORTING ACCOUNTANT**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: MONTH 1 FINANCE REPORT – EXECUTIVE SUMMARY**

BACKGROUND AND EXECUTIVE SUMMARY

The Trust achieved a £0.5m deficit in April, which is £0.5m below the planned position.

Due to the on-going Covid-19 pandemic, the traditional NHS funding and administration process remains suspended for the first half of 2021/22, with fixed funding arrangements at a System level (Kent & Medway (K&M) Integrated Care System (ICS)) similar to the second half of 2020/21.

In addition to baseline funding provided at the average level of expenditure in Q3 2020/21, systems have access to additional funding through the Elective Recovery Fund (ERF), subject to meeting the required activity thresholds and gateways. At this time, it is unclear what the funding arrangements will be for the second half of the financial year.

The planned contribution to the K&M ICS system plan from EKHUFT is to achieve a breakeven position for April to September 2021 (H1).

The breakeven H1 plan requires that the Trust:

1) Receives £7.5m of additional Elective Recovery Funding for treating planned patient activity above a nationally-set threshold.
2) Reduces the average monthly spend on Covid-19 from c.£3m per month in the second half of 2020/21 to c.£2m per month for H1.

	Year to Date		
£'000	**Plan**	**Actual**	**Variance**
EKHUFT Income	65,957	65,719	(238)
EKHUFT Pay	(39,775)	(40,465)	(690)
EKHUFT Non-Pay	(26,329)	(25,692)	637
EKHUFT Financial Position	**(147)**	**(438)**	**(291)**
Spencer Performance After Tax	30	(45)	(75)
2gether Performance After Tax	117	(65)	(182)
Consolidated Income & Expenditure (I&E) Position (pre Technical adjs)	**0**	**(548)**	**(548)**
Technical Adjustments	0	51	51
Consolidated I&E Position (including Top Up)	**0**	**(497)**	**(497)**

The Trust has identified £2.9m of additional costs due to Covid-19 in April as compared to £5m identified in March. This includes £0.3m of 'out of envelope' Covid costs which are funded separately by NHS England/NHS Improvement (NHSE/I).

The Trust achieved a £0.5m deficit in April, which was £0.5m worse than the plan. The main drivers of this adverse position were as follows:

- Expenditure on Covid-19 of £2.9m compared to £2m within the plan. This was a significant reduction compared to previous months, but further work is required to reduce the level of expenditure incurred to reflect the significant reduction in patients presenting with Covid-19. An action plan is being developed to monitor and drive discretionary costs down.
- Lack of certainty on the Elective Recovery Fund due to timing of confirming System level performance meant the Trust recognised half of the c.£1m overperformance against trajectory driving an overall income underperformance of £0.2m. In future months underwriting of ERF by the system will enable the Trust to recognise this income in full.
- A non-pay underspend of £0.6m due to a combination of less independent sector activity purchased than planned and less expenditure on clinical supplies and disposables due to lower than planned elective activity.

The Trust's cash balance at the end of April was £29m which was consistent with the plan but a significant drop from the March 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.

Total capital expenditure at the end of April was £0.2m which was £2.1m below the planned level. The capital plan has been phased with more capital expenditure anticipated in the first half of the year than usual. Progress against this plan is being managed by weekly meetings led by the Deputy Chief Executive Officer (CEO) to ensure the Trust delivers in line with this.

In light of the national directive to focus on the operational response to Covid-19 EKHUFT has a reduced ability to make efficiency savings and delivered £0.1m of savings in April which was £0.1m below the plan of £0.2m.

Please note that there is no requirement for external financial reporting this month therefore we have provided a condensed M1 highlight finance report for the Board. The full length report will resume from M2.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Failure to deliver Cost Improvement Programme (CIP) requirement increases costs.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our future;** • **Our sustainability.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR 5: Failure to achieve financial plans as agreed by NHSI under the Financial Special Measures Regime.
RESOURCE IMPLICATIONS:	Key financial decisions and actions may be taken on the basis of this report
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	FINANCE AND PERFORMANCE COMMITTEE (FPC)

East Kent Hospitals University NHS Foundation Trust

SUBSIDIARY IMPLICATIONS:	None

PRIVACY IMPACT ASSESSMENT: NO	**EQUALITY IMPACT ASSESSMENT:** NO

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to review the financial performance and actions being taken to address issues of concern.

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2021/22

April 2021

Director of Finance and Performance Management
Philip Cave

Executive Summary
Month 1 (April) 2021/22

Executive Summary

The Trust achieved a £0.5m deficit in April, which is £0.5m below the planned position.

Due to the on-going Covid-19 pandemic, the traditional NHS funding and administration process remains suspended for the first half of 2021/22, with fixed funding arrangements at a System level (Kent & Medway ICS) similar to the second half of 2020/21.

In addition to baseline funding provided at the average level of expenditure in Q3 2020/21, systems have access to additional funding through the Elective Recovery Fund (ERF), subject to meeting the required activity thresholds and gateways. At this time, it is unclear what the funding arrangements will be for the second half of the financial year.

The planned contribution to the K&M ICS system plan from EKHUFT is to achieve a breakeven position for April to September 2021 (H1).

The breakeven H1 plan requires that the Trust:

- Receives £7.5m of additional Elective Recovery Funding for treating planned patient activity above a nationally-set threshold.
- Reduces the average monthly spend on Covid-19 from c.£3m per month in the second half of 2020/21 to

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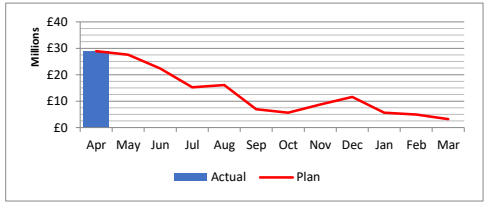
Consolidated I&E Position (pre Technical adjs)	**0**	**(548)**	**(548)**
Technical Adjustments	0	51	51
Consolidated I&E Position (incl Top Up)	**0**	**(497)**	**(497)**

The Trust has identified £3.3m of additional costs due to Covid-19 in April as compared to £5m identified in March. This includes £0.3m of 'out of envelope' Covid costs which are funded separately by NHSE/I.

Income and Expenditure A

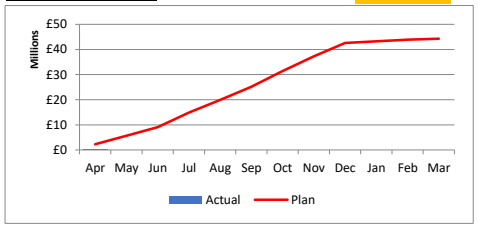
The Trust achieved a £0.5m deficit in April, which was £0.5m worse than the plan. The main drivers of this adverse position were as follows:
- Expenditure on Covid-19 of £2.9m compared to £2m within the plan. This was a significant reduction compared to previous months, but further work is required to reduce the level of expenditure incurred to reflect the significant reduction in patients presenting with Covid-19. An action plan is being developed to monitor and drive discretionary costs down.
- Lack of certainty on the Elective Recovery Fund due to timing of confirming System level performance meant the Trust recognised half of the c.£1m overperformance against trajectory driving an overall income underperformance of £0.2m. In future months underwriting of ERF by the system will enable the Trust to recognise this income in full.
- A non-pay underspend of £0.6m due to a combination of less independent sector activity purchased than planned and less expenditure on clinical supplies and disposables due to lower than planned elective activity.

Cash G



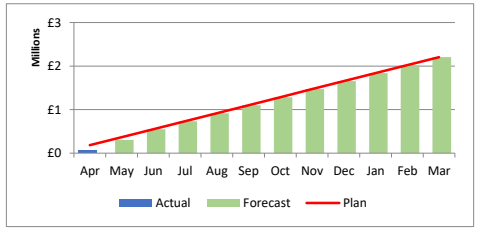
The Trust's cash balance at the end of April was £29m which was consistent with the plan but a significant drop from the March closing balance of £68m due to a combination of capital payments clearing creditor balances and the reversal of the NHSE/I block payment on account to cover anticipated operational costs in advance.

Capital Programme A



Total capital expenditure at the end of April was £0.2m which was £2.1m below the planned level. The capital plan has been phased with more capital expenditure anticipated in the first half of the year than usual. 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 R



In light of the national directive to focus on the operational response to Covid-19 EKHUFT has a reduced ability to make efficiency savings and delivered £0.1m of savings in April which was £0.1m below the plan of £0.2m.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**27 MAY 2021**
REPORT TITLE:	**BOARD ASSURANCE FRAMEWORK (BAF)**
BOARD SPONSOR:	**GROUP COMPANY SECRETARY**
PAPER AUTHOR:	**RISK MANAGER**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: BAF**

Purpose:

The purpose of this paper is to follow up on the progress made in completing the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR) as detailed in the April 2021 Board Paper. In addition, this report identifies the next steps required to ensure the Trust meets the requirements of the NHS England/NHS Improvement (NHSE/I) Governance Review and builds upon this to become an organisation with an approach to risk that is recognised as best in class.

Context:

Following the outputs of the NHSE/I Governance Review the management of risk at the Trust was identified as an area requiring improvement. A dedicated workstream was initiated to deliver the associated outputs. As identified in the April 2021 Board report a significant amount of activity has been undertaken to deliver these outputs namely; a Risk Management Policy A3; an optimised risk register template; a flowchart identifying risk Groups and Committees so as to visualise and clarify the process. All these materials have been approved for use. In addition, meetings have been held with each Care Group to engage them in the revised processes and assist with creating risk register which better reflect their local situation. Subsequently this exercise has led to a more robust and accurate CRR being produced, the CRR will be refined at the Executive Management Team meeting in May. The Board and Board Committees will receive the revised CRR at its next meeting(s). One to one focus meetings have also been held with Executive Directors to identify their key risks and align these with the We Care initiatives thereby updating the (BAF). The difference between the risk registers has been documented below to give the Board context during their reviews and this information will be included in the Trust Risk Management Policy to ensure it is accessible to all staff.

- Board Assurance Framework (BAF)

A Trust Board document that identifies Executive Directors strategic objectives within their portfolio and details the associated risks that may prevent achievement of those objectives, and includes current Controls, Assurances, Gaps and Actions to be taken. Executive Directors update their progress against the objectives and mitigation of the risks via quarterly peer group review sessions, presenting a refreshed BAF at the following Trust Board session. Objectives may be 'in year' or longer term following on to the next years BAF. The BAF is monitored by the Trust Board.

- Corporate Risk Register (CRR)

A high-level Risk Register that capture overarching risks scoring 12 or 15 and above that may be escalated from the Risk Registers and that take on a wide scope, these may have

an associated project plan to address the actions. It identifies current Controls, Assurances, Gaps and Actions from which action plans will be created. Underpinning these high-level risks will be many more granular risks from the Care Group and Corporate risk register. The CRR is on of the sources that may be used to determine the following years Executive Director objectives for Trust-wide issues. The CRR is monitored by the Board sub-Committees regularly and the Trust Board once a year.

- Risk Registers (RR)

Risk Registers may be from clinical areas, or from corporate areas such as Finance, Security, Information Governance, etc. They contain more granular operational risks also containing current Controls, Assurances, Gaps and Actions from which action plans will be created. These risks affect the day to day running and safety of the Trust and underpin the high-level risks on the CRR. If risks on the Risk Registers are Trust wide or score 12 to 15 or above they may be considered for inclusion on the CRR. Risk Registers are monitored by the Care Groups and potential CRR risks by the Risk Group.

Updated Board Assurance Framework:

Appendix 1 contains the updated BAF. Following one to one's with Executive Directors this has been refreshed to reflect the current status of the Trust; it should be noted that the BAF is in place to provide assurance as to how the Trust is performing against delivering its strategic priorities for this year; therefore it is a very focussed document. There is now a thread that runs from this material through to the CRR and the Care Group risk registers (which are still being updated and refined). As such the BAF reflects the impact of the recent updates from the We Care initiative. The work to ensure that the Care Group risk registers are reflective of their local situation will review the risk registers against similar organisations and use data captured within the Trust to ensure all relevant risks are identified. A business case has been submitted for this financial year to support this work.

The proposal is for the BAF to be presented to Board on a quarterly basis to provide assurance that the strategic objectives of the Trust will be met. This will be undertaken with the corresponding indicators in the Integrated Performance Report to enable oversight of performance against objectives. The BAF will also be presented to the Board committees to enable the Non-Executive Directors whether the actions identified in relation to the risks are sufficiently robust and provide challenge to these mitigation tactics when required. Board committees will also be able to identify any additional risks to achieving the strategic objectives through the simplified reporting structures and will report this to the Board through the Chair's report.

Next Steps:

A Board risk workshop is scheduled for 1 July 2021. This session will include a Political, Economic, Sociological, Technological, Legal and Environment (PESTLE) analysis. This strategic exercise will ensure that the trusts risks reflect a considerably changed environment given the impacts of pandemic and the changes in oversight and upcoming legislation in 2022.

The workshop will also assist the development of the Trust's risk appetite approach as well as gain approval for a new regulatory action tracker. This document will identify each condition the Trust has to meet and describe the activities and strategies deployed to address these issues. Making tracking regulatory conditions and their associated risks therefore easier.

In addition, a proposal as to how to manage issues and risks that materialise will be brought for discussion to the development session.

East Kent Hospitals University NHS Foundation Trust

Following the Board risk workshop, the risk management policy and strategy will be updated to reflect the described changes and will also include the Trust's risk appetite for the forthcoming year.

The Board is asked to note the BAF content following approval of the revised template at April 2021 and the next steps as detailed.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	As outlined in the appendices attached.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	This paper provides an update on the Board Assurance Framework Risks to the Trust.
RESOURCE IMPLICATIONS:	None specifically identified other than in the Risk Registers.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	None

PRIVACY IMPACT ASSESSMENT: NO	**EQUALITY IMPACT ASSESSMENT:** NO

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to review and **APPROVE** the attached Board Assurance Framework objectives for the forthcoming year.

The Board is asked to **AGREE** the approach for delivery of the next steps of the risk workstream.

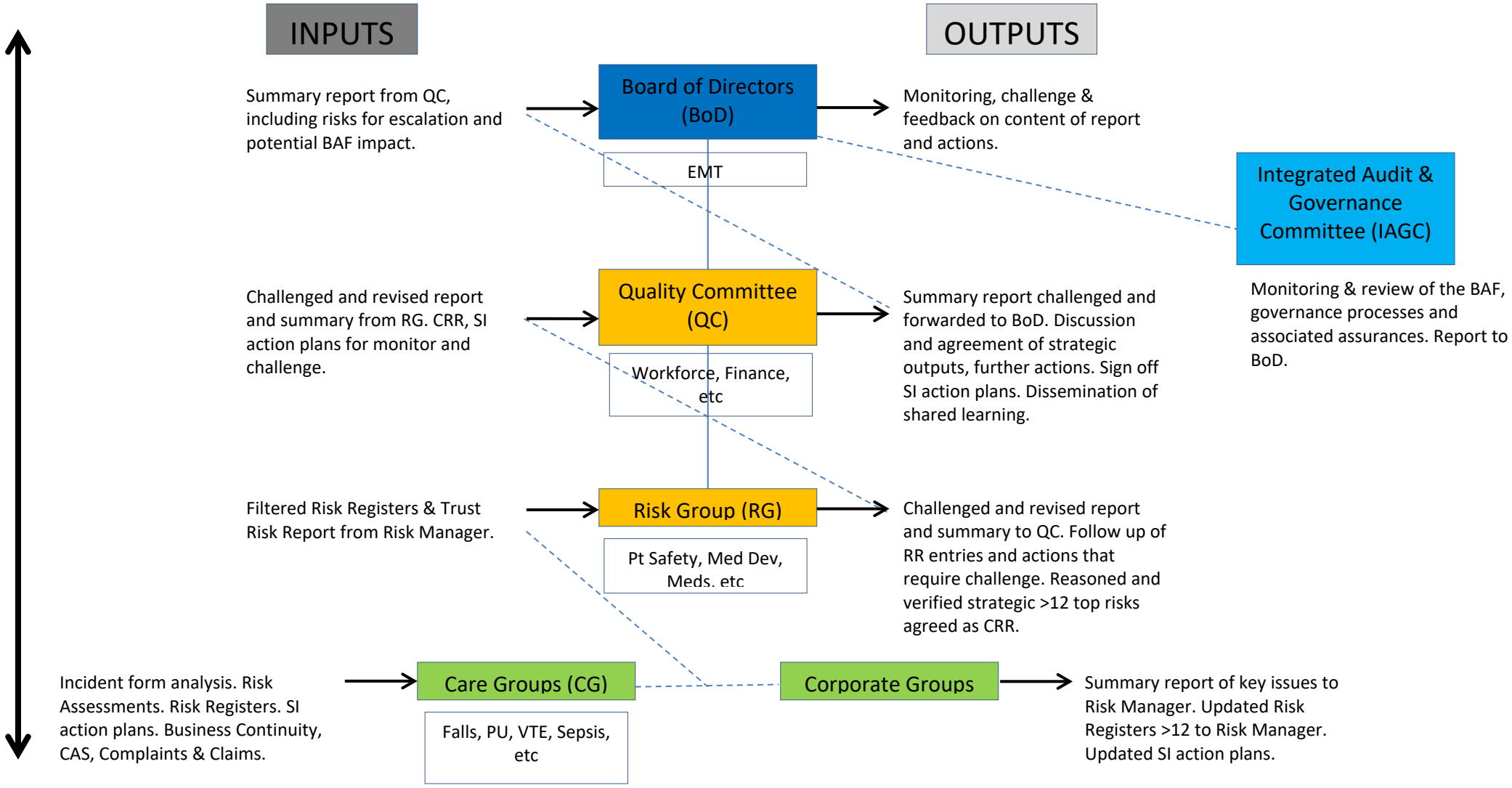
East Kent Hospitals University NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK

Quarter 1 - 2021/2022

East Kent Hospitals University NHS Foundation Trust

Inputs and Outputs from the Risk Pathways, Ward to Board



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STRATEGIC GOALS AND OBJECTIVES

The Trust Board have identified, agreed and published the following Strategic Goals and Objectives for 2021/22. They form the basis of the Trust's Annual Business Plan for 2021/22.

2021/22 Top 5 objective headings	Objectives linked to 'We Care Deliverables'
1) Our Quality & Safety: (Linked to prioritised Trust Risk No. 5. IPC and Harm) Improve **patient safety** reduce harm. CMO/CN, DIPC	1a) Achieve compliance with Trust Scorecard for pressure ulcers, falls with harm, VTE risk assessments. 1b) Show year on year reduction in the Hospital Standardised Mortality Ratio (HSMR) 1c) Reduce Covid-19, MRSA, Clostridium difficile and other key infections.
2) Our Patients: (Linked to prioritised Trust Risk No. 4. Patient Experience) Improve **Patient Experience** deliver excellent clinical outcomes. Gov Dir, CMO/COO	2a) Develop and implement a Quality Strategy, including annual Quality Account reporting and clinical audit arrangements. 2b) Develop, implement and monitor the Trust Board Scorecard trajectories for improvements in patient experience as measured by the national patient survey 2c) Deliver patient waiting times agreed with commissioners including standards for timeliness of care in A&E and Cancer waiting time targets.
3) Our People: (Linked to prioritised Trust Risk No. 1. Workforce) Reduce WTE vacancies and **enable staff** to maximise their potential. Director of HR & OD	3a) Achieve set trajectories for improvements in staff experience as measured by the national staff survey. 3b) Ensure that staff trajectories for appraisal and mandatory training compliance is met by the end of the year. 3c) Recruit to WTE staff vacancies and skill mix.
4) Our Future: (Linked to prioritised Trust Risk No. 3. 'Statutory Compliance') Develop and implement governance strategies that continually improve both the delivery and quality of Trust services**.** DQG, DCEO, CoSec	4a) Embed an integrated and forward-looking governance and performance management system across the Trust. 4b) Ensure that the Trust is compliant with its terms of authorisation at all times. 4c) Commence construction of the new ED Centres.
5) Our Sustainability: (Linked to prioritised Trust Risk No. 2. Infrastructure) Achieve sustainable **financial health.** DoF	5a) Achieve income, expenditure, efficiency and cash targets as agreed by the Board. 5b) Develop and implement a plan for long term productivity and efficiency savings. 5c) Accurate activity recording and clinical coding to enable recovery of income in line with contractual and other obligations

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STRATEGIC GOAL: 1) Our Quality & Safety: (Linked to prioritised Trust Risk No. 5. IPC and Harm) **Objective:** Improve **patient safety** reduce harm.							
	Objective Owner: Chief Medical Officer (CMO)						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: 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. **Origin Date:** 17/05/2021 **CRR Ref:** 71, 77, 110, 36, **Source**: Risk registers, CQC reports, CCG led Quality Review group, external reports of quality, triangulation of incidents, complaints and claims, NHSEI Improvement Directors review of Governance **CQC:** **Is it Safe** **Is it Effective** **Is it Caring**	1) The Quality Strategy (2019-2022), approved at Quality & Safety Committee (Q&SC), Sep 19 2) NHSEI led Governance review supported restructure and revised terms of reference for the Q&SC 3) Reduction in harm and reduction in mortality are True North objectives agreed by the Executive team and progress monitored monthly at Executive management Team meetings and reported in the Board Integrated Performance Report (IPR) 4) Breakthrough Objectives aligned to True North are monitored at monthly Executive management	**Int**: 1) Approval and monitoring of the Trust Quality Strategy, We Care objectives and Trust priority improvement projects through EMT, Q&SC and BoD. **Ext**: 1) CQC reports monitored by the BoD and action plans developed and monitored by CQC and NHSEI	1) The Quality Strategy needs realigning with the We Care improvement programme to support quality and safety priorities and the Medium-Term Improvement Plan 2)Q&SC oversight to be strengthened by the introduction of Care Group Governance reports from Jun 21 3) Roll out of We Care programme to frontline teams where improvements delivered were delayed by the Covid-19 Pandemic	1) Write an updated Quality Strategy for 21/22 incorporating We Care and medium-term improvement plan agreed priorities for safety and quality. **Who by?, Date, ASAP. TBC** 2a) Approval of Quality Strategy by Q&SC. **Who by? Date, ASAP. TBC** 2b) Standardised Governance Agenda to be agreed for all Care Groups to feed reporting template. **Director of Quality Governance, Date TBC** 3a) Building on training and experience of centre of excellence team by KPMG. **Director of Strategy Date?,** 3b) Revised trajectory for roll out to frontline teams agreed by 'Centre of	L4 x L3 x L1 x		

Is it Responsive **Is it Well-led**	Team meetings and reported in the Board IPR 5) Monthly performance Review Meetings established to ensure Care Group accountability against the delivery of quality and safety priorities, and to escalate new concerns to driver metric status through Catchball when identified 6) CQC Improvement meeting established under the Chair of CNO to monitor regulatory requirements to deliver safe care		4) Revised Quality and Safety reporting structures and reporting to be established. Initial meeting of CNO, CMO and DoQG to describe quality and safety meetings needed to deliver agenda now being implemented into structures with agreed ToR and chairs 5) Additional IPR metrics need to be identified to give greater oversight that supports delivery of quality and safety 6) Improve oversight of health and safety governance that impacts on patient safety 7) Establish responsibility and accountability for Hospital Director teams for delivery of safe care on their respective sites 8) Improve clinical outcomes through internal review, effective use of data and implementation of	Excellence' team to complete **Director of Transformation xxxxx Date** 4) Implement outputs of quality and safety reporting meetings and structure review with emphasis on learning within ToR. **Who by?, Date** 5) Update IPR metrics with agreed thresholds taken through Catchball session with full Board. **Who by? Date** 6) Review of subsidiary governance and reporting structures and feed into Q&S reporting structures. **Group Company Secretary, Date xxx** 7a) Agree model for matrix working. **Who by? Date?** 7b) Implement agreed model. **Who by? Date?** 8a) Review clinical effectiveness structures and meetings. **Who by? Date?**			

			recommendations from national clinical audits and outcomes, NICE recommendations and GIFRT	8b) Establish effective governance of NICE guidance. **Who by? Date?** 8c) Review governance and approval for clinical guidelines. **Who by? Date?**			

STRATEGIC GOAL: 1) Our Quality & Safety: (Linked to prioritised Trust Risk No. 5. IPC and Harm) **Objective:** Improve **patient safety** reduce harm.							
	Objective Owner: Director of Infection Prevention and Control (DIPC)						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: 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 **Origin Date:** 14/05/2021 **CRR Ref:** 85, **Source**: Risk Registers, "hygiene code" gap analysis, CQC reports, surveillance data	1) Surveillance and reporting of HCAI via Public Health England (PHE) Data Capture System (DCS) and national Covid-19 reporting – reported monthly to Quality and Safety Committee with progress against objectives where relevant 2) Compliance with requirements of the "hygiene code" with a plan to address any gaps reported monthly to the Quality and Safety Committee	**Int**: 1) Formally reportable data are signed off by the CEO and are reported monthly to the Quality and Safety Committee and annually, publicly via DIPC Annual Report 2) Infrastructure issues reported via Director of Strategic Development and Capital Planning (reference to strategic goal 4 and statutory compliance) "3) Hygiene Code" gap analysis report to Quality and Safety Committee, Covid third wave planning reports to	1) "Hygiene Code" gap analysis not yet completed 2) Process to identify IPC risks associated with infrastructure not complete, outputs will be from 2SS not IPC (related to 6 facet survey described in BAF for strategic objective 4)	1) Completion of gap analysis, identification of gaps, adjustment of risk and BAF and new actions stemming from any gaps. **DIPC end Jun 21** 2a) Completion and agreement of priorities for infrastructure investment and inclusion in business planning and investment strategy **DIPC/MD of 2SS and Director of Strategic Development and Capital Planning (timescale governed by others, unclear atm)**	TB C	TB C	L1 x

CQC: **Is it Safe** **Is it Effective** **Is it Caring** **Is it Responsive** **Is it Well-led**	3) Collaboration and agreement with 2gether Support Solutions (2SS) on priorities for investment to address gaps in infrastructure compliance, based on clinical (infection prevention) risk and included in business planning 4) We Care Breakthrough Objective focussed on externally reportable HCAI organisms -reported monthly to Executive Management Team and Monthly to Board 5) Third wave of Covid-19 business continuity planning	Covid Gold command, twice weekly **Ext**: 1) Data are shared with CCG and are available to NHSEI and CQC (automatically)	3) We Care Breakthrough Objective in early stages and not guaranteed to impact on outcome at this stage 4) Covid-19 third wave planning not complete	2b) Implementation of year one of agreed plan for infrastructure improvement **MD 2SS Mar 22, (BAF Objective 4)** 3) Implement We Care Breakthrough Objective and monitor impact on outcome metric on a monthly basis **DIPC monthly until end Mar 22** 4) Complete Desk top resilience exercise for Covid-19 third wave planning **Covid Medical Director/DIPC/ Emergency Planning leads May/Jun 21 (TBC)**			

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STRATEGIC GOAL: 2) Our Patients: (Linked to prioritised Trust Risk No. 4. Patient Experience) **Objective:** Improve **Patient Experience** deliver excellent clinical outcomes							
	Objective Owner: Director of Quality Governance (DQG) and Company Secretary (CoSec)						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: Failure to adequately resource, implement and embed effective governance processes throughout the Trust may result in inadequate identification, management and escalation of risks that require mitigation, poor delivery and quality and safety of services, and subsequently failure to meet statutory and regulatory requirements resulting in damage to reputation, regulatory action, and harm patients. **Origin Date:** 19/05/2021 **CRR Ref:** 78, **Source**: Risk Registers, CQC reports, audit data **CQC:** **Is it Safe** **Is it Effective** **Is it Caring** **Is it Responsive** **Is it Well-led**	1) Suite of governance policies / strategies in place, 4Policy system provides a reminder system for documents reaching their renewal date 2) Additional Executive post created, and portfolios split to provide more capacity and expertise. Director of Quality Governance appointed and joined the Trust May 21 3) Organisational structure in place below Executive Level to support the governance agenda 4) Governance structure in place 5) Governance Review Action plan in place and agreed with NHSEI	**Int**: 1) Strategies and major policies signed off in line with the Trusts Policy on Document management by the BoD 2) Document in place showing the current governance structure signed off by the BoD 3) Executive led Regulatory Compliance Committee (RCC) in place to oversee compliance with statutory and regulatory requirements **Ext**: 1) Data are shared with CCG and are available to NHSEI and CQC (automatically) 2) NHSEI governance review highlighted concerns that quality governance is not embedded.	1) Feedback is that strategies / policies are not consistently followed and are not embedded 2) The new structure / job descriptions have not been tested and it will take time to assess any gaps, overlaps or challenges 3) Corporate and Care Group structure to support quality governance is not well resourced. 4) Possible gaps in understanding of the breadth of both the clinical and	1a) Undertake a review of all strategies / policies in relation to governance framework to streamline / simplify, **AF/TI Jul 21** 1b) Once revised strategies / polices are in place communicate / train and embed. **AF/ TI Dec 21** 2) Review the structure in 6 months' time, **SAc /AA Dec 21** 3) Undertake a review of the clinical & corporate governance team structure, **TI Jul 21** 4a) Undertake a review of the Care Group governance support and team structure and present a business case	L2 x	L2 x	L1 x

		3) Well-led governance review (NHSEI Dec 2020)	corporate governance agenda 5) Regulatory Compliance Committee (RCC) not fully embedded into the governance structure and requires a review to avoid duplication and ensure no gaps (linked to assurance 3 but more specific in relation to the actual risk identified) 6) Evidence sign-off process required. 7) delivery of all actions 8) Agree how delivery and embedding of the actions will be monitored as part of business as usual.	to ensure adequate resource is in place. **RC/TI Jul 21** 4b) ensure the knowledge, qualification and skills in the job descriptions are fit for purpose, **AF/TI Jun 21** 5) Undertake a review of the terms of reference and modus operandi of RCC to ensure this supports the Director of Quality Governance and the Company Secretary in discharging their roles in relation to compliance **AF/TI Aug 21** 6) Agree evidence sign-off process **Jun 21 PC** 7) Action plan to be delivered **PC Aug 21** 8) Agree how the focussed work will move to business as usual **PC Aug 21**			

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STRATEGIC GOAL: 2) Our Patients: (Linked to prioritised Trust Risk No. 4. Patient Experience) **Objective:** Improve **Patient Experience** deliver excellent clinical outcomes							
	Objective Owner: Chief Operating Officer (COO)						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: Failure to deliver the operational constitutional standards due to the national directive to stop all planned care following the Covid-19 Pandemic **Origin Date:** 10/05/2021 **CRR Ref:** 78, **Source**: Risk assessment **CQC:** **Is it Safe** **Is it Effective** **Is it Caring** **Is it Responsive** **Is it Well-led**	1) Kent and Medway System Elective Care Programme Board provides system wide strategic direction attended by the COO 2) 4R programme is overseen by the Clinical Director 3) Waiting list validation of prioritisation codes by clinicians is at 97% 4) Weekly monitoring at the PTL meeting is chaired by the COO 5) Live reporting via the RTT App is monitored by the Deputy COO for planned care 6) Use of the independent sector is managed by the Deputy COO for planned care	**Int**: 1) We Care Breakthrough Objective 'Improving theatre capacity' monitored monthly through the Integrated Performance Report presented to the BoD **Ext**: 1) Kent and Medway System Elective Care Programme Board reports to the ICS Partnership Board	1) Development of a Systemwide PTL 2) Delivery of 80% of outpatient appointments virtually 3) Optimisation of independent sector 4) Optimisation of additional capacity via CCG	1) Delivery of workstream supporting development of PTL and patient access to any provider, **COO, Sep 21** 2) Review of outpatient areas to increase virtual outpatient appointments, **Ops Dir, Jun 21** 3) Maximise use of independent sector, **Dep COO, Planned Care, Sep 21** 4) Contracts to be developed with community providers, **Dep COO, Planned Care, Jun 21**	L4 x S4 = 16	L4 x S4 = 16	L2 x S4 = 8

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STRATEGIC GOAL: 3) Our People: (Linked to prioritised Trust Risk No. 1. Workforce) **Objective**: Reduce WTE vacancies and **enable staff** to maximise their potential.							
	Objective Owner: Director of HR and OD						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: Failure to recruit and retain high calibre staff could potentially result in negative patient outcomes and experience and impact on the Trust's reputation. **Origin Date:** 23/02/2016 **CRR Ref:** 76, **Source**: Risk Registers, Incident reports, CQC reports, NHS People Plan **CQC:** **Is it Safe** **Is it Effective** **Is it Caring** **Is it Responsive** **Is it Well-led**	1) A five-year People Strategy – People at the Heart 2020-2025 has been approved by Trust Board and is monitored via the Strategic Workforce Committee (SWC). 2) Engagement of staff scores and Turnover are True North measures which are reported and monitored monthly via We Care and Staff Committee. 3) A Recruitment & Retention Strategy with associated plans has been signed off and is monitored via the SWC. 4) A Rural & Coastal Strategy led by the Associate Medical Director has been developed and agreed at Trust Board and is monitored via the SWC.	**Int**: 1) Approval and monitoring of the agreed HR KPIs (Inc. vacancy rate, turnover and engagement scores) are monitored via We Care and PRMs and reported at SWC. 2) Workstreams and project work is monitored via the HR Senior Leads meeting, We Care and reported through SWC to BoD. **Ext**: 1) Review of EKHUFT's People Strategy via NHSEI. Benchmarking and links with national People Team. 2) Director of HR & OD part of Future of NHS & OD national programme.	1) Lack of supply of professional qualified staff is a national issue. 2) Hard to recruit areas such as Nursing and Consultants have been identified. 3) Highest turnover identified in Nursing and HCA workforce.	1&2) Use of bank, agency and other temporary workforce solutions in place via NHS Professionals platform. **Dir. HR&OD ongoing** 1&2) International Nurse recruitment pipeline utilisation with cohorts planned throughout 2021 to achieve 300 additional Nurses by winter 2021. **Deputy Dir HR Mar 22** 1&2) Links with ICP and newly formed KMMS to develop rotational and joint posts to support medical staff recruitment. **Dir. HR&OD ongoing** 3) Ready to Care Programme launched to address Nursing and HCA retention. **Associate Dir of OD ongoing**	L4 x 25	L3 x 25	L2 x 25

	5) The Director of HR &OD attends ICP workforce groups to align plans and develop other system side opportunities and agendas. 6) A Diversity & Inclusion action plan has been developed and published as part of WRES and WDES and is monitored via the EDI Steering Group, Staff Committee and reported to SWC.				

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STRATEGIC GOAL: 4) Our Future: (Linked to prioritised Trust Risk No. 3. 'Statutory Compliance') **Objective:** Develop and implement governance strategies that continually improve both the delivery and quality of Trust services**.**							
	Objective Owner: DCEO						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: 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. **Origin Date:** 27/04/2021 **CRR Ref:** 78, 13, **Source**: Risk Registers, Medium Term Risk Assessment, CQC reports, Clinical Senate advice, Royal College recommendations **CQC:** **Is it Safe** **Is it Effective** **Is it Caring** **Is it Responsive** **Is it Well-led**	1) The Chairman and CEO confirm that the STP/ICS Partnership Board prioritises and signs off the East Kent Transformation for agreement with NHSEI. 2) The Director of Strategic Development and Capital Planning ensures that the PCBC is signed off by the Trust's FPC and BoD. 3) The Director of Strategic Development and Capital Planning ensures that the implementation of the clinical strategy receives oversight from the Joint Development Board and FPC. 4) The Trust's position in terms of statutory compliance is published, reported and reviewed six-monthly by CEMG and the BoD.	**Int**: 1) Approval and monitoring of the Trust framework proposals and workstreams through SIG, CEMG, JDB, QC, FPC and BoD. **Ext**: 1) Sign off by ICP, STP/ICS and NHSEI.	1) Final sign off and approval of capital investment is outstanding from NHSEI. 2) Gaps and risks relating to backlog and statutory compliance have been identified.	1a) The outstanding actions from NHSEI's Stage Two Assurance process have now been completed and a final meeting with NHSEI is being set for completion of the Stage Two process in May. **DSD&CP May 21** 1b) Clear lines of accountability and responsibility for the sign off, of the East Kent Transformation (including the PCBC) is identified in the STP/ICS Partnership Board Strategic Priorities. **CEO Mar 22** 1c) Lobby MP's to secure funding, **DCEO Aug 21** 2a) Continue to implement annual investment plan for statutory compliance and monitor in year improvements against the agreed trajectory. **DSD&CP Mar 22**	L4 x 25	L3 x 25	L1 x 25

	5) The Trust's investment programme in statutory compliance is approved by CEMG, FPC and BoD. 6) The Trust wide backlog maintenance plan is approved and reviewed by SIG, CEMG, FPC and BoD.		3) Current estate risks do not map well from Ward to Board.	2b) Prioritise through SIG the investments for backlog maintenance as part of the PEIC capital investment programme. This will be informed by the Six Facet Survey, the work undertaken for NHSEI on reducing the backlog position and the ARUP report. Investment will be monitored through FPC and BoD. **DSD&CP May 21** 3) Finalisation of the Site Control Plans, based on the Six Facet Survey and ARUP Report to include a full ward decant and refurbishment programme. **DSD&CP Jul 21**			

East Kent Hospitals University NHS Foundation Trust

STRATEGIC GOAL: 5) Our Sustainability: (Linked to prioritised Trust Risk No. 2. Infrastructure) **Objective**: Achieve sustainable **financial health**							
	Objective Owner: Director of Finance (DoF)						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: Failure to deliver the financial breakeven position of the Trust as requested by NHSEI may result in the Trust not having adequate cash to continue adequate operations of the organisation and will result in reputational damage and non-compliance with regulators. **Origin Date:** 11th May 2021 **CRR Ref:** 102, **Source**: Regulatory target. **CQC:** **Is it Safe** **Is it Effective** **Is it Caring** **Is it Responsive** **Is it Well-led**	1) There is a first half year financial plan in place which will be presented at Board on 27th May 2021. 2) The Director of Finance is the lead for this risk, and it is managed through the Finance and Performance Committee, Clinical Executive Management Group, Finance and Investment Oversight Group, Performance Meetings with Care Groups and Directors. 3) Individual finance reports go to Care Groups on a monthly basis. Finance is monitored through the monthly IPR plus Finance report which goes to Finance and Performance Committee and Trust Board on a monthly basis.	**Int**: 1) The plan and monthly performance are monitored and minuted at monthly performance meetings with care groups, with the Finance and Performance Committee, and the Trust Board. **Ext**: 1) The financial performance of the Trust is monitored by NHSEI through a monthly return. This is approved by the Director of Finance. In addition, the Trust has a monthly oversight meeting with the regional NHSEI team to discuss financial performance (amongst other agenda items).	1) Plan for second half of the year needs to be developed. 2) Trust doesn't have a medium term or long-term financial plan. The Trust is likely to remain in finance special measures (FSM) until a balanced longer-term plan is developed.	1a) Care Groups to complete business planning cycle **Director of Finance, Jun 21** 1b) NHSEI to release planning guidance for the second half of the year and the Trust should build into expected plan. **Director of Finance,** expected date is **Q3 21** 2) Trust to develop medium term and long-term financial plans in conjunction with NHSEI and Kent and Medway ICS. **Director of Finance**, **Sep 21**	L4 x	L3 x	L1 x

	4) Other controls in place; annual business planning process, annual cost improvement programme developed, weekly activity review group in place.						

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BOD)**
DATE:	**27 MAY 2021**
REPORT TITLE:	**INFECTION PREVENTION AND CONTROL (IPC) BOARD ASSURANCE FRAMEWORK (BAF)**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC)**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: IPC BAF**

BACKGROUND AND EXECUTIVE SUMMARY

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

The incidence and prevalence of Covid-19 has reduced markedly and at the time of writing there are no cases of active Covid-19 in the Trust. During April 2021 there were no outbreaks and a single case classified as “probable healthcare associated” (positive specimen 8 or more days after admission).

Key updates are identified in red on the main document for ease:

Section 1:
- Due to very low incidence of Covid-19 and suspected Covid-19, all cases are now isolated in single rooms. No Covid-19 cohorts remain.

Section 2:
- New national cleaning standards published, 2gether Support Solutions working with the Trust on an implementation plan.

Section 4:
- Communications team reviewing newly published material from NHS England/NHS Improvement (NHSE/I) for local implementation (signage to reinforce messages around hands, face and space and behaviours of staff, patients and visitors).

Section 8:
- Due to very low incidence of Covid-19 all presumptive positives are being confirmed by laboratory swab and serum antibody tests.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Covid-19 represents a key risk to the organisation. A full integrated Infection Prevention Improvement plan is in place and is being implemented. An implementation group has been set up and meets weekly. Regular updates and exception reports are provided to the Executive Management Team (EMT) and Infection Prevention and Control Committee (IPCC).

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LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	CRR 47 – Inability to prevent Healthcare Associated Infections (HCAI). CRR 90 – Risk of death in service from Covid-19. CRR 91 – Risk that staff will contract hospital acquired Covid-19. CRR – 87 – Risk that patients will contract hospital-acquired Covid-19.
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	None

PRIVACY IMPACT ASSESSMENT: **NO**	**EQUALITY IMPACT ASSESSMENT:** **NO**

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and **NOTE** the contents of the IPC BAF report.

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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 Quality Committee (QC) and Trust Board on a monthly basis during the Covid-19 pandemic.

Key updates are identified in red on the main document for ease:

Section 1:
- Due to very low incidence of Covid-19 and suspected Covid-19, all cases are now isolated in single rooms. No Covid-19 cohorts remain.

Section 2:
- New national cleaning standards published, 2gether Support Solutions working with the Trust on an implementation plan.

Section 4:
- Communications team reviewing newly published material from NHS England/NHS Improvement (NHSE/I) for local implementation (signage to reinforce messages around hands, face and space and behaviours of staff, patients and visitors).

Section 8:
- Due to very low incidence of Covid-19 all presumptive positives are being confirmed by laboratory swab and serum antibody tests.

Infection Prevention and Control board assurance framework

1. Systems are in place 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 posed by their environment and other service users audit

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	• Emergency Department (ED) triage in place. Patients are assessed with temperature check and observations prior to booking in. Infection risk assessed and documented in ED notes. Pathway documented by a Navigating Decision Tree and Covid clerking proforma agreed by Gold command • Triage document in place to fully risk assess patients at the entrance to ED. Additional questions around previous admissions, contacts, travel and self-isolation have been added and is regularly updated in line with any new guidance • Triage document discussed at huddles daily with staff reminded to complete the proforma. Spot checks to ensure compliance. Audit data shows >95% compliance • Flag for contacts of positive cases added to Patient Tracking List (PTL) • Additional procedures in place for immunosuppressed individuals attending ED • All patients (including maternity), visitors and staff have temperature check at the front		

• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	door. Mask provided to staff and to patients and visitors who do not have face coverings • All patients streamed to the Covid (blue) area of ED are swabbed. All admissions through the non-Covid (red) stream are swabbed • Swabbing audit run daily. Wards notified of any missed swabs • Obstetric patients are triaged in maternity triage and swabbed on admission • Renal Units and oncology check patient temperature on arrival and asked Covid questions • Limited and controlled visiting restarted in general ward areas and for partners of pregnant women attending for antenatal care (e.g. scans). • Patients with confirmed Covid infection cohorted in specified wards. Patients moved for escalation of care and de-escalation from Intensive Care Unit (ICU) care only. • Stated aim is to keep confirmed cases in the Covid cohort are throughout their inpatient stay. Where step-down is necessary for clinical reasons or due to bed pressures, patients can only be moved after 14 days from their first positive test and where they have been asymptomatic for at least 48 hours (no fever without medication and some respiratory improvement). Guidance published on Trust intranet page • Due to very low incidence of Covid-19 and suspected Covid-19, all cases are now isolated in single rooms. No Covid-19 cohorts remain.		

• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• National guidance followed in all cases • Negative patients swabbed within 48 hours of expected discharge date for discharge to residential care facility and result available before transfer • Updated guidance does not require routine swabbing of post-covid patients prior to discharge when 14+ days since diagnosis. Swabbing undertaken on a case by case basis where requested by residential home • Covid positive patients within 14 days of diagnosis requiring discharge to care facility are only discharged to designated centres		
• Monitoring of compliance with IPC practices, ensuring resources are in place to enable compliance with IPC practice	• Daily observations of hand hygiene and Personal Protective Equipment (PPE) practice undertaken • Results collated on electronic audit system and available to view by matrons • Peer audit in place • Infection control team audit for triangulation • Other IPC audits in place including commodes and saving lives • Audit data reported to IPCC		
• Monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	• PPE officers on duty • Infection Prevention and Control Team (IPCT) visit wards daily and review compliance with PPE • IPC champions (medical) and IPC link nurses in place to encourage best practice		
• Staff testing and isolation strategies are in place and a process to respond if transmission rates of Covid-19 increase	• Covid testing available to all staff. • Information and Standard Operating Procedure (SOP) on staff testing and isolation available on staff zone		

	• Lateral flow testing for patient facing staff roll out from 30 November 2020. • Occupational Health manage staff contact tracing and testing • Isolation for staff contacts changed to 10 days in response to updated guidance		
• Training in IPC standard infection control and transmission-based precautions are provided to all staff	• All staff have IPC training which includes transmission-based precautions and the use of PPE • In addition to national standard training package level 1 and level 2, viewing of local video is mandatory for all staff. • Further training provided co-located with fit testing		
• IPC measures in relation to Covid-19 should be included in all staff induction and mandatory training	• Training in IPC for Coivd-19 is included in training packages for induction and annual mandatory training		
• All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	• Regular reminders through staff zone, Chief Executive Officer (CEO) blog, the Leader newsletter for managers, daily safety huddles, IPC ward visits. • Posters displayed in communal areas, corridors and on wards • Site based silver huddle daily		
• All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context and have access to the PPE that protects them for the	• Trust Covid PPE policy reflects national PHE guidance • All staff are trained in donning and doffing (See above) • Signage to support knowledge and practice • PPE available in all clinical areas and other areas as required		

appropriate setting and context as per the national guidance	• National guidance for PPE implemented within the Trust. FIT testing for FFP3 masks in place with resources identified. Fit testing at times adjusted to suit different staff shifts • Repeat FIT testing available as needed depending on type of mask available • Ongoing FIT testing sessions on all sites. Certificates provided to staff once tested • Repeat FIT testing provided following recent national withdrawal of one type of mask • Powered air respirators with hoods and reusable half masks available as required • PPE managed by the 2gether Procurement Services team 7 days per week with resilience plans in place. • PPE SOP available on Covid section of Trust intranet • Posters and signage with PPE information in donning and doffing areas. • Additional fit testing for FFP2 masks to enable increased use where required		
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Director of Infection Prevention and Control (DIPC) checks for updates to national guidance and advises executive team and Gold committee. • Changes to SOPs approved by Gold committee • Updates shared with staff in daily safety huddles and on Covid intranet page • IPC team and matrons support ward staff in implementing changes • IPC team work arrangements flexed to provide 24/7 cover during escalation • Emerging risk of *Burkholderia aenigmatica* infection associated with the use of multi-use bottles of ultrasound gel on Intensive		

	Therapy Unit (ITU). Information shared with clinicians and sterile single patient use gel implemented (this risk has now been downgraded nationally although advice for sterile gel remains)	• Limited assurance that Trust is fully compliant with Hygiene Code • A number of non-Covid IPC policies are beyond review date	• Gap analysis to be undertaken • Policies undergoing review. • Plan to adopt national catalogue of policies
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• DIPC is a member of the exec team and updates as required • DIPC reports to Trust Board through Quality Committee and directly • BAF reviewed at Quality committee and Trust Board on a monthly basis		
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	• Corporate risk register reflects IPC risks associated with Covid-19 • DIPC attends Trust Board meetings • Board assurance framework recognises findings from Care Quality Commission (CQC) review		
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• All pre-existing IPC risk assessment processes and policies remain in place for non-Covid-19 infections • The site teams determine placement of patients with suspected or proven infections prioritised into side rooms as per trust guidance • Daily meeting between Clinical Site managers and IPC. • IPCT reinforce practice at ward level • IPC PPE requirements for non-Covid infections are superseded by Covid requirements. Additional risks recognised e.g. for C. difficile and Covid co-infection, line infection associated with staff in full PPE unable to be bare below the elbows		

	• IPC team advising on a case-by-case basis. Variation to some policies required. • ITU staff wearing short sleeved gowns or rolling sleeves up above the elbows • ITU have stepped down from being considered an Aerosol Generating Procedure (AGP) “hot spot” in line with national guidance		
• Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measuring and testing of patient protocols are activated in a timely manner	• CEO or exec sign off for data submissions • DIPC signs off IIMARCH forms for outbreaks • Daily Sitrep analysis shared with senior staff • National outbreak database launched • EKHUFT IPC team have passwords enabled		
• Ensure Trust Board has oversight of ongoing outbreaks and action plans	• Outbreak update is a regular agenda item at Covid Gold committee • IPC discussed at Board and Quality committee • IPCC reports to Quality committee • Weekly IPC update to Covid Gold • A portfolio of assurance including weekly evidence returns on all aspects of infection prevention and control, in combination with very positive feedback from a CQC inspection at the William Harvey Site, has led to the successful lifting of the previous CQC Section 31 Order.		

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: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• Covid cohort areas on all three acute sites including ICU escalation • Training in use of non-invasive ventilation provided on all 3 hospital sites • ICU training for non-ICU staff to work on ICU on all three sites. Staff who have returned to original workplace are continuing to have rotational days to keep up skills • Consultant anaesthetist 24/7 on-site ICU cover during escalation • ICU-trained nurse/patient ratio decreased during escalation with additional staff to assist • Covid wards fully staffed. Named consultant for each ward. • Increased consultant cover at the front door • Safety officers and IPC Team support to Covid wards. • Nursing and medical staff upskilled in Non-Invasive Ventilation (NIV)		
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	• Cleaning services provided by 2gether • IPC training for facilities staff includes PPE usage, donning/doffing and fit testing • Training videos for facilities staff have been developed including translated version for staff who do not have English as their first language		

	• Training by the British Institute for cleaning standards rolled out to all domestic staff over a month (February/March). Including training in inspection for supervisors • Updated manual audit to be used until an electronic solution is developed • New national cleaning standards published, 2gether Support Solutions working with the Trust on an implementation plan		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with Public Health England (PHE) and other national guidance	• Decontamination and terminal cleaning completed according to national guidelines. • All surfaces cleaned with Tristel Fuse including walls • Hypochlorite wipes used alongside Tristel • HPV and UVC decontamination available when required • UVC machines purchased by 2gether to provide in-house UVC service • New 'Which Clean?' guidance posters rolled out across the Trust		
• increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	• Cleaning frequencies follow national guidance, x2 daily as a minimum. • Regular audits undertaken and results monitored • Increased attention is given to the cleaning of bathrooms and toilets • Ongoing reminders to staff to ensure that this is maintained		
• Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum	• Tristel Fuse confirmed as suitable cleaning agent for enveloped viruses by ICPT		

strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (ICPT) should be consulted on this to ensure that this is effective against enveloped viruses			
• Manufacturer's guidance and recommended product contact time' must be followed for all cleaning/disinfectant solutions/products	• Manufacturer's guidance is followed in all areas • Instructions are displayed where needed • Environmental cleaning policy reflects manufacturers requirements • Workplace assessor audits		
• As per national guidance:			
○ 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids	• In place • Public area touch points cleaned by dedicated team • Cleaning discussed at handover and huddles • Spot checks by matrons and managers in clinical areas		
○ Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	• Staff advised to clean equipment as in guidance 'time out to clean'. • Disinfectant wipes and sanitizer are available in all offices • Twice daily cleans in all areas of frequently touched areas		

○ Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• In place – double amber clean team available. ICU has dedicated cleaning staff		
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• All linen from Covid cohort wards is treated as infectious linen. • The policy mirrors the infected linen handling procedure as laid out in national guidance. • This is audited and all findings from the audits are shared with the IPC teams for action		
• single use items are used where possible and according to Single Use Policy	• Single use items are used widely across the Trust • Policy in place and available on the Trust intranet		
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	• The provider of surgical reusable instrument decontamination for EKHUFT: IHSS Ltd: is run in accordance with audited quality management systems. • The service is accredited to EN ISO 13485:2012 and MDD 93/42/EEC-Annex V. • In respect of Covid-19 all processes have been assessed to meet the current guidance. Additional precautions and measures have been put in place in line with local, PHE and national policy. •Guidance available for the decontamination and care of re-usable masks and hoods		

• ensure cleaning standards and frequency are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	•Cleaning standards in non-clinical areas are monitored as part of the audit schedule. Scores are consistently >95% •Any required actions are implemented immediately with repeat audit the following day •Rolling programme of UVC decontamination in place for non-clinical areas		
• Ensure the dilution of air with good ventilation e.g.. Open windows in admission and waiting areas to assist the dilution of air	•Given the age of the EKHUFT estate, the admission and waiting areas are all naturally ventilated with tempered fresh air ventilation only. Windows are opened to improve the dilution of airborne contaminants where possible •Windows in ward bays and side rooms to be opened for 10 minutes 3 times per day to improve ventilation •With the rapidly decreasing incidence of Covid and impending warm weather, air conditioning units are being recommissioned on the basis of a balance of risks		
• There is evidence organisations have reviewed the low risk Covid-19 pathway, before choosing any decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	•Tristel fuse remains the disinfectant of choice within the Trust for all areas including the low risk pathway •The exception is the kitchen where an alternative disinfectant is used		

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: • arrangements around antimicrobial stewardship are maintained	• The Antimicrobial Stewardship Group (ASG) includes the consultant microbiologists, antimicrobial pharmacist. • Antimicrobial Stewardship Group reports to Infection Prevention and Control Committee • Consultant microbiologist identified as antimicrobial lead • Key aspects of antimicrobial stewardship are reviewed in the daily microbiologist meetings and twice weekly IPC team virtual meetings • Meetings have recommenced following a cessation during the first peak of the pandemic • Ward pharmacists review prescribing • Business case approved for Consultant pharmacist specializing in antimicrobial stewardship • Information on national increase of Aspergillus infection in Covid patients in the ITU setting has been shared with ITU clinicians	• Insufficient dedicated time in microbiologist job plans for AMS	• Ongoing job planning review to provide additional dedicated time for antimicrobial stewardship
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Mandatory reporting of antimicrobial usage has continued throughout • IPCC has reported to Patient Safety in the past. In the new governance structure, the IPCC reports to Quality committee, a sub-committee of the Board		

	• Antimicrobial stewardship report is a standing item on IPCC agenda • Some aspects of antimicrobial stewardship audit that ceased due to pharmacy going into business continuity in wave 2 are restarting at the beginning of May 2021		

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: • implementation of national guidance on visiting patients in a care setting	• All visitors to the sites have their temperature checked at the entrance, asked to clean their hands and provided with a face mask if they do not already have a face-covering • Visitors to inpatients are permitted only on compassionate grounds and to assist patients with specific needs • A birth partner is allowed and partners can attend anomaly scans. • Out patients can have an accompanying person only when required for care needs • Mortuary viewings are not allowed • A parent or appropriate adult is able to visit their child • iPads and mobile phones are available for patients to communicate with loved ones • Booked updates to Next of Kin (NoK) by clinician in place • Families able to send photos and messages through Patient Advice and Liaison Service		

	(PALS) which are printed and laminated and given to patients • Partners able to attend anomaly scans • Keep left system in hospital corridors • Floor signage to encourage social distancing • Chairs removed from waiting rooms in ED with additional waiting areas identified. • Physical clear barriers between chairs in outpatients • Visiting policy in place to minimise visiting to compassionate circumstances and carers only • Visiting maternity services updated to reflect new national guidance from 19/04/2021 • Visiting guidance for inpatient areas updated to reflect low incidence of Covid from 16/04/2021 in line with national guidance		
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	• There are signs from the entrances to the hospital and throughout the corridors and hospital areas identifying the Covid areas - stop signs on doors • Advice is given at points of entry relating to PPE, visiting expectations and managing hygiene • Masks are available at the exit of all Covid areas allowing change of mask on leaving the area • Access to Covid wards through locked doors only		
• information and guidance on COVID-19 is available on all	• There is a separate dedicated staff Covid area on the intranet and a patient information area on the website relating to Covid – these are accessible to all and		

Trust websites with easy read versions	describe the areas within the sites that are Covid, the PPE expectations and how staff and public are to conduct their business safely within the various EKHUFT sites and areas. • The national patient information leaflets are available through the website • https://www.ekhuft.nhs.uk/staff/news-centre/coronavirus/ • All policies and SOPs are also available on the intranet		
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• Patient infection status is included on all inter hospital transfers and discharge documentation. • PHE guidance on discharge of patients is implemented • Discharge team manages complex discharge of patients to residential care facilities • Covid positive status is flagged on the patient administration system. • Patients are tested prior to discharge to a continuing care environment • Staff use appropriate PPE for all patient transfers • Any patients self-isolating following confirmed Covid contact are able to complete their self-isolation at home if medically fit. Patients are directed to the 'Stay at home' guidance and written confirmation of the day that their isolation ends • All patients have an EDN on discharge		

• there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice	• Information is prominently displayed on posters in public areas • Face masks provided at the main entrances • Floor signage to encourage 2m spacing in queuing areas • Communications team reviewing newly published material from NHSE/I for local implementation (regarding hands, face, space and other appropriate behaviours in staff, patients and visitors).		
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: • Screening and triaging of all patients as per IPC and National Institute for Health and Care Excellence (NICE) guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	• See below		
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non-Covid-19 cases to minimise the risk of cross-infection as per national guidance	• ED triage in place. Patients are assessed with temperature check and observations prior to booking in. Infection risk assessed and documented in ED notes. Pathway documented by a Navigating Decision Tree and Covid clerking proforma agreed by Gold command • Updated triage document in place to fully risk assess patients at the entrance to ED.	• Estates work required to separate paediatric streams in William Harvey Hospital (WHH) ED	• Plans developed to be implemented in December to create Covid paediatric area in WHH ED

	Additional questions around previous admissions, contacts, travel and self-isolation have been added. Audit data shows >95% compliance • Covid and non-covid streams segregate patients according to symptoms in ED. • Additional isolation rooms identified for immunocompromised and shielding patients attending ED • Training for all staff in ED on the management of immunocompromised patients • Training videos developed including Q&A with DIPC • Blue (suspected Covid) patients are placed in a cohort bay pending swab results. A new bay is identified each day as the pending bay. If a patient has a positive swab they are moved out of the bay, bay is closed and the other (negative) patients remain in their cohort until they either go home, test positive or 14 days has passed. If all patients in a bay are negative they are placed into red stream beds after clinical review • Patients streamed to blue (covid) or red (non-covid) zones • Negative pressure isolation room available for patients requiring Aerosol Generating Procedure (AGP) in Emergency Department • All elective patients have Covid swab 24-48 hours prior to admission including patients for outpatient procedures All patients and visitors entering through main entrances have temperature check and are given masks		

• staff are aware of agreed template for triage questions to ask	• Non-elective paediatric patients triaged in paediatric assessment area which is zoned for Covid risk • Triage at paediatric outpatients. Clinical review undertaken whenever temperature is high • Obstetric patients undergo triage in maternity triage. Covid side rooms available for suspected cases. All admissions to maternity are swabbed • All patients streamed to the Covid (blue) area of ED are swabbed immediately. All patients admitted through the non-Covid (red) stream are swabbed following a decision to admit. • Non-Covid stream patients have rapid Covid tests using SAMBA point of care test • ED Covid (known or suspected) pathway reviewed and approved by Gold, definition of 'contact' rationalized resulting in fewer contacts and improved management • 'Merging' of contact cohorts discontinued as numbers much lower and pilot of increased Covid testing of contacts to every 48 hours until 14 days post contact • Patients are cohorted into blue and red areas until results are known. • Positive patients are transferred from red to blue as soon as results are known. • Negative patients remain in their admission cohort until all results are known to avoid placing a contact of a positive case in a non-exposed bay. • Non-admitted patients who are swabbed and positive followed up by infection control	• Lack of side rooms results in cohorting of non-elective patients awaiting swab results. Potential for cross infection	• A live patient tracking system has been developed which identifies all Covid-19 positive patients showing which stream and wards the patient has been in on each day of admission together with any other Covid-19 positive patients enabling rapid identification of any contacts.

• triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	• Updated triage form has been developed and implemented • Training for ED staff implemented • Regular audit in place • Additional audit questions following updated national triage tool • Additional questions to reflect new risks (e.g. SA variant etc.) • Registered nurse at front door allocates patient to correct pathway		
• face coverings are used by all outpatients and visitors	• All outpatients and visitors wear masks except for those carrying exemption certificates • Masks provided at front entrance if required		
• facemasks are available for patients with respiratory symptoms	• All patients (including those with respiratory symptoms) in ED encouraged to wear face masks		
• provide clear advice to patients on use of facemasks to encourage the use of surgical facemasks by all inpatients in the medium and high risk pathways if this can be tolerated and does not compromise their clinical care	• All inpatients encouraged to wear face masks if tolerated. • Patients must wear a mask when leaving the bedside unless clinically unable to		
• ideally segregation should be with separate spaces, but there is potential to use screens e.g. to protect reception staff	• Reception staff are protected with screens • Patients in ED separated by clear curtains in majors • Social distancing in place in waiting areas		

	• Vaccination centres have been organized with social distancing and separate spaces • Clear curtains between beds rolled out and in use across the Trust		
• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	• Inpatients who develop symptoms are isolated wherever possible, bay closed pending results • Contact tracing carried out for all inpatients who test positive • Patients who develop symptoms in a non-covid area are tested promptly. The rationale for testing is documented in the patient's notes • Patients admitted on the Covid pathway who test negative initially have a medical review and are reassessed to either no longer suspected or continuing high risk of Covid. The high risk patients are re-swabbed 48 hours after admission • All patients who test negative on admission are re-tested at day 3 then 5-7 days in line with national guidance. • Day 3 testing compliance being measured and showing month on month improvements in the data		
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• Patients attending out-patient appointments have their temperature checked at the front door • If temperature is high, patients reviewed by clinician in ED • Patients for elective admission who are unwell on the day of admission despite a negative pre-admission Covid swab have a medical review to determine if their planned treatment can proceed.		

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: • Separation of patient pathways and staff flow to minimize contact between pathways. For example this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage and restricted access to communal areas	• Separation challenging due to estate. • Keep left signage in corridors • Additional entrances available for staff • Patients not permitted to use staff restaurants		
• all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	• All staff undergo IPC, Health and safety e-learning and Fit testing. • Locum and agency staff are fit tested and have local induction in IPC • IPC link assessor checks hand hygiene competence and records on Electronic Staff Record (ESR) • All new staff have induction training including IPC and FIT testing as appropriate • Updated induction process to include infection prevention session in addition to on line package • DIPC PPE video is mandatory training for all staff. • Facilities staff have videos for different staff groups including translated version for staff		

	who do not have English as their first language • Staff PPE and hand hygiene training repeated in all outbreak areas together with Fit test checking. • ICU training in place for non-ICU trained staff working in ICU. • Medical and nursing training and at induction. National IPC e-learning modules in use. Level 1 for non-clinical and level 2 for clinical. Recorded on ESR • Covid protocols on microguide for medical staff. ICS/Root Cause Analysis (RCA) on-line COVID hub • PPE officers provide face to face training on wards • IPC team provide ad hoc training in clinical areas • Covid-secure areas identified in non-clinical areas • Risk assessments in place to assess the number of people able to occupy an area maintaining social distancing. Posters displayed on doors • Any concerns are raised in the daily morning silver site huddles attended by representatives from all staff areas including 2gether staff and the designated site clinical and management leads. • IPC Team available in real time • Remobilisation IPC guidance implemented in full for surgery, theatre and ITU with supporting SOPs. Not implemented in other areas to provide consistency for staff and avoid confusion regarding AGP patients.		

• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	• PPE information materials to reinforce appropriate use of PPE available on staff area of the Trust Intranet • sessional and single use PPE information cascaded and available on the intranet • FIT testing available for all staff who need it. Repeat FIT testing undertaken for new types of mask • Signage and posters displayed on wards and in donning and doffing areas • Estates work on Oxford and Cambridge J complete, providing donning and doffing areas		
• a record of staff training is maintained	• An electronic log of staff training is in place • A record of FIT testing is maintained		
• appropriate arrangements are in place that any reuse of PPE in line with the Central Alerting System (CAS alert) is properly monitored and managed	• The continual training program also includes re-usable equipment and methods of cleaning • Respirator hoods are managed by Electronics and Medical Engineering (EME). They are issued, once authorized, via the medical equipment libraries (MEL). Short term loans are returned (socially clean) to the MEL where they are cleaned again and ATP tested • Other PPE will only be re-used with Gold and IPC agreement and release of clear guidance		
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	• All incidents related to PPE reported as Datix incidents • Incidents investigated and learning shared • Product quality issues are sent to procurement for investigation and action		

• adherence to PHE national guidance on the use of PPE is regularly audited	• Gold command monitor incidents and takes urgent action as appropriate by cascading to procurement for response. • Incidents causing harm are raised as potential Serious Incident (SI) to panel – If agreed then 72-hour report and full RCA • PPE usage is audited as part of outbreak investigation • Combined PPE and Hand hygiene audit in use in clinical areas		
Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimize Covid-19 transmission such as: • hand hygiene facilities including instructional posters • good respiratory hygiene measures • maintaining physical distancing of 2m wherever possible unless wearing PPE as part of direct care • frequent decontamination of equipment and environment in both clinical and non-clinical areas	• All hand hygiene facilities have hand hygiene instructions on the splash back • All staff, outpatients and visitors wear masks • Inpatients encouraged to use masks as much as tolerated • Social distancing encouraged • Signage on doors stating maximum occupancy • Additional break areas available • Disinfectant wipes provided for non-clinical areas • Domestic and nursing cleaning tasks implemented in clinical areas. Records kept of cleaning • Advice available by posters, verbal advice at the entrances. • PPE policy available on staff zone		

• clear advice on the use of face coverings and face masks by patients/individuals, visitors and by staff in non-patient facing areas • staff regularly undertake hand hygiene and observe standard infection control precautions	• In place. Daily audits of hand hygiene compliance reported to daily safety huddle and available electronically • Antimicrobial hand rub widely available and at the end of all beds • Updated audit covers hand hygiene and PPE reflecting current practice • Discussion at safety huddles and handover • Hand hygiene included in PPE video for mandatory and induction training • All staff given small bottles of hand rub and refilling stations provided • 2gether maintain all hand rub bottles (except those at the end of patients' beds) • Additional stocks of hand rub for wall mounted dispensers identified • Hand rub provision reviewed on all wards to ensure that all entry and exit points have provision • All clinical areas hand wash basins are co-located with paper towel dispensers • All portable sinks have back boards to hold soap and towel dispensers and hand washing instructions • Full review of placement of all portable hand wash basins ongoing		
• 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	• All hand wash basins have hand washing and drying guidance on back boards or posters in both clinical and public areas		

the risk of splash contamination, as per national guidance • Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff toilets • staff understand the requirements for uniform laundering where this is not provided for on site	• 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 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		
• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	• Staff are aware of and understand the process for reporting absence. • Information on symptoms of Covid shared widely including posters, staff Intranet site and daily huddles • SOP published on Covid pages of intranet • On-line appointment system available to book testing • Occupational health available via email and phone to access advice from dedicated staff • Occupational Health staff explain the self-isolation process to symptomatic and Covid positive staff • Occupational health under-take contact tracing and staff screening as necessary. • Occupational Health are instrumental in providing advice, results and follow ups as and when required, keeping staff informed and managing their well-being.		

	• Symptomatic positive staff self -isolate for a minimum of 14 days. Asymptomatic positive staff self-isolate for 10 day		
• A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organization onset cases (staff and patients/individuals)	• Community rates of infection are continuously monitored with information disseminated to senior managers • Daily sitrep analysis available to all managers • Discussion at daily exec Covid Gold committee • Covid variant with 70% increased transmissibility identified in Kent and Medway		
• 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 and outbreak investigation and are reported	• Outbreaks declared according to national guidance • Outbreaks are investigated and Serious incidents declared as appropriate • IIMARCH forms completed for all outbreaks • Outbreaks reported via national online platform		
• Robust policies and procedures are in place for the identification of and the management of outbreaks of infection	• Outbreak SOP in place • Active management by infection control team • Daily outbreak meetings		

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: • Restricted access between pathways if possible (depending on the size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	• Pathways clearly identified • Surgical green pathway implemented and reviewed according to prevalence of infection • Visitors not permitted in Covid positive areas except for end of life visiting • Green capacity being re-introduced in response to falling incidence of Covid		
• Areas/wards are clearly signposted, using physical barriers as appropriate so patients/individuals and staff understand the different risk areas	• Ward doors are locked • Restricted access to covid areas • Signage in place		
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• All suspected and confirmed Covid patients are placed in designated Covid wards. Suspected cases are cohorted chronologically until test results are available • Negative pressure side room in ED (at WHH) for Covid patients requiring Aerosol Generating Procedures. • Isolation ward is designated for Covid AGP during escalation • Covid ICU is negative pressure on all three sites.		

• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• Covid NIV patients nursed in cohort bays to enable nursing expertise to be best deployed to keep patients safe • Negative pressure bay have been created for care of NIV patients • Most bays now have doors • Cohort bays have privacy curtains between the beds to minimize opportunities for close contact • Cohort wards are separated from non-segregated areas by closed doors • Signage displayed warning of the segregated area to control entry • Cohort areas differentiate the level of care (general and Covid ICU) • Suspected or confirmed paediatric patients accommodated in side rooms with en-suite facilities • Maternity has a green pathway for elective C-section • Ward area windows opened for 10 minutes three times per day to improve ventilation	• A designated self-contained area or wing is not available for the treatment and care of Covid patients. No separate entrance is available	• Access is through closed doors accessible using PIN number • Fob access to maternity/ paeds/Neonatal Intensive Care Unit (NICU) for staff. Intercom for patients and visitors • Not used as staff/visitor thoroughfare
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Pre-existing IPC policies continue to apply • Some variance required to meet the requirements of Covid levels of PPE in co-infected patients • Active management of side room provision between ICT and site managers through daily meetings	• Some pre-existing IPC policies are past their review date.	• Ongoing work to review and update • Plan to implement the national catalogue of policies

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: • Ensure screens taken on admission are given priority and reported within 24 hours • Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Laboratory pathway in place to ensure priority for ED samples. Red bags in use • Turnaround times closely monitored and reported daily • Near patient testing fully deployed at WHH and Queen Elizabeth the Queen Mother Hospital (QEQMH). • Turnaround times monitored daily for near patient testing • Testing undertaken by registered biomedical scientists with documented competencies • Methods validated prior to diagnostic testing • Tests sent to Pillar 2 labs when demand outstrips capacity • Extended laboratory working hours to deliver service • All non-elective patients are tested on admission (day 1), on day 3 then day 5-7. • Results available through electronic PTL in real time • Positive results followed up by IPC team • All results reported to PHE via Co-surv • All elective patients tested 72 hours prior to admission • On line booking system for staff testing • All staff tested as part of one-off screen at the end of July 2020	• Turnaround times not yet consistently below 24 hours • Unable to monitor patient-result TAT for laboratory tests • Audit data showed low day 3 test compliance	• Additional small batch analysers introduced • Increased pathology transport runs between QEQMH, Kent & Canterbury Hospital (K&CH) and WHH • Patient Tracking List (PTL)/whiteboard alert for test required • Reminder at huddles • Data showing month on month improvement

• 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	• Staff results sent by text message directly from the on-line system. Occupational health follow-up positive staff members • Antibody testing available to all patients and staff on request • Covid testing SOP is agreed by Gold and is available on the Trust intranet • Due to very low incidence all presumptive positive Covid-19 are being confirmed by laboratory swab and serum antibody tests • Results monitored and flagged on PTL • Automatic reminders for swabs due appear on ward PTL • All routine diagnostic tests remain available • Testing for other respiratory viruses available. Testing algorithm in place in microbiology. Consultation with clinical teams has been undertaken • Admission MRSA, GRE and CPE screening continues as in pre-covid policies • Routine testing for *C. difficile* in patients with diarrhoea continues		
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: • staff are supported in adhering to all IPC policies, including those for other alert organisms	• IPC team supports wards. All wards visited daily by matrons and IPCT. Fully range of Covid SOPs in place	• Some pre-existing IPC policies are past their review date.	• Ongoing work to review and update • Plan to implement the national catalogue of IPC policies

	• Advice available from IPC team and consultant microbiologists. On call rotas in place		
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• DIPC responsible for checking for updates to national guidance and advising executive team • Updates shared with staff through Covid Gold, Team briefs, huddles and ward catch up meetings and through the staff page of the Trust intranet. Clinical areas have a nominated individual to check the intranet daily for updates • Trust wide emails sent to all staff as and when appropriate • PPE SOP is approved by Gold committee and available on the intranet • IPC team support ward staff in implementing any changes		
• all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• All clinical waste related to possible, suspected or confirmed Covid-19 cases is disposed of in the Category B(orange) clinical waste stream • New guidance for disposal of lateral flow tests and vaccination centres –current practice already in line with guidance		
• PPE stock is appropriately stored and accessible to staff who require it	• PPE central stocks are held on all sites • Active management of stock levels by procurement to ensure safe levels of stock • Wards receive a top up delivery of PPE 2-3 times weekly and can order additional stock by phone from the stores on each site which is delivered promptly • Information for ward staff available on the Trust Intranet		

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**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• Staff risk assessment in place • Redeployment opportunities and working from home for high risk staff • Employee assistance programme in place including 'grab bags', free parking, staff areas, psychological support, access to counselling, health and fitness advice. • Annual leave continues to be taken • Staff advised to observe track and trace rules and self-isolate if requested to do so. • Staff advised to observe all quarantine rules when returning from other countries • Vaccine roll out commenced with high risk groups identified for priority vaccination • Vaccine offered to all staff		
• that risk assessments are undertaken and documented for any staff members in an at-risk shielding group, including Black, Asian and minority ethnic (BAME) and pregnant staff	• 99% of BAME staff risk assessments completed • Risk assessments on all staff undertaken		
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a	• FIT testing in place. • A log of staff training is available • SOP available on staff intranet for reusable respirators		

record of this training is maintained	• Staff given training and guidance on cleaning		
• staff who carry out fit test training are trained and competent to do so	• Fit testers all have recognised national training competence		
• all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	• All staff required to wear a FFP respirator are fit tested • Fit testing on new models available as required		
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	• A central log of Fit testing is maintained • Staff given results identifying type of mask to be worn		
• for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	• As above • Re-usable masks and hoods are available for staff who fail fit testing with disposable masks		
• for 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	• Redeployment options are available. These are discussed with each member of staff where the risk assessment and fit testing identifies redeployment as suitable and appropriate mitigation.		

• 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	• Records are kept and stored electronically		
• following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	• An electronic system is in place to record and store details for risk assessments and any necessary mitigations to support individual members of staff. Any redeployment decision is retained as part of this record. This process adopts and follows the nationally agreed algorithm. This is in place for current staff and forms part of the pre-employment process for new starters.		
• 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 centrally held record is maintained. But this sits outside of ESR currently. This is being reviewed in order to facilitate routine reporting as part of statutory and mandatory training compliance to the board		
• Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways	• Green pathways for elective care have been developed. SOP in place • Theatre SOP in place designating green and blue pathways to avoid cross over. SOP in place • Dedicated green elective surgical wards on all three sites		

and urgent and emergency care pathways, as per national guidance			
• All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Masks worn at all times in the hospital buildings except when in a designated covid-secure area or when eating and drinking • Staff social distancing in corridors and queues • Assessments undertaken in all work areas. The number of people able to occupy a room whilst maintaining social distancing is displayed on the door. • Staff working from home wherever possible • Rotation of teams in some services to maintain covid secure workplaces eg admin teams • Additional outdoor seating to provide extra socially distanced space for staff breaks • Maximum occupancy signage on doors of break rooms • Chairs removed and screens put up in staff canteen to facilitate social distancing • Floor signage in place • Messages reinforced in safety huddles		
• 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	• All non-clinical areas assessed for Covid security. • Maximum occupancy identified on signage • Disinfectant wipes available to staff in non-clinical areas to clean workstations		
• staff are aware of the need to wear facemask when moving	• Advice given to staff to don masks whenever moving around Covid secure area		

through COVID-19 secure areas.			
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• Employee assistance programme in place including psychological support, access to counselling, health and fitness advice. • On-line booking for testing for all staff • Drive through testing centres on all 3 acute sites • Occupational health monitor shielding staff at the request of employee and/or manager. • Staff who are self-isolating are monitored by their line-manager within the absence management process and can be review on request by occupational health		
• staff that test positive have adequate information and support to aid their recovery and return to work.	• Occupational Health staff explain the self-isolation process to symptomatic and Covid positive staff. Have updated PHE self-isolation information to reflect Trust policy • Occupational Health have provided return to work information on Trust Intranet for employees and managers. • Occupational health available via email and phone to access advice from dedicated staff. • Occupational Health and HR have maintained staff wellbeing pages on intranet keeping staff informed on managing their well-being, signposting for both physical and mental health. This includes information regarding the Employee Assistance Programme, partnership working with Remploy and self-referral to OH Wellbeing Advisor.		

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**27 MAY 2021**
REPORT TITLE:	**ESTATES STATUTORY COMPLIANCE AND HEALTH & SAFETY UPDATE**
BOARD SPONSOR:	**DIRECTOR OF STRATEGIC DEVELOPMENT AND CAPITAL PLANNING/DEPUTY CHIEF EXECUTIVE OFFICER (CEO)**
PAPER AUTHOR:	**INTELLIGENT CLIENT / ASSOCIATE DIRECTOR OF SAFETY /DIRECTOR OF CAPITAL & TECHNICAL**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

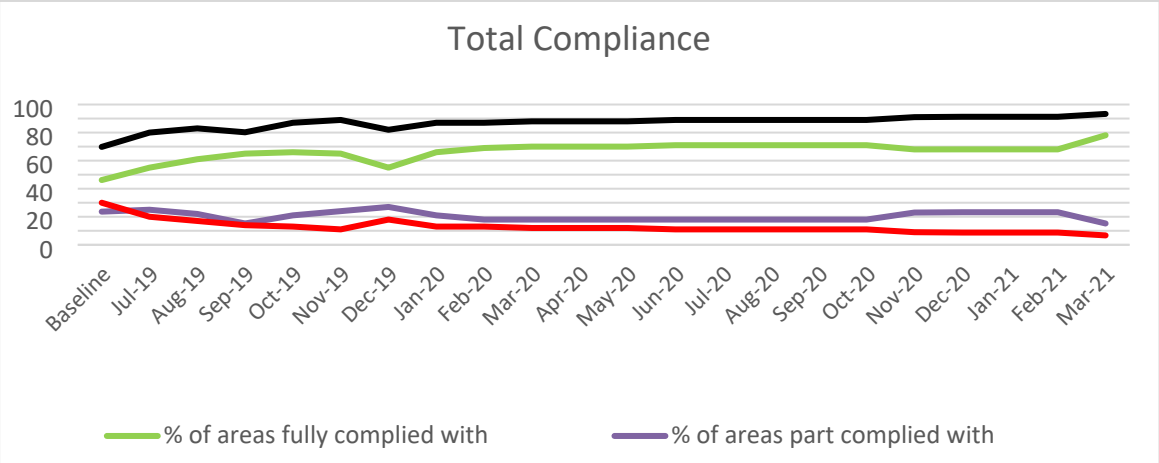
Background and Executive Summary

This report updates the Trust Board on the Trust's position in relation to statutory compliance and progress to date on the annual Health & Safety Toolkit Audit (HASTA) performance.

Estate Statutory Compliance Update

The level of statutory compliance across the Trust improved in all Trust areas and is now at 78% full compliance and 15% partial compliance as detailed in the below table.

This follows an increase of £500,000 investment in year and through targeted Planned Preventive Maintenance (PPM) works in electrical and fire safety disciplines. This increase in investment and subsequent compliance performance is expected to continue to increase through to 2024/25 in line with the agreed prioritised investment approved by the Trust in the Statutory Compliance Business Case (previously presented).



The Trust is supporting 2gether Support Solutions (Trust subsidiary), to implement best practice and move to an evidence based, real-time asset-based compliance management software programme called Zetasafe. The software has been purchased as part of the Water Safety Tender and will be implemented 2021/22.

As part of the implementation, all assets across sites are being asset tagged. This exercise involves barcoding all plant and equipment that's subject to PPM in adherence with Building Services Research and Information Association (BSRIA) and SFG20 guidance, (the definitive standard for PPM, recognised industry standard).

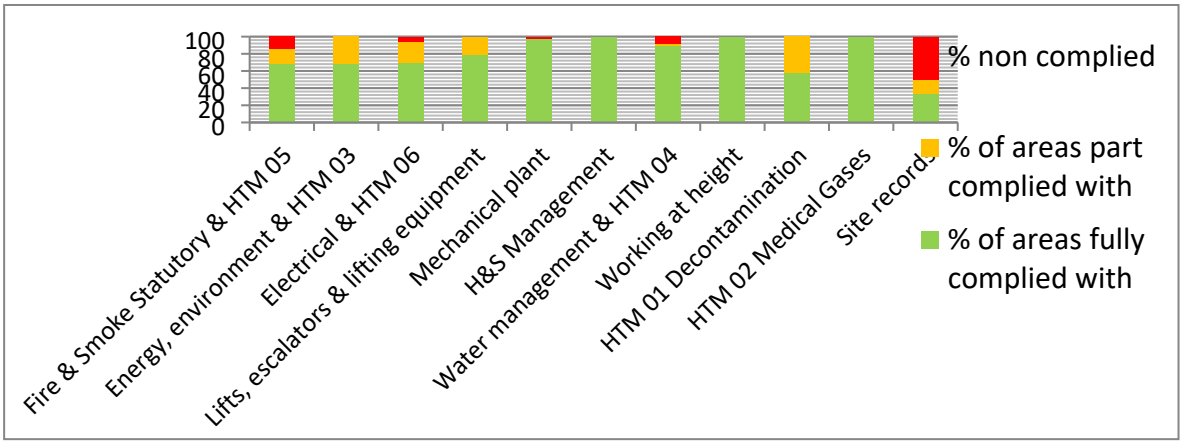
Oakleaf (an asset management firm) was appointed in 2019 to undertake this work, but the process was put on hold during both waves of Covid. The exercise was restarted in March 2021 and site surveys were resumed, with a plan for completion in Q1 2021/22.

The table below shows overall and site compliance levels. Full compliance levels are recorded at: Kent & Canterbury Hospital (K&CH) 84%; William Harvey Hospital (WHH) 77%; and Queen Elizabeth the Queen Mother Hospital (QEQMH) 73%.

Compliance Overview March 2021 - Desk Top Audit	KCH			WHH			QEQM			Overall Total		
Category	No of Compliance areas	% of areas fully complied with	% of areas part complied with	No of Compliance areas	% of areas fully complied with	% of areas part complied with	No of Compliance areas	% of areas fully complied with	% of areas part complied with	No of Compliance areas	% of areas fully complied with	% of areas part complied with
Fire & Smoke Statutory & HTM 05	12	66.67	16.67	21	71.43	14.29	17	64.71	20.00	50	68.00	18.00
Energy, environment & HTM 03	19	73.68	36.84	19	63.16	22.00	19	68.42	33.33	57	68.42	31.58
Electrical & HTM 06	17	76.47	33.33	17	70.59	23.53	18	61.11	33.33	52	69.23	25.00
Lifts, escalators & lifting equipment	9	75.00	17.65	9	77.78	22.22	11	81.82	18.18	29	79.31	20.69
Mechanical plant	15	100.00	0.00	16	100.00	0.00	16	93.75	0.00	47	97.87	0.00
H&S Management	2	100.00	0.00	2	100.00	0.00	2	100.00	0.00	6	100.00	0.00
Water management & HTM 04	24	100.00	0.00	24	87.50	0.00	24	79.17	8.33	72	88.89	2.78
Working at height	4	100.00	0.00	4	100.00	0.00	3	100.00	0.00	11	100.00	0.00
HTM 01 Decontamination	3	100.00	0.00	9	55.56	44.44	7	42.86	57.14	19	57.89	42.11
HTM 02 Medical Gases	9	100.00	0.00	9	100.00	0.00	9	100.00	0.00	27	100.00	0.00
Site records	6	33.33	16.67	6	33.33	16.67	6	33.33	16.67	18	33.33	16.67
Total	120	84.17	12.50	136	77.21	14.71	132	73.48	18.18	388	78.09	15.21

In the last quarter (Q4) of 2020/21 there were seven categories recording non-compliance, there are five with medical gases and lifts now recording full or partial compliance. The top three areas for improvement are site records; fire; and water safety. Electrical (HTM 06) has also seen an improvement, due to additional work on emergency lighting that has taken place in 2020/21.

Quarter 4 Showing Compliance and Non Compliance in Specific HTM Standards



The Trust recognises improvements are required relating to fire and site records. The fire contract, including the Innovation and Technology Tariff (ITT) was subject to a procurement process at the end of April 2021. Site records will also dramatically improve once all assets are loaded in to Planet following the asset survey.

The water deterioration was due to the 'in house' services being unable to cover the provision during the two waves of Covid, as this is normally provided by an external contractor who could not come to site. The water safety contract has recently been re-

awarded and this is anticipated to improve to full or partial compliance within the next quarter.

Fire Investment Plan

The next phase of fire safety improvement works relates to completion of the comprehensive compartmentalisation desktop exercise which is currently 98% complete. By next quarter these will be finalised and passed to Oakleaf for physical surveys to be conducted, in advance of associated compartmentalisation maintenance works on Fire Smoke Dampers and Fire Doors. This will directly contribute to increased compliance in this area by Q4 2021/22. The Fire Safety Group is continuing to meet and monitor these improvements, with a continued focus on Fire Risk Assessments (FRAs) and Fire Training.

Health & Safety

All the audits that were postponed due to Covid-19 restrictions, have now been completed for 2020/21. Overall and, particularly given the pressures all services have been under in the 2020/21 audit period, the scores continue to be positive.

HASTA Audit Scores by Care Group:

Care Group	2020/21	2019/20	2018/19	2017/18
Cancer	94%	94%	72%	87%
Clinical Support Services	96%	97%	78%	87%
Corporate	93%	89%	82%	85%
General and Specialist Medicine	89%	88%	63%	81%
Head & Neck	91%	89%	58%	86%
Surgical & Anaesthetic	88%	92%	70%	79%
Urgent & Emergency	81%	62%	45%	66%
Women & Children	94%	90%	66%	73%
Trust	91%	90%	71%	82%

Health & Safety Team- 2gether Support Solutions (2gether)

The Team continue to provide a good service to the Trust and the teams work was recently recognised in 2gether staff awards programme. The Health & Safety Team has secured training to develop their skills and therefore enhance the internal skill set for the Trust. The additional training provided to the team includes fire safety management, construction safety and general health & safety.

Trust Health & Safety Leads

It should be noted that the Trust Health & Safety Leads have worked to embed Health & Safety standards in the Care Groups over the past challenging year. The table above demonstrates improvements in all Care Groups with the exception of Surgery and Anaesthetics, this was due to a vacancy in the Health & Safety Lead post which has now been filled by a senior matron.

Link Worker Meetings

Quarterly Link Worker meetings continue to be conducted via WebEx and / or Microsoft Teams, with some face to face meetings planned for 2021. The introduction of subject matter experts into the meetings will take place with the first speakers being the Fire Manager and Security Manager. It is planned to invite speakers from outside agencies in the near future.

Health & Safety Training

The first slots for Health & Safety link worker training in 2021/22 has been scheduled for April and May 2021. Further sessions will be scheduled for September and October 2021 and 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.

Conclusion

Health & Safety performance has continued to improve cumulatively in 2020/21 despite the challenges of the pandemic.

The Health & Safety Team (2gether) with Health & Safety Leads (Trust) have worked together to ensure continued compliance against the HASTA framework. HASTA outcomes will continued to be monitored via monthly Health & Safety meetings chaired by the Intelligent Client. Formal quarterly compliance reports are presented to the Strategic Health & Safety Committee chaired by the Trust's Deputy Chief Executive Officer (CEO).

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	CRR34 – Inadequate Health & Safety systems embedded within the Care Groups.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability; and** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	CRR 34 – Inadequate Health & Safety systems embedded within the Care Groups.
RESOURCE IMPLICATIONS:	N/A
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Strategic Health & Safety Meeting.
SUBSIDIARY IMPLICATIONS:	2gether is providing health & safety advice and guidance in line with the Service Level Agreement.

PRIVACY IMPACT ASSESSMENT: NO	**EQUALITY IMPACT ASSESSMENT:** NO

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and **NOTE** the progress statement regarding Estates Statutory Compliance and Health & Safety.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**27 MAY 2021**
REPORT TITLE:	**CONSTITUTION REVIEW – COUNCIL OF GOVERNORS' RECOMMENDATIONS**
BOARD SPONSOR:	**TRUST CHAIRMAN**
PAPER AUTHOR:	**GROUP COMPANY SECRETARY**
PURPOSE:	**DECISION**
APPENDICES:	**APPENDIX 1: RECOMMENDATIONS FOR CHANGE FROM COUNCIL**

BACKGROUND AND EXECUTIVE SUMMARY

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 at the Council meeting on 20 May 2021.

Appendix 1 provides:

- notes of the discussions by the C&PRG;
- the recommendations made by them for Council deliberation;
- brief notes of the Council discussions; and
- the recommendations that Council has agreed to bring to the Board.

Amendments to the Constitution must have the support of over half of both Council and Board and must comply with schedule 7 of the 2006 National Health Services Act, otherwise they have no effect. Both Board and Council must agree for the change to be implemented. Agreed amendments must then be taken to the next Annual Public Meeting of the Trust; any changes affecting the role of the Governor will need approval at that meeting.

For context, 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 comprises:

- Governors - Alex Lister (AL) (Chair), Carl Plummer (CP), Bernie Mayall (BM), Ross Britton (RB) and Ken Rogers (KR).
- Non-Executive Director (NED) - Nigel Mansley (NM).
- Group Company Secretary - Alison Fox (AF).

Prior to the meeting the group was provided with a list of the issues already identified to be considered for change within the Constitution and had an opportunity to add further items. To help inform the meeting, the Trust had arranged for comments to be provided from NHS Providers in relation to proposed constitution changes.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The recommended changes are designed to support robust corporate governance which meet legislation requirements and best practice.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;**

East Kent Hospitals University NHS Foundation Trust

	• **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	None
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Council of Governors
SUBSIDIARY IMPLICATIONS:	None

PRIVACY IMPACT ASSESSMENT: *NO*	**EQUALITY IMPACT ASSESSMENT:** *NO*

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss the items presented within Appendix 1 and consider the specific recommendations made:

Recommendation 1:
Revise the Constitution to state that confidential votes are used in extremis by agreement in Council and in a way which ensures that the individual's votes remain private. The timeframe for confidential votes to be five days, but can be shorter if required, by agreement with Council.

Recommendation 2
Revise the Constitution so that virtual voting is undertaken via a secure electronic system and passed by a simple majority of the number of Governors on Council, unless already stated otherwise in the Constitution. Public Governors must be the majority of those voting.

Recommendation 3
The change to allow Partner Governors to have deputies should not be accepted.
Check to be made to ensure the definition for Partner Governors is consistent and clear.

Recommendation 4
No constitutional change needed in relation to governors standing down if they move out of area mid-term.

Recommendation 5
Revise the Constitution to:

- Increase the maximum number of NEDs on the Board to eight excluding the Chairman.
- Define Non-voting NEDs and Executive Directors.
- Define Associate Directors.
- Remove the reference to South East Coast Ambulance Service NHS Foundation Trust (SECAmb).

NHS
East Kent
Hospitals University
NHS Foundation Trust

Recommendations for change from Council

Ref	Description	Constitution reference	Constitution and Policy Review Group meeting points Council meeting points Outcome from Council discussion: recommendation to Board or a further action or no action
1.	**Voting** Should the need arise for a confidential vote which should not be very often then this needs to be carried under proper conditions and within an agreed timeslot	Annex 7 Section 3.12 Voting	• Confidential votes should be the exception, not the norm. • Confidential needs to be absolute – no one should know how individuals voted. • The term Confidential needed to be defined clearly in the constitution. • The Constitution already defined some votes which must be confidential – such as those involving disciplinary processes and these should be retained. • The Constitution definition of when a vote should be confidential should not be too proscriptive; there needed to be flexibility to adjust to circumstances while avoiding a cumbersome process that would require a vote on whether a vote was confidential before it could be taken. • There should be a clear time frame for the vote and it should not be counted until this expires. • AF advised that the pandemic had brought the issue of virtual voting to the fore and was being discussed nationally. The direction of travel was that software needed to be used for virtual voting and there may be changes to Company Law in the future to support proper process. • Admin control had a virtual voting feature which could be used. • The Group Company Secretary (GCS) advised that enquiries were being made to confirm that the Admin Control system could be used to run a confidential ballot. Recommendation 1: Revise the Constitution to state that confidential votes are used in extremis by agreement in Council and in a way which ensures that the individual's votes remain private. The timeframe for confidential votes to be five days, but can be shorter if required, by agreement with Council.

2.	**Virtual Voting** Making voting in virtual votes mandatory Practical issue: abstaining in a virtual vote has the same effect as a no vote when calculating the % agreement. Should this be addressed?	Annex 7 3.12 Virtual voting	Points noted: • On a practical basis, voting cannot be made mandatory; there will be circumstances where a governor cannot vote, due to illness for example, and this cannot be allowed to invalidate a voting process. • The problem which has occurred with virtual voting recently was in reaching the required % of governors voting, especially as governor numbers reduced; currently 75%. • Voting in a face to face meeting is based on a simple majority of those present, as long as quoracy has been met. Virtual voting is currently based on a % of the number in Council with 65% of those being in agreement to pass the vote. • On the basis that a secure electronic system can be introduced for electronic voting, the vote should be based on the number of governors in Council and be passed by a simple majority, unless already stated otherwise in the Constitution. • Public governors must be the majority of those voting. • There should be options for Yes/No/Abstain. • Abstain is a neutral vote. • The GCS explained that the move to virtual meetings as a result of the pandemic had prompted a re-examination of the criteria around virtual voting. Currently the bar was set higher for virtual votes – 65% majority as opposed to a simple majority. The view now developing in corporate governance circles was that the if a secure electronic system was used which guaranteed one vote per persona and that papers were readily accessible by all, the higher bar was not needed. The GCS noted that there were some instances in the Constitution which outlined circumstances where a higher bar was needed and these should remain. For example the disciplinary process requires 75% approval. • The requirement for Public governors to be in the majority of those voting is included to protect the principle that public elected governors should be in the majority. Recommendation 2 Revise the Constitution so that virtual voting is undertaken via a secure electronic system and passed by a simple majority of the number of governors on Council, unless already stated otherwise in the Constitution. Public Governors must be the majority of those voting.

3.	**Governor Term of Office** The max term of Governors of nine years to be removed.	16.3 Governor Tenure	Points noted: • Given the time taken for governors to learn the role, coupled with the low numbers stepping forward for election, it was not of benefit to the Trust to have a maximum term. • This had resulted in positions becoming vacant for a significant period of time when an incumbent was forced to leave because they had reached the maximum term. • There was difference between the role of the Non-Executive Director (NED) and the Governor which meant that the argument that there should be maximum terms to maintain independence and fresh view points was relevant for NEDs, not for governors. • Over time governors built up skills and knowledge to perform well in the role and this experience should not be lost to the whim of having a maximum term of office. • Governors were elected by their constituents; therefore their constituents should be responsible for deciding when they were no longer fit for the role. • This was a democratic process, and such restrictions on length of term did not apply to any other similar role, such as MPs, Councillors or School governors. It should not be applied to the Council of Governors. • The Constitution recognised that all governors were the same, so there should be no distinction between public, staff and partner governors. • Nigel Mansley noted that there was a 10 year restriction on taking public service roles. • AF noted that NHSE/I had advised that they were not in favour of agreeing to removing the maximum term; in the current climate it is incumbent on the Board to consider such advice with care. • KR noted that there was no justification for the Board to be influenced by NHSEI. There did need to be clearly recorded reasons as to why the Board held a view and what that view is in detail. • A decision taken to remove the maximum term could be revisited when governor elections attracted higher numbers of candidates with good experience and skills to offer. At present having a maximum term was not constructive. • AL commented that other Trusts were removing the maximum term requirement. AF noted that one Trust had done so, it was now trying to reverse the decision.

			• The GCS commented that a maximum term of nine years was considered good governance practice and NHSEI had indicated that they would not support removing the maximum. Replies to an enquiry made to the Company Secretary network confirmed all had the maximum term rule bar one. In that case the change had been an accidental outcome of drafting which was being rectified. • The change would prevent recurrence of recent election history where a governor had to leave having reached the end of the maximum term and no candidates came forward for the subsequent election. Refreshing Council had to be balanced with the need for experience on the Council and avoiding long term vacancies. • Having a vacancy which could not be filled when there was a person of experience being blocked from standing by a maximum term rule was unproductive. • The view was expressed that the role of the governor different to the role of the NED and not comparable with respect to the rationale for having maximum terms. • Engaging with communities in a different way to invigorate interest in the role of Council and Governors was another way to address the problem of having positions elected unopposed or elections having to be repeated. There was a danger in being perceived as acting in a paternalistic manner. • It was acknowledged in the discussion that there was potential for conflict of interest for governors present who were in their final time under the current rules. • The benefit of experience needs to be balanced against the risk of stifling new ideas or thinking. Council had to be accessible to new people and there was potential for this to be blocked if governors were able to serve for very long periods. • Current history suggested that unfilled vacancies was more likely than refreshing of Council being blocked; this suggested that the maximum term served no purpose but could be reviewed at a later date if the situation changed. • A proposal was made that the three terms of three years maximum be retained but the flexibility added that in exceptional circumstances, which should be defined, this could be extended on a one year basis. • Governors leaving the Council at the end of the maximum term would be able to attend public meetings. • The Chairman commented that it was unlikely given the Trust's high profile with regulators that the Board would be amenable to making a change which was known not to be supported by them. Future regulatory inspections of the Trust will be looking at adherence to expected practice and modern governance does tend to restrict

			terms of office. Accepting the point that public and staff governors were elected, the electoral process for governors is not so robust to create a counterweight of accountability. A set maximum term does encourage governors to serve with time period in mind to make their mark. The Chairman acknowledged that differing views had been expressed by governors during the discussion; some supported the proposal, others did not. He proposed that he have further discussion with the Lead Governor and with the Board and seek to arrive at a compromise solution. This was agreed. Chairman to carry forward.
4.	Taking over a term of office from another governor. Confirm that this is for the remainder of the term only. How is this counted with respect to the maximum term.	14.4 Council composition	In discussion it was clarified that the point was raised because of the link to item 3 above: when the first term for is shorter than the normal 3 years (because they have stepped into a vacated position mid term), if they serve for three terms the total years they will have served will be less than 9. Governors in this position wishing to stand again could only serve part of the term, or they would exceed the maximum of nine years. It was noted that the principle that governors stepping into a vacated position serve out the existing term of office for that post was designed to keep Governor elections in an annual cycle as far as possible as Governor end of terms of office would occur in the same month each year. This avoided the costs of repeated elections, both in monetary and staff resource terms. It was agreed that this point only became relevant if the recommendation made at reference 3 was not supported by the Board. If that happened, then the Board should suggest how this reference (4) should be taken forward. AF noted that the Trust's approach was standard across the NHS. At the Council meeting Governors agreed that there was no further points to raise on this item. No immediate action required, pending outcome of 3 above.
5.	**Composition of Council**	N/A	It was confirmed that this item was no longer relevant as it related to the time when there were vacancies on the Council which did not attract any candidates when elections were run.

	Council to consider how to manage the vacancies created by recent resignations.		No action required.
6.	Allowing partner governors to have deputies	Annex 4 Annex 7 Section 3.18 Quorum	Points noted: • Alternate would be a better description than deputy. • That said, it was difficult to see how the needs of the fit and proper persons test could be met if a partner governor could deputise. • Similarly, there were problems around understanding issues and continuity. • Deputising should only be undertaken by another governor, for example Ross standing in for Carl at this meeting. • The constitution should be checked to ensure the definition for partner governors is consistent and clear. At the Council meeting Governors agreed that there was no further points to raise on this item. Recommendation 3 The change to allow partner governors to have deputies should not be accepted. Check to be made to ensure the definition for partner governors is consistent and clear.
7.	Looking at Governors standing down when they move out of area mid term.	Section 16 16.2	Points noted: • Similar issues expressed as for reference 3 above in relation to losing experience and creating a vacancy which may be difficult to fill. • Councillors are not required to resign if they move out of area mid-term. • Governors moving slightly out of their constituency area may still be able to represent members in that area, it would be more difficult if the move was further away as the local issues would be different. At the Council meeting Governors agreed that there was no further points to raise on this item. Recommendation 4 No constitutional change needed in relation to governors standing down if they move out of area mid-term.

8.	Involving younger members in Council meetings.	N/A	This is an issue for the MECC to take forward. Minimum age for members is 16 and they are eligible to stand for election. No action required.
9.	**NED Appointments** The Council is responsible for voting on the need and help required when considering the engagement of NEDs	Annex 7 Section 5.2 Nominations & Remuneration Committee	Points noted: Fully accepted. Noted that support from external recruitment consultants was of value but should be for the Council to decide on the scope and manage the procurement. At the Council meeting Governors agreed that there was no further points to raise on this item. Recommendation taken to Council: That the policy for recruiting NEDs be explicit about Council responsibility for deciding on the external help required. As this is not a constitution change there is no recommendation to be made to the Board.
10.	All of terms of NEDs will only be renewed after the position has been put out to competition. Make open recruitment a requirement when filling all NED vacancies – going to advert, not just considering the performance of the incumbent if they are open to a further term	Annex 7 Sections 8 and 9 Process for the appointment of NEDs/Chair respectively	As the discussion developed it was recognised that references 10 and 11 were closely linked and should therefore be taken together. Points noted: • The principle should be that the default should be to go to open recruitment. If a NED is seeking or open to a second term, there must be clear evidence that their performance has been to a high standard, they deliver on objectives and that their skill set meets the requirements for a balance on the Board at that time. • Nigel Mansley was invited to comment. He noted that as a NED he could be seen to have a slight conflict on this issue, though he was now in his second term so had no personal conflict. He cautioned that requiring open competition for all vacancies risked losing a good NED; participating in an open recruitment process took up time and this may deter an incumbent NED from seeking a further term. • In his view NED positions should not be for those needing the salary, they needed to be independent. Without the monetary element in play, there was less incentive to voluntarily submit to a recruitment process you may not be successful in. • Council had responsibility for NED appraisal, working with the Chairman and the Senior Independent Director as appropriate.
11.	Governors will have an input to the annual review of NEDs and the objectives.		

			• AL noted that he could only recall one objective setting/appraisal process for NEDs since he became a governor. • AF acknowledged that the process had not been as regular as it should have been; some of that was due to the instruction from the centre that appraisal processed be suspended during the pandemic. • It was agreed that appraising performance in a robust and objective manner was essential if this was to be a key element in considering a second term of office for a NED. At the Council meeting Governors agreed that there was no further points to raise on this item. Recommendation taken to Council: Take these points forward as part of the review of the NED Appraisal and Recruitment policies. Ensure that the documents make it clear how a judgement is to be made on whether a second term of office is offered to a NED or if the vacancy is to go to open recruitment. It was not agreed to make open recruitment mandatory. As this is not a constitution change there is no recommendation to be made to the Board.
12.	**Composition of the Board** That should the balance of Executive and Neds on the board not have a greater number of NEDs the Council can make a temporary appointment or arrangements. To increase the maximum number of NEDs on the Board from 7 to 8, excluding the Chair.	Section 25	Points noted: • Constitutionally there must be at least one more NED on the Board than Executives. • The run of NED resignations at the end of last year presented a problem as it meant that the Executives out-numbered the NEDs. • This was managed via a number of temporary measures including making the Associate NED a voting member and making temporary appointments. This had been out-with the Constitution and required formal agreement from Council. • Non-voting NEDs and Executive Directors and Associate Directors need to be defined within the Constitution. • Increasing the number of NEDs on the Board to eight excluding the Chairman was agreed.

	Should the constitution cover appointment of Associate and/or Non-Voting NEDs. Should there be specific reference to representation on the Board or Council from the Medical School. Having representation on Board/Council from the Medical School Remove reference to SECamb as an Appointed Governor	Annex 4	• The current Associate NED position was specifically for a representative from the Medical School. The Universities Partner Governor role provides similar representation on the Council. At the Council meeting Governors agreed that there was no further points to raise on this item. Recommendation 5 Revise the Constitution to: • Increase the maximum number of NEDs on the Board to eight excluding the Chairman. • Define Non-voting NEDs and Executive Directors. • Define Associate Directors • Remove the reference to SECamb.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**27 MAY 2021**
REPORT TITLE:	**FINANCE AND PERFORMANCE COMMITTEE (FPC) CHAIR REPORT**
BOARD SPONSOR:	**NIGEL MANSLEY, CHAIR FPC**
PAPER AUTHOR:	**GROUP COMPANY SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY:

The purpose of the Committee is to maintain a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. This will include:-

- Overseeing the development and maintenance of the Trust's Financial Recovery Plan (FRP), delivery of any financial undertakings to NHS Improvement (NHSI) in place, and medium and long-term financial strategy.
- Reviewing and monitoring financial plans and their link to operational performance overseeing financial risk evaluation, measurement and management.
- Scrutiny and approval of business cases and the capital plan. Approval limits:
  - Revenue: £2.5m over 5 years
  - Capital up to £2.5m
- Maintaining oversight of the finance function, key financial policies and other financial issues that may arise.

The Committee also has a role in monitoring the performance and activity of the Trust. The following provides feedback from the May 2021 FPC meeting.

1 Month1 Finance Report

The finance report provides the Board with oversight of the financial position and therefore only highlights are below:

1.1 The Committee requested clarity on how the Trust could access the £7.5m of additional elective recovery funding for treating planned patient activity above a nationally set threshold. It was confirmed there were a number of risks to achieving this and it is also contingent upon the system achieving. Reassurance was provided that the Trust is in a good position to contribute to the system target.

1.2 The Trust achieved a £0.5m deficit in April which is £0.5m worse that plan. Lack of certainty on the elective recovery fund due to confirming system level performance meant that the Trust only recognised half of the £1m.

1.3 Reduction in Covid spend in April was seen and reassurance was provided that the reduction required was achievable but this required more work to assess what spend was still required across the Trust.

2 Contract Change Notice

2.1 The Committee reviewed and approved the contract change notices between the Trust and its Subsidiaries and these require approval by the Trust Board.

3 Month 1 Savings and Efficiencies Update

3.1 The Trust is required to report efficiencies of approximately £1.2m in the first half of the financial year, the Trust booked efficiencies of £0.1m against a plan of £0.2m as the Care Groups are focussed on recovering the elective activity.

3.2 There is a risk in relation to developing schemes for the second half of the year where the target is likely to be significantly greater that the first half of the year.

3.3 The Committee recognised the need to balance quality and safety with finance but sought assurance that there will be a focus on developing efficiencies. The Head of Programme Management Office (PMO) advised that a new approach was being embraced using the We Care methodology with a view to removing waste to bring the efficiencies through.

4 Board Assurance Framework

4.1 The Committee requested an additional objective under 2) Our Patients to bring out the Reset, Restore and Recovery programme as this is so critical for the recovery of the NHS. System reliance should be added as a risk.

4.2 Some tightening of the actions in terms of dates for achieving and ownership was recommended.

5 We Care Integrated Performance Review (IPR): National Constitutional Standards for Emergency Access, Referral to Treatment Time, Cancer and Diagnostics

5.1 The Committee focussed on the areas within its remit. Performance has improved against all standards, with the exception of Accident & Emergency (A&E) 4-hour access standard which has remained static.

5.2 The Committee highlighted that the target to increase the use of technology and innovation in the delivery of high-quality care of 80% of outpatients being virtual is potentially unrealistic and it is recommended that this is reviewed. The Committee acknowledged the good progress in the area of virtual clinics to date.

6 Update on Recovery, Reset, Restore and Recovery Programme

6.1 The Committee received an update on the progress with the Reset, Restore and Recovery programme.

6.2 Assurance was sought that job plans / rotas were in place to achieve the elective recovery. It was confirmed that this work was underway now that the clinical teams were returning to full compliment.

6.3 A summer surge was predicted and assurance was requested around funding and resource to support this. System plans were being drawn up to address this prediction which were made up of a number of initiatives.

6.4 It was confirmed that the orthopaedic centre was likely to come on line from July 2021 but this would be checked as it was critical to supporting the recovery.

7 Use of Independent Sector

7.1 The Committee ratified the Chairman's action to subcontract £4.3m of activity.

8 Financial / Business / Operational Plan 2021/22

8.1 The Committee received assurance that the gap identified last month had been bridged. The breakeven position has been agreed across the Integrated Care System (ICS) and as such there was shared risk for the business plan for the first half of the year.

8.2 The Committee approved the six-month financial plan and noted the challenges already discussed in respect of the second part of the year.

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9 Business Cases – Harmonia Village

9.1 The Committee was asked to support the preferred option to re-launch and market the Harmonia Dementia facility without significant further investment.

9.2 Assurance was sought as to who the partner might be and how long this may take. It was confirmed that there could be local partners but the timescale would be around 5-6 months, due to procurement protocols. In the long-term if the facility could not be used for the purpose it was set up the grant would have to be repaid.

9.3 Assurance was sought that there remains a market for the facility. It was confirmed that the demand for this facility is there but marketing was crucial.

10 2021/22 Capital Plan – Risks and Priorities

10.1 There was a slight reduction on the capital plan related to funding for the stroke plan moving to the ICS from the NHS England (NHSE/I).

10.2 A prioritised list is in place for funding should capital become available throughout the year.

11 Monitor Provider Licence Compliance

11.1 The Committee sought assurance on a number of the areas of the licence, specifically around conflicts of interest declarations and the Trust remaining in Financial Special Measures (FSM). The Director of Finance has been working with the system and NHSE/I to establish how the Trust can exit FSM.

12 Other reports

12.1 Covid-19 Cost Reimbursement Review – no matters of serious concern.

12.2 Strategic Investment Group.

12.3 Draft Annual Accounts.

12.4 Joint Development Group.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Failure to achieve financial plans as agreed with NHSI under the FSM Regime.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR5: Failure to achieve financial plans as agreed with NHSI under the Financial Special Measures Regime.
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	N/A

PRIVACY IMPACT ASSESSMENT: *NO*	**EQUALITY IMPACT ASSESSMENT:** *NO*

East Kent Hospitals University NHS Foundation Trust

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and **APPROVE** the:

- FPC Chair report;
- Contract change notices between the Trust and its Subsidiaries.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**27 MAY 2021**
REPORT TITLE:	**QUALITY AND SAFETY COMMITTEE (QSC) CHAIR REPORT**
BOARD SPONSOR:	**SARAH DUNNETT, CHAIR OF THE QSC**
PAPER AUTHOR:	**GROUP COMPANY SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The Committee is responsible for providing the Board with assurance on all aspects of quality, including strategy, delivery, governance, clinical risk management, clinical audit; and the regulatory standards relevant to quality and safety. The report seeks to answer the following questions in relation to the quality and safety performance.

This was the first meeting where the Care Group / Site Leadership Triumvirates were invited and the new template tested. There were a number of suggestions to improve the Care Group reporting template and there is a need for continued support for those completing it.

1. Integrated Performance Report (IPR) – We Care Breakthrough Objectives and Watch Metrics

The Committee received the report which will be discussed in detail at the Board. The Committee raised the following points.

1.1. The pressure ulcer (PU) number continues to include all PUs and not just hospital acquired, work is on-going to resolve this; assurance was sought as to when the figures will be reported accurately and it was confirmed this would be corrected by next month;
1.2. Hospital Standardised Mortality Ration (HSMR) continues to be reported within the bracket 'as expected' and the latest published rolling 12-month HSMR to December 2020 is 104.7. This is driven by a high January 2021 in month HSMR (132.9) which is significantly higher than expected and likely to be due to the pandemic second peak, similar to the pattern seen in April 2020; the Committee accepted the reassurances provided regarding the impact of the pandemic.
1.3. A never event was declared in May 2021 that occurred in 2010; assurance was given that the process changes made since 2010 should prevent this type of incident from reoccurring.
1.4. What action has the Trust taken in relation to optimal cord clamping; it was confirmed that clarification was required as to the babies that should be included in these metrics to make them meaningful.
1.5. Assurance was sought as to the progress made with the one patient awaiting a scan to obtain a cancer diagnosis, it was confirmed that the scan was being booked.
1.6. In respect of assurance around mental health patients it was confirmed that there was regular liaison with the Children and Adolescent Mental Health Services (CAHMS) team and the Trust engages specialist mental health nurses.
1.7. Assurance was sought as to technological advances that could support discharges; it was confirmed that voice recognition has been trialled across the

Trust and electronic records were being used to support discharges and were considered as superior.

1.8. Recognition was given to the need for Non-Executive Director (NED) familiarisation with the We Care methodology and particularly how and which metrics are chosen and how support for those metrics is generated through the Trust.

2. Principal Mitigated Quality Risks and Board Assurance Framework (BAF)

2.1. Assurance was taken from the updated BAF which will be presented to the Board. It was noted that there is work on-going to continue to populate and improve the document.

3. Safe Staffing

3.1. Assurance was received that the work to ensure the Trust was compliant with the National Quality Board and NHS Improvement (NHSI) requirements is being progressed.

4. Care Quality Commission (CQC) Update

4.1. The Committee took assurance that the actions to address the “must do’s” from the May 2018 CQC report were being progressed; 13 had been completed. In the case of 12 actions, further evidence was required to assure the Chief Nurse that these actions are fully complete and embedded.

4.2. In terms of the 2020 CQC report relating to maternity, 22 actions were complete. Five “must do’s” remained outstanding. This was of concern and will be taken forward for follow up actions and there was a suggestion that this should be taken through the Maternity Improvement Committee.

4.3. The Committee were reassured that the process to close the actions was robust.

5. Duty of Candour (DoC)

5.1. The Committee received a follow-up paper following concerns raised about compliance with DoC. The Patient Safety Team are focussed on providing support to improve compliance and a task and finish group has been established. A number of actions are being progressed to support improvement in this area.

5.2. The Committee supported the actions proposed including the need to add this to induction training and mandatory training programmes. This will also be reported on the IPR and through the Care Group reporting template to this Committee.

6. Subsidiary Escalations

6.1. Assurance was sought as to the safety of the sites in relation to fire and smoke statutory compliance. The Committee was advised that this related more to the technical competencies within the Trust. Compliance is supported by a 9-point plan signed off by the Fire Brigade.

6.2. Concern was raised about a contradictory statement about water compliance and site records in general.

6.3. Central Alerting System (CAS) alerts relating to allergies was not included and this was a risk to the Trust. Assurance around implementation was requested.

6.4. Safeguarding training for 2gether Support Solutions (2gether) staff was also of concern and a request for evidence of compliance was requested.

6.5. The backlog maintenance position meant that the Trust was not as safe as it could be and it was confirmed that this was on both the 2gether and the Trust’s Board agendas.

6.6. Ligature risk assessments were on-going, the William Harvey Hospital assessments should be completed by the end of next week. This will lead to an improvement plan to remove, where possible, the ligature points.

6.7. Escalation to the Decontamination Committee on the clinical risks around compliance was requested.

7. Infection Prevention and Control (IPC)

7.1. The Committee took assurance from the IPC report and the IPC BAF.

8. Patient Experience Committee (PEC)

8.1. The Committee took assurance from the PEC report and noted the patient account in relation to End of Life Care.

9. Patient Safety Committee (PSC)

9.1. There were a number of issues identified in the report however, there were actions and assurances to support these concerns. The Chair advised that she would identify, with the Chair of PSC, an area for a deep dive to ensure the Committee maintained good oversight of the matters raised.

9.2. Concern was expressed that of the 9 CAS alerts, 6 are related to 2gether, so continued focus is required to manage progress with resolving them.

10. National Institute for Health and Care Excellence (NICE) / Clinical Audit and Effectiveness Committee

10.1. Assurance was received that there was now an audit lead for general and specialist medicine.

10.2. Assurance was sought on the mitigation on the risk around the backlog of and process around reviewing NICE guidance; the forward process has been agreed in order to meet the 5 days timescale and then brought back to Committee. The backlog is being reviewed and at this point no concerns raised.

10.3. Transition in relation to paediatric diabetes has been added to the risk register and this provided some assurance that escalation was in place.

11. Mortality / Learning from Deaths Report – Quarter 3

11.1. The report provided assurance over the work around learning from deaths and structured judgment reviews.

12. Deteriorating Patient

12.1. The Committee received assurance about the deteriorating patient project. Sepsis and respiratory failure are the biggest contributors to this metric. Digital platforms have been utilised and are being well adopted by the clinicians.

12.2. Assurance was sought over the transfer of care policy as this was an area that impacted on patient safety in this area. It was confirmed that this has been raised with the Executive Management Team and has been escalated to ensure this is addressed.

OTHER REPORTS RECEIVED AND DISCUSSED

13. External Visits 6 Month report.

14. Interim External Screening Quality Assurance Review.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to **APPROVE** the Quality and Safety Committee report.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**27 MAY 2021**
SUBJECT:	**CHAIR REPORT FROM THE STRATEGIC WORKFORCE COMMITTEE (SWC)**
BOARD SPONSOR:	**JANE OLLIS, CHAIR OF THE SWC**
PAPER AUTHOR:	**GROUP COMPANY SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: PEOPLE STRATEGY** **APPENDIX 2: MODERN SLAVERY STATEMENT**

BACKGROUND AND EXECUTIVE SUMMARY

The Committee is responsible for providing the Board with assurance on all aspects relating to the workforce, including strategy, delivery, governance, and risk management.

This report presented reflects Committee activity for the May 2021 meeting.

Matters Arising:
The Committee heard some feedback about the comments made in the Staff Survey responses and whilst the Trust's results were poor it was noted that there were many positive comments and these would also inform the strategy going forward.

1. We Care Update and People Strategy

1.1. The Committee received an updated version of the People Strategy which has been updated to align with the strategic direction both nationally and locally in the Trust. Assurance was taken in relation to its focus on people management and leadership in terms of recruitment and retention with a focus on culture and leadership.
1.2. Assurance was also taken on how the Strategy supported opportunities for collaborative working and engagement across Kent and Medway, particularly across the Integrated Care Partnership. It was likely that given system working which will lead to changes, the Strategy will be iterative.
1.3. The Committee has requested a quarterly update on progress against delivery.
1.4. The Committee recommends the Strategy to the Board for approval.

2. April 2021 Integrated Performance Report (IPR) – HR Performance Metrics

2.1. The Committee received assurance that, whilst the focus for this report is True North for the people domain, the department remained focussed on other HR metrics.
2.2. Reassurance was provided in relation to a number of the watch metrics which were improving, namely appraisal compliance and mandatory training.
2.3. The Committee sought additional information in relation to the breakdown on turnover for different staff groups and this was agreed.
2.4. Assurance was sought on the future workforce needs, it was confirmed that qualified nursing and consultant vacancies are crucial and work had just commenced on looking at these areas to start with. In addition, the team were looking at new roles to support clinical activity. Innovation and digital improvements may bring changes to clinical delivery and hence workforce and so horizon scanning is important to inform where the focus should be.

3. Board Assurance Framework (BAF)

3.1. The Committee took assurance from the new format of the BAF. Feedback around ownership and timescales was highlighted and was confirmed as a common theme across the Board Committees this month, this would be taken forward.
3.2. The Committee sought assurance as to whether the BAF held the expected risks and it was explained that the suite of documents (BAF, Corporate Risk Register and Care Group risk registers) will be presented to the Board at its development session which should provide

assurance but the opportunity will be there for discussion.

4. Provider Licence – Annual Statutory Declaration

4.1. This was noted and assurance taken over the process followed.

5. Guardian of Safe Working Report

5.1. Exception reporting throughout Covid-19 was not used and payments made this has made comparing against previous months difficult.
5.2. Exception reporting is seen as positive to ensure gaps in rotas are known and appropriate levels considered and where appropriate recruited to. The Committee took assurance that work was in progress to encourage exception reporting.
5.3. It was suggested that the findings should also link with the work around safety cultures across the Trust.
5.4. The Committee is assured of the positive reporting culture evidenced by the fact no Care Groups have been fined.

6. Modern Slavery Statement

6.1. The Committee approved the statement for inclusion on the website and in the Annual Report and Accounts.

7. Other Reports

The Committee received and discussed the following reports:

- Feedback from the Local Negotiating Committee (LNC); Joint Chairs of the LNC and of the British Medical Association (BMA).
- Feedback from Joint Chairs of Staff Committee.
- Integrated Education, Training and Leadership Development Group.
- Occupational Health Activity Quarterly Report.
- Tribunal Activity Report, Settlements and Redundancy Report – a business case has been submitted (approved at Strategic Investment Group) to support early resolution of cases and support decision making. Long-terms approach to supporting Just Culture.
- Statutory and Mandatory Training Report.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and **APPROVE** the:

- People Strategy;
- Modern Slavery Statement;
- Strategic Workforce Committee Chair Report.

East Kent Hospitals University NHS Foundation Trust

People at the heart...






People Strategy 2020- 2025

We care

Contents

Foreword

The last year has been unprecedented in the life of the NHS we know we will be living with the consequences of the Coronavirus for a number of years to come. The challenges have been significant; physical, mental and emotional, however, I feel confident that we have developed a comprehensive plan to support leaders, teams and individuals through this current phase and beyond.

The way people have pulled together over the last year, demonstrated flexibility and collaboration has been outstanding and our aim, through this people strategy, is to continue to build on this positive change, seize opportunities for growth and move closer toward achieving our vision of delivering ***'great healthcare from great people'***.

In developing our five-year people strategy, I have considered both national and regional priorities and thought about how we work closely with our partner organisations across the local integrated care system (ICS) so that we can deliver first-class, holistic care to our patients across Kent & Medway.

Most importantly, I have considered what we need to focus on to make EKHUFT both the best place to work, and the best place to receive care; to create the healthcare 'employer of choice' in the South East. We are now almost a year into our strategy and in reviewing our ambitions for our people I am delighted to reaffirm our commitment to you.

The EKHUFT Board recognises that by investing in you – your development and careers, your health and wellbeing, – our patients will ultimately benefit. We want ***everyone*** who works at EKHUFT to feel valued, engaged and able to make improvements to enhance their working lives and the care they give to patients. We want you to feel proud to work for our Trust.

I believe that we all have a part to play in this, both in terms of what we do and how we do it; using our values as the foundation for building positive, respectful and collaborative relationships – by working together we can achieve our ambitions.

Andrea

Andrea Ashman

Director of Human Resources and Organisational Development

Overview

This strategy sets out EKHUFT's aims to engage and develop our people to deliver our vision and True North priorities.

The People Strategy will be reviewed annually to ensure that it is still supporting and enabling the Trust's over-arching strategy and responding to issues relevant to all levels of colleagues.

Section 1

considers the external context highlighting key aspects of the NHS Long Term Plan, the NHS People Plan and the NHS People Promise

Section 2

outlines EKHUFT's True North – the long-term strategy to achieve the Trust's mission and vision, underpinned by its values

Section 3

provides an overview of the priorities for our people to support the delivery of both the Trust's long-term strategy, and our response to national and regional challenges

Section 4

details our approach to the delivery of our priorities and how we will monitor our progress

Section 1 The National Context

The NHS Long Term Plan (2019)

"The performance of any healthcare system ultimately depends on its people – the NHS is no exception"

The NHS Long Term Plan sets out an ambitious 10-year vision for healthcare in England.

This vision recognises that for the NHS to succeed:

> *"….we must keep all that's good about our health service and its place in our national life. But we must tackle head-on the pressure our staff face, while making our extra funding go as far as possible. And, as we do so, we must accelerate the redesign of patient care to future-proof the NHS for the decade ahead"*

The Long Term Plan commits to the following:

- A new service model in which patients get more options
- More NHS action on prevention and health inequalities
- Further progress on care quality and outcomes
- Digitally-enabled care which will go mainstream across the NHS
- Tax-payers investment being used to maximum effect
- NHS staff getting the backing they need

The Long Term Plan demonstrates the need to focus on **attracting**, **retaining** and **developing** all people.

The NHS People Plan: #We Are The NHS

This plan, published in July 2020, acknowledges:

"The clapping has now stopped, but our people must remain at the heart of our NHS, and the nation, as we rebuild"

The plan sets out actions to support transformation across the whole NHS. It emphasises the need for us all to continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people and work together differently to deliver patient care. It focuses on:

- **Looking after our people**
  Making the NHS an employer of excellence – valuing, supporting, developing and investing in our people, keeping them safe, healthy and well
- **Belonging in the NHS**
  Creating an organisational culture where everyone feels they belong, by developing inclusive, compassionate and improvement focused leadership
- **New ways of working and delivering care**
  Emphasising the need to develop a more varied and richer skill mix, new types of roles and different ways of working, ready to exploit the opportunities offered by technology and scientific innovation to transform and release more time for safe, high-quality care
- **Growing for the future**
  Building on the renewed interest in NHS careers to expand and develop our workforce, as well as retaining colleagues for longer

The current NHS People Plan has been developed with a particular focus on looking after our people, given the impact of COVID-19 which will continue for some time to come. To strengthen the commitment the plan includes a 'people promise'

Colleagues from different healthcare roles have said what matters most to them, and what would improve their experience of working in the NHS
Their responses have led to the themes on the rainbow – creating the NHS People Promise

We want everyone at EKHUFT to make this promise to each other - to make these ambitions a reality for us all

Our five-year people strategy will help us get there

Section 2 EKHUFT's True North

EKHUFT's Board have committed to a holistic approach (We Care) to develop all areas of the Trust. The 'We Care' approach requires a sustained focus on a limited number of priorities – True North. The True North priorities are shown below, along with their key metrics. More specific objectives to achieve the priorities will vary across Care Groups. The people strategy will contribute to the all of the priorities, with particular attention on 'Our People'

True North

(our strategy for the next 5-10 years)

Made up of 5 domains

True North domains

- Our Patients
- Our People
- Our Future
- Our Sustainability
- Our Quality & Safety

To know if we are winning or losing we have metrics assigned to each domain that we will continuously measure to gauge improvement.

True North metrics

1 A&E 4 hour	5 Retention	7 Medically fit	9 I&E margin	11 Avoidable harm
2 RTT 18 weeks	6 Staff engagement	8 Hours released through innovation	10 Carbon footprint	12 Mortality
3 Cancer 62 day				
4 FFT				

Using the inch wide mile deep principle 3-5 metrics will be selected that are operational in nature and identify where the organisation wants to focus it's improvement efforts for the next 12 months.

Section 3 The People Priorities

The people priorities will contribute to achieving EKHUFT's True North and to meeting the four aims identified in the NHS People Plan (#We Are The NHS)

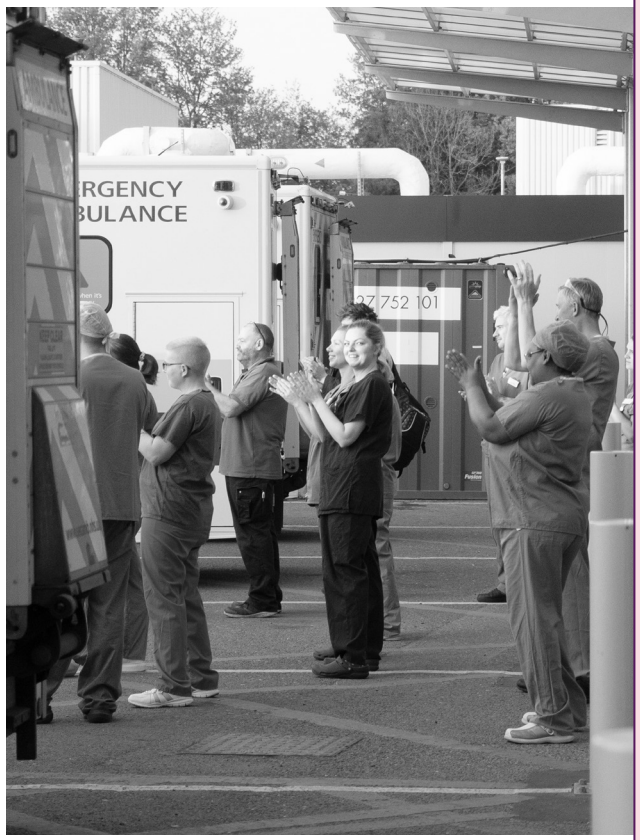
1. Looking after our people
2. Belonging to the NHS
3. New ways of working and delivering care
4. Growing for the future

The people priorities will also respond to regional challenges by:

5. Developing a new operating model for workforce

1 Looking after our people

We aim to be the healthcare 'employer of choice' in the South East by valuing, supporting, developing and investing in our people and keeping them safe and well



What does this look like in 2025?

- Health and Wellbeing interventions are developed and embedded to support colleagues throughout the recovery phase of COVID-19 and beyond
- All colleagues have access to psychological support and treatment as required
- Respect for all colleagues and behaviour in line with EKHUFT's values are demonstrated consistently
- Behaviours that are inconsistent with our values are challenged
- New colleagues are fully supported during their first year of employment and as they progress in their career
- Opportunities for flexible, remote and virtual working are being maximised to meet the needs of colleagues, their teams and their services
- All colleagues have a meaningful appraisal, which includes a personal development plan to support them in their career development
- A comprehensive Reward and Recognition programme is in place
- Our quality improvement approach (We Care) enables colleagues to make a positive difference to both the quality of their working lives and patient experience

Key Measures

- At least 70% of colleagues recommend EKHUFT as a place to work
- Our staff engagement score, in the annual NHS staff survey, is in the top 30% of acute trusts
- Retention rate of colleagues in their first year at EKHUFT has improved by 10%

"I feel listened to and valued"

"I am supported to make improvements in my work, for the benefit of my team and patients"

"I love my job and feel proud to work for EKHUFT"

"I know that EKHUFT cares about my wellbeing"

2 Belonging in the NHS

We aim to develop an inclusive, compassionate and improvement focused culture; a place where discrimination does not occur

What does this look like in 2025?

- An inclusive and diverse culture is embedded throughout the Trust and ***all*** colleagues feel valued
- An increase in leaders from underrepresented groups, including black, Asian and minority ethnic (BAME) colleagues
- BAME and disabled colleagues believe that there are equal opportunities for career progression
- All colleagues feel able to use their voice to inform learning and improvement
- A Leadership Framework clarifies the key competencies required for an inclusive, compassionate, improvement focused leader
- Leaders demonstrate compassion and a focus on equality, diversity and inclusion
- Development is available to support leaders in systems leadership, quality improvement and talent management
- Talent Management is in place which identifies colleagues' potential and builds on their skills and aspirations, and facilitates succession planning
- Coaching and mentoring, including reverse mentoring, are available for colleagues to help them transition to new leadership roles

Key Measures

- Inclusive talent management and succession planning is embedded across the Trust
- The number of AfC BAME colleagues in leadership roles has increased to 10%
- 50% of colleagues feel that their work is valued after appraisal

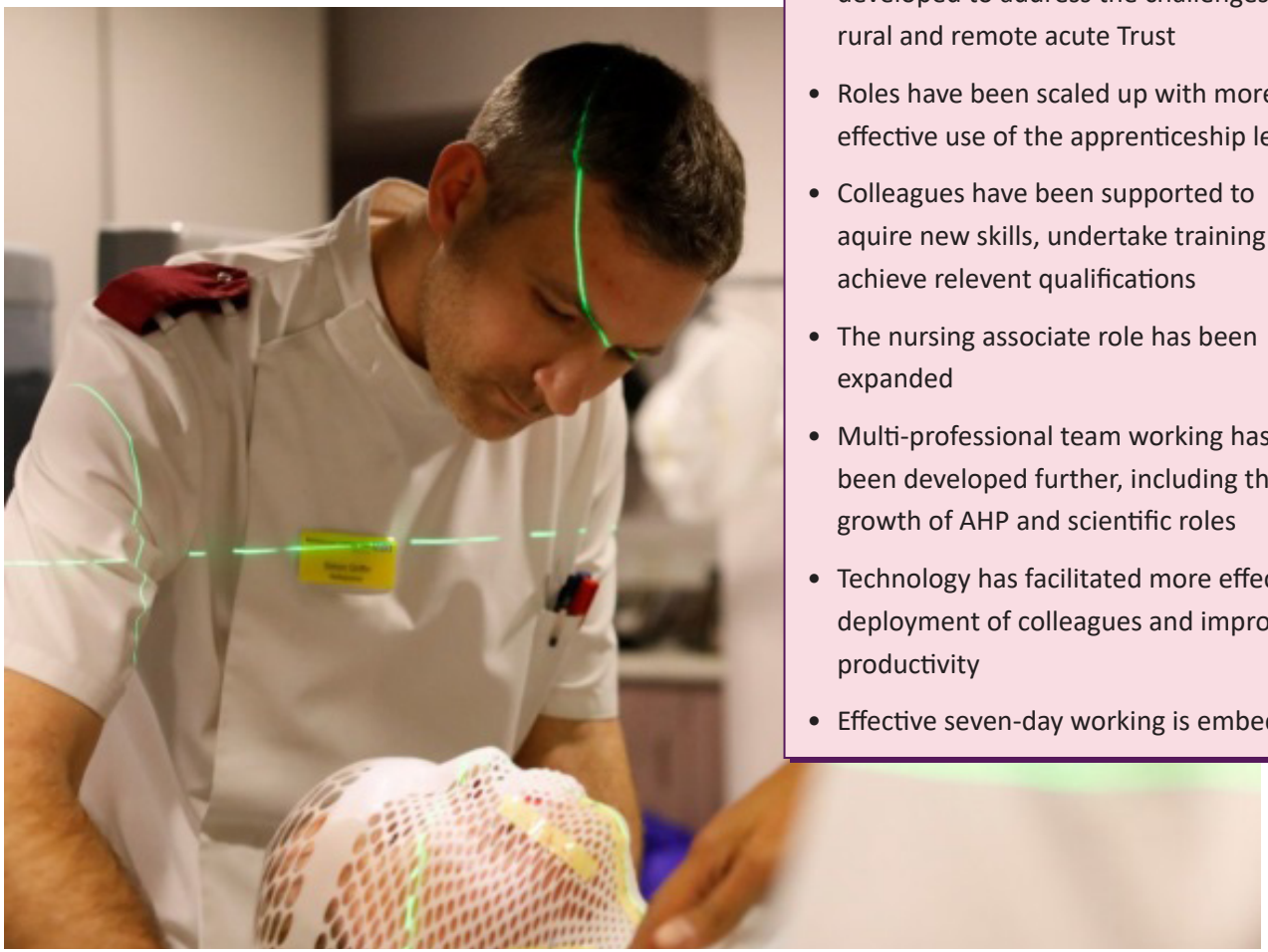
"As a BAME colleague, the Trust has invested in my development and supported me in attaining a leadership role"

"I understand what is required of me as a leader at EKHUFT and am supported in my development"

"I have an annual appraisal where my manager spends timing talking about my development which builds on my skills and career aspirations"

3 New ways of working and delivering care

We aim to transform our workforce with a more varied and richer skill mix, new types of roles and different ways of working, ready to exploit the opportunities offered by technology and scientific innovation to transform care



What does this look like in 2025?

- The workforce has transformed and demonstrates a more varied and richer skill mix, with new types of roles
- Different ways of working have been developed to address the challenges of a rural and remote acute Trust
- Roles have been scaled up with more effective use of the apprenticeship levy
- Colleagues have been supported to aquire new skills, undertake training and achieve relevent qualifications
- The nursing associate role has been expanded
- Multi-professional team working has been developed further, including the growth of AHP and scientific roles
- Technology has facilitated more effective deployment of colleagues and improved productivity
- Effective seven-day working is embedded

Key Measures

- EKHUFT is using the full functionality of individual e-rostering and e-job planning to ensure that the **right skills** are deployed at the **right time** in the **right place**, supporting new ways of working (NHSE/I level 2 attainment)

"I am confident my team is stronger through upskilling and the development of new roles"

"My roster and job plan ensure that I am doing the work that I am skilled to do"

"My team has used technology to transform our service which, in turn, has improved patient care"

"I can focus on delivering patient care – not on admin"

4 Growing for the future

We aim to attract high-quality candidates from a diverse talent pool and recruit to all of our 'hard to fill' roles, reducing a reliance on temporary staff

What does this look like in 2025?

- A comprehensive attraction strategy encompasses diverse talent pools - those that haven't traditionally considered the NHS, those returning to practice and international candidates
- A robust recruitment pipeline is in place, incorporating a system-wide approach
- Development opportunities include a wide range of clinical and non-clinical apprenticeships
- Local terms and conditions enable colleagues to work flexibly, reducing reliance on temporary staff
- Joint appointments with Kent and Medway Medical School are in place and have attracted best in class candidates
- We have embedded the EKHUFT career framework

Key Measures

- Our vacancy rate has reduced to 6%
- The EKHUFT apprenticeship levy is fully utilised for both clinical and non-clinical apprenticeships
- BAME candidates are equally likely to be appointed for vacant roles as white candidates

"I know I can fill the vacancies in my team with the right people"

"I joined the Trust through the nurse associate apprenticeship and am flourishing"

"I was given the opportunity for flexible working and feel very committed to EKHUFT and want to spend my career here."

5 Developing a new operating model for workforce

We aim to continue to work collaboratively and to be clear what needs to be done locally, regionally and nationally, with more people planning activities undertaken by local integrated care systems (ICSs)

What does this look like in 2025?

- Work across the Integrated Care System (ICS) has included developing and implementing people and transformation plans
- Partnership working, across the ICS, has led to the development of strategic workforce models to ensure a system-wide approach to resourcing local healthcare and a workforce with the relevant skills is in place.

Key Measures

- A comprehensive workforce strategy has been developed to support the public consultation and deliver the East Kent Clinical Strategy
- A detailed workforce plan is in place to facilitate the East Kent Intergrated Care Partnership (ICP) and supports the aims of the Kent & Medway Integrated Care System (ICS)

"Our clinical strategy is underway and I feel confident it will improve patient care and experience"

"I feel that we are much better at collaborating both across the Trust and more widely with our partners in Kent and Medway"

Section 4
Our Approach

Each of the teams in Human Resources and Organisation Development (HR&OD) will work with the Executive team and Care groups to develop **detailed annual plans**, ensuring the key measures are achieved by 2025.

Progress will be monitored in a number of ways:

- At monthly senior HR&OD meetings
- As part of the Care Group monthly performance reviews
- At bi-monthly Strategic Workforce Committees
- Regularly at Board meetings

The people strategy will be reviewed, updated and approved annually.

East Kent Hospitals University NHS Foundation Trust

SLAVERY AND HUMAN TRAFFICKING STATEMENT

Aim

East Kent Hospitals University NHS Foundation Trust (EKHUFT) is committed to equality of opportunity and we believe there is no place in our society for modern slavery and human trafficking. As an organisation we hold a zero tolerance approach to modern slavery and breaches in human rights. We have established business and organisation practices internally and with our partners and suppliers externally, to identify, address and prevent this issue in so far as is possible. The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

What is modern slavery?

Slavery is a violation of a person's human rights. It can take the form of human trafficking, forced labour, bonded labour, forced or servile marriage, descent-based slavery and domestic slavery. A person is considered to be in modern slavery if they are:

1. forced to work through mental or physical threat;
2. owned or controlled by "an employer", usually through mental or physical abuse;
3. dehumanised, treated as a commodity or sold or brought as "property";
4. physically constrained or has restrictions placed on their freedom of movement.

Our approach

EKHUFT complies with the NHS England Modern Slavery Statement and anti-slavery programme. We will support our staff to:

1. understand and respond to modern slavery and human trafficking, and the impact that each and every individual working in the NHS can have in keeping present and potential future victims of modern slavery and human trafficking safe;
2. have access to training on how to identify those who are victims of modern slavery and human trafficking. This training will include the latest information and will help staff develop the skills to support individuals who come into contact with health services;
3. work with NHS funded organisations to ensure modern slavery and human trafficking are taken seriously and features prominently in safeguarding work plans;
4. follow our policies on safeguarding and training programmes to ensure that Modern Slavery and human trafficking are integral within the content and staff are directed to support and advice as needed.

Adult Safeguarding

The organisation has in place policies that describe our approach to the identification of modern slavery risks and steps to be taken to prevent slavery and human trafficking across all areas of activity.

Human Trafficking and Modern slavery guidance is included in the Trust's Safeguarding Adult, People at Risk Policy 2019.

Staff with direct patient contact (Level 2 adult Safeguarding training) are trained and informed of their responsibility to identify and report any concerns using the Trust's incident reporting system. Specifically they are taught to look out for sexually transmitted infections, unwanted pregnancy, spiral fractures and other injuries or disfigurements that would inhibit their ability to work. They are also taught to observe if the patient is never left alone and to gain time alone with the patient so that they can express any concerns in private. Those who do not have English as a first language have access to interpreter services.

The response to Human Trafficking and Modern Slavery is coordinated under the safeguarding adult and/or safeguarding children processes. The Police are the lead agency and staff are directed to the appropriate Home Office website for further information.

A database is kept on all safeguarding alerts and there is a facility to code and identify any such alert as a case of trafficking or modern slavery.

Procurement Services

The Trust has a supply chain that is a combination of Distributors and direct supply arrangements. Where a Distributor (e.g. NHS Supply Chain) or Procurement Hub (e.g. NHS Commercial Solutions) contracts for Goods and Services on behalf of the

Trust, the Trust places the obligation for monitoring compliance with the Modern Slavery Act, on this organisation. The Trust retains responsibility for all its suppliers.

A declaration on Modern Slavery is contained within the Pre-Qualification stage of the procurement process. The Trust's Procurement Strategy and Policies includes a commitment to the Trust's obligations under the Care Act (2014) and the Modern Slavery Act (2015) and the actions it will take in its procurement processes. When procuring goods and services, we additionally apply NHS Terms and Conditions (for non-clinical procurement) and the NHS Standard Contract (for clinical procurement). Both require suppliers to comply with relevant legislation.

The department's senior procurement team are all Chartered Institute of Purchasing and Supply (CIPS) qualified and abide by the CIPs code of professional conduct. We will train our internal supply chain management team on matters relating to modern slavery and human trafficking. The Trust intranet includes an ethical procurement module which is available to all members of staff.

The Trust has evaluated the risks associated with slavery and human trafficking and identifies them as:

1. Reputational
2. Lack of assurances from suppliers
3. Lack of anti–slavery clauses in contracts
4. Training staff to maintain the trust's position around anti-slavery and human trafficking.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our organisation's slavery and human trafficking statement. The Board approved this statement at its meeting on 4 April 2019.

Chair Chief Executive

Date: Date:

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**27 MAY 2021**
REPORT TITLE:	**REPORT FROM THE NOMINATIONS AND REMUNERATION COMMITTEE (NRC)**
BOARD SPONSOR:	**SUNNY ADEUSI, CHAIR OF NRC**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The Nominations and Remuneration Committee is a Committee of the Board and fulfils the role of the Nominations and Remuneration Committee for Executive Directors described in the Trust's constitution and the NHS Foundation Trust Code of Governance.

The purpose of the committee will be to decide on the appropriate remuneration, allowances and terms of and conditions of service for the Chief Executive and other Executive Directors including:

(i) all aspects of salary (including performance related elements/bonuses).

(ii) provisions for other benefits, including pensions and cars.

(iii) arrangements for termination of employment and other contractual terms.

To appoint and set the terms and conditions for subsidiary Board members and review any Key Performance Indicators/performance bonus. Receive a recommendation from the subsidiary Board and Nominations and Remuneration Committee on achievement against these.

To recommend the level of remuneration for Executive Directors and monitor the level and structure of remuneration for very senior management.

To agree and oversee, on behalf of the Board of Directors, performance management of the Executive Directors, including the Chief Executive.

The Trust Chairman and other Non-Executive Directors and Chief Executive (except in the case of the appointment of a Chief Executive) are responsible for deciding the appointment of Executive Directors.

The appointment of a Chief Executive requires the approval of the Council of Governors.

MEETING HELD ON 4 MAY 2021

The Committee received and discussed the following reports:

1.1 Executive/Very Senior Managers (VSMs) Pay Policy

The Committee received and discussed a report regarding annual uplift review of salaries for VSMs and Executive Directors. It was noted that formal guidance on national pay recommendations is expected to be released soon. The Committee considered the proposal to undertake a review of pay structures. The Committee agreed to the following:

- That an annual review of VSMs and Executive Directors remuneration will be undertaken following the release of national pay award recommendation;
- That a more comprehensive review of pay structures will be undertaken for VSMs and Executive Directors salary levels with comparator organisations.

1.2 Annual Board Effectiveness/Self-Assessment

The Committee received and noted a report recommending that annual effectiveness review and skills audit be undertaken later in the year. This is because there has been significant changes to the Board, with the recruitment of several new Non-Executive Directors and two non-voting Executive Board members. In the near term focus will be placed on Board development programme to agree the Trust's priorities and ambition going forward.

1.3 Succession Planning: Executive Directors/Business Critical Posts update

The Committee received a verbal report that a formal review of succession planning will be carried out at Executive Director, Deputy Director and Senior Manager levels. This review will look at the development of a succession plan identifying any gaps in business critical roles, career aspirations and support needed to accomplish internal career progression. This review will be supported by the Trust's appraisal process and talent management programme. An internal leadership programme is being developed to support upskilling staff throughout the organisation and provide opportunities for staff to become future leaders in the Trust.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and **APPROVE** the Nominations and Remuneration Committee Chair Report.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**27 MAY 2021**
REPORT TITLE:	**COMMUNICATIONS AND ENGAGEMENT STRATEGY**
BOARD SPONSOR:	**DIRECTOR OF COMMUNICATIONS AND ENGAGEMENT**
PAPER AUTHOR:	**DIRECTOR OF COMMUNICATIONS AND ENGAGEMENT**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: COMMUNICATIONS AND ENGAGEMENT STRATEGY 2021-25**

BACKGROUND AND EXECUTIVE SUMMARY

The Trust's Communication and Engagement strategy is an enabling strategy which supports the Trust's strategic objectives to provide safe, high quality care; improve patients' experience of our services, support staff recruitment and retention and support our future plans.

We have developed our strategy and the plan that supports it, using feedback from patients and staff, our governors and the public.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Patient confidence Staff morale Regulator and stakeholder support
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	None
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Clinical Engagement and Membership Committee
SUBSIDIARY IMPLICATIONS:	The Trust will work with its subsidiaries to involve them in this strategy.

PRIVACY IMPACT ASSESSMENT: *NO*	**EQUALITY IMPACT ASSESSMENT:** *NO*

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to **APPROVE** the Trust's Communications and Engagement Strategy 2021-2025.

East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals' Communication and Engagement Strategy 2021-2025

We care

3. About East Kent Hospitals University NHS Trust

East Kent Hospitals is one of the country's largest Trusts, covering a largely remote and rural geography where more of the population is classified as deprived than the rest of the county.

The Trust has more than one million patient contacts a year. Around 7000 families use our maternity service each year.

In comparison to England, east Kent has more 50-69 year olds and more older people particularly over 70. There is a high prevalence of co-morbidities in the local population. Canterbury has a larger proportion of BAME residents compared with the Kent average.

The Trust has more than 8000 staff, with a wholly-owned subsidiary, 2gether Support Solutions, and a strong volunteer base.
It has more than 10,000 members.

The Trust has begun a new quality improvement approach called We care which focusses on the areas that will make the biggest difference to our patients and staff.

We are working with its NHS and social care partners to develop plans for using our three acute hospitals at Canterbury, Margate and Ashford, in different ways in future to improve standards and deliver care and treatment in the best way possible.

This Communication and Engagement Strategy sets out how we will listen to and communicate with our patients, staff, local communities and key stakeholders over the next five years, to make sure people feel cared for, safe, respected and confident that we're making a difference to their health and wellbeing.

Our Communications and Engagement Strategy on a page

Our mission: Improve Health and Wellbeing

Our vision: Great healthcare from great people

Our strategic objectives:

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

Our communication and engagement objectives

Keep **patients informed** throughout their health journey with us, **be open, involve** them in decisions and **use their feedback** to improve their experience	Our **staff** are **listened to**, **informed** and **engaged,** and **feel valued** and **able to make a difference**	Our **stakeholders** are **informed** about the Trust's performance and feel **involved** so they can support their communities and hold us to account

What success will look like

▪ People will feel we are open, transparent and they are involved in decisions about their own treatment and care. ▪ People will feel they are engaged and confident their feedback makes a difference. ▪ People will feel involved when we make changes to services or re-design care pathways. ▪ People will feel the decisions we make about the future respond to the needs of our communities.	▪ Our staff will understand how their roles contribute to the purpose and values of the Trust, their teams and departments. ▪ Staff will have lots of ways to give feedback and ideas, raise questions and concerns. ▪ Staff will experience our values through the way we communicate with and about them, and engage them. ▪ Leaders and managers will feel supported and able to listen to, communicate with and engage their teams.	▪ Our stakeholders will have regular information about the performance and plans of the Trust and will feel informed. ▪ Our stakeholders will feel engaged and will have regular opportunities to engage with us and provide feedback. ▪ We will have an 'open door' approach to access to our hospitals and services to provide assurance and build confidence. ▪ As part of the wider system, we will involve and engage patients, staff and the public in service change and our plans for the future.

Our strategy is underpinned by our values

People feel **cared** for as individuals	People feel **safe**, reassured and involved	People feel teamwork, trust and **respect** sit at the heart of everything we do	People feel confident we are **making a difference**

How we developed our strategy

The Communications and Engagement Strategy provides a framework for how the Trust will communicate and engage with patient, staff, stakeholders and the public.

We have used feedback from patients and staff, our governors and the public to inform our strategy and it was developed in consultation with;

- East Kent Hospitals Council of Governors
- Healthwatch Kent
- Patient Experience Committee
- Patient and voluntary sector representatives
- East Kent Hospitals staff

We have followed these principles:

- We value compassionate communication - every communication should at all times be consistent with our values
- We are open and transparent about how the Trust is performing and observe our duty of candour
- We adhere to the NHS Constitution, ensuring people can exercise their statutory right to have their say on current and future NHS services
- We work to meet the communication needs of diverse and hard-to-reach groups, and ensure their voice is heard
- We use NHS resources efficiently and effectively.

These are our aims, we recognise that we are not achieving this at the moment and there is much to do to make these aspirations a reality:

- Keep **patients informed** throughout their health journey with us, **be open**, **involve** them in decisions and **use their feedback** to improve their experience
- Ensure our staff are **listened** to, **informed**, **engaged** and **feel valued** and **able to make a difference**
- ensure our stakeholders (eg, MPs, Healthwatch, patient and community representative groups, our members) are **informed** about the Trust's performance and feel **involved** so they can support their communities and hold us to account.

Future key developments:

Development of the Council of Governors communications and membership engagement strategy.

A new co-designed model of patient engagement which embeds the use of patient experience to improve patient care.

An interactive digital platform to communicate and engage with staff more effectively.

A staff events co-ordinator to facilitate staff engagement events.

Roles and responsibilities

This is a strategy for the whole organisation. Everyone in the Trust has a role to play in supporting its delivery, to be good communicators and engage and involve other people.

Some groups have specific roles;

Council of Governors

Governors provide an important link between the communities they represent, and we serve, and the Board. Governors need to be well informed and aware of what is happening in the Trust and engage with their constituents so they can feed their views into the Trust's strategy.

Trust Board of Directors

The Trust Board's role is one of leadership and support. Board members individually and collectively represent the organisation and sets the strategy for how it communicates and engages with the public. Our chairman also has a leading role in chairing the east Kent Integrated Care Partnership.

Executive Directors

Executive Directors have an on-going day-to-day responsibility for delivering the organisation's strategic objectives which includes this strategy.

Communications and Engagement Team

The Communications and Engagement Team is a small team of dedicated communications professionals providing leadership, technical expertise, advice and guidance. It has a lead role in providing information for staff, patients, the public and stakeholders, upholding the Trust's brand and reputation, developing communication channels and co-ordinating media relations. The Communications and Engagement Team should add value to others to enable them to do their work.

Care Group and Hospital leadership teams

The Senior Management Team has a responsibility to directly support the delivery of this strategy and to encourage their teams to do so, and has a responsibility in ensuring this strategy is delivered and information is cascaded throughout the organisation.

4. The communications environment

There are a number of additional drivers that shape our strategy

Social

- Growing and ageing population
- Public pride in NHS, public fear over its future
- Importance placed on institutional transparency and integrity
- Public expectation of speedy response from service industries
- Increasingly technologically-enabled mobile workforce

Environmental

- East Kent's peninsula geography, 'remote and rural'
- Multi-site working
- Growing climate change/environmental impact awareness

Political

- NHS Long Term Plan priorities
- Increased integration and partnership, eg, ICSs and ICPs

Economic

- Potential long-term impact of Covid response on economy
- Impact of austerity on health and social care
- Availaibility of resources to the NHS

Technological

- Increased use of digital healthcare, eg, video consultations, NHS app
- Customer service via social media and smartphone apps
- Electronic health record
- Increased use of digital and social media for staff communication

Legal

- Information Standard
- GDPR
- Patient confidentiality
- Duty of candour

Our patients

Our aim is to keep patients **informed** throughout their health journey with us, **be open**, **involve** them in decisions and **seek feedback** on their experiences and needs to improve their experience

Our patient and public engagement strategy will focus on four areas:

- Be open and transparent and involve people in decisions about their own treatment and care, so they feel cared for, safe, respected and confident we're making a difference
- Engaging people in on-going service delivery so our services meet their needs
- Engaging people in making changes to services or re-designing care pathways, so the patient experience is at the forefront of service design
- Informing and engaging people in organisational decision-making, so we can respond effectively to the needs of our local communities.

Keeping patients informed

We have a range of channels for communicating with patients, from individual letters and information leaflets, to the Trust's website, social media and *Your hospitals* magazine. The Trust is developing a patient app.

Our quality and safety

Patient feedback

The Trust asks patients for feedback from the Friends and Family Test and a number of individual services are developing local surveys to gain further insight into patient experiences and needs.

A number of services also have patient groups, which are a valuable source of feedback. Patients are invited to tell their stories at the Trust's Board of Director meetings and patient stories are shared with staff through the staff newsletter and intranet.

The Trust also works with the CCG to engage patients and members of the public on decisions about services that may affect them.

Involving patients

We know much more needs to be done to establish a good foundation for effective patient engagement within the Trust and so we have engaged Healthwatch Kent to audit our current provision and make recommendations for improvement.

We want to co-design our engagement programme with patients, carers and members of the public, including seldom heard groups. We also want to give carers more opportunity to give us feedback on how we can improve. We will embed patient engagement within our new 'We care' quality improvement approach, so it becomes integral to our frontline-led improvement culture.

Our objectives for patient communication and engagement

Objective	How we will achieve this objective	How we will measure our progress
Listening and understanding		
Use data to engage staff in quality improvement	We will communicate key themes from patient feedback (eg, Friends and Family Test and complaints themes) with staff through our internal communication and as part of the 'We care' approach. We will gather patient feedback on new or redesigned services, to understand what's going well and where we can improve.	Increase in measurable staff innovation to solve patient experience problems; examples of improvement work shared across the organisation through internal communication channels and shared externally through 'you said, we did' Improvement in NHS staff survey responses on 'I am able to make improvements in my area of work'; 'I look forward to going to work'; and staff FFT responses
Develop tools for listening to and engaging with service users	We will develop our use of social media to engage with service users. We are piloting a new approach to service user engagement and feedback via social media with the maternity Facebook provision for expectant and new mums. We will take lessons learned to other Trust services. Patient-facing staff are a rich source of patient feedback. We will provide regular opportunities for staff to tell the Trust what they are learning from patients. Develop a regular range of drop in, listening events and roadshows in partnership with our local stakeholders including Healthwatch and voluntary/advocacy services to facilitate improving patient experience	Quarterly patient experience dashboard developed and shared with the Board of Directors, Council of Governors and EKHUFT leaders, including ward managers Improvement in NHS Staff Survey responses to 'Patient care is a priority for my organisation'

	and service re-design. Attend voluntary sector regular meetings and forums – such as the Mental Health Forums in Kent or Carers groups and community events, eg, Pride	
Understand our local communities	Develop a robust 'stakeholder map' to understand the communities we serve and identify seldom-heard groups so we can effectively communicate with and engage with these groups. Build relationships with the voluntary sector, forming a 'champions' group to co-design solutions for regular, open and honest dialogue. Work with and support our public governors to listen to and feedback the views of their constituents.	Increased access and feedback from hard to reach groups
Communication		
Develop communications materials and tools that help staff inform and support patients, families, carers and referrers, so they access our services and have a positive experience	We will implement the Information Standard across the Trust, including in patient appointment letters. We will ensure our website is compliant and all staff can access resources to help them produce Information Standard compliant patient information. We will provide resources to help all staff develop high standard patient communication materials. We will use one branding and style guide across the Trust, and provide templates and 'tone of voice' guides for all staff to access on Staff Zone. We will audit patient letters and make recommendations for improvement based on best practice and patient feedback. We will review our 'servicescape' (the environment in which we	Reduction in complaints on the quality of patient communication

	provide our services) and make changes to improve the patient experience, eg, improved wayfinding. We will develop a 'menu of options' to improve access to information about the hospitals and the Trust, and opportunities to get involved.	
Develop the Trust's website and digital communication channels	We will review the 'Information for patients' section of our website, taking into account patient feedback, identify good practice and implement changes.	Increased use of patient information pages on the website, measured through page analytics
Ensure patients and referrers can access clear and up-to-date information about the quality and performance of our services	We will ensure patients and referrers can easily access nationally-published performance and quality data about each of our services on our website.	Improved user experience measured through search function analytics
'You said, we listened'	We will tell patients what we have changed as a result of their feedback via our website, social media and servicescape. We will work with patient 'champions' to co-design how to share where patient feedback is used to inform changes across the Trust. We will also share patient experiences (with consent), including feedback via Patient Opinion, on social media.	
Engagement		
Review patient, family and carer engagement across the Trust and develop a road map for improvement by	We are working with Healthwatch Kent to review patient engagement across the Trust and develop recommendations and a methodology for improvement, testing this out with patient and public groups	Patient engagement improvement plan developed by 2022

2022		
Develop our patient and public engagement structures	We will increase the number of patients and carers who work with us, and develop 'experts through experience' panels We will review the membership of the Patient Experience Committee We will develop relationships with patient advocate and representative stakeholders, including Healthwatch Kent, charitable organisations and MPs	Increase in recruitment of patient/carer representatives
Develop patient engagement tools that help staff engage patients, families and carers in quality improvements and service co-design	We will provide resources to help all staff engage patients, families and carers in service improvement, including an engagement 'toolkit' and training	Increased engagement of patients, families and carers in service improvement Improvement in NHS staff survey responses on 'I am able to make improvements in my area of work'; 'I look forward to going to work'; and staff FFT responses

Our people

Our aim is to ensure our staff are **informed**, **engaged** and **feel able to make a difference**. This requires purposeful internal communication that is two-way.

Strong internal communication supports retaining good people and enabling people to work at their best. Staff are ambassadors for the organisation and support major change.

People make life-changing decisions based on what they are told at work, eg, when they make choices about where to live, how to save for retirement or whether or not to change jobs. The integrity of what we tell staff matters.

Our internal communication strategy will focus on:

- A strategic narrative that provides a clear 'line of sight' between the purpose and values of the Trust, teams, departments and people's daily work
- Supporting leaders and managers to communicate with and engage their teams
- Ensuring there are regular and varied ways for people to give feedback and ideas, ask questions and raise concerns

Our quality and safety

- Caring for the caregivers, to ensure our people experience our 'We care' values

Supported by an internal communications infrastructure that is in line with current and future uptake of communication technologies in our daily lives.

Keeping staff informed

We have a range of channels for communicating with staff, from a weekly email newsletter and intranet, to webinars (replacing large face-to-face briefing meetings during Covid) and walk-rounds. The CEO writes a weekly email message to staff and the CEO podcast is available on the intranet.

We began using Mailchimp for the weekly staff newsletter and all-staff emails in 2020, which allows us to track open rates and the content staff are most interested in.

Staff engagement

We will embed staff engagement within our new 'We care' quality improvement approach, so it becomes integral to our frontline-led improvement culture.

Our objectives for internal communication and staff engagement

Objective	How we will achieve this objective	How we will measure our progress
Listening and understanding		
Ensuring there are regular and varied ways for people to give feedback and ideas, ask questions and raise concerns	We will provide regular opportunities for staff to tell the Trust how it feels to work here, what they are learning from patients and their ideas for improvement, including face-to-face or webinars, the staff Friends and Family Test and NHS Staff Survey, and through the 'We care' programme. We will provide a single point of information on our intranet on 'who can I tell?' for any staff concerns, and publicise this at least quarterly through our internal communication channels. We will continue to ensure the executive and leadership teams are accessible for staff, eg, through walk-rounds, ensuring contact details are included at the end of staff messages. Work with and support our staff governors to listen to and feedback the views of staff. We will identify digital technology that improves the variety of feedback mechanisms available to staff, eg, a staff app.	Annual NHS Staff Survey Staff Friends and Family Test Number of staff raising concerns Number of staff joining webinars

Communication		
P**rovide communications materials and tools that help the Trust attract, inform, support and involve staff so they feel motivated, fulfilled and able to give their best**	We will provide resources to help all staff develop high standard internal communication materials. We will use one branding and style guide across the Trust, and provide templates and 'tone of voice' guides for all staff to access on Staff Zone. We will continue to develop digital opportunities for staff communication and engagement, eg, exec-led webinars, and identify new channels, eg, staff app. We will explore the options and bring forward a business case for a replacement intranet which provides a high level of user engagement	Annual NHS Staff Survey Staff Friends and Family Test Staff retention rates Number of staff joining webinars
Support staff well-being	We will ensure information about mental health services is available on Staff Zone and publicised regularly, alongside information for staff on accessing other health services, including going smoke-free. We will make information about staff benefits more accessible for staff. We will help foster an EKHUFT team culture though a team narrative and shared experiences. We will increase the profile and opportunities for staff to participate in special occasions, such as the NHS birthday and national celebration days. We will ensure the communications planning grid meets the needs of BAME and other staff groups, working with staff networks such as the BAME, LGBT	Annual NHS Staff Survey Staff Friends and Family Test Staff retention rates

	and Disability staff networks.	
Improve employee information	We will regularly update staff on organisational priorities, such as quality and safety, and be clear about our performance and future plans. We will ensure clear information on practical issues, such as pensions or staff facilities on site, is easy for staff to access.	Annual NHS Staff Survey Staff Friends and Family Test Staff retention rates
Engagement		
Support leaders to communicate and engage with staff	We will further develop leaders' communications channels, to provide useful tools on Trust policy updates, key decisions and resources for our leaders. We will provide resources to help leaders engage their teams, including an engagement 'toolkit' and training through the 'We care' programme.	Annual NHS Staff Survey Staff Friends and Family Test Staff retention rates
Help staff engage with and drive the Trust's 'We care' vision and values, so they feel able to provide the highest standards of care	We will develop the 'We care' narrative and materials for use across the Trust's communications and in the 'We care' wards. We will help staff tell their 'We care' stories and share good practice through the Trust's internal and external communications and events. We will recognise staff who 'go the extra mile' through our reward and recognition scheme.	Annual NHS Staff Survey Staff Friends and Family Test Staff retention rates

Our future

Our aim is to ensure our stakeholders (eg, MPs, Healthwatch, patient and community representative groups, our members) are informed about the Trust's performance and involved in major service decisions so they can support their communities and hold us to account.

Our stakeholder strategy will focus on:

- Providing regular information on the performance and plans of the Trust
- Providing regular opportunities for dialogue
- An 'open door' approach, where we facilitate access to our hospitals and services as much as possible.

Our sustainability

Building on engagement

In recent years, we have worked with the CCG to involve and engage patients, staff and the public in a number of service changes and our wider plans to use our three acute hospitals at Canterbury, Margate and Ashford, in different ways in future. We provide regular, written briefings to MPs on our performance and future plans.

Our objectives for communication and engagement with stakeholders

Objective	How we will achieve this objective	How we will measure our progress
Listening and understanding		
Facilitating public consultation and engagement on major service changes	In addition to day-to-day engagement with our service users on service re-design, we will support our commissioners in public consultation and engagement on major service changes within the legal framework.	Involvement in engagement activities
Communication		
Providing regular briefings and opportunities for dialogue	We will provide regular written briefings for stakeholders, including a monthly bulletin, and face-to-face meetings as required, being clear about the challenges we face. We will provide regular briefings/releases to the media. We will facilitate access to our hospitals and services as much as possible whilst preserving patient confidentiality. We will offer regular meetings between MPs and the CEO and the Chair of the Trust, and facilitate visits to services and opportunities to meet or shadow staff.	Take up of communications and meetings NHS position included in media coverage
Engagement		
Working in partnership to support public health and well-	We will seek the support of our stakeholders in health campaigns and local recruitment, to help us reach	Increased reach of communications

being	areas of the community we may not have contact with. We will work with our GP, CCG, ICP, PCN, KCC and LMC partners in constructive dialogue on day-to-day service provision. We will support the work of our stakeholders to improve health and well-being in our local communities.	Take up of communications and increased feedback

5. Our reach

Your hospitals magazine – over 30,000 copies distributed to 300 pick-up points in east Kent (digital only during Covid).

Our website has more than 140,000 visitors each month.

We increase our social media reach month on month.

Our weekly staff newsletter has an average open rate of 37%.

We issue an average of 11 press releases each month, alongside a monthly stakeholder newsletter and regular direct engagement.

Appendix 1: Our current communication channels

Channel	One-way (awareness)	Two-way (engagement)
Patients and public		
Website	■	■
Your Hospitals magazine	■	
Information screens/posters in waiting areas	■	
Social media		■
Traditional media (press, radio, TV)	■	
Patient committees and focus groups		■
Board meetings live streamed	■	
Calendar of engagement events and annual members meeting		■
Patient Engagement Network		■
Staff		
Face-to-face staff forums		■
Engagement in QII hubs		■
The Leader briefing for managers		■
Staff Zone (intranet)	■	■
Team Talk for people managers/team meetings		■
CEO blogs	■	■
Listening into Action tool	■	■
CEO and Exec visibility programme	■	■
Weekly Trust newsletter	■	■
PC ‘desktop wallpaper’	■	
Mid-week round-up	■	
Staff information boards	■	
Professional journals	■	
Governors		
Face-to-face briefing sessions and Q&As		■
Site and service visits		■
Email briefings on emerging issues	■	
Weekly communications briefing	■	

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Members		
Trust magazine		
Members' newsletters		
Dedicated area of public website		
Calendar of engagement events/annual meeting		
Meet your Governors events		
Patient Engagement Network		
Partner organisations		
Whole system meetings		
Monthly stakeholder e-bulletin		
Programme of engagement		
Stakeholders		
Monthly stakeholder e-bulletin		
Programme of engagement		