Board of Directors - open meeting

Thu 29 April 2021, 09:30 - 12:15

WebEx teleconference - as per details in diary invite

Agenda

09:30 - 09:30
0 min

Agenda

00 - Agenda - BoD Public - 29.04.21 FINAL.pdf (4 pages)

09:30 - 09:45
15 min

21/1.
Chairman's welcome (09:30)

To Note *Chairman*

Verbal

09:45 - 09:45
0 min

21/2.
Apologies for Absence

To Note *Chairman*

Verbal

09:45 - 09:45
0 min

21/3.
Declaration of Interests

To Note *Chairman*

21-03 - REGISTER 2021-22 V21 - from April 2021.pdf (4 pages)

09:45 - 09:45
0 min

21/4.
Minutes of Previous Meeting held on 11 March 2021

Approval *Chairman*

21-04 - Unconfirmed BoD 11.03.21 Public Minutes.pdf (16 pages)

09:45 - 09:45
0 min

21/5.
Matters Arising from the Minutes on 11 March 2021

Approval *Chairman*

21-05.1 - Front Sheet Actions from Public Board.pdf (3 pages)
21-05.2 - Appendix 1 Public Board of Directors Action Log.pdf (2 pages)

09:45 - 09:50
5 min

21/6.
Chairman's Report (09:45)

Discussion *Chairman*

21-06 - Chair Report April 2021 BoD ND 22.04.21 FINAL.pdf (4 pages)

09:50 - 10:00
10 min

21/7.
Chief Executive's Report (09:50)

Discussion *Chief Executive*

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

21-07 - CEO Report FINAL.pdf (5 pages)

10:00 - 10:40
40 min

21/8.
Corporate Reporting (10:00)

Discussion

21/8.1.
Integrated Performance Report (IPR) (10:00) 20 mins

Discussion *Chief Executive/Executive Team*

21-08.1.1 - Front sheet IPR Refresh Board 29 April 2021.pdf (2 pages)
21-08.1.2 - Appendix 1 IPR_v3.0_Mar21_final.pdf (23 pages)

21/8.2.
Strategic Risks Report (10:20) 10 mins

Approval *Acting Director of Quality Governance/Executive Team*

21-08.2.1 - Front sheet Risk Board Paper.pdf (3 pages)
21-08.2.2 - Appendix 1 Risk Management A3 (1) V3.pdf (1 pages)
21-08.2.3 - Appendix 2 BAF and CRR Examples.pdf (8 pages)
21-08.2.4 - Appendix 3 Risk Committee Pathways.pdf (2 pages)

21/8.3.
Infection Prevention and Control (IPC) Board Assurance Framework (BAF) (10:30) 10 mins

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

21-08.3.1 - Front Sheet for BoD IPC Board Assurance Framework 19_04_21.pdf (2 pages)
21-08.3.2 - Appendix 1 IPC Board Assurance Framework review_19_04_21.pdf (40 pages)
21-08.3.3 - Appendix 2 IPC CQC Board paper April 2021.pdf (4 pages)

10:40 - 10:50
10 min

21/9.
Chief Medical Officer's Report (10:40)

Discussion *Chief Medical Officer*

21-09 - CMO Ethics Committee report April 2021 FINAL.pdf (2 pages)

10:50 - 11:00
10 min

TEA/COFFEE BREAK (10:50 - 11:00)

11:00 - 11:10
10 min

21/10.
Finance and Performance Committee (FPC) – Chair Report (11:00)

Approval *Chair FPC - Nigel Mansley*

- Month 12 Finance Report
- FPC Terms of Reference (ToR)

21-10.00 - FPC April 21 Chair Report.pdf (3 pages)
21-10.1 - FRONT SHEET - M12 Finance Report.pdf (3 pages)
21-10.2 - Appendix 1 M12 Finance Report.pdf (26 pages)
21-10.3 - FPC Chair Report - April 2021.pdf (2 pages)
21-10.4 - Appendix 1 FPC TOR in review March 2021.pdf (7 pages)

11:10 - 11:20
10 min

21/11.
Maternity Improvement Committee (MIC) – Chair Report (11:10)

Approval *Chair MIC - Jane Ollis*

21-11.1 - Front Sheet MIC BoD report.pdf (3 pages)
21-11.2 - Appendix 1 MIC Highlight Report.pdf (1 pages)
21-11.3 - Appendix 2 Deep Dive RCOG Recommendations Closure Report.pdf (9 pages)

11:20 - 11:30
10 min

21/12.
Quality Committee (QC) - Chair Report (11:20)

Approval *Chair QC - Sarah Dunnett*

21-12.1 - QC Chair Report April 2021.pdf (4 pages)
21-12.2 - Appendix 1 - Final draft Quality Committee ToR 0.3.pdf (7 pages)

11:30 - 11:40
10 min

21/13.
Integrated Audit and Governance Committee (IAGC) – Chair Report (11:30)

Approval *Chair IAGC - Barry Wilding*

21-13 - IAGC Chair Front Sheet April 2021.pdf (3 pages)

11:40 - 11:45
5 min

21/14.
Nominations and Remuneration Committee (NRC) – Chair Report (11:40)

Approval *Chair NRC - Sunny Adeusi*

21-14 - NRC Chair Report March 2021.pdf (2 pages)

11:45 - 11:50
5 min

21/15.
Charitable Funds Committee (CFC) – Chair Report (11:45)

Approval *Chair CFC - Sunny Adeusi*

21-15 - CFC Chair Report March 2021.pdf (3 pages)

11:50 - 11:55
5 min

21/16.
Any other business (11:50)

Discussion *Chairman*

Verbal

11:55 - 12:05
10 min

21/17.
QUESTIONS FROM THE PUBLIC (11:55)

Discussion *Chairman*

Verbal

Date of Next Meeting: Thursday 27 May 2021, 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 29 APRIL 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 12.15 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

01	Chairman's welcome		**09:30**	Chairman
02	Apologies for Absence			
03	Declaration of Interests			
04	Minutes of Previous Meeting held on 11 March 2021			
05	Matters Arising from the Minutes on 11 March 2021			

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

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

We care

08	Corporate Reporting		**10:00**	
	08.1 Integrated Performance Report (IPR)	**Discussion**	**10:00** **20 mins**	Chief Executive/ Executive Team
	08.2 Strategic Risks Report	**Approval**	**10:20** **10 mins**	Acting Director of Quality Governance/ Executive Team
	08.3 Infection Prevention and Control (IPC) Board Assurance Framework (BAF)	**Discussion**	**10:30** **10 mins**	Chief Executive/ Chief Medical Officer/ Interim Chief Nurse/ Director of IPC
09	Chief Medical Officer's Report	**Discussion**	**10:40** **10 mins**	Chief Medical Officer
	TEA/COFFEE BREAK	**10:50 – 11:00** **10 mins**		
10	Finance and Performance Committee (FPC) – Chair Report • Month 12 Finance Report • FPC Terms of Reference (ToR)	**Approval**	**11:00** **10 mins**	Chair Finance and Performance Committee – Nigel Mansley
11	Maternity Improvement Committee (MIC) – Chair Report	**Approval**	**11:10** **10 mins**	Chair Maternity Improvement Committee – Jane Ollis
12	Quality Committee (QC) - Chair Report	**Approval**	**11:20** **10 mins**	Chair Quality Committee – Sarah Dunnett
13	Integrated Audit and Governance Committee (IAGC) – Chair Report	**Approval**	**11:30** **10 mins**	Chair Integrated Audit and Governance Committee – Barry Wilding
14	Nominations and Remuneration Committee (NRC) – Chair Report	**Approval**	**11:40** **5 mins**	Chair Nominations and Remuneration Committee – Sunny Adeusi
15	Charitable Funds Committee (CFC) – Chair Report	**Approval**	**11:45** **5 mins**	Chair Charitable Funds Committee – Sunny Adeusi
	CLOSING MATTERS			
16	Any other business		**11:50** **5 mins**	

17	**QUESTIONS FROM THE PUBLIC**	**11:55** **10 mins**

Date of Next Meeting: Thursday 27 May 2021, WebEx teleconference

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


Our mission:
Improve health and wellbeing
Our vision:
Great healthcare from great people
We care about...
Our patients
Our people
Our future
Our sustainability
Our quality and safety
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

REGISTER OF DIRECTOR INTERESTS – 2021/22 FROM APRIL 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	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 APRIL 2021

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
DICKSON, NIALL	Chair	Director, Leeds Castle Enterprises (started 31 May 2012) **(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
JOLLY, MARTIN	Non Executive Director	None	1 April 2021 (First term)
JORDAN, SIOBHAN	Interim Chief Nurse	None	1 December 2020 (Interim)
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)

REGISTER OF DIRECTOR INTERESTS – 2021/22 FROM APRIL 2021

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
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)
SHUTLER, LIZ	Director of Strategic Development and Capital Planning/Deputy Chief Executive	None	Appointed January 2004
WILDING, BARRY	Senior Independent Director	None **Closed interest** Trustee of CXK, a Charity in Ashford inspiring people to thrive (started 16 May 2018/finished 11 March 2021) **(4 & 5)**	11 May 2015 (Second term)

REGISTER OF DIRECTOR INTERESTS – 2021/22 FROM APRIL 2021

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 & NINTH MEETING OF THE BOARD OF DIRECTORS THURSDAY 11 MARCH 2021 AT 9.30 AM AS A WEBEX TELECONFERENCE

PRESENT:

Mrs J Ollis	Acting Chair	JO
Ms S Acott	Chief Executive Officer (CEO)	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
Professor C Corrigan	Interim Non-Executive Director	CC
Ms S Dunnett	Interim Non-Executive Director	SD
Professor C Holland	Non-Executive Director	CH
Ms S Jordan	Interim Chief Nurse	SJ
Mr N Mansley	Non-Executive Director	NM
Dr R Martin	Chief Medical Officer (CMO)	RM
Ms L Shutler	Director of Strategic Development and Capital Planning/ Deputy Chief Executive	LS
Mr B Wilding	Non-Executive Director	BW

ATTENDEES:

Ms J Dawes	Interim Group Company Secretary	JD
Mrs A Fox	Acting Director of Governance and Project Director Independent Investigation into East Kent Maternity Services	AF
Dr Sara Mumford	Director of Infection Prevention and Control (DIPC)	SM
Mrs N Yost	Director of Communications and Engagement	NY

IN ATTENDANCE:

Ms C Allen	Ward Manager, Kings C Ward (minute number 20/178)	CA
Dr H Hajallie	Registrar, General and Specialist Medicine (minute number 20/178)	HH
Miss S Robson	Board Support Secretary (Minutes)	SR
Mr J Scott	Board Advisor on Emergency Flow (minute number 20/177)	JSc
Ms F Wise	Executive Maternity Services Strategic Programme Director/ Improvement Director, NHSE/I	FW

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mr R Britton	Governor
Ms L Fulci	Member of the Public (Non-Executive Director start date 1 April 2021)
Ms C Gregory	Member of the Public
Mrs C Heggie	Member of the Public
Mr J Ho	NHS Graduate Management Trainee
Mr S Horne	NHS Graduate Management Trainee
Mr C Plummer	Governor
Mrs P Pryer	Member of the Public
Mr B Rylands	Member of the Public
Mr P Schofield	Governor
Mrs M Smith	Member of the Public
Mr M Vince	Member of the Public
Ms O Vynohradska	NHS Graduate Management Trainee
Mrs M Warburton	Governor
Dr N Wigglesworth	Member of the Public (Director of Infection Prevention and Control start date 15 March 2021)

MINUTE NO.		ACTION
20/167	**CHAIRMAN'S WELCOME** The Acting Chair welcomed those in attendance. The Acting Chair welcomed Dr Neil Wigglesworth, who would be commencing with the Trust the following week as the Director of Infection Prevention and Control (DIPC). The Acting Chair extended thanks to the incumbent DIPC, Dr Sara Mumford, for all her hard work, commitment and support to the Trust around its IPC improvements, her advice and guidance to all its staff, particularly the IPC team. The Acting Chair stated the Board meeting would be held in line with the Trust's values.	
20/168	**APOLOGIES FOR ABSENCE** No apologies for absence were received.	
20/169	**DECLARATION OF INTERESTS** There were no new declarations of interest.	
20/170	**MINUTES OF THE PREVIOUS MEETING HELD ON 11 FEBRUARY 2021** RM raised an omission that Dr Sara Mumford, DIPC, had not been recorded as having sent apologies for the previous meeting held. **DECISION:** The Board of Directors **APPROVED** the minutes of the previous meeting held on 11 February 2021 as an accurate record, with the exception of the amendment noted above.	
20/171	**MATTERS ARISING FROM THE MINUTES ON 11 FEBRUARY 2021** **B/015/20 – Kent & Medway (K&M) Stroke Services** LS confirmed she had followed up the issue with the Clinical Commissioning Group (CCG) regarding when an announcement on the decision of K&M Stroke Services was expected. The CCG had provided a further briefing to NHS England/NHS Improvement (NHSE/I) and a discussion was being arranged with the Department of Health and Social Care (DHSC). She would update the Board once more information was available and clarification regarding a decision date. The Board agreed to close this action. **B/016/20 – Urgent Emergency Care (UEC) Improvement Programme** The Board noted a report regarding progress of the UEC Improvement Programme was presented to this meeting. The Board agreed to close this action. **DECISION:** The Board of Directors noted the updates and **APPROVED** the two actions for closure.	

20/172 **CHAIR'S REPORT**

The Acting Chair reported she was Acting Chair following the departure of Professor Stephen Smith. She extended thanks to Stephen for his commitment, support and hard work during his three years term of office with the Trust.

The Acting Chair confirmed the good news following the appointment of an experienced Chairman, Niall Dickson CBE, who would be taking up post on 5 April 2021.

The Acting Chair stated two experienced high calibre candidates had been appointed as Non-Executive Directors (NEDs) commencing with the Trust on 1 April 2021. She welcomed Ms Luisa Fulci, who was observing this meeting, and Dr Olu Olasode who would be attending the next meeting.

The Chair reported a Council meeting had been held on the Tuesday that week, this had been a productive meeting with good discussions, a number of new Governors had been welcomed and noted the Lead Governor was in attendance at this Board meeting.

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

20/173 **CHIEF EXECUTIVE'S REPORT**

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

SAc welcomed the new Chairman, Niall Dickson, and looked forward to working with him, as well as the new NEDs and Governors that had joined the Trust.

SAc highlighted the key elements in her report:

- An internal incident occurred the previous morning, resulting in the data centre being closed down and IT systems interrupted. Thanks were extended to RC and all the Trust staff who worked tirelessly co-ordinating the management of bringing these systems back on line later in the morning;
- Number of Covid positive patients continued to reduce, currently below 100 compared with 500 at the peak during wave 2;
- Trust continued to remain very busy with regards to critical care activity, some Covid positive patients were acutely unwell resulting in long term recovery. Surge capacity remained in place that was anticipated to be stepped down in the next few weeks, with provision of mutual aid support across the region. Additional staff resources had been deployed to critical care in respect of buddies to support critical care staff. This reduced activity would enable focus on the restore and recovery programme of work;
- Regional visit to the Trust's critical care services with positive feedback regarding these, its capacity and the focus around the provision of support for staff with regards to mental health and health and well-being;
- Re-launching the Trust's We Care quality improvement (QI) programme, a proven systematic methodology and sustained approach to QI, successfully implemented in other trusts. Its rollout had been impacted by the pandemic. This would include scheduled walkabouts by the Executive Directors to wards and departments providing the opportunity to talk and listen to staff;

- Approval by the Clinical Executive Management Group (CEMG) of the Infection Prevention Control (IPC) business case to expand staff resources in the IPC team;
- The vaccination hub remained at the Kent County Cricket ground in Canterbury, with just over 28k vaccines delivered to date, which included at risk members of the public, Trust staff of which over 90% had been vaccinated, bookings for second doses were now taking place;
- Care Quality Commission (CQC) inspections:
    - IPC inspections took place at Queen Elizabeth the Queen Mother Hospital (QEQMH) and William Harvey Hospital (WHH), including interviews held with key senior members of staff, and submission of over 100 documents for review. An initial letter had been received with positive feedback regarding a real visible change in culture with respect to IPC. The Trust had been invited to submit a request for the removal of the Section 31 IPC notice;
    - Winter pressure inspection also took place at QEQMH and WHH focussed on the Emergency Departments (EDs), with positive feedback regarding staff resilience and the inspection team were warmly welcomed. Immediate actions were required that had been put in place regarding adjustments to the provision of the mental health room in ED at WHH;
    - The formal reports from these visits would not be received for a couple of months.
- Appointments had been made to the Chief Nurse and Director of Quality Governance roles and start dates were being negotiated;
- Thanks to Dr Sara Mumford, DIPC, for all her hard work, guidance and direction to the IPC team and the Trust supporting the IPC improvements achieved, recognising the challenge having to split her time working with the Trust and Maidstone and Tunbridge Wells NHS Trust (MTW);
- Welcomed the new DIPC, Dr Neil Wigglesworth, noting the Trust had also appointed a Deputy DIPC;
- Congratulated Lindsay Berry, a specialist children's cystic fibrosis nurse, who had received a national award 'Respiratory Nurse of the Year' from the British Journal of Nursing. In recognition of her exceptional innovation and professionalism.

NM enquired regarding the IT incident and what processes were in place to address a major incident. SAc confirmed strong internal business continuity plans were in place that had been instigated with pre-agreed processes undertaken that included manual processes, and a clear recovery process bringing these systems back online.

CH commended the Trust and its example of good practice in promoting 'Explain my Procedure', provided with easy-to understand animations helping people to understand the treatments patients received in intensive care. He would be encouraging MTW where he worked as a clinician to also adopt this.

SAc reported We Care re-launch would be promoted in her weekly blogs, setting out how staff and teams would be working with this programme, supported by staff WebEx sessions. LS confirmed the initial wards implementing the programme had already received training, weekly coaching sessions were held and the new

scorecard version had been used that was aimed to be fully implemented the following month. Further training to Care Groups would be provided at the end of March to ensure staff were clear of the work required focussing on the Trust's priorities. Executive Directors would be undertaking regular Gemba visits to talk to front line staff, wards and departments, providing the opportunity for staff to provide feedback on progress of the programme. These visits would support the ward to board communications and it was hoped post-Covid, NEDs and Governors would be included in these in the future. JO commented it would be good to receive updates on staff feedback from these visits in future Chief Executive reports.

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

20/174 **CORPORATE REPORTING:**

20/174.1 **INTEGRATED PERFORMANCE REPORT (IPR)**

RC reported January 2021 had been a challenging month and extended thanks to all staff and the teams working together enabling the continuation of services during the pandemic, treatment and looking after patients. This was supported by mutual aid and whole health care system collaborative working that continued around the management of Covid. During the month of January there had been an increase and high demand on ambulances. She stated the new escalation process and pilot patient pathway in place in respect of mental health admissions to the EDs was working well.

RC reported the Trust continued to focus on the restore and recovery programme that was clinically led and supported by the Medical Director (Covid Incident Response). This was around increasing routine elective activity enabling patients to be seen as quickly as possible, taking into consideration innovative changes implemented during the pandemic and those to be retained. This work would also be supported by the Urgent Emergency Care (UEC) improvement programme.

SAc highlighted due to the pandemic nationally all trusts were seeing significant increased activity for Child and Adolescent Mental Health Services (CAMHS) services. The rise in attendances and those patients who were very vulnerable and distressed, it was challenging to meet this demand as there was limited capacity, mitigations were in place at a national level.

SD highlighted the number of patient unplanned re-attendances in the EDs of 10.50%, querying that these appeared to be high and how the Trust compared nationally. SAc commented this was a challenge for the Trust as it had a number of very complex patients, particularly at QEQMH. There was collaborative work being progressed with the CCG and local partners, including the Police, to improve and reduce the number of re-attendances. RC commented that other trusts were also seeing an increasing number of re-attendances.

ACTION: 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 improve and reduce the number of Emergency Department patient unplanned re-attendances. RC

SA raised patients receiving treatment after their 52-week breach date and how

these were being managed clinically. RC reported these patients were being actively managed by the Care Groups, with clinical nurse specialist involvement, a clinical harm reviews process in place for each patient, and Datix used to report risk and harm. SD stated a harm review report had been presented and discussed in detail at the QC meeting held the previous week and assurance received regarding the robust patient review process in place. She noted with regards to the cancer 62 day standard, the eight patients waiting 104 days or more for treatment or potential diagnosis had all been reviewed and receiving their treatment. She emphasised the importance of completing the restore and recovery programme as soon as possible.

The Board of Directors discussed and **NOTED** the IPR.

20/174.2 **STRATEGIC RISKS REPORT**

AF reported a complete review of the risk registers would be undertaken over the next couple of weeks, with a workshop to commence this review process, noting a different format would be presented at the April 2021 Board meeting.

AF highlighted the key updates:

- Risk BAF 24: If leadership and management is not effective staff may not be engaged to deliver a high quality, caring service. Residual risk score reduced from 20 (extreme) to 16 (high), as a result of the mitigating actions. The controls would be reviewed to further reduce this risk score;
- No additional risks added to the register and no risks closed;
- Risk CRR 85: Increased demand for emergency patients with a mental health issue. This risk remained outside of the Trust's risk appetite. A deep dive report was presented at the last meeting of the Integrated Audit and Governance Committee (IAGC) regarding the work being progressed to mitigate and reduce this risk score. Assurance had been taken of the next steps in place with regards to a revised pathway aimed for full implementation in April 2021;
- Risk BAF 22: Urgent Treatment Centre (UTC) may not become established and result in increased demand to ED. A detailed review of this risk and UTC demand would be undertaken by the COO and the register updated with the mitigating actions and whether the level of risk score was appropriate.

SD commented the benefit of changes being clearly identified in colour in the IPC Board Assurance Framework (BAF), ensuring the prompt identification of where changes had been made and robust monitoring. She suggested this same process be followed and updates in the risk registers be identified in colour.

ACTION: Updates in risk registers to be identified in colour enabling prompt identification of changes made. AF

BW welcomed the review of the risk registers highlighting the importance of improving the updating process and the need for the new format provide the required assurance and evidence regarding the mitigating actions and that these were successfully reducing the level of risk.

NM reiterated the need to ensure timely progress updates and evidence of the actions in place to reduce the risk scores, noting partial assurance had been taken at the last meeting of the Finance and Performance Committee.

The Board of Directors discussed and **NOTED** the Strategic Risks report.

20/175 **CHIEF MEDICAL OFFICER'S (CMO) REPORT**

- **LEARNING FROM DEATHS**

RM reported the key highlights from the report, providing an update on progress against the requirements of the National Quality Board 'Learning from Deaths (LfD)', and the findings from quarter 2 (Q2) and quarter 3 (Q3) 2020.

- The Medical Examiner (ME) Service had been successfully established in the Summer 2020 and was positively contributing to the LfD process. This service provided the initial screening review, identified any learning and was the key point of contact for patients' relatives, as well as developing a supporting relationship with bereaved families;
- A Structured Judgement Review (SJR) was undertaken on those deaths that met national or locally required criteria, around a more detailed clinical review. Performance had been impacted by insufficient clinical time available during wave two of the pandemic, with 17.9% reported in Q2 and 11.3% in Q3, below the Trust's ambition to review 30% of all deaths;
- 87% of cases reviewed reported good or excellent care and where potential harm was identified thematic review reported infection issues as the commonest concern raised;
- The Trust continued to improve its processes in relation to identifying learning for sharing and embedding across the organisation, which would be supported by the enhancements being taken forward with the existing digital platforms to provide more robust information.

SAc enquired whether there was sufficient clinical staff resources within the ME service ensuring SJR work was sustainable. RM reported the service was managed by a Lead ME, additional clinicians had been recruited and recruitment would continue to ensure sufficient support was in place to be able to undertaken the reviews against the expected number of deaths. As well as additional provision of staff training on the SJR process. She highlighted in time the service would include community deaths that would result in the need for additional resources, noting interest from GPs to support this service.

SA questioned the processes and mitigations in place to address themes identified. RM confirmed robust Morbidity & Mortality (M&M) meetings established across Care Group specialities to review and have detailed discussions regarding thematic data. This would also be supported by the LfD panel to ensure wider sharing and continuous learning throughout the organisation.

SD reported as part of the review regarding the remit and function of the QC to focus on key areas of responsibility, emphasising this needed to include oversight of the We Care programme. It was vital that regular progress updates were presented to identify and discuss areas that were performing well as well as those that were not, with a particular focus on M&M.

JO thanked RM for her hard work in relation to the improvements achieved regarding LfD, the strengthened review, learning and M&M meeting processes in place.

The Board of Directors discussed and **NOTED** the CMO report and how the Trust was meeting the requirement of the National Quality Board Learning from Deaths.

20/176 **MATERNITY IMPROVEMENT COMMITTEE (MIC) – CHAIR REPORT**

FW highlighted the key elements from the MIC report:

- Focussed discussions regarding the MIC's purpose and resetting the Terms of Reference (ToR) presented for approval. Key area of focus, review and monitor progress against the overarching integrated improvement action plan and 90 day stabilisation plan;
- Overarching action plan, total of 291 recommendations of which 72 were assured, 137 completed but awaiting evidence review sign off, 81 were in progress and there was one red rated due to difficulties delivering training optimally due to Covid pressures;
- Stabilisation plan, 36 actions of which 28 had been completed. The remaining actions were in the Clinical Negligence Scheme for Trusts (CNST) and required longer time frame to be evidenced (in line with revised dates set by NHS Resolution (NHSR)). These CNST actions would continue to be monitored and were currently on track;
- MIC reporting direct to the Board and not Quality Committee (QC) to avoid duplication;
- Development of a cross site strategy;
- ToR for noting of the Maternity Evidence Review Committee (MERM).

NM questioned a disparity in the MERM ToR, point 6.1 mentioned reporting to the Board and 6.2 mentioned reporting to the QC. FW confirmed there was an exception regarding reporting of the CNST elements that were required to be reported to the Board.

The Acting Chair reported good progress was being made against the improvement plan, noting a further MIC meeting would be held the following week.

The Board of Directors discussed and:

- **APPROVED** the MIC Chair Report
- **APPROVED** the MIC ToR, reporting direct to Board by MIC;
- **NOTED** the MERM ToR and progress on implementing the integrated action plan.

20/177 **URGENT AND EMERGENCY CARE (UEC) IMPROVEMENT PROGRAMME**

RC reported this programme was already resulting in a positive impact. JSc explained the Trust was not alone in its challenge to achieve the Accident & Emergency (A&E) 4 hour access standard. Noting the key elements of the programme:

- Improvement plan developed and incorporated into the We Care

programme around 'safer, calmer, care';
- Improving the process and reducing delays of patients following a decision to admit and being transferred from ED to a ward bed;
- Reduce attendances to EDs and increasing activity to the Urgent Treatment Centres (UTCs);
- Newly developed Emergency Village operating assessment units and Same Day Emergency Care facility, aimed at seeing 60% of emergency activity and reducing admissions into the main bed base by over 40%;
- Reducing Length of Stay (LoS), increasing inter-department actions, improving patient pathways and eliminating outliers;
- Improving the discharge process, increasing weekend discharges and the use of the Discharge Lounge, and implementation of the Hospital Discharge Service, Policy and Operating Model;
- Frailty unit implemented at WHH ensuring patients were seen quickly and promptly discharged if medically fit that was already having a positive impact on ED capacity;
- Importance of early decision making and increased provision of support for clinicians during the weekend, assisting discharging patients at weekends;
- The need to review the Trust's bed base and alignment with the various clinical specialties;
- Working with staff to embed the Criteria to Reside concept and working with local system partners to ensure those no longer meeting the criteria had appropriate support is in place to enable patients to be discharged.

The Board of Directors **NOTED** the UEC Improvement Programme Report.

20/178 **STAFF EXPERIENCE STORY**

SJ welcomed and introduced CA and HH who had been invited to present their experiences during the Covid pandemic in respect of their strong joint working as a team with clinicians, nurses and support staff in the management of patients and the difficulties presented communicating with families.

CA explained her experience and that of the ward staff in manging the patients during the unprecedented pandemic:

- Staff were scared for their own health and safety as well as their family in managing what was at the beginning this unknown disease;
- Feeling of being in a battle situation that was against Covid;
- Challenges around constant changes regarding Personal Protective Equipment (PPE);
- Changes implemented on the ward with regards to restricting staff access to certain areas;
- Difficulties presented as a result of visitor restrictions and alternative methods of communications utilised for families to remain in contact with relatives. This included the use of iPads as well as staff personal mobiles to ensure patients saw and kept in touch with relatives, providing regular updates regarding their treatment. As well as personal aspects having sight of their environment, family photos around their beds and wearing their own clothes;
- Managing staff resources due to staff Covid sickness absence;

- Second wave was very different from the first wave and significantly more challenging;
- Impact on staff managing, dealing and coping with patient deaths, and communicating the sad news to relatives, low points. Highlighting the high points as a sign of respect where ward staff lined the corridor to say goodbye and clap when patients were discharged. This was important to the morale of ward staff and also in supporting patients as their relatives were not able to accompany them when they left the ward;
- Complaints and compliments had been received during the pandemic. In response to a specific complaint from someone who was grieving, she had had a discussion with the complainant to listen to them and explain and reassure them regarding the treatment provided to their relative;
- She sought support during this difficult time from having counselling that had helped her being able to talk to someone and she also practised mindfulness;
- The Trust continued to promote the services and support accessible to staff;
- Recognition of what staff in the NHS had gone through and experienced as a result of the pandemic.

The Acting Chair expressed her heartfelt thanks to CA for all she had done and continued to do in treating patients as well as her colleagues and for attending to present her experience to the Board.

HH presented her experience during the pandemic:

- She stayed in a hotel from November 2020 to mid-February 2021 to keep her mother safe;
- There were positive and good things during this period in respect of all staff working together as a whole team, clinicians, nurses, physiotherapists and support staff;
- Working on the wards, staff felt like they were soldiers fighting in a war that was against Covid;
- She found a positive release in writing a poem in her blog on 20 December following the Government lock-down restrictions put in place prior to Christmas. She read her poem around how staff felt very tired, updating and agreeing with consultants patient plans, regularly providing updates to patient relatives, keeping patients comfortable, staff remaining on the wards beyond the end of their shifts supporting and comforting patients and their relatives. The profound impact of Covid on patients their families and staff in managing the pandemic. The importance of everyone following the Government rules around face, hands, space to stop the spread of Covid;
- The importance of everyone considering, discussing and planning for End of Life (EoL).

CH resonated with the experiences presented from the staff, which he too had experienced being an ITU Consultant, commenting it had been an extremely difficult time for clinicians, nurses and all NHS staff. He highlighted as a result of the pandemic the change in attitude with regards to staff resilience, their health and well-being and the importance of looking after and supporting staff.

It was noted consent would be obtained to share the full content of the poem with

Board members.

SD raised concern and sadness regarding the increase in abuse from members of the public towards NHS staff whilst doing their jobs. SAc commented an increase in poor behaviour towards staff was being seen, particularly verbal aggression, and there was a need for the Trust to address this supporting its staff. She stated this would be around having in place a zero tolerance policy and closer involvement with the Police and mental health trust.

The Acting Chair on behalf of Board members, the Trust and the population of East Kent thanked CA and HH for attending and sharing their very personal and moving experiences with the Board, and their continued commitment and hard work in treating and looking after patients.

The Board of Directors discussed and **NOTED** the Staff Experience Story.

20/179 **QUALITY COMMITTEE (QC) – CHAIR REPORT**

SD provided a verbal report noting the key points from the meeting:

- A&E performance needed to remain a key area of focus to ensure performance was improved, and welcomed the UEC improvement programme to support this;
- IPC improvement report discussed noting the important and really good work following Matrons' IPC workshops and developmental sessions focussed on waste disposal at WHH, commode standards at QEQMH and Linen standards at Kent & Canterbury Hospital (K&CH);
- QC workshop was well attended with focussed discussion regarding the QC's remit and membership. Next steps and proposed changes would be taken forward ensuring a clear focus on the provision of quality and safety services and in turn providing the required assurance to the Board of these being in place.

The Board of Directors discussed and **NOTED** the verbal QC Chair report.

20/180 **INFECTION PREVENTION AND CONTROL (IPC) BOARD ASSURANCE FRAMEWORK (BAF)**

The Chair expressed thanks to SM for all her hard work and supporting the Trust's IPC improvements, the advice, guidance and support she had provided to the Trust, its staff and particularly the IPC staff. SM extended appreciation to SAc, the Executive Directors, IPC staff and all Trust staff for their support and continued commitment in making the necessary changes enabling the achievement of the IPC improvements.

SM highlighted the key IPC BAF updates:

- Improvement in the audit data for front door triage and risk assessment showing greater than 95% compliance;
- New questions added to triage tool in response to new risks in respect of Covid new variants, implemented in the EDs;
- Provision of additional training to all domestic staff during February and

March 2021 by the British Institute of Cleaning Science (BICS), including training in inspection and audits for supervisors;
- Implementation of new 'Which Clean' posters introducing a purple clean using UVC light decontamination;
- Completion of the non-Covid stream patients having rapid Covid tests using SAMBA point of care test.

SAc highlighted the format of the IPC BAF developed by SM that clearly identified in colour where there were updates, which was really helpful in providing the assurance and evidence of the work being taken forward. She reiterated thanks to SM for her support and the firm improved position of the Trust that would be supported by the new DIPC.

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

20/181 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR REPORT**

- **STANDING FINANCIAL INSTRUCTIONS (SFIs)**

BW highlighted the key points:

- Partial assurance from risks report presented as timelier progress updates on the actions taken to mitigate the risks was required;
- Internal Audit report provided partial assurance regarding the Maternity Action Plan, noting the recommendations for areas of improvement. This related to the policy and procedure for locum doctors' induction and documentation, ensuring a robust process was in place and being adhered to, ensuring accessible files provided the appropriate records and evidence to demonstrate compliance;
- Approval of the revised SFIs with minor changes made and recommended for Board approval.

JO commented in respect of the Internal Audit report recommendations and the locum doctors' induction and documentation checklist, this had been reviewed by the Maternity Evidence Review Group. She confirmed assurance had been received regarding the completion of these checklists.

DECISION: The Board of Directors discussed and:

- **APPROVED** the IAGC Chair report;
- **APPROVED** the SFIs.

20/182 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR REPORT**

- **MONTH 10 FINANCE REPORTS**

NM provided a verbal report highlighting the key points discussed:

- Financial and operational risks were reviewed, the Committee took partial assurance from the report presented in respect of the actions work, and it was vital that the upcoming risk register review provide the appropriate level of assurance required regarding mitigations in place;

- Raised concern regarding poor performance against the A&E 4-hour access standard and the need for this to be improved;
- Concern had previously been raised regarding the capital programme and ability to spend the full significant funding allocation, received assurance of this expenditure by year-end;
- Progress update report on the implementation of the recommendations regarding the QE facilities Ltd (QEF) Post Implementation Report (PIR) in relation to the establishment of 2gether Support Solutions (2gether) as a wholly owned subsidiary. Noting a detailed action plan to monitor implementation needed to be developed;
- Bi-annual Horizon Scanning summary report highlighting a national issue with regards to the need at Government level of a long term workforce plan. This was around the need to address the aging workforce within the NHS, and insufficient recruitment of staff resources required for the future;
- The Trust's Cost Improvement Programme (CIP) and the proposed savings and efficiency projects for 2020/21 Q3 and Q4.

PC reported the Trust was on target to spend the £69.5m capital plan by year-end, additional costs due to Covid-19 of £5.8m during January 2021 with a total of £51.2m year to date (YTD). The NHS business planning process had been paused nationally as a result of impact due to Covid, guidance was awaited and anticipated this would be published at the end of March 2021.

SA enquired regarding what preparation work was in place to ensure the Programme Management Office (PMO) was in a position to deliver the 2020/21 CIP. PC stated a pipeline CIP totalling £15m schemes had been developed to be taken forward once national guidance was published. The majority of the PMO staff had been redeployed to provide front line support and when guidance was received, would return to support delivery of the CIP.

The Board of Directors **NOTED** the verbal FPC Chair report.

20/183 **STRATEGIC WORKFORCE COMMITTEE (SWC) – CHAIR REPORT**

AA noted the key points:

- Positive position and performance against the overarching HR metrics, with a reduction in staff turnover and consideration regarding the risk of this increasing post-Covid and how this would be addressed;
- Trust continued to attract new staff resulting in significant recruitment activity;
- Following the impact of the pandemic, restarting formal appraisal and objective setting process;
- Report outlining the vital support in place for front line staff with regards to staff health and well-being, including the provision of nine clinical psychologists across the acute hospital sites in place until March 2022, staff Take 5 rooms, and recognition of the longer term impact for staff due to the pandemic and the need for enhanced long term support.

JO extended thanks to AA and her team for their continued support to Trust staff, ensuring access to health and well-being services as well as establishing the

successful vaccination programme implemented at pace.

In response to a question raised regarding plans in place for overseas nurses to take the Objective Structured Clinical Examination (OSCE) assessments; AA confirmed a comprehensive programme was in place for overseas nurses in preparation for this assessment supported by the Chief Nurse.

BW queried the ratio of agency workers to substantive staff that appeared to had deteriorated over the last seven months and enquired as to the reasons for this and the action to address this. AA highlighted the increased headcount, reporting that additional support was required as a result of the pandemic resulting in increased use of bank and agency staff.

DECISION: The Board of Directors **APPROVED** the SWC Chair report.

20/184 **TRUST TWO YEAR IMPROVEMENT PLAN**

SAc highlighted the presented two year improvement plan was around the True North domains with five clear areas of focus and metrics identified in the 90-day plans supported by NHS England/NHS Improvement (NHSE/I). The plan set out a methodology framework for implementation and sustainability driving forward improvements at ward and department level, with a clear communications structure from ward to board. It was important as progress was made to reflect on actions and areas where things had not gone well, if off target and make changes as necessary to ensure delivery. As well as acknowledging and promoting areas of success. The Board would be kept up to date with monthly progress updates.

SAc stated with the provision of the centralised Elective Orthopaedic Centre (EOC) at K&CH that year, this would enable the areas vacated across the other hospital sites to be utilised to support elective activity.

DECISION: The Board of Directors **APPROVED** the Trust Two Year Improvement Plan, to continue with implementation of these improvements and to use this document and its contents in wider internal and external communications.

20/185 **ANY OTHER BUSINESS**

There were no other items of business raised for discussion.

20/186 **QUESTIONS FROM THE PUBLIC**

Mrs Warburton submitted a question in advance of the meeting regarding the number of safeguarding serious incidents (SIs) reported in January and in the One Year Improvement report it recorded 95% of staff had completed safeguarding training. She highlighted safeguarding had been identified the previous year as requiring improvement and raised concern that this was still identified as an issue, the number of SIs even though 95% of staff had been trained. SJ set out the improvement actions put in place that included strengthening the training provided with an increase in staff uptake. A review of the Trust's training, policies and procedures was also being undertaken with external expert support to ensure the right actions were being taken to achieve the right outcomes and that this resulted in a positive impact. Tools used by other trusts were also being reviewed for

consideration for implementation within the Trust with respect to staff handbooks reminding staff to always think about safeguarding and recognition of safeguarding issues to ensure appropriate and prompt actions were implemented when necessary.

Mrs Pryer enquired regarding staff ratio resources in critical care. SJ reported the standard 1:1 patient care in ITU, due to Covid guidance had been issued extending this to 1:2 and 1:3 with ITU staff being supported by a buddy from outside of ITU. The Trust had enacted 1:2 only and with the reduction of ITU patients, the nurse ITU buddies would be returning to their normal ward base areas. CH confirmed this process had been implemented within critical care services across the Country.

Mrs Pryer commented it had been good to see the Trust advertised its Chief Nurse role in the Royal College of Nursing (RCN) bulletin and hoped this had proved positive in attracting interested candidates.

Mrs Pryer questioned the Clinical Negligence Scheme for Trusts (CNST) rebate shortfall in respect of its impact on maternity services. PC commented CNST was the provision of insurance coverage for clinical negligence and for the current financial year equated to around £21m, majority of costs were associated with maternity services. He noted the incentive in receiving rebates over the past few years, which the Trust had been required to return. He emphasised this had not had an impact on maternity services expenditure budgets and these had not been reduced.

Mrs Pryer enquired whether the Trust was considering putting in place contingency plans as the RCN had put aside strike funding in preparation if RCN members were asked to vote on strike action. SAc commented it was too early in the national recommendations process in relation to pay uplifts as this was still being negotiated as evidence was gathered and offers for consideration presented. She confirmed the Trust worked closely with Unions in respect of industrial disputes and hoped this would not reach the need for industrial action to be taken.

PC reported the question received from Mr Rylands regarding if the Trust would act within the legislation regarding Freedom of Information (FoI) requests. He stated the Trust's commitment to being open and transparent and that it acted within the legislation, this related to an FoI enquiry received from Mr Rylands that was being dealt with.

PC reported the question received from Mr Rylands regarding whether the Trust intended to publish its hospital acquired infections data. He commented the Board would be discussing a proposed new IPR format at its Closed meeting that afternoon.

Mr Britton raised the moving staff experience story and how praise and appreciation for what front line staff had done during the pandemic was being communicated to staff. SAc commented the Trust continued to acknowledge staff contributions, hard work and commitment during the pandemic as part of the regular internal staff communications as well as daily and weekly discussions with staff throughout the organisation. Noting this was important to staff recognising the impact of the pandemic and what staff had been through. She emphasised the health, wellbeing and mental health support in place accessible by staff. The Trust had recently

been visited by a regional lead to its critical care services who had the opportunity to talk to front line staff.

Mrs Heggie raised a question related to IPC regarding the British Institute of Cleaning Science (BICS) modules training, highlighting there were at least a total of seven cleaning modules and that staff had only received training for three. She enquired when the Trust would be providing training to staff on all these modules. LS agreed to check and confirm the position regarding the provision of staff training for all BICS modules.

ACTION: Check and confirm the position regarding the provision of British Institute of Cleaning Science training for staff and whether all seven training modules would be provided in addition to the three modules already provided. — LS

Mrs Heggie raised the 'Which Clean' posters that had been implemented in utility cupboards highlighting the importance of communication with domestic staff from the ward staff giving appropriate direction of the areas that required cleaning and which of the different cleans were required for each specific area.

ACTION: Clarify the appropriate communication processes were in place regarding the Which Clean posters confirming to domestic staff the areas to be cleaned and which of the different cleans were required for each specific area. — LS

Mrs Heggie raised an issue regarding the linen storage area at the K&CH the previous day, highlighting numerous cages of linen obstructing access routes. Noting the Health & Safety lead had been informed. There was also an issue with the cages of linen when on the wards that held clean linen and the cages being left open and clean linen accessible. It was important to ensure the fresh linen cages were unloaded and linen stored appropriately on the wards as soon as possible.

ACTION: Ensure Health and Safety procedures were being adhered to within the linen storage area at the Kent & Canterbury Hospital (K&CH) in respect of cages of linen not obstructing access routes. Emphasise the importance that fresh linen cages were unloaded and the linen appropriately stored on the wards as soon as possible following delivery. — LS

The Chair closed the meeting at 12.35 pm.

Date of next meeting in public: Thursday 29 April 2021 as a WebEx Teleconference.

Signature _____

Date _____

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**29 APRIL 2021**
REPORT TITLE:	**MATTERS ARISING FROM THE MINUTES ON 11 MARCH 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 actions 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/019/20	Check and confirm the position regarding the provision of British Institute of Cleaning Science (BICSc) training for staff and whether all seven training modules would be provided in addition to the three modules already provided.	Apr-21	LS	to Close	All our frontline domestic staff must achieve BICSc Licence to Practice (LTP) before any skills training can be provided. This has been achieved. BICSc has a suite of over 40+ skill sets to train staff in and 2gether Support Solutions (2gether) has chosen 5 Base Unit (BU) key skills to train staff in through 2021. All Team Leaders and managers have also been trained as BICSc accredited trainers and Manager and auditors have achieved Assessor status to ensure we maintain standards. **Action for agreement for closure at 29.04.21 Board meeting.**

B/020/20	Clarify the appropriate communication processes were in place regarding the 'Which Clean' posters confirming to domestic staff the areas to be cleaned and which of the different cleans were required for each specific area.	Apr-21	LS	to Close	The new 'Which Clean' poster was focussed on being of benefit to the clinical staff to enable them to have clarity on which clean is required for an area, dependent on the type of infection. The clinical staff will then call the Helpdesk requesting the colour type i.e. 'purple' and location and the Rapid Response cleaning team are trained to respond accordingly. This is also documented in the poster for clarity. Each clean is then signed off by a Trust member of staff on completion. **Action for agreement for closure at 29.04.21 Board meeting.**
B/021/20	Ensure Health and Safety procedures were being adhered to within the linen storage area at the Kent & Canterbury Hospital (K&CH) in respect of cages of linen not obstructing access routes. Emphasise the importance that fresh linen cages were unloaded and the linen appropriately stored on the wards as soon as possible following delivery.	Apr-21	LS	to Close	There is an issue with storage on site and this is partly due to excess stock from Covid requiring storage. This stock is not just linen but provisions from other service areas i.e. procurement. 2gether is in the process of reconfiguring the Linen room to release space which will take some of the pressure away. This is a large task and they are aiming to complete this by the end of May 2021. A risk assessment has been carried out and 2gether is reviewing the recommendations. All fresh linen that is brought on site is covered at all times in adherence to Infection Prevention and Control (IPC) guidelines. 2gether has increased the linen runs to the ward to reduce stock in linen room and corridors and are also putting additional checks in place outside of core hours to ensure the corridor is clear and linen

					store is secure. **Action for agreement for closure at 29.04.21 Board meeting.**

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 and **APPROVE** the actions 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 improve and reduce the number of Emergency Department patient unplanned re-attendances.	May-21	RC	Open	Update on progress will be provided in the Integrated Performance Report (IPR). Chief Operating Officer will have a discussion with the Board Advisor on Emergency Flow regarding presentation of a further progress update report.
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	AF	Open	Draft Board Assurance Framework risk register presented to April 2021 Board meeting, updates and changes identified in the risk register in colour will be implemented for the report to be presented at the May 2021 Board meeting.
B/019/20	11.03.21	20/186	Questions from the public	Check and confirm the position regarding the provision of British Institute of Cleaning Science (BICSc) training for staff and whether all seven training modules would be provided in addition to the three modules already provided.	Apr-21	LS	to Close	All our frontline domestic staff must achieve BICSc Licence to Practice (LTP) before any skills training can be provided. This has been achieved. BICSc has a suite of over 40+ skill sets to train staff in and 2gether Support Solutions (2gether) has chosen 5 Base Unit (BU) key skills to train staff in through 2021. All Team Leaders and managers have also been trained as BICSc accredited trainers and Manager and auditors have achieved Assessor status to ensure we maintain standards. **Action for agreement for closure at 29.04.21 Board meeting.**

B/020/20	11.03.21	20/186	Questions from the public	Clarify the appropriate communication processes were in place regarding the 'Which Clean' posters confirming to domestic staff the areas to be cleaned and which of the different cleans were required for each specific area.	Apr-21	LS	to Close	The new 'Which Clean' poster was focussed on being of benefit to the clinical staff to enable them to have clarity on which clean is required for an area, dependent on the type of infection. The clinical staff will then call the Helpdesk requesting the colour type i.e. 'purple' and location and the Rapid Response cleaning team are trained to respond accordingly. This is also documented in the poster for clarity. Each clean is then signed off by a Trust member of staff on completion. **Action for agreement for closure at 29.04.21 Board meeting.**
B/021/20	11.03.21	20/186	Questions from the public	Ensure Health and Safety procedures were being adhered to within the linen storage area at the Kent & Canterbury Hospital (K&CH) in respect of cages of linen not obstructing access routes. Emphasise the importance that fresh linen cages were unloaded and the linen appropriately stored on the wards as soon as possible following delivery.	Apr-21	LS	to Close	There is an issue with storage on site and this is partly due to excess stock from Covid requiring storage. This stock is not just linen but provisions from other service areas i.e. procurement. 2gether is in the process of reconfiguring the Linen room to release space which will take some of the pressure away. This is a large task and they are aiming to complete this by the end of May 2021. A risk assessment has been carried out and 2gether is reviewing the recommendations. All fresh linen that is brought on site is covered at all times in adherence to Infection Prevention and Control (IPC) guidelines. 2gether has increased the linen runs to the ward to reduce stock in linen room and corridors and are also putting additional checks in place outside of core hours to ensure the corridor is clear and linen store is secure. **Action for agreement for closure at 29.04.21 Board meeting.**

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**29 APRIL 2021**
REPORT TITLE:	**CHAIRMAN'S REPORT**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

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**

I was delighted to join the Trust as the new Chairman on 5 April and look forward to working with our staff, governors and members of the Board.

I am grateful to Jane Ollis, my deputy who was Acting Chairman in the brief interregnum before I started in April.

Today we welcome three new Non-Executive Directors (NEDs) who also took up their posts this month, following their three-year appointment by the Council of Governors. Luisa Fulci, Olu Olasode, and Martin Jolly bring a wealth of experience and I am sure will be real assets to the Board and the Trust.

My thanks and that of us all go to Barry Wilding, who will end his term of office as a NED on 10 May after six years of service. Barry's commitment, hard work and wisdom have been of huge value to the organisation during difficult times and we are enormously grateful for his significant contribution.

2. **Visits to hospitals, staff, teams, wards and departments**

I have begun what I plan to be weekly visits to front-line and corporate services across the organisation. As Covid restrictions lift, I know that NEDs and governors are keen to re-engage with staff and patients, and see first-hand how our services are being delivered. I have already had the opportunity to visit a number of front-line services including among others, the renal unit, theatres and Wards at Kent & Canterbury Hospital (K&CH), the Emergency Department (ED) and Wards at William Harvey Hospital (WHH) and the special care baby unit, Wards and the ED at the Queen Elizabeth the Queen Mother Hospital (QEQMH) at Margate. In each case the enthusiasm and commitment of our teams has shone through and crucially, a determination to do everything they can continuously to drive improvements in the services we provide.

3. **Initial Reflections**

Last week our Chief Executive issued an unreserved apology to the Richford family for failings in our care which led to a prosecution by the Care Quality Commission (CQC). It was the right and proper thing to do but Susan's statement was also a renewed commitment by us all to learn from mistakes and for us to become a learning organisation and that this should be at the centre of all we do wherever we work. We have also recently seen the publication of the terms of reference of the independent investigation into our maternity services, the outcome of which will undoubtedly be hard to read because we know that there are families we have failed by not providing the right standard of care. Again, we must approach this without defensiveness and use it to understand as fully as possible the experience of mothers, babies and their families. This must be about building on the very significant steps that have already been undertaken to improve services and the ongoing efforts to place continuous learning and improvement in this area of our work. We have great staff who are hugely committed and have already made great strides, but we also know we have more to do and we must use the investigation to help us take this forward.

The same lesson on our need to learn comes from the staff survey results which are not good. My sense is that there have been positive changes since the survey was undertaken during some of the most challenging periods last year, but we clearly have a lot to do both to understand different concerns, to address and importantly embed them so they are sustained. As a Board we will be committed to supporting whatever is needed to turn this around and make sure we have a fully engaged workforce at every level and across every team.

The good news is that we have begun our journey and we can see signs of that. Following an NHS Improvement (NHSI) assessment (which is used by CQC) we have been rated as good in how we use our resources. We will continue to have significant financial challenges and big opportunities to reform service delivery, but this is a great endorsement in our ability to manage our finances and so really encouraging.

Likewise, the latest CQC reports on infection control and on our two EDs tell a story of an organisation that is on the move and making progress. Our goal must be to move all our CQC ratings to good and then outstanding.

As I begin my tenure though, I just want to record my appreciation to all our staff for their dedication and hard work looking after and caring for patients in the past year, sometimes in the most difficult of circumstances personally and professionally. Our thanks also go to all those who supported that effort in so many ways. I am proud to join the Trust and to see what has been achieved and excited about what together we can achieve going forward.

4. **League of Friends (LoF)**

We are also so grateful to the LoF for their great support. The QEQMH LoF have recently funded an ultrasound machine in Rainbow Ward, chairs for the discharge lounge, reclining chairs for birthing partners and expectant mums and 25 portering wheelchairs.

5. **Council of Governors (CoG)**

As part of my induction I have been meeting with each of the governors and the Council of Governors will be developing its plan to support the Trust on its improvement journey. I know there is a commitment on all sides to build an open and supportive relationship between the Board and Council; working together we are determined to do everything we can to take the Trust to a position of excellence.

I will be chairing my first Council meeting on 20 May. It will be an opportunity to agree priorities, including how we can resume governor visits alongside Board colleagues.

At Council we will also welcome newly elected governors Paul Verrill, one of two public governors for Dover, and staff governors James Casha, Consultant Orthopaedic Surgeon, and Sophie Pettifer, deputy Head of Nursing Resourcing.

In April I will be joining governors for a training session and will Chair the interview panel for NED vacancies.

Non-Executive Directors' (NEDs) Commitments

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

Chair	13 April – East Kent (EK) Integrated Care System (ICS)/Sustainability and Transformation Partnership (STP) Board meeting 22 April - Chairing East Kent Integrated Care Partnership (ICP) Board meeting Introductory meetings with new NEDs Introductory meetings with Executive Directors Introductory meetings with Governors Introductory meetings with local partners, regulators and others Visits to WHH, QEQMH and K&CH
Acting Chair	9 March – CoG Council meeting 9 March and 18 March – East Kent (EK) Integrated Care Provider (ICP)/Strategic Transformation Partnership (STP) Board meetings 10 March – 2gether Support Solutions (2gether) Board Away Day and Board meeting 11 March and 25 March – South East (SE) Leaders Broadcast with NHS England/NHS Improvement's (NHSE/I's) Regional Director (SE) NEDs briefings with Chief Executive 12 March - Kent & Medway (K&M) Chair's fortnightly meeting Introductory meetings with new NEDs 16 March – Nominations and Remuneration Committee meeting 22 March – Joined Chief Executive on Gemba visit to Clarke Ward at Kent & Canterbury Hospital (K&CH) 22 March – NHS Reset Chairs meeting 1 April – 2gether Board meeting 15 April – 2gether Board Away Day and Audit Committee meetings
Non-Executive Directors	16 March – Nominations and Remuneration Committee meeting 16 March and 13 April – Maternity Improvement Committee meetings 30 March – Charitable Funds Committee meeting 20 April – Integrated Audit and Governance Committee 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.**
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

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**29 APRIL 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. Welcome and Congratulations

I would like to take this opportunity to formally welcome Niall Dickson as our new Chairman and extend my appreciation to Jane Ollis for covering the role in the period following Professor Stephen Smith's departure.

On behalf of my executive colleagues, I would like to say goodbye to Barry Wilding and thank Barry for his considerable contribution to the Board. Welcome to our three new Non-Executive Directors, Olu Olasode, Luisa Fulci and Martin Jolly. The substantial changes in our Board will provide us with new and different skills and oversight in are ongoing development as a Trust. We are grateful for their commitment to the We Care programme of improvement as it is key for the Board to lead and support this way of working.

On a separate note but continuing with the positive news for our staff, I would like to offer my congratulations to Chris Hamson, Deputy Head of Nursing for General and Specialist Medicine, for being awarded the Chief Nursing Officer award.

2. Operational Update

There has been improved performance in Emergency Care helped by the Safe Calmer Care initiative at William Harvey Hospital (WHH) which started at Queen Elizabeth the Queen Mother Hospital (QEQMH) on the 19 April.

The decreasing COVID prevalence has also supported the improved flow from Emergency Department (ED) and allowed increasing levels of elective activity.

The extended Easter plan worked very well, with good collaboration with system partners. Our thanks to Rebecca Carlton, Chief Operating Officer, for developing a robust plan together with the care groups and the hospital leadership teams.

I am pleased to report the introduction of a Hospital Out of Hours project and team which will provide a multidisciplinary framework for managing unstable and poorly patients outside of the normal hours, improving handover and communication between teams in the day and night. This is another We Care inspired development led by the Medical Director team

whose aim is to improve patients care and communication arrangements for clinical teams at night.

For information, James Devine is leaving as Chief Executive Officer (CEO) at Medway NHS Foundation Trust and being replaced by Dr George Findlay, who will be joining from Western Sussex.

3. Care Quality Commission (CQC) Update

Last week's report by the CQC recognised the hard work and significant improvements our staff have made to infection prevention and control at the Trust.

Their report followed a focussed inspection at QEQMH and WHH in early March to look at infection prevention and control practices, following enforcement action by the regulator in August.

The inspection team identified several areas of outstanding practice, including how staff were protecting clinically extremely vulnerable patients from infection, and changes to resuscitation areas in the EDs to help keep staff and patients safe.

It found staff were focused on the infection prevention and control needs of patients receiving care. Keeping our patients and staff safe is always our top priority and I am glad the CQC has recognised our efforts to make improvements.

I would like to thank our hard-working staff for their incredible care and commitment over the past 12 months and for their determination to do their absolute best for the people we look after and for each other. We will continue to strive for the highest possible standards.

4. Clinical Executive Management Group (CEMG)

Business Cases APPROVED or recommended at the 10 March meeting of the CEMG included:

- Independent Investigation into East Kent Maternity Services Resourcing.

Business Cases APPROVED or recommended at the 14 April meeting of the CEMG included:

- The Centralised Temporary Workforce Booking Team.

5. Vaccine Update

The Medicines and Healthcare products Regulatory Agency (MHRA) has issued new advice, concluding a possible link between COVID-19 Vaccine AstraZeneca and extremely rare blood clots. The benefits of vaccination continue to outweigh any risks, but the MHRA advises careful consideration be given to people who are at higher risk of specific types of blood clots because of their medical condition. As a result, if colleagues had their first dose of the Oxford-AstraZeneca vaccine they have been advised to still attend for their second dose of Oxford-AstraZeneca (irrespective of age).

I would like to extend my personal thanks to those who ensured that the vaccination hub remained open and functioning over the Easter weekend; congratulations to the whole team for staffing the only hub operating in Kent over this period.

I would also like to highlight the incredible hard work and dedication of the renal vaccinators. Knowing how vulnerable people with kidney failure are to Covid-19, especially those on dialysis or who have had kidney transplants, the renal department decided to establish a

dedicated team of vaccinators to work alongside the existing vaccination hubs and GP surgeries. Led by head of department Dr Hannah Kilbride, acting dialysis Matron Helen Swanborough and transplant Sister Lucy Greenfield, the team of nurses, doctors and support staff had, by the end of March, given 499 vaccinations with the Pfizer vaccine at the Kent County Cricket Ground. A mobile vaccination squad has also worked around Kent and Medway giving the AstraZeneca jab to a further 190 people. As well as ensuring almost complete coverage of our Clinically Extremely Vulnerable (CEV) population, we've also been able to offer shots to carers of CEV people and recipients and donors of planned live related kidney transplants, meaning that our transplant programme can begin again very soon. Although the team still has around 190 more jabs to give - mostly second doses - almost 90% of the most vulnerable kidney patients had been given at least one vaccination by 10 March, the highest rate for any region in England. This is an amazing achievement and I am extremely grateful to everyone involved for making this possible; it is a great example of genuine team working.

The Trust delivered nearly 50,000 doses of vaccine until closing the centre on Sunday 11 April 2021. All subsequent staff vaccinations will be delivered via Occupational Health for our new starters and any remaining second doses as required.

6. Staff Survey

The Organisational Development team are meeting with Care Group triumvirates working with HR Business Partners, to feedback key findings and develop local action plans focussed on health and wellbeing bullying and harassment, discrimination, safety culture under the broader umbrella of We Care. Of particular note is the way in which the survey has highlighted concerns with regard to race discrimination. We are working closely with the Black, Asian and minority ethnic (BAME) network and external colleagues with expertise to implement changes that will reach out and support all our staff, but especially our BAME colleagues. Specific actions are being developed with direct input and support from the chair of the BAME network and the chair of the Local Negotiating Committee (LNC) and the Staff Committee.

7. GEMBA Visits

As part of We Care, myself, the executive and senior team have been undertaking Gemba Visits which allow us to listen and see what our staff, are working on and what their challenges and issues are and most importantly what their solutions and improvements are. Non-Executive Directors and Governors will also be able to join these visits now that the lock-down restrictions are easing.

8. Staff Webinar

Myself and senior clinical and operational colleagues hosted a webinar for all staff on Monday 29 March giving an update on where the Trust is in terms of ‘restarting’ services following the recent wave of Covid-19. It also covered staff wellbeing and progress on our ‘We care’ improvement programme.

9. Health and Well-being Day

I am delighted to report that the note I sent out regarding the extra health and well-being day for staff has been incredibly well received. I have had so many emails of appreciation and thanks. It is the least we can do after all staff have given in the last year. I’ve also enjoyed hearing what people intend to do with their extra day and want to encourage everyone to use it as a special and restorative day.

East Kent Hospitals University NHS Foundation Trust

10. Use of Resources Report

The Trust has had an NHS England and Improvement's (NHSEI's) Use of Resources (UoR) assessment carried out in March 2020, which resulted in the Trust receiving a UoR rating of 'Good'.

During the assessment, the Trust demonstrated good evidence of productivity including examples of innovative practices and stabilisation of its financial position. As a result, the Trust has been assessed as 'Good' for its use of resources. The assessment focuses on the Trust's position at the time of the assessment, in March 2020, and that of the previous 12 months during which period, the Trust generally benchmarked favourably compared to other trusts at national level. There were some recommendations however, which will be taken through the Finance and Performance Committee.

11. Paying Our Respects

I would like to pay our respects to His Royal Highness Prince Philip, the Duke of Edinburgh, further to his sad passing. Our Union flags have been flying at half-mast and a one-minute silence was observed on Saturday 17 April, at 3.00 pm.

12. National Updates

Latest national updates are as follows:

NHS 2021/22 priorities and operational planning guidance https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-nhs-operational-planning-and-contracting-guidance.pdf

Consultation on a new NHS System Oversight Framework 2021/22 https://www.engage.england.nhs.uk/consultation/system-oversight-framework-2021-22/user_uploads/b0381-consultation-on-a-new-nhs-system-oversight-framework-2021-22.pdf

Trusts Operating in a Rural Environment https://nhsproviders.org/trusts-operating-in-a-rural-environment

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
SUBSIDIARY IMPLICATIONS:	None

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

East Kent Hospitals University NHS Foundation Trust

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:	**29 APRIL 2021**
REPORT TITLE:	**INTEGRATED PERFORMANCE REVIEW (IPR)**
BOARD SPONSOR:	**DIRECTOR OF FINANCE AND PERFORMANCE**
PAPER AUTHOR:	**DIRECTOR OF FINANCE AND PERFORMANCE**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: MARCH 21 IPR**

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;
- 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.

East Kent Hospitals University NHS Foundation Trust

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.

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 any of the information contained within the scorecard. e.g. publishing hospital acquired inf that have not been previously published. 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) 27 April 2021
SUBSIDIARY IMPLICATIONS:	The Trust is working with its subsidiaries to involve them in We Care.

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

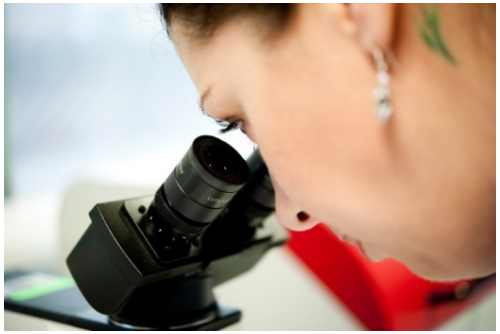
RECOMMENDATIONS AND ACTION REQUIRED:

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

NHS
East Kent
Hospitals University
NHS Foundation Trust

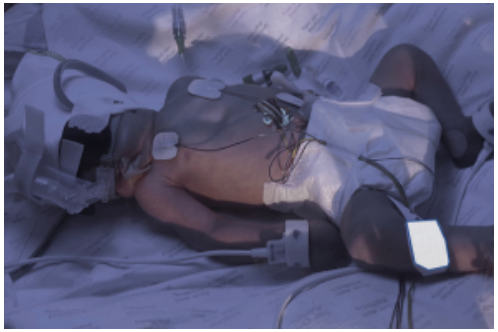
Integrated Performance Report

March 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)?

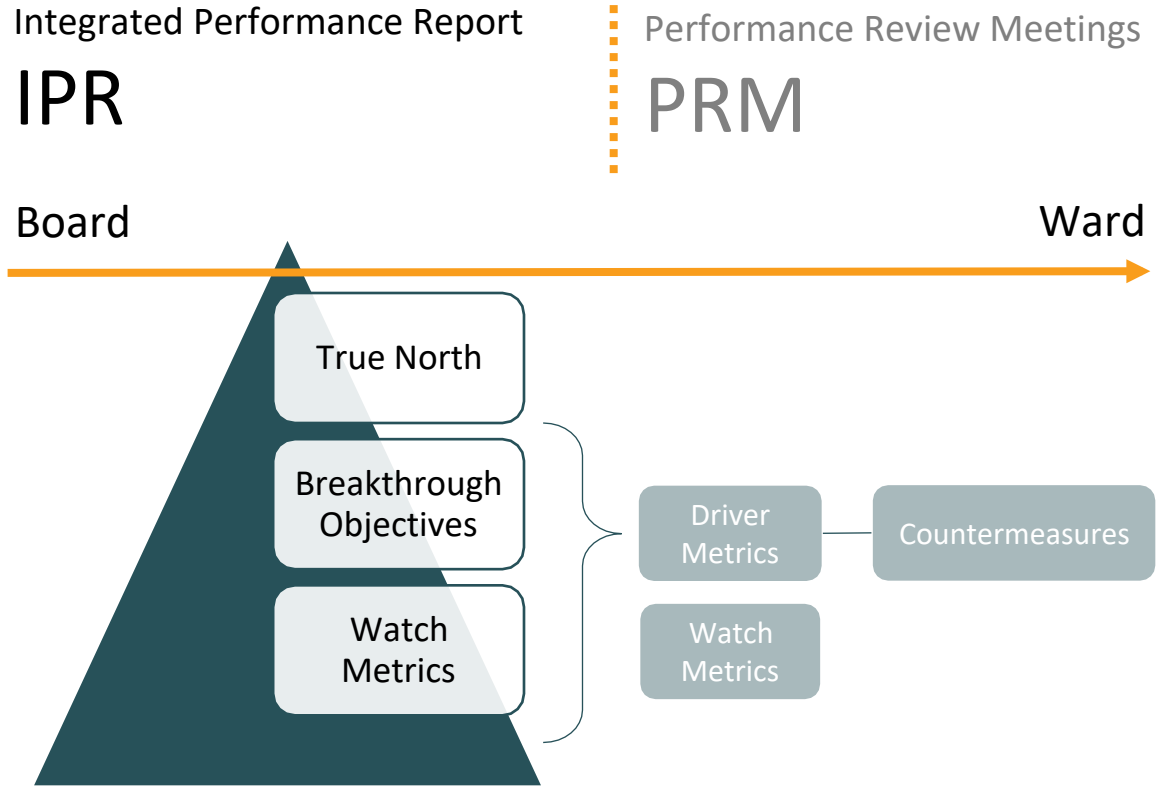
To turn these strategic themes into real improvements, we're focusing on five key objectives that contribute to these themes for the next year.

- 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** (i.e. no significant change.

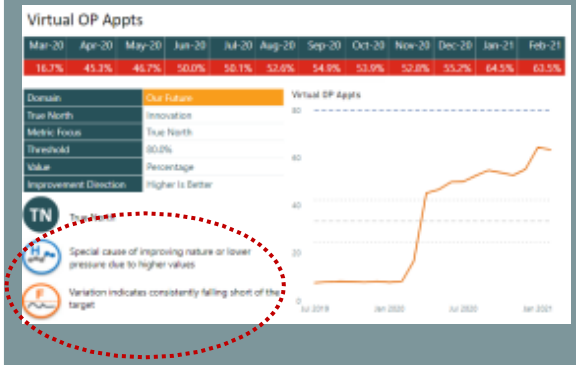
NHS Improvement SPC icons

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

Where to find them

True North

Breakthrough Objectives



What are the Business Rules?

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)

Executive Summary

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;

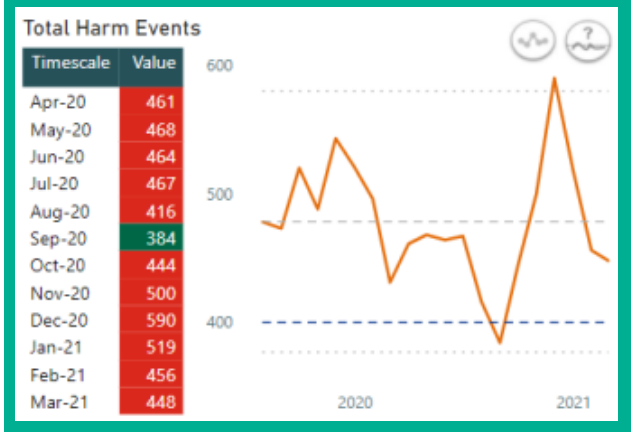
- Falls
- Pressure Ulcers
- C Difficile (in-hospital)
- E.Coli (in-hospital)
- Covid Infections (in-hospital)
- Nutrition Incidents
- Medication Errors

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.



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

Executive Summary

NHS
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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

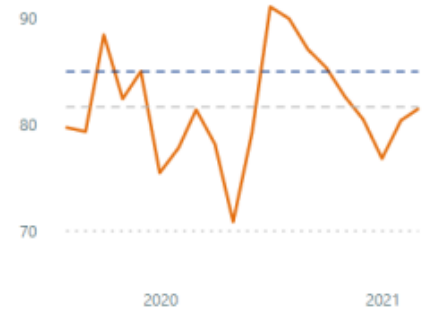
Patient Experience (FFT)
The Family and Friends Test is a national measure which confirms how likely patients are to recommend the Trust as a place for treatment. This data collection incorporates a scale for quantitative analysis and an area for free text comments and is gathered on a monthly basis.

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

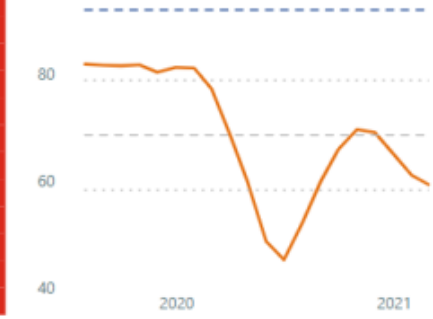
Timescale	Value
Apr-20	78.2%
May-20	70.9%
Jun-20	79.2%
Jul-20	91.1%
Aug-20	90.0%
Sep-20	87.1%
Oct-20	85.4%
Nov-20	82.6%
Dec-20	80.5%
Jan-21	76.8%
Feb-21	80.4%
Mar-21	81.5%



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

RTT Incomplete Performance

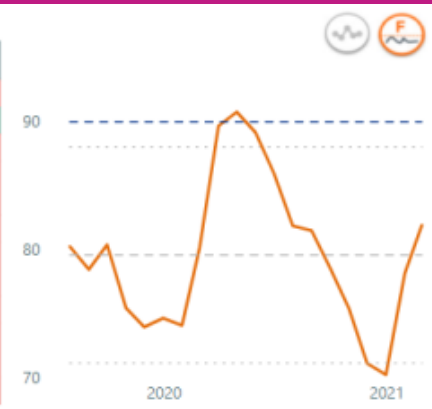
Timescale	Value
Apr-20	68.6%
May-20	59.7%
Jun-20	48.6%
Jul-20	45.1%
Aug-20	52.1%
Sep-20	59.8%
Oct-20	65.9%
Nov-20	69.5%
Dec-20	69.0%
Jan-21	65.0%
Feb-21	61.0%
Mar-21	59.3%



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

ED Compliance

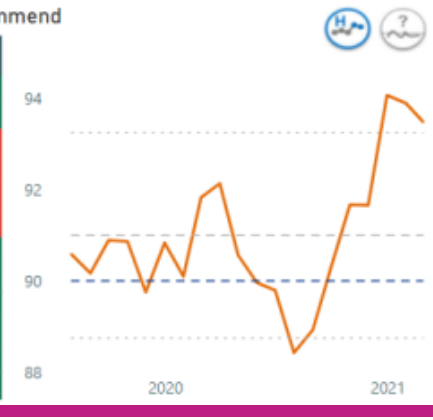
Timescale	Value
Apr-20	89.7%
May-20	90.8%
Jun-20	89.2%
Jul-20	86.0%
Aug-20	81.9%
Sep-20	81.5%
Oct-20	78.6%
Nov-20	75.4%
Dec-20	71.1%
Jan-21	70.2%
Feb-21	78.1%
Mar-21	81.9%



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

FFT Trust Recommend

Timescale	Value
Apr-20	92.1%
May-20	90.6%
Jun-20	90.0%
Jul-20	89.8%
Aug-20	88.4%
Sep-20	88.9%
Oct-20	90.3%
Nov-20	91.7%
Dec-20	91.7%
Jan-21	94.1%
Feb-21	93.9%
Mar-21	93.5%



Executive Summary

NHS
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
Apr-20	10.9%
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%

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

Data not yet available

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 remain with 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.

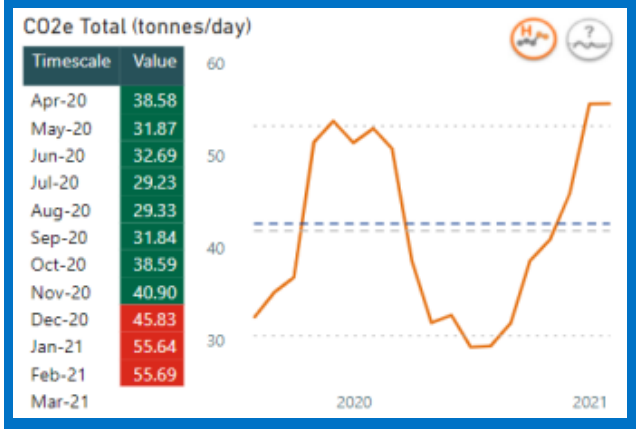
The Trust's carbon emissions are made up of:

- 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.

Carbon Footprint
To achieve an organisational carbon neutral footprint.



Executive Summary

NHS
East Kent
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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'.

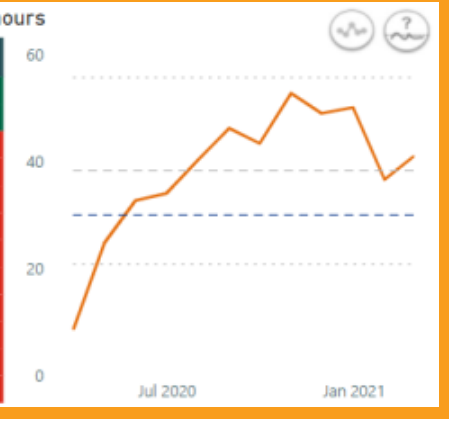
Innovation (Virtual OP Apps)
The current process for achieving innovation at the Trust is cumbersome and timely. A cultural shift needs to take place using IT as a key enabler to drive the process.

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 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

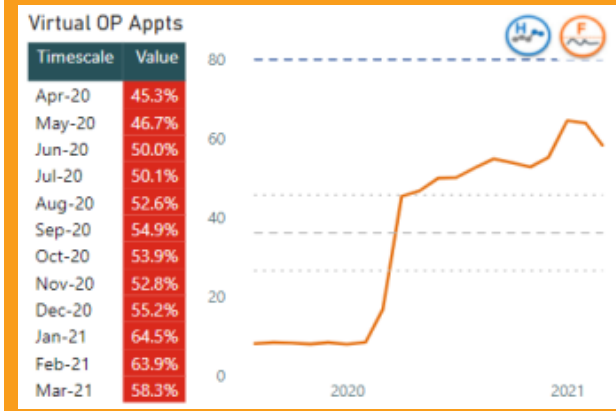
Timescale	Value
Apr-20	8.7
May-20	24.7
Jun-20	32.7
Jul-20	34.0
Aug-20	40.3
Sep-20	46.3
Oct-20	43.4
Nov-20	52.8
Dec-20	49.1
Jan-21	50.1
Feb-21	36.6
Mar-21	40.9



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
Apr-20	45.3%
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	63.9%
Mar-21	58.3%



2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Falls

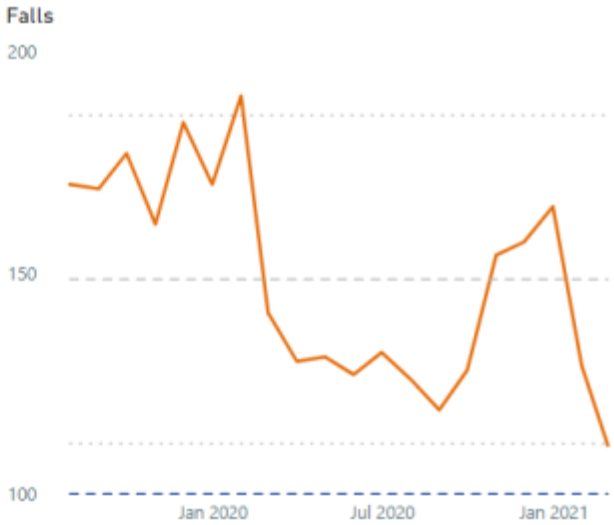
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
130	131	127	132	126	119	128	154	157	165	129	111

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.

Performance

Current Performance is 111 falls recorded in March 2021. This number has been trending negatively for the last three months representing an improving picture.

Our investigations into this breakthrough objective demonstrate that 13 wards across the Trust contribute to 94% of all falls. Reasons attributed to falls are varied however the single highest number recorded are 'unwitnessed – found on floor'. Root cause analysis so far suggests there is a lack of clarity of the outcome of the fall and in some cases the cause.

In order to reduce the number of falls the first wave of frontline 'We Care' teams have carried out root cause analysis on their own ward based data and developed A3's detailing improvement projects bespoke to their findings. The falls steering group have investigated the root cause of unwitnessed falls and suggested potential improvements. The Trust Priority Improvement Project (TPIP) has provided an interim solution for the accurate recording of harm as a result of a Fall, pending the national Datix upgrade in the Autumn.

Risks

Risk of barriers with communication between frontline teams regarding A3 progress. To mitigating against this, we have invited the Ward Managers to join our weekly Driver meetings and share their improvements.

M_00320_Falls | Last Updated | 19/04/2021 07:09:00

2020/21 Breakthrough Objectives

NHS
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Composite HSMR: Sepsis/Resp

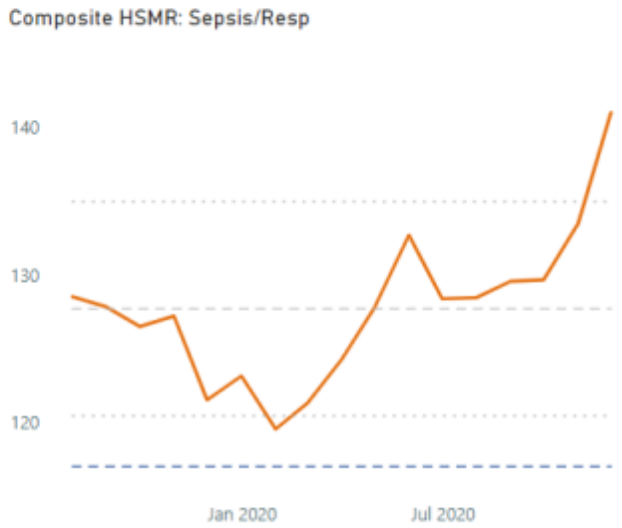
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
124.3	127.8	132.7	128.4	128.4	129.6	129.7	133.5	141.0			

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 | 16/04/2021 09:14:00

Performance

Current performance shows a rolling 12-month composite Hospital Standardised Mortality Ratio (HSMR) for respiratory failure and sepsis of 141.0 for December 2020. This is driven by December 2020 in month HSMR which is significantly higher than expected and likely to be due to the pandemic second peak, similar to the pattern seen in April 2020.

Key areas for focus to achieve the overall goal

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

Achievements over the last 30 days

- Established driver meetings for 7 frontline ward teams on 3 sites
- Launch of Hospital out-of-hours team at acute sites in March 2021
- Appointment of 3 Consultants to Learning from Deaths panel to focus on Structured Judgement Reviews (SJR) and Mortality and Morbidity (M&M) meetings

Ambition for the next 30 days

- Agree Sepsis audit design with the Deteriorating Patient panel
- Gap analysis of M&M meetings against Terms of Reference agreed in May 2021 to optimise learning from SJRs
- Conference with BO frontline teams to share learning

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

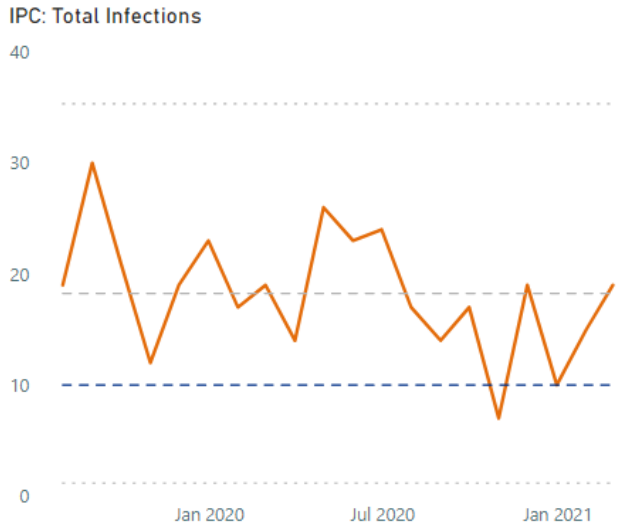
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
14	26	23	24	17	14	17	7	19	10	15	19

Domain	Our Quality & Safety
True North	Harm Events
Metric Focus	Driver
Threshold	10
Value	Number
Improvement Direction	Lower is Better

D2 Driver is red for 2

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*, 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.

Performance

Current Performance for total in-hospital infections is 19 in March, driven largely by an in-month increase in C diff cases (12). This may be associated with the second wave of Covid driving antibiotic use. Performance has shown common cause variation over the last three months.

To improve our performance in this area we have, combined this information with the supporting metric data for Infection Prevention Practice Audits to identify the ten lowest scoring wards across the three sites. These wards are at the early stages of undertaking structured analysis at ward level to identify root causes and undertake PDSA cycles of improvement to sit alongside the improvements delivered through the integrated improvement plan. Some have begun Plan Do Study Act (PDSA) improvement work, some are yet to have their We Care training.

Additional countermeasures are focussed on reducing avoidable ward moves with a structured problem solving tool (A3) being developed with WHH Site team and reducing antimicrobial prescribing outside of guidelines (antimicrobial stewardship team having We Care training in April – A3 to be developed).

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 will require a recalculation of the threshold and performance which may cause some temporary uncertainty.

... | M_01142_IPC_Infections_Combined

Last Updated | 19/04/2021 07:30:00

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

ED - Aggregated Patient Delay

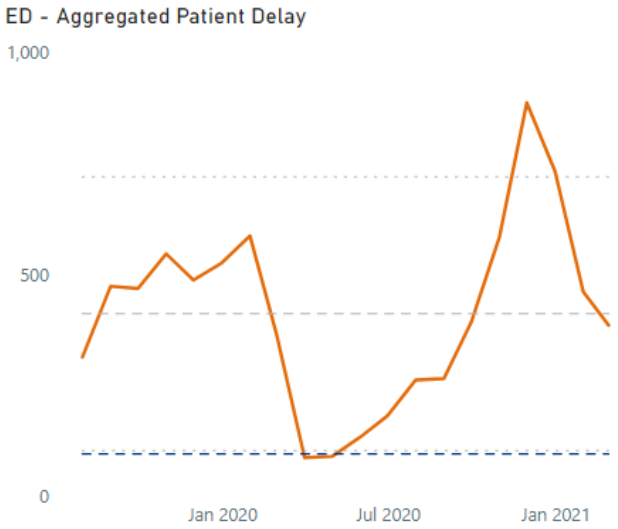
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
87	89	133	181	261	265	392	584	886	732	460	385

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 March is an aggregated delay of 385 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:

- 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
- a review of Urgent Treatment Centre (UTC) to reduce the number of patients in emergency department (ED) Majors
- Implementation of new Same Day Emergency Care (SDEC) pathways to reduce the number of admissions to ward beds and to reduce the number of patients in ED majors
- A review of ED processes to ensure that patient care is delivered in a timely and safe way at all times.
- QEQM Safer, Calmer Care event and opening of the Frailty Unit

Risks

Further work required to remove obstacles to enable expansion of SDEC, this will create more space and reduce the risk of over crowding.

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

Revision of care group metrics to improve engagement with staff on improvement objectives support ED performance.

... | M_00888_Agg_Delay

Last Updated | 16/04/2021 11:24:00

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Theatre Session Opp.

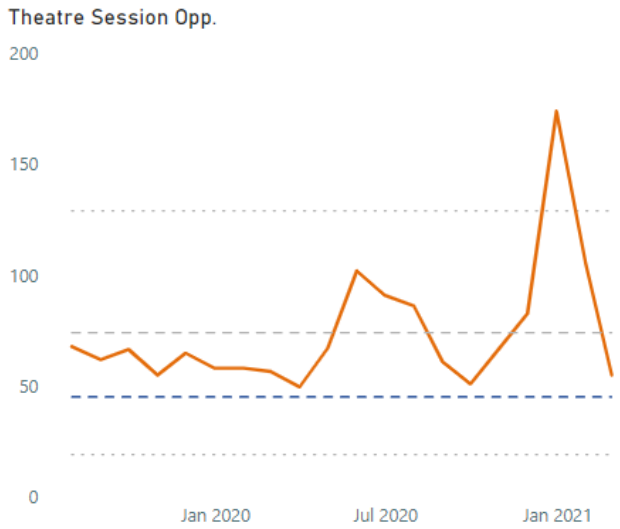
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
50	67	102	91	86	61	51	67	83	174	106	55

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

D2 Driver is red for 2

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.

Performance

Current Performance shows the equivalent of 55 sessions unused i.e. opportunity for March 2021. We have been displaying an improving performance for the last two 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.

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 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 (e.g. late starts, early finished) and creation of a rota system to optimise respire allocation and booking. We will also review our pre operative assessment process to ensure patients are fit, ready and prepared for surgery.

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.

... | M_00146_Theatres_Utilisation

Last Updated | 19/04/2021 09:18:00

Alerting Watch Metrics: Our Quality & Safety

True North Domain	Type	BO	KPI	Thres.	Dec-20	Jan-21	Feb-21	Mar-21
Harm Events	W4		Covid-19 HCAI	1	179	112	95	53
	W4		MSSA Cases	1	6	3	3	3
	W1		Nutrition Incidents	20	15	13	20	31
	W4		Optimal Cord Clamping <32w	85.0%	0.0%	66.7%	72.7%	60.0%
Mortality	W4		Extended Perinatal Mortality	6.35	10.41	12.87	7.05	6.78

Performance

Harm Events

Between December and March we cared for 3,250 Covid-19 positive patients, a significantly higher number of patients compared to the first wave. The high number of patients needing hospital care reflected the extremely high rates of community infection and was contributed to by the second wave surge and Kent variant. Our rate of hospital acquired infection during this period was 13.32%.

The threshold for MSSA is being reviewed as part of the revision to the Total Infections Breakthrough Objective as detailed earlier in the pack.

The main contributing areas where incidents have been raised relating to nutrition during March are delays in nutrition provision and plans, issues relating to parenteral nutrition either due to split bags or incorrect prescriptions, Patients with dysphagia (swallowing difficulties) receiving incorrect texture meals or drinks. All of these incidents are shared at the Nutrition Steering 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 delayed cord clamping as one of their focused improvement projects recognising there has been inconsistent performance in this area. They have undertaken a structured analysis to identify the countermeasures that will have the greatest impact on performance. and are focussing on raising awareness and setting up a multi-professional working group to identify and address blockers to implementation.

Mortality

The extended perinatal mortality is a rolling 3 month average representing stillbirths and neonatal deaths using the MBBRACE criteria. The rolling average is falling and was affected by a higher than usual number of stillbirths in November and a smaller rise in January. We have undertaken a review including oversight of cases through the LMS to ensure we have captured all themes from learning into clinical pathways.

Alerting Watch Metrics: Our Patients

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Dec-20	Jan-21	Feb-21	Mar-21
Cancer 62d			Cancer 31d Performance	96.0%	100%	97.6%	98.4%	94.3%
	W4		Radiology Diags vs Plan	Traj.	14,111	13,276	13,061	15,467
	W4		Endoscopy vs Plan	Traj.	968	983	896	1,119
RTT - 18 Weeks			RTT 52w Breaches	2,586	2,544	3,613	4,632	5,232
	W4		DM01 Compliance	99.0%	77.6%	64.7%	67.7%	73.6%
			RTT 35w Undated	8,500	7,128	7,088	7,523	8,122
	W4		Referrals vs Plan	Traj.	18,311	17,315	18,393	22,089
	W4		OPA vs Plan	Traj.	52,326	49,015	50,545	61,953
	W4		Elective Admissions vs Plan	Traj.	3,770	3,164	3,146	4,223
			RTT 1st OPA Booking Breaches	14,000	11,634	12,331	12,346	12,888
ED Compliance	W4		Clinical Assessment within 1hr	50.0%	39.7%	44.1%	42.5%	41.8%
	W4		DTAs within 4hrs	600	700	777	1,137	1,326
	W4		A&E Atts vs Plan	Traj.	16,148	13,905	14,136	13,680
	W4		Unplanned Re-attendance ED	10.0%	10.5%	10.7%	10.5%	10.6%
	W4		Super Stranded >21D	75	103	100	103	124
	W4		NEL Admissions vs Plan	Traj.	5,143	4,873	5,251	6,517
FFT	W4		FFT IP Response Rate	25.0%	15.8%	16.6%	16.0%	17.2%
			FFT ED Response Rate	12.0%	15.2%	14.6%	13.5%	14.2%
	W4		FFT Maternity Response Rate	18.0%	5.7%	6.3%	5.5%	5.6%
	W4		Mixed Sex Breaches	500	963			

Performance

Cancer 62 Day

31d cancer performance is alerting in March 21 due to a dip in performance below the lower confidence limit. This is down to the continued impact of the second wave of Covid-19 and we expect performance to return to a compliant position in April as we continue our theatre recovery programme.

Radiology and Endoscopy performance against plan is also linked to the second Covid-19 wave (plans set after wave 1) and operational teams are working through a detailed planning process in order to bring activity levels back up to 70% of pre-Covid levels in April 2021.

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. 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, Our Future & Our Sustainability

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Dec-20	Jan-21	Feb-21	Mar-21
Staff Engagement	W4		Appraisals Compliance	85.0%	70.2%	69.5%	68.8%	69.8%
	W4		Mandatory Training	93.0%	90.3%	90.3%	90.7%	91.1%
Financial Position			Premium Pay	18.6%	16.9%	17.4%	17.5%	17.7%
	W4		Non Pay	0.0%	-2.8%	-3.2%	-3.1%	-11.3%
Carbon Footprint			CO2e Gas (tonnes/day)	38.19	27.87	37.43	37.65	
Med. Fit for Disch.	W4		MFFD: Spot Purchase	5.0	17.3	19.3	12.1	11.3
	W4		MFFD: Community Hospital	5.0	8.0	7.6	5.9	10.1
	W4		MFFD: Home With Support	5.0	11.1	7.6	7.6	10.3

Performance

Staff Engagement

Appraisal compliance is steadily increasing now that there is more capacity away from the immediate pressures of the pandemic. This is an alerting watch metric if not a driver in all care groups and is being used to support individual plans for the year ahead. This should include wellbeing conversations and personal risk assessment reviews.

Mandatory training is also improving as there is more capacity to plan training sessions with care groups having this as an alerting watch metric for review at monthly PRMS.

Financial Position

The financial position watch metrics are alerting because pay and non-pay are up on the expected position. This increase has been driven by the Covid-19 response costs and have therefore been funded centrally by the NHS. Overall for the financial year 21/22 the Trust has broken even (subject to external audit).

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.	Dec-20	Jan-21	Feb-21	Mar-21
Harm Events	W		52w Severe Harm Review	0	0	0	0	0
	W		MRSA Cases	1	0	0	1	0
	W		C Diff Cases	8	5	4	7	12
	W		E Coli Cases	10	8	3	4	4
	W		Medication Errors	90	56	54	62	57
	W		Pressure Ulcers: Grade 1 & 2	200	170	168	152	180
	W		Pressure Ulcers: Grade 3 & 4	40	26	25	19	30
	W		IPC: Audits Composite	80.0%	79.2%	86.4%	85.6%	87.5%
	W		VTE Assessment Compliance	90.0%	92.9%	93.4%	93.7%	93.9%
	W		Safeguarding Incidents	20	13	8	7	14
	W		IP Spells with 3+ Ward Moves	500	419	452	419	540
Cancer 62d	W		Cancer 2ww Performance	93.0%	97.6%	98.3%	98.1%	98.7%
	W		Cancer 28d Performance	75.0%	69.4%	59.4%	73.7%	79.3%
ED Compliance	W		ED Non-Admitted Compliance	90.0%	83.5%	84.7%	89.7%	91.2%
	W		Ref to Spec 2.5h	40.0%	81.1%	93.4%	91.0%	90.2%
	W		Discharges by Midday	15.0%	15.1%	13.9%	14.5%	14.0%
	W		NEL Readmissions	15.0%	11.8%	11.3%	10.7%	12.2%

Appendix 1: Non-Alerting Watch Metrics

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Dec-20	Jan-21	Feb-21	Mar-21
FFT	W		FFT DC Response Rate	30.0%	32.9%	37.1%	33.1%	33.9%
	W		FFT OP Response Rate	20.0%	19.1%	20.2%	19.4%	19.1%
	W		Complaints	100	55	60	60	65
	W		Complaint Responses <30 days	90.0%	73.7%	61.9%	100%	100%
	W		PALS Enquiries	550	572	493	447	596
Staff Turnover Rate	W		Vacancy Rate	9.0%	6.1%	6.6%	6.4%	6.3%
	W		Staff Turnover: HCA	13.5%	11.8%	10.9%	11.6%	11.1%
	W		Staff Turnover: Nursing	10.0%	10.0%	10.5%	10.6%	11.0%
	W		Premature Turnover Rate	25.0%	21.6%	20.8%	20.4%	20.1%
Staff Engagement	W		Sickness	5.0%	7.4%	6.3%	4.2%	
	W		Safeguarding Children Training	85.0%	85.7%	85.5%	86.8%	86.0%
Financial Position	W		Total Pay	0.0%	0.3%	0.5%	1.7%	0.2%
Carbon Footprint	W		CO2e Waste (tonnes/day)	0.28	0.23	0.21	0.21	
	W		CO2e Electricity (tonnes/day)	18.00	17.32	17.44	17.31	
	W		CO2e Water (tonnes/day)	0.55	0.42	0.56	0.52	
Med. Fit for Disch.	W		MFFD: Assessment	5.0	2.4	3.7	1.3	0.7
Innovation	W		Virtual OP Appts - First	25.0%	43.0%	53.1%	54.5%	49.0%
	W		Virtual OP Appts - Follow Up	60.0%	60.5%	69.0%	67.8%	62.1%

Appendix 2: Glossary of Terms

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

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**29 APRIL 2021**
REPORT TITLE:	**STRATEGIC RISKS REPORT**
BOARD SPONSOR:	**ACTING DIRECTOR OF GOVERNANCE**
PAPER AUTHOR:	**RISK MANAGER**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: RISK MANAGEMENT** **APPENDIX 2: BOARD ASSURANCE FRAMEWORK AND RISK REGISTER TEMPLATE** **APPENDIX 3: RISK COMMITTEE PATHWAYS**

BACKGROUND AND EXECUTIVE SUMMARY

Purpose and Background:

The intension of this paper is to detail progress to date against the Governance Programme and detail the next steps. The Board is asked to note the progress to date and approve the approach for the next stages of the programme as detailed in illustrated in this paper.

Following the outputs of the NHS England/NHS Improvement (NHSE/I) Governance Review risk was identified as an area requiring attention. There is a specific workstream in the Governance Programme Plan with a series of actions. The objectives in this workstream have been completed apart from the on-going We Care activities.

The Board is asked to approve the proposed templates and proposals contained in this paper. There will be continuing work with Care Groups to refine their risks and calibrating them as some of their risks are legacy items and attention should be given to archiving or confirming them. Work is on-going with the Executive Directors to focus on the new models of working and the Board Assurance Framework (BAF) risks with completion by the May Board meeting.

The risk template and draft BAF documents have been presented to the Executive Management Team, Integrated Audit and Governance Committee, Quality Committee and Finance and Performance Committee. The feedback received was that a simplified process was helpful and the inclusion of trajectories would support the Board of Directors in seeking assurance that the risks are being managed effectively. Following approval at the Board of Directors the Risk Management Policy will be updated to include the revised materials. The BAF and Corporate risks will be updated and refined with the Executive Directors using the new format and will be presented to the Board of Directors and its sub-Committees in May.

Risk Management Changes:

The changes identified resulted in the following:

- An A3 providing a one page on the risk process – Appendix 1;
- A revised risk BAF and Risk Register Template with a change in the approach to the wording of risks – Appendix 2;
- A revised risk pathway – Appendix 3.

Progress against the Governance Plan:

Simplify risk template / Condense and place a summary of the current risk policy onto an A3 and simplify the risk pathway:

A new A3 sized poster (appendix 1) has been produced to be displayed in non-clinical areas and on the Trust intranet that represents an easy aide memoir of the risk processes, condensing the Risk Policy into a sharp visual. This has been shared with Care Groups and well received.

A Risk Register template (appendix 2) has been produced and discussed with the Care Groups that is intended as an example of the proposed output reports from 4Risk - the recording system, it brings to the fore the Risk, Controls (what is in place now to mitigate the risk?), Assurances (what evidence is there that the controls are working?), Gaps (are there any controls missing to mitigate the risk?) and Actions (what is being done to close the gaps?). The risk grading should then fall naturally from the assessment.

The pathway of information flow through groups and committees has been streamlined, and the inputs and outputs to and from those groups and committees clearly defined (appendix 3). A flowchart of risk Groups and Committees has been developed with inputs and outputs from each, becoming more strategic as they go to the Board, enabling more focused discussions around the Trust risks.

Once new materials are created, central risk team to actively engage with Care Groups to explain the 'What 'and 'How' of risk management to ensure improved compliance. Ensure risk management is placed onto the induction agenda for new starters.

Meetings have been held with the Care Groups to start the discussion on risk. The templates have been shared and have been well received. The feedback received to date is that these meetings have driven enthusiasm on risk and there has been good engagement. The Risk Manager is engaged with HR to include risk management in staff induction.

Review and refine the current risks in the Corporate Risk Register (CRR), during the upcoming integration of Strategic Risk Register (SRR) and BAF into one material and undertake the same exercise for external matters - to ensure the BAF is complete and accurate. Ensure the BAF and Risk Register are complete and accurate and aligned with We Care.

Focus meetings have taken place with Executive Directors to identify their key risks and align them with current on-going work around We Care and the BAF. This work has then been aligned with the CRR. A mapping exercise across the three levels of risk register have identified that they are aligned in identifying the risks to the Trusts activities. The pathway of information flow through groups and committees has been streamlined, and the inputs and outputs to and from those groups and committees clearly defined. Work is ongoing with the Executive Directors to define and refine their key risks on the BAF, and respectively with senior managers for the CRR.

The BAF is being updated to reflect the key strategic risks to the Trust based on the completed Executive Director risk meetings and an example of how this would look has been populated following a review by Elizabeth Shutler, Deputy Chief Executive/Director of Strategic Development and Capital Planning of BAF risk number four, 'Our Future' (linked to prioritised risk No. 3, Statutory Compliance). These examples are included in appendix 3.

A similar exercise has been carried out with Siobhan Jordan, Interim Chief Nurse and Director of Patient Experience and Quality to refine the reduction in patient harm risks on the CRR.

Next Steps

The Board is asked to **review and approve** the templates to enable the next phase of work to continue with the Executive Directors and Care Groups to populate the risk registers so that a more comprehensive r register can be presented to Committees and Board in May.

A Board Risk Workshop has been agreed with the Chair to receive a training session on the use of the tools and a facilitated session to undertake a Political, Economic, Sociocultural, Technological, Legal and Environmental (PESTLE) analysis to ensure the captured risks are reflective of the Trust's risk profile and takes account of it's position in the relevant environments that impact the organisation. This exercise will support the development of the Trust's risk appetite for the forthcoming year.

Following this, further workshops will take place with the Care Groups.

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 BAF Risks to the Trust and the risks on the CRR that sit outside the Trust's risk appetite.
RESOURCE IMPLICATIONS:	None specifically identified other than in the Risk Registers.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	This paper does not have an impact on the business of any of the Trust Subsidiary Companies. The companies manage their risks separately to the Trust.

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to review and **APPROVE** the attached Risk Tools that are designed to simplify the risk processes and enable capture and monitoring of the key outcomes and shared learning.

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

Risk Management Policy

Rhiannon Adey, Risk Manager

Purpose

Risk Management is the identification, assessment and control of the impact of events to which the Trust is exposed. This process is carried out in order to minimise the likelihood and impact of adverse events and take advantage of opportunities. It includes financial, regulatory, reputational, clinical and non-clinical risk as well as any risk that threatens the achievement of the Trust's annual and strategic objectives.

Duties

Executive Directors are responsible for the oversight of the processes for identifying and assessing risk. They must ensure that, so far as is reasonably practical, resources are available in order to manage risk.

Care Group/Site Directors are responsible for leading risk management strategies within their area of responsibility and ensuring appropriate risk structures and processes are maintained and delivered. They are also responsible for promoting an open culture and facilitating Trust wide learning from risk issues.

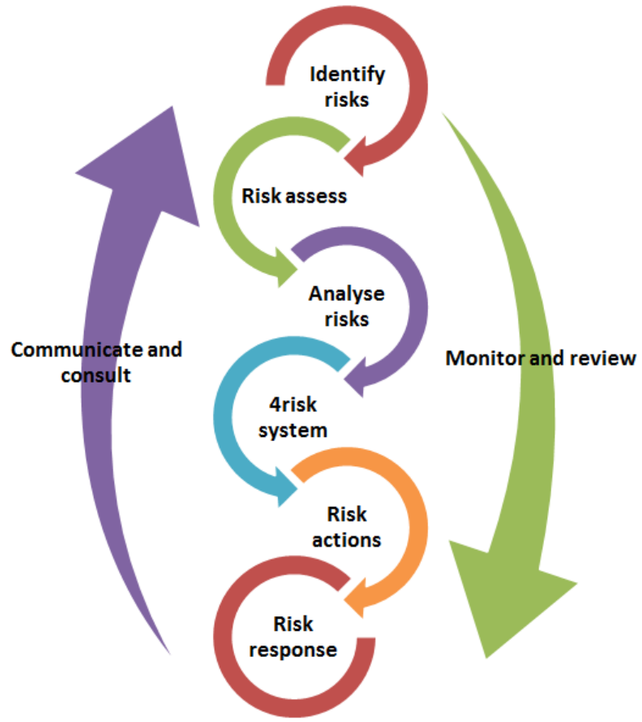
Risk Manager is responsible for the development of strategy, policies and process documents with regard to risk management.

All staff are responsible for maintaining a general risk awareness and accept personal responsibility for maintaining a safe environment, notifying line managers of any identified risks.

Vision

Our approach to risk management aims to be forward looking, innovative and comprehensive; to make the effective management of risk an integral part of every practice. The vision is to ensure our strategic objectives are not jeopardised by risks that have not been identified and managed and continually improve the maturity of the risk management framework.

Risk Management Process



Controls

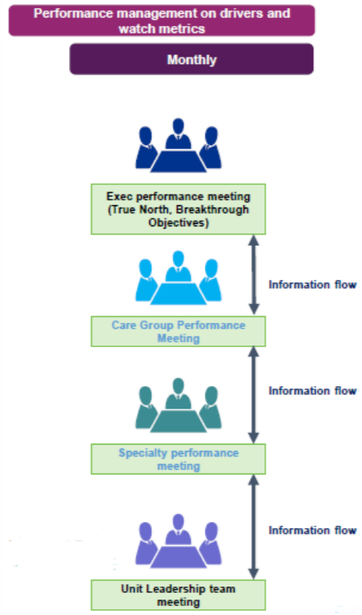
When determining how to manage the risk we need to consider how we will respond to the risk.

- **Treat** the risk to reduce the likely impact/exposure
- **Tolerate** the risk and its likely impact
- **Terminate** activity generating the risk
- **Transfer** the risk to another party

Where we want to be

- Highlight to the Trust Board any risks which may threaten the achievement of the Trust's objectives;
- Become leaders in healthcare risk management;
- Appropriately manage risks between partner organisations
- Have a process for escalation where risks fall outside of the Trust's risk appetite
- Separate risks and issues to enable effective identification and management of risks

Risk Management Reporting (Governance Committee Structure to be confirmed)



Monitoring

Care Group Governance leads at their performance meetings will review local risk registers to monitor the process for managing risks locally.

Reporting arrangements into the Board will be reviewed annually when reviewing the Terms of Reference of the Board of Directors.

Ensuring that strategic risks are assessed, reviewed and aligned with the annual objectives will be assessed by an audit of process by the Trust's internal auditors annually.

Risk management training for Board members and very senior managers including Care Group leadership teams will be reported annually with a report of compliance.

A formal review of the Trust's risk management maturity will be conducted annually.

Find out more

https://www.ekhuft.nhs.uk/staff/clinical/risk-management/

East Kent Hospitals University NHS Foundation Trust

Examples of two Board Assurance Framework (BAF) risks and one Corporate Risk Register (CRR) risk

The templates below are in the proposed new format demonstrating the output report style from 4Risk that is recommended for approval by the Board.

It is intended that the Care Group Risk Registers, Corporate Risk Register (CRR), and Board Assurance Framework (BAF) will all follow the same format to enable all Groups and Committees to be looking at the same style of information.

The key information requested on the template is:

- That the risk is defined.
- Controls are identified and are in place at the time of writing.
- Assurances (evidence that the controls are working) are identified.
- Gaps in control are identified, what is missing to mitigate the risk?
- Actions are described to address any gaps in control and mitigate the risk.

Once an action is completed to address the gap it becomes a control. When all actions are controls the risk is mitigated and archived.

The BAF examples have been worked up by the Trust Director of Strategic Development and Capital Planning from objectives within their portfolio and associated risks. The narrative is of a high-level strategic overview of the risks to the Trust.

The CRR example has been worked up by the Chief Nurse. and supports more tactical narrative, which in turn is supported by operational narrative via the Risk Registers.

Further work will be scheduled with the Executives with BAF level objectives, to capture and define their risks to complete the BAF making it a working tool for the Board of Directors in managing and mitigating their risks. This is hoped to be completed in time for the May Board.

East Kent Hospitals University NHS Foundation Trust

BAF Risk Example 1

STRATEGIC GOAL: 4) Our Future: (Linked to prioritised Trust Risk No 3 Statutory Compliance) Develop a clinical strategy for the Trust that addresses key risks faced in terms of **service delivery, workforce and estate condition (backlog and statutory compliance).**							
BAF	**Objective Owner: Director of Strategic Development and Capital Planning**						
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:** **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**	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,	**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 March 22** 2a) Continue to implement annual investment plan for statutory compliance and monitor in year improvements against the agreed trajectory. **DSD&CP March 22**	L4 x S 5	L3 x S 5	L1 x S 5

Is it Responsive **Is it Well-led**	reported and reviewed six-monthly by CEMG and the BoD. 5) The Trust's investment programme in statutory compliance is approved by CEMG, FPC and BoD. 6) The Trust wide backlog maintenance plan is approved and reviewed by SIG, CEMG, FPC and BoD.		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 July 21**			

BAF Risk Example 2

STRATEGIC GOAL: 4) Our Future: (Linked to prioritised Trust Risk No 3 Statutory Compliance) Develop a Trust wide strategy to deliver **innovation and change through the implementation of new technology.**							
BAF	**Objective Owner: Director of Strategic Development and Capital Planning**						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: Utilising new technology to implement innovation and change in multiple areas will involve several complex change programmes running concurrently. Failure to implement these programmes in a co-ordinated manner, reflecting adequately the resources required for execution and the administration and clinical teams capacity for change, could result in system failure, increased down time and patient safety issues. These will impact on the Trust's reputation and compliance with operational standards. **Origin Date:** 27/04/2021 **CRR Ref:** 60, 72. **Source**: Risk Registers, Medium Term Risk Assessment and CQC reports.	1) The CEO leads the STP/ICS Partnership Board priority for digital to ensure the Trust's programme of work is incorporated into the County wide Digital Strategy and the capability and resources are available for the programme. 2) The Director of Strategic Development and Capital Planning ensures that the Trust's plan is signed off by the T3 PB, CEMG, FPC and BoD. 3) The Director of IT chairs the East Kent Digital Strategy Group, to ensure alignment with east Kent providers.	**Int**: 1) Approval and monitoring of the Trust's programme through SIG, CEMG, FPC and BoD. **Ext**: 1) Sign off by ICP and STP/ICS. 2) National sign off for business cases by NHSEI.	1) National policy developments may create the need for changes in priority. 2) Capital may restrict the Trust's ability to expand the Strategy. 3) Contractual imperatives (such as products being withdrawn from or restricted in the market) may require unplanned change. 4) Availability of staff with the appropriate level of expertise and experience,	1) The Strategy will continually be monitored at an East Kent and County level in the light of new national policy through the ICP / STP / ICS governance arrangements. **CEO March 2022** 2) The competing demands for investment will be monitored and recommendations for re-prioritisation will be led by SIG, but approved at CEMG, FPC and BoD. **DSD&CP March 2022** 3) Regular supplier monitoring meetings will minimise short term, unplanned changes. **Director of IT March 2022**	L4 x S 1	L2 x S 1	L1 x S 1

CQC: **Is it Safe** **Is it Effective** **Is it Caring** **Is it Responsive** **Is it Well-led**			at the volume required, may limit transformation. 5) The programme of change may not deliver an outcome that is optimal for use by clinicians.	4) The investment in the Transformation Team will continue to be monitored to ensure the skills and capacity of the workforce match the requirements. Project timelines will need to moved if either of these is an issue. **Director of IT March 2022.** 5) The Clinical Design Authority will have clinical oversight and sign off of all technology developments. **The Chief Clinical Information Officer Dec 2021**			

East Kent Hospitals University NHS Foundation Trust

CRR Risk Example

STRATEGIC GOAL: 4) Our Future: (Linked to prioritised Trust Risk No 3 Statutory Compliance) Develop a Trust wide strategy to deliver **innovation and change through the implementation of new technology.**							
BAF	**Objective Owner: Director of Strategic Development and Capital Planning**						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: Patient outcome, experience and safety may be compromised as a consequence of not have the appropriate nursing and midwifery staffing levels and skill mix to meet patient's needs. **Origin Date:** 27/04/2021 **Source**: CQC, Risk Assessments, Risk Registers, Datix **CRR Ref:** 76 **CQC:** **Is it Safe** **Is it Effective** **Is it Caring** **Is it Responsive** Is it Well-led	1) Recruitment strategy linked to Trust projected requirements 2) Action plan in place following NHSEI gap analysis against NQB and NHSI 2018 standards. 3) Care Group ownership of staffing levels to ensure safe staffing at all times. Proactive review of rosters and weekend plan undertaken by Care Group site team and corporate nursing to provide supportive layers of assistance. 4) Safe Care Live tool for internal staffing – Committed resource to oversee e-rostering. Rosters reviewed 6 weeks in advance.	**Int**: 1) Nurse Staffing Data is published on Trust website 2) Monthly safe staffing reports to Quality Committee **Ext**: 1) Nurse staffing data submitted to Unify. Data and forums details which supports benchmarking. A number of workforce submissions provided as requested to NHSEI.	1) Some gaps in compliance against NHSEI 2018 Governance standards. 2) Staffing policy needs to be ratified. 3) Complete the Gap analysis on Developing Workforce Safeguards (2018) and report to Trust Board 31 May 2021. 4) Funding is not available for the required staffing levels to deliver care.	1) Address action plan gaps in response to NHSE/I findings to strengthen system and process. **HoN/DDoN May 21** 2) Develop and ratify safe staffing policy including establishment setting and governance process. **HoN/DDoN Jun 21** 3) Develop and ratify safer staffing policy –inc staffing controls / governance and escalation of staffing levels. **HoN/DDoN Jul 21** 4) Complete 28 day SNCT evaluation report to Trust Board – seek funding in place to include ED, Theatres, ICU, Maternity and CNS workforce. **HoN/DDoN Apr 22**	L4 x S 4	L2 x S 4	L1 x S 4

	5) Strong relationships with NHSP, temporary staff booked where gaps are identified. 5) Strong relationships on flexible workforce, established relationships with agencies 6) Clearly documented Trust processes in place to monitor and manage staffing levels, at Ward; Care Group and Trust level 7) Weekly NHSP shift fill reports received to monitor usage and flag areas requiring targeted action		5) Need to maximise retention of skilled staff and understand /address unwarranted variation. 6) The safer nursing care tool has not been reviewed and approved by the Board since 2019 7) Staffing levels have not been consistent in clinical areas due to pandemic	5) Analysis of retention data to identify areas of local variation and concern. Follow up retention collaborative action plan. **HoN/DDoN May 21.** 6) Interim Chief Nurse requested support of NHSIE. Clinical Fellow in Trust one day a week. Undertaking safer staffing nursing care tool at present **CN Sep 21** 7) The 4R programme is working with Care Groups to support the delivery of services in a pandemic. This involves planning for workforce to support low Covid prevalence and the return of an elective programme but also plans to respond to further waves or recurrence of covid in the community or hospital environment. **COO Deadline TBC**			

			8) Due to reduced nurses in clinical areas there has been a reduction in completion of the patient acuity tool twice daily	8) Action plan in place to address compliance with NQB standards and refresher training to be rolled out in May 2021 **CN September 2021**	

East Kent Hospitals University NHS Foundation Trust

Ward to Board Group and Committee Pathways

The Flow chart of Groups and Committees below depicts the High-Level Risk Committees of the Trust, where key information and communication flows are channelled toward the Board.

At each stage the inputs become more concise, and the outputs more strategic until the information that goes to the Quality Committee and Trust Board is of an overarching nature without the operational granularity. This will be dealt with at Care Groups.

Care Groups will need to undertake further work to determine how their Specialties and Departments feed into them, and how they connect with Site, and other key Groups and Committees such as Patient Safety, Falls, Pressure Ulcers, Medical Devices, Medicines Management etc. to enable them to report to the Risk Group.

The Risk Group will have equivalent level Groups and Committees reporting to them, and the Quality Committee likewise.

Executive Management Team (EMT) and the Finance and Performance Committee (FPC) report to the Trust Board, and assurance oversight is provided by Integrated Audit and Governance Committee (IAGC).

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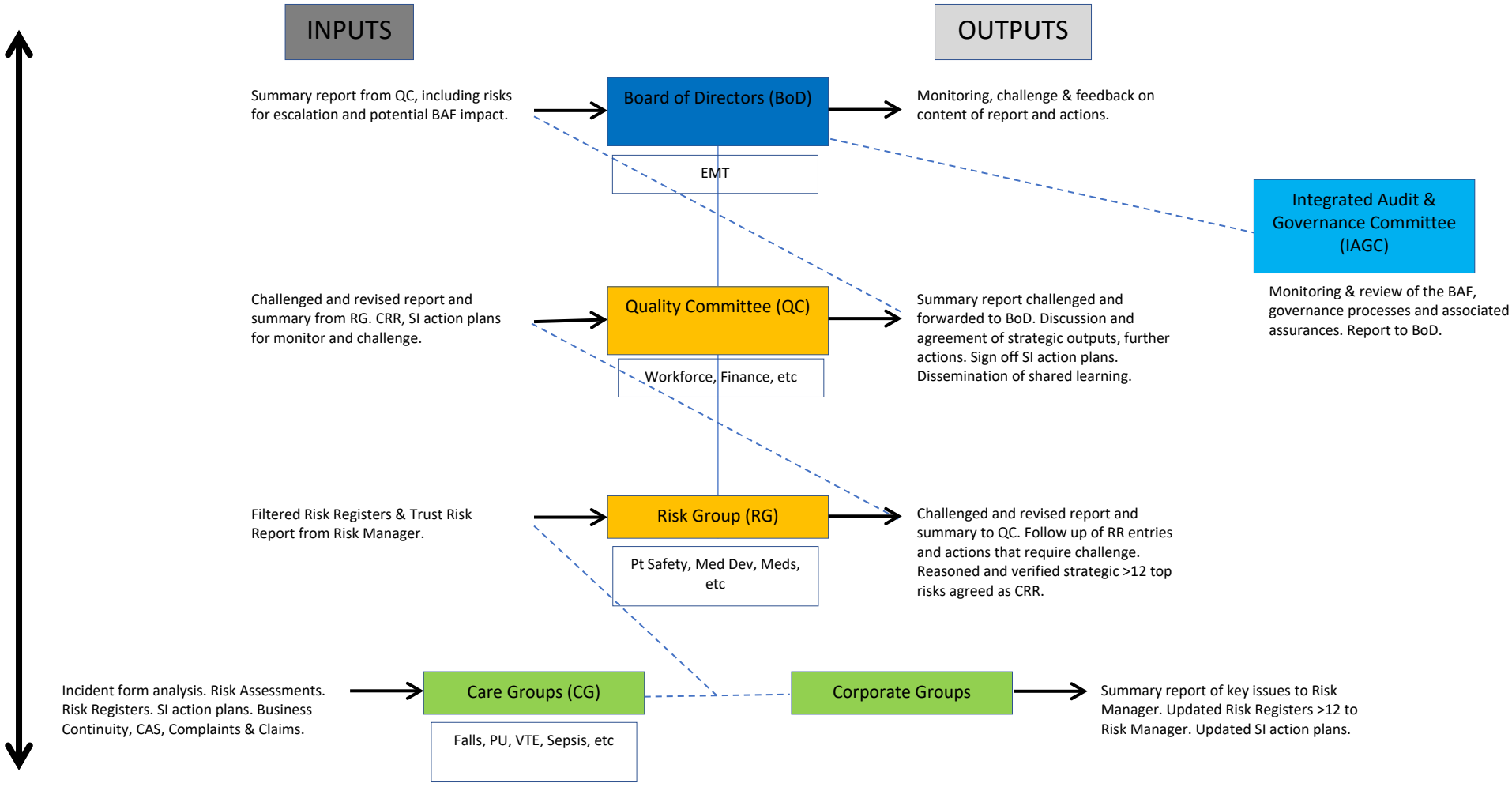
Hospitals University
NHS Foundation Trust

Inputs and Outputs from the Risk Pathways, Ward to Board



East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**29 APRIL 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** **APPENDIX 2: UPDATE ON CARE QUALITY COMMISSION (CQC) IPC INSPECTION 2 MARCH 2021 AND SECTION 31**

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.

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

Section 1:

- Limited and controlled visiting restarted in general ward areas and for partners of pregnant women attending for antenatal care (e.g. scans).
- Intensive Therapy Unit (ITU) have stepped down from being considered an Aerosol Generating Procedure (AGP) “hot spot” in line with national guidance for low Covid incidence.
- A portfolio of assurance including weekly evidence returns on all aspects of IPC, in combination with very positive feedback from a Care Quality Commission (CQC) inspection at the William Harvey Hospital (WHH) Site, has led to the successful lifting of the previous CQC Section 31 Order (Appendix 2).

Section 2:

- 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.

Section 3:

- Some aspects of antimicrobial stewardship auditing that ceased due to pharmacy going into business continuity in wave 2 are restarting at the beginning of May 2021.

Section 4:

- Visiting guidance for inpatient areas updated to reflect low incidence of Covid from 16 April 2021 in line with national guidance.
- Visiting maternity services updated to reflect new national guidance from 19 April 2021.

Section 5:

- Emergency Department (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 (with a view to putative wave 3 planning).

Section 7:

- Green capacity being re-introduced in response to falling incidence of Covid.

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).
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.

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:
- Limited and controlled visiting restarted in general ward areas and for partners of pregnant women attending for antenatal care (e.g. scans).
- Intensive Therapy Unit (ITU) have stepped down from being considered an Aerosol Generating Procedure (AGP) “hot spot” in line with national guidance for low Covid incidence.
- A portfolio of assurance including weekly evidence returns on all aspects of infection prevention and control, in combination with very positive feedback from a Care Quality Commission (CQC) inspection at the William Harvey Hospital (WHH) Site, has led to the successful lifting of the previous CQC Section 31 Order.

Section 2:
- 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.

Section 3:
- Some aspects of antimicrobial stewardship auditing that ceased due to pharmacy going into business continuity in wave 2 are restarting at the beginning of May 2021.

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- Visiting maternity services updated to reflect new national guidance from 19 April 2021.

Section 5:
- Emergency Department (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 (with a view to putative wave 3 planning).

Section 7:

- Green capacity being re-introduced in response to falling incidence of Covid.

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	• 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 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 possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	• 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		
• compliance with the national guidance around discharge or	• National guidance followed in all cases		

transfer of COVID-19 positive patients	• 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 Infection Prevention and Control Committee (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 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)		
• 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	• 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
• 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 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 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 Care Quality Commission (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		
• 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 • Human Papillomavirus (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 strength of 1,000ppm available chlorine, as per national guidance. If an alternative	• Tristel Fuse confirmed as suitable cleaning agent for enveloped viruses by ICPT		

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	• In place – double amber clean team available. ICU has dedicated cleaning staff		

coincide with periods immediately after PPE removal by groups of staff (at least twice daily)			
• 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	•Cleaning standards in non-clinical areas are monitored as part of the audit schedule. Scores are consistently >95%		

maintaining a clean environment	•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 (AMS) 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 April 2021 • Visiting guidance for inpatient areas updated to reflect low incidence of Covid from 16 April 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		
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 the 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. Additional questions around previous admissions, contacts, travel and self-isolation have been added. Audit data shows >95% compliance	• Estates work required to separate paediatric streams in WHH ED	• Plans developed to be implemented in December to create Covid paediatric area in WHH ED

	• 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 • 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	• 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.
• staff are aware of agreed template for triage questions to ask	• 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		
• 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 Altering 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		

	• Gold command monitor incidents and takes urgent action as appropriate by cascading to procurement for response. • Incidents causing harm are raised as potential SI to panel – If agreed then 72-hour report and full RCA		
• adherence to PHE national guidance on the use of PPE is regularly audited	• 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	• All hand hygiene facilities have hand hygiene instructions on the splash back		
• good respiratory hygiene measures	• All staff, outpatients and visitors wear masks • Inpatients encouraged to use masks as much as tolerated		
• maintaining physical distancing of 2m wherever possible unless wearing PPE as part of direct care	• Social distancing encouraged • Signage on doors stating maximum occupancy • Additional break areas available		
• frequent decontamination of equipment and environment in both clinical and non-clinical areas	• Disinfectant wipes provided for non-clinical areas • Domestic and nursing cleaning tasks implemented in clinical areas. Records kept of cleaning		

• clear advice on the use of face coverings and face masks by patients/individuals, visitors and by staff in non-patient facing areas	• Advice available by posters, verbal advice at the entrances. • PPE policy available on staff zone		
• 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		
• The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	• 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		

• Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff toilets	• All hand wash basins have hand washing and drying guidance on back boards or posters in both clinical and public areas		
• 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.		

	• 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		
• 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	• 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/Neo-natal 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 • Staff results sent by text message directly from the on-line system. Occupational health follow-up positive staff members	• 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 • 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	• Antibody testing available to all patients and staff on request • Covid testing SOP is agreed by Gold and is available on the Trust intranet • 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 • Advice available from IPC team and consultant microbiologists. On call rotas 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
• any changes to the PHE national guidance on PPE are quickly identified and	• DIPC responsible for checking for updates to national guidance and advising executive team		

effectively communicated to staff	• 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 record of this training is maintained	• FIT testing in place. • A log of staff training is available • SOP available on staff intranet for reusable respirators		

	• 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 e.g. 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 through COVID-19 secure areas.	• Advice given to staff to don masks whenever moving around Covid secure area		
• 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:	**29 APRIL 2021**
REPORT TITLE:	**UPDATE ON CARE QUALITY COMMISSION (CQC) INFECTION PREVENTION AND CONTROL (IPC) INSPECTION 2 MARCH 2021 AND SECTION 31**
BOARD SPONSOR:	**DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC)**
PAPER AUTHOR:	**QUALITY PROGRAMMES LEAD**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: WEEKLY REPORTING**

BACKGROUND AND EXECUTIVE SUMMARY

This paper provides an update on CQC related IPC activity.

1. Background

On 11 August 2020 the CQC undertook a focused inspection of infection prevention and control (IPC) procedures at the William Harvey Hospital (WHH).

On 20 August 2020 the CQC wrote informing the Chief Executive Officer (CEO) that it would be imposing conditions upon our registration under Section 31 of the Health and Social Care Act 2008. This included the requirement to report on a regular basis as follows:

- Weekly reporting to provide assurance of improvements related to 10 areas identified in the letter. This can be found at Appendix 1 for information.
- Monthly submission of Board and Board Sub Committee papers and minutes relating to IPC.

From 3 September 2020 until 25 March 2021 evidence has been submitted at weekly and monthly intervals to the CQC.

On 7 October 2020 the CQC published their final reports following the visit. As a result of the Section 31 conditions the Safe domain for the WHH site was downgraded to inadequate. Medical care and urgent and emergency care were also rated inadequate for Safe.

2. Integrated IPC Improvement Plan

Since notification of the conditions of registration a comprehensive Trust Wide Infection Prevention and Control Improvement Plan has been in place overseen by the then Interim Director of Infection Prevention and Control (DIPC), Dr Sara Mumford.

The Plan has been overseen by a weekly Task and Finish Group with monthly reporting via the Infection Prevention and Control Committee (IPCC) and Quality Committee into the Board. The Improvement Plan has received external oversight as well as intensive support from NHS England/NHS Improvement (NHSE/I) supported by the Clinical Commissioning Group (CCG) with regular reporting in place via the IPC 90-day Improvement Plan.

Intensive support was stepped down in February 2021 and the IPC 90-day Improvement Plan is in the process of being formally stepped down.

3. IPC Inspection March 2021 and Section 31

The CQC carried out an announced, focused IPC inspection at the WHH and Queen Elizabeth the Queen Mother Hospital (QEQMH) sites on 2 March 2021. 24 hours' notice was received. This inspection was part of a national programme of IPC inspections.

Immediate feedback from the visit was positive and draft reports were received on 29 March for factual accuracy checks, returned on 31 March and we are expecting the final reports to be published week commencing 19 April.

In summary findings include:

- Leaders had the skills and abilities to run the service and manage IPC priorities.
- Leaders were visible and approachable.
- The Trust had a vision and strategy that included infection prevention and control.
- Staff felt respected, supported and valued and were focused on the IPC needs of patients receiving care.
- The Trust has structures, processes and accountability to support infection prevention and control standards.
- The Trust had a comprehensive assurance system for infection prevention and control which enabled performance issues and risks to be monitored and addressed.
- The Trust collected reliable infection prevention and control data and analysed it.
- The Trust encouraged staff and patients to provide feedback on infection prevention and control.
- All staff were committed to continually learning and improving infection prevention and control performance.

There were several examples of outstanding practice highlighted:

- In emergency departments, there were negative pressure rooms used for patient resuscitation with support rooms that were linked via video and audio. Staff in the support rooms supplied the resuscitation staff with medicines and equipment which reduced the need to store items in the resuscitation area and risked the spread of Covid-19 to patients and staff.
- The Trust had a developed approach for screening clinically vulnerable patients including shielding them from other patients.
- The Trust continued to look for new infection prevention and control risks during extraordinary pressure on their resources.
- The Trust recorded their infection control training video in Nepalese – in particular for 2gether Support Solutions Staff.

There were no "must do" actions in the report. There were areas where the CQC have advised that we "should" act:

- The Trust should ensure the capacity of the IPC leadership team is sufficient to support all staff.
- The Trust should consider the layout of the doctor's mess to facilitate social distancing.
- The Trust should consider the supply of administrative space for therapy staff to reduce the number of staff required to be on the wards.

- The Trust should ensure that when wards are converted to the Covid-19 positive stream consideration is given to staff changing facilities.
- The Trust should ensure that all staff receive feedback about IPC audit outcomes and performance information.
- The Trust should ensure that they continue to improve their compliance with daily ward safety huddles.
- The Trust should ensure that staff continue to challenge non-compliance with the Trust's policy for staff to be bare below the elbow.
- The Trust should continue to improve their compliance with their Covid-19 testing policy.
- The Trust should ensure that throughout the night, people entering the hospital are consistently screened for Covid 19 symptoms
- The Trust should consider standardising nursing documentation across all wards.
- The Trust should ensure that all staff know how to access patient information leaflets.
- The Trust should consider how to increase staff involvement in their quality improvement projects.

On 26 March official notification was received that, on the basis of our application to the CQC, the CQC would be lifting the Section 31 regulation notice. Weekly and monthly reporting has at this point ceased.

Dr Neil Wigglesworth, DIPC, started in the organisation on 15 March and is chairing the weekly IPC Improvement Working Group. This group will continue to meet but its purpose is being reviewed to ensure that where appropriate some of the workstreams transition to business as usual with IPC Committee overview as appropriate.

The reduction of healthcare acquired infections is a Breakthrough Objective and organisational priority as part of the We Care programme.

Appendix 1

- Staff and patients observe social distancing throughout the hospital.
- Staff adhere to the requirements of wearing personal protective equipment.
- All staff groups have received up-to-date training on the safe and effective use of personal protective equipment and that such training is included in any induction for new-starters.
- Staff adhere to Trust policy on the frequency of cleaning the environment and equipment, and that this cleaning is recorded.
- Staff consistently triage patients appropriately and consistently according to their Covid-19 symptoms.
- There is a policy/guidance to support staff to identify patients at low or high risk of Covid-19.
- There is adequate provision of suitable hand washing facilities and antimicrobial hand rubs where appropriate.
- There are policies/guidance to support staff to identify patients that are immunocompromised and create appropriate care plans.
- There are timely updates to policies, procedures and guidance relating to infection prevention and control following national guidance updates and such updates are effectively and quickly communicated to staff.
- Daily safety huddle documentation is completed.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risk – decrease in momentum of IPC improvements due to lack of external focus.

East Kent Hospitals University NHS Foundation Trust

	Mitigation – strengthened leadership and governance surrounding IPC evidenced in March 2021 inspection with leadership from new DIPC.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER:	BAF 17 – Risk to safety, quality and experience as a result of not achieving strategic objectives.
RESOURCE IMPLICATIONS:	No
COMMITTEES WHO HAVE CONSIDERED THIS REPORT:	CQC Update Paper (including IPC Update) – Quality Committee, 27 April 2021
SUBSIDIARY IMPLICATIONS:	No

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

RECOMMENDATIONS AND ACTION REQUIRED:

Board members are asked to receive the above report and accept the below recommendations:

- Any residual actions on the 90 Day plan (including the Should Dos highlighted in the draft CQC report) will continue to be overseen by the IPC Improvement Plan Working Group until arrangements are agreed for this work to transition into business as usual where possible (Care Group governance into IPC Committee).
- Continuous ongoing improvement will be managed via the IPC Breakthrough Objective as part of We Care with reporting as agreed.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**29 APRIL 2021**
REPORT TITLE:	**CHIEF MEDICAL OFFICER'S REPORT**
BOARD SPONSOR:	**CHIEF MEDICAL OFFICER (CMO)**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY / CHIEF MEDICAL OFFICER**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The focus of this report is to update the Board on the Ethics Committee meeting held on 20 April 2021 and the issues discussed, and an update of the Maternity Incentive Scheme Year 3.

Covid-19 Ethics Committee

There were no issues that had been raised by staff this month for consideration by the Committee.

The CMO with support from a Committee member will be working together to look at the future structure and function of the Committee going forward changing its purpose from current Covid-19 to establishing a Clinical Ethics Committee with a broader remit.

The CMO reported an area of focus for the next Committee meeting to receive an update and presentation from the Medical Director: Covid Incident Response on the Trust's restore and recovery programme.

The Committee considered and discussed the proposed Yellow Card Warnings and Red Card Sanction Procedures policy with regards to ethical elements. They recommended the procedures to be amended to support the process being more clinically led, provide the ability to pull on senior expertise and support in assessing vulnerable patients, and enable the system to be a timelier process to support front line clinical teams. An additional Committee meeting will be scheduled for members to have a further detailed discussion on the proposed procedures and provide any additional feedback to the policy authors.

Maternity Incentive Scheme Year 3

The requirements for the Maternity Incentive Scheme for current year have been further updated in March 2021 in response to the impact of the Covid-19 pandemic.

The Maternity service has collated extensive evidence to date to demonstrate progress in implementation of the ten safety actions and the benefits in care for women and babies these deliver. This is presented for scrutiny to an Evidence Review Group of which the

Executive Director and Non-Executive Director Board Safety Champions are members. All evidence is held on 'Admin Control' and is now available to all Board members.

The revised date of submission of 15 July 2021. Currently, following the recent adjustments to the requirements, the Trust is on target to meet the ten safety actions but a full and final submission will be presented ahead of the July deadline.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	None
LINKS TO STRATEGIC OBJECTIVES:	**We care about...** • **Our patients;** • **Our people;** • **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 requested to discuss and **NOTE** the CMO's report.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**27 APRIL 2021**
REPORT TITLE:	**FINANCE AND PERFORMANCE COMMITTEE (FPC) CHAIR REPORT**
BOARD SPONSOR:	**NIGEL MANSLEY, CHAIR FPC**
PAPER AUTHOR:	**GROUP COMPANY SECRETARY / ACTING DIRECTOR OF GOVERNANCE**
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 27 April 2021 FPC meeting.

1 Month 12 Finance Report

Month 12 Finance Report provides the Board with oversight of the financial position and therefore only highlights are below:

1.1 The Trust achieved a £0.6m deficit in March 2021 resulting in a breakeven position for 2020/21;

1.2 The Trust's cash position at the end of March 2021 was £68m above the plan of £65m;

1.3 The Trust has identified £5.1m of additional costs due to Covid-19 in March along with lost income of £0.7m, bringing the total financial impact of Covid-19 to £62.8m for the full financial year;

1.1 The Committee is assured that the financial position is in line with the plan for 2020/21 which will be further assured by the audit which is planned to complete by the end of June 2021.

2 NHSE/I Use of Resources Assessment

2.1 The Chair congratulated the Trust on the positive outcome of the assessment which rates the Trust as "GOOD" the second highest rating;

2.2 An action plan is being developed to implement the recommendations.

3 Financial and Operational Risks

3.1 Focus has been on simplifying risk management processes, reports and templates; once the processes and templates have been reviewed the content will be developed. The Board will receive a couple of "live" examples;

3.2 A number of useful formatting points have been highlighted and these will be incorporated;

3.3 The Committee is supportive of the approach and welcomed the Board workshop being planned.

4 We Care Integrated Performance Report: National Constitutional Standards for Emergency Access, Referral to Treatment, Cancer and Diagnostics

The FPC received a highlight report on the National Constitutional Standards, which is covered in detail in the Integrated Performance Report (IPR).

4.1 Emergency Department (ED) performance an improving position with an 11.7% improvement over the last two months;

4.2 Cancer Care Group working extremely hard to deliver the 62 days standard for all cancers;

4.3 The 104-day compliance is of concern but is improving. The Chief Operating Officer (COO) will be reporting to the Quality Committee later today;

4.4 Referral to treatment times is also of concern. The Trust has the highest number of 52 week waiting patients in Kent which is due to the size of the organisation and in response to the national guidance received in December 2020 to reduce elective surgery and only focus on the Priority 1 and 2 patients (clinically urgent and cancer). The Trust is clear on its prioritisation for patients and was commended on a recent system wide meeting because of its advanced validation compared to other Trusts;

4.5 The Committee received assurance in relation to the restore and recovery programme which is overseen by the Clinical Executive Management Group. Innovation and Getting it Right First Time (GIRFT) will be a key in the restore and recovery process;

4.6 Opportunities orthopaedic elective centre coming on line;

4.7 Referrals and demand has not returned to pre-pandemic levels and this needs to be kept under review;

4.8 County-wide shared Patient Tracking List (PTL) is a challenge but focus is on shared management and the practicalities need to be worked through and that work will start over the next couple of weeks. This should support some of the longer waiting patients at the Trust.

5 Update on Winter Planning and Capacity

The paper provided an overview of the Covid Pandemic response, EU transition and the elective recovery programme. The Committee will retain oversight of the Restore and Recovery programme going forward.

6 Financial / Business / Operational Plans 2021/22

6.1 Planning guidance has been received for the first 6 months of the year. NHSE/I have released planning guidance for the first six months of the year. There will be no NHS contracts and an expectation that our cost base will be around £395m for that period based on Q3 cost levels. Our current estimate is that there is a £10m pressure which we are currently negotiating with the Integrated Care System (ICS);

6.2 There is an opportunity to receive additional income, as a system, for surpassing agreed elective activity levels;

6.3 There is a requirement for a £1.2m Cost Improvement Programme (CIP) for the first 6 months of the year which is felt to be deliverable, key risk is around working up schemes worth £7m for the second part of the year.

7 Capital Programme Month 12 2020/21

7.1 The final 2020/21 capital outturn position achieved a net planned underspend of £0.8m. The £0.8m slippage was transferred to Dartford & Gravesham NHS Trust under an agreed sharing arrangement of the Kent & Medway ICS CDEL (capital spend limit). The Trust carries into 2021/22 a £3.8m pressure where schemes didn't deliver in year, this has been highlighted to the system planning group and will need to be managed in year by either slipping 2021/22 schemes or attracting additional funding;

7.2 The Committee noted the achievement of delivery of the capital plan given the additional capital received (£31.5m) which required significant delivery.

8 Capital Plan 2021/22

8.1 The final capital plan funding currently identified for 2021/22 is £44.51m including internal and external funding. For 2022/23 onwards, this reduces to the level of internally generated capital until any additional external funding is confirmed. Backlog maintenance has been prioritised for 2021/22 and capital allocated over the next 3 years to address this issue;

8.2 An investment programme to deliver statutory compliance has been agreed for this year.

9 National Costs Collection 2020/21

9.1 The Committee noted and is assured of the robustness of the processes in relation to the national cost collection for 2020/21.

10 Other Reports

The Committee received and discussed the Cancer Centre – Strategic Outline Case. The Committee noted that additional work is required to develop the proposals and the need to identify funding for this proposal.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Failure to achieve financial plans as agreed with NHSI under the Financial Special Measures Regime.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our future;** • **Our sustainability.**
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*

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and **APPROVE** the FPC Chair report

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**29 APRIL 2021**
REPORT TITLE:	**MONTH 12 FINANCE REPORT**
BOARD SPONSOR:	**DIRECTOR OF FINANCE AND PERFORMANCE**
PAPER AUTHOR:	**REPORTING ACCOUNTANT**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: MONTH 12 FINANCE REPORT**

BACKGROUND AND EXECUTIVE SUMMARY

The Trust achieved a £0.6m deficit in March, which brought the year-to-date (YTD) position to breakeven. This is consistent with the planned position, excluding the impact of the estimated value of un-used annual leave at the end of the year, planned to be £5m, which has subsequently been fully funded.

The impact of Covid-19 has paused the NHS business planning process. Nationally-mandated interim financial regime and contracting arrangements were in place for 2020/21.

From April to September 2020 the Trust was funded to financial breakeven through National block and top-up payments. For October 2020 to March 2021 the Trust was funded via:

1) A block payment based on estimated services commissioned by NHS England and Clinical Commissioning Groups (CCGs) to cover all costs including an estimate for Covid-19 costs;
2) A variable payment linked to the volume of patients treated and some specific high costs drugs;
3) A retrospective top-up to refund some specific 'out of envelope' costs incurred due to Covid-19.

Under the new rules the EKHUFT financial plan for 2020/21 is breakeven, excluding an assessment for the value of un-used annual leave at year-end of £5m, which has subsequently been fully funded at the actual value of £4.1m.

East Kent Hospitals University NHS Foundation Trust

£'000	This Month Plan	This Month Actual	This Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance
EKHUFT Income	63,512	88,095	24,584	743,559	777,769	34,211
EKHUFT Pay	(46,888)	(47,737)	(849)	(470,560)	(469,543)	1,017
EKHUFT Non-Pay	(21,750)	(45,651)	(23,902)	(279,222)	(314,308)	(35,086)
EKHUFT Financial Position	**(5,126)**	**(5,293)**	**(167)**	**(6,224)**	**(6,082)**	**142**
Spencer Performance After Tax	52	(416)	(467)	271	357	86
2gether Performance After Tax	76	362	286	1,001	1,405	404
Reprofiling Plan adjustment	(1)	3	4	(24)	56	80
Consolidated I&E Position (pre Technical adjs)	**(5,000)**	**(5,344)**	**(344)**	**(4,975)**	**(4,263)**	**712**
Technical Adjustments	0	4,749	4,749	(25)	4,256	4,281
Consolidated I&E Position (incl Top Up)	**(5,000)**	**(595)**	**4,405**	**(5,000)**	**(7)**	**4,993**

The technical adjustments remove factors which are not considered by NHS England/NHS Improvement (NHSE/I) when assessing our financial performance. The £4.2m year-end adjustment is driven by the net impact of an £8.4m impairment following the annual revaluation exercise partially offset by £4.2m of capital donations/grants received.

The Trust has identified £5.1m of additional costs due to Covid-19 in March along with lost income of £0.7m, bringing the total financial impact of Covid-19 to £62.8m for the full financial year.

The Trust's cash balance at the end of March was £68m which was £65m above plan due to a combination of Public Dividend Capital (PDC) capital receipts ahead of supplier payments and the NHSE/I block payment on account to cover anticipated operational costs in advance.

Total capital expenditure at the end of March was £70.7m which includes £3.6m of donated equipment recognised in March for which the Trust has received external funding.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Failure to deliver Cost Improvement Programme (CIP) requirement increases costs.
LINKS TO STRATEGIC OBJECTIVES:	Healthy finances: Having Healthy Finances by providing better, more effective patient care that makes resources go further.
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)
SUBSIDIARY IMPLICATIONS:	Subsidiary figures are incorporated

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 review and **NOTE** the financial performance and actions being taken to address issues of concern.

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2020/21

March 2021

Director of Finance and Performance Management
Philip Cave

Contents and Appendices

Month 12 (March) 2020/21

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Month 12 (March) 2020/21

Executive Summary

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The impact of Covid-19 has paused the NHS business planning process. Nationally-mandated interim financial regime and contracting arrangements were in place for 2020/21.

From April to September 2020 the Trust was funded to financial breakeven through National block and top-up payments. For October 2020 to March 2021 the Trust was funded via:

1) A block payment based on estimated services commissioned by NHS England and Clinical Commissioning Groups (CCGs) to cover all costs including an estimate for Covid-19 costs
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Under the new rules the EKHUFT financial plan for 2020/21 is breakeven, excluding an assessment for the value of un-used annual leave at year-end of £5m, which has subsequently been fully funded at the actual value of £4.1m.

The technical adjustments remove factors which are not considered by NHSE/I when assessing our financial performance. The £4.2m year-end adjustment is driven by the net impact of an £8.4m impairment following the annual revaluation exercise partially offset by £4.2m of capital donations/grants received.

	This Month			Year to Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
EKHUFT Income	63,512	88,095	24,584	743,559	777,769	34,211
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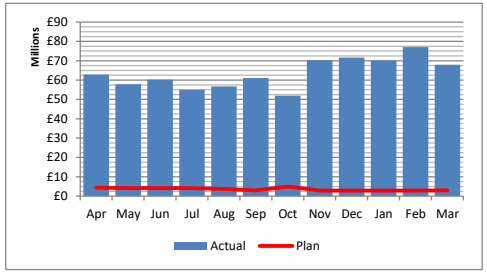
Consolidated I&E Position (pre Technical adjs)	**(5,000)**	**(5,344)**	**(344)**	**(4,975)**	**(4,263)**	**712**
Technical Adjustments	0	4,749	4,749	(25)	4,256	4,281
Consolidated I&E Position (incl Top Up)	**(5,000)**	**(595)**	**4,405**	**(5,000)**	**(7)**	**4,993**

The Trust has identified £5.1m of additional costs due to Covid-19 in March along with lost income of £0.7m, bringing the total financial impact of Covid-19 to £62.8m for the full financial year.

Income and Expenditure G

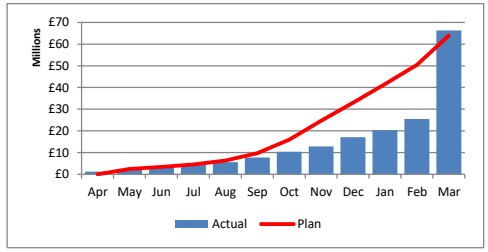
The Trust achieved a £0.6m deficit in March, which was £4.4m better than the plan. There were a number of year-end adjustments required, following national guidance, causing some significant variances in month as compared to the 2020/21 financial plan:
- A non-clinical income favourable variance of £20.2m, due to a combination of £14m relating to DHSC PPE outbound stock, £4m from NHSE/I to cover the cost of annual leave carried forward due to the Covid-19 pandemic, and £2m to cover Covid-19 costs falling outside the Trust's funding envelope.
- A clinical variance of £4.4m mainly due to additional CCG funding received at year-end for growth.
- A non-pay overspend of £23.9m mainly due to a combination of £10m PPE procured centrally via the DHSC offset by non-clinical income, a £8.4m impairment as a result of the annual estate valuation process (which is a technical adjustment and does not count against our I&E target), agreed 2gether equipment purchases (beds, mattresses, linen etc) totalling £3.2m and the impact of movement in stock holding £0.5m.

Cash G



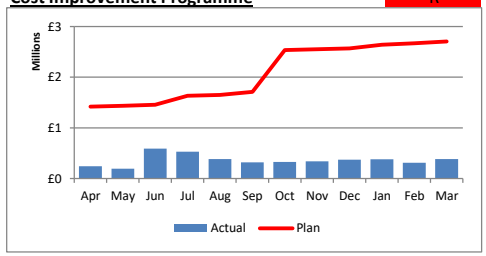
The Trust's cash balance at the end of March was £68m which was £65m above plan due to a combination of PDC capital receipts ahead of supplier payments and the NHSE/I block payment on account to cover anticipated operational costs in advance.

Capital Programme G



Total capital expenditure at the end of March was £70.7m which includes £3.6m of donated equipment recognised in March for which the Trust has received external funding.

Cost Improvement Programme R



The Trust planned to deliver £25m of CIP in 2020/21 in our submitted NHSE/I draft plan. In light of the national directive to focus on the operational response to Covid-19 EKHUFT had a reduced ability to make efficiency savings and delivered £0.4m of savings in March bring the full year savings total to £4.4m.

Income and Expenditure Summary
Month 12 (March) 2020/21

Unconsolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Electives	8,082	4,823	(3,259)	71,122	54,361	(16,761)	71,122
Non-Electives	16,635	17,453	818	181,205	179,489	(1,716)	181,205
Accident and Emergency	3,107	2,091	(1,016)	33,750	30,379	(3,371)	33,750
Outpatients	7,239	7,174	(65)	67,338	66,665	(674)	67,338
High Cost Drugs	5,260	4,075	(1,185)	57,315	54,444	(2,871)	57,315
Private Patients	(13)	(9)	4	(1,652)	155	1,807	(1,652)
Other NHS Clinical Income	19,536	13,953	(5,583)	246,440	212,102	(34,338)	246,440
Other Clinical Income	276	14,932	14,656	2,890	64,216	61,326	2,890
Total Clinical Income	**60,121**	**64,491**	**4,371**	**658,408**	**661,810**	**3,402**	**658,408**
Non Clinical Income	3,391	23,604	20,213	85,151	115,960	30,808	85,151
Total Income	**63,512**	**88,095**	**24,584**	**743,559**	**777,769**	**34,211**	**743,559**
Expenditure							
Substantive Staff	(41,246)	(40,341)	905	(407,876)	(403,070)	4,806	(407,876)
Bank	(2,028)	(3,302)	(1,274)	(23,568)	(28,048)	(4,479)	(23,568)
Agency	(3,614)	(4,094)	(480)	(39,116)	(38,426)	690	(39,116)
Total Pay	**(46,888)**	**(47,737)**	**(849)**	**(470,560)**	**(469,543)**	**1,017**	**(470,560)**
Non Pay	(19,443)	(36,508)	(17,064)	(254,739)	(283,607)	(28,868)	(254,739)
Total Expenditure	**(66,332)**	**(84,245)**	**(17,913)**	**(725,299)**	**(753,150)**	**(27,851)**	**(725,299)**
Non-Operating Expenses	(2,306)	(9,144)	(6,838)	(24,484)	(30,701)	(6,217)	(24,484)
Income and Expenditure Surplus/(Deficit)	**(5,126)**	**(5,293)**	**(167)**	**(6,224)**	**(6,082)**	**142**	**(6,224)**

Consolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Clinical Income	61,075	86,284	25,209	669,775	695,130	25,355	669,775
Non Clinical Income	3,169	20,718	17,549	83,024	110,637	27,613	83,024
Total Income	**64,244**	**107,002**	**42,758**	**752,799**	**805,767**	**52,968**	**752,799**
Expenditure						-	
Pay	(49,722)	(68,944)	(19,222)	(505,397)	(525,291)	(19,894)	(505,397)
Non Pay	(17,176)	(33,741)	(16,565)	(227,262)	(253,605)	(26,343)	(227,262)
Total Expenditure	**(66,898)**	**(102,685)**	**(35,787)**	**(732,659)**	**(778,896)**	**(46,237)**	**(732,659)**
Non-Operating Expenses	(2,346)	(9,661)	(7,315)	(25,115)	(31,134)	(6,019)	(25,115)
Income and Expenditure Surplus/(Deficit)	**(5,000)**	**(5,344)**	**(344)**	**(4,975)**	**(4,263)**	**712**	**(4,975)**

Clinical Income

The Covid-19 income regime changed in October- still supporting, but not guaranteeing, Group income at a level which delivers a break-even position.

All NHS Trusts were required to submit a new plan reflecting the change in payment methodology and part of this was to reset the M1-6 plan to actuals. There are no commissioning contracts in year. After Month 6, the Commissioner allocated payments have remained, but there are a number of changes:

We have been allocated a budget of £3.0m per month to cover Covid-19 costs, the Top up funding has also been increased by £0.9m to £4.0m and we were granted an additional £3.5m growth funding. This includes CCG invoices from Spencer Private Hospitals and the costs of the new Urgent Treatment Centres. These funding streams replace the retrospective top up received in M1-6. All these payments have moved from being funded by NHSE/I centrally to being commissioned by Kent and Medway CCG. The level should allow the Trust to breakeven with the exception of the value of the Annual Leave accrual.

The UTCs are still being directly commissioned by CCGs at present and are expected to move to be hosted by the Trust within the short-term.

For presentation, the Covid-19 specific payments, Top-Ups and Growth funding have all moved from Other Income to Clinical Income from M7 onwards.

The consolidated clinical income position includes £16.5m of additional pension contribution which offsets an equal increase in pay cost, in line with national guidance.

Non-Clinical Income and Expenditure

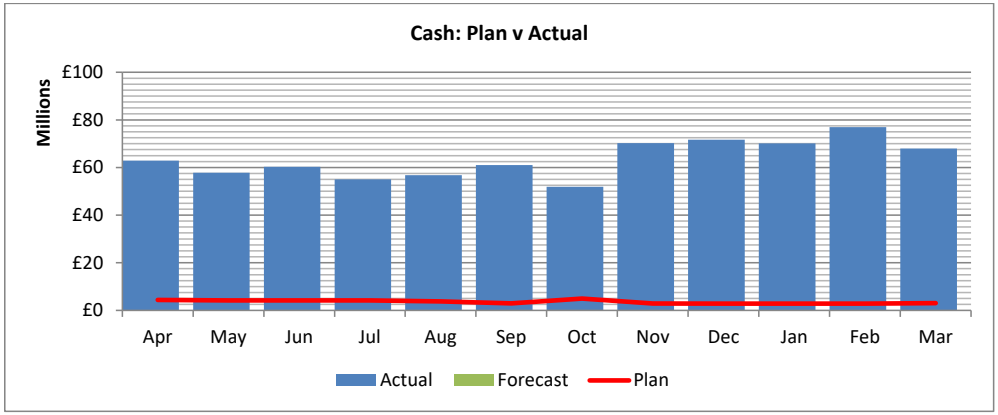
Non-clinical income is favourable to plan in March by £20.2m and by £30.8m YTD. In month the trust received £4.0m income to cover the cost of annual leave carried forward, and £2.2m net income for Covid-19 costs falling outside the Trust's funding envelope. Cash donations for the purchase of capital assets are favourable to plan by £13.8m in month relating to DHSC PPE outbound stock and donated capital assets. The YTD variance includes favourable variances of £9.0m income relating to Covid-19, £4.0m for carried forward annual leave and £14.3m donated asset income. Income relating to the capital goods scheme stands at £0.6m and income relating to education and training, car parking, overseas nurse recruitment and GP trainee salary recharges is favourable to plan by a total of £1.9m.

Total expenditure is adverse to plan in March by £17.8m and adverse to plan YTD by £27.8m. Covid-19 expenditure stands at £5.1m in month and £55.3m YTD.

Pay performance is adverse to plan in March by £0.8m and favourable to plan by £1.0m YTD. Total expenditure on pay in March was £47.7m, an increase of £7.0m when compared to February. This increase relates mainly to accrued expenditure for annual leave and Covid Wellbeing days carried forward totalling £5.1m, recognition of £1m for costs relating to the Flowers case and increased agency costs of £1.2m.

Expenditure on non-pay is adverse to plan in March by £17.1m and by £28.9m YTD, mainly driven by DHSC PPE stock of £10.1m offset by other income, contract changes and equipment purchases through 2gether of £3.2m and overspends on drugs and clinical supplies of £7.5m. Non-pay expenditure increased by £11.0m in March, mainly relating to the PPE stock adjustment and increased 2gether costs, offset by reduced bad debt provisions.

Cash Flow
Month 12 (March) 2020/21



Unconsolidated Cash balance was £67.9m at the end of March 21, £64.9m above plan.

Cash receipts in month totalled £72.3m (£16.4m above plan)

As part of the Covid-19 response, the Trust moved to block contract payments from April 20. The March block payments were received from Kent & Medway CCG in February, with only £4.8m received from the CCG in March, £38.4m below plan .

Capital PDC receipts totalled £48.9m in March. (48.9m above plan)

HMRC VAT reclaim receipt in March was £4.5m (£3.0m above plan)

No PDC revenue support was required in month.

Cash payments in month totalled £81.4m (£25.6m above plan)

Creditor payment runs including Capital payments were £26.8m (£15.4m above plan).

Payments to 2gether Support Solutions were £16.8m (£5.5m above plan)

Payroll was £34.7m (£4.0m above plan).

Working Capital Facility

In September, all revenue and capital loans were converted to PDC, reducing the Trusts borrowings to nil.

Revenue PDC

£4.0m was drawn down as PDC in April 2020 as per plan.

No additional support has been required since April due to the block and top up payments received in 2020/21.

Creditor Management

In the closing 2 weeks of March 2020, the Trust moved to pay invoices to 7-day terms to protect suppliers through COVID-19. This has continued throughout the year and will continue until further guidance is received in 2021/22.

At the end of March 2021, the Trust was recording 55 creditor days (Calculated as invoiced creditors at 31st March/ Forecast non-pay expenditure x 365).

Clinical Income

Month 12 (March) 2020/21

Trust Income Plan	Trust Actual Income	Income Variance
£658.408m	£661.810m	£3.402m

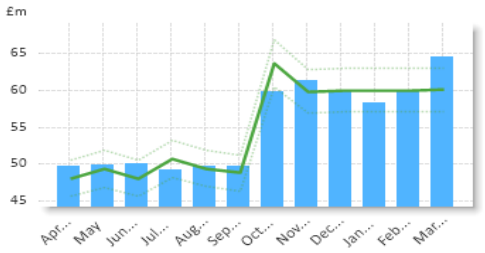
2020/21 - Month 12 Model

East Kent Hospitals University NHS
NHS Foundation Trust

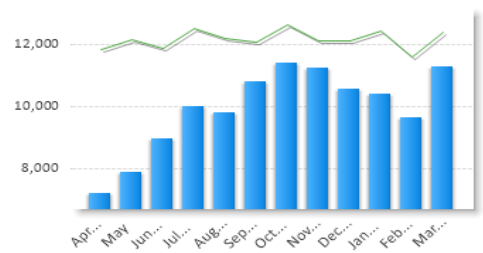
	Year to Date			This Month vs. Run Rate		
Summary	Plan	Actual	Variance	Actual	Run Rate to M11	Var to M11 Run Rate
1a Total Non Elective Spells	176.6	176.1	(0.5)	17.1	14.4	2.7
1b Total Non Elective Excess Bed Days	4.6	3.4	(1.2)	0.3	0.3	(0.0)
2 Accident & Emergency	33.7	30.4	(3.4)	2.0	2.6	(0.6)
3a Total Elective Spells	70.5	53.9	(16.5)	5.0	4.4	0.6
3b Total Elective Excess Bed Days	0.7	0.5	(0.2)	0.0	0.0	0.0
4a New Outpatient Attendances	29.2	28.3	(0.9)	3.0	2.3	0.7
4b Outpatient Follow Up Attendances	36.6	36.6	0.1	3.7	3.0	0.7
5a Other PbR Cost Per Case	38.6	39.0	0.4	3.3	3.2	0.1
5b Non-PbR Cost Per Case	124.7	115.4	(9.4)	10.1	9.6	0.5
6 Block Agreements	158.3	183.1	24.7	15.3	15.3	0.0
7 Risks and Adjustments	(15.1)	(4.8)	10.3	1.8	(0.6)	2.4
8 Contract Adjustments	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
9c Adjust Prior Month Reported Position	(0.0)	-	0.0	2.7	(0.2)	3.0
Grand Total	**658.4**	**661.8**	**3.4**	**64.5**	**54.3**	**10.2**

	This Month			Year to Date			Annual
Care Group Income £m	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Cancer Services	4.0	4.0	0.0	47.9	47.9	(0.0)	47.9
Central	12.9	17.2	4.3	70.7	73.8	3.1	70.7
Clinical Support Services	4.6	4.6	0.0	59.7	59.7	0.0	59.7
General and Specialist Medicine	14.0	14.0	0.0	149.6	149.9	0.3	149.6
Surgery - Head and neck, Breast Surgery a...	3.0	3.0	(0.0)	44.2	44.2	0.0	44.2
Surgery and Anaesthetics	8.5	8.5	0.0	119.1	119.1	0.0	119.1
Urgent and Emergency Care	7.1	7.1	(0.0)	89.7	89.7	(0.0)	89.7
Women's and Children's Services	6.0	6.0	(0.0)	77.6	77.6	(0.0)	77.6
	60.1	**64.5**	**4.4**	**658.4**	**661.8**	**3.4**	**658.4**

Income by Month



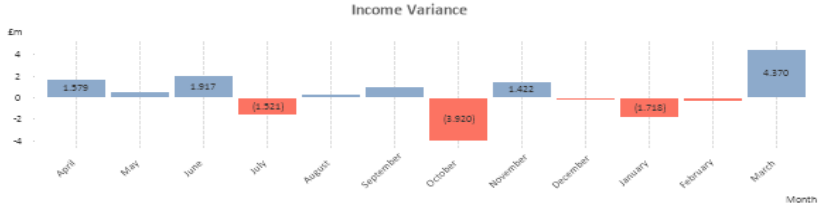
Monthly WAU - vs Plan



	This Month			Year to Date			Annual
Commissioner Group	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Kent and Medway CCG	49.8	50.3	0.5	541.8	541.5	(0.3)	541.8
NHS England SS	5.5	5.1	(0.4)	82.1	76.8	(5.3)	82.1
Public Health & Secondary Dental	1.2	1.4	0.1	14.6	15.8	1.1	14.6
NHS England - Rechargeable Drugs	2.3	1.9	(0.4)	13.9	14.6	0.6	13.9
Cancer Drugs Fund and Hep C	0.4	(0.2)	(0.6)	4.1	4.1	0.0	4.1
Other Organisations	0.3	1.7	1.4	2.0	5.4	3.4	2.0
Out of Area CCGs	0.6	0.2	(0.5)	(0.0)	2.2	2.3	(0.0)
Prior Year Income	0.0	4.2	4.2	(0.1)	1.4	1.5	(0.1)
	60.1	**64.5**	**4.4**	**658.4**	**661.8**	**3.4**	**658.4**

Total Income Var

Income Variance



Almost all Income up to for the year has been set by NHSE/I and allocated to commissioners at a level of £49.4m per month due to the Covid-19 payment methodology.

In addition, £10.5m per month of Covid-19 and other top-ups have been transferred from Other Income from Month 7 onwards. These payments are now paid by Kent and Medway CCG and are fixed, rather than being flexed to keep the Trust at breakeven. The elements are Covid-19 Prospective funding £3.0m, Central Top-Up £4.0m and Growth of £3.5m, and include the CCG-funded elements of Spencer Private Hospitals and the new UTCs. Whilst previously the income for UTCs was included in our position, and was therefore showing an adverse variance. The CCGs have agreed to pay the full planed value of £3.6m so no longer showing an adverse variance.

The Variable element of High Cost drugs with NHS England has been reconciled with NHSE is favourable to plan by £2.2m

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

The Trust has released £1m of provisions in month as year end positions on high cost drugs have been reached with commissioners. However, the Trust has made provisions for Breast screening, international nursing and the clinical excellence award totalling £0.89m plus a provision been made for the cancer drugs fund of £0.6m.

Activity

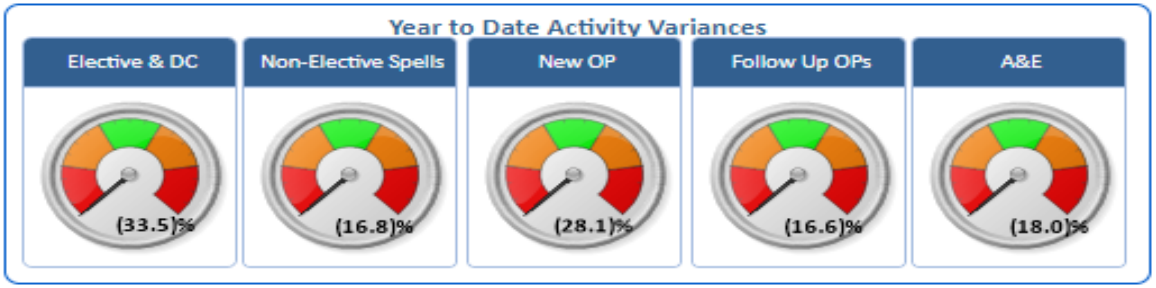
Month 12 (March) 2020/21

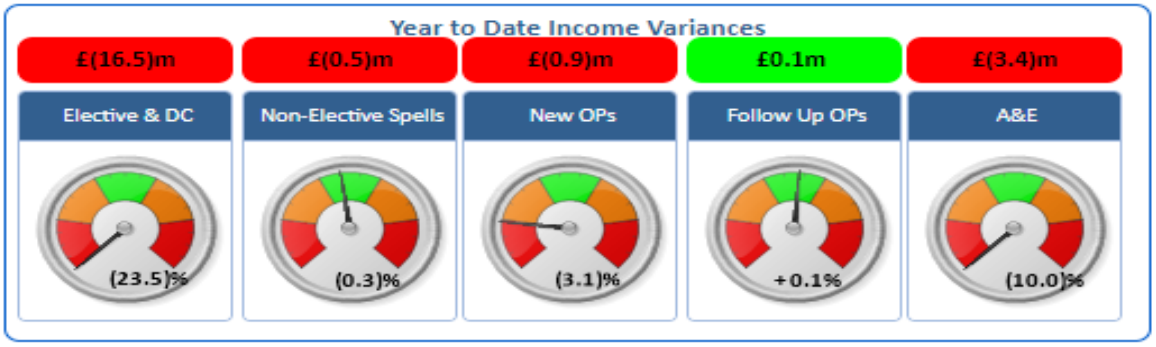
Trust Income Plan	Trust Actual Income	Income Variance
£658.408m	£661.810m	£3.402m

2020/21 - Month 12

East Kent Hospitals University NHS
NHS Foundation Trust

	Year to Date Activity			Year to Date Income £m			Average Tariffs	
Point of Delivery	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual
1a Total Non Elective Spells	87,457	72,784	(14,673)	£176.6 m	£176.1 m	£(0.5)m	£2,019	£2,419
2 Accident & Emergency	231,228	189,705	(41,523)	£33.7 m	£30.4 m	£(3.4)m	£146	£160
3a Total Elective Spells	88,772	59,044	(29,728)	£70.5 m	£53.9 m	£(16.5)m	£794	£913
4a New Outpatient Attendances	240,267	172,802	(67,465)	£29.2 m	£28.3 m	£(0.9)m	£122	£164
4b Outpatient Follow Up Attendances	506,367	422,364	(84,003)	£36.6 m	£36.6 m	£0.1 m	£72	£87
	1,154,090	**916,699**	**(237,391)**	**£346.6 m**	**£325.3 m**	**£(21.3)m**	**£300**	**£355**





The recent change in Covid-19 cases means that services have been under pressure, but the Trust has been more prepared to deal with challenges in this second wave. Electives and day cases are operating at 32% under planned levels in March, compared to 57% under in February. YTD performance is 33% adverse against plan.

Outpatients have operated at 17% over plan during March, compared to 20% adverse against plan in February and January which was 28% adverse to plan. YTD outpatients are 20% adverse against plan.

Physical Outpatient capacity on the Hospital sites has been reduced following Government guidance, but the Trust continues to work hard to increase Virtual outpatient capacity up to the level required to fill the gap. Virtual capacity has been over 50% of total possible Outpatient activity for the last eight months and above 60% for the last three months.

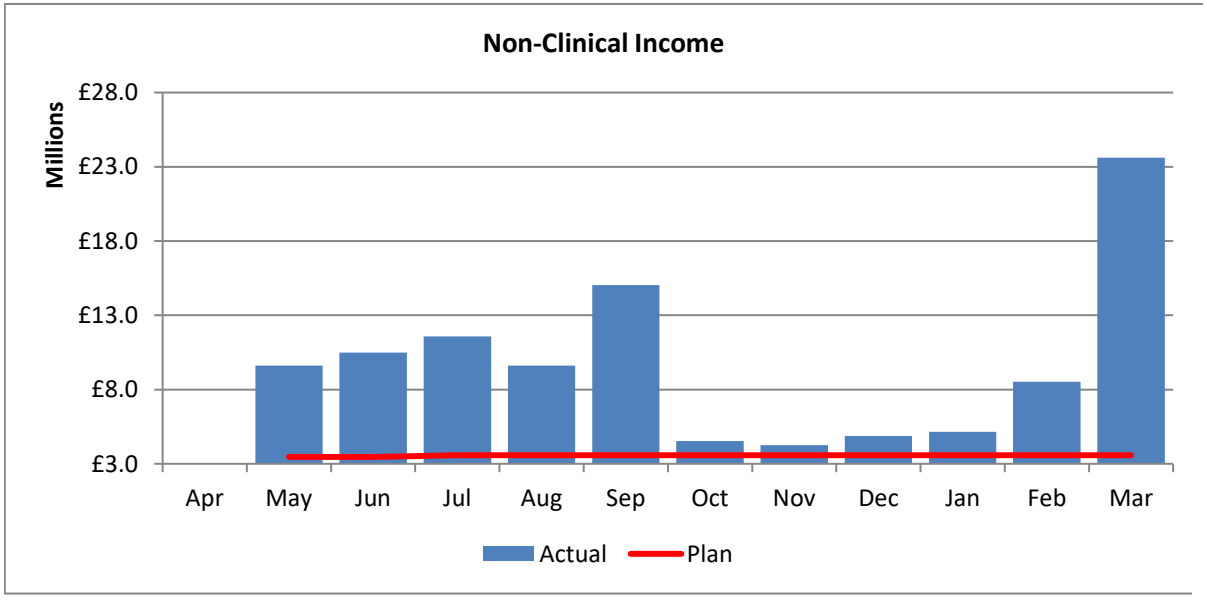
The levels of A&E attendances is continuing to show an underperformance against plan, although the level of adverse variance is reducing. March being 18% adverse compared to February which was 24% and 27% in January.

Non-Electives actual activity continues to underperform against plan, however similar to A&E this adverse variance is reducing month on month. March adverse variance is 3% compared to February which was 19% adverse, with 27% adverse in January and December.

Non Clinical Income

Month 12 (March) 2020/21

Non-Clinical Income	This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Non-patient care services	1,156	1,552	395	14,958	18,133	3,175	14,958
Research and development	229	194	(35)	2,752	2,736	(16)	2,752
Education and Training	1,363	1,261	(102)	16,235	16,678	443	16,235
Car Parking income	56	99	43	541	729	188	541
Staff accommodation rental	181	227	46	2,224	2,285	61	2,224
Property rental (not lease income)			()	1		(1)	1
Cash donations / grants for the purchase of capital assets	81	13,834	13,754	899	15,192	14,293	899
Charitable and other contributions to expenditure	13	15	2	154	166	12	154
Other	313	6,423	6,109	47,387	60,041	12,653	47,387
Total	**3,391**	**23,604**	**20,213**	**85,151**	**115,960**	**30,808**	**85,151**
			596.06%			36.18%	
			Favourable			Favourable	



Non-clinical income is favourable to plan in March by £20.2m and by £30.8m YTD. In month the trust received £4.0m from NHSI to cover the cost of annual leave carried forward due to the Covid-19 pandemic, and £2.2m net income for Covid-19 costs falling outside the Trust's funding envelope, including loss of non-NHS income. Cash donations for the purchase of capital assets are favourable to plan by £13.8m in month relating to DHSC PPE outbound stock (£10.1m offset to clinical supplies expenditure) and donated capital assets (£3.6m removed from accounts as a technical adjustment).

The YTD variance includes favourable variances of £9.0m income relating to Covid-19, £4.0m for carried forward annual leave and £14.3m donated asset income. Income relating to the capital goods scheme stands at £0.6m and income relating to education and training, car parking, overseas nurse recruitment and GP trainee salary recharges is favourable to plan by a total of £1.9m.

Pay
Month 12 (March) 2020/21

Pay Expenditure	WTE This Month			This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Permanent Staff										
Medical and Dental	1,280	1,274	6	(13,773)	(11,940)	1,833	(127,997)	(122,329)	5,669	(127,997)
Nurses and Midwives	2,684	2,372	311	(10,648)	(10,858)	(210)	(108,017)	(108,056)	(39)	(108,017)
Scientific, Therapeutic and Technical	1,554	1,512	42	(5,237)	(6,230)	(993)	(60,999)	(62,235)	(1,236)	(60,999)
Admin and Clerical	1,589	1,472	116	(5,727)	(4,430)	1,297	(41,221)	(40,263)	957	(41,221)
Other Pay	1,647	1,544	104	(5,037)	(5,786)	(749)	(60,094)	(59,553)	542	(60,094)
Permanent Staff Total	**8,754**	**8,174**	**580**	**(40,423)**	**(39,244)**	**1,179**	**(398,329)**	**(392,436)**	**5,893**	**(398,329)**
Waiting List Payments										
Medical and Dental	0	0	0	(113)	(183)	(70)	(1,019)	(1,346)	(327)	(1,019)
Waiting List Payments Total	**0**	**0**	**0**	**(113)**	**(183)**	**(70)**	**(1,019)**	**(1,346)**	**(327)**	**(1,019)**
Medical Locums/Short Sessions										
Medical and Dental	0	51	(51)	(711)	(914)	(204)	(8,527)	(9,288)	(760)	(8,527)
Medical Locums/Short Sessions Total	**0**	**51**	**(51)**	**(711)**	**(914)**	**(204)**	**(8,527)**	**(9,288)**	**(760)**	**(8,527)**
Substantive	**8,754**	**8,225**	**529**	**(41,246)**	**(40,341)**	**905**	**(407,876)**	**(403,070)**	**4,806**	**(407,876)**
Bank										
Medical and Dental	17	36	(19)	(356)	(510)	(154)	(4,271)	(4,519)	(249)	(4,271)
Nurses and Midwives	99	380	(281)	(916)	(1,725)	(810)	(10,226)	(13,258)	(3,032)	(10,226)
Scientific, Therapeutic and Technical	6	11	(6)	(51)	(67)	(16)	(608)	(611)	(3)	(608)
Admin and Clerical	25	90	(66)	(139)	(262)	(124)	(1,663)	(2,158)	(495)	(1,663)
Other Pay	92	255	(163)	(567)	(737)	(170)	(6,801)	(7,501)	(701)	(6,801)
Bank Total	**238**	**773**	**(536)**	**(2,028)**	**(3,302)**	**(1,274)**	**(23,568)**	**(28,048)**	**(4,479)**	**(23,568)**
Agency										
Medical and Dental	34	94	(60)	(1,403)	(1,310)	93	(15,813)	(14,873)	941	(15,813)
Nurses and Midwives	168	298	(130)	(1,381)	(1,666)	(285)	(13,626)	(13,329)	297	(13,626)
Scientific, Therapeutic and Technical	2	7	(5)	(29)	(44)	(15)	(273)	(548)	(275)	(273)
Admin and Clerical	0	0	0	(2)		2	(27)	(14)	14	(27)
Other Pay	0	147	(147)	(1)	(348)	(347)	(8)	(699)	(691)	(8)
Agency Total	**204**	**546**	**(342)**	**(2,816)**	**(3,367)**	**(551)**	**(29,747)**	**(29,462)**	**285**	**(29,747)**
Direct Engagement - Agency										
Medical and Dental	8	44	(37)	(707)	(650)	57	(8,204)	(8,090)	114	(8,204)
Scientific, Therapeutic and Technical	6	10	(5)	(91)	(77)	14	(1,165)	(874)	292	(1,165)
Direct Engagement - Agency Total	**13**	**55**	**(41)**	**(798)**	**(727)**	**71**	**(9,369)**	**(8,964)**	**405**	**(9,369)**
Agency	**217**	**601**	**(383)**	**(3,614)**	**(4,094)**	**(480)**	**(39,116)**	**(38,426)**	**690**	**(39,116)**
Total	**9,209**	**9,599**	**(390)**	**(46,888)**	**(47,737)**	**(849)**	**(470,560)**	**(469,543)**	**1,017**	**(470,560)**
						-1.81%			0.22%	
						Adverse			Favourable	

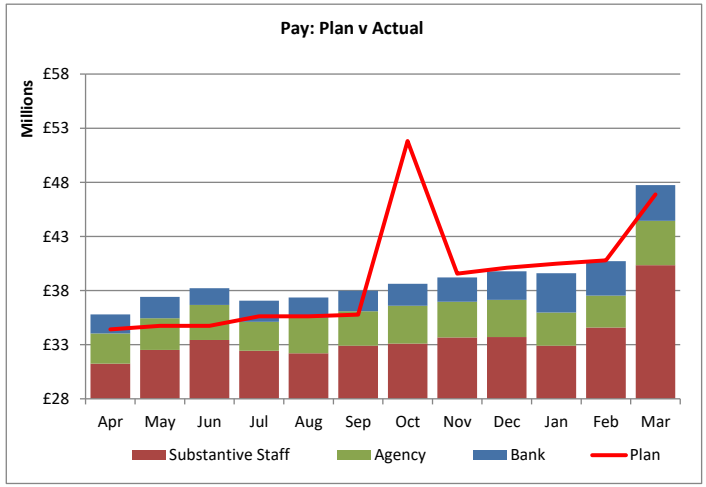
Pay performance is adverse to plan in March by £0.8m and favourable to plan by £1.0m YTD (0.22%).

Total expenditure on pay in March was £47.7m, an increase of £7.0m when compared to February. Costs grew in all pay headings in March but the increase relates mainly to substantive staff, where expenditure to recognise annual leave carried forward and the Wellbeing Day relating to the Covid-19 effort totals £5.1m. Costs of £1.0m relating to the Flowers case were also provided for in March. Expenditure on agency and directly engaged staff increased by £1.2m.

Expenditure on all substantive staff, including locums and waiting list payments is favourable to plan in March by £0.9m and by £4.8m YTD.

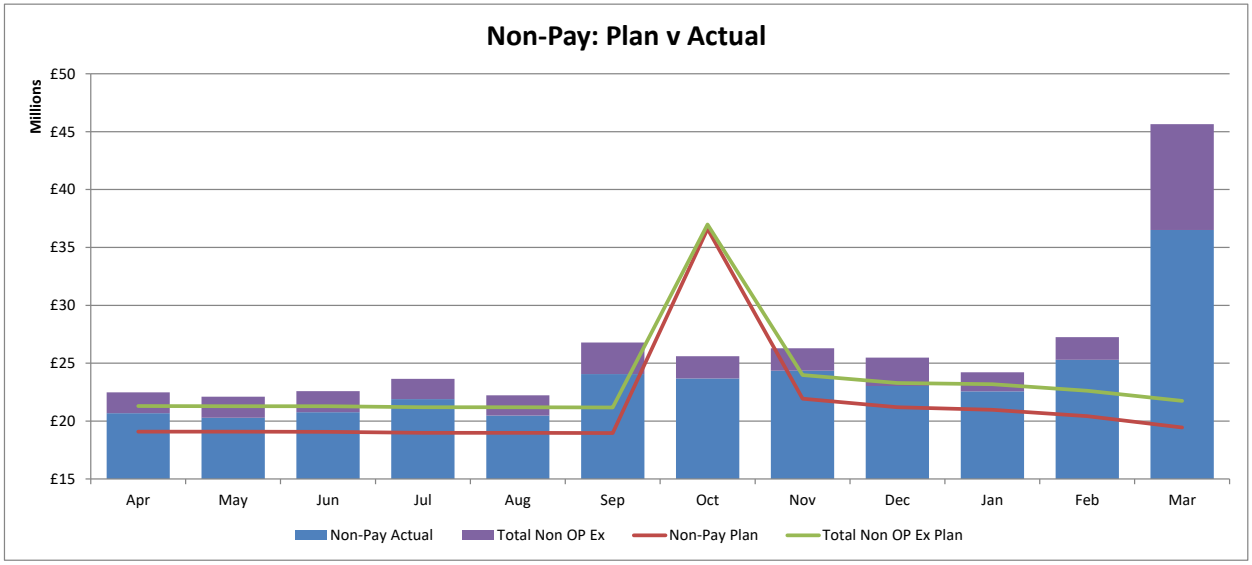
Expenditure on bank and agency staff is adverse to plan in March by £1.8m and by £3.8m YTD, reflecting the continued increase in usage of temporary staffing to manage the impact of Covid-19.

The significant spike in plan in October was due to rebasing the Trust's financial plan to align with the national resubmission requirement.



Non-Pay
Month 12 (March) 2020/21

	This Month			Year to Date			Annual
£000	**Plan**	**Actual**	**Var.**	**Plan**	**Actual**	**Var.**	**Plan**
Drugs	(5,235)	(6,631)	(1,396)	(62,058)	(67,770)	(5,712)	(62,058)
Clinical Supplies and Services - Clinical	(992)	(12,961)	(11,969)	(28,027)	(39,943)	(11,916)	(28,027)
Supplies and Services - Non-Clinical	(8,116)	(12,283)	(4,167)	(103,999)	(110,366)	(6,367)	(103,999)
Non Executive Directors	(16)	(11)	5	(192)	(180)	12	(192)
Purchase of Healthcare	(572)	(222)	350	(6,165)	(4,579)	1,586	(6,165)
Education & Training	(94)	(873)	(779)	(1,127)	(2,475)	(1,348)	(1,127)
Consultancy	(104)	(139)	(34)	(938)	(1,398)	(461)	(938)
Premises	(1,058)	(2,040)	(981)	(13,789)	(14,102)	(313)	(13,789)
Clinical Negligence	(2,030)	(2,030)		(25,836)	(25,836)		(25,836)
Transport	(174)	(182)	(8)	(2,087)	(2,099)	(12)	(2,087)
Establishment	(253)	(443)	(191)	(3,034)	(3,863)	(829)	(3,034)
Other	(799)	1,307	2,106	(7,488)	(10,996)	(3,508)	(7,488)
Total Non-Pay Expenditure	**(19,443)**	**(36,508)**	**(17,064)**	**(254,739)**	**(283,607)**	**(28,868)**	**(254,739)**
Depreciation & Amortisation-Owned Assets	(1,676)	(1,315)	361	(16,860)	(15,274)	1,585	(16,860)
Impairment Losses		(8,411)	(8,411)		(8,411)	(8,411)	
PDC Dividend	(571)	(185)	386	(6,893)	(6,303)	590	(6,893)
Interest Receivable	198	1,007	809	2,375	2,326	(50)	2,375
Interest Payable	(257)	(241)	16	(3,107)	(3,041)	66	(3,107)
Total Non-Operating Expenditure	**(2,306)**	**(9,146)**	**(6,839)**	**(24,484)**	**(30,703)**	**(6,219)**	**(24,484)**
Total Expenditure	**(21,750)**	**(45,653)**	**(23,904)**	**(279,222)**	**(314,310)**	**(35,088)**	**(279,222)**



Non-pay expenditure is adverse to plan in March by £17.1m and adverse to plan by £28.9m YTD (11.33%).

Drug expenditure is adverse to plan in March by £1.4m and by £5.7m YTD. Pass-through drugs are adverse to plan in March by £1.2m and by £3.5m YTD. All other drugs are adverse to plan in month by £0.2m and by £2.2m YTD.

Supplies and services - clinical are adverse to plan in March by £12.0m and by £11.9m YTD. In month, PPE procured centrally via the DHSC costing £10.1m was accounted for as clinical supplies expenditure and offset by donated income. Breast screening and National Blood contracts are adverse to plan by £0.2m and notional CIP schemes are adverse to plan by £0.3m.

Supplies and services - non-clinical are adverse to plan in March by £4.2m and adverse to plan by £6.4m YTD. In month, agreed 2gether contract increases and equipment purchases (beds, mattresses, linen etc) totalling £3.2m and the impact of movement in stock holding was £0.5m. YTD variances are driven mainly by above plan consumable costs purchased via the OHF and contract variations with the subsidiary.

Management consultancy is marginally adverse to plan in month and adverse to plan by £0.5m YTD, mainly relating to the We Care programme and emergency flow consultancy.

Premises costs are adverse to plan by £1.0m in month and by £0.3m YTD. In month computer equipment purchases are adverse to plan by £0.5m and utilities are adverse to plan by £0.3m.

Other expenditure is favourable to plan in March by £2.1m and adverse to plan by £3.1m YTD. In month, provisions for bad debts have reduced by £2.6m following review and clarification of NHSI and Covid-19 related income streams. This is offset by a reduction of £0.4m to the business activity VAT rebate accounted for in February. YTD the variance is driven mainly by provisions for legal costs and bad debt provisions outside plan totalling £5.0m offset by gains on VAT rebates and slippage on planned developments.

Actual expenditure on non-pay in March was £36.3m, an increase of £11.0m when compared to expenditure in February. The increase is driven by DHSC PPE stock adjustment of £10.1m, offset by other income, £3.2m of agreed 2gether contract changes and equipment purchases and a total of £2.1m increase in drug and premises costs. This is offset by reduced provisions for bad debt.

The significant spike in plan in October was due to rebasing the Trust's financial plan to align with the national resubmission requirement.

Year-to-date, Non-Operating Expenditure is £6.2m worse than plan, driven by a combination of an £8.4m impairment following the Trust's annual valuation process partially offset by a £1.6 reduction in depreciation due to construction delays due to Covid.

Cost Improvement Summary

Month 12 (March) 2020/21

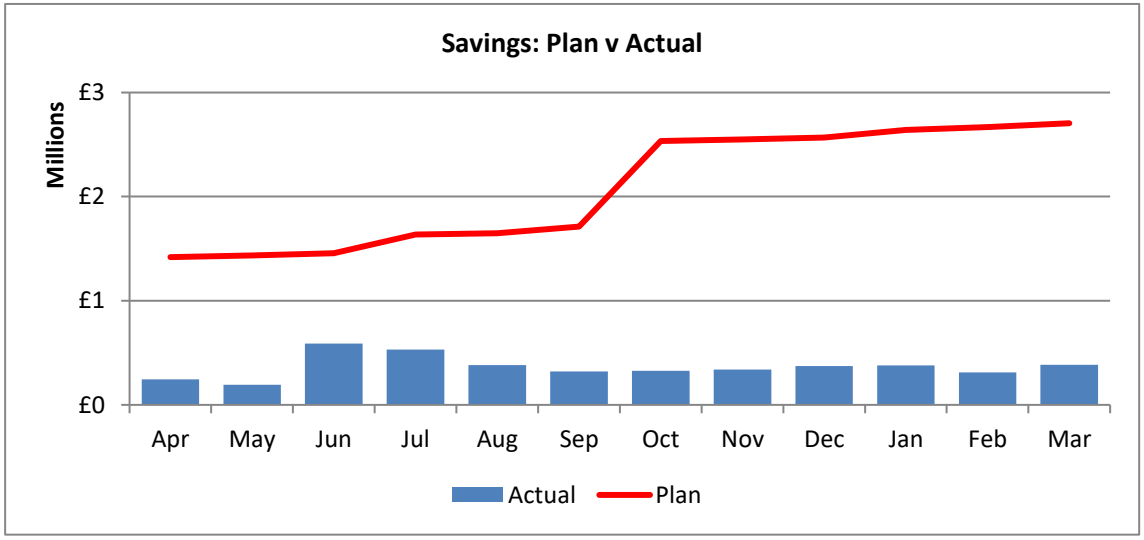
Delivery Summary	This Month			Year to Date		
Programme Themes £000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Agency	170	52	(119)	2,112	470	(1,643)
Bank	9	-	(9)	106	-	(106)
Workforce	141	42	(99)	1,401	840	(561)
Outpatients	40	-	(40)	250	-	(250)
Procurement	7	14	6	83	166	83
Medicines Value	56	82	27	865	653	(212)
Theatres	50	-	(50)	600	-	(600)
Care Group Schemes *	2,373	195	(2,178)	21,096	2,247	(18,850)
Sub-total	**2,846**	**385**	**(2,461)**	**26,514**	**4,375**	**(22,138)**
Central	(141)	-	141	(1,541)	-	1,541
Grand Total	**2,705**	**385**	**(2,320)**	**24,973**	**4,375**	**(20,598)**

* Smaller divisional schemes not allocated to a work stream

Delivered £000		
Month	**Target**	**Actual**
April	1,419	244
May	1,434	194
June	1,457	589
July	1,635	530
August	1,648	382
September	1,711	320
October	2,535	328
November	2,550	341
December	2,568	374
January	2,642	379
February	2,669	310
March	2,705	385
	24,973	**4,375**
		17.5%

Savings and Efficiencies

The annual savings plan of £25m is net of the cost of delivery. Savings achieved in March of £0.4m were below the plan of £2.7m. Most areas underperformed in month due to the ongoing operational focus on Covid-19 and Restore & Recover programme. Recurrent savings in March amounted to £0.35m, with £0.04m being on a non-recurrent basis. The YTD position shows £3.6m recurrent, and £0.8m non-recurrent savings. This shows a substantial decrease against the original plan. A pipeline of ideas is being developed as the basis for the 2021-22 efficiency programme.



Capital Expenditure
Month 12 (March) 2020/21

Capital Programme	Annual	Year to Date		
£000	Plan	Plan	Actual	Variance
Medical Equipment replacement (MDG)	2,517	2,517	4,282	(1,765)
Backlog maintenance/ patient environment (PEIC)	2,400	2,400	4,391	(1,991)
IT/ Systems replacement (IDG)	1,800	1,800	2,557	(757)
Electronic Medical Record (T3 system)	547	547	647	(100)
Replacement of Gamma cameras (CT SPECT)	605	605	417	188
Conversion of staff rooms QEQM	100	100	95	5
Installation of MRI QEQM	1,708	1,708	1,006	702
Installation of CT K&C	766	766	665	101
RAP area - ED WHH	1,983	1,983	1,238	745
New IR room K&C	500	500	982	(482)
Cardiac Catheter lab replacement	2,332	2,332	591	1,741
Radiology equipment (x-ray)	1,904	1,904	1,875	29
Endoscopy decontamination	1,563	1,563	924	639
COVID-19 - SEAU/ GAU tfr to OP from ED WHH	1,000	1,000	1,111	(111)
COVID-19 - 8 bed ITU WHH Build works	1,481	1,481	1,490	(9)
Right-sizing Womens Health (W&C 15)	40	40		40
Right-sizing Gynae nursing (W&C 16)	84	84	54	30
Costing Server	56	56	28	28
Donning & Doffing	690	690	817	(127)
Pathology TAT testing	288	288	176	112
Closed circuit smoke evacuation AIRSEAL	208	208	187	21
CEMG small estates schemes agreed at risk	234	234	89	146
Nasoendoscopes	329	329	346	(17)
ITU Expansion WHH	16,487	16,487	16,318	169
Renal Unit MTW - Remedial works	97	97		97
Medical Gases WHH - VIE	50	50	345	(295)
Donated assets	1,054	1,054	1,065	(11)
Elective Orthopaedics Centre	9,941	9,941	10,067	(126)
Energy Performance Contract (EPC - Breathe)	3,018	3,018	4,668	(1,650)
NEEF Lighting Retrofit	1,254	1,254		1,254
Kent and Medway Care Record (KMCR)	190	190	205	(15)
UTC's - EKHUFT 'host' of Primary Care	250	250	162	88
Emergency Department Expansion	7,000	7,000	2,762	4,238
Dental Lab KCH	305	305	270	34
Radiology mobile x-rays & ultrasound machines			408	(408)
Maternity CTG machines - LMS	97	97	81	16
Laboratory Information Management System			774	(774)
Medical equipment - prior year deferrals/ VAT rec	1,115	1,115	4,895	(3,780)
Unallocated Capital Funds			1,266	(1,266)
Total Trust position	**63,993**	**63,993**	**67,254**	**(3,261)**
2gether Support Solutions	350	350	716	(366)
Spencer Private Hospitals	176	176	196	(20)
Total Group position	**64,519**	**64,519**	**68,167**	**(3,648)**

Group depreciation	15,585
Donations	5,117
NHSE/I PDC	46,247
SALIX Government loan - EPC	2,018
Agreed System underspend	(800)
Total Group Capital funding	**68,167**

Capital Spend - YTD Position: The Group gross capital year-to-date spend to the end of Month 12 (March 2021) is £67.25m, plus £3.45m spend on Covid-19 capital. The actual spend position, excluding the Covid-19 related schemes spend, is £2.73m above the annual plan. However, the monthly phasing of the capital plan had been frozen at the July 2020 submission profile, as an update to capital plans was declared by NHSE/I as outside the scope of the Phase 2 plan submission in October 2020.

Capital Plan - YTD Position: Building on a capital plan first agreed in March 2020, as required by NHSE/I, the Trust resubmitted its 2020/21 capital plan at the end of May 2020 to meet a reduced CDEL (capital spending limit) issued to the Kent & Medway STP/ ICS. Subsequently, the Trust was required to re-submit its capital plan in July 2020 following Critical Infrastructure Risk (CIR) funding of £8.2m being awarded to the Trust by NHSE/I. Following confirmation of additional external funding for A&E expansion (£30m with £7m in 2020/21) and ITU capacity (£14m build only), a further re-prioritisation of the 2020/21 capital programme took place in August/ September, accommodating vital Covid-19 related schemes agreed by the Trust Board to proceed ahead of confirmation of external funding from NHSE/I.

The revised capital plan forecast position for Month 12 incorporates all additional funding streams confirmed for 2020/21, most significantly £4.2m of Covid-19 capital funding confirmed in mid-February 2021.

Major schemes - Key dates for completion: Elective Orthopaedics Centre (ELOC) - Spring 2021; ITU Expansion WHH - July 2021; ED Expansion WHH & QEQM - December 2021. Following an assessment of expected year-end accruals, £11.67m were identified, of which £8.4m related to the ITU Expansion - WHH and £2.3m to the Elective Orthopaedic Centre (ELOC). Further accruals included £0.2m for Radiology Equipment (X-Ray), £0.6m for NEEF Lighting Retrofit and £0.14m for the Fracture Clinic move to Management Offices.

The need to operate within the agreed CDEL limit, combined with a £1.6m reduction in the Group Depreciation, as a result of lower-than-expected recognised completed assets throughout the year, limited the level of accrued capital spend to £7.89m, allocated against the ITU Expansion - WHH scheme.

The gap between the identified accruals of £11.67m and the actual accrued spend of £7.89m will add a £3.78m cost pressure on the 2021/22 Capital Programme.

Standing Committees: The Patient Environment Investment Committee (PEIC), Medical Devices Group (MDG) and Information Development Group (IDG) have a collective overspend of £0.1m at the end of Month 12.

Capital Forecast: The capital forecast outturn is now monitored on a weekly basis, including a formal review by scheme, with a regularly updated delivery risk assessment completed.

Covid-19 Capital: Covid-19 related capital spend at the end of March 2021 (that had not been internally funded)

Statement of Financial Position
Month 12 (March) 2020/21

£000	Opening	To Date	Movement	
Non-Current Assets	**349,404**	**393,893**	**44,488**	▲
Current Assets				
Inventories	4,118	4,198	80	▲
Trade and Other Receivables	38,525	32,169	(6,356)	▼
Assets Held For Sale			-	
Cash and Cash Equivalents	13,893	67,943	54,050	▲
Total Current Assets	**56,536**	**104,311**	**47,775**	▲
Current Liabilities				
Payables	(33,470)	(38,167)	(4,697)	▲
Accruals and Deferred Income	(43,220)	(84,013)	(40,793)	▲
Provisions	(1,088)	(3,826)	(2,737)	▲
Borrowing	(125,325)		125,325	▼
Net Current Assets	**(146,567)**	**(21,695)**	**124,872**	▲
Non Current Liabilities				
Provisions	(3,054)	(3,171)	(117)	▲
Long Term Debt	(101,349)	(87,360)	13,988	▼
Total Assets Employed	**98,435**	**281,666**	**183,232**	▲
Financed by Taxpayers Equity				
Public Dividend Capital	207,655	394,480	186,825	▲
Retained Earnings	(165,923)	(172,005)	(6,082)	▼
Revaluation Reserve	56,702	59,191	2,489	▲
Total Taxpayers' Equity	**98,435**	**281,666**	**183,232**	▲

Non-Current asset values reflect in-year additions (including donated assets) less depreciation charges of £1.3m (£1.3m February) and the impact of the revaluation exercise. Non-Current assets also includes the loan and equity that finances 2gether Support Solutions.

Trust closing cash balances for January was £67.9m (£77.0m February) £64.9m above plan. See cash report for further details.

Trade and other receivables have decreased from the 2020/21 opening position by £6.4m (£27.9m decrease in February). Invoiced debtors have decreased from the opening position by £15.5m to £8.2m (£10.3m February) at the end of March.

All Working Capital and Capital borrowing was cleared by PDC in September 2020.

Payables have increased by £4.7m YTD (£3.5m decrease in February).

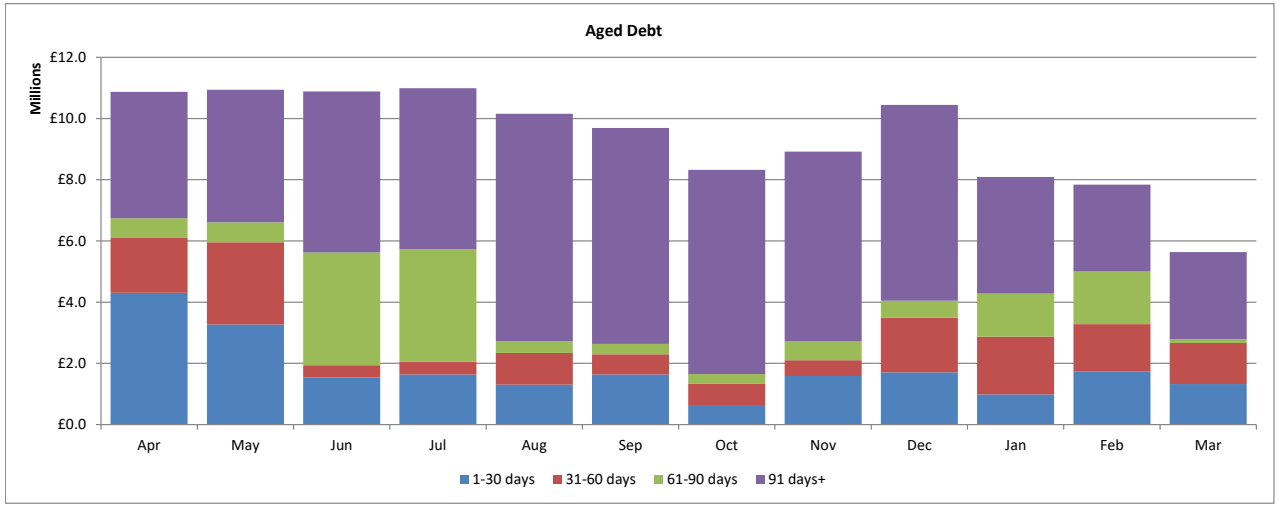
The large increase in accruals relate to capital and expenditure identified as part of the year-end process.

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

Working Capital
Month 12 (March) 2020/21

Top ten debtor balances outstanding as at 31/03/2021

Debtor Name	Current	1-30 Days	31-60 Days	61-90 Days	Over 90	Total
MEDWAY NHS FOUNDATION TRUST	79	55	55	111	619	920
SPENCER PRIVATE HOSPITALS LIMITED	432	39	331	50	61	914
2GETHER SUPPORT SOLUTIONS LTD	599	271			9	879
KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	293	259	276		13	841
DARTFORD AND GRAVESHAM NHS TRUST	62	62	62	123	386	693
PUBLIC HEALTH ENGLAND	479					479
HEALTH EDUCATION ENGLAND T1510	97				352	449
NHS ENGLAND Q88 SOUTH EAST (KENT, SURREY AND SUSSEX) LOC	296	1			139	437
NHS KENT AND MEDWAY CCG	359	9			3	371
MONITOR 90T	34			195		229
Total	**2,731**	**696**	**724**	**478**	**1,582**	**6,211**



Top ten creditor balances outstanding as at 31/03/2021

Supplier Name	Current	1-30 Days	31-60 Days	61-90 Days	Over 90	Total
2gether Support Solutions Ltd		10,991	0	59		11,050
Medway NHS Foundation Trust (RPA)	178	43	20		764	1,005
Spencer Private Hospitals Ltd		73	55	56	441	625
Maidstone & Tunbridge Wells NHS Trust (RWF)	488		18		25	531
Dell Corporation Ltd	501	6			1	508
NHS Professionals Ltd	485					485
NES Holdings (UK) Ltd	249	175				423
Abbott Medical UK Ltd		300			107	406
Softcat Ltd	308	16	12			336
CDW	252				1	251
Total	**2,460**	**11,602**	**107**	**115**	**1,337**	**15,621**

Total invoiced debtors have decreased from the opening position of £23.7m by £15.5m to £8.2m (of which £2.7m is current debt) following good work clearing historic debts and improving inter-company processes.

At 31st March there were no debtors owing over £1m.

- Medway NHS Foundation Trust owe £0.9m of which £0.6m is over 90 days old. Work is ongoing to resolve outstanding disputes.
- Spencer Private Hospitals owe £0.9m, of which £0.4m is current debt.
- 2gether Support Solutions owe £0.9m, of which, £0.6m is current debt.

Better Payment Practice Code	Last Year YTD Number	Last Year YTD £'000	This Year YTD Number	This Year YTD £'000
Non NHS				
Total bills paid in the year	57,064	460,732	62,848	512,018
Total bills paid within target	51,973	411,498	57,507	460,726
Percentage of bills paid within target	**91.1%**	**89.3%**	**91.5%**	**90.0%**
NHS				
Total bills paid in the year	2,691	41,092	2,926	43,202
Total bills paid within target	1,970	35,778	2,135	37,087
Percentage of bills paid within target	**73.2%**	**87.1%**	**73.0%**	**85.8%**
Total				
Total bills paid in the year	59,755	501,824	65,774	555,220
Total bills paid within target	53,943	447,276	59,642	497,813
Percentage of bills paid within target	**90.3%**	**89.1%**	**90.7%**	**89.7%**

Invoiced creditors have decreased by £4.9m from the opening position to £20.2m.

27% relates to current invoices with 10% or £2.1m over 90 days.

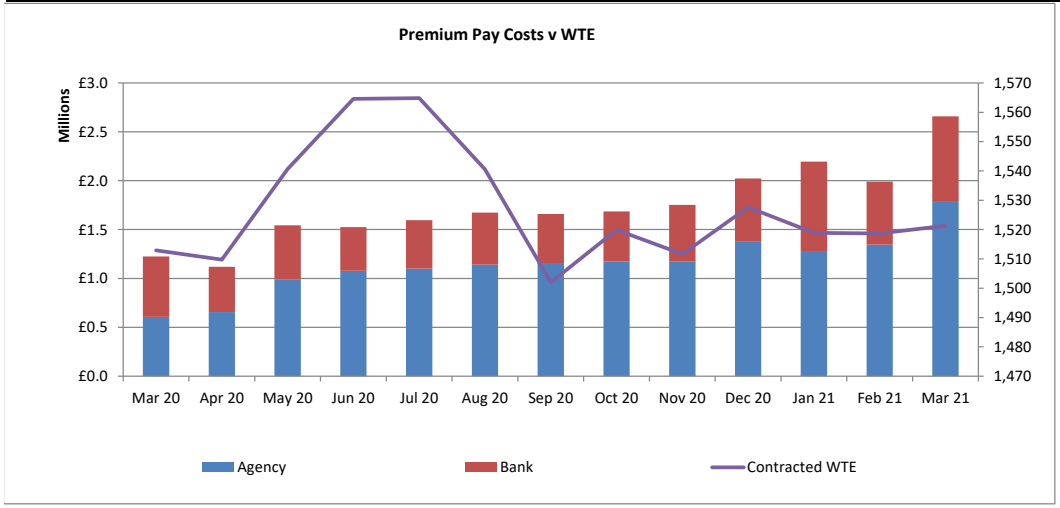
Overdue NHS creditors have decrease by £200k in the Month:

- Kings College Hospital NHS Foundation Trust (RJZ) - £36k
- Maidstone & Tunbridge Wells NHS Trust (RWF) - £-254k
- UCL Hospitals NHS Foundation Trust (RRV) - £37k
- NHS Resolution (ST1150) - £-39k

General and Specialist Medicine

Month 12 (March) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	2,829	1,367	(1,462)	20,650	14,984	(5,666)
Non-Electives	6,609	6,965	357	70,661	78,293	7,632
Accident and Emergency						
Outpatients	1,871	1,935	63	24,848	18,077	(6,771)
High Cost Drugs	802	930	128	9,629	9,767	139
Private Patients	5	4	(1)	58	16	(42)
Other NHS Clinical Income	1,848	2,808	960	23,576	28,655	5,079
Other Clinical Income	16		(16)	189	73	(117)
Total Clinical Income	**13,980**	**14,009**	**29**	**149,611**	**149,865**	**254**
Non Clinical Income	48	(44)	(92)	503	390	(113)
Total Income	**14,028**	**13,965**	**(63)**	**150,114**	**150,255**	**141**
Expenditure						
Substantive Staff	(5,512)	(6,332)	(820)	(69,276)	(70,864)	(1,588)
Bank	(712)	(875)	(164)	(8,488)	(7,170)	1,318
Agency	(1,431)	(1,783)	(352)	(11,460)	(14,254)	(2,793)
Total Pay	**(7,655)**	**(8,991)**	**(1,336)**	**(89,224)**	**(92,288)**	**(3,063)**
Purchase of Healthcare	(213)	(233)	(20)	(3,607)	(3,804)	(197)
Supplies and Services Clinical	(585)	(1,011)	(427)	(7,996)	(9,053)	(1,057)
Supplies and Services General	(74)	(82)	(7)	(898)	(865)	33
Drugs	(1,071)	(1,149)	(77)	(12,360)	(12,254)	106
All Other, incl Transport	(148)	(112)	36	(939)	(2,038)	(1,099)
Total Expenditure	**(9,746)**	**(11,577)**	**(1,831)**	**(115,024)**	**(120,301)**	**(5,277)**
Contribution	**4,282**	**2,388**	**(1,893)**	**35,090**	**29,954**	**(5,136)**



The Care Group financial position deteriorated by £1.9m in March to £5.1m adverse to plan YTD. Income is £0.1m favourable to plan, expenditure is adverse by £5.3m primarily due to unachieved savings of £3.5m and Covid-19 spend exceeding allocation by £1.5m, but also by high non-recurrent costs and premium pay in Month 12. The position YTD is offset by favourable variances during prior months on clinical non-pay.

Income:

The cumulative SLA Income "top-up" to reflect lost activity through Covid-19 is £7.8m, a £1.2m increase from February. Elective and Outpatient activity has been particularly impacted by the surge in Covid-19 admissions since December and is now £12.5m adverse YTD, a deterioration of £1.4m partly driven by a high back-ended endoscopy plan. March activity is ahead of plan for non-elective by £0.4m (£7.6m favourable YTD), notably due to additional bed capacity remaining open.

Pay:

Pay deteriorated by £1.3m to £3.1m adverse YTD; the run rate has increased by £1m from February predominantly due to increased temporary staffing costs and non-recurrent year end costs for pay arrears and selling annual leave. Monthly Covid-19 pay costs increased by £0.15m compared to February and are £0.65m higher than monthly allocation, driving the overspend in pay and predominantly due to the premium costs of opening additional capacity to manage bed pressures. Agency costs increased overall by £0.4m to £1.7m, driven by an increase in Nursing at WHH/QE to provide a pool of nursing, and enable delivery of Frailty.

Non-Pay:

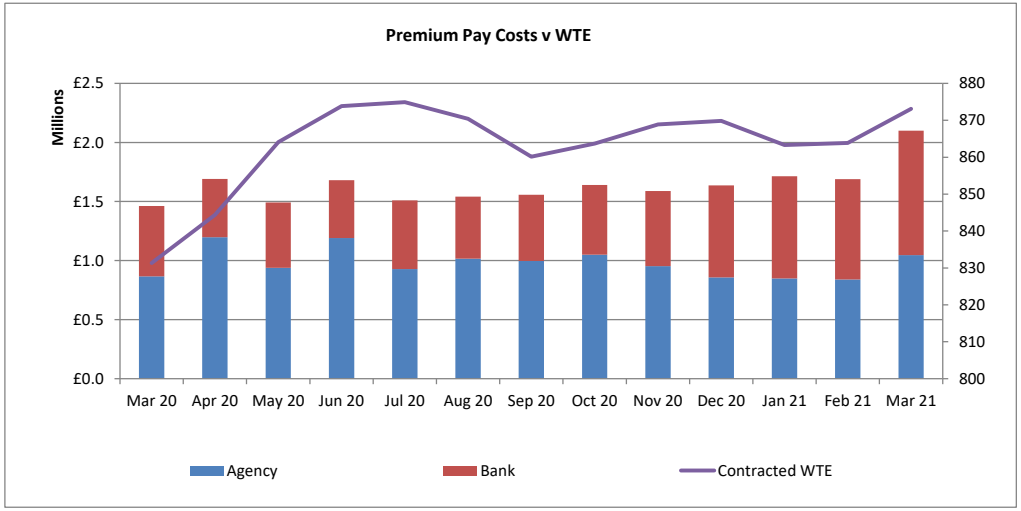
Non-Pay deteriorated by £0.5m in March and is £2.2m adverse YTD, with an increased run rate of £0.5m notably for purchases of consumables within elective services. The adverse position is also impacted by unachieved savings of £0.5m in-month and £3.4m YTD offset by prior month underspends on clinical consumables, and Covid-19 slippage of £0.2m. £0.2m cost is included within the position to offset the clinical income over-performance.

Covid-19:

Covid-19 costs of £1.5m have been incurred in March, an increase of £0.2m compared to February and is £0.5m higher than plan which reflects as an overspend within the Care Group pay position.

Urgent and Emergency Care
Month 12 (March) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	34	73	39	1,448	816	(632)
Non-Electives	4,324	4,277	(47)	50,362	37,799	(12,562)
Accident and Emergency	2,576	2,091	(485)	36,275	30,379	(5,896)
Outpatients		45	44	1	380	379
High Cost Drugs	16	21	5	195	39	(156)
Private Patients						
Other NHS Clinical Income	0	478	478	0	19,330	19,330
Other Clinical Income	118	83	(34)	1,412	949	(463)
Total Clinical Income	**7,068**	**7,068**		**89,693**	**89,693**	**()**
Non Clinical Income	12	12	()	51	56	4
Total Income	**7,080**	**7,079**	**()**	**89,744**	**89,749**	**4**
Expenditure						
Substantive Staff	(3,715)	(4,074)	(358)	(45,752)	(47,206)	(1,454)
Bank	(623)	(1,053)	(430)	(6,455)	(7,975)	(1,519)
Agency	(1,090)	(1,046)	43	(11,739)	(11,864)	(125)
Total Pay	**(5,428)**	**(6,173)**	**(745)**	**(63,947)**	**(67,045)**	**(3,098)**
Purchase of Healthcare						
Supplies and Services Clinical	(168)	(126)	42	(1,920)	(1,615)	306
Supplies and Services General	(20)	(23)	(4)	(237)	(242)	(5)
Drugs	(172)	(169)	3	(1,801)	(1,640)	161
All Other, incl Transport	(21)	(142)	(121)	(404)	(1,283)	(879)
Total Expenditure	**(5,809)**	**(6,635)**	**(825)**	**(68,309)**	**(71,824)**	**(3,515)**
Contribution	**1,271**	**445**	**(826)**	**21,435**	**17,924**	**(3,511)**



The Care Group's position deteriorated by £0.8m in March and finished the year £3.5m adverse to plan. The worsening position in month was primarily driven by increasing temporary and substantive staffing costs, as well as savings shortfalls.

Income:
Clinical income has been adjusted to breakeven by £0.5m for the impact of Covid-19 in month and by £19.3m for the year. March's attendances were 18% below plan, compared to 24% last month and have started to grow compared to earlier in the year. Overall, attendances were 18% below plan at the end of the year.

Pay:
Pay was £0.7m adverse to plan this month and was £3.1m adverse for the year, with unmet CIP targets being a driving factor (£0.1m in month and £1.3m YTD). However, the deterioration is also being driven by an increase in agency and bank costs linked to Covid-19. Overall Covid-19 costs were £0.2m above the funding allocation in March. The allocation was based on average month 1-6 expenditure. Nursing agency and bank costs have also increased due to staffing levels being set to pending business case levels. In addition, substantive staff costs have also increased due to payments associated with winter incentives and the selling of annual leave, as well as through recruitment. The incentive and annual leave payments will not be repeated in April. The Care Group has developed business cases for staffing investment and, consequently, to reduce temporary staffing expenditure. Progress of the cases through approval committees is currently paused pending further executive review and 21/22 business planning. A decision on the cases is expected to be taken shortly.

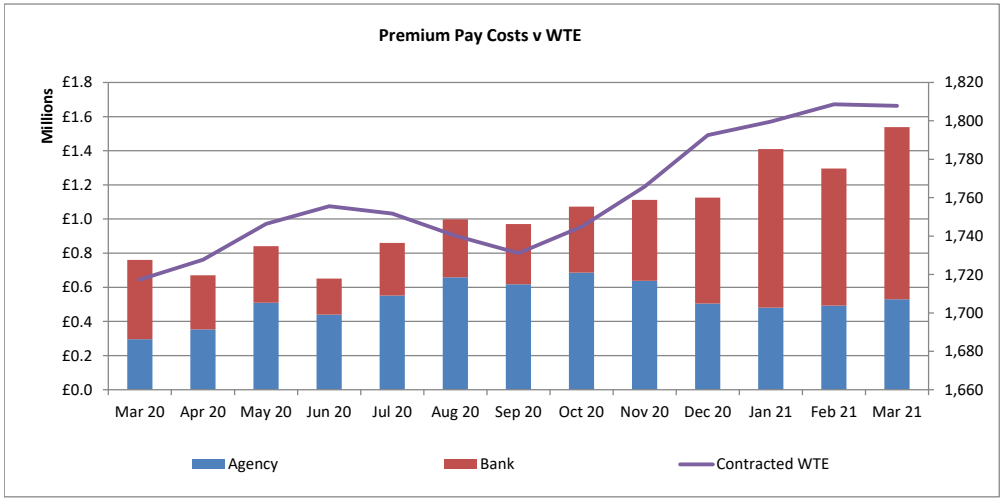
Non-Pay:
Non-pay was overspent by £0.1m in month and finished the year £0.4m overspent. The main pressure on the budget is also the shortfall in CIP schemes, totalling £0.1m per month. This has been partially offset by lower clinical supplies expenditure, a consequence of lower activity levels.

CIPs:
The annual CIP target for the Care Group is £2.5m. A relatively small value of non-recurrent pay savings is being recognised due to vacancies. Savings associated with consultant recruitment are also being achieved. However, schemes continued to perform considerably below plan. At the end of the year performance was £2.2m adverse to plan.

Prepared by: Stephen Lazell
Reviewed by: Julia Bournes David Bogard

Surgery and Anaesthetics
Month 12 (March) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	2,713	1,538	(1,175)	43,723	20,515	(23,208)
Non-Electives	2,860	3,610	751	39,257	35,216	(4,041)
Accident and Emergency						
Outpatients	1,275	1,587	313	16,147	15,195	(952)
High Cost Drugs	32	31	(1)	381	298	(83)
Private Patients	11	(15)	(26)	132	117	(16)
Other NHS Clinical Income	1,587	1,731	144	19,170	47,645	28,476
Other Clinical Income	22	16	(6)	262	84	(177)
Total Clinical Income	**8,499**	**8,499**		**119,072**	**119,072**	**()**
Non Clinical Income	124	52	(73)	1,496	698	(798)
Total Income	**8,624**	**8,551**	**(73)**	**120,568**	**119,770**	**(798)**
Expenditure						
Substantive Staff	(7,524)	(8,334)	(811)	(88,572)	(91,796)	(3,224)
Bank	(655)	(1,009)	(354)	(5,569)	(6,082)	(513)
Agency	(416)	(530)	(114)	(5,016)	(6,464)	(1,448)
Total Pay	**(8,595)**	**(9,873)**	**(1,278)**	**(99,157)**	**(104,343)**	**(5,186)**
Purchase of Healthcare	(2)	(11)	(9)	(22)	(16)	6
Supplies and Services Clinical	(1,602)	(1,198)	404	(19,244)	(12,561)	6,683
Supplies and Services General	5	52	48	(628)	(244)	384
Drugs	(351)	(343)	8	(4,410)	(3,690)	720
All Other, incl Transport	204	(289)	(494)	3,164	(1,425)	(4,588)
Total Expenditure	**(10,341)**	**(11,662)**	**(1,321)**	**(120,297)**	**(122,279)**	**(1,982)**
Contribution	**(1,717)**	**(3,111)**	**(1,393)**	**271**	**(2,509)**	**(2,780)**



The Care Group is £2.8m adverse to plan YTD, a deterioration in month of £1.4m. This is due to unmet CIP target and high staffing costs in month. Income is adverse by £0.8m YTD from a reduction in Non-Clinical Income recharges and Expenditure is adverse by £2.0m YTD as the CIP target has not quite been offset by the underspends on clinical supplies & drugs.

Income:

SLA Income has been adjusted year to date to break-even by £25.2m, for the impact of Covid-19. The impact on activity has been considerably adverse, across all specialties and points of delivery apart from Critical Care where activity is 18% above plan. However, for March this adjustment was negative £0.6m as activity overperformed plan for the first time in the financial year.

4 R plans have now been developed for all specialties to deliver activity in line with National Planning guidance for 2021/22 financial year.

Non-Clinical Income is adverse £0.8m, with a reduction in services provided to other NHS organisations and Spencer Hospital due to Covid-19 measures.

Pay:

Pay is adverse £5.2m YTD, with unmet CIP targets across substantive and agency staff. Medical & Nursing agency costs have risen to support Covid-19 pressures, sickness and vacancies. Covid-19 pay costs were £0.8m higher in the second wave than the first. March's pay costs were particular high with one off costs for staff selling annual leave and enhanced bank rates.

Non-Pay:

Non-Pay is favourable £3.2m YTD, with underspends on clinical supplies £6.7m and Drugs £0.7m from reduced patient activity. Non-pay CIPs are under performed by £4.6m.

Covid-19 additional costs incurred of £7.6m are in the above and relate to temporary staffing £6.9m and Non-Pay £0.7m, both of which mainly relate to costs incurred supporting Critical Care services and also backfilling of staff. All but £0.8m has been funded, for which this is the additional cost of wave 2 above that incurred for wave 1 of the pandemic.

CIP:

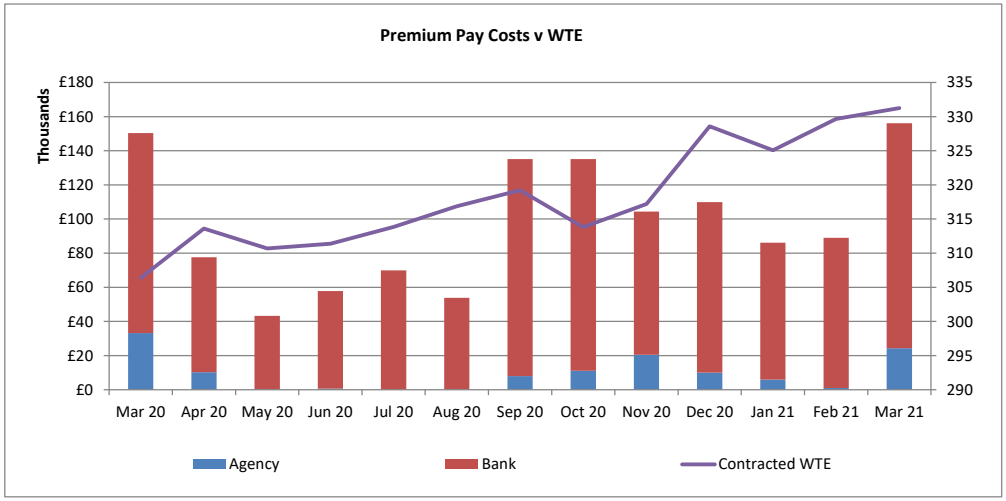
CIPs target of £6.5m YTD has been under achieved by £6.2m, of which £0.6m Income, £1.0m Pay and £4.6m Non-Pay are currently offset within the underspends.

Prepared by: James Isard
Reviewed by:

Surgery - Head and neck, Breast Surgery and Dermatology

Month 12 (March) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,016	832	(184)	15,119	8,765	(6,354)
Non-Electives	112	92	(19)	1,972	1,210	(761)
Accident and Emergency						
Outpatients	1,437	1,899	462	21,955	17,174	(4,782)
High Cost Drugs	327	306	(22)	3,926	2,857	(1,069)
Private Patients	4	2	(3)	54	8	(46)
Other NHS Clinical Income	104	(131)	(234)	1,217	14,223	13,006
Other Clinical Income			()	3	8	5
Total Clinical Income	**3,000**	**3,000**	**()**	**44,246**	**44,246**	
Non Clinical Income	10	11	1	124	87	(38)
Total Income	**3,011**	**3,012**	**1**	**44,370**	**44,333**	**(38)**
Expenditure						
Substantive Staff	(1,581)	(1,643)	(62)	(18,031)	(18,038)	(7)
Bank	(85)	(132)	(47)	(877)	(1,026)	(148)
Agency	(14)	(24)	(10)	(158)	(92)	66
Total Pay	**(1,680)**	**(1,799)**	**(119)**	**(19,067)**	**(19,157)**	**(90)**
Purchase of Healthcare	(95)	12	107	(1,626)	(553)	1,074
Supplies and Services Clinical	(89)	(81)	8	(1,074)	(842)	232
Supplies and Services General	(1)	(2)	(1)	(14)	(11)	3
Drugs	(403)	(402)	1	(4,047)	(3,913)	134
All Other, incl Transport	(8)	(43)	(35)	(166)	(353)	(187)
Total Expenditure	**(2,276)**	**(2,314)**	**(38)**	**(25,995)**	**(24,829)**	**1,166**
Contribution	**735**	**698**	**(37)**	**18,375**	**19,504**	**1,128**



The Care Group is £1.1m favourable to plan YTD, a slight reduction in month of £0.04m. Whilst Income is breakeven YTD, Expenditure is favourable with underspends across Non-Pay.

Income:

SLA Income has been adjusted YTD to break-even by £12.9m, for the impact of Covid-19. The impact on activity has been considerably adverse, across all specialties and points of delivery. However, for March this adjustment was negative £0.4m as activity overperformed plan for the first time in the financial year.

4 R plans have now been developed for all specialties to deliver activity in line with National Planning guidance for 2021/22 financial year. The main risk to achieving this is around Day Case activity, as there is still limited access to theatres.

Pay:

Pay is adverse £0.09m YTD. Reductions in medical waiting list payments and agency didn't quite offset an increase in temporary bank costs and unmet Pay CIP's.

Non-Pay:

Non-Pay is favourable £1.3m YTD, with underspends on clinical supplies £0.2m and drugs £0.1m from reduced patient activity, together with the cessation of the external ophthalmology healthcare provider £1.0m.

Covid-19 additional costs of £0.19m have been funded in the above and relate mostly to temporary staffing.

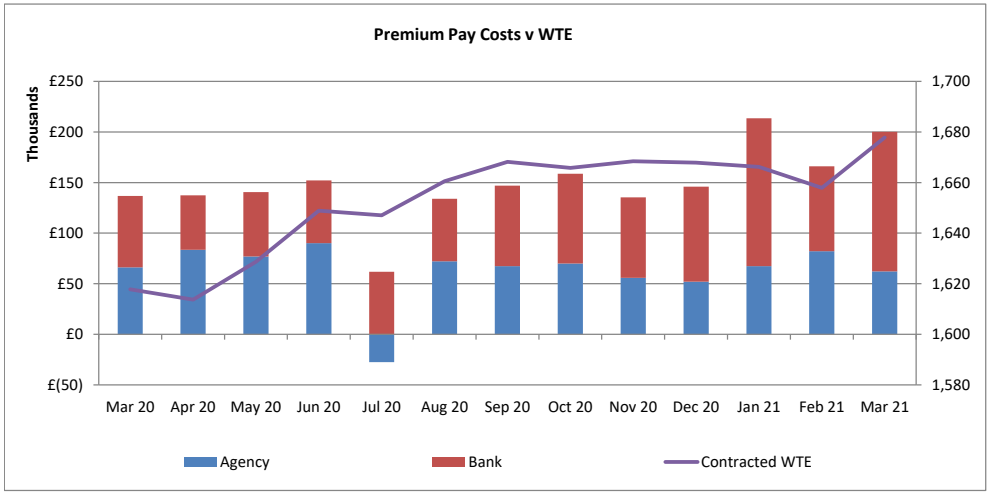
CIP:

CIPs target of £1.0m YTD has been under achieved by £0.4m, of which £0.2m Pay and £0.2m Non-Pay are currently offset within the underspends.

Prepared by: James Isard
Reviewed by: Sarah Hyett

Clinical Support
Month 12 (March) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	56	34	(22)	919	476	(444)
Non-Electives	7		(7)	115	6	(109)
Accident and Emergency						
Outpatients	221	168	(53)	3,540	1,333	(2,207)
High Cost Drugs	1,297	1,807	511	15,559	17,297	1,737
Private Patients	7		(7)	86	13	(73)
Other NHS Clinical Income	3,046	2,624	(422)	39,462	40,557	1,095
Other Clinical Income		0	()		0	()
Total Clinical Income	**4,634**	**4,634**		**59,682**	**59,682**	
Non Clinical Income	671	277	(394)	7,927	7,629	(297)
Total Income	**5,305**	**4,911**	**(394)**	**67,608**	**67,311**	**(297)**
Expenditure						
Substantive Staff	(6,237)	(6,084)	153	(67,204)	(68,705)	(1,501)
Bank	(95)	(138)	(43)	(942)	(1,013)	(70)
Agency	(112)	(62)	50	(1,589)	(752)	837
Total Pay	**(6,444)**	**(6,284)**	**160**	**(69,736)**	**(70,470)**	**(734)**
Purchase of Healthcare	(5)	(6)	(1)	(56)	(87)	(31)
Supplies and Services Clinical	(2,587)	(2,779)	(191)	(31,404)	(29,085)	2,319
Supplies and Services General	(15)	(24)	(10)	(176)	(198)	(22)
Drugs	(1,924)	(1,534)	390	(18,926)	(18,691)	235
All Other, incl Transport	373	(270)	(642)	(203)	(3,140)	(2,938)
Total Expenditure	**(10,602)**	**(10,896)**	**(294)**	**(120,501)**	**(121,671)**	**(1,170)**
Contribution	**(5,297)**	**(5,985)**	**(688)**	**(52,893)**	**(54,360)**	**(1,467)**



The Care Group deficit increased to £1.47m at the end of the financial year. The deficit of £0.7m in March was caused mainly by unmet CIPs typical of this year due to the Covid-19 pandemic landscape.

Income:

The total Clinical income adjustment is now £12.1m recognising the impact of Covid-19 on the Care Groups' ability to deliver its non-acute activity plan in Radiology (£6.1m), Pathology (£4.5m), Therapies (£2.1m) and Audiology (£1.0m). The adjustment in March was only £0.07m this month on due to Homecare drugs being above plan by £0.5m, which offset the adjustments for activity underperformance on Radiology, Pathology, Audiology and Therapies for outpatients and direct access. Therapies, Radiology and Audiology delivered material higher volumes of primary care and outpatient activity than in February.

Pay:

Total Pay cost for March was £6.3m, £0.27m higher than last month. This was due to the selling of annual leave (£1.0m), Clinical Excellence awards paid (£0.08m) as well as increase Bank costs (£0.04m). There are 2 departments with underspends in pay. Pathology have the benefit of continued out of envelope Covid-19 funding for testing and Medical Physics have vacancies. Radiology have the highest overspend of £0.8m, split between medical staff and PAMs staff types. Despite the challenges, the Care Group has managed to keep its agency costs underspend throughout the year.

Total Covid-19 Pay cost in CSS for the year is £2.3m.

Non-Pay:

There was a substantial increase in non-pay spend this month which was mainly in relation to the Homecare drugs costs (£0.6m). Pathology and Radiology non-pay costs were also increased compared with last month mainly due to laboratory consumables and outsourced MRI capacity. However, all departments remain underspent on non-pay. Unmet CIP accounts for £3.8m and Covid-19 non-pay costs YTD is £4m which materially relates to supplies for PCR testing.

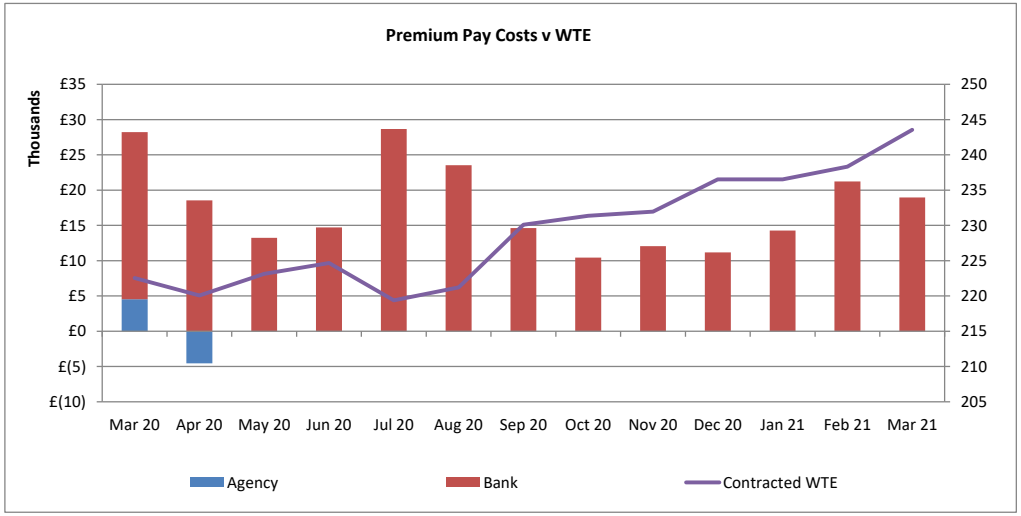
CIP: Total unmet CIP in the CSS Care Group is £4m.

Covid-19: The total cost impact is £6.3m in addition to income losses of £13m (Clinical & Non-clinical)

Prepared by: Vivienne Bertram
Reviewed by: Chris Hudson

Cancer Services
Month 12 (March) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	411	551	140	4,602	4,980	378
Non-Electives	18	6	(13)	303	116	(187)
Accident and Emergency						
Outpatients	743	740	(3)	8,751	7,384	(1,367)
High Cost Drugs	2,043	2,594	551	24,520	25,484	963
Private Patients						
Other NHS Clinical Income	817	142	(675)	9,704	9,839	135
Other Clinical Income	1		(1)	6	84	78
Total Clinical Income	**4,034**	**4,034**		**47,886**	**47,886**	**()**
Non Clinical Income	86	73	(13)	1,033	1,045	11
Total Income	**4,120**	**4,106**	**(13)**	**48,920**	**48,931**	**11**
Expenditure						
Substantive Staff	(992)	(965)	27	(10,133)	(10,266)	(133)
Bank	(13)	(19)	(6)	(167)	(201)	(35)
Agency	()	0		(5)	5	9
Total Pay	**(1,006)**	**(984)**	**21**	**(10,305)**	**(10,463)**	**(158)**
Purchase of Healthcare	()	0		(4)	(4)	
Supplies and Services Clinical	(215)	(208)	6	(2,576)	(2,396)	180
Supplies and Services General	(7)	(7)	()	(85)	(84)	2
Drugs	(2,646)	(2,603)	43	(26,256)	(25,802)	454
All Other, incl Transport	(10)	(130)	(120)	(268)	(927)	(659)
Total Expenditure	**(3,884)**	**(3,934)**	**(50)**	**(39,494)**	**(39,675)**	**(181)**
Contribution	**236**	**173**	**(63)**	**9,426**	**9,256**	**(170)**



The CCHH care group position delivered a small deficit against income and expenditure plans in March which is attributable mainly to undelivered CIP plans.

Income:

Income was above plan this month, therefore there was a negative adjustment removing £0.6m from the CCHH position. This was mainly due to high cost drugs above plan at £0.5m. Both Clinical Oncology and Clinical Haematology high costs drugs were above plan. The total top up adjustment for activity underperformance due to the Covid-19 impact totals £0.6m for 2020-21.

Clinical Oncology (esp. Outpatients, regular attenders and High costs drugs) and Palliative Care (Inpatient beddays) specialties both ended the year with net income over performance against plan. The other specialties in the Care Group were overall below income plan.

Pay:

Pay cost increased again this month due to increases in basic pay, clinical excellence awards payments, bank and overtime, mainly bank and overtime costs. Unmet Pay CIP is now total £0.3m offset by Pay underspends across most departments.

Non-pay:

There was an increased cost of rechargeable High cost Drugs and Blood products this month (£0.4m). This was also adjusted by increase to budget. Total Drugs and clinical supplies remained underspent by the end of the year. This was offset by a bad debt provision for QVH Hospital recharge of the Cancer Collaborative costs which are facing challenge and remain unpaid. The unmet CIP within non-pay is £0.4m.

CIP:

Total Unmet CIP is now £0.73m.

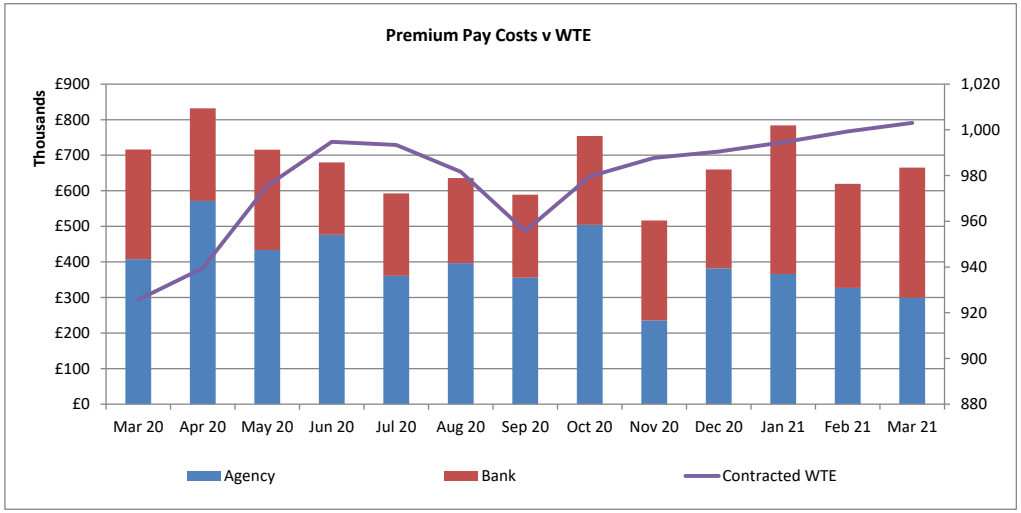
Covid-19:

Total Covid-19 costs claimed is now £0.17m, in addition to the £0.6m patient care income loss., including the cost of successfully delivering the vaccination programme for patients.

Prepared by: Vivienne Bertram
Reviewed by: Sarah Collins

Women's and Children's Services
Month 12 (March) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	559	427	(132)	7,642	3,817	(3,825)
Non-Electives	2,130	2,502	372	28,669	26,848	(1,821)
Accident and Emergency						
Outpatients	643	800	157	8,840	7,122	(1,718)
High Cost Drugs	18	24	6	217	289	72
Private Patients			()	2	1	(1)
Other NHS Clinical Income	2,647	2,236	(411)	32,074	39,347	7,272
Other Clinical Income	9	17	8	113	134	21
Total Clinical Income	**6,007**	**6,007**	**()**	**77,558**	**77,558**	**()**
Non Clinical Income	116	117	1	1,101	1,124	23
Total Income	**6,123**	**6,124**	**1**	**78,659**	**78,682**	**23**
Expenditure						
Substantive Staff	(4,811)	(4,612)	199	(55,501)	(52,180)	3,321
Bank	(299)	(366)	(66)	(3,077)	(3,334)	(257)
Agency	(268)	(300)	(31)	(3,030)	(4,708)	(1,678)
Total Pay	**(5,379)**	**(5,277)**	**102**	**(61,609)**	**(60,223)**	**1,386**
Purchase of Healthcare	(2)	(2)		(22)	(36)	(13)
Supplies and Services Clinical	(249)	(247)	2	(3,071)	(2,642)	430
Supplies and Services General	(11)	(7)	3	(139)	(65)	74
Drugs	(163)	(205)	(42)	(1,988)	(2,036)	(47)
All Other, incl Transport	29	(149)	(178)	930	(1,085)	(2,016)
Total Expenditure	**(5,774)**	**(5,887)**	**(113)**	**(65,900)**	**(66,087)**	**(187)**
Contribution	**349**	**237**	**(112)**	**12,759**	**12,595**	**(164)**



The Care Group's position deteriorated by £0.1m in March and finished the year £0.2m adverse to plan. The worsening position in month was primarily driven by savings shortfalls, as well as a temporary increase in substantive pay costs.

Income:
Clinical income has been adjusted to breakeven by £0.6m for the impact of Covid-19 in month and by £8.3m for the year. The adjustment this month is similar to the average for the year. Outpatient activity has continued to grow. However, Elective, NICU and maternity pathway activity dropped back after recent improvements.

Pay:
Pay was £0.1m favourable to plan in month and is £1.4m favourable for the year. Covid-19 costs increased only slightly on last month and were £0.1m below the funding allocation in March. The allocation was based on average month 1-6 expenditure. Covid-19 costs have reduced due to an end of the use of fixed term contract staff used predominantly in the first phase of the pandemic. Substantive staff costs have also increased due to payments associated with winter incentives and the selling of annual leave, as well as through recruitment. The incentive and annual leave payments will not be repeated in April.
The budget has also been supported by £0.05m of business case funding this month.

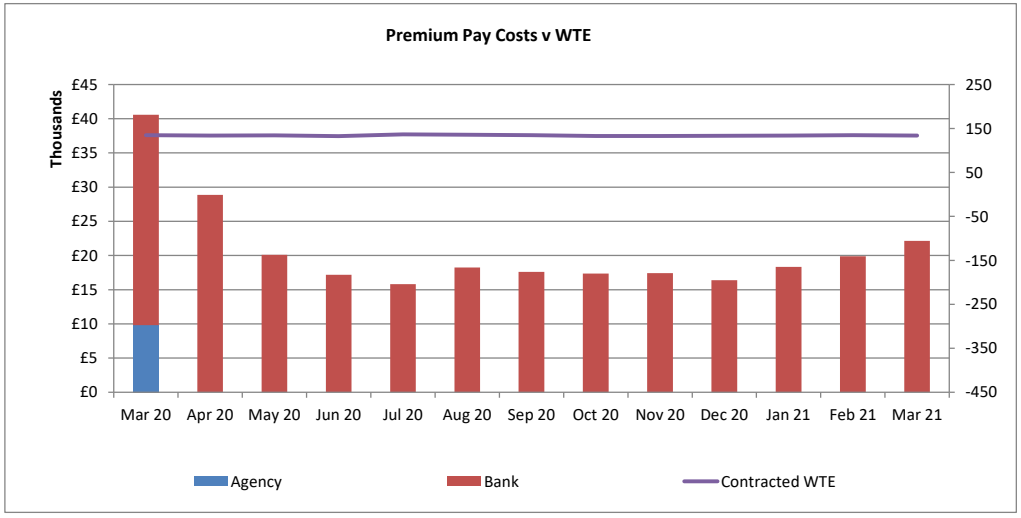
Non-Pay:
Non-pay is adverse to plan by £0.2m in month and £1.6m for the year. The main pressure on the budget is the gap in CIP schemes, totalling £0.2m per month- including a shortfall in the CNST rebate. The majority of the Care Group's savings targets are set against the non-pay budget. This is partially offset by clinical supply underspends resulting from lower activity levels.

CIPs:
The annual CIP target for the Care Group is £3.0m. A relatively small value of non-recurrent pay savings is being recognised due to vacancies. Savings associated with medical recruitment are also being achieved, but overall schemes continued to perform considerably below plan. At the end of the year performance was £2.4m adverse to plan.

Prepared by: Stephen Lazell
Reviewed by: Karen Costello

Strategic Development and Capital Planning
Month 12 (March) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Non Patient Care Services	22	161	139	222	501	279
Car Parking	51	99	48	611	733	122
Staff Accommodation	198	229	31	2,371	2,374	3
All Other Income	173	180	7	2,116	2,250	134
Total Income	**444**	**669**	**225**	**5,320**	**5,858**	**538**
Expenditure						
Substantive Staff	(539)	(555)	(16)	(6,475)	(6,199)	276
Bank	(32)	(22)	10	(386)	(229)	157
Agency	0	0	0	0	0	0
Total Pay	**(571)**	**(577)**	**(6)**	**(6,861)**	**(6,428)**	**433**
Supplies and Services General	(4,181)	(4,173)	8	(50,172)	(50,078)	93
Establishment	(134)	(176)	(42)	(1,593)	(1,656)	(63)
Premises and Rates	(249)	(250)	(1)	(2,987)	(2,979)	7
Premises Other	(485)	(1,303)	(817)	(8,758)	(9,951)	(1,193)
Transport	(23)	(12)	11	(271)	(145)	126
Education and Training	(72)	(70)	2	(147)	(144)	3
All Other	(76)	14	91	(321)	158	478
Total Expenditure	**(5,791)**	**(6,545)**	**(754)**	**(71,110)**	**(71,224)**	**(115)**
Contribution	**(5,347)**	**(5,876)**	**(529)**	**(65,790)**	**(65,366)**	**423**



Strategic Development and Capital Planning is favourable to budget by £423k as at the end of March.

Income:

Income is favourable £225k in month and favourable £538k YTD. IT income is favourable £144k in month and £385k YTD due to backdated invoices to external customers, the income offsets expenditure incurred by IT. Car parking is favourable £48k and £122k favourable YTD. Staff accommodation is favourable £31k in month and £3k YTD.

Pay:

Pay is adverse £6k in month and £433k favourable YTD. Facilities favourable £10k in month and £159k favourable YTD which is attributable to inter site transfers, ongoing review of service specification being carried out. Strategic Development £11k favourable in month and £234k YTD due to vacant posts which are out to recruit/have been recruited into and awaiting to start. This has been reconciled and agreed with the department. IT adverse £27k in month of which £12k is due to the sale of A/L and £39k favourable YTD.

Non-Pay:

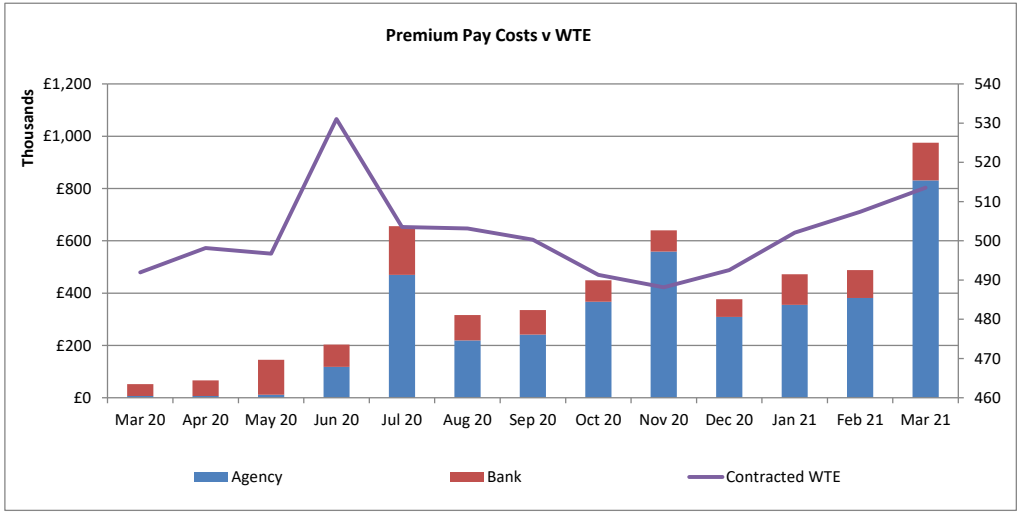
Non-Pay is adverse £749k in month and £548k adverse YTD.

The adverse position in month is due to computer hardware being adverse £301k and £328k YTD, the majority is offset by income, however, there was a large amount of expenditure this month due lead times in deliveries, issues with staff redeployed, capital issues with regards to ordering meaning the revenue spend fluctuated.

Utilities adverse £46k in month and £405k adverse YTD there were issues with the accrual process causing fluctuations, also there has been a subjective movement in month with saving £274k adverse in month. Liaising with PMO going forward due to energy project.

The adverse variance YTD is being partly offset by accommodation £150k YTD due to underspends on building works and £71k on patients travelling expenses due to lower activity.

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Non Patient Care Services	163	272	109	1,140	1,216	76
Research and Innovation	132	139	7	2,531	2,509	(22)
Education and Training Income	1,294	1,226	(68)	15,059	15,045	(14)
All Other Income	(60)	(55)	5	(102)	(147)	(44)
Total Income	**1,529**	**1,581**	**53**	**18,628**	**18,623**	**(4)**
Expenditure						
Substantive Staff	(2,041)	(2,667)	(626)	(26,882)	(27,889)	(1,006)
Bank	(130)	(144)	(14)	(709)	(1,255)	(546)
Agency	(752)	(831)	(79)	(3,648)	(3,868)	(221)
Total Pay	**(2,924)**	**(3,642)**	**(718)**	**(31,239)**	**(33,012)**	**(1,773)**
Supplies and Services General	(94)	(100)	(6)	(3,900)	(3,930)	(30)
Establishment	(116)	(145)	(30)	(952)	(1,063)	(111)
Premises Other	(871)	(744)	127	(5,448)	(5,694)	(246)
Transport	(182)	(178)	4	(722)	(543)	180
Clinical Negligence	(2,030)	(2,030)	()	(24,361)	(24,361)	
Education and Training	(1,046)	(790)	256	(2,646)	(2,200)	446
All Other	(1,420)	(865)	555	(14,330)	(12,902)	1,428
Total Expenditure	**(8,682)**	**(8,493)**	**189**	**(83,599)**	**(83,705)**	**(106)**
Contribution	**(7,154)**	**(6,912)**	**242**	**(64,971)**	**(65,082)**	**(110)**



The Corporate position is favourable £242k in month and £110k adverse YTD and is made up as follows: Clinical Quality & Patient Safety (CQ&PS) adverse £75k, HR adverse £517k, Finance favourable £99k, Operations adverse £65k, Trust Board favourable £67k, PGME and R&I favourable £379k.

Income:

Income is favourable £53k in month and adverse £4k YTD.

The favourable position in month is due to Nurse Associate funding from HEE within CQ&PS.

The position YTD is attributable to under-achievement of £320k in Occupational Health, which is mostly due to the loss of KMPT contract. Work is on-going with Occupational Health to ascertain what expenditure budgets can be given up to offset the loss of KMPT contract. These shortfalls are being offset by a favourable position of £332k against the Covid-19 envelope.

Pay:

Pay is adverse £718k in month and adverse £1.8m YTD. The adverse position in month includes £99k of expenditure for the sale of A/L in the Corporate Care Group and agency recharge from 2gether for Covid-19 relating to prior periods approximately £400k. Otherwise, the position in month and YTD is due to overspends on Covid-19 pay £1.5m YTD, this indicates expenditure is adverse against the allocation for months 7 - 12 due to revised plan. In addition to the overspend subjectively on Covid-19 staffing, pay savings targets not being realised but being partially offset by vacancies. The total Covid-19 envelope income, pay and non-pay is £334k favourable.

The corporate areas have a vacancy rate of just under 8% comparing contracted to budgeted WTE. The majority of the favourable benefit from these are being offset by the pay savings targets, pay savings year to date position adverse £960k YTD.

Non-Pay:

Non-Pay is favourable £906k in month and £1.7m favourable YTD.

CQ&PS adverse £26k in month and adverse £2k YTD. Adverse position in month is due to training and legal costs overspends. The position YTD is combination of underspends on interpreter fees £116k reduced activity, travel £48k and computer software £35k being offset by legal fees which are currently adverse £212k, these being monitored with the department.

HR favourable £83k in month and adverse £84k YTD. The position in month is due to trainings underspends which offset adverse variances such as work permits £155k. The position YTD is due to Overseas Nurses and work permits within HR Resourcing. This is due to operating over baseline funded activity levels.

Finance favourable £38k in month and favourable £242k YTD. Favourable YTD position is due to underspends on audit £122k contract renewed and computer software £95k in costing/planning.

Operations favourable £658k in month favourable £1.4m YTD due to Covid-19 underspends against the non-pay allocation which, at present, being used to offset the shortfall in pay. Again, the total Covid-19 envelope income, pay

Spencer Private Hospitals
Month 12 (March) 2020/21

Summary Profit & Loss March 2021 and Outturn Forecast

£'000s	Month			YTD			Full Year 2020-21		
	Actual	Budget	Variance	Actual	Budget	Variance	Outturn	Budget	Variance
Income	1,199	1,178	21	13,467	13,718	(251)	13,467	13,718	(251)
Pay	(471)	(662)	191	(6,281)	(7,955)	1,674	(6,281)	(7,955)	1,674
Non Pay	(358)	(311)	(47)	(4,079)	(3,737)	(342)	(4,079)	(3,737)	(342)
Other Costs	(460)	(133)	(327)	(2,603)	(1,604)	(999)	(2,603)	(1,604)	(999)
Operating Profit	(90)	71	(161)	503	422	81	503	422	81
OP %	*-7.5%*	*6.0%*	*-755.1%*	*3.7%*	*3.1%*	*-32.1%*	*3.7%*	*3.1%*	*-32.1%*
Interest Receivable									
Interest Expense	(449)	(4)	(445)	(26)	(50)	24	(26)	(50)	24
Net Profit before Tax	(539)	67	(606)	477	372	105	477	372	105
NPBT %	*-45.0%*	*5.7%*	*-2804.8%*	*3.5%*	*2.7%*	*-41.9%*	*3.5%*	*2.7%*	*-41.9%*
Tax	124	(15)	139	(120)	(101)	(19)	(120)	(101)	(19)
Net Profit after Tax	(416)	52	(467)	357	271	86	357	271	86
NPAT %	*-34.6%*	*4.4%*	*-2022.1%*	*2.7%*	*2.0%*	*-34.6%*	*2.7%*	*2.0%*	*-34.6%*

Salient comments on month / YTD results:

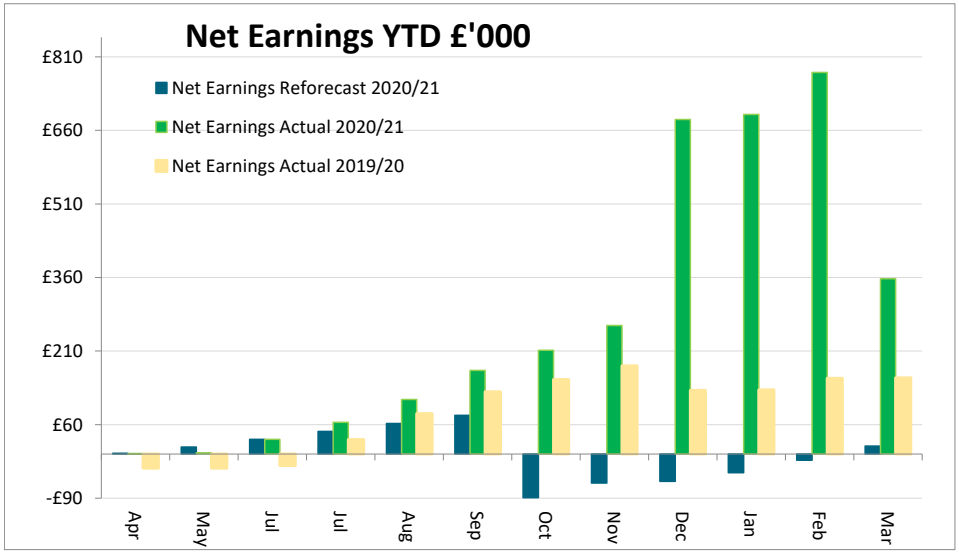
Spencer remained under the NHSE Covid-19 response contract throughout March.

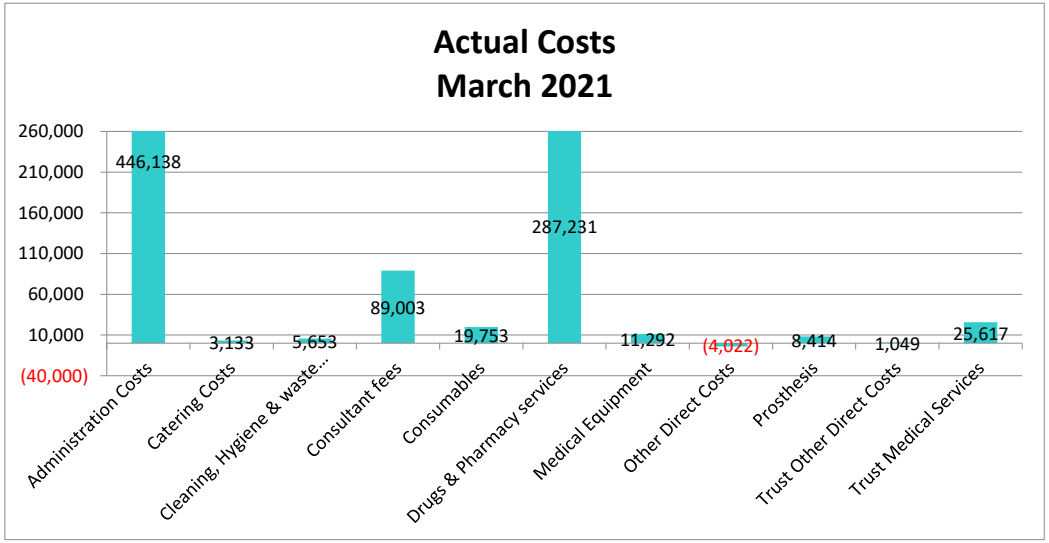
Due to restrictions on theatre access & Red patient status on ward there was limited private income in March.

Funding received in March from NHSE was calculated on a formula which was based on the average reimbursement for October & November 2020.

Excluding high cost drugs, other Non-Pay costs are £2.83m below budget YTD due to elective care activity significantly below budgeted activity levels.

Net earnings of £0.36m YTD against a budgeted profit of £0.27m.





Summary Profit & Loss March 2021

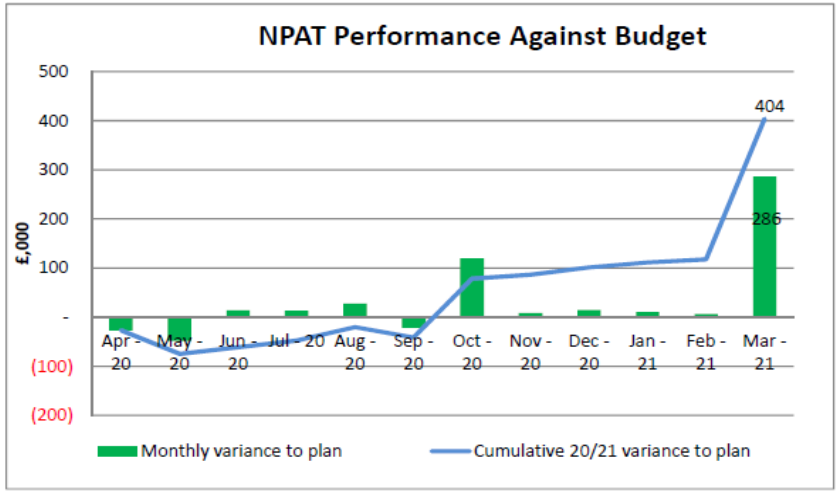
£'000s	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
Income	13,592	8,261	5,331	113,604	100,833	12,771
Costs	(13,575)	(8,132)	(5,443)	(112,223)	(99,472)	(12,752)
Operating Profit/(Loss)	17	129	(112)	1,381	1,361	20
OP %	(0)	(0)	0	*1.2%*	*1.3%*	*-0.1%*
Interest Receivable	245	245	(0)	3,037	3,037	(0)
Interest Expense	(189)	(192)	3	(2,302)	(2,302)	(0)
Net Profit/(Loss) before Tax	73	182	(109)	2,115	2,096	19
NPBT %	*0.5%*	*2.2%*	*-1.7%*	*1.9%*	*2.1%*	*-0.2%*
Tax	289	(106)	395	(710)	(1,095)	385
Net Profit/(Loss) after Tax	362	76	286	1,405	1,001	404
NPAT %	*2.7%*	*0.9%*	*1.7%*	*1.2%*	*1.0%*	*0.2%*

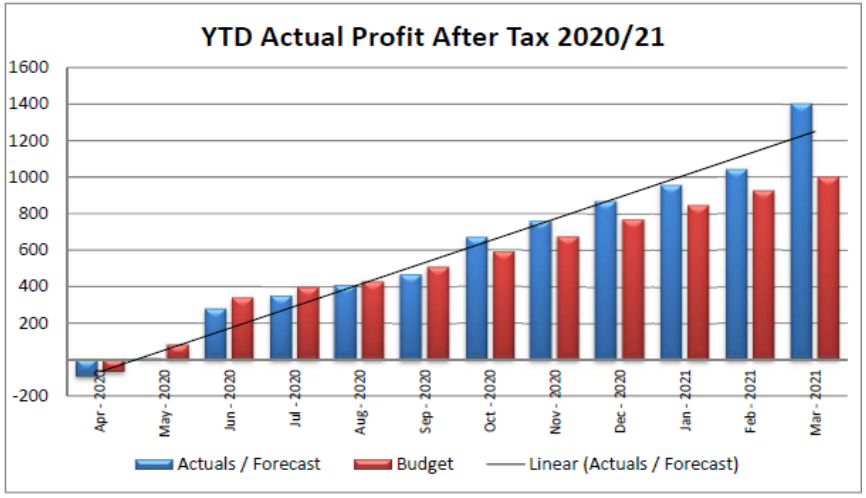
2020/21 (£'000)	YTD Split by Income Stream			
	Actual	EKHUFT	Retail	3rd Party
Income	113,604	111,721	1,369	514
Costs	(112,223)	(110,838)	(907)	(477)
Operating Profit/(Loss)	1,381	883	461	37
OP %	*1.2%*	*0.8%*	*33.7%*	*7.2%*

The full year profit is ahead of plan. The income and costs variances are primarily driven by Covid-19 recharges and consumables ordered by EKHUFT. In addition CCN16 income and associated costs (£1.6m) transacted in March 2021.

3rd Party and retail income was £1.8m (against a budget of £1.9m). The budget had allowed for the impact of Covid-19.

The tax position is based on draft tax computations from our external advisors.





Cash Flow

Month 12 (March) 2020/21

Year to Date		This Month			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual		Plan	Actual	Variance	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual
13,893	**Opening Cash Balance**	2,891	77,009	74,118	13,893	62,893	57,842	60,246	54,984	56,745	61,060	51,896	70,279	71,663	70,128	77,009
	Prior Year Main Contract CCGs															
531,845	Kent & Medway CCG Contract	39,616		(39,616)	80,473	40,237	40,237	40,237	40,238	40,237	40,237	71,706	43,694	43,694	50,855	
17,464	Prior Year Main Contract CCGs		4,816	4,816		(482)	1,297	(1)	657	14	72		7,101	3,989		4,816
2,128	Other CCG block Contracts				418	209	209	209	201	115	166	165	105	165	165	
185,499	NHS England	8,346	8,755	409	31,214	14,143	14,836	13,725	19,041	17,985	12,537	9,032	14,367	12,945	16,918	8,755
34,843	All Other NHS Organisations	1,275	1,824	550	7,786	797	1,332	3,181	4,880	1,486	1,631	5,564	1,051	1,576	3,735	1,824
0	Capital Receipts															
252,685	All Other Receipts	3,372	56,939	53,568	7,148	7,792	2,013	8,863	2,086	139,311	5,527	6,961	1,762	5,341	8,942	56,939
0	Provider Sustainability Fund															
4,015	PDC Loans	3,289		(3,289)	4,015											
0	Loans Repaid															
1,028,479	**Total Receipts**	**55,897**	**72,335**	**16,438**	**131,054**	**62,696**	**59,923**	**66,213**	**67,104**	**199,147**	**60,170**	**93,430**	**68,080**	**67,711**	**80,615**	**72,335**
	Total Movement In Bank Balance															
(394,262)	Monthly Payroll inc NI & Super	(30,670)	(34,700)	(4,030)	(30,927)	(31,819)	(32,543)	(32,868)	(32,500)	(32,440)	(33,043)	(32,875)	(33,108)	(33,505)	(33,934)	(34,700)
(563,275)	Creditor Payment Run	(21,160)	(41,586)	(20,426)	(48,955)	(35,438)	(24,775)	(38,414)	(32,167)	(162,309)	(31,901)	(39,243)	(33,369)	(35,483)	(39,633)	(41,586)
(10,465)	Capital Payments	(1,400)	(2,003)	(603)	(2,172)	(491)	(200)	(193)	(58)	(83)	(4,391)	(232)	(219)	(258)	(165)	(2,003)
(5,808)	PDC Dividend Payment	(2,400)	(3,112)	(712)								(2,696)				(3,112)
(619)	Interest Payments	(129)		129					(619)							
(974,428)	**Total Payments**	**(55,759)**	**(81,401)**	**(25,642)**	**(82,054)**	**(67,747)**	**(57,519)**	**(71,475)**	**(65,343)**	**(194,832)**	**(69,334)**	**(75,046)**	**(66,696)**	**(69,246)**	**(73,733)**	**(81,401)**
54,050	**Total Movement In Bank Balance**	**138**	**(9,066)**	**(9,204)**	**49,000**	**(5,051)**	**2,404**	**(5,262)**	**1,760**	**4,315**	**(9,164)**	**18,384**	**1,383**	**(1,535)**	**6,882**	**(9,066)**
67,943	**Closing Bank Balance**	**3,029**	**67,943**	**64,914**	**62,893**	**57,842**	**60,246**	**54,984**	**56,745**	**61,060**	**51,896**	**70,279**	**71,663**	**70,128**	**77,009**	**67,943**
	Plan				4,356	4,191	4,157	4,157	3,742	2,997	4,961	2,891	2,891	2,891	2,891	3,029
	Variance				58,537	53,651	56,090	50,827	53,003	58,063	46,934	67,388	68,772	67,237	74,118	64,914

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**29 APRIL 2021**
REPORT TITLE:	**FINANCE AND PERFORMANCE COMMITTEE (FPC) CHAIR REPORT**
BOARD SPONSOR	**NIGEL MANSLEY, CHAIR OF THE FPC**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: FPC TERMS OF REFERENCE (TOR)**

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.

FPC ToR

The FPC meeting held on 2 March 2021 received, discussed and approved the FPC ToR attached (Appendix 1) and recommend these for approval by the Board of Directors.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Failure to achieve financial plans as agreed with NHSI under the Financial Special Measures Regime.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our future;** • **Our sustainability.**
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

East Kent Hospitals University NHS Foundation Trust

COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None	
SUBSIDIARY IMPLICATIONS:	N/A	
PRIVACY IMPACT ASSESSMENT: NO		**EQUALITY IMPACT ASSESSMENT:** NO

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to **APPROVE** the FPC terms of reference.

East Kent Hospitals University NHS Foundation Trust

TERMS OF REFERENCE
FINANCE AND PERFORMANCE COMMITTEE

1 CONSTITUTION

1.1 The Board of Directors has established a committee of the Board known as the Finance and Performance Committee. It is a Non-Executive committee and has no executive powers, other than those specifically delegated in these Terms of Reference. These Terms of Reference can only be amended with the approval with of the Board of Directors.

2 PURPOSE

2.1 The purpose of the Committee is to maintain an 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. As well as maintaining an overview of the Trust's operational performance and activity. This will include:-

- Overseeing the development and maintenance of the Trust's financial and performance plans and medium and long term financial strategy
- Overseeing the development of specific financial plans as may from time to time be required by NHSI/E including financial recovery plans, and other financial undertakings
- To consider the impact of Kent and Medway STP plans on the Trust
- reviewing and monitoring financial plans and their link to operational performance
- ensuring that there is good triangulation between financial, performance, quality and safety and workforce plans
- overseeing financial risk evaluation, measurement and management
- scrutiny and approval of business cases and oversight of the capital programme
- maintaining oversight of the finance function, key financial policies and other financial issues that may arise
- maintaining oversight of the Trust's performance against the contract activity plan;
- maintaining oversight of the Trust's performance against the national standard and recovery trajectories

3 OBJECTIVES

3.1 Financial Strategy

3.1.1 To consider the Financial Strategy, ensuring that the financial objectives are consistent with the strategic direction and quality priorities.

3.1.2 To review long term financial models and strategies including the impact of the Kent and Medway STP.

3.1.3 To review annual operational plans including efficiency targets and savings projects.

3.1.4 To review key medium term planning assumptions.

3.1.5 To review NHSI/LAT /CCG/NHS England, etc publications around financial and operating environment and their link to planning assumptions and models.

3.2 Monitoring Performance

3.2.1 Monitor the achievement of the financial strategy, and financial targets (including agency spend), associated activity targets and how these relate to the performance of the trust in non-financial domains such as patient safety and effectiveness.

3.2.2 Monitor the trajectories for activity performance and financial performance.

3.2.3 Monitor productivity, cost improvement and savings targets.

3.2.4 scrutinise financial and non-financial performance, trends, projections and underlying data on a monthly basis so that assurance can be sought around any action plans that address emerging patterns in finance or activity.

To oversee the development of financial and non-financial performance reporting, to include:

3.2.5 Greater emphasis on interpretation of the financial position and development of corrective plans where necessary.

3.2.6 Structuring monitoring reports around the key performance statements.

3.2.7 Developing high level metrics to focus the Committee on areas where corrective action may need to be developed

3.2.8 Linking the narrative to implications of compliance with the FT licence, in particular the financial risk rating and other licence conditions

3.2.9 Monitoring agreed actions

3.2.10 To consider the annual reference costs and review profitability analyses.

3.2.11 To review the annual accounts prior to IAGC and Board approval (see section 12).

3.3 Financial Risk Management

To review financial risk and advise the IAGC and Board accordingly:

3.3.1 Review and evaluate key financial risks e.g. tariff changes, contract penalty considerations, CCG/SCG Commissioning intentions, achievement of savings, control of recruitment (and hence pay bill), costs and benefits of underlying additional activity.

3.3.2 Development of risk management process around the evaluated risks linking to Board Assurance Framework providing assurance around active financial risk management [Note: the formal link between the finance risk register and Corporate Risk Register will be through the Risk Management and Governance Group).

3.4 Business Case consideration and Capital Programme management

3.4.1 To perform a preliminary review of proposed major investments.

3.4.2 To establish the overall controls which govern business case investments, using NHSI's guidance on Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts, and to approve the Trust's Business Case Procedure. In accordance with the Business Case Procedure (ref FPP/B1) and Scheme of Delegation rigorously review and approve business cases. (see section 5.2 below)

3.4.3 To ensure that robust processes are followed, evaluating, scrutinising and monitoring investments so that benefits realisation can be confirmed.

3.4.4 To ensure testing of all relevant options for larger business cases prior to detailed workup

3.4.5 To focus on financial metrics within cases e.g. payback periods, rate of return etc.

3.4.6 Review the rolling capital programme including scrutiny of the prioritisation process, forecasting and remedial action, and report to the Board accordingly.

3.5 Commercial Income

3.5.1 Ensure new income generating opportunities from non-clinical activities are identified, appropriately vetted and safely implemented;

3.5.2 Ensure mechanisms are in place to provide assurance that all income generating projects are implemented timely and safely;

3.5.3 Review current income streams from all non-clinically related activities;

3.5.4 Ensure a database of all contracts and service agreements are in place and updated regularly;

3.5.5 Benchmark the Trust's commercial income against other NHS providers;

3.5.6 Receives assurance that commercial opportunities are being identified and acted upon;

3.5.7 Ensure that robust processes are followed, to evaluate, scrutinise and monitor implementation of income generating opportunities so that benefits realisation can be confirmed;

3.5.8 Commission internally supported market opportunity reviews.

3.6 Other Matters

3.6.1 To provide an opportunity for examination of fitness for purpose of the finance function compared to the scale of the financial challenge

3.6.2 To consider ad hoc financial issues that arise (e.g. Private Patient Cap, estate revaluation etc.)

3.6.3 To develop the Trust’s Treasury and cash management policies in line with NHSI guidance on Managing Operating Cash. To scrutinise arrangements for a working capital facility and other long terms loans if required, and investment of surplus cash.

3.6.4 To periodically consider changes required to Trust Standing Financial Instructions due to structural change within the Trust, developments in the NHSI regime and the wider statutory/regulatory framework.

3.6.5 To oversee arrangements for outsourced financial functions and shared financial services.

3.6.6 To consider such other matters and take such other decisions of a generally financial nature as the Board shall delegate to it.

4. MEMBERSHIP AND ATTENDANCE

Members

4.1 The membership of the Committee shall consist of at least three Non-Executive Directors, together with the Chief Operating Officer, Director of Finance and Performance and Director of Strategic Development and Capital Planning. The committee meetings shall be open to all the members of the Board of Directors.

Quorum

4.4 Business will only be conducted if the meeting is quorate. The Committee will be quorate with at least two Non-Executive Directors and One Executive Director present. If the Trust Chair is in attendance, this will count towards the quorum.

4.5 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Board of Directors meeting as an urgent item.

Attendance by Members

4.6 The Chair and Lead Executive, or their nominated deputy, of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 80% of all meetings and be allowed to send a Deputy to one meeting per annum.

Attendance by Officers

4.7 The Committee will be open to the Chair, Chief Executive and Trust Secretary to attend.

4.8 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

Voting

4.9 When a vote is requested, the question shall be determined by a majority of the votes of the members present for the item. In the event of an equality of votes, the person presiding shall have a second or casting vote.

5. FREQUENCY

5.1 Meetings of the Committee shall generally be held monthly. At the discretion of the Chair, other meetings may be held to fulfil its main functions.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

6.2 Reference should be made as appropriate, to the Standing Orders and Standing Financial Instructions of the Trust.

6.3 The committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the committee. However, Board Committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Trust Board (Standing Order 5.5 refers).

6.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7 SERVICING ARRANGEMENTS

7.1 A member of the Board Secretariat shall attend meetings and take minutes.

7.2 Agendas and papers shall be distributed in accordance with deadlines agreed with the Committee Chair.

7.3 Members will be encouraged to comment via correspondence between meetings as appropriate.

7.4 The Committee will maintain a rolling annual work plan that will inform its agendas and seek to ensure that all duties are covered over the annual cycle. The planning of the meetings is the responsibility of the Chair.

8 ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

8.2 Chair reports will be provided to the Board of Directors to include: committee activity by exception; decisions made under its own delegated authority; any recommendations for decision; and any issues of significant concern.

8.3 Approved minutes will be circulated to the Board of Directors. Requests for copies of the minutes by a member of public or member of staff outside of the Committee membership will be considered in line with the Freedom of Information Act 2000.

10 MONITORING EFFECTIVENESS AND REVIEW

10.1 The Committee will provide an annual report outlining the activities it has undertaken throughout the year.

10.2 A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

10.3 The terms of reference will be reviewed and approved by the Board of Directors on an annual basis.

Approved by the Board of Directors:

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**29 APRIL 2021**
REPORT TITLE:	**MATERNITY IMPROVEMENT COMMITTEE (MIC) CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF MIC**
PAPER AUTHOR:	**MATERNITY SERVICES STRATEGIC PROGRAMME DIRECTOR**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: PROGRESS AGAINST REGULATOR'S ACTIONS** **APPENDIX 2: ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS DEEP DIVE REPORT**

BACKGROUND AND EXECUTIVE SUMMARY

1. Summary

This report provides the Trust Board with a summary of the discussions at the MIC on 16 March 2021 and 13 April 2021.

The MIC received highlight reports for both February and March 2021 and notes of the associated Evidence Review meetings.

The 90-day stabilisation action plan has now been closed down and signed off with NHS England/NHS Improvement (NHSE/I). The Committee is now working to close down all of the actions subject to supporting evidence. The action plan is as the Board is aware themed but to facilitate process of closure and further assurance the Committee has agreed to take a deep dive into each of the Regulator reports.

It has so far considered the recommendations from the Coroner's Report, the Royal College of Obstetricians and Gynaecologists Report (RCOG) which was originally reviewed by the Learning and Review Committee (LRC) and the LRC Workforce Report.

2. Highlight Report

Integrated action plan has 290 recommendations. The table attached (Appendix 1) sets out progress against the Regulator's actions. Delivery of these actions are now nearly complete for six out of the seven Regulator reports. The exception of Clinical Negligence Scheme for Trusts (CNST) actions which have a longer lead in time and have been subject to some changes by National Health Service Resolution (NHSR) who oversee the CNST scheme.

The Committee made the decision to recommend to the Board that the CNST actions are now removed from the oversight of MIC and revert to the Quality Committee for oversight. There is a statutory sign off process at Board level to confirm completion of CNST standards.

3. Deep Dive into the Coroner's Report (February 2020)

The Coroner's recommendations of which there were 18 in total, were supported by 39 associated maternity actions. MIC took the decision that the one recommendation related to paediatric working would not be overseen by MIC and should be considered by the Children's Care Group. A formal recommendation has been made to them.

4. Deep Dive into Royal College of Obstetricians and Gynaecologists (RCOG)

In March 2020 the LRC was established in response to Regulatory recommendations and RCOG was one workstream within this. In June 2020 the Chief Medical Officer (CMO) undertook an analysis of the Trust's and Care Group's compliance to the 23 RCOG recommendations. This was reported to the Trust Board in June 2020. At that time MIC revisited the CMO's report and captured what has changed since then.

The report to MIC is attached as Appendix 2. There are elements of the recommendations that are not relevant to the current time and the review has sought to bring to a conclusion those elements and recommend to the Board that as sufficient assurance has now been obtained that the actions in this report can now be closed.

5. Learning and Review Committee Workforce Closure Report

This was another working group of the LRC and two outstanding actions relating to obstetric workforce and are now closed. The relevant Care Groups have asked to ensure separate assurance in respect of Paediatric cover to obstetrics and this will be considered through the Trust's review of the Facing the Future Standards for Paediatric Care.

6. Next Steps

The MIC will be reviewing the outstanding Regulator reports over the next two months as well as seeking assurance that the learning from these reports is embedded within the Care Group through its 'Business as Usual ' arrangements.

7. Recommendation

The Board is asked to note this report, to confirm that it feels sufficient assurance has been obtained in respect of the RCOG Report, and to agree oversight of CNST actions move to the Quality Committee and are removed from the integrated plan.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	CR77 - Women may receive sub optimal quality of care and poor patient experience in our maternity services.
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	CR77 - Women may receive sub optimal quality of care and poor patient experience in our maternity services.
RESOURCE IMPLICATIONS:	None

East Kent Hospitals University NHS Foundation Trust

COMMITTEES WHO HAVE CONSIDERED THIS REPORT	N/A
SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

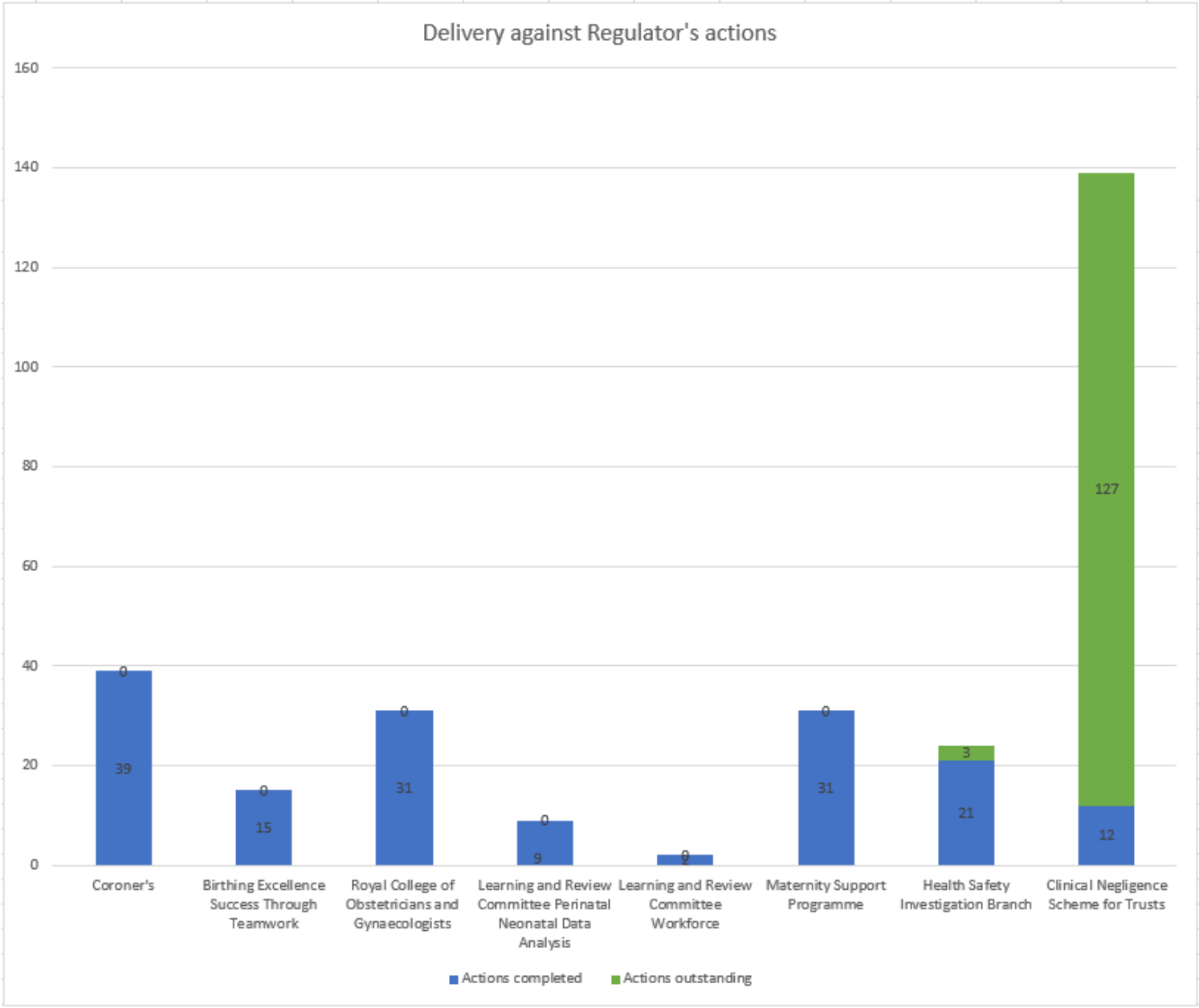
The Board of Directors is asked to:

- discuss and note the MIC Chair Report;
- **CONFIRM** that it feels sufficient assurance has been obtained in respect of the RCOG Report; and
- **AGREE** oversight of CNST actions move to the Quality Committee and are removed from the integrated plan.

Maternity Improvement Plan

- **Delivery against Regulator's actions**

Regulator	Actions completed	Actions for review	Total actions
Coroner's	39	0	39
Birthing Excellence Success Through Teamwork	15	0	15
Royal College of Obstetricians and Gynaecologists	31	0	31
Learning and Review Committee Perinatal Neonatal Data Analysis	9	0	9
Learning and Review Committee Workforce	2	0	2
Maternity Support Programme	31	0	31
Health Safety Investigation Branch	21	3	24
Clinical Negligence Scheme for Trusts	12	127	139
Maternity Improvement Plan Total Actions =			290



East Kent Hospitals University NHS Foundation Trust

REPORT TITLE:	**ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS (RCOG) RECOMMENDATIONS CLOSURE REPORT**
BOARD SPONSOR:	**MATERNITY IMPROVEMENT COMMITTEE (MIC) CHAIR**
PAPER AUTHOR:	**WOMEN'S HEALTH CARE GROUP MANAGEMENT TEAM**
PURPOSE:	**PROVIDE ASSURANCE TO THE MIC ON RCOG RECOMMENDATIONS**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

In March 2020, the Learning and Review Committee Working Groups were established in response to the regulatory recommendations and RCOG was one workstream within this. These groups were focussed on; review of the recommendations, agreeing actions which would fulfil the recommendations, and then monitoring implementation of those actions.

In June 2020, the Chief Medical Officer (CMO) undertook an analysis of the Trust's and the Women's and Children's Health Care Group's compliance to the 23 RCOG recommendations. This analysis, along with the RCOG recommendations and the work of the RCOG Learning and Review Committee Working Group, informed the RCOG actions within the Maternity Improvement Plan.

The Maternity Improvement Plan brings together the regulatory recommendations within a central repository, many of these actions are a retrospective 'look back' and so efforts have been focussed on collating and reviewing evidence in respect of this. However, since the formation of the Maternity Improvement Committee there has also been some significant developments such as increased consultant presence on both acute sites. Further progress on delivery of the Maternity Improvement Plan has meant compliance to all regulatory recommendations, including the RCOG actions, has positively developed since the CMO's report.

Between November 2020 and March 2021, the Maternity Evidence Review Meeting Group reviewed evidence in relation to the RCOG actions and these have now been agreed as fully met, with the exception of recommendation 5 which has been partially met (please see page 3 for progress against recommendation 5). The Maternity Improvement Plan RCOG Extract captures all RCOG recommendations and actions, when they were reviewed and agreed as met and the list of evidence which was presented against each.

This report revisits the CMO's report from June 2020 and captures what has changed. The CMO's report graded the RCOG recommendations under the following compliance scores; Met (Care Group Level), Not Met (Trust Level), Not Met (Care Group Level), Partially Met (Trust Level) and, Partially Met (Care Group Level); for ease of reference this report captures in brackets next to each recommendation the CMO's June 2020 grading. Please note, that the Maternity Evidence Review Meeting Group has reviewed the actions in the context of the Care Group, rather than at a Trust Level.

<u>RCOG Recommendations</u>

The intention of recommendation 1 is to ensure guidelines are kept up to date and are informed by best practice.

Recommendation 1. Clinical guidelines need to reflect current evidence-based best practice and national guidance. If a guideline is non-compliant with NICE guidance,

Trust policy with escalation to the Clinical Advisory Board should be followed. (CMO's June 2020 Grading: Not Met - Trust Level)

Governance posts have been strengthened to ensure there is ringfenced time for guideline development; this includes ensuring guidelines are both aligned to current best practice and that there is multi-disciplinary engagement within their development. The monthly Guideline Group and Maternity Governance Meetings ensure; a thorough ratification and approval process is followed; that guidelines are revised in a timely manner, and changes to practice are disseminated to the relevant teams.

The aim of recommendations 2 and 3 are to ensure a rigorous approach to guideline development so that ultimately policies are informed by best practice and are updated in a timely manner following revision to, or publication of new national guidance.

Recommendation 2. A system would be in place to ensure guideline review and revision occurs in a timely fashion when new national guidance is published. Important changes to fetal heart monitoring and assessment of fetal growth restriction, published in 2014 and 2013 respectively, have not been incorporated into the Trust's local guidelines with no apparent plans for revision.
(CMO's June 2020 Grading: Partially Met - Trust Level)

Recommendation 3. Multidisciplinary engagement should be encouraged in the writing of clinical guidelines. (CMO's June 2020 Grading: Partially Met - Trust Level)

Governance posts have been strengthened and this includes appointment to a Compliance Midwife who is responsible for undertaking a gap analysis following revision to or publication of new national guidance. The monthly Guideline Group and Maternity Governance Meetings are the mechanism for approval of new policies and the Compliance Midwife attends both of these forums. Agreed processes are in place to ensure practice is aligned to the governing policies and the Compliance Midwife's role is one example of how this is achieved. Auditing is a key part of the Compliance Midwife's post, and this includes scoping and implementing audit programmes which reflect issues identified by local and national guidelines. Actions arising from the audit are monitored by the Compliance Midwife and there is further oversight via the monthly Maternity Governance Meeting to ensure improvements identified are implemented.

The guideline development and approval process within the Care Group encourages multi-disciplinary engagement, and staff are allocated time to participate in guideline development. All Care Group guidelines are developed and revised via this process, including the Fetal Heart Monitoring and Assessment of Fetal Growth policies which are both in date. Physiological interpretation has been adopted within East Kent Maternity Services and this approach has also been approved by the CCG.

The intention of recommendation 4 is specifically around medical colleagues' participation within and contribution to guideline development.

Recommendation 4. There is a lack of medical (consultant, SAS doctors and trainees) engagement in guideline development. Obstetric guidelines are written predominantly by midwives.
(CMO's June 2020 Grading: Partially Met – Care Group Level)

Time has been allocated within job plans to foster and facilitate medical staff engagement within guideline development. A lead consultant has also been identified to oversee the Guideline Group. The Guideline 'Multiple Pregnancy' is an example of a policy that has recently been reviewed and revised by an Obstetric Registrar.

The intention of recommendation 5 is to identify and implement improvements to the diabetic pathway for pregnant women, and for continuous improvement to be fostered within urogynaecological procedures through ongoing monitoring of consultant's performance in relation to this.

Recommendation 5. The Trust should participate in the National Pregnancy in Diabetes Audit as the resulting benchmarking exercise would identify areas for improvement and ultimately improve quality of care. All urogynaecologists should enter their pre-, intra- and postoperative data relating to any incontinence and/or prolapse procedure into the BSUG national database. This data should form part of the consultant's personal development and appraisal.
(CMO's June 2020 Grading: Partially Met – Care Group Level)

The Trust continues to participate in the National Pregnancy in Diabetes audit however the number of women meeting the criteria for this audit are few and so opportunities identified from the findings are limited and often skewed due to the rounding approach utilised. In response to this, the Care Group also conduct a local audit on pregnancy in diabetes which has an increased scope and therefore includes review of more women. The guideline 'Diabetes in Pregnancy' was revised following a gap analysis against NICE guidance with further revisions being discussed currently, and Midwife Led Diabetic Clinics have been implemented.

The Maternity Improvement Committee agreed that the urogynaecological element of the above recommendation could be removed from the Maternity Improvement Plan and be monitored within the appropriate governance framework. Due to capacity issues caused by the pandemic, nearly all urogynaecological operating has been paused. As well, a new database is being explored nationally. There is a meeting scheduled in early April 2021 to further refine and strengthen the ongoing monitoring plan of the regulatory actions within the Maternity Improvement Plan; whilst the urogynaecology action has been removed from the Maternity Improvement Plan this action will be discussed at the meeting to identify next steps. The action has also been added to the Care Group Risk Register which ensures there is a monthly review.

Recommendation 6 is aimed at ensuring all incidents are reported and actions arising from the related investigations are implemented.

Recommendation 6. A system should be in place to ensure all incidents are reported and appropriately actioned. Compliance with this should be audited on a regular basis, with data taken into consideration with that collected on the maternity information system. (CMO's June 2020 Grading: Partially Met - Trust Level)

The Governance Team, on a daily basis, utilise a variety of sources to ensure all incidents are reported as well as undertake an assessment of incidents to check the severity captured is accurate and to allocate an appropriate investigator. If following review of an incident, there is learning to be taken then the case will be discussed by a multi-disciplinary team at the weekly Risk Meeting. Agreed learning points are then added to the

Change Register and monitored by the Compliance Midwife, with further oversight via the Maternity Governance Meeting to ensure their implementation. The strategy 'Women's Health – Governance and Risk Management' has been developed and further details the framework embedded within the Care Group to ensure all incidents are identified, reviewed and addressed.

The intention of recommendation 7 is to ensure effective performance management of medical staff, including consultants.

Recommendation 7. If practice issues and performance management of medical staff, including consultants, are identified as root causes and/ or contributory factors, these should be addressed in the timeline with the recommendations and action plans. (CMO's June 2020 Grading: Not Met - Trust Level)

The framework followed for serious incident investigations ensure a holistic assessment is undertaken, including practice issues where this might have been a concern.

Learning identified through all incident investigations is captured on the 'Change Register' following a multi-disciplinary review at the weekly Risk Meeting. The Change Register actions are monitored by the Compliance Midwife with further oversight via the monthly Maternity Governance Meeting to ensure these actions are implemented.

There are increased methods of escalation for all staff to raise concerns, and in particular there is a clear escalation route for concerns involving medical staff and consultants. In addition, enhanced support is in place for Clinical Leads on employee relation matters and a Clinical Leadership Development Programme is being rolled out this year.

The intention of recommendation 8 is to ensure that incidents are learnt from.

Recommendation 8. The Clinical Governance team should ensure that final reports are circulated to all staff. Evidence obtained from interviews suggests that shared learning from action plans depended on staff either attending a SI presentation at a perinatal morbidity/mortality meeting and/or accessing the Risky Business newsletter. (CMO's June 2020 Grading: Not Met - Care Group Level)

To demonstrate compliance with this recommendation, the CMO's report states that incidents should be grouped by theme and over time incidents within that theme should reduce.

Incident Reports are reviewed monthly at the Maternity Governance Meeting. The reports group incidents by theme and evidence has been sighted at the Maternity Evidence Review Meeting Group which demonstrates a 50% reduction in incidents categorised as 'Delay/Failure' between October and November 2020. Incident Report data from December 2020 to February 2021 show the percentage of incidents categorised as 'Delay/Failure' out of total incidents reported to be consistently lower (average 10% = 72 'Delay/Failure incidents out of 722 total incidents reported in this period) than the percentage reported in October 2020 (17% = 37 'Delay/Failure' incidents out of 218 total incidents reported). The Health Safety Investigation Branch also reported in October 2020 that previous themes were not reoccurring.

The intention of recommendation 9 is additional scrutiny of incidents, including monitoring the effectiveness of actions taken.

Recommendation 9. Supervisors of Midwives should undertake regular audits of their twice-daily phone calls to both units made to identify reported incidents. SoMs should be given appropriate time from their clinical duties to undertake supervisory investigations with support from the LSA in a timely manner. (CMO's June 2020 Grading: Not Met - Care Group Level)

The CMO's report suggested that the gap in compliance was in relation to the Perinatal Mortality Review Meetings not being attended by an external member. These meetings are now attended by an external member and the Maternity Evidence Review Meeting Group have reviewed evidence in relation to this.

The intention of recommendation 10 is to identify unreported incidents.

Recommendation 10. Cross -referencing of incidents against data entered electronically on the maternity information system should be undertaken by the clinical governance team. (CMO's June 2020 Grading: Not Met - Care Group Level)

The Governance Team, on a daily basis, utilise a variety of sources to ensure all incidents are reported as well as undertake an assessment of incidents to check the severity captured is accurate and to allocate an appropriate investigator.

Recommendation 11 is aimed at ensuring the review of serious incidents occur within a timely manner.

Recommendation 11. If the non-adherence to the 45 days' timescale for submission of RCA Reports to Kent and Medway Commissioning Support and other external agencies as appropriate is to be addressed, the Trust needs to ascertain at what point in the investigation the delays are occurring.
(CMO's June 2020 Grading: Partially Met - Trust Level)

Investigation paperwork now reflects the correct timeframe of 60 days for RCA reports. Timeframes within the Care Group's control are being met; Governance posts have been strengthened and this is facilitating adherence. At a Trust Level, an action plan is in place to improve adherence to reporting timeframes.

The purpose of recommendation 12 is to ensure accurate record keeping.

Recommendation 12. All medical staff should be reminded of their legal responsibility to legibly date and sign each entry along with a printed signature and their GMC registration number.
(CMO's June 2020 Grading: Partially Met – Care Group Level)

An audit on record keeping has been undertaken with a further audit scheduled for 2021/22 to support continuous improvement. Antenatal Care records are captured on the Maternity Information System and this automatically documents the date of entry and the professional who has input the information. Name stamps with the professional's job title and GMC number have been ordered for all medical staff at the Queen Elizabeth the Queen Mother Hospital (QEQMH) with a further order for the William Harvey Hospital (WHH) to be raised.

The intention of recommendation 13, copied below, is to have continued assurance that consultants are attending in accordance to their on-call responsibilities.

Recommendation 13. An Audit of compliance with the local guideline 'Consultant Obstetricians: Referral to and attendance on Labour Ward when on-call' may identify poor practice and improve care provision.
(CMO's June 2020 Grading: Not Met - Care Group Level)

Following the CMO's review in June 2020, there is now increased consultant presence on both acute sites (14 hours at the QEQMH and 24 hours at the WHH). A spot check of compliance to the policy was undertaken against 14 cases selected at random across both sites between July and November 2020 where consultant attendance may have been required and this demonstrated 100% compliance. In addition to this, a further audit is scheduled for 2021 and system development work is in the pipeline for this compliance check to be automated in the future.

Recommendations 14 and 15 were graded as 'Met (Care Group Level)' within the CMO's report and so this report does not revisit these recommendations. However, all RCOG actions, including those relating to recommendations 14 and 15, have been reviewed by the Maternity Evidence Review Meeting Group.

The intention of recommendation 16 is to understand if there is a correlation with consultant and trainee presence and incidents occurring, and for concerns identified to be addressed.

Recommendation 16. Compare the frequency of SUI's out of hours between consultants on call with Specialty and Associate Specialist (SAS) Doctors and consultants on-call with trainees. The Trust has addressed the poor ratings from the 2015 General Medical Council (GMC) National Training Survey by placing trainees at the QEQMH site with consultants committed to teaching and supervision. The assessors are concerned that doing this does not address the root cause. Furthermore, the QEQMH site remains vulnerable as consultants not committed to teaching and supervision are now on call with locum middle grade doctors with only 2 out of 4 SAS doctors are currently at work.
(CMO's June 2020 Grading: Not Met - Care Group Level)

Consultant presence has been increased at both the WHH and QEQMH, with 24-hour and 14-hour resident cover respectively. The Guideline 'Guidance for Obstetric Staffing' has been developed and this outlines the principles for the rotas; they foster a fair and equitable approach and are focussed upon safety of women and families.

The Maternity Evidence Review Meeting Group has reviewed evidence which demonstrates thorough investigation of incidents, including timing of incidents where this is applicable. As part of the incident investigation process, any learning identified is reflected within the Change Register which is monitored by the Compliance Midwife, with further oversight via the monthly Maternity Governance Meeting to ensure the actions are undertaken.

In addition, there are increased mechanisms available for Clinical Leads to access employee relations support, and this has been further strengthened through a Clinical Leadership Development Programme due to commence in 2021.

The intention of recommendation 17 is that where necessary concerns in relation to consultants are escalated to the Chief Medical Officer and these are addressed.

Recommendation 17. Failure to comply with the guidelines 'consultant duty of care' should prompt the Medical Director to instigate a formal investigation into conduct allegations in line with the Trust's procedure for dealing with conduct, capability and health issues for medical and dental staff. To-date, poor consultant behaviour regarding lack of accessibility and presence on the delivery suite has not been challenged by management. Plans are that consultant presence will be monitored on both sites. (CMO's June 2020 Grading: Not Met - Trust Level)

The policy 'Consultant Obstetricians referral to, and attendance on Labour Ward when on call' has been developed and implemented. All incidents, including those in relation to consultant attendance, are to be captured on the Datix system. The Maternity Training programme covers scenarios for escalation and staff are also reminded of when the consultant on call should be requested through other communication mechanisms such as 'Message of the Week'. Datixes raised in relation to consultant attendance are investigated by the most appropriate lead and there is a clear escalation process including to the Chief Medical Officer where this is deemed necessary. A spot check was undertaken between July and November 2020 across both sites on 14 random cases where consultant attendance may have been required and this demonstrated 100% compliance. A further consultant attendance audit is scheduled for 2021 and system development work is planned to enable this compliance check to be automated in the future.

The intention of recommendation 18 is for consultants identified as requiring additional support for their education and supervisory responsibilities to trainees to access this.

Recommendation 18. The RCOG e-learning Strat OG resources on " Communication Skills" and "improving Workplace Behaviour" should be accessed by all consultants and especially the ones identified as having problems with education and supervision of trainees. (CMO's June 2020 Grading: Not Met - Care Group Level)

Human Factors training is mandatory for all of the Maternity Team including consultants. In addition to this, a Civility Saves Lives Training session was recently held and this was attended by consultants. The purpose of the RCOG e-learning is therefore being met by the core Maternity Training Programme; however, the e-learning does continue to be suggested to consultants as additional learning and they can choose to complete this as part of their continued professional development which forms part of their appraisal.

Recommendation 19 is aimed at improving behaviours and communication between consultants.

Recommendation 19. Interpersonal, teamwork and communication courses may enhance communication and respect between consultants. Evidence obtained from interviews points to behavioural issues concerning relationships between consultants. (CMO's June 2020 Grading: Not Met - Trust Level)

Human Factors is intertwined within the core Maternity Training Programme; in addition to this a Civility Saves Lives session was recently held and this was attended by the Maternity Team, including consultants. The Senior Management Team meeting is attended by the Care Group HR Business Partner and the Clinical Leads and this acts as

a regular forum for staff to raise any concerns they might have. There is a healthy reporting culture within the Care Group and this is reflective of staff feeling able to speak up. The Trust Strategy 'We Care' further re-enforces acceptable behaviours.

The objective of recommendation 20 is to foster cross site working and a shared vision across the maternity units.

Recommendation 20. Consultants and midwives should aspire to work together between two sites that are part of one Trust. Joint working, enabling centralisation of subspecialty services and development of services, would ultimately strengthen both maternity units. (CMO's June 2020 Grading: Partially Met – Care Group Level)

A Cross-Site Strategy has been developed; this captures the increased opportunities such as the Daily Cross-Site Call that have been introduced and which facilitate collaborative working as 'one team' across the sites. Staff feedback in relation to cross-site working has been positive with comments on shared problem solving and developing cross-site relationships.

The intention of recommendations 21, 22 and 23 are to foster a culture whereby staff are supported and feel secure to raise concerns.

Recommendation 21. Address the current belief in the futility of raising concerns amongst staff by discussing the Trust's Raising Concerns (whistleblowing) Policy and Procedure at Specialty and Clinical Governance meetings, Senior Midwives meetings and Supervisors of Midwives Forum.
(CMO's June 2020 Grading: Partially Met - Trust Level)

Recommendation 22. Promote a culture of raising concerns without blame amongst staff by awareness and feedback events organised by the Executive Team across specialties. Raising Concerns (whistleblowing) Policy and Procedure so that staff who feel unable to raise concerns or fail to achieve a satisfactory outcome with their line manager are aware of whom to contact.
(CMO's June 2020 Grading: Partially Met - Trust Level)

Recommendation 23. Identify a named Executive Director in the Trust's Raising Concerns (whistleblowing) Policy and Procedure so that staff who feel unable to raise concerns or fail to achieve a satisfactory outcome with their line manager are aware of whom to contact. (CMO's June 2020 Grading: Partially Met - Trust Level)

There are multiple mechanisms for staff to raise their concerns, including via the Freedom to Speak Up Guardians. The Freedom to Speak Up Policy does identify a named Executive Director however requires further updating as there have been changes. Nonetheless, Freedom to Speak Up data demonstrates that staff do access this forum and the Maternity Evidence Review Meeting have been sighted on an anonymised reflection from an employee within the Care Group on their recent experience of having used this service.

Other forums and mechanisms also act as a 'safe place' for staff to voice their concerns including the Maternity Safety Champion Meeting and the 'Respect' campaign. The Maternity Safety Champion Meeting action plan further demonstrates staff are listened too and their concerns are acted upon.

East Kent Hospitals University NHS Foundation Trust

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risk to mothers and babies through not responding and delivering improvement against regulators recommendations Scale of action plan and risks to delivery at pace Reputational damage if not delivered at pace
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	CRR 77 – Women may receive sub-optimal quality of care and poor patient experience in our maternity services.
RESOURCE IMPLICATIONS:	The scale of work identified within the action plan will demand staff time to both deliver change and also to programme manage the work and report on progress and updates.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	
SUBSIDIARY IMPLICATIONS:	No

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Maternity Improvement Committee are requested to review and note the formal closure of the RCOG Recommendations.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**29 APRIL 2021**
REPORT TITLE:	**QUALITY COMMITTEE (QC) CHAIR REPORT**
BOARD SPONSOR:	**SARAH DUNNETT, CHAIR OF THE QUALITY COMMITTEE**
PAPER AUTHOR:	**GROUP COMPANY SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: QUALITY & SAFETY COMMITTEE TERMS OF REFERENCE**

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.

1. Quality Committee Terms of Reference (ToR)

The Committee agreed the Quality and Safety Committee ToR with the following points to be clarified ahead of the Board on Thursday:

1.1. Whether the elements of the Clinical Negligence Scheme for Trusts (CNST) that require sign-off by the Board can be delegated to the QC and if so, does the Board wish to delegate these. If so the ToRs will be updated to reflect this as will the Standing Financial Instructions;
1.2. Whilst the Care Groups will report to the Committee on their day to day safeguarding the Board will receive the annual reports directly;
1.3. The next step of the governance work will identify what needs to report directly to the Board and what will report through the Quality & Safety Committee. This should not impact on the Board approving the ToR.

The ToR are appended (appendix 1) for approval by the Board.

2. Integrated Performance Report – 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:

2.1. The pressure ulcer data is currently counting non hospital acquired instances and this is being addressed;
2.2. 12-month Hospital Standardised Mortality Ratio (HSMR) to December 2020 is 101.9. This is driven by a rise in December 2020 in month HSMR (134.5) which is significantly higher than expected and likely to be due to the pandemic second peak, similar to the pattern seen in April 2020. Focus is on identification of sepsis and respiratory failure as these are the admission diagnosis that contribute most overall;
2.3. The Infection Prevention and Control (IPC) metrics require review by the new Director of IPC (DIPC);
2.4. Inpatients saw an increase of 1.2% of highly likely to recommend with no change in day case. Emergency Departments and outpatients had a slight decrease of highly likely to recommend of 0.1% and 0.6% respectively. Maternity response

rate has decreased again by 0.7% Extremely likely to recommend has also decreased by 3.2 %;

2.5. Referral to Treatment (RTT) remains the outstanding area of concern as the organisations' performance has deteriorated to 61% in February and 59.3% in March 2021. All care groups reviewed their Patient Tracking Lists (PTLs) and assigned the patient to the relevant category and this was recorded on the PTL so that the trust had visibility of the priority of all patients on the waiting list. The Trust has the best validation record in Kent with 97% of all patients coded and validated. The Trust is actively engaged in the Kent system Planned Care Board with an aim to maximise the opportunity to work together where possible to reduce risk for patients waiting for surgery. Clinical Harm reviews for patients treated after their 52-week breach date are managed through Care Groups. The new Elective Orthopaedic centre will be opening in July 2021 and this will help to reduce the backlog;

2.6. Whilst Cancer performance continues to improve with 62-day compliance likely in May. In March there were 12 patients who had waited over 104 days for their treatment or potential diagnosis. 7 patients have been treated or removed as they did not have cancer. 5 patients have complex pathways which include Tertiary centre Multi-Disciplinary Meeting (MDM);

2.7. The Committee is concerned regarding the backlog of serious incidents and was supportive of the focus on clearing this but also retaining compliance with new Serious Incidents (SIs);

2.8. The risk to achieving the medically fit for discharge relates to further surges of Covid and is a share risk across the system. National work on criteria led discharges is underway;

2.9. Theatre utilisation: in terms of staffing levels there has been a historic issue but is not currently flagging as a concern;

2.10. The Committee is supportive of the focussed work on grade 3 and 4 pressure ulcers.

3. NICE / Clinical Audit and Effectiveness Committee

3.1. The Trust's audit outcomes have improved in the national stroke audit following the consolidation of the service onto one site at Kent and Canterbury Hospital;

3.2. The National Lung Cancer Audit for 2018 data showed the Trust to be a negative outlier for one metric, with 60% of patients seen by a Nurse Specialist vs. the national mean of 74% The service has appointed a further 3 specialist nurses since 2018 to ensure that the service meets the required national standards;

3.3. There is a risk in relation to improving assurance on the implementation of The National Institute for Health and Care Excellence (NICE) Guidance and work is underway to ensure a more robust process. The committee sought assurance on the timeline for review and implementation of the backlog of NICE guidance. The Lead is meeting with the Care Group leads to agree a timeline for this piece of work and will provide an update at the next meeting.

4. Patient Safety Committee

4.1. Assurance was sought around the do not attempt (DNA) cardiopulmonary resuscitation (CPR) process. The palliative care team has been expanded and they are actively supporting the Care Groups;

4.2. The Committee asked for assurance in relation to the Trust responding to alerts and ensuring that none are missed. It is hoped that a further update on this can be provided at the next meeting as the Chairs of the Committees are currently working on improving this;

4.3. The Committee noted and was supportive of the continuing work on the deteriorating patient. There remains a risk to the scope of work that can be undertaken across three sites due to resource. A business case will be revisited with Clinical Lead for We Care Deteriorating Patient workstream.

5. Infection Prevention and Control Committee

5.1. The Committee reviewed the IPC Board Assurance Framework and the falling incidence of Covid is supporting an improved picture;

5.2. C. difficile cases have exceeding the objective set by Public Health England with 119 cases seen against a year-end trajectory of 95, cases have increased in the final quarter of 2020/21 – possibly associated with wave 2 of Covid-19;

5.3. Covid has influenced infections more widely, such as reductions in instances of flu, and a question around whether the practises in the Trust or in the community were the main factor. It is likely a combination of the two although it was stated that the southern hemisphere flu season seen later onset;

5.4. Assurance was sought that on the IPC Board Assurance Framework (BAF) where there are no gaps showing this was indicative of processes being in place, robust and working and in addition there was continual review. It was confirmed that on-going review is required and any gaps in control added and mitigations highlighted.

6. Safer Staffing Review

6.1. The Committee is aware that there is a need to review and strengthen the existing process in relation to reporting safer staffing. The Committee is pleased to note the timeline to receiving a report that will ensure compliance, be understandable and robust;

6.2. In the interim the old-style report is provided; this draws on a wide range of strategies to support safer staffing;

6.3. A safer staffing policy is being drafted to support staff in this area;

6.4. It was highlighted that this did not include midwives and indeed some other areas and it was envisaged that once the safer staffing report was in place it can be expanded to include all staffing.

7. Still Births Report

7.1. The Committee received a presentation which showed that neo-natal death rate remains low;

7.2. Crude still birth rate is returning to expected levels after increases in November 2020 and January 2021;

7.3. Low levels of still births throughout 2020 until November 2020 led to a deep dive. The Care Group is implementing the resulting actions with pace and they will be auditable;

7.4. The Committee agreed that this would form part of business as usual but that the use of a regulatory tracker will provide more robust oversight.

8. Quality Risks

8.1. Given the work on the forward looking register the Committee could not take assurance on the current risk register in terms of its active management; but was supportive of the work on the forward-looking registers and looked forward to a fully revised register from May 2021.

9. Care Quality Commission Update

9.1. The Care Quality Commission (CQC) carried out 2 winter pressures inspections in March 2021. The final reports are expected to be published in early May 2021 and are expected to show areas of improvement;

9.2. The CQC also carried out an announced, focused IPC inspection at the William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQMH) sites on 2 March 2021. Immediate feedback from the visit was the final report has been published which highlights the significant improvements made;

9.3. The Chair has requested more details on the Children and Young people 2018 Inspection with a focus on the status of the actions, this will be provided at the May 2021 meeting;

9.4. The CQC Improvement Steering Group is well attended and the Care Groups are fully engaged to ensure compliance and improvement.

10. Section 31 Closure

10.1. As a result of a focussed unannounced inspection of infection prevention and control the Trust applied for the section 31 to be lifted and this was approved on 26 March 2021. Outstanding actions will be delivered through business as usual (BAU).

11. Quality Account 2020/21

11.1. The Committee is keen that resource is focussed on 2021/22 and therefore suggests that resource is sought to enable the narrative and data to be pulled together as swiftly as possible, noting that there is no requirement to submit by 30 June 2021.

OTHER REPORTS RECEIVED AND DISCUSSED

12. Patient Experience Committee.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to **APPROVE** the Quality and Safety Committee Terms of Reference and **NOTE** the report.

East Kent Hospitals University NHS Foundation Trust

QUALITY AND SAFETY COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors has established a committee of the Board known as the Quality and Safety Committee (the Committee). It is a Non-Executive committee and has no executive powers, other than those specifically delegated in these Terms of Reference. These Terms of Reference can only be amended with the approval of the Board of Directors.

2. PURPOSE

2.1. The Committee is responsible for seeking and obtaining assurance on all aspects of quality and safety of care across the Trust (including the statutory and mandatory requirements relating to quality and safety of care). If not assured, the Committee will oversee the appropriate actions for improvement or escalation of relevant issues to the Board for consideration.

2.2. The Committee will promote an open and transparent reporting and learning culture across the Trust to support quality, safety and clinical effectiveness.

3. OBJECTIVES

Quality and Safety Strategy and Performance

3.1. Oversee the development implementation and communication of a Quality and Safety Strategy with a clear focus on improvement, which draws on and benchmarks against ideas and best practice from external organisations.

3.2. Ensure that the Trust's Quality and Safety Strategy and performance are consistent with mandatory requirements and national guidance.

3.3. Oversee and seek assurance of an effective system for delivering a high-quality experience for all its patients and service users, including carers, with particular focus on involvement and engagement for the purposes of learning and making improvement.

3.4. Oversee the effectiveness of the clinical systems to ensure they maintain compliance with the Care Quality Commission's Fundamental Standards of quality and safety.

3.5. Review Reports from Care groups, Committees and Subject Matter Experts (SMEs) as follows:

- monthly - receive reports from care groups using the template as provided as Appendix 1 on trends in patient safety, experience, clinical effectiveness and outcomes
- monthly -receive reports by exception from reporting committees
- quarterly - review the Claims, Incidents and Complaints report to provide assurance to the Board on performance
- As required – undertake 'deep dives' into areas as appropriate

3.6. Review nursing and midwifery staff establishments and provide assurance to the Board that ward nursing and midwifery staff establishments provide an appropriate and safe staff level and skill mix to support the delivery of safe and effective patient care to patients.

3.7. Oversee an effective system for safety within the Trust, aligning with the National Patient Safety strategy reporting principles of:

- Openness and transparency
- Just culture
- Learning and continuous improvement

Supporting a particular focus on; patient safety, and including the quality impact assessments for financial improvement, staff safety and wider health and safety requirements.

Clinical Effectiveness and Outcomes

3.8 Oversee an effective system for monitoring clinical outcomes and clinical effectiveness; with particular focus on ensuring patients receive the best possible outcomes of care across the full range of Trust activities.

3.9 Obtain assurance from individual care groups that the Trust is compliant with guidance from NICE and other related bodies.

3.10 Obtaining assurance from learning from deaths.

3.11 Receive the outcomes of participation in and learning from the national clinical audit programme and provide assurance to the Board that clinical audit supports the care groups to provide safe and clinically effective patient care.

Governance

3.12 Monitor the progress against actions to mitigate the quality risks on the corporate risk register and provide assurance to the Board that adequate steps are taken to reduce the risks in line with the Board's risk appetite.

3.13 Review the controls and assurance against relevant quality risks on the Board Assurance Framework and provide assurance to the Board that risks to the annual objectives are being managed and facilitate the completion of the Annual Governance Statement at year end.

3.14 Consider external and internal assurance reports and monitor action plans in relation to clinical governance resulting from improvement reviews / notices from NHS Improvement, the Care Quality Commission, the Health and Safety Executive and other external assessors.

4. MEMBERSHIP AND ATTENDANCE

4.1 The membership of the Committee shall consist of:

- Non-Executive Director (Chair)
- Non-Executive Director
- Non-Executive Director
- Chief Nurse and Director of Patient Experience and Quality (Joint Executive Lead)
- Chief Medical Officer (joint Executive Lead)
- Chief Operating Officer

4.2 Required Attendees:

- Director of Infection Prevention and Control
- Director of Quality Governance
- Deputy Director of Risk, Governance and Patient Safety
- 2gether Support Solutions Managing Director
- Chief Pharmacist

4.3 Attendees:

- Kent and Canterbury Hospital Site Leadership Triumvirate
- Queen Elizabeth the Queen Mother Hospital Site Leadership Triumvirate
- William Harvey Hospital Site Leadership Triumvirate
- Cancer Care Group Triumvirate
- Children and Young People's Care Group Triumvirate

- Clinical Support Services Care Group Triumvirate
- General and Specialist Medicine Care Group Triumvirate
- Women's Health Care Group Triumvirate
- Surgery and Anaesthetics Care Group Triumvirate
- Surgery, Head, Neck, Dermatology and Breast Care Group Triumvirate
- Urgent and Emergency Care; Care Group Triumvirate

Quorum

4.4 Business will only be conducted if the meeting is quorate. The committee will be quorate with four members, including at least two Non-Executive Directors, and one Executive Director. If the Trust Chair is in attendance, this will count towards the quorum.

4.5 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Board of Directors meeting as an urgent item.

Attendance

4.6 The Chair and Lead Executives, or their nominated deputy, of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 80% of all meetings and be allowed to send a Deputy to one meeting per annum.

4.7 Care Group and Site Leadership Triumvirates: Invites will be extended to the triumvirates and at least one clinical representative from each is required at meetings.

Others Invited to Attend

4.8 The Committee will be open to the Chair, Chief Executive and Group Company Secretary to attend.

4.9 Other staff may be invited to attend meetings as considered appropriate by the Committee on an ad hoc basis.

Voting

4.10 When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the person presiding shall have a second or casting vote.

5. FREQUENCY

5.1 Meetings of the Committee shall generally be held monthly. The Chair may call additional meetings to ensure business is undertaken in a timely way.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

6.2 Reference should be made as appropriate, to the Standing Orders and Standing Financial Instructions of the Trust.

6.3 The Committee has decision making powers with regard to the approval of clinical procedural documents.

6.4 The committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the committee. However, Board Committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Trust Board (Standing Order 5.5 refers).

6.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7 SERVICING ARRANGEMENTS

7.1 A member of the Board Secretariat shall attend meetings and take minutes.

7.2 Agendas and papers shall be distributed in accordance with deadlines agreed with the Committee Chair.

7.3 Members will be encouraged to comment via correspondence between meetings as appropriate.

7.4 The Committee will maintain a rolling annual work plan that will inform its agendas and seek to ensure that all duties are covered over the annual cycle. The planning of the meetings is the responsibility of the Chair.

8. ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

8.2 Chair reports will be provided to the Board of Directors to include: committee activity by exception; decisions made under its own delegated authority; any recommendations for decision; and any issues of significant concern.

8.3 Approved minutes will be circulated to the Board of Directors. Requests for copies of the minutes by a member of public or member of staff outside of the Committee membership will be considered in line with the Freedom of Information Act 2000.

9 RELATIONSHIPS WITH OTHER COMMITTEES

9.1 The Committee will receive exception reports for scrutiny from the following meetings (minutes to be available to Committee members):

- Patient Safety Committee
- Patient Experience Committee
- NICE/Clinical Audit and Effectiveness Committee
- Infection Prevention and Control Committee
- Mortality Information Steering Group
- Highlight reports (as per Appendix X) from the Care Group Governance meetings

9.2 The Committee shall refer (and have referred to it) from the other Board Assurance Committees (the Integrated Audit Committee and the Finance and Performance Committee) matters considered by the Committee deemed relevant to their attention. The Committee, in turn, will consider matters referred to it by those two Assurance Committees.

9.3 The annual work plan of the Committee may be reviewed by the Integrated Audit Committee at any given time.

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10. MONITORING EFFECTIVENESS AND REVIEW

10.1 The Committee will provide an annual report to the Board outlining the activities it has undertaken throughout the year to be included in the Annual Report.

10.2 A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

10.3 The terms of reference will be reviewed and approved by the Board of Directors on an annual basis.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**29 APRIL 2021**
SUBJECT:	**REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) CHAIR**
BOARD SPONSOR:	**CHAIR OF THE IAGC**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The Integrated Audit and Governance Committee (IAGC) is the high-level committee with overarching responsibility for risk. The role of the IAGC is to scrutinise and review the Trust's systems of governance, risk management, and internal control. It reports to the Board of Directors (herein shown as the Board) on its work in support of the Annual Report, Quality Report, Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness of risk management arrangements, and the robustness of the self-assessment against Care Quality Commission (CQC) regulations.

The report seeks to answer the following questions in relation to risk, governance and assurance:

- What positive assurances were received?
- What concerns in relation to assurance were identified?
- Were any risks identified?
- What other reports were discussed?

MEETING HELD ON 20 APRIL 2021

Discussed the revised format of the Highest Mitigated Strategic and Corporate Risk Registers as presented against the Board Assurance Framework (BAF) format

1. The Committee noted the new draft format of the Highest Mitigated Strategic and Corporate Risk Registers as presented against the BAF format. The Committee requested future reports be provided in alignment with the 'We Care' quality improvement programme and the True North Strategic Objectives. Because of the work being done to change the format of these reports it was not possible to review progress and updates on mitigating actions and the Committee re-emphasised the importance of providing timely and up to date reports so that it can discharge its responsibility to scrutinise the robustness of the management of the Trust's risks.

Limited assurance was received in relation to:

2. The Committee received and discussed the Data Security and Protection Toolkit (DSPT) 2020/21 report noting the revised submission date of June 2021. It was noted the Trust was compliant with 115 of 116 evidence requirements and DSPT status, which meant 'Standards not met'. This was due to not achieving the required 95% compliance for staff annual mandatory information governance (IG) training, currently at 87% compared to the previous year of 89%. The Committee agreed an action that the Director of

Finance and Performance ensure letters were issued to staff who were non-compliant to prioritise the completion of this annual training required to be undertaken.

3. The Committee received and discussed a Freedom of Information (FOI) Act 2020/21 annual report. The Committee raised concern regarding the 51 breaches outside of the 20 working days target against the total 494 requests received, noting the number of 'late' responses had been higher than expected that mainly related to Covid based requests where information requested was often not held by the Trust in the form requested. It was noted the particularly difficult subject matters covered in the FOI requests during the previous year.

Other reports received and discussed:

4. The Committee received and discussed a report regarding the Clinical Audit Plan 2021/22 Annual Programme. The Committee noted a positive key area going forward focussing on outcomes, learning and the must do audits.

5. The Committee received and discussed a quarterly Freedom to Speak Up (FTSU) report. It was noted the need to identify a Board Champion as the current Non-Executive Director (IAGC Chair) incumbent's term of office ended mid-May 2021. There will also be consideration to review the current Board Committee reporting structure, as reports were presented to the IAGC and it was questioned whether it was more appropriate for these to be reported to one of the other Board Committees.

6. The Committee received and approved a Losses and Special Payments report to 31 March 2021.

7. The Committee received and discussed a Single Tender Waiver (STW) report.

8. The Committee received and discussed an Informing the Audit Risk Assessment 2020/21 report, considered and noted the management responses were consistent with their understanding of the Trust.

9. The Committee received and approved the External Audit Plan for 2020/21.

10. The Committee received and discussed the Internal Audit progress report and the draft Head of Internal Audit Opinion 2020/21. The Committee noted the finalised six internal audit reports as noted below, all of which issued with Reasonable Assurance;
    - Financial Systems;
    - Payroll;
    - Covid Lessons Learned;
    - Board Assurance Framework;
    - Remote Working arrangements;
    - Overseas Recruitment.

11. The Committee received and noted a progress report from RSM Risk Assurance Services LLP Local Counter Fraud Specialist (LCFS), the Trust's Local Counter Fraud provider. The Committee noted the activities undertaken in accordance with the LCFS workplan and also in respect of investigations, which included cases of potential abuse of enhanced payments/benefits in relation to Covid-19 pandemic support. The Committee received and approved the LCFS workplan for 2021/22.

12. The Committee received and noted a report from the Regulatory Compliance Committee (RCC) meeting held on 8 April 2021. This included an update regarding the position in respect of out of date policies, noting 33 of the 227 Trust policies (14.5%) on the

4policies system were past their review date. The main area of concern remained the 23 Infection Prevention and Control (IPC) policies past their review dates. The Committee noted the new Director of IPC will be looking at these to provide an outline plan to be taken forward for prompt resolution to update the policies within a realistic timeframe. The Committee raised concern regarding the findings of the annual Duty of Candour (DoD) audit report in relation to the poor 66% compliance that needed to be significantly improved as this is a statutory (legal) requirement of trusts. The Committee noted a Task and Finish Group will develop an improvement plan against the agreed revised target date to achieve compliance within three months.

13. The Committee received and noted a verbal Risk Management update report in relation to the review of the Trust's Risk Appetite and Risk Management Policy. These reviews will be undertaken following completion of the governance review as the outcome of which will feed into these reviews.

14. The Committee received and noted a verbal update report regarding the process and schedule for the production of the 2020/21 annual documentation in respect of the Annual Accounts, Annual Report, Annual Governance Statement, Review of Compliance against Foundation Trust (FT) Code of Governance, Statutory Declaration to NHS Improvement (NHSI) – Compliance with Provider Licence. It was noted the deadline for submission had been deferred to mid-June 2021. The Committee also noted the date for submission and uploading of the Quality Account/Report had been extended to 31 December 2021.

15. The Committee received and noted the 2021 annual work programme for IAGC.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and **APPROVE** the IAGC Chair report.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**29 APRIL 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 16 MARCH 2021

The Committee received and discussed the following reports:

1.1 Executive Appointments

- **Director of Quality Governance (DoQG)**
- **Chief Nursing Officer (CNO)**

The Committee received and noted an update report regarding appointing substantively to the DoQG and CNO Executive roles. This involved a vigorous interview process that included stakeholder sessions and good quality candidates were interviewed.

The Committee noted successful appointments had been made to both roles, with strong candidates recruited who will be joining the Trust and supporting it on its quality improvement journey. The Committee noted those appointed as below and progress to complete the appointment documentation and agree start dates:

- DoQG – Dr Tina Ivanov appointed, who has extensive experience in patient safety and patient experience, as well as clinical and managerial experience, and will bring a wealth of expertise in respect of improving quality governance. She has worked in large, complex, multi-site organisations and created strong links across partners in health care provision. She currently works at the London Ambulance Services as the Deputy Director of Education and Quality and will be commencing with the Trust on 10 May 2021;
- CNO – Sarah Shingler appointed, who is an experienced Nursing Director across commissioners and providers. She has previously held Board posts in clinical Commissioning Groups and is currently on the Board of a community services provider. Her experience demonstrates her ability to drive improvements to performance as a transformational leader from the front line enabling staff to succeed by engagement and compassionate leadership. She currently works for the Hounslow and Richmond Community Healthcare Trust as Director of Nursing and Non-Medical Professionals. She will be joining the Trust on 7 June 2021.

1.2 2gether Support Solutions (2gether) (Uplift Base Pay)

The Committee received, considered but did not support a proposal regarding an uplift base pay recommendation for a Director. The Committee acknowledged and noted the potential risk associated with this decision. However, actions have been considered to mitigate this risk.

The Committee received and approved amendments to the Executive and Non-Executive Directors Remuneration Policy for 2gether.

The Committee considered and noted a proposed EKHUFT Group approach to talent and succession planning.

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:	**29 APRIL 2021**
REPORT TITLE:	**CHARITABLE FUNDS COMMITTEE (CFC) CHAIR REPORT**
BOARD SPONSOR:	**SUNNY ADEUSI, CHAIR OF CHARITABLE FUNDS COMMITTEE**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The Charitable Funds Committee remit is to maintain a detailed overview of the Charity's assets and resources in relation to the achievement of the agreed Charity Strategy.

Chair's summary of key deliberations and decisions at the CFC meeting held on 30 March 2021 are:

1. Applications for Grants

The Committee received and considered two applications for grants as detailed below:

1.1 Paediatric Laparoscopic Equipment at Queen Elizabeth the Queen Mother Hospital (QEQMH):

1.1.1 The Committee received and approved an application for funding for £36k for Paediatric Laparoscopic Equipment. The Committee noted this new service and agreed an action for the Chief Medical Officer to ensure a process was put in place ensuring appropriately trained and skilled surgeons undertake these paediatric laparoscopic procedures. The Committee has made a referral to the Quality Committee for an on-going audit of this new service;

1.1.2 The Committee noted the key benefits of this equipment:

1.1.2.1 Provision of key hole surgery for children, reducing the number of patients having to have an open surgical procedure;

1.1.2.2 Less post-operative pain for the patient;

1.1.2.3 Reduction in recovery time that enables patients to return to normal activities and education faster than with open surgery;

1.1.2.4 Potential to reduce hospital length of stay;

1.1.2.5 Minimal scarring with key hole surgery compared with open surgery;

1.1.2.6 Improved patient experience and outcomes.

1.2 Hamilton MRI T1 Ventilator – Intensive Therapy Unit (ITU) at Kent & Canterbury Hospital (K&CH):

1.2.1 The Committee received and approved an application for funding for £26k for an MRI compatible ventilator, enabling ITU patients to receive an MRI scan without having to be transferred to either QEQMH or William Harvey Hospital (WHH) to be scanned;

1.2.2 The Committee noted the key benefits of this equipment:

1.2.2.1 Enable on-site scanning at K&CH of ventilated patients;

1.2.2.2 Reduce risks for patients having to be transported to another hospital site;
1.2.2.3 Prevent delays to patient being scanned and reduce stress for both patients and relatives;
1.2.2.4 Improved diagnosis and patient care pathway;
1.2.2.5 Ensure equipment provision consistency across all hospital sites.

2. Charity – Raising our game

2.1 The Committee received and discussed a presentation providing an update on fundraising activities. The Committee commended the team on their presentation that provided a visual update regarding fundraising, income, expenditure, as well as examples of key funding that had been granted in respect of Sir Captain Tom money. The Committee noted continued community support and fundraising for the East Kent Hospitals Charity (EKHC) and an update on proposed fundraising events during 2021. The Charity team continues to prioritise relationships around working to develop and maintain corporate relationships with high profile local organisations. The presentation included a project plan, strategic aim with a focussed clear vision and framework for the next six months to two years to increase charitable funding, by increasing sustainable donations and making charitable funding less restrictive. The Committee recognised there are many uncertainties for fundraising in the coming months and years, recognising this may impact on future spending being more conservative and moderate.

3. Finance Report

3.1 The Committee discussed and noted a report on the current financial position, income and expenditure of the EKHC. This included the following key elements (as at 28 February 2021):
3.1.1 Charity fund balances of £3.0m adjusted for commitments £2.1m;
3.1.2 Cash position of £0.5m;
3.1.3 Investments (portfolio) of £2.4m;
3.1.4 Income for the period 1 April 2020 to 28 February 2021 of £1.2m;
3.1.5 Gains on Investments 1 April 2020 – 28 February 2021 £0.3m
3.1.6 Expenditure for the period 1 April 2020 to 28 February 2021 of £1.1m of which:
3.1.6.1 Grants to Trust 1 April 2020 to 28 February 2021 amounted to £0.9m with a further £0.9m committed.
3.1.7 The Committee approved the Charity plan for 2021/22, an indicative plan that will be reviewed during the year and adjustments made in line with post-Covid funding income.

4. Donor Guidance - Fundraising Update

4.1 The Committee received and discussed a written report setting out guidelines around donor giving and how the Charity acknowledges and responds to donations (large and small). As well as an update on current and forthcoming Charity related fundraising events. The Committee also received an update regarding the Devereux Trust, the property the Charity holds a share in, with regards to its landlord responsibilities.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The Charity has to remain financially stable and cannot over commit to projects that could lead to an overreach of funding capacity.

East Kent Hospitals University NHS Foundation Trust

	The Committee oversees the financial position and activities to ensure the Charity achieves its strategies and objectives.
LINKS TO STRATEGIC OBJECTIVES:	The broad objectives of the Charity link to all the strategic objectives of the Trust. **We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	No
RESOURCE IMPLICATIONS:	Not applicable
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 **APPROVE** the Charitable Funds Committee Chair report.